

2011

ASSESSMENT OF SERVICES PROVIDED TO VICTIMS OF GENDER BASED VIOLENCE BY STATE AND NON-STATE AGENCIES IN PILOT AREAS



The Assessment of Services Provided to Victims of Gender Based Violence (GBV) by State and Non-state Agencies in Pilot Areas

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The Assessment of Services Provided to Victims of Gender Based Violence (GBV) by State and Non-state Agencies in the Pilot Areas

Executive Summary

The Assessment of Services Provided to Victims of Gender Based Violence (GBV)¹ by State and Non-state Agencies in the Pilot Areas was commissioned by the United Nations Population Fund (UNFPA) in Afghanistan as a part of the Gender Component of the 2010 - 2013 Country Program Action Plan of the Government of Afghanistan and UNFPA. The Assessment is a part of expert support provided by UNFPA to the Ministry of Public Health and the Ministry of Women's Affairs.

The goal of the Assessment was to examine state and non-state agencies providing services for GBV victims on provincial, district and community levels in three pilot areas of Afghanistan (Bamyan and Nangarhar provinces and Kabul city).

Data collection for the Assessment was carried out in August - September of 2011 in the country's capital and locations in the Bamyan and Nangarhar provinces. Semi-structured individual and group interviews, observation during field visits and the analysis of written sources provided material for the Assessment. The data was collected from both governmental and non-governmental actors working in the area of GBV response: healthcare facilities of various levels, police and judiciary, provincial/regional departments of the Ministry of Women's Affairs, Ministry of Public Health, and regional branches of the Afghanistan Independent Human Rights Commission, community-based structures, women's rights organizations, defense lawyers and shelter staff. For every state and non-state agency examined in the course of the Assessment, the information was analyzed based on a framework involving seven basic components.

In all locations examined by the Assessment *the majority of GBV victims mentioned in the interviews were women and girls*. The Assessment found that *in all locations women seeking assistance from state and non-state agencies engaged in GBV response encountered economic, social, cultural and organizational barriers*. GBV victims faced cultural norms that proscribed the disclosure of GBV outside of family circle and sometimes

¹ In the Assessment Report the terms "gender-based violence" (GBV) and "violence against women" (VAW) were used interchangeably. It is important to note that GBV also includes violence perpetrated against men and boys, however the examples of GBV brought up by the respondents in the course of Assessment almost always referred to violence against women and girls.

informed negative attitude of service providers to women seeking assistance and protection from gender based abuse. Families' control over women's health stopped many women in rural areas from accessing Basic or Comprehensive Health Centers. Many female residents in rural and urban areas did not have resources, freedom to travel and time necessary for visiting several agencies and navigating bureaucratic system in order to find assistance and protection from gender based abusive behavior.

The Assessment found that:

On the level of organizational structure most service providers did not have units responsible for addressing special needs of GBV victims. The agencies did not develop inter-departmental programs or projects custom-made to strengthen the involvement in GBV response.

On the level of capacity the quality and reach of services provided by state and state agencies to GBV victims suffered from the shortage of trained female professionals and lack of specialized knowledge and skills among key staff members. Interviews conducted by the Assessment team with healthcare providers, police officers and Prosecutor's office revealed that the dearth of female professionals had a negative effect on the operations of public agencies involved in GBV response and often stopped women from using these public services. Most healthcare facilities did not have separate facilities for examination and interviewing of GBV victims.

On the level of access to services majority of actors working in the area of GBV response did not promote the services among target population groups. The interviews conducted in state and non-state agencies revealed that service providers placed the responsibility for starting the interaction solely on the beneficiaries (victims of GBV or their families). The majority of agencies also did not make any arrangements to provide GBV victims with fast and easy access to relevant staff members or facilities.

On the level of processing of GBV cases all agencies examined by the Assessment suffered from the lack of relevant policies, Standard Operating Procedures, protocols and ethical and safety guidelines regulating the treatment of GBV victims. Communication between the agencies regarding GBV cases was affected by numerous gaps and inconsistencies.

The Assessment found that healthcare facilities in rural and urban areas were often the only chance for GBV victims to seek assistance and protection outside of family circle. However, the ability of primary level healthcare facilities to serve as an entry point for GBV victims was seriously undermined by the healthcare staff's vulnerability to pressures from local communities and family members of GBV victims. The staff members in secondary and tertiary level healthcare facilities were less affected by societal pressures compared to the healthcare providers in primary facilities. The healthcare staff in Kabul seemed to be most open to identifying GBV and helping the victims. However all across urban and rural facilities the lack of necessary skills and knowledge among healthcare staff presented a serious obstacle for delivery of services to patients suffering from GBV.

In all locations healthcare facilities, MOWA offices and AIHRC offices served as entry points for the violence victims. Police departments served as entry points in some locations.

One of the important findings produced by the Assessment related to *the common use of "reconciliation approach" in treatment of GBV cases* by the police officers, MOWA officials, the staff of Prosecutor's Offices and courts. The Assessment revealed that the parties involved in GBV related incident(s) were offered the opportunity to reconcile and not proceed with official investigation. The respondents explained these attempts to reconcile the parties by the desire to protect the parties involved in the case from engaging in lengthy and costly court proceedings and prevent the dissolution of families. The Assessment data suggested that this practice routinely generated the situation where state institutions responsible for the protection of victims or impartial investigation of crimes assumed a mediatory and reconciliatory function. Reconciliation of victim and perpetrator, regardless of its outcomes or the good intentions of the mediating body, generates and secures the impunity of violence perpetrators. The Assessment also revealed that majority of agencies using "reconciliation approach" did not routinely monitor "reconciled" cases. Thus, the mediating body did not carry any responsibility for monitoring the adherence of the parties to the promises made in the course of "reconciliation".

The Assessment found that some prosecutors and judges had *concerns and questions regarding specific provisions of the EVAW Law* and believed that its punitive measures may actually push GBV victim towards concealing the crime in cases involving family violence.

The prosecutors and judges in the locations examined by the Assessment stressed the need for training on the implementation of EVAW Law.

With regard to referral of GBV cases the Assessment findings demonstrated that state and non-state agencies used various procedures for referral of GBV victims. However, the referral networks in Bamyan, Nangarhar and Kabul suffered from a number of problems sometimes presenting a circuitous and lengthy route for GBV victims seeking protection, assistance and justice.

The Assessment found that, *healthcare facilities in all examined areas* had a potential to play leading role in referral system, however currently healthcare facilities *present an impasse in the referral and reporting network* that connected agencies working in the field of GBV response. The reporting of GBV in healthcare facilities was not required by any rules or regulations and neither was the assistance to the GBV victims in the form of information sharing or referrals.

The Assessment found that in Afghanistan the security of healthcare providers had a serious impact on the health sector's involvement in GBV response. The proximity (both physical and social) to the community made the healthcare staff in primary healthcare facilities very reluctant to identify or assist patients suffering from GBV. The healthcare providers in these settings are particularly vulnerable to the threats and pressure from patients' families and local communities. In Afghanistan the risks for the security of healthcare providers engaged in GBV response present an important challenge for building efficient GBV response system. The mechanisms reducing these risks and strengthening the safety of the healthcare providers should be built into the system of GBV response. The analysis of the data collected by the Assessment suggested that coordinated multi-sectoral system of GBV response has a potential of addressing the security problem and increasing the protection of all parties engaged in assisting GBV victims.

The Assessment revealed that *engaging communities in cooperation or even productive dialogue presented one of the main challenges for state and non-state agencies* involved in GBV response. Differences in approach to GBV by community dispute resolution mechanisms and state agencies affect relations between the power holders within communities and the state working in the field of GBV response. Community-based dispute resolution mechanisms (CDRMs) are geared toward maintaining the peace and social

cohesion within communities. However, these important factors are often directly linked to the preservation of the existing power balance within communities, which is often done at the expense of disempowered groups. Thus, on many occasions the resolutions provided by CDRMs do not give priority to the security and well-being of GBV victims and do not serve the goal of maintaining the rule of law in relation to GBV. The differences between CDRMs and state agencies (or local NGOs) in addressing gender-based violence should be bridged through engaging diverse community based structures (CDRMs, women's shuras, teacher's shuras, health shuras) in advocacy and educational campaigns revealing the roots and consequences of GBV for individuals, families and communities.

On the level of coordination the Assessment found that respondents in all locations identified weak coordination between agencies delivering services to GBV victims as one of the main obstacles in their daily operations. All service providers expressed frustration over delayed, incomplete and inaccurate communication on GBV cases. The dissatisfaction with outcomes of medical examination provided by healthcare facilities was among the most common problems identified by the Assessment.

The findings demonstrated that the top down coordination effort, albeit successful in addressing GBV cases on an ad hoc basis, was not efficient in bringing change to the routine operations of the agencies. The Assessment revealed that coordination and information exchange are not incorporated in the routine operations of participating agencies. Subsequently the issue of coordination depends solely on the commitment of key decision makers in specific agencies. The transfer of responsibilities among officials responsible for participation in the inter-agency commission or change in priorities of individuals in decision making positions can immediately affect the agency's involvement in coordinating body. Thus, the main problem lies in the approach to the coordination rather than the commitment of the participating agencies. *The steps securing coordination and communication should be introduced on an institutional level and should affect the rules and regulations governing the daily practices of the relevant agencies.*

The Assessment presented detailed recommendations addressing the needs and gaps in service provision identified through the examination of services provided to GBV victims by key agencies in the pilot areas.

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INTRODUCTION

The Assessment of Services Provided to Victims of Gender Based Violence (GBV)² by State and Non-state Agencies in the Pilot Areas was commissioned by the United Nations Population Fund in Afghanistan as a part of the Gender Component of the 2010 - 2013 Country Program Action Plan of the Government of Afghanistan and UNFPA. The Assessment is a part of expert support provided by UNFPA to the Ministry of Public Health and the Ministry of Women's Affairs.

The goal of the Assessment was to examine state and non-state agencies providing services for GBV victims on provincial, district and community levels in three pilot areas of Afghanistan (Bamyan and Nangarhar provinces and Kabul city).

The Assessment set forth the following objectives:

- to identify key actors providing services for GBV victims.
- to identify existing entry points for GBV response;
- to examine gaps in coordination among main service providers;
- to examine existing policies and procedures that regulate GBV response on all levels;
- to assess the existing information management system on GBV cases used by service providers;
- to identify main needs and challenges of the agencies providing services for GBV victims.

Data collection for the Assessment was carried out in August - September of 2011 in the country's capital and locations in the Bamyan and Nangarhar provinces.

² In the Assessment Report the terms "gender-based violence" (GBV) and "violence against women" (VAW) were used interchangeably. It is important to note that GBV also includes violence perpetrated against men and boys, however the examples of GBV brought up by the respondents in the course of Assessment almost always referred to violence against women and girls.

Chapter 1: Methodology, structure and country background.

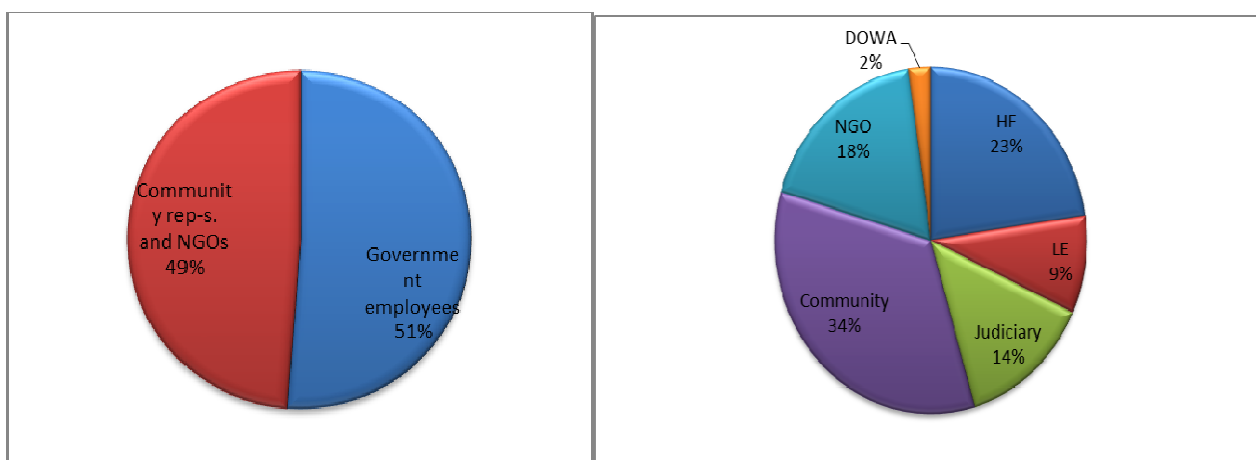
1.1 Methodology

The choice of sites for data collection reflected the general methodological approach of the Assessment: to examine GBV response in urban and rural, central and remote settings. The level of security risk had some impact on the selection of locations. While the security situation in Bamyan allowed the Assessment team to visit both, urban (Bamyan city) and remote rural areas (villages in Yakawlang district), security threats in Nangarhar limited the scope of data collection to Jalalabad city and the rural area just outside of it. Facilities located in provincial centers provide services to people all across the provinces or sometimes regions. Interviews conducted in the provincial and regional level facilities generated extensive information on the situation in urban and rural areas.

Semi-structured individual and group interviews, observation during field visits and the analysis of written sources provided material for the Assessment. Data was collected from both governmental and non-governmental actors working in the area of GBV response: healthcare facilities of various levels, police, judiciary, provincial/regional departments of the Ministry of Women's Affairs, Ministry of Public Health, regional branches of the Afghanistan Independent Human Rights Commission, community-based structures, women's rights organizations, defense lawyers and shelter staff. Every attempt was made to ensure that the categories of agencies/organizations selected for data collection were similar in all three general sites (Bamyan, Nangarhar and Kabul).

The Assessment team conducted 83 interviews (mostly individual, some group interviews), with 109 respondents (45 women and 65 men) representing 55 agencies/organizations and working on provincial, district and community levels. Analyzing the capacity of local health facilities to provide services for GBV victims constituted one of the Assessment's priorities (23 percent of all respondents represented health facilities of various levels).

The charts below demonstrate the distribution of interviews among the governmental and non-governmental actors and also among the actors representing all the key areas engaged in GBV response.



The Assessment Report presents the findings along several axes:

- analogous institutions in three general sites;
- urban (Kabul, Jalalabad, Bamyán city) and rural (rural areas of Bamyán, and Nangarhar) areas;
- the lower security risk (Bamyán) and higher security risk (Nangarhar, Kabul) areas;
- the capital (Kabul) and the regions (Bamyán province, Nangarhar province);
- religious and ethnic minority populated area (Hazara, Shia of predominantly Ja'fari *mazhab* in Bamyán) and ethnic and religious majority populated area (Pashtuns, Sunni of Hanafi *mazhab* in Jalalabad).

The questionnaire for the semi-structured interviews was developed by Dr. Vazirova with contributions from Dr. Hassanzai. The questionnaire consisted of five sections with 5-10 open-ended questions in each section. (For a copy of the questionnaire please see Annex I). The main topics explored by the questionnaire were:

- structure and functions of organization or agency (or a relevant department within the organization/agency)

- mandate in relation to GBV response
- policies and procedures regulating GBV response
- practical experience with regard to GBV response
- capacity of the personnel to deliver relevant GBV response
- capacity for being an “entry point” for GBV victims
- referral of GBV cases
- coordination with other agencies/organizations working in the area of GBV
- Information Management System (IMS) for GBV cases
- Needs and challenges in the delivery of services
- Good practices in organization of GBV response

The Assessment team relied on a set of strategies for interviewing key actors engaged in GBV response in Afghanistan and analyzing the data collected by the fact-finding mission (for the copy of the Strategies, please, see Annex II). The main objective in the use of strategies was to ensure the cultural sensitivity of the examination, appreciate the complexity of analyzed socio-cultural context and capture the variety of factors informing the organization of GBV response in given locations. The strategies were formulated in compliance with the framework of human rights and gender equality³.

1.2 Structure of the Assessment Report

The Assessment findings are presented in the current report in three sections. Each section covers the analysis of data collected in one of three general assessment sites (Bamyan, Nangarhar and Kabul). Each section is divided into five sub-sections corresponding to the main sectors providing services to the victims of gender based violence: healthcare sector, community based structures, law enforcement, judiciary, lead ministry and non-governmental organizations. The sub-sections feature the information for each agency

³ Due to security and confidentiality concerns the names of respondents are not indicated in the Report.

examined in the course of data collection missions. For example, the sub-section for the healthcare sector in Bamyan would present information on specific healthcare facilities in rural and urban areas of the Bamyan province. For each sector, the Assessment identified the list of needs and challenges preventing successful service delivery and efficient coordination with other sectors. Each sub-section is followed by the discussion of needs and challenges faced by a respective sector.

Figure 1. Analysis framework for individual agencies: seven components.



For every state and non-state agency examined in the course of the Assessment, the information was analyzed based on a framework involving seven basic components (Figure1).

Each component presents findings on a specific aspect of agency's involvement in GBV response. In the current report, the presentation of the findings for individual agencies

overall complies with this framework. However, on several occasions additional components were included to address the issues presenting challenges for specific agencies. Conclusions and Recommendations are presented in the last section of the Assessment report.

1.3 Country background

All throughout the 19-20th centuries Afghanistan's experience of modernity was closely intertwined with the struggles of major world powers over regional domination. The modern Afghan nation-state developed amid wars, foreign invasions and internal conflicts. The last decades once again brought Afghanistan to the forefront of the international political agenda. The country's transition to peace and democracy after years of civil war and brutal reign of Taliban regime presented the society with numerous challenges.

For many, the introduction of social changes necessary for building a strong modern state in Afghanistan had to be balanced with an overarching concern for the preservation of national and religious identities. For almost a century, attempts to bring about social change in Afghanistan have been championed by central governments imposing varying versions of modernization through a top-down approach. These efforts were consistently resisted by a wide range of social groups that regarded social reforms as the encroachment of centralized power on traditional values and way of life. Women's rights along with secular education and the primacy of state law over local customs belonged to the most controversial issues in the agenda of social change⁴. The attempts at introducing revolutionary social changes in the position of women enforced by the state frequently resulted in violent backlashes⁵.

In present day Afghanistan, the issue of women's rights occupies an important position in the discourse of the international aid community, as well as in the government's vision of national developmental priorities. Women in Afghanistan experience high maternal mortality rate. According to Afghanistan Mortality Survey 2010 maternal mortality rate in the country

⁴ Thomas Barfield, *Afghanistan. A Cultural and Political History*, Princeton University Press, 2010, pp. 339-340.

⁵ Lina Abirafeh, *Gendered and International Aid in Afghanistan. The politics and Effects of Intervention*, McFarland&Company, Inc., Publishers Jefferson, North Carolina and London, 2009, p. 15.

was 327 per 100,000 births in 7 years preceding 2010⁶. The average female life expectancy in Afghanistan is 61.5-64.2 years (61.7-63.6 years for men)⁷. Pregnancy and childbirth are among the leading causes of death among women of reproductive age. 76 percent of women in the country have no education⁸. According to the 2008 study of 4,700 households in 16 provinces 87.2 percent of women, experienced at least one form of physical, sexual or psychological violence or forced marriage. The majority of respondents reporting exposure to violence (62.0 percent), experienced it in multiple forms. Overall, 17.2 percent of women reported sexual violence, while 11.2 percent related experiencing rape. 52.4 percent of respondents reported that they were subjected to physical violence. The majority of women were subjected to violence by family members, with husband and mother-in-law most often mentioned as perpetrators⁹.

The issue of service provision to victims of gender based violence is directly linked to the way state and various social groups imagine and regulate “violence”. In Afghanistan’s recent history the discussion of violence against women has become one of the central topics in politically charged public deliberations on nation building, women’s rights, preservation of cultural authenticity in the face of a strong foreign presence and the obligations of the state towards its citizens.

In this context the provision of services to the victims of gender based violence (especially, family violence) presents one of the most serious challenges for the Afghan state. Every intervention in the area of GBV response brings state actors very close to the realm of private life. Service provision to GBV victims provides legitimacy for the state’s interference into the family affairs, a sphere that in the context of “the general erosion of the `social

⁶ Afghan Public Health Institute, Ministry of Public Health (APHI/MoPH) [Afghanistan], Central Statistics Organization (CSO) [Afghanistan], ICF Macro, Indian Institute of Health Management Research (IIHMR) [India] and World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) [Egypt]. 2011. Afghanistan Mortality Survey 2010. Calverton, Maryland, USA: APHI/MoPH, CSO, ICF Macro, IIHMR and WHO/EMRO, p.16.

⁷ Afghan Public Health Institute, Ministry of Public Health (APHI/MoPH) [Afghanistan], Central Statistics Organization (CSO) [Afghanistan], ICF Macro, Indian Institute of Health Management Research (IIHMR) [India] and World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) [Egypt]. 2011. Afghanistan Mortality Survey 2010. Calverton, Maryland, USA: APHI/MoPH, CSO, ICF Macro, IIHMR and WHO/EMRO, p.16.

⁸ Afghan Public Health Institute, Ministry of Public Health (APHI/MoPH) [Afghanistan], Central Statistics Organization (CSO) [Afghanistan], ICF Macro, Indian Institute of Health Management Research (IIHMR) [India] and World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) [Egypt]. 2011. Afghanistan Mortality Survey 2010. Calverton, Maryland, USA: APHI/MoPH, CSO, ICF Macro, IIHMR and WHO/EMRO, p 9.

⁹ All data on violence against women was obtained from Living with Violence: A National Report on Domestic Abuse in Afghanistan, Global Rights, 2008.

capital' of trust beyond the circles of family and close kinsmen¹⁰ is perceived by many in Afghanistan as a last bastion of cultural and moral values.

Thus, despite its seemingly practical nature the problem of service provision to GBV victims reflects the complex developments in relations between the state and its citizens, centralized power and community based authority, formal and informal justice mechanisms, groups that connect modernization and nation building to the advancement of women's rights and those who consider changes in gender roles detrimental for the preservation of national and religious identity. The analysis of services provided by the state and non-state actors to individuals suffering from GBV in Afghanistan should take into consideration the complex tapestry of interests, sensitivities, grievances and expectations invoked by the notion of external involvement in the situations of violence against women.

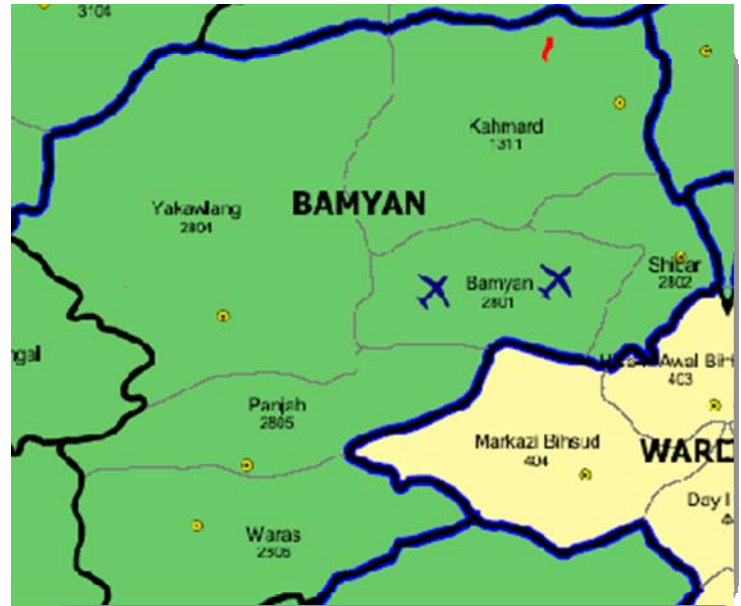
The task of building coordinated and comprehensive response to GBV in Afghanistan carries specific importance for the project of nation-building. The ability of the state to deliver assistance, justice and protection to women and girls across the country will serve to build public trust in state institutions and strengthen peoples' reliance on public services. Well-organized and comprehensive service delivery to victims of GBV will also mark a crucial contribution by the state and non-state actors to the protection of human rights and the establishment of the rule of law in Afghanistan.

¹⁰ Shahrani, M. Nazif. "Resisting the Taliban and Talibanism in Afghanistan." *Perceptions: Journal of International Affairs*. Volume V, number 4. December, 2000, - February, 2001. 121-140, p.127.

Chapter 2: BAMYAN PROVINCE.

Provincial profile

Located in the dry, mountainous areas in the highlands of Afghanistan, the province of Bamyan stretches across the area of 17414 km². The population of the province (411700 people¹¹) mostly resides in rural areas. The average household in Bamyan consists of 7 people. The population has equal number of men and women. Among the ethnic groups residing in Bamyan, Hazara constitute a majority. Other ethnic groups include Pushtuns, Tadjiks,



Map of Bamyan.¹

Tatars and Kuchi¹². Hazara are mostly Shia of Jafari *mazhab* – a religious minority in the otherwise Sunni Afghanistan. The majority of people in Bamyan work in the agricultural sector, with yearlong activities closely tied to the agricultural cycle. 86 percent of all households in the province derive their income from agricultural labor. Only 13 percent of all villages in the province produce industrial commodities, such as cotton, sugar, sesame, tobacco, olives and sharsham. Small industrial production, trade and services exist on a very small scale. The economic development in the province suffers from the severely underdeveloped infrastructure. The poor state of the roads (only 21 percent of all roads can provide car traffic year round) makes communication between various rural settlements and the provincial center very difficult. Communication with remote areas is limited especially in the winter season, due to severe weather conditions. On average, only 8 percent of all households in the province have access to safe and clean drinking water, only 6 percent use electricity. Public electricity is not provided.

¹¹ Statistical year book, 2010-2011, [http://cso.gov.af/en/page/4725\(last](http://cso.gov.af/en/page/4725(last) accessed on 11/28/2011)

¹² Up to 2255 people from nomadic Kuchi groups move to Bamyan pastures in summer.

Overall literacy rate in the province is 29 percent. The literacy rate among female population (12 percent) is considerably lower compared to male population (41percent)¹³. At the same time the data provided by the Central Statistics Organization for 2010-2011 shows some promising trends: in 2010-2011 girls constituted 42% of all students in public schools. This indicator has grown since 2007-08 when the share of girls in public schools totaled 37 percent¹⁴.

The province has modest healthcare infrastructure: 23 Basic Health Centers, 10 Comprehensive Health Centers and 4 hospitals (239 beds)¹⁵. The number of medical personnel employed by the Ministry of Public Health totals 349 people¹⁶.

During last ten years Bamyan remained among the safest areas of Afghanistan. In the midst of deteriorating security environment across the country the situation in Bamyan stayed relatively stable. This stability was largely based on strong anti-Taliban sentiments of local population and wide support rendered by provincial residents to the central government and allied forces. However in 2011 the insurgent groups conducted attacks on both national security and NATO forces¹⁷. These recent developments suggest that Bamyan province is affected by general trend towards growing security risk persisting across the country.

¹³ Bamyan provincial profile,

¹⁴ Statistical Year book, 2010-2011, Table 4-19: Number of Students in Government General Education Schools 2009-10, <http://cso.gov.af/en/page/4725>(last accessed on 11/28/2011)

¹⁵ Healthcare Management Information System 2010

¹⁶ Statistical Year book, 2010-2011, Table 4-19: Number of Students in Government General Education Schools 2009-10, <http://cso.gov.af/en/page/4725>(last accessed on 11/28/2011)

¹⁷ Bamyan governor warns over fragile state of security, September 13, 2011, Khaama press Afghan online newspaper and magazine

ASSESSMENT FINDINGS: BAMYAN PROVINCE

1. Healthcare sector

Bamyan province with its estimated population of 411,700 has 78 healthcare facilities¹⁸. The province also has 358 Health Posts, that provide only primary healthcare services. Population's access to healthcare services in Bamyan is seriously hindered by the lack of facilities, trained medical personnel, poor road condition and lack of transport infrastructure in the province. 20 percent of all households in the province are located more than four hours away and 54 percent are 2 - 4 hours away from the nearest healthcare facility. Only in 26 percent of all households in Bamyan, can people reach some type of healthcare facility in less than 2 hours.

Following sub-sections present the analysis of specific service providers in the healthcare sector.

1.1 Provincial Public Health Directorate (PPHD), Ministry of Public Health

Involvement in GBV response

- **Structure, functions and services provided to GBV victims.** The Provincial Public Health Directorate is a provincial branch of the Ministry of Public Health responsible for overseeing and coordinating the implementation of the Basic Package of Health Services (BPHS)¹⁹ and Essential Package of Hospital Services (EPHS)²⁰ in Bamyan. The Assessment team met with the Director of Provincial Public Health Department (PPHD) of the Ministry of Public Health and other staff of PPHD's office in Bamyan

¹⁸ The term "healthcare facility" includes all public facilities providing healthcare services except for the Health Posts. The data on healthcare facilities was sourced from Healthcare Management Information System 2010, a database of healthcare sector in Afghanistan

¹⁹ Information about BPHS used throughout the Assessment Report is based on A Basic Package of Health Services for Afghanistan, 2005/1384, Islamic Republic of Afghanistan, Ministry of Public Health, http://www.msh.org/afghanistan/pdf/Afghanistan_BPHS_2005_1384.pdf (last accessed on 04/12/23011)

²⁰ Information about EPHS used throughout the Assessment Report is based on The Essential Package of Hospital Services for Afghanistan, 2005/1384, Islamic Republic of Afghanistan, Ministry of Public Health http://www.msh.org/afghanistan/pdf/Afghanistan_EPHS.pdf (last accessed on 04/12/23011)

provincial center. Both respondents demonstrated acute awareness of GBV's being a serious public health hazard and the high level of GBV prevalence in the country. However, the interview revealed that:

- PPHD does not have any specific structure/unit responsible for coordination of GBV related services in the healthcare facilities.
- PPHD does not have any programs building the capacity of healthcare professionals and healthcare facilities in the province to identify, treat and refer patients suffering from GBV.
- The staff of the PPHD is not trained to develop mechanisms and tools for coordination of healthcare services to GBV victims on the provincial level.

The respondents emphasized the need for capacity building of PPHD officers. Although some staff members were trained on psychosocial counseling through UNFPA's training program, the lack of specific knowledge and skills prevents PPHD staff from establishing and monitoring coordinated service delivery to GBV victims within the healthcare facilities in the province. The respondents also stressed the importance of building the skills of female healthcare staff in recognizing the signs of GBV and assisting female patients subjected to violence.

- **Access to services.** The access to PPHD's office is unrestricted; the office is open for visitors from 08:00 to 4:00 every day of a 5-day working week.
- **Processing GBV cases.** PPHD directly receives a very limited number of cases (on average, one in two months). Women contacting PPHD mostly suffer from physical violence by a family member.
- **Data collection on GBV in the province.** PPHD does not receive data on GBV cases from the health facilities across the province on a regular basis and in a standardized format. Subsequently, the Directorate at the moment cannot accumulate and analyze comprehensive information on the situation with the state of health service delivery to GBV victims in the province.

- **Referral.** Cases are almost always referred to PPHD by the provincial police department and then directed by PPHD to the nearest healthcare facility. However, the reverse referral link (PPHD and health facilities referring patients to the police) does not seem to function properly. One of the respondents related that health facilities rarely refer GBV victims to the police even if directly asked to do so by a patient.

- **Working with communities.** PPHD interacts with local communities mainly through the mechanism of Health Shura, a council of well-respected community members that serves as a bridge between local healthcare facilities and communities. Health Shuras play crucial role in disseminating health related messages and supporting the service provision in the healthcare sector. Health Shura is a strong vehicle facilitating communication with local communities. PPHD's activities in the area of GBV response could benefit from closer cooperation with this structure in disseminating messages on the negative health impact of GBV on individuals and families.

- **SOPs, guidelines and protocols.** The Directorate does not have SOPs, guidelines or protocols specifically addressing the needs of GBV victims.

- **Coordination with other agencies.** The coordination with other agencies working in the field of GBV response in Bamyan is seriously underdeveloped and operates exclusively on an ad hoc basis. PPHD's representative participates in the meetings of Coordination and Cooperation Commission (CCC), the provincial level coordinating body led by the Provincial Governor, Dr. Habiba Sarabi. CCC addresses individual cases of GBV on a bi-weekly basis. Participating agencies coordinate efforts within this structure on a case-by-case basis (with individual cases selected by the Governor or one of the participating agencies). Thus the coordinated activities do not involve any level of institutionalization. Routinely, PPHD only works with health providers and does not engage in coordinated activities with other agencies or organizations working in the field of GBV response.

Needs and challenges in providing services to GBV victims.

- **Challenge: GBV response is not sufficiently incorporated into PPHD activities.**
- **Need for a policy outlining a vision for PPHDs involvement with GBV response.**
The assessment did not discover any policy or strategy presenting the Directorate's vision of addressing the problem of GBV through the involvement of the healthcare sector in the province. The lack of such vision prevents the development of consistent and planned intervention measures for GBV response.
- **Need for structure/unit responsible for GBV related interventions.** *PPHD currently does not have any specific structure/unit responsible for the coordination of GBV related services in the healthcare facilities across the province. In order to strengthen its input in the building of stronger coordinated response to GBV the Directorate needs to establish specific unit responsible for developing and coordinating GBV related interventions in the healthcare facilities and supporting inter-agency cooperation.*
- **Need for data collection and assessment of the healthcare sector's response to GBV on the provincial and district level.** *Currently, the Directorate does not receive information on GBV cases entering healthcare facilities and services provided to patients suffering from GBV. Even if this data was recorded in general activity reports received by PPHD from the healthcare facilities, the assessment did not reveal any analysis of GBV related data performed by PPHD.*
- **Need for custom made programs strengthening the healthcare sector's response to GBV.** *PPHD does not have any programs building the capacity of healthcare professionals and healthcare facilities in the province, to identify, treat and refer patients suffering from GBV.*
- **Need to strengthen cooperation with Health Shuras on dissemination of information about negative impact of GBV on the health of individuals and**

families. Health Shura is a strong vehicle facilitating communication with local communities. PPHD needs specific programs aimed at building closer cooperation with Health Shuras in disseminating messages on the negative health impact of GBV on individuals and families.

- ***Need to build the capacity of PPHD staff to develop stronger cooperation with other agencies.*** The staff of the PPHD is not trained to develop province level initiatives (programs or projects) addressing the coordination between the agencies working in the field of GBV response.
- ***Need to educate PPHD personnel on the roots, consequences and types of GBV.*** The respondents demonstrated general awareness of GBV issues. However the assessment found that PPHD staff did not receive any training on GBV as a major problem affecting public health. The PPHD staff could benefit from training that focused on the impact of GBV on national public health and the role of the healthcare sector in GBV response. This type of training could provide a necessary foundation for more comprehensive educational initiatives in the area of GBV and health that will be developed by PPHD for the healthcare sector in Bamyan province.

1.2 Healthcare facilities

Involvement in GBV response

The healthcare facilities (HF) examined in Bamyan differed in capacity, size of catchment area and location in relation to the provincial center and the communities they serve. In the course of data collection in Bamyan, the assessment team visited the healthcare facilities of various scales. Some were situated either in the provincial center or very close to it, while others, like the sub-center in Andah, were selected specifically based on their remote location. The assessment revealed that the HF at all levels face serious challenges in providing assistance to the victims of GBV. Some of these challenges were shared by the HF on all levels of the healthcare system. However certain problems were directly related to the characteristics of the specific HF type. This diverse context allowed the assessment team to register the differences in opportunities and needs that characterize various HF in the province.

a) Small size HF in central location. Level: Primary Care Service.

The Health Post in Shevaqat village (20 minute ride from the provincial center) represented the most basic level of healthcare facilities within the BPHC package.

- **Structure, functions and services provided for GBV victims.** Serving 110 families in the community where it is located, the Health Post in Shevaqat at the time of the assessment had only one Community Health Worker (CHW). CHW, young woman with 12 classes of school education, currently in her second year of training as a teacher, received a 21-day, three-phase CHW training that enabled her to treat basic physical injuries, the common cold and diarrhea.
- **Access to services.** The Health Post was located in the same village as the community it serves. The venue for the Health Post was provided by a member of the local *Health Shura* which owned a spacious house adjacent to the Health Post's small office. The entrance to the venue was not restricted.

- **Processing of GBV cases.** The CHW was also in charge of registering visits to the HP (HP uses a pictorial tally sheet, which on the day of the assessment team's visit registered 1352 patient visits since the beginning of the year), distributing family planning information and contraceptives and referring patients to higher level healthcare facilities. The CHW did not report any GBV related traumas or complaints by community members and was reluctant to discuss the impact of gender based violence on the health of community members. The CHW had very weak awareness of GBV and its impact on women's health. She explained that female patients never disclose health issues caused by any kind of violence and have to seek the permission of family members to share pregnancy related problems.

- **Referral.** The facility does not have any rules regarding the referral of patients subjected to GBV. All patients with serious physical injuries are referred to the higher level healthcare facility.

- **Working with communities.** The Health Post works closely with local Health Shura, however the messages delivered to the community through Health Shura do not include information on GBV and its health related outcomes.

- **SOPs, guidelines and protocols.** The Health Post did not have any guidelines on the treatment and referral of GBV victims.

- **Coordination with other agencies.** The facility is not engaged in coordination with other actors involved in providing services to GBV victims.

b) Small size HF in a remote location. Level: Primary Care Service.

The Community Sub-Center (CSC) in Anbah, one hour ride from Yakawlang district center, presented another example of a basic level health facility, one level above the Health Post and a level below Basic Health Center.

- **Structure, functions and services provided for GBV victims.** The CSC had two staff members (male nurse and female midwife) and one guard. The sub-center provided pre- and post-natal care, assistance in deliveries, OPD, advice on family planning and referral to higher level health facilities. The catchment area covers 17 villages (800 families or about 4000 people). The staff had very limited experience in dealing with GBV cases²¹. According to the nurse most of these cases did not reach the sub-center. People with serious injuries tended to go directly to the district hospital or receive treatment at home.
- **Access to services.** The Sub-Center is located in a small three room house outside of villages that it serves. The entrance to the venue is not restricted. The road connecting the CSC to the district center is in a very poor condition and closes during the snowy winter months.
- **Processing of GBV cases.** The registration book kept in the sub-center did not record whether specific health problems were caused by GBV. The Community Health Supervisor responsible for supervising the sub-center related that no GBV cases were registered or reported from any Health Posts or sub-centers in his area.
- **Referral.** The Health Post only referred the patients to a higher level HF, the district level Comprehensive Health Clinic. There were no specific referral path for GBV victims.
- **Working with communities.** The sub-center staff worked closely with village Health *Shura* to disseminate health related information (the topics included family planning, personal hygiene and vaccination). However the cooperation with the Health *Shura* did not address GBV related health hazards.

²¹ The male nurse related that his experience with GBV patients comes from working as a Community Health Worker in the Dai Kundi province.

- **SOPs, guidelines, procedures.** The sub-center did not have any guidelines on the treatment and referral of GBV victims and the staff did not receive specialized training on assisting the patients suffering from GBV.
- **Coordination with other agencies.** The facility is not engaged in coordination with other actors involved in providing services to GBV victims.

“I had one patient with a head injury. She told me that it was caused by her husband’s hitting her. Very shortly afterwards her husband joined us in the examination room. My patient then immediately changed her story. She said that she has fallen from the roof of their house and got a head injury. She looked very depressed and scared.” – midwife in small size healthcare facility in Bamyan

c) Medium sized HF close to provincial center. Level: Secondary Care Service.

- **Structure, functions and services provided to GBV victims.** Comprehensive Health Center near the provincial center of Bamyan has a catchment area of 23,000 people. The Center has 2 midwives responsible for assisting female patients.
- **Access to services.** The Center was located very close to one of the communities it serves. The entrance to the venue was not restricted. However limited mobility of women in public space restrict the access of female patients to healthcare service provided by the Center.
- **Family’s control over women’s health.** According to the Center’s midwife (26-year old local resident, graduated from the 18 months course in community midwifery, offered by the Aga Khan Foundation) female patients almost never attend the Center alone. Family members would normally accompany a woman to the HF and would be present during the examination. Based on the midwife’s observations, families exercise tight control over women’s access to healthcare. Any disclosure of health issues (especially those caused by domestic violence) if unsanctioned by the family

will thus be dangerous for the female patient. Female patients often hide the fact that they visited the Clinic even when their health problem is not an outcome of violent treatment. Female patients subjected to physical, sexual or psychological violence are allowed to visit the doctor (in most cases accompanied by family members) if they experience severe health problems.

- **Referrals.** Although the CHC is a medium-scale healthcare facility and receives the patients from nearby Health Posts, GBV cases do not arrive to the Center as a part of these referrals. A small number of GBV cases is referred to the Center by local police, while the direct entries are very rare. The facility does not have policy requesting the staff to refer patient to other agencies. The staff does not refer patients to the police, the Department of Women's Affairs (provincial branch of the Ministry of Women's Affairs) or shelter. Sometimes the patients are directed to a higher level healthcare facility. CHC staff is not aware of possible referral options and is under considerable pressure from the community to conceal GBV cases.
- **Working with communities.** The topics covered by the coordinated efforts of HF and Health Shura do not address the negative impact of GBV on the lives of family and community members. Thus the potential for cooperation between the HF and the community based structures in dissemination of knowledge on the negative outcomes of violent practices remains thoroughly underused.
- **SOPs, guidelines, procedures.** The identification and treatment of patients suffering from gender based abuse in the Center is not regulated through any set of guidelines and is hindered by a set of problems.
- **Heavy workload.** Due to heavy work load, the midwives have very limited time they can dedicate to individual patient. Thus even when the midwives observe certain signs suggesting that the patient is scared or depressed, they do not have an opportunity to further investigate the issue.

- **Community pressure and the vulnerability of the healthcare staff.** The healthcare facility is located in the same residential area as one of the communities that it serves. As the healthcare professionals directly responsible for assisting female patients 2 midwives working in the facility are very visible and well-known in the community. According to the information provided by one of the midwives, the attempts to inquire about possible violent acts that cause physical injuries and mental health problems in some female patients, caused very negative responses and even open threats on the side of the patients' family members. These reactions and the vulnerability of medical staff in small HF make every inquiry into possible GBV case or the referral to the agencies outside of healthcare system dangerous for the security of the healthcare practitioner.

"I am a resident of this area if I send my female patient to get legal assistance their relatives will be angry with me. Then I or my family members may become a target."
– midwife in the healthcare facility, Bamyan.

- **Coordination with other agencies.** The CHC is located close to the provincial center, with its range of governmental and non-governmental agencies working in the field of GBV response. However, as other small and medium size healthcare facilities examined in Bamyan, the Center is not involved in any coordinating structures and delivers its limited assistance to GBV victims in a completely isolated way. The interviews demonstrated that even patients requesting protection, are left without any assistance, because the staff does not know how they can help.

"Even when I see that the patient is scared I am always in a hurry, I do not have time to ask her questions" – midwife in Bamyan.

d) Large size HF: Level: Tertiary Care Service

- **Structure, functions and services provided for GBV victims.** District Hospital in Yakawlang is the largest and best equipped healthcare facility in the district and provides comprehensive medical treatment. With the catchment area of 60,000 the hospital receives patients from the district center and the villages (some located more than a four hour drive away from the hospital).
- **Access to services.** The entrance to the hospital is monitored but not restricted.
- **Processing GBV cases.** The hospital most often receives female patient with injuries caused by physical violence by a family member, and sometimes the victims of sexual assault. A large share of these patients is sent in by the district police department. Women arrive with a letter from the police, requesting medical examination. The letter is written in a standard format that allows some room for a response from the healthcare facility. Normally, the letter does not explain in detail what type of information is requested. Thus the information provided by the hospital may be incomplete.
- **Referral.** According to the Head of the hospital, they do not normally ask the patients whether they need a referral to the police or other agencies.
- **Working with communities.** *The hospital worked closely with several local Health Shuras to disseminate health related information (on family planning, personal hygiene and vaccination). However the cooperation with the Health Shuras did not address GBV related health hazards. Health workers in large size HF were less vulnerable to pressures and risks caused by reporting GBV.* Hospital staff did not express concerns related to community or family pressure caused by identifying patients suffering from GBV. They also did not express concerns regarding the reporting of GBV cases to other agencies.
- **SOPs, guidelines and protocols.** The hospital does not have any guidelines regulating the identification, examination and referral of patients subjected to GBV. The hospital personnel have not received any training on the subject. The hospital

does not have guidelines regulating ethical treatment of GBV victims. The facility does not have written procedures for protecting safety of GBV victims.

- **Coordination with other agencies.** The facility does not have any policy or guidelines on coordination with other agencies that work with GBV cases and does not participate in any bodies that ensure coordinated GBV response. The interviews with the hospital staff revealed a set of specific issues that impact facility's involvement in GBV response and coordination.
- **Lack of female doctors.** Compared to other HF in the area the hospital had relatively large staff of female healthcare providers (four midwives and five nurses). However, the Head of the hospital, emphasized that the facility struggles with the lack of female doctors. Due to the lack of Afghan female doctors willing to apply for the position (according to the head of the hospital, both low salaries and poor living conditions contribute to this situation), the facility contracts three female gynecologists from Tajikistan. The doctors from Tajikistan take leave every three months to go back home and sometimes do not return. This creates challenges for timely service provision. It is important to note that the lack of proper accommodation for the families of resident doctors leads to a frequent change in hospital personnel, because doctors (this is especially relevant for outsourced female doctors) are not willing to stay for a long period of time without their families.
- **Hospital staff is not trained to work with GBV victims.** The hospital staff did not receive training on the identification, medical examination and ethical treatment of patients subjected to GBV. The staff also was not aware of safety precautions necessary for treatment of GBV victims. On one occasion the police requested a young patient to be examined in order to establish whether the sexual assault had taken place. As no female doctor was in the hospital at that time, the examination was performed by hospital midwife who was not trained to conduct this procedure and was only able to identify the loss of virginity.

“There were some women who asked me about protection, but I did not know where to send them, I did not have any advice for them. I can only provide counseling,” – midwife in the large size healthcare facility, Bamyān.

e) Community Health Supervisor – institutional link between small and large HF in the area

- **Structure, functions and services provided to GBV victims.** The mechanism of Community Health Supervisors (CHS) is serves to supervise the small size healthcare facilities (such as Health Posts or Sub-centers) and ensuring steady communication and coordination between the small and large size HF, Health Shuras, BPHS implementing organization and the PPHD. CHS is an employee of the Ministry of Public Health²². In Yakawlang, CHS reports to the head of district hospital and BPHS implementing partner. The CHS, interviewed in Yakawlang district, was a 30-year old man (12 years of school education, received general training on health issues and post-delivery service and attended 12 months nursing course) with 8 years of experience as a Community Health Worker. He supervises 15 Health Posts (serving about 100 families each) located in the villages across the district and is responsible for maintaining communication between the health posts and the district hospital. CHS also is regularly training HP staff on various health issues, relates the problems faced by the HP staff to the district hospital and BPHS implementing partner and provides the necessary supply of medicine and health related print materials to the HP.
- ***CHS involvement in addressing GBV.*** The interview demonstrated that the CHS is not involved in reporting GBV cases or any coordinating or information sharing activities in the field of GBV response. Given that the CHS are tasked with collecting the information from the HP, spreading the messages through regular meetings of HP staff and dissemination of relevant materials, the institution of CHS could be used in a much more productive way for the coordination and information sharing in the area of GBV response between smaller and larger size HF and PPHD.

²² However the contract of CHS in Yakawlang was issued by AADA, MOPHs implementing partner in Bamyan.

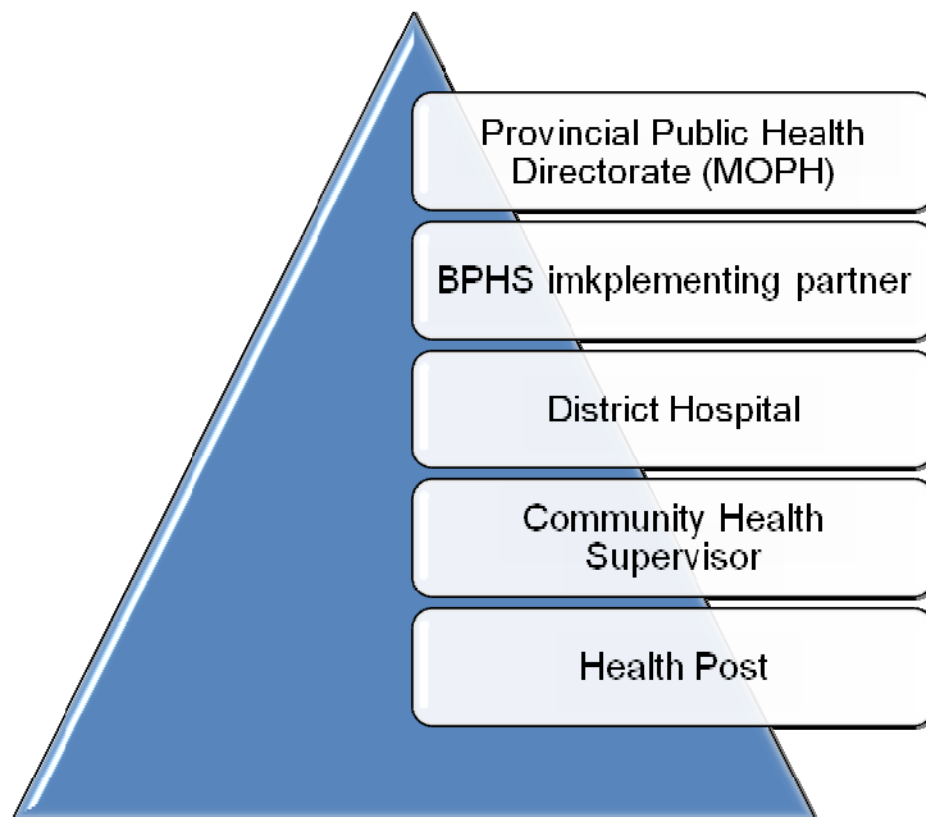


Figure 2. Reporting pyramid as described by the CHS in Yakawlang district, Bamyan province

Healthcare facilities in Bamyan: needs and challenges in providing service for GBV victims.

The Assessment found that the following needs and challenges were relevant for all HF examined in Bamyan:

- ***Challenge: HFs at the moment present an impasse in the referral and reporting network*** that connects other agencies working in the field of GBV response in the province. The reporting of GBV is not required by any rules or regulations and neither is the assistance to the GBV victims in the form of information sharing or referrals. As a result, the staff of the HF does not report or record any gender based violence. GBV victims attending the HF are not given any options for referral or offered any information on where to seek help.
- ***Need to introduce mechanisms to strengthen the involvement of HF in overall referral and reporting network.*** The Assessment revealed that medium and large healthcare facilities frequently serve as an entry point for patients suffering from various forms of GBV. However the insufficient involvement of HFs in GBV referral and reporting network contains the information on GBV cases within the healthcare sector. Subsequently, the patients subjected to GBV are deprived of opportunity to benefit from services provided by other agencies. Involvement in the referral and reporting network should be strengthened through the introduction of SOPs that incorporate referral and reporting of GBV victims in the routine operations of the HFs.
- ***Need to train healthcare staff in tertiary and secondary level HFs to identify, treat and refer patients suffering from GBV.*** The Assessment found that the ability of secondary and tertiary level HFs to serve as an entry point for GBV victims is seriously undermined by the lack of necessary skills and knowledge among healthcare staff. This problem should be addressed through the development of training programs specifically geared to build the capacity of HF personnel to identify and treat patients suffering from GBV. The training programs should include guidelines on referral procedures as well as ethical rules and safety precautions important for dealing with people subjected to gender based abuse.
- ***Need to strengthen the capacity of primary level HFs to serve as an entry point for GBV victims.*** The Assessment found that the ability of primary level HF to serve

as an entry point for GBV victims is seriously undermined by the lack of necessary skills and knowledge among healthcare staff and the vulnerability of the healthcare staff to pressures from local communities. These problems should be addressed through the training of HF staff and introduction of reporting and referral procedures that will take into consideration the safety of HF personnel.

- **Challenge: The lack of female doctors and a heavy workload of the hospital personnel create un-welcoming environment for the patients that suffer from GBV and seek assistance.** This challenge limits the ability of HFs to reach out to female patients subjected to GBV.
- **Need to introduce further incentives for female healthcare professionals to enter the field of public healthcare** in Bamyan and address the issues (such as low salaries and poor housing conditions) that currently prevent women from choosing employment opportunities in the provincial healthcare sector.

The following needs and challenges were relevant for the small scale HF in Bamyan:

- **Infrastructural challenges.** *The small scale HFs located in remote areas are seriously limited in their ability to provide assistance or refer the patients to higher level HF or other agencies because of the poor road infrastructure. Travel not only takes time and may be dangerous for patients with serious injuries, but also requires mobility and resources that patients from these poor rural areas do not have. This is specifically relevant for female patients since their ability to travel is highly restricted. Women in rural areas also usually lack personal money to cover the travel expenses.*
- **Need to further develop mobile healthcare facilities** and equip the staff with knowledge necessary to identify patients suffering from GBV and render them necessary assistance (in the form of treatment, and referral).
- **Challenge: ties to community and socio-cultural norms regulating the disclosure of GBV.** *Small scale healthcare facilities are often closely tied to the community(s) that they serve. The connection may include residence in the community, close social interactions with community members through the Health Shura and staff's family ties to community members. This makes HF staff reluctant to*

encourage the disclosure of GBV outside of close family circle or pass the information regarding the GBV case outside the community.

- **Challenge: Vulnerability of the staff.** The proximity (both physical and social) to the community makes the HF staff in these types of facilities particularly vulnerable to the threats issued by the families rejecting the outside interference in the GBV related situations. This factor carries even more weight for the staff in remote locations, separated from the nearest law enforcement and other government offices by miles of bad roads.
- **Need to strengthen the educational** activities among local communities, explaining the devastating impact of GBV on individuals and families.
- **Need to incorporate the measures protecting the safety of HF personnel** in all SOPs, guidelines and protocols regulating the treatment, reporting and referral of patients subjected to GBV.

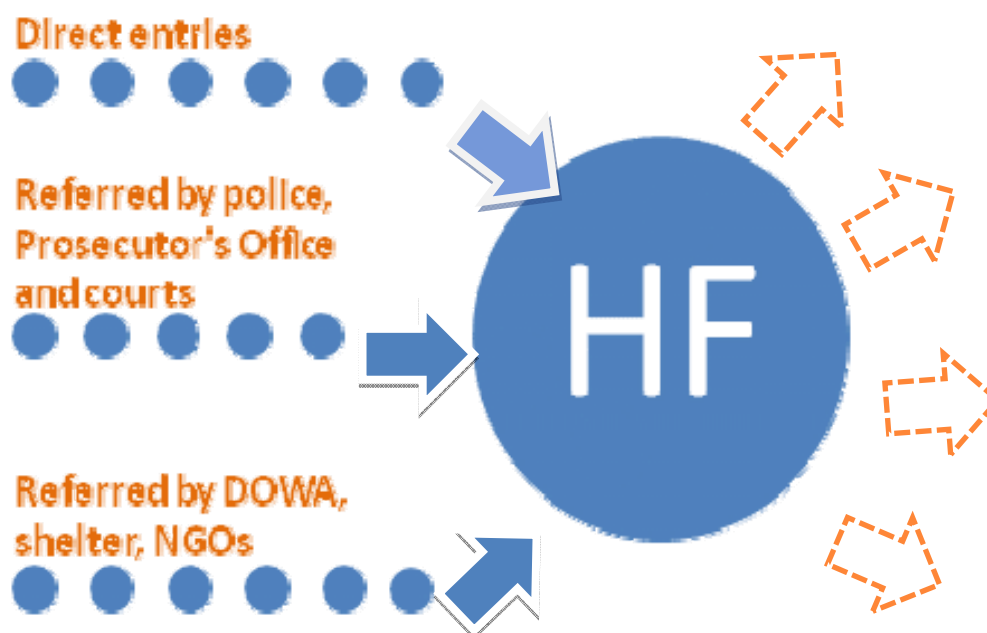


Figure. Healthcare impasse

2. Community based structure

Involvement in GBV response

2.1 Community based *Health Shura*²³

The assessment team conducted group interviews with Health Shura members in two different locations (Shavaqat, village close to provincial center, and Yakawlang district center).

Health Shuras are community based groups tasked with providing a “bridge between the health facilities and the communities they serve”. The Health Shuras were created by the government as a part of BPHS and are modeled after the traditional community based dispute resolution structures (like village or *qawm shuras*). They consist of several members of the community who gather on a regular basis to meet the health facility staff. At the meeting, the participants normally discuss current health issues they consider relevant for their community and receive health related information that they then disseminate among the community members.

The *Health Shura* in Shavaqat village (community of 110 families) consisted solely of the village residents. Although Shura members informed the assessment team that the council has two female members they were not present at the meeting. The discussion gave some indication of the power structure within the Shura: most of the answers and opinions were presented by two older men, one of them Haji²⁴ was the chairman of the Shura. Other members, including a young man in his 20s, were silent throughout the meeting.

The meeting in Yakawlang district center gathered representatives of eight village Shuras that together constitute a *Health Shura* working directly with the Yakawlang district hospital. Women (most of them teachers) constituted an absolute majority of meeting participants. However they had very limited opportunity to voice their opinions and concerns. The chairman of *Health Shura* and one Shura member (both older males) insisted on raising issues, answering questions and providing inputs on behalf of all group.

²³ Health Shura was selected for assessment among the variety of other community based structures because of its close links to the healthcare facilities.

²⁴ The title of haji indicates that its carrier performed the pilgrimage to Mecca, a journey that requires considerable financial investment. A title of haji would normally elevate the social status of its holder in the community.

Benefits and challenges of working with Health Shuras

The discussions held with health shuras elucidated both strengths and weaknesses of this mechanism for the cause of building an efficient coordinated response to GBV. Out of all respondents interviewed throughout the assessment mission in Bamyan, the Health Shura members were most reluctant, to discuss the subject of violence against women. They, for the most part, insisted that these problems did not exist in their community, or are rare and successfully resolved by the traditional dispute resolution mechanisms (normally, the council of elders (“white-beards”)). Shura members considered violence against women within the families or even within the community the matter best solved through mediation.

- ***Challenge: discussion of GBV in Health Shuras Conflict situation rather than health concern.*** *The discussions held with Health Shura members revealed that those who have the authority to speak most often view the problem of GBV in the community as a conflict/dispute situation rather than a health concern. The perception of violence against women as a “conflict/dispute situation in need of mediation” provided the main framework shaping the discussion of GBV by the Health Shuras.*
- ***Power structure within Health Shuras.*** *Modeled after the traditional community based dispute resolution bodies, Health Shuras are nevertheless the product of the operations of centralized government seeking to deliver its policies to local communities through somewhat familiar channels. Along with healthcare facilities it serves to strengthen the reach of the centralized government through bringing policies developed in a top-down fashion to local communities. At the same time Health Shuras, despite the formal adherence to egalitarian requirements of the central government and international donors, reflect gendered and generational hierarchies that shape the organization of local communities. In fact, as some of the interviews suggested, this accurate replication of local power structures allows the Health Shuras to effectively disseminate the information and practices that otherwise would not be accepted by local communities. The approval and involvement of Health Shura adds legitimacy to the messages that otherwise might have been rejected (such, for example, as the practices related to family planning) and ensures the*

dissemination of resources and information among the community members. However, this efficiency comes at a certain cost.

- **Challenge: limited opportunities to present diverse opinions.** The exchange of opinions throughout the meetings conducted by the assessment team was limited by the traditional power structures influencing the modes of conduct: female participants (and younger male participants) were mostly silent, while older male participants were dominating the discussion and speaking on behalf of the group. Thus the groups, such as younger men and women (of all ages), did not have opportunity to participate in formulating agenda, voicing concerns and opinions and proposing solutions. Thus the issues that are considered unimportant by a group of authority figures are marginalized and left outside of Shura's agenda.

The exclusive power of authority figures in Health Shuras to formulate and pursue certain agenda presents a serious challenge to the cause of engaging community structures in coordinated GBV response. For example, the authority figures that dominated the conversation in two Health Shuras examined by the assessment team in Bamyan, were not interested in discussing topics related to the impact of GBV on individuals, families and community. They believed GBV related problems to be irrelevant and preferred to focus on other issues (the lack of healthcare staff, insufficient supply and quality of medicine). "We respect women in our communities, these things are left in the past" – was the most common response to the question about the role of Health Shuras in addressing GBV. Attempts of the female participants (in the Health Shura in Yakawlang) to present different opinions were promptly silenced by the Shura Chairman.

- **Challenge: reluctance to work with government agencies.** The opinions presented by the Health Shuras also reflected a reluctance to work of the government structures as possible mechanism for resolving conflicts that emerge within the community. This mistrust along with the firm belief in community's power to regulate the conduct of its members, the limited opportunities for groups outside of the "power and authority circle" to participate in decision-making and the lack of knowledge about negative impact of GBV prevents the community groups from cooperating closely with other actors working in the field of GBV response and constitutes one of the

obstacles in the implementation of the rule of law and protection of human rights in relation to GBV.

“We respect women in our community. We used to have badal before but now all these things are in the past. Now women order us around,”- older man, Health Shura member, Yakawlang district, Bamyan.

“Men here used to stop their daughters from receiving education, they used to beat their wives, it is better now...” – young woman, Health Shura member, Yakawlang district.

3. Law Enforcement

Involvement in GBV response

3.1 Police

Mission team members met with the police staff in two types of locations: Bamyan provincial center (central provincial police department) and the district center (district police department). In Bamyan provincial center the mission team had separate meetings with the Chief of the Police Department, the Head of the Family Response Unit (FRU), the team also interviewed the Head of the Human Rights Department, the Head of the Organized Crime Department and other police staff members. In Yakawlang district center, the team conducted an interview with the Head of the Criminal Investigation Department (CID) and other police officers. Some of the Bamyan police force members (Chief of Police Department, Head of Family Response Unit and the Head of the criminal investigation department in Yakawlang) exhibited high level of awareness of GBV issues and openly discussed the challenges they face in conducting preliminary investigation of GBV cases providing protection for GBV victims. Others were less inclined to engage in open discussion.

Bamyan province has 48 police posts. According to the Chief of Provincial Police Department the level of criminal violence in the province is relatively low compared to the rest of the country. However, the access to the central police office is fairly restricted. There are no specific days or hours assigned for visitors. The police department, according to the Chief of Police, mainly receives GBV cases involving “domestic violence (physical), early marriages, forced marriages, exchange marriages (*bada*) and running away from home”. Cases involving sexual violence are rare. All police officers interviewed in Bamyan related that a huge load of cases involving GBV (according to some respondents up to 70 percent) are processed through the community based dispute resolution mechanisms and do not even reach local police departments²⁵.

²⁵ This opinion is backed by a research on community based dispute resolution mechanisms conducted in Bamyan by the Afghanistan Research and Evaluation Unit.

a) Family Response Unit in Bamyan.

- **Structure, functions and services provided for GBV victims.** The provincial police department in Bamyan recently started its Family Response Unit (FRU). The FRU is a part of the Criminal Investigation Department. The Family Response Unit consists of three staff members (all female police officers) and is charged with investigating cases that involve physical violence within families. The cases involving sexual violence normally fall under the responsibility of the other officers within the Criminal Investigation Department. The Head of the FRU reports to the Head of Criminal Investigation Unit. She is a graduate of police academy in Kabul (one year program). She received training on human rights and child protection and general gender and GBV sensitivity training.
- **Access to services.** Accessing Family Response Unit is one of many challenges that women, victims of GBV, face in their pursuit of protection and justice. The FRU does not have specified days or hours assigned for receiving visitors, and there is no procedure to ensure easier access to the Unit by female visitors.
- **Referral.** The procedure for submitting complaints to the FRU is complicated. The Unit staff does not accept any direct complaints. Every visitor is instructed first to apply to the Governor's office. The instructions do not specify which department in the Governor's office receives complaints regarding family violence. The interviews revealed that the Governor's office, in fact, does not have a specific unit in charge of assisting family violence victims. According to the Head of the FRU, the officials in Governor's office review each complaint and decide whether to channel it to the Ministry of Women's Affairs or police²⁶. After receiving directions from the Governor's office, citizens can return to the police and submit their complaints. The FRU staff then can send the alleged victim to the provincial hospital for examination or, if the citizens require protection, direct them to MOWA where they will possibly be referred to the shelter. Evidently, the procedure is complicated and requires considerable time and freedom of mobility that female citizens often do not have. Given the numerous destinations that women have to visit in order to submit their complaint most of them, according to the interview, have to

²⁶ The procedure does not comply with the requirements of EVAW Law. The Article 7, paragraph 1 of EVAW Law stipulates that the victim or her relative can directly complain to police. ("A woman victim of violence, she by herself or her relatives may complain to police, Huqooq (rights) Departments of the Ministry of Justice, courts and any other relevant offices".)

travel with the caretaker. Travel expenses present another burden that many citizens in this poverty stricken region can't afford.

The FRU refers GBV victims to the provincial hospital for examination and treatment. The procedure includes the letter issued by FRU to the head of provincial hospital. The letter requests information on the injuries and the health condition of the victim. The response from the hospital is then photocopied. One copy stays in the FRU's case file and another one is sent to the Prosecutor's office with other information regarding the case.

FRU does not have direct connection with local shelter. In a situation, when FRU staff determines that going back home presents imminent danger for the victim, the FRU sends her back to MOWA. MOWA then directs her to the shelter.

- **Processing GBV cases.** The preliminary investigation of all cases involving physical violence by a family member was performed by the FRU officers. The FRU staff also assisted other officers in the Criminal Investigation Department in working with female witnesses and victims of sexual violence. The Head of Bamyan police and other police officers interviewed in Bamyan emphasized the importance of having women police officers on the force and the capacity building of police officers on addressing GBV cases. The division between public and private spheres in Afghanistan is regulated by gendered set of rules. Based on these rules the access to private sphere for male outsiders is considered inappropriate. The restrictions for entering the private sphere are more flexible when it comes to women. Female officers are instrumental in "entering the houses and talking to female household members".

The investigation begins with interviews. The FRU staff interviews the alleged victim and then arranges a separate interview with the alleged perpetrator. The interview normally includes questions regarding the nature of the abuse, the history of previous abuse and any experience of other forms of violence. Then, if necessary, the officers pay a visit to the family and community to collect further information and talk to the witnesses. Often after establishing the basic facts, FRU officers conduct a meeting involving both sides. The goal of these meetings, as explained by the Head of FRU, is to reconcile the sides and stop violent behavior. It is a routine practice to request a letter of commitment from the alleged perpetrator, confirming that he promises to stop violent actions. In this case,

the complaint is not registered, the “victim” returns to her home, and the FRU does not open the case.

The FRU staff tries to continue monitoring the situation by calling the victim and checking if the violence actually stopped. It is unclear, though, how consistent the procedure is and how long the monitoring period lasts.

- **Transferring GBV cases to the Prosecutor’s office.** If one of the sides does not accept reconciliation the FRU registers the complaint and opens the case. The case file maintained by the FRU normally includes the following documents:
 1. Criminal record form (Form N1);
 2. Filed complaint;
 3. Letter requesting the alleged perpetrator to visit FRU;
 4. Interview minutes (another copy is kept in FRU’s case file);
 5. Letter to the health facility (if the alleged victim was sent there for examination) that contains medical examination report;
 6. Letter to the Prosecutor’s office.

The FRU staff is tasked with monitoring GBV cases after the Prosecutor’s office takes over the investigation. “We try our best to monitor the cases that we sent there, we actually go there and ask questions” – explained the Head of the FRU. However, no written procedure seems to regulate how the monitoring should be performed.

- **Working with communities.** The FRU officers interact with community based structures (elders shura, women’s shura) while collecting case related information. The officers also sometimes involve community members in the process of reconciling the victims and perpetrators of GBV.
- **Awareness of EVAW Law.** The FRU staff is aware of EVAW Law and the unit relies on it in its operations. That awareness, however, is not very high among the rest of the police officers. The Chief of police mentioned the necessity of training that will raise the awareness about the EVAW Law among the police officers.

- **SOPs, guidelines, protocols.** There are no specific SOPs regulating the treatment of GBV cases. The FRU staff related that it would make their work much easier if they had guidelines regulating the processing of GBV cases (including interview questions, referral procedure and case monitoring procedure).
- **Coordination with other agencies.** The Assessment revealed certain gaps in coordination between the police the prosecutor's office and the court on the procedural level. The procedures regulating information sharing on GBV cases among the police, prosecutor's office and courts do not always ensure the transfer of necessary data. The information requests that police department receives from the prosecutor's office and courts are not detailed and specific. As a result, police officers are not certain which specific information to include in a response letter. Sometimes the requests are sent twice to obtain all the necessary data.

The low capacity of healthcare facilities to provide accurate and thorough examination of GBV victims constitutes another problem for the police officers conducting preliminary investigation. This issue was repeatedly mentioned by police officers in both urban and rural locations. The complaint matched the opinions expressed by healthcare staff in the health facilities examined by the assessment team in Bamyān.

b) Police department in a rural Bamyān (Yakawlang district).

The procedures used in the district police with regard to GBV cases in certain aspects differed from the ones employed by the provincial police department.

- **Structure, functions and services provided to GBV victims.** Yakawlang Criminal Investigation Department (CID) did not have a Family Response Unit at the time of the interview. The Unit had to stop its operations due to the lack of staff. One female employee that the Unit had retired several months ago and the position has not been filled yet. According to the Head of CID, the lack of female police officers makes the investigation of GBV cases particularly difficult. He believed that, if the female police officers were there to receive GBV related complaints, people would be more willing to go to the police for help. The CID currently receives 5 - 6 GBV cases per month. Overall, according to the respondent, people tend to take GBV related complaints to the *jalasas* (community based dispute resolution mechanisms). The cases mostly received by

Yakawlang CID involved the deprivation from food and shelter (women are denied food and forced to leave their house by family member, most often husband and/or mother-in-law) and deprivation from inheritance. The cases of physical and sexual violence were relatively rare.

“We do our work and we do not involve the communities in it. Their involvement can compromise the impartiality of the investigation” – police officer in rural Bamyan.

- **Access to service.** The district police office is easier to access than the provincial office. The venue is guarded. However, small groups of people are able to come in and out of the building.
- **Processing GBV cases.** Unlike the provincial police department, the CID in Bamyan accepts complaints directly without channeling them first to Governor's district office. The CID starts with determining whether the case is legal (huquqi) or criminal (jezai). Then based on the type of the case, they proceed with either sending the case to the court (legal cases, such as deprivation from inheritance) or registration and preliminary investigation (criminal cases, such as physical or sexual violence or kidnapping). The registration process uses Form N 1. The copy of the Form for each GBV related case is sent to FRU in the provincial police department (as a part of monthly report). CID also keeps the incident registration book which allows checking for the history of abuse for individual perpetrator and/or victim. After the preliminary investigation is complete the CID sends the case file to the Prosecutor's office. In the absence of the FRU, on a district level no monitoring of the case in Prosecutor's office or court takes place.
- **Referral.** People come to CID directly to file complaints regarding GBV. The Department refers some GBV victims to the district hospital for medical examination. The CID does not receive GBV cases from any healthcare facility.
- **Working with communities.** Compared to healthcare staff the respondents among the police force in Bamyan rarely indicated the desire to work with the community based

structures. The prevalent opinion stressed the partiality of the community based dispute resolution mechanism, that if engaged will influence the impartiality of investigation and prevent the perpetrators from receiving the punishment stipulated by law. At the same time, the rural police staff confirmed the information provided by their colleagues in the provincial center: a big share of GBV related cases does not reach the police and is resolved through the community dispute resolution mechanisms.

- **Coordination with other agencies.** FRU in the provincial police department seems to be the only connection between the district CID and services that provide shelter for GBV victims. CID refers women who are scared to go back to their houses to the FRU in Bamyan (more than an hour long trip). No shelters for GBV victims operate in Yakawlang. The district office of DOWA did not respond to CID's requests for closer cooperation.
- **SOPs, guidelines and protocols.** CID does not have specific SOPs, guidelines or protocols regulating the processing of GBV cases and treatment of GBV victims.

Police: needs and challenges in providing services to GBV victims

- **Challenge: limited access to services.** *In the provincial center due to tighter security measures (compared to rural police office) it is difficult for the visitors to submit their complaints. The FRU does not have special days or hours assigned for receiving visitors and there is no procedure in place to ensure easier access to the Unit by female visitors. Given the predominantly male environment in the office entering it for women involves crossing certain cultural barriers.*
- **Need for special access channel for female visitors** *to the FRU (special hours, clear and easy procedure, separate reception room).*
- **Challenge: police officers do not always distinguish between the protection of human rights and dispute resolution in treatment of GBV cases.** *The interviews conducted by the Assessment team, demonstrated that some police officers perceive family violence within the framework of dispute resolution and believe it to be one of the responsibilities of the police force to reconcile the victim and the perpetrator. This*

attitude presents an impediment for efficient and accurate preliminary investigation of GBV cases and serves to maintain impunity of GBV perpetrators.

- ***There is a need for training*** specifically geared toward police officers and focused on explaining the duties of law enforcement in relation to GBV.
- ***Challenge: strained relations with community based structures.*** _The interviews revealed certain tension between the police force and community based dispute resolution mechanisms. Police officers expressed clear mistrust of Community Dispute Resolution Mechanisms (CDRMs) as efficient support for the implementation of the rule of law. The involvement of community based structures, according to the respondents among police officers, may influence the impartiality of investigation and prevent the perpetrators from receiving punishment stipulated by law. At the same time all police officers confirmed that a majority of cases involving GBV is resolved through CDRMs.
- ***There is a need to strengthen the capacity of the police officers*** to work closely and efficiently with community based dispute resolution mechanisms.
- ***Need to create new policies and procedures for processing of GBV cases.*** All respondents confirmed the absence of written policies and procedures regulating the processing of GBV cases. The Chief of Bamyan Police Department, as well as some other police force members in Bamyan province (Head of FRU unit, Head of Yakawlang District Criminal Investigation Department), emphasized the need for SOPs regulating the processing of GBV cases and specific training for police officers on processing GBV cases. The police facilities also need guidelines on ethical treatment and safety of GBV victims.
- ***Need to strengthen awareness of EVAW Law.*** The assessment found that the police officers outside the FRU need more information on the EVAW Law and its importance for the work of police in the area of combating GBV. The training sessions and educational materials presenting clear and relevant information about the Law would assist in improving the response of police officers to the situations involving GBV and the assistance rendered to GBV victims.
- ***Information sharing among agencies requires more elaborate and comprehensive policies and tools.*** The procedures and tools that provide a format for information

requests and information sharing (such as the standard letters requesting information from the health facilities or the information requests directed from the Prosecutor's office and the court to the police) fail to facilitate specific, detailed and structured communication. This failure results in the waste of time and efforts of the officers responsible for the investigation of GBV cases. The information accumulated through these tools is incomplete and does not produce a comprehensive case record, which adds to the time spent in further investigation of the case by agencies other than police. In addition, the incomplete or inconsistent case records do not allow for tracing the history of abuse if the violence is perpetrated repeatedly by the same perpetrator or towards the same victim. The data base of cases is not computerized and is difficult to navigate.

- **Need to develop SOPs and tools** to secure smooth and comprehensive mechanism of information sharing between police and other agencies involved in GBV response.
- **Need to recruit more female police officers and train them to address GBV cases.** Several respondents mentioned that female police officers play vital role in dealing with victims and female witnesses of GBV. Police force needs more female police officers trained in processing GBV cases and interviewing the victims and witnesses of GBV.
- **Need to develop the expertise of the healthcare facilities in the field of forensic medicine.** The cooperation with health facilities is greatly impeded by the lack of forensic medicine specialists and equipment. The healthcare facilities often do not have capacity (trained specialists, equipment, units specifically designated to conduct forensic examination) to provide information requested by the police.
- **Challenge: Excessive centralization that results in complicated and long procedure.** The central police department located in the urban provincial center is involved in a complex centralized structure of GBV response specific to Bamyan. All elements of this structure are strongly tied to the Governor's office that serves as a hub for defining and channeling GBV related complaints. The structure presents certain problems for GBV victims who seek protection, assistance and justice:

- *Although the structure seems to tie together several agencies working in the field of GBV response its overly centralized organization limits the number of entry points through which the GBV victims access the services.*
- *The lack of clear procedures of screening and referral, as well as the absence of a specific unit and trained personnel in the Governor's office tasked with examining and channeling GBV cases makes the whole process even more complicated.*
- *The complex and lengthy route that GBV victims have to travel in order to submit their complaint or receive protection makes it very difficult for those with limited time mobility and resources to benefit from the services in the area of GBV response. The lengthy route also increases the chances that women subjected to pressure and abuse decide not to use the services or drop their complaint mid-way.*
- *The complex and lengthy route that GBV victims have to travel in order to submit their complaint or receive protection increases the risk for the security of GBV victims, who often have to seek assistance under the threat of retaliation f violence from the perpetrator of violence.*
- *The complex and lengthy route that GBV victims have to travel in order to submit their complaint or receive protection also may serve as additional argument for those who decide to apply for community based dispute resolution mechanisms where the process is performed by a single body, is prompt and available for every community member.*

The rural police department was not included in the centralized structure. The visitors did not have to go to DOWA's district office prior to submitting their complaint to police. Hence, the rural Police Department provided a fairly easy entry point for GBV cases. However, the department faced problems stemming from the lack of services for GBV victims in rural area (very low capacity of healthcare facilities, absence of shelters, NGOs providing legal assistance etc.), poor connections with relevant service providers in the provincial center and low level of support from DOWA.

- ***To address this challenge the province needs new model of coordination*** that will secure higher number of entry points for GBV victims, offer multiple and easy referral options, provide prompt and comprehensive information exchange mechanisms for

participating agencies and guarantee maximum security and confidentiality for people subjected to GBV.

4. JUDICIARY

4.1 Prosecutor's Office

Involvement in GBV response

The Prosecutor's office in Bamyan includes provincial and district level departments. The mission team met with the prosecutors in two types of locations: Bamyan provincial center (Chief Prosecutor of Bamyan province) and the district center (Yakawlang district prosecutor).

- **Structure, functions and services to GBV victims.** The Prosecutor's office conducts the primary investigation of criminal cases related to GBV. The prosecutor plays a crucial role in determining the nature of GBV cases and identifying victims and perpetrators. Bamyan province has one central provincial level office and seven districts offices reporting to the center. The provincial office has 16 staff members. Every district office has three staff members.
- **Access to services.** Prosecutors receive the main bulk of GBV cases from the police. On the rare occasions that the cases are submitted by the National Security Service the provincial office of the Ministry of Justice or individual community members. If the case submitted by a citizen or a community group involves physical injuries or a security risk exists for parties involved the prosecutor would send the case to police. The interviews with prosecutors on provincial and district level revealed that the number of GBV cases they receive is fairly small (approximately one case per months for both central provincial and district offices). The types of GBV related crimes that most commonly reach Prosecutor's office include physical violence, the deprivation from food and shelter (for the Yakawlang district), divorce complications, wife battering and running away from home. The cases involving sexual assault are relatively rare.

“Women can’t bring their families to stay with them, because salary we offer is extremely low. Nobody wants to come to Bamyan for this salary. So we have to recruit local residents and most of them do not have sufficient education or experience.” – respondent. Prosecutor’s Office. Bamyan.

- **Processing GBV cases.** The prosecutor’s office reviews the information contained in the case file submitted by the police. Based on the outcomes of preliminary investigation they question the victim, perpetrator and witnesses, collect evidence and when necessary request medical examination of the victim to be performed by the health facility (provincial or district hospital). The quality of investigation of GBV cases suffers considerably from the lack of female staff in the prosecutor’s offices across the province. According to the Chief Prosecutor of Bamyan, his attempts to convince female graduates of the Department of Law of Kabul University to work in his office in Bamyan failed due to the low salaries assigned to the staff.

Case details are recorded in the incident record form (Form N1). The office maintains a record of all processed cases in the case registration book. While investigating the case, staff of prosecutor’s office collects information from the police, healthcare facilities, family and neighbors of the alleged victim and perpetrator and other community members. The information received from both police and healthcare facilities, as indicated by the respondents, is often incomplete. The letters requesting information do not have a standard list of questions and the requests differ depending on the nature of each case.

- **The “reconciliation approach”.** The approach is applied at several stages of investigation. The assessment revealed that the parties involved in GBV related incident(s) are offered the opportunity to reconcile and not proceed with official investigation both in the police office and later in the prosecutor’s office. Thus the number of criminal cases involving GBV that enters the system through the police department is normally larger than the number that makes it to the Prosecutor’s office and the latter is larger than the number of cases eventually submitted by the prosecutors to the courts. The respondents explain these attempts to reconcile the parties by the

desire to protect the parties involved in the case from engaging in lengthy and costly²⁷ court proceedings and prevent the dissolution of families (in cases involving violence by a family member)²⁸. As in the case with the FRU, once again, the state body responsible for the impartial investigation of crime assumes a mediatory and reconciliatory function traditionally performed by the community based dispute resolution mechanisms. The impact of this consistent practice on the security and well-being of the victims is unclear and should be carefully examined in the future. However, it is clear that the reconciliation of the parties in cases involving GBV, regardless of its outcomes or the good intentions of the mediating body, generates and secures the impunity of violence perpetrators. It is also important to note, that the assessment did not reveal any practice of monitoring “reconciled” cases by the prosecutor’s office. Thus the mediating body does not carry any responsibility for monitoring the adherence of the parties to the promises made in the course of reconciliation. This arrangement differs considerably from the practices of CDRMs. Members of jalasa, normally residents of the same community, have numerous ways of monitoring the situation and ensuring the compliance of the parties to the commitments that they made. Members of jalasa are also easily accessible for all parties involved in a GBV case.

- **Referral.** The cases not closed at the reconciliation phase are submitted to the court. The victims of GBV who require legal assistance or protection have to take a circuitous route through an extensive government bureaucracy. In the situations when individuals subjected to GBV request legal assistance or protection the prosecutor’s office directs them back to FRU. FRU then sends them to DOWA where they are directed to the shelter of a local NGO rendering legal assistance to the individuals affected by GBV. In

²⁷ Corruption as a factor was not mentioned by the respondents in police or the Prosecutor’s office. The cost of court proceedings, according to the interviews, mainly involved the expenses related to the frequent trips to the city or staying in the city for rural residents. However the corruption in courts was mentioned by other respondents in Bamyan and should not be ignored as yet another factor influencing citizens’ decision to drop criminal charges or not press the charges at all.

²⁸ The respondent in Yakawlang also mentioned that they offer the parties to submit their case to Shura-i-Ulema, a body of Muslim jurists that would solve the case within the tenets of Islamic law (in case of Bamyan that would be a Shia scholars using Jafari mazhab). Shura-i-Ulema is a nation wide institution with branches in provinces and districts across the country. Yakawlang’s Shura-i-Ulema has 25 members. He mentioned that this option offers a faster process compared to the court proceedings. The Chief Prosecutor however denied that Shura-i-Ulema is involved in resolving GBV cases.

the case of district branches of the Prosecutor's office, the route is even longer and starts with the trip to FRU in Bamyan.

- **Awareness and use of ERAW Law.** According to the prosecutors, the awareness of ERAW Law is high among the staff. Both prosecutors confirmed that they use the Elimination of Violence against Women Law in their routine treatment of GBV cases. The respondents also stressed the importance of training on the implementation of ERAW Law for the prosecutors on both the provincial and district level.
- **Working with communities.** Prosecutors in the provincial and district offices described the coordination with community structures as “undesirable” and capable of compromising the bipartisan investigation. This point was specifically emphasized by the Yakawlang district prosecutor, who mentioned that community members sometimes try to conceal/distort the information or influence the investigation if consulted. According to the respondent, this behavior stems from the community's desire to solve the issue through the internal dispute resolution mechanism. “This attitude”, added the respondent “can cause the impunity of GBV perpetrators and result in the obstruction of justice”.
- **SOPs, guidelines and protocols.** There are no written policies or procedures in place to regulate the treatment of GBV cases. The procedures currently used do not address the gaps in communication, mentioned by the staff. The procedures do not require specific steps to ensure coordination with other agencies.
- **Coordination with other agencies.** While working on GBV cases the Prosecutor's office directly interacts with police, healthcare facilities and courts. According to the respondents, one of the main problems in their work with police is the pace of the preliminary investigation. The preliminary investigation often takes much longer than the period stipulated by the law²⁹. By the time the Prosecutor's office starts its investigation and sends the victim for medical examination the injuries or other physical signs of violence have had disappeared. This leads to a loss of important evidence. Productive

²⁹ According to Afghanistan's Interim Criminal Code the police are to report the crime to the Prosecutor's Office within 24 hours. According to the respondents, criminal investigation conducted by the prosecutor's office can't exceed 15 days.

coordination with healthcare sector is affected by a lack of facilities and skilled professionals in the area of forensic medicine. The Chief Prosecutor's office sends the requests for medical examination to the provincial hospital, while the district branch works mainly with the Yakawlang district hospital. The incomplete information regarding the medical examination of GBV victims submitted by the healthcare facilities, according to respondents, presents a major challenge for their work. The representative of the Prosecutor's Office participates in the meetings of the Governance Commission. However the Chief Prosecutor described the participation in the meetings as "observation" rather than active involvement.

- **Investigating zina.** The team members specifically focused part of their questions on the investigation of cases qualified as zina (consensual sexual act outside of marital unit) , According to the interviews conducted by the assessment team with NGOs in Bamyan, zina is one of the most common allegations put forward against women who were raped or run away from their families. As related by the district prosecutor, several factors affect the qualification of the situation as zina. Along with the evidence collected from witnesses, the medical examination of the woman or girl is a procedure routinely requested by the prosecutors. Sometimes the signs of physical abuse and/or sexual assault are crucial in determining whether the case should be qualified as zina (consensual sexual act outside of marital unit) or tajavuzi jinsi (sexual assault). However, due to the slow pace and delays in preliminary investigation conducted by the police this crucial evidence is often gone by the time of medical examination. The lack of trained experts of forensic medicine also leads to incomplete or flawed examination results. The interviews also revealed that the staff of prosecutor's office is not trained on interviewing the individuals possibly subjected to sexual or physical violence. Thus some cases of sexual violence may remain unidentified because of the poor capacity and coordination among the agencies. That, in turn, has a direct impact on parties involved in the case. In a case of zina both parties would be considered equally responsible for committing a crime. However, if the situation is qualified by the prosecutor as a case of sexual assault only the perpetrator will be deemed responsible for the crime. Building the capacity of police officers and healthcare professionals, as well as training the prosecutors on the interviewing and evidence collection in cases possibly involving sexual violence, can

have a positive impact in identifying the crimes of sexual assault that otherwise will be qualified as zina.

Prosecutor's office: needs and challenges in providing services to the victims of GBV.

- **Challenge: lack of trained female professionals in the prosecutor's office.** *The lack of female professionals creates problems for the Prosecutor's office in interviewing female GBV victims, accessing female witnesses and collecting evidence in private houses. Prosecutor'*
- **Need to address the gaps in coordination with the police force.** *The slow pace of the preliminary investigation conducted by the police results in the loss of important evidence. The information received from the police regarding GBV cases is sometimes incomplete. The information sharing is not regulated by a detailed procedure and suffers from the absence of detailed and comprehensive information request forms.*
- **Need to address the gaps in coordination with healthcare facilities.** *The quality of investigation suffers from the poor coordination with the healthcare facilities. The information provided by healthcare facilities is often incomplete and sometimes inaccurate. The procedure of requesting information does not include the comprehensive form that would ensure the provision of structured, standardized and detailed data.*
- **Need for forensic medicine expertise.** *The investigation of GBV cases requires proper forensic medicine specialists and equipment. The healthcare facilities in Bamyan do not have capacity (trained specialists, equipment, units specifically designated to conduct forensic examination) to conduct forensic medical examination.*
- **Need for SOPs, guidelines and protocols.** *There are no written policies or procedures in place to regulate the treatment of GBV cases. The procedures that are currently used*

do not address the gaps in coordination and information sharing. The procedures do not require specific steps to ensure coordination with other agencies and do not take into consideration the safety of individuals involved in GBV cases.

- ***Need to examine the impact of the “reconciliation approach” to family violence on GBV victims.*** *The option to reconcile and drop the charges is offered by the prosecutor’s office staff to parties involved in GBV case. The impact of this practice on the security and well-being of the alleged victim is unclear and requires further examination. However, it is clear that the reconciliation of the parties in the cases involving GBV, regardless of its outcomes or the good intentions of the mediating body, generates and secures the public belief in the impunity of violence perpetrators. The practice of “reconciling” the parties is not complemented by any monitoring mechanism that would allow preventing the violence from resuming or holding the violence perpetrator responsible for breaking the agreement.*
- ***Need to transform the circuitous referral route.*** *The Prosecutor’s office in the provincial center is engaged in the general centralized system of coordination between agencies currently existing in Bamyan. The victims of GBV who require legal assistance or protection are not referred to respective NGOs directly but have to take a route through the FRU and DOWA. The lengthy procedure requires time, mobility and resources which many people in the region do not have and is particularly burdensome for women. The procedure also puts GBV victims at additional risk of retaliation on the side of violence perpetrator.*
- ***Need to strengthen the awareness of EVAW Law.*** *The staff of the Prosecutor’s Office both on the provincial and district level need more information on the EVAW Law and its relevance for the prosecutors investigating GBV. The training sessions and printed materials that present clear and relevant information about the Law would be beneficial for the prosecutors and other staff members working with GBV cases.*

- ***Need to strengthen relations with community based structures.*** *The staff in the prosecutor's office expressed strong reservations at building closer cooperation with community based structures. The prosecutors related strong doubt in the ability of CDRMs to support the investigation. However, the prosecutors confirmed that the majority of cases involving GBV is resolved through CDRMs. In this situation, the quality of investigation conducted by the prosecutor's offices depends among other factors on the ability of the staff to work closely and efficiently with the community based dispute resolution mechanisms and other community based structures. There is a need for specific educational and advocacy programs aimed at building trust between the Prosecutor's Office and community based structures.*

4.2 City Primary Court

Involvement in GBV response

The Assessment team met with the judges of the City Primary Court, located in Bamyan provincial center. The respondents were first reluctant to discuss GBV cases. However, after the Assessment team inquired about the challenges of coordination with other agencies on the level of routine procedures the respondents actively engaged in discussion.

- **Structure, functions and services provided to GBV victims.** The Central Primary Court consists of following dewan (sections): General Criminal Dewan, Civil Dewan, Public Rights Dewan, Public Security Dewan and Traffic Criminal Dewan. Each dewan has up to four members. Criminal cases (including criminal cases involving GBV) are tried in General Criminal Dewan. The Public Rights Dewan resolves civil cases.
- **Processing GBV cases.** The information on GBV cases is mostly submitted to the court by the Prosecutor's office. The court has an internal committee that reviews all the evidence submitted with the case. The court staff can request additional information from the police, the healthcare facility or the Prosecutor's office. Sometimes joint meetings are held with all the agencies in order to share information on the case. All respondents mentioned the lack of professionals, and specifically qualified and trained, female

personnel as one of main obstacles in prompt and professional processing of GBV cases.

- **Referral.** The judges complained that women subjected to GBV often have very low awareness of the opportunities for legal assistance that exist in Bamyan. The judges sometimes refer GBV victims to the international and local NGOs that provide free legal consulting (ILF, Women to Women). However, they suggested that the citizens should receive this information at earlier stage, in the Prosecutor's office. The court staff does not provide referrals to the shelter.
- **Working with communities.** The Primary Court does not work with community based structures.
- **Awareness of EVAW Law.** The respondents emphasized that judges rely on EVAW law in their deliberations over the cases involving GBV. They did not mention any complications with the implementation of the Law in everyday court practice.
- **SOPs, guidelines and protocols.** The Primary Court does not have any policies, SOPs or guidelines regulating the treatment of individuals subjected to GBV or the processing of GBV cases. The forms for information sharing used in Court are not sufficiently detailed and specific. The judges expressed support for the idea of introducing standard procedures into the recording and sharing of information on GBV cases.
- **Coordination with other agencies.** In the course of examining the evidence in GBV cases the court staff works closely with the police, the Prosecutor's Office and healthcare facilities. The assessment revealed several gaps in coordination and information sharing between these agencies. The respondents related that the police sometimes takes months to finalize preliminary investigation which in certain GBV cases (for example, rape) results in the lack of evidence. They also related that the majority of women among the witnesses are illiterate and sign the record of their statements in the Prosecutor's office without understanding the contents. The healthcare facilities,

according to the judges, in response to court's inquiries often present unsubstantiated conclusions without proper examination. The health facilities have a hard time with establishing exact age of the individuals sent for medical examination. In the cases involving physical and sexual assault, the age of the victim constitutes an important element of the evidence and can influence a court decision. Thus the lack of facilities and professionals providing forensic medical examination, as well as a poor capacity of existing healthcare facilities creates an impediment for the proper assessment of evidence in cases involving GBV.

City Primary Court: needs and challenges in providing services to the victims of GBV.

Need for SOPs, guidelines and protocols regulating the processing of GBV cases. The City Primary Court as well as other courts in Bamyan currently does not have any SOPs regulating the treatment of individuals subjected to GBV or the witnesses in the cases that involve GBV.

Need for regulations ensuring better coordination and information sharing with other agencies. The existing procedures allow for gaps in coordination and information sharing with the prosecutor's office, police and healthcare facilities. There is a need for detailed and comprehensive information request forms that will generate consistent and comprehensive body of information regarding the case.

Need to recruit and trained female professionals was stated by the judges as one of the priorities for improving the quality of primary investigation since the female judiciary staff plays key role in working with female plaintiffs and witnesses. The need should be addressed through educational and awareness raising programs encouraging women to seek employment with the court system.

Need to have an open discussion regarding the implementation of the EVAW Law. Although the assessment team did not receive any feedback from the judges in Bamyan regarding the problems in implementation of the EVAW Law the data collected in Nangarhar province suggests that these problems may exist. Open and candid discussion addressing

the problems that judges and prosecutors face in the implementation of the EAW Law, can have a positive impact on the processing of GBV cases.

5. Ministry of Justice, provincial department.

Involvement in GBV response

The mission team met with the member of the professional committee in the provincial department of the Ministry of Justice.

- **Structure, functions and services provided to GBV victims.** The respondent described the Department's involvement in GBV response as very limited. The department receives a small number of legal cases involving GBV from the provincial police department.
- **Processing GBV cases.** The cases are registered and sent to court. The information received by the assessment team indicated that the limited scope of the involvement of the Ministry's provincial branch in the processing of legal GBV cases leaves very little room for any coordination with other agencies.
- **Referral.** The Ministry of Justice sometimes applies to the healthcare facilities with a request to conduct medical examination of GBV victims (mostly for the purposes of age determination). The respondent expressed dissatisfaction with the quality of expertise provided by the healthcare facilities.
- **Coordination with other agencies.** The limited scope of the involvement of the Ministry's provincial branch in the processing of legal GBV cases leaves very little room for any coordination with other agencies.

Ministry of Justice: needs and challenges in providing services for GBV victims

- **Need to develop SOPs and improve the capacity of ministry staff involved in processing GBV cases.** Based on assessment findings in Bamyan the provincial department of the Ministry plays a minor role in the network of organizations dealing with

GBV. The Ministry does not have any written procedures regulating GBV response. However, given the small number of cases that enter the department the Ministry's representative did not feel that the introduction of comprehensive policy regulating the processing of GBV cases was needed. He mentioned the need for the general training in the field of GBV response. The department employees dealing with legal cases that involve GBV did not receive training on processing GBV cases or working with GBV victims.

6. Ministry of Women's Affairs, the provincial Department of Women's Affairs (DOWA)

Involvement in GBV response

The assessment team interviewed the Head of the provincial department of the Ministry of Women's Affairs and some of her colleagues in DOWA's office in Bamyan provincial center.

- **Structure, functions and services to GBV victims.** As a provincial branch of the Ministry of Women's Affairs the Department of Women's Affairs (DOWA) is responsible for implementing the state policy in the area of women's affairs and coordinating the activities of other state agencies working in field of protection and promotion of women's rights and opportunities across the Bamyan province. The Department is responsible for supporting and coordinating the activities of governmental and non-governmental bodies providing services for GBV victims and working to combat GBV. DOWA has two departments working in the field of GBV response: the legal department provides legal assistance to GBV victims, while the education department organizes awareness campaigns to inform communities about the negative impact of GBV on the individuals, families and communities.
- **Access to services.** DOWA's office is open for visitors.
- **Processing GBV cases** The Department receives GBV cases from the Governor's office, police and Afghanistan Independent Human Rights Commission (AIHRC). Some people come directly to DOWA with complaints about GBV. After inquiring about the details of the case, the Department registers it and records case related information in a standard form. The cases entering DOWA mainly involve GBV in situations of family violence (mainly physical abuse by husband or mother-in-law), forced marriages, divorce complications and running away from home. The initial interviews with GBV victims conducted by DOWA staff do not include questions on the history of previous abuse or experience of various types of violence. At this early stage the experts from DOWA's legal department render initial legal assistance to GBV victims. The assessment found

that the respondents consider reconciliation of victim and perpetrator a first step in their efforts to help GBV victim. The process is conducted through talking to both sides separately and later having a joint meeting.

- **Referral.** If the mediation does not yield results the agency proceeds with referring the victim to the police or Prosecutor's office (criminal cases) or the Ministry of Justice (civil cases). The victims who cannot go back to their homes and need protection are referred to the NGO running shelter in Bamyan (Cooperation Center for Afghanistan). The decision on whether it is safe for the victim to go back to her family is made by DOWA Head and is founded on the conclusions she made from the victim's account of events and discussion with victim's and perpetrator's family members. DOWA sometimes refers GBV victims to healthcare facilities for treatment. Healthcare facilities never refer any individuals suffering from gender based abuse to DOWA.
- **Working with communities.** DOWA works with local communities to promote women's rights and disseminate information on negative impact of gender based violence on the lives of women and children. Sometimes DOWA engages community members in mediation process in order to reconcile GBV victims with violence perpetrators.
- **SOPs, guidelines and protocols.** The assessment findings suggest that apart from the initial registration form DOWA's work with GBV cases is not regulated by any elements of standard operating procedures. The staff does not use check lists or guidelines for interviewing or referral. Coordination with other agencies is also not regulated by SOPs. The introduction of SOPs regulating the recording, referral and follow-up of GBV cases by DOWA as well as training of DOWA staff is necessary for establishing efficient mechanism of assisting GBV victims.
- **Coordination with other agencies.** DOWA cooperates with the Ministry of Justice, police and shelter to follow-up on GBV cases and organize protection for GBV victims.

The follow-up, though, seems to stop after the case leaves the police, as the Head of DOWA related that they do monitor the case investigation in the Prosecutor's office.

DOWA works as a second (after the Governor's office) hub receiving GBV related complaints and channeling cases through the various routes within the bureaucratic system (police, Prosecutor's office, Ministry of Justice). The decisions on the channel most suitable for particular case are made by the Department staff. Some of the cases come back to DOWA if the individual subjected to GBV requires protection or further legal assistance. The Department does not routinely provide information regarding the cases to other agencies. During the interview with the Head of DOWA there were several mentions of the case data base maintained by DOWA. However the assessment team members were not given a chance to familiarize themselves with the database. Interviews with the representatives of Afghanistan Independent Human Rights Commission (AIHRC), police, Prosecutor's office, NGOs and other agencies demonstrated that they do not have access to DOWA's database of GBV cases. The coordination between main agencies providing services for GBV victims could benefit from further development of such database, if the access is granted to selected personnel of the key service providers.

- ***Coordination through the activities of inter-agency Commissions.*** Bamyan has two inter-institutional bodies dealing with GBV response. Cooperation and Coordination Commission (CCC) looks at specific GBV cases (selected by DOWA) along with other governance issues such as infrastructural development. CCC is chaired by the Governor of Bamyan. CCC meetings are taking place twice a month and are facilitated by DOWA. The members of CCC in Bamyan include: DOWA, United Nations Assistance Mission to Afghanistan (UNAMA), Police Department, [Prosecutor's Office, MoPH, Ministry of Justice (check against Abby's report)]. In the course of the meetings the Commission members discuss the details of the cases and the Governess gives instructions to relevant agencies on the necessary steps in processing specific cases. Based on the interviews with the agencies participating in CCC, the Commission does not seem to apply any standard procedures in addressing GBV cases. During the discussions the identity of victim and perpetrator, as well as, the witnesses are revealed in public.

The Head of DOWA brought up the provincial level ERAW Commission as another structure that deals with selected GBV cases in Bamyan province. The Commission is also coordinating efforts of various government bodies, non-governmental organizations and UN to promote the awareness of the Law on Elimination of Violence against Women (ERAW Law). The Commission is chaired and facilitated by DOWA. The Commission includes representatives from the following agencies: the Governor's Office, Provincial Council, DOWA (MOWA), PPHD (MoPH), Prosecutor's Office, Ministry of Justice, Ministry of Culture (provincial Department), Afghanistan Independent Human Rights Commission (regional office) and UNAMA. The Commission also includes the defense lawyers, provided by various NGOs.

DOWA: needs and challenges in providing services to GBV victims.

- ***Need to introduce SOPs regulating the screening and processing of GBV cases.*** *As the provincial branch of leading government agency responsible for the promotion of women's rights the Department receives a considerable number of complaints from women suffering from discrimination. However women are often reluctant to disclose violence especially when committed by a family member. The reporting of sexual violence is even more difficult. The ability of the agency's staff to identify GBV cases and encourage women to disclose the abuse is crucial for expanding DOWA's assistance to GBV victims. The Department needs SOPs regulating the screening and processing of GBV cases. DOWA staff could benefit from the training focusing on the development and implementation of such procedures.*
- ***Need to introduce new approach to coordination.*** *Despite the presence of three bodies responsible for building coordination between the agencies involved in GBV response, the respondents identified lack of coordination as the main obstacle in addressing violence. Clearly, there is a need for new approach to coordination. The findings of the Assessment demonstrate that the top down coordination effort, albeit successful in addressing GBV cases on an ad hoc basis, is not efficient in bringing change to the routine operations of the agencies. The changes should be introduced on*

an institutional level and should affect the rules and regulations governing the daily practices of the relevant agencies. DOWA should facilitate the process of incorporating specific steps that ensure coordination in the procedures that regulate the treatment of GBV cases by all agencies.

- ***Need to develop better mechanism of information sharing.*** *The Assessment found that although DOWA maintains the data base of GBV cases other agencies do not have access to this information. The Department needs a policy regulating the information sharing on GBV cases. DOWA also needs tools that will facilitate the prompt and efficient information exchange among the agencies working on specific cases. The tools should also incorporate strong mechanisms protecting the security and dignity of GBV victims.*
- ***Need to introduce changes to the referral path.*** *The Assessment findings demonstrate that citizens willing to file a complaint regarding GBV to the police have to first apply to the Governor's office, and then are often directed to DOWA. There is a pressing for easier procedure that will allow the GBV victims to apply directly to police, DOWA or other agencies. Greater number of entry points will increase the chances of GBV victims to receive assistance. Furthermore, the passing of information from one agency to another should not be assigned to a victim as many women in Bamyan have very limited opportunities to visit public places.*
- ***Need to reach out to the communities in rural areas.*** *The delivery of assistance to GBV victims residing in rural areas remains one of the main challenges for DOWA. The situation is further complicated by the challenges of reaching rural areas during the winter season. There is a pressing need to develop specific mechanisms that will increase the opportunities for rural residents to access DOWA (through field visits, informational campaigns and cooperation with local community based structures).*
- ***Need to examine the effects of "reconciliation approach" and build the sound system for monitoring reprisals of violence in "reconciled" cases.*** *DOWA's staff*

routinely employs the reconciliation approach in addressing GBV cases. However the Department does not have written procedures regulating the monitoring of reconciled cases. Thus DOWA does not have a mechanism capable of detecting the reprisals of violence as well as other consequences of the “reconciliation approach” for the well-being of the victims.

7. Afghanistan Independent Human Rights Commission (AIHRC)

Involvement in GBV response

Mission team members met with the Monitoring and Investigation Officer and the acting Head of AIHRC's regional office in AIHRC's office in Bamyan.

- **Structure, functions and services to GBV victims.** Established in 2002 under the article 58 of the Constitution of Afghanistan AIHRC is an independent body responsible for monitoring, promotion and protection of human rights in Afghanistan, as well as investigation of human rights violations. AIHRC's regional office covers Bamyan province and parts of Parwan (two districts), Ghazni (three districts), and Wardak (three districts) provinces. The regional office consists of six units, among them Women Rights Support Unit specifically dealing with violation of women's rights and Investigation Unit, tasked with investigating violation of human rights. The unit employs two female officers, both holding Bachelor's degrees in Law. Since its establishment in the province, AIHRC received 42 cases involving GBV. Within last five months the regional office received only one case. All 42 cases were presented directly to AIHRC office. No other agency referred GBV cases to AIHRC.
- **Access to services.** The Commission is open for visitors every day of the week except Friday. Access to the venue is not restricted. All the cases involving GBV were submitted directly by the individuals that visited the Commission's office.
- **Processing GBV cases.** Women's Rights Support Unit uses specific case record forms and maintains their own data base of all cases involving the violation of women's rights that enter the organization.
- **Referral.** AIHRC does not provide legal assistance to GBV victims and would normally refer the victim requesting legal help to the International Lawyers Foundation (ILF,

independent country-wide public defender organization) and Legal Aid Organization of Afghanistan (LAOA, organization that provides legal aid and trains defense lawyers in several provinces of Afghanistan). If violence is reported by the returnee, the AIHRC staff refers the victim to UNHCR's office in Bamyan. A large number of cases is referred to DOWA for further assistance. In some cases AIHRC staff recommends the victims to immediately apply to the police department for assistance.

- **Working with communities.** AIHRC works with a number of local community based structures to disseminate information about human rights. The Commission does not run community based activities aimed at spreading messages regarding GBV.
- **SOPs, guidelines, protocols.** AIHRC uses specific form for recording cases. However, the “written procedures regulating the case processing” presented to the mission team consisted of the copies of international Conventions on human rights and women's rights. No written SOPs regulating the processing of GBV cases exist in the organization. AIHRC staff did not receive any training on GBV response.
- **Coordination with other agencies.** AIHRC is available as one of the entry points for GBV victims in the province. However, the coordination and information sharing with government agencies working on GBV cases (specifically, police and the Prosecutor's office) is one of the biggest challenges faced by AIHRC in their work. AIHRC staff responsible for monitoring the cases frequently can't obtain the information from the police and Prosecutor's office. The limited (or at times completely blocked) access to the information regarding the case processing does not allow IHRC officers to monitor and reveal possible violations of victim's rights that take place within the law enforcement system. Thus AIHRC's potential as a strong external mechanism for monitoring the quality of services provided to GBV victim's within the law enforcement and judicial bodies is seriously limited by the lack of cooperation on the side of these agencies, which in turn affects AIHRC's ability to assist GBV victims in their struggle for protection and justice.

AIHRC: needs and challenges in providing services to GBV victims.

- ***Expanding AIHRC involvement in GBV response.*** *The interviews with the staff of the agencies involved in GBV response demonstrated that AIHRC is perceived by many as one of the institutions capable of providing efficient help for the victims of GBV. However this belief does not necessarily translate into the active referral of the victims to AIHRC on the side of other agencies. The strong case monitoring capacity rendered by AIHRC's mandate remains underused by many agencies and GBV victims who encounter right violations in the law enforcement or judiciary bodies.*
- ***Need to build better coordination and information sharing with other service providers.*** *The services that AIHRC delivers to the victims of GBV fall into two broad categories: legal assistance (through referral to legal assistance NGOs) and case monitoring. While the performance in the area of legal assistance does not seem to encounter major problems, the monitoring of GBV related cases suffers considerably from the lack of cooperation with the agencies involved in investigation of GBV cases and protection of GTBV victims. The procedures regulating information sharing with regard to GBV cases between the police and prosecutor's office and AIHRC would assist the Commission in fulfilling its mandate and would provide additional mechanism of protection against human rights violation for the victims. The joint training sessions with the police and prosecutor's office would also assist in incorporating the cooperation into the system. At the same time, other agencies could benefit from the data base of GBV cases maintained by AIHRC's Women's Support Unit.*
- ***Need for the capacity building among AIHRC staff.*** *The staff of the regional office of the AIHRC received extensive training on the protection of Human Rights. However AIHRC employees (especially those in Women's Support Unit and the investigative Unit) could benefit from the training courses on the treatment of GBV victims, information sharing, coordination and cooperation with other service providers (jointly with the police and prosecutor's office) and improving internal procedures for processing GBV cases.*

- ***Need to reinforce the cooperation with community based structures in addressing GBV.*** Building connections with the CDRMs and other community based structures could strengthen AIHRC's ability to monitor GBV cases and assist the victims. This assistance can be rendered, for example, in the cases when the interference of CDRM fails to stop the violence or the violence resumes after the parties accepted the conditions for reconciliation offered to them by CDRM or one of the state agencies. The victim should be aware of AIHRC's capacity to provide legal assistance and monitor the case if she/he decides to press official charges against the perpetrator. Working together with the community based structures is also crucial for spreading the awareness of the GBV as human rights violation among the general public.

"They need to understand that 'independent' does not mean 'isolated'" - respondent, AIHRC, regional office.

8. Non-governmental Organizations

8.1 Cooperation Center for Afghanistan

Involvement in GBV response

- **Structure, functions and services provided to GBV victims.** Cooperation Center for Afghanistan (CCA) is a non-governmental organization working in the field of women's rights, the organization runs a shelter for women in Bamyan. The assessment team met with the Head of the Regional Office of Cooperation Center for Afghanistan in the organization's office in the Bamyan provincial center. The team also visited the shelter and interviewed the manager and one of the shelter's staff members.

Established 1990, Co-operation Center for Afghanistan (CCA) is an Afghan non-governmental, non-political, non-profit making organization working to promote and protect human rights and alleviate poverty. The operations of the regional office located in Bamyan cover all of the Bamyan province and parts of Wardak and Madyan provinces. As a part of its *Protection of Women at Risk Program*, CCA established a safe-house (shelter) for women, victims of family violence in Bamyan. The organization also provides legal assistance to women subjected to violence.

8.2 Shelter

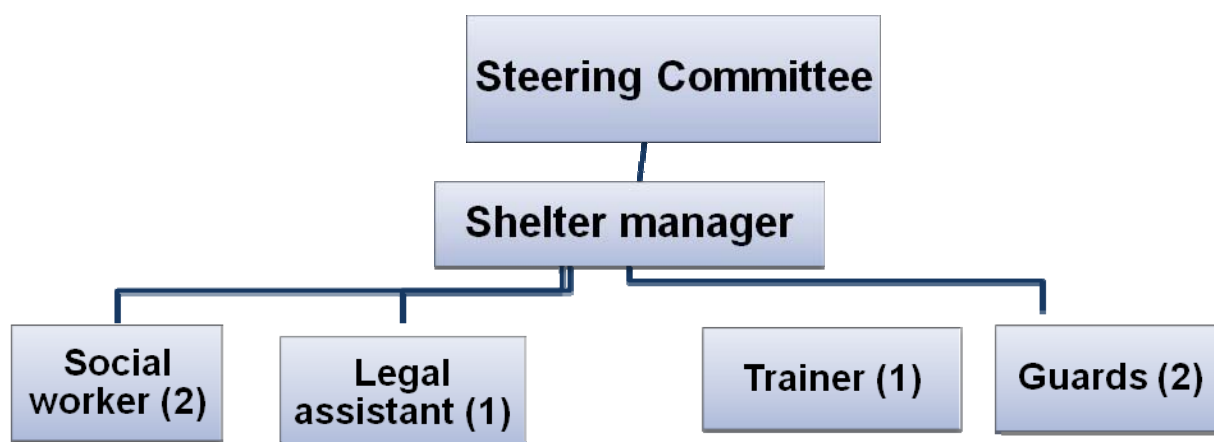
Involvement in GBV response

- **Structure, functions and services provided to GBV victims.** The shelter (safe-house) managed by CCA is located in the provincial center of Bamyan. The exact location of the shelter is kept confidential in order to protect the safety of shelter residents and staff members. The shelter is funded by UN Women and operates in close coordination with the provincial Department of Women's Affairs (DOWA). All crucial decisions related to the operations of the shelter are discussed and adopted by the Steering Committee.

Among other issues the Steering Committee, based on the reports from the shelter staff, makes decisions regarding the acceptance of women into the shelter, the extension of their stay or their release. The Steering Committee members include CCA, DOWA, UNAMA, UNHCR, Provincial Police Department, Prosecutor's Office, Provincial Directorate of Public Health (PPHD), AIHRC and Primary Court. The staff of the shelter consists of the shelter manager, two social workers, legal assistant, trainer and two guards. The facility can accommodate 9 residents with children and has room for two extra residents in the case of emergency.

In addition to providing accommodation, food and protection to the female victims of gender based violence the shelter offers some educational opportunities. There are classes on cooking, sewing, legal education, basic health and physical education. The shelter also offers literacy classes. Those who decide to file complaint with the police are assisted by the shelter's lawyer or lawyers provided by other NGOs. Although the shelter has its own legal assistant the facility also engages the services of the defense lawyers provided by other NGOs. The legal assistant accompanies women to the police, prosecutor's office and court, providing necessary help and presenting information about the case. The shelter staff continues to monitor the situation after the shelter resident is released and joins her family.

Figure. Shelter management structure.



- **Access to services.** The shelter is located in a gated residence guarded by security personnel. Most neighbors, according to the respondents, are not aware of the purpose of the facility. The location of the shelter is kept confidential and the access is very restricted. In order to enter the shelter, a woman needs to receive and bring a letter from DOWA. The letter normally carries her signature confirming that she agrees to reside in the shelter. Following the acceptance, the Steering Committee decides on the duration of the stay. In 2010 23 women stayed in the shelter for varying periods of time. By August 2011 the shelter received 11 cases. At the time of the assessment, four women, two of them with children, were residing at the shelter.
- **Processing GBV cases.** The facility uses in-take registration forms that are kept in files for easy reference. The women and girls who left their families due to various forms of abuse (physical and sexual violence, forced marriage, prevention from receiving education, deprivation from getting inheritance) constitute the majority of shelter residents. Some women are sent in from the local prison after completing their term – this category stays in the shelter in order to avoid violent reprisals by family members. This is specifically relevant for women accused of *zina* (at the time of examination, two shelter residents completed terms in prison based on this accusation). Female children of any age and male children up to seven years old can stay in the shelter with their mothers. At the beginning of their stay, women are required by the shelter rules to undergo medical examination in the provincial hospital. According to the shelter staff, this is done in order to identify any health problems that would require women to stay in the hospital rather than the shelter.
- **Referral** Women are normally referred to the shelter by DOWA. If the case is referred by another agency the GBV victim still has to obtain a letter from DOWA.
- **Release from the shelter.** The release from the shelter requires the approval of the Steering Committee. Prior to the release, the shelter staff examines whether it is safe for the woman to return to her family and community. They negotiate with the family

of GBV victim in order to ensure that she will be accepted and will not be subjected to violence. The family member (often husband or father, sometimes the violence perpetrator) is required to sign a letter guaranteeing the safety of the shelter resident if she is released. According to the shelter staff, the social workers try to keep in touch with the former shelter resident to monitor for possible out-breaks of violence. The shelter worker related that in one case the monitoring demonstrated that husband continued to abuse former shelter resident. The social worker passed the information to the Prosecutor's office through the Steering Committee. Finally the abusive husband was imprisoned based on a court decision.

- ***Working with communities.*** *The procedure of release sometimes involves cooperation with the shura members of relevant community. The members of shura confirm by their signatures the guarantees of security provided by the family. The same practice is used when the victim and perpetrator are offered "reconciliation". In this case, the victim does not press charges with the police, the shelter staff requests a signed commitment from the perpetrator (and sometimes shura members) and releases the women.*
- ***SOPs, guidelines and protocols.*** *Although the shelter staff described certain ways of organizing the acceptance and release of the shelter residents, the interviews revealed that the shelter does not have any written standard policies or procedures regulating the treatment of GBV victims. The information regarding cases is recorded in the in-take forms and stored in a filing system. The shelter staff did not receive any training specifically focusing on the treatment of GBV victims and complained about the lack of expertise.*
- ***Coordination with other agencies.*** *The Steering Committee provides an efficient format for coordinating with other agencies working in the field of GBV response. The meetings take place bi-weekly and allow for the exchange of information regarding individual cases, as well as coordination in addressing the needs of the shelter. One*

example of such coordination is the special arrangement that allows shelter residents to receive fast medical assistance. Based on the agreement between PPHD and CCA, while visiting the hospital for medical examination the shelter residents are allowed to use the fast track. The Provincial Police department provides the car and the driver to take women to the court or hospital. AIHRC assists the shelter with monitoring the cases during the investigation and in court.

CCA Shelter: needs and challenges.

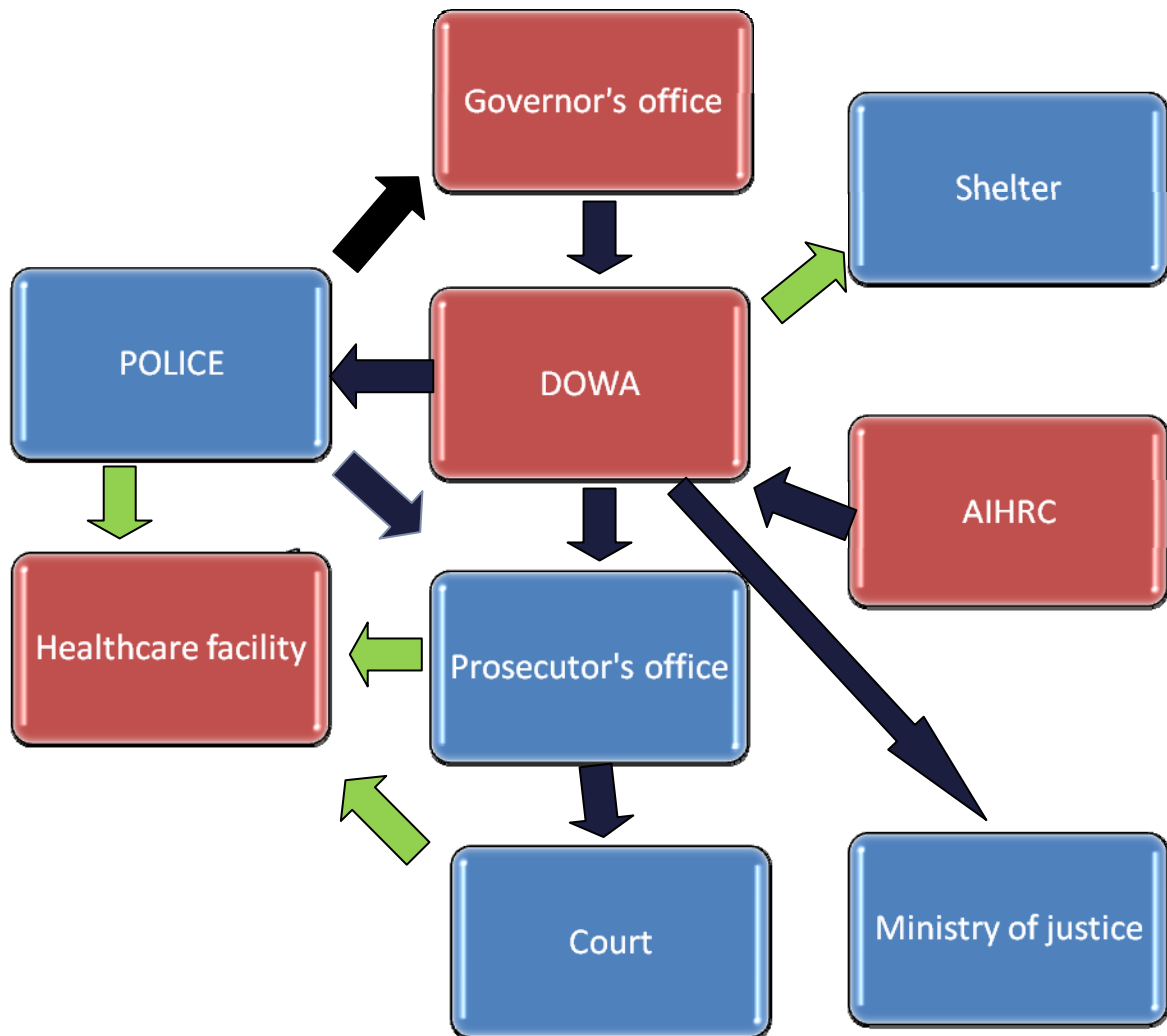
- ***Need for the in-house medical professional.*** *The shelter could benefit from the regular visits of a physician that would provide basic healthcare service on site. Otherwise the shelter residents have to wait for the police car to take them to a hospital.*
- ***Need for written procedures regulating the coordination between agencies.*** *The hand-over of information regarding coordination with the shelter in the government agencies is not well-organized. According to the interviews, CCA has to introduce every newly appointed official to the current agenda as well as to the general framework of cooperation.*
- ***Need for psycho-social counseling for GBV victims in the shelter.*** *The capacity for psycho-social counseling in the healthcare facilities is very low. The shelter residents often suffer from stress and depressions caused by GBV and require the services of psycho-social counselor.*
- ***Need for more elaborate guidelines regulating the treatment of GBV victims and coordination with other agencies.*** *The shelter does not have written guidelines that stipulate the rules and regulations for interviewing and treating GBV victims. There*

are no rules and regulations regarding the procedures for “reconciliation” and release of the shelter residents, as well as the guarantees of their safety.

- **Challenge of re-integrating shelter residents into their families and communities.** *The stigma carried by many victims who dared to disclose their experience of abuse is intensified when they leave their homes to reside in the shelter. Thus shelter residents often have to deal with the double burden of accusations and threats caused by the fact that they spoke publicly about GBV and stayed outside of their family home. Re-integrating these women into their families and communities is a difficult task, that requires joint efforts of government agencies, shelter workers and authority figures within the respective communities. There is a need for special programs addressing the issue of re-integration and protection of released shelter residents.*
- **Need to build the capacities that increase the empowerment and protection of women.** *Giving the shelter residents a set of skills that will allow them to achieve some level of economic independence and increase their ability to protect themselves and their children is crucial for their well-being outside of the shelter walls. It is important to support the shelter in equipping the women with the skills that will be relevant for their individual circumstances.*
- **Need to expand the number of facilities that provide similar services to the population in the rural areas.** *The shelter capable of accommodating 11 people clearly cannot satisfy the need for protection of GBV victims across the province. For many GBV victims from the districts, reaching the facilities located in the provincial center is nearly impossible. There is a need for the safe houses located closer to rural areas. The situation also calls for a variety of facilities offering services that would range between full-time residence and short term assistance (for example, crisis centers or family counseling groups).*

BAMYAN PROVINCE.

GBV RESPONSE: MAIN SERVICE PROVIDERS



Entry points for GBV victims.



Two-directional movement of cases



Single-directional movement of cases and information

Chapter 3: NANGARHAR PROVINCE

Nangarhar provincial profile³⁰

Nangarhar province is situated in the East of Afghanistan. The province shares borders with Kunar and Laghman provinces to the North and Kabul, Logar and Paktya provinces in the West. Nangarhar borders with Pakistan in the East and South. The province has a territory of 7616 km² and is divided into 22 districts. Mountainous or semi-mountainous terrain covers more than a half of Nangarhar's territory (54.8 percent), the rest of the area is a flat land. The population of Nangarhar province totals 1383,900 people³¹.



Map of Nangarhar

Around 87 percent of people in the province reside in rural areas. Urban residents constitute 13 percent of overall population. The average household in Nangarhar consists of 8 people. The population has a slightly larger share of men (51 percent) than women (49 percent). Among the ethnic groups living in the province, Pashtuns constitute a majority (90 percent). Other ethnic groups include Pashayee, Tajiks, and Gujjars. 92.1 percent of rural residents in the province speak Pashtu. Nangarhar has a large population of Kuchi, nomadic groups that migrate to the province in winter months. Most common religious affiliation among the residents of Nangarhar is Sunni Islam (*Hanafi mazhab*).

According to some estimates close to half of the population of Nangarhar migrated to Pakistan during the war and later returned to the province. Massive migration created certain tension concerning the issues of land ownership.

Agriculture is a major source of income for rural residents. Nangarhar province includes the Jalalabad plain, one of the most important agricultural areas of Afghanistan. Rich land and abundant water resources secure good agricultural production in the province. The

³⁰ The profile uses information from the Statistical Year book 2010-2011, prepared by Afghanistan's Central Statistics Organization, Afghanistan National Risk and Vulnerability Study 2007-08, Provincial Development Plan, and the Nangarhar Provincial Profile prepared by the Ministry of Rural Rehabilitation and Development (MRRD), 2007.

³¹ Statistical Year book 2010-2011, Tables 5-3,5-7,[http://cso.gov.af/en/page/4725\(last](http://cso.gov.af/en/page/4725(last) accessed on 11/28/2011)

agricultural sector produces a wide variety of crops, vegetables and fruits including rice, maize, sunflower, beans, potato, wheat, oranges, tomatoes, cucumbers and egg plants. Nangarhar was once a centre of opium poppy production in the country. However as a result of government efforts in recent years the production decreased.

The province's capital Jalalabad is located at the junction of Kabul and Kunar rivers. The city has a population of 188,300. The residents of Jalalabad benefit from intensive trade supported by the constant flow of goods from Pakistan. Strategic location at the trade route between Kabul and Peshawar makes the areas around Jalalabad one of the most economically developed areas of the country. More than half of all roads in the province (54%) are able to take car traffic in all seasons, and a third (34%) able to take car traffic in some seasons.

On average, 24 percent of all households in the province have access to safe drinking water, 19 percent use electricity. The province has a system of public electricity supply.

Overall literacy rate in the province is 29 percent. However the private education sector seems to be burgeoning in Jalalabad. The city streets are filled with advertisements of private colleges and lyceums. The literacy rate among female population (8 percent) is considerably lower compared to male population (40 percent)³². According to the data provided by the Central Statistics Organization for 2010-2011 girls constituted 37 percent of all students in public schools³³. This indicator has not seen much increase since 2007-08 when the share of girls in public schools totaled 36 percent³⁴.

The province has 73 Basic Health Centers, 19 Comprehensive Health Centers and 6 hospitals (694 beds). The number of medical personnel employed by the Ministry of Public Health totals 349 people. 65 percent of province's population can reach the nearest healthcare facility within one hour (by some transportation vehicle)³⁵.

³² National Risk and Vulnerability Assessment , 2007-08

³³ Statistical Year book, 2010-2011, Table 4-19: Number of Students in Government General Education Schools 2009-10, <http://cso.gov.af/en/page/4725>(last accessed on 11/28/2011)

³⁴ Statistical Year book, 2010-2011, Table 4-19: Number of Students in Government General Education Schools 2009-10, <http://cso.gov.af/en/page/4725>(last accessed on 11/28/2011)

³⁵ Statistical Year book 2010-2011, Tables 5-3,5-7,<http://cso.gov.af/en/page/4725>(last accessed on 11/28/2011)

All aspects of daily life in the province are affected by highly volatile security situation. In 2011 the armed attacks on police officers and government employees continued. Armed robbery is common in Jalalabad. The security risks in the southern districts of Nangarhar are higher than in the northern areas. The insurgents active in the area are most prevalent in the southern districts that they use as a base for infiltrating the rest of the province³⁶.

³⁶ Information on the security situation in the province derived from the provincial profiles prepared by the Institute for the Study of War, <http://www.understandingwar.org/region/regional-command-east#Nangarhar> (last accessed on November 29, 2011)

ASSESSMENT FINDINGS: NANGARHAR PROVINCE

1. Healthcare sector

124 healthcare facilities deliver services to the population of Nangarhar province (1,383 900 people)³⁷. The province also has 850 Health Posts that deliver primary healthcare services³⁸. Jalalabad city with its population of 188,300 has healthcare facilities ranging from Health Posts to the Regional Hospital. Population's access to healthcare services in the province is seriously hindered by the lack of facilities and trained medical personnel. In last two years increasing security risks made it more difficult for the people from remote rural areas to travel to the large healthcare facilities in the provincial center. Deteriorating security situation leads to families imposing more restriction on women's mobility, which in turn affects women's access to healthcare facilities. The returnees constitute a large population group in the province. While some returnee communities live in the camps others have already moved to the permanent residence both in rural and urban areas. Intensive rural urban migration increases the workload of healthcare facilities in the city.

1.1. Provincial Public Health Directorate, Ministry of Public Health.

Involvement in GBV response

- **Structure, functions and services provided to GBV victims.** The Provincial Public Health Directorate is responsible for overseeing and coordinating the implementation of the Basic Health Care Package and Essential Hospital Service Package in the province. The Assessment team interviewed employees of the Provincial Public Health Directorate (PPHD) of the Ministry of Public Health in PPHD's office in Jalalabad.

³⁷ Statistical Year book 2010-2011, Tables 5-3,5-7,[http://cso.gov.af/en/page/4725\(last](http://cso.gov.af/en/page/4725(last) accessed on 11/28/2011)

³⁸ Healthcare Management Information System 2010

The interview revealed that the involvement of PPHD in GBV response is currently weak and requires further development. The direct service provision is not a part of PPHDs mandate.

PPHD does not receive data on GBV cases from the health facilities across the province on a regular basis and in a standardized format. As a result PPHD can't accumulate and analyze comprehensive information on the situation with the state of health service delivery to GBV victims in the province.

PPHDs work with the healthcare facilities in the province does not regularly address the role of healthcare sector in the service provision for GBV victims. The Directorate does not currently run any province level programs or projects aimed at strengthening GBV response by the healthcare sector.

- ***Processing GBV cases.*** The staff of the Directorate rarely directly interacts with GBV victims, because a very small number of them apply to PPHD for assistance. Those who apply are always referred by the provincial police department. Majority of women contacting PPHD suffer from physical violence inflicted by a family member (mostly, husband). The respondent related that women are very reluctant to disclose GBV experience to PPHD's male staff members and prefer to talk to the female officers. Currently there are two female Public Health officers among the PPHD personnel. The officers received training on The Rights of Women in Islam provided by DOWA and Agha Khan Foundation. The assistance to GBV victims provided by the female officers consists of "counseling" and referral to the regional hospital located very close to PPHD office. The "counseling", as described by the respondent, had a strong focus on the duties of husband and wife according to Islam. The PPHD staff was not trained to provide psycho-social counseling for GBV victims and the respondent expressed interest in receiving such training. The interview demonstrated that the respondent's knowledge on the subject of roots, consequences and types of GBV is minimal.
- ***Referral.*** Very small number of GBV cases is referred to PPHD by police. The staff of the Directorate refers GBV victims to the regional hospital for medical treatment.

- ***Working with communities.*** The Directorate is not involved in activities that engage community based structures in addressing GBV.
- ***SOPs, guidelines and protocols.*** The Directorate does not have written policies or procedures regulating the processing of GBV cases and coordination with other agencies for GBV response.
- ***Coordination with other agencies.*** PPHD involvement in coordinated efforts on GBV are mainly focused on addressing selected GBV cases within the framework of Cooperation and Coordination Commission (CCC.) PPHD's representative participates in the meetings of the CCC that address individual GBV cases (for the most part selected and presented by DOWA) on a monthly basis. The coordinated activities do not translate into institutionalized practices. Outside of participation in CCC meetings, PPHD only works with health providers and does not engage in coordinated activities with other agencies or organizations working in the field of GBV response.

We provide counseling to assist women with their stress and give them awareness about women's rights in Islam. If wife and husband knew their rights according to Islam there would be no violence" –female officer, PPHD, Jalalabad.

PPHD: needs and challenges in providing services to GBV victims.

- ***Challenge:*** GBV response is not sufficiently incorporated into PPHD activities.
- ***Need for a policy outlining a vision for PPHDs involvement with GBV response.*** The assessment did not discover any policy or strategy presenting the Directorate's vision of addressing the problem of GBV through the involvement of the healthcare

sector in the province. The lack of such vision prevents the development of consistent and planned intervention measures for GBV response.

- **Need for structure/unit responsible for GBV related interventions.** PPHD currently does not have any specific structure/unit responsible for the coordination of GBV related services in the healthcare facilities across the province. In order to strengthen its input in the building of stronger coordinated response to GBV the Directorate needs to establish specific unit responsible for developing and coordinating GBV related interventions in the healthcare facilities and supporting inter-agency cooperation.
- **Need for data collection and assessment of the healthcare sector's response to GBV on the provincial and district level.** Currently, the Directorate does not receive information on GBV cases entering healthcare facilities and services provided to patients suffering from GBV. Even if this data was recorded in general activity reports received by PPHD from the healthcare facilities, the assessment did not reveal any analysis of GBV related data performed by PPHD.
- **Need for custom made programs strengthening the healthcare sector's response to GBV.** PPHD does not have any programs building the capacity of healthcare professionals and healthcare facilities in the province, to identify, treat and refer patients suffering from GBV.
- **Need to strengthen cooperation with Health Shuras on dissemination of information about negative impact of GBV on the health of individuals and families.** Health Shura is a strong vehicle facilitating communication with local communities. PPHD needs specific programs aimed at building closer cooperation with Health Shuras in disseminating messages on the negative health impact of GBV on individuals and families.
- **Need to build the capacity of PPHD staff to develop stronger cooperation with other agencies.** The staff of the PPHD is not trained to develop province level

initiatives (programs or projects) addressing the coordination between the agencies working in the field of GBV response.

- ***Need to educate PPHD personnel on the roots, consequences and types of GBV.*** *The respondents demonstrated general awareness of GBV issues. However the assessment found that PPHD staff did not receive any training on GBV as a major problem affecting public health. The PPHD staff could benefit from training that focused on the impact of GBV on national public health and the role of the healthcare sector in GBV response. This type of training could provide a necessary foundation for more comprehensive educational initiatives in the area of GBV and health that will be developed by PPHD for the healthcare sector in Bamyan province.*

1.2. Healthcare facilities

Involvement in GBV response

The volatile security situation in Nangarhar and neighboring provinces inevitably affects the opportunities to access the healthcare facilities across the area. Due to security considerations the assessment team could not travel to the remote rural areas of the province and the data collection was conducted in Jalalabad City. The healthcare facilities examined in Jalalabad City area differed in their capacity and size of catchment area. The assessment team selected the healthcare facilities based on the size, proximity to the city center and type of community serviced by the facility. The presence of refugee population is one of the most important factors informing the socio-economic situation in the province. Thus the selection included the healthcare facility that delivered services to refugee population. The healthcare facilities visited for the assessment included: the provincial hospital in Jalalabad city, general Basic Health Facility (BHC) in Jalalabad city and Basic Health Facility (BHC). In order to obtain information about the small size healthcare facility in the areas outside of Jalalabad the assessment team conducted extensive semi-structured interviews with two staff members of the Basic Health Center located in a village outside of the city area. The facility was also selected due to its connection to the refugee community residing in the village. Thus the group of healthcare facilities examined by the assessment team featured:

- large and small size facilities,
- facility located close to the downtown Jalalabad as well as the one situated in rural area outside the city
- facility serving communities across Nangarhar and three neighboring provinces(Nuristan, Kunar and Laghman) , facility serving small community in one of Jalalabad's districts and facility serving the village with large refugee community

The assessment findings demonstrated that the HF at all levels experience serious challenges in providing assistance to the victims of GBV. Some of these challenges were common for the HF on all levels of the healthcare system. Other problems were pertinent for the specific HF type. The assessment findings elucidate the differences in challenges, needs and opportunities present in HF in Jalalabad and rural areas outside the city.

a) Large size HF in Jalalabad City, close to the downtown area.

Level: Tertiary Care Service.

Regional Hospital, Jalalabad city.

- ***Structure, functions and services provided to GBV victims.*** The catchment area of the Regional Hospital covers all four eastern provinces (Nangarhar, Nuristan, Kunar and Laghman). The assessment team visited hospital's Obstetrics/gynecology and interviewed two female doctors. One of the respondents was also the focal point of the Forensic Medicine Unit (FMU) in the Obstetrics/gynecology Department and was routinely invited by FMU to examine the patients subjected to sexual abuse. Also present at the meetings was the Public Health Officer, PPHD who also works as OBG in the regional hospital. The respondents related that most patients suffering from sexual abuse arrive to the hospital to visit the FMU, they are then directed to OBG Department. Otherwise the number of female patients disclosing subjection to any type of violence is extremely small. Among these patients the complaints related to physical violence are more common compared to disclosure of sexual violence. The respondents are not

required by any procedure and routinely do not ask probing questions to identify if the patients' health issues are related to undisclosed GBV.

- **Access to services.** The access to the venue is unrestricted however receiving the medical assistance may take hours. There was no guard or reception/registration area at the hospital's entrance and people were coming in and out of the building freely. At the time of assessment team's visit women constituted the majority of visitors. They were sitting and standing in small groups inside and outside the hospital building. The volume of visitors clearly exceeded the capacity of the hospital. The hospital yard was filled with patients who spend hours in line to receive medical assistance.
- **Processing GBV cases.** The OBG Department does not have a procedure stipulating and regulating the registration of the patients suffering from GBV. Since the actual disclosures of GBV happen rarely and are not encouraged or supported by the doctors the registration or reporting of such cases is not a part of any routine practices performed by the department personnel. The respondents related, that as "almost all GBV cases entering the Department are already registered by FMU there is no need to register them again". The doctors are not required to record or report the patients' histories of GBV to FMU or any other unit inside the hospital. The hospital maintains a criminal registry book for the cases that involve injuries received as a result of armed assault. According to the respondents, they do not remember the cases involving GBV being ever recorded in the book.
- **Referral.** Most of the patients suffering from GBV are sent to the hospital by the provincial police department. Some are referred to the hospital by DOWA. Unwritten procedure regulates the movement of patients referred by police within the hospital system. They first have to visit PPHD (PPHD's office is located very close to the hospital building), then are directed by PPHD staff to FMU and then, based on the decision by FMU staff, are sent to the OBG Department for examination or treatment. The department staff related that sometimes they refer the patients to AIHRC and DOWA. However, when asked what kind of assistance they provide to women who find

themselves under the threat of violence if they go back to their families, the respondents said, that they never encountered the patient with this type of problem.

- ***SOPs, guidelines and procedures.*** In hospital departments (apart from FMU) the treatment and referral of the patients suffering from GBV is not regulated by any SOPs, guidelines or procedures. The OBG Department that has female doctors may be the place where women are most likely to disclose the exposure to GBV. However the Department does not have any internal procedures requiring and regulating the screening, registration and referral of GBV victims. The Department staff is not trained to perform these functions and has poor understanding of the extent of assistance that healthcare facility can render to the women suffering from GBV.
- ***Working with communities.*** The respondents could not provide any information on the HFs work with community based structures. The HFs staff did not express any concerns regarding the pressure from family and community when violence is exposed by victim or medical personnel. This, however, may be caused by a very limited scope of the GBV cases identified by the HF staff.
- ***Coordination with other agencies.*** The facility is not involved in any coordinated activities that bring together various agencies assisting the victims of gender based abuse. The department staff is aware of the work of Coordination and Cooperation Commission (Governance Commission), however there was no indication regarding the participation of the regional hospital in CCC.

b) Forensic Medicine Unit, Regional Hospital, Jalalabad city.

- ***Structure, functions and services provided to GBV victims.*** The crucial role played by the Forensic Medical Unit (FMU) in the investigation of GBV cases was repeatedly mentioned by the staff of law enforcement and judicial bodies interviewed in Jalalabad. At the same time some of the respondents expressed their concerns regarding the

accuracy of information provided by FMU. However, overall opinion was that the presence of FMU is increasing the quality of investigation and thus helps to generate fair and accurate evidence in cases involving GBV. The assessment team interviewed the Chief of FMU in the Unit's office in the regional hospital. Three FMU staff members were present during the interview and periodically participated in the conversation.

FMU is a part of regional hospital. The Unit was established 2.5 years ago and currently has 6 doctors trained in forensic medicine. It is located in the building of regional hospital in two very small rooms³⁹. The small size of current venue makes it difficult for 6 doctors to conduct several forensic examinations at the same time. The respondent also complained that FMU does not yet have the equipment necessary for conducting advanced forensic examination or even a laboratory. The Unit does not have its own ambulance, which makes it difficult to reach the rural areas. The respondent brought an example of the recent case that involved the murder of woman by her father-in-law. The murder took place in one of the villages. The FMU staff had to wait for more than 24 hours before they could find an ambulance and take the doctors and necessary equipment to the crime scene.

- **Access to services.** The FMU is located within the hospital building, the access to the FMU's office is unrestricted during the working hours.
- **Processing GBV cases.** In the last 6 months only the Unit registered and examined 3,700 cases (that is more than FMU in Kabul). Of those 300 cases involved the procedure of age determination. Among them the requests for the examinations related to GBV cases were rather frequent (no specific number available). GBV cases mostly involve physical violence against women perpetuated by close family member (husband or mother-in-law). Some people approached FMU directly when they or their relatives were subjected to GBV and required forensic examination (often as evidence for divorce procedure). Big share of requests came from the police department. Slightly smaller number was directed to FMU by the prosecutor's office. Very small number of requests was submitted by the AIHRC. All cases entering the Unit are registered. The Unit does not accept the cases directed from police or prosecutor's office without the information

³⁹ According to the respondent the Unit should move to its own new building soon. *Interview with the Chief of FMU, September 12, 2011, Jalalabad City.*

request letter (*iste'lam*). The Unit follows the procedure of registration established by forensic medicine guidelines they received through training. The information on all cases (not specifically the cases involving GBV) is recorded and stored in accordance the guidelines. The procedure followed by FMU does not require the staff to report GBV cases to any other agency. However the FMU shares quarterly reports on the Units activity with MoPH (PPHD), DOWA and AIHRC.

- **Referral.** The vast majority of cases is referred to the FMU by the provincial police department and the provincial Prosecutor's Office. The respondent related that the Unit needs female staff members for the cases that require the examination of sexual assault victims. At the moment the examination is routinely conducted by the doctor from regional hospital's OBG department. The results of forensic examination are sent back to respective agencies. The FMU staff does not refer the patients subjected to GBV to any other agency.
- **Examination of GBV cases.** FMU does not have specific written procedures that regulate the processing of GBV cases. However, the Unit staff follows specific unwritten procedure to arrange the virginity tests⁴⁰ and examination of patients subjected to sexual assault. Patients have to be examined by a female OBG in the presence of two other members of OBG Department (the Head of the Department and the Deputy). All three doctors then should sign the document certifying the examination results. The document is filed in FMU's office. The examination results are then recorded on the same information request letter that was submitted by the agency. This is done to ensure that the information is not misplaced or assigned to other case.
- **Working with communities.** The facility is not engaged in any work with community based structures.

⁴⁰ The respondent related that virginity tests are often requested for the girls who run away from their homes. However other interviews suggest that virginity test is performed in cases that involve kidnapping and is sometimes used to substantiate an accusation of committing *zina*. Based on the evidence generated by the Assessment, the practice of using virginity test as evidence and its implications for women and girls subjected to GBV raises serious concerns and require further examination.

- **SOPs, guidelines and procedures.** *The treatment of GBV cases is not regulated by special set of procedures and the OBG doctor or FMU staff members did not receive any training on the treatment or examination of the patients subjected to GBV.*
- **Coordination with other agencies.** According to respondents, the information request letters (*iste'lam*) received from police and prosecutors are sometimes not clear as to which information the agency requires. .At times the same patient had to approach the Unit with the request letters twice within a couple of days, because the agencies did not indicate in *iste'lam* all information that it needs from FMU. There were cases when the same person was directed to FMU several times from various agencies, which certifies to the lack of information sharing between the institutions involved in investigation of these cases. Multiple examinations require time and resources (for travelling or staying in the city, for rural residents) that many people find very hard to invest. This practice also may put GBV victim under additional threat if her visits are discovered by violence perpetrator. Multiple examinations of the same case also increase the workload of the Unit.
- **Pressures of working with GBV cases.** The FMU doctors reported experiencing pressure from the families of patients or other agencies throughout the forensic examination of GBV cases. In order to avoid the complications they normally try to finalize the examination procedure within an hour. According to EVAW Law the violence against girls is subject to more severe punitive actions. Thus the determination of patients' age can be crucial for the investigation of GBV cases. However, identifying the age of the victim is often difficult. Large portion of the population in Afghanistan does not possess ID cards, birth certificates or other documents that could certify their age. Police frequently has to request forensic examination In order to establish the age of GBV victims. The interviews revealed that the issue of age determination is generating considerable tension. The Unit staff communicated that they are subjected to accusation of corruption and other types of pressure in relation to age determination results. It is important to note, that these accusations were related to the assessment team by the respondents in the prosecutor's office.

c) Small size HF in Jalalabad City. Level: Primary Care Service.

Basic Healthcare Center (BHC), Zarinabad, Jalalabad City

- **Structure, functions and services provided to GBV victims.** BHC is located in Zarinabad district of Jalalabad city. The Basic Health Center has a catchment area of 8000 families (approximately 56000 people). This population size, according to Afghanistan's Basic Health Service Package, requires a higher level health facility, Comprehensive Health Clinic, CHC. The BHC has only 8 staff members, among them a lead doctor and BHC manager, a vaccinator, a pharmacist, two midwives and a guard. The assessment team conducted group interview with BHC staff (chief doctor, vaccinator, pharmacist and two midwives). The facility had female patients that disclosed the experience of GBV perpetrated by family member (most often husband). The cases mostly involved physical injuries and depression caused by the violent acts.
- **Access to services.** The BHC is located in the modest and quiet neighborhood away from the noisy city center. The access to the venue is unrestricted.
- **Processing GBV cases.** The healthcare facility maintains the general tally sheet for the registration of incoming patients. It contains brief description of a nature of the patient's healthcare problem. There is no specific procedure for registration and reporting of GBV cases. The facility does not keep record of possible criminal cases. As in other healthcare facilities the midwives in Zarinabad BHC are the first healthcare professionals who receive female patients. The midwives as well as other staff members of BHC did not receive any training on the screening, treatment and referral of GBV victims. However the interviews with midwives in BHC revealed that they developed their own methods for the identification of patients suffering from GBV.

The chief doctor and the midwives related that depression and physical injuries are the main signs that alert doctors to a possibility of GBV. While filling the female patients' history form, the midwives routinely check for the signs of depression or physical injuries. If the symptoms of depression or injury signs are in place the midwives ask carefully worded probing questions (the technique they developed based solely on to their own experience and cultural sensitivity). If they have reasons to suspect that the patient is a victim of GBV

they do not immediately share their suspicion with her. As explained by the midwives this type of statement may scare or embarrass the patient. As a next step the midwives ask to talk to the patient's family. Without disclosing their suspicions regarding GBV the midwives explain to the family members the health consequences of depression and physical injuries. They recommend protecting the patient from any kind of stress. In cases of severe depression they refer the patient to the Comprehensive Health Clinic that has a doctor trained in psychosocial counseling.

- **Referral.** The BHC staff does not refer its patients subjected to GBV to any other agency or organization except for the higher level healthcare facility (CHC or regional hospital). To the patients subjected to severe abuse BHC's midwives recommend filing a complaint with AIHRC. However they do not provide the patients with contact details for AIHRC or any other organization. The staff is required to inform police about GBV cases.
- **SOPs, guidelines, procedures.** The BHC does not have any written procedures or general guidelines regulating the processing of GBV cases.
- **Working with communities.** The BHC staff maintains close connections with the neighborhood community. The doctors and midwives regularly meet with Health Shura members. The facility organizes weekly open meetings to talk to community members about the importance of hygiene, give information on disease prevention and family planning. The Health Shura members, according to BHC staff, trust the facility and are keen to spread health related messages. The discussions with Health Shura do not normally address GBV related health problems.
- **Coordination with other agencies.** The facility is not involved in coordinated efforts to address GBV.

d) Small size HF serving refugee community in the rural area. Level: Primary Care Service.

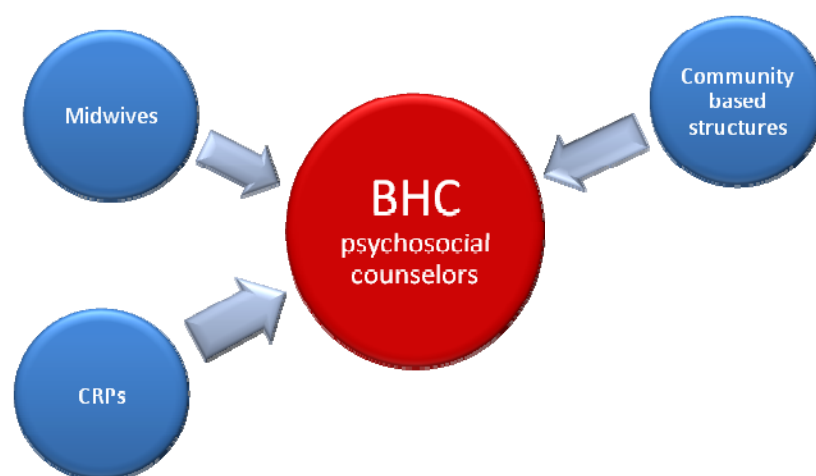
Basic Health Center (BHC), Saraycha village (supported by IMC).

In order to collect the information on the organization of GBV response in rural health facility the assessment team requested International Medical Corp's (IMC) support in organizing the interviews with Saraycha village BHC staff in Jalalabad city. IMC is managing the BHC in Saraycha along with 6 other healthcare facilities in the province. IMC arranged for two psychosocial counselors to come to Jalalabad for the interview. The interview took place in IMC's office in Jalalabad City. The assessment team met two psychosocial counselors (woman and man in their 20s). The counselors were trained by IMC to assist GBV victims in Saraycha village.

- **Structure, functions and services provided to GBV victims.** The BHC, earlier located in returnee camp, was moved to Saraycha village following the request from UNHCR. Saraycha village recently became a place of residence for a large group of returnees (the Afghan refugees to Pakistan that came back to Afghanistan). The facility has 13 staff members and catchment area with 4,360 people. BHC employees routinely dealing with GBV cases include a midwife and two psychosocial counselors (male and female). The counselors received training on psychosocial counseling and general gender concepts (IMC), human rights (UNAMA), protection from human trafficking (Women for Afghan Women) and women's rights in Islam (DOWA).
- **Access to services.** BHC is located in the village and is easy to access for village residents.
- **Processing GBV cases.** The facility is managed by IMC and employs IMC's model of screening and treating the victims of GBV. BHC mostly receives cases of physical violence perpetrated by victim's husband and/or mother-in-law. Cases of sexual violence are never reported. Women subjected to abuse rarely come to the facility. For the most part the GBV cases enter BHC through three different channels. The cases identified by the midwives during routine visits to the patients in the village. The midwives are trained to detect the signs that suggest patients' possible exposure to GBV. Midwives then inform the psychosocial counselors in BHC about possible GBV case and encourage the

patient to talk to the counselors. The cases discovered by the Community Resource Personnel (four couples that are community members trained to recognize basic signs of GBV) and then reported to the psychosocial counselors. The cases identified and referred to BHC by the community based structures, such as Health Shura, Women's Shura and Teacher's Shura. The members of these bodies meet BHC staff regularly and can suggest that certain family faces the problems tied to violent behavior and needs the counseling or medical assistance. According to the respondents, they most often receive signals about gender abuse from the Community Resource Personnel (CRPs).

Figure. BHC (managed by IMC) in Saraycha village, Nangarhar: screening for GBV



Upon receiving information concerning GBV, the psychosocial counselors visit the family and talk to the patient. The visit is normally presented as a part of vaccination or hygiene awareness campaign. The counselors do not ask the patient direct questions regarding the abuse. They examine her mental health condition and invite her to visit BHC. During the patient's visit to the facility she is received by midwife who registers her and fills her in-take form. The patient is then directed to the psychosocial counselor or the doctor (in case of physical injuries). Apart from the conversation with the patient, the counselors sometimes have talks with her family (separately) and violence perpetrators. After the counseling sessions are over the staff monitors the case by visiting the patient in her home.

The information regarding the patient's medical history and GBV experience is stored in BHC and is kept confidential. The BHC staff does not report the cases involving GBV to any other agency. The BHC does not have a criminal registry book so even the possibly criminal

cases are not reported to the police. The facility prepares monthly report for the IMC's office in Jalalabad on the number and types of GBV cases treated in the facility.

- **Referral.** If the patients request help outside of the healthcare system the counselors provide them with the referral sheet listing the contact details for local police unit. The staff does not provide any information outside of the one given on the referral sheet and does not assist the patients to get in touch with these agencies. The same is done for the patients that are scared to return back to their homes.
- **Working with communities.** Psychosocial counselors and midwives meet the members of local communities regularly to present talks and hold discussions on various health related issues. The strategy employed by IMC in building cooperation with local communities locates GBV within the narrative of general health concerns. The GBV related messages were introduced in dialogue with local communities at a later stage and were discussed as a public health issue. According to the respondents, certain community based structures (for example, Women's Shura) are more open to discussing GBV while others (Elder's Shura, the primary decision making body in the area of dispute resolution in the community) are still fairly reluctant to do it.
- **SOPs, guidelines, procedures.** The facility bases its processing of GBV cases on IMC's Standard Operating Procedures. These procedures do not require any type of coordination with agencies working in the field of GBV response.
- **Coordination with other agencies.** The BHC is not involved in any activities building coordinated response to GBV.

1.3 International Medical Corps and its GBV response model for healthcare facilities.

- **Structure, functions and services provided to GBV victims.** The operations of IMC's regional office in Jalalabad cover four eastern provinces of Afghanistan (Nangarhar,

Nuristan, Laghman and Kunar). Due to deteriorating security in Kunar and Nuristan IMC's activities in these provinces are very limited. IMC's work in the area of GBV response in Nangarhar province specifically targets the communities of returnees (Afghan citizens returning from Pakistan, where they lived as refugees). The organization operates in six healthcare facilities serving the returnees in three provincial districts (out of 22) and works in the areas of GBV prevention, healthcare and psychosocial counseling for GBV victims. IMC trained its staff on the psychosocial counseling (training was provided for midwives), clinical case management and general GBV information (training organized for nurses and doctors). IMC has male and female psychosocial counselors working exclusively with GBV victims in all 6 healthcare facilities managed by the organization in Nangarhar. At the same time the organization hires male and female Community Resource Personnel (CPR) that are community members in 4 returnee settlements and work to collect information on family violence, report to the IMC staff in the respective healthcare facility and advise the victims to seek healthcare assistance and psychosocial counseling. The assessment team interviewed the Project Manager and the GBV Project Officer of IMC's regional office.

Majority of the cases identified through this model involve physical abuse within family. Cases of sexual violence are almost never reported. Healthcare facilities receive the information regarding GBV cases from CRPs, midwives and community based structures (for example, Health Shuras).

- ***Impact of high security risks on the organization of GBV response.*** The respondents related that in many rural communities the presence of law enforcement bodies is very weak. In these settlements the security risks are heightened and referral of any GBV case to local police is dangerous. The influence of Taliban groups on some rural communities is strong. In certain areas the governance of communities is conducted by certain Taliban groups. Often “police are scared to enter these areas”. In this environment the international organizations work under huge pressure and the issues involving women's rights are capable of producing a dangerous tension between the international organizations and local communities. For example, in 2008 the Norwegian Refugee Council started the project that provided legal assistance to GBV victims in returnee camps. However after a little while NRC had to stop the project due to

the threats received by the project staff. At the same time the respondents emphasized that not all of the Taliban groups are necessarily against cooperation with international NGOs even in such sensitive areas as women's health and education.

- **Coordination with other agencies.** IMC is co-charing the GBV sub-cluster and participates in a GBV Case Taskforce (IMC, UNAMA, UNHCR, DOWA, provincial police department) working to build coordinated GBV response in the province. The coordination within these structures presents serious challenges. Respondents communicated that despite several invitations the representatives of the Governor's office and police department did not attend sub-cluster meetings.

The information Management System on GBV cases developed and used by IMC was recently accepted by the Ministry of Public Health as national standard. The system will be piloted in Rabia Balkhi and Istiqlal Hospitals in Kabul.

There are no reports of sexual abuse. We mainly get reports of physical violence against women. Reporting any other type of crime may be dangerous – psychosocial counselor, BHC, Saraycha village.

- **IMC's model of GBV response and its impact on coordinated community actions.** The model introduced by ICM provides for multiple channels of information exchange and cooperation between the healthcare facility and the community it serves. Community Resource Personnel, Health Shuras and midwives – all work to provide the smooth flow in information between the healthcare facility and communities. The multiple levels and channels for information exchange and interaction constitute a strong side of IMC's model. However the model has its limitations. The model is located strictly within the healthcare system and does not involve coordination with any other agencies and organizations. On the level of referrals, the healthcare staff is provided with referral sheets (contact details for local police, AIHRC and DOWA) that they give to the patients requesting help outside the healthcare system. The staff is not assisting the patients in contacting other agencies and is not providing them with any additional information. For

the most part the staff refers GBV victims to higher level healthcare facilities in the provincial center (often, provincial hospital). The assessment found that In the BHC the staff is not required to report even the most severe cases of GBV to the police or any other agency. The information accumulated within the IMS is not shared with any other agencies. Thus IMC's model does not provide an enabling environment for coordination between key agencies working in the area of GBV response

IMC's experience: advantages and limitations of CRP mechanism. Community Resource Personnel is mainly functioning as a communication channel between BHC and the community. CRPs can alert the BHC staff to the incidents of GBV in the community, but are never a part of any intervention measures. CRPs work with the members of various shuras to spread the information on good health practices. The mechanism seems to work well in supporting good communication between the health facility and the community based structures, alerting the healthcare staff to certain cases of GBV and assisting the healthcare staff's access to private homes. However the use of CRPs in the screening of GBV cases has its limitations. The respondents related that the cases involving sexual violence are never reported to BHC by any of the channels they use. That can be explained by a strong cultural stigma associated with being a victim of sexual abuse. The victim's fear of being accused of adultery (zina) and having to serve a prison term may also play an important role. At the same time, close ties between CPRs, shuras and other community members may generate the fear or reluctance to report this type of violence. The physical and socio-cultural proximity of midwives and CPRs to the community increases their vulnerability and makes reporting GBV a dangerous task. Furthermore, complex connections bringing the community members together give the decision to report sexual violence a power of affecting the status of the reporting individual in the community. All of these factors may result in selective reporting.

Healthcare facilities: needs and challenges.

Challenges faced by all examined HF in providing assistance to the victims of gender based violence:

- **Challenge: volatile security situation.** *Deteriorating security presents a serious challenge for GBV response. It affects the service provision to GBV victims on several levels. Security concerns put further limits on the mobility of women in the public space that includes the access to the healthcare facilities. It also influences the decisions of families and individuals to take longer trips in order to visit certain (larger) healthcare facility. The threats of retaliation on the side of armed groups controlling certain areas of the province also sometimes stop families and communities from using the state healthcare facilities. At the same time weak presence and low authority of law enforcement institutions in the province make healthcare staff trying to help GBV victims very vulnerable in the face of possible backlash from the victims' families, community members or armed groups controlling certain areas. All programmatic interventions should take into consideration the high risks involved in GBV disclosure and assistance to GBV victims in the volatile security situation.*
- **Challenge: cultural restrictions on disclosing family abuse or other types of GBV.** *Both urban and rural respondents stressed the restriction that affect women's access to public health and cultural stigma of revealing the exposure to GBV. Stigma of revealing the violence perpetrated by one's family member is very strong and women attending doctors normally do not disclose GBV. At the same time it is worth noting that cultural norms are in a constant flux and are constantly re-interpreted and re-negotiated by various groups and individuals in the society. The assessment found examples of institutions and individuals that developed ways of working around the existing restrictions (midwives in BHC Zarinabad, psychosocial counselors working within IMC's model in BHC Saraycha, Health Shura members in Zarinabad).*
- **Challenge: healthcare impasse.** *In Jalalabad, similar to situation in Bamyan, the HF at the moment present an impasse in the referral and reporting network that connects other agencies working in the field of GBV response in the province. The reporting of GBV is not required by any rules or regulations and neither is the assistance to the GBV victims in the form of information sharing or referrals. As a result the staff of the HF is not reporting or recording any gender based violence. GBV victims attending HF are not*

given any options for referral or even information. The BHC managed by IMC is an exception to this rule. However the regulations in BHC Saraycha also do not require coordination with other agencies.

- **The lack of personnel trained to identify, treat and refer the patients suffering from GBV** is a problem for both large and small HF in Jalalabad. The staff directly working with female patients (midwives, OBGs, nurses) could benefit from the training on the screening and treatment of patients suffering from GBV. The separate training on referral of GBV victims should be introduced after the agencies working in the area of GBV response develop common referral network.
- **Need to develop SOPs regulating identification, treatment and referral of GBV patients in the healthcare facilities.** The healthcare facilities in Jalalabad do not have a common set of SOPs that regulate identification, treatment and referral of GBV patients. Common SOPs that include options for various levels of HF and incorporate modules for high security risk areas would be crucial for strengthening institutional involvement in service provision to GBV victims.
- **Need to examine the services and possibilities in the rural areas.** The examination of the service available for GBV victims in the rural areas across the province has fallen outside of the scope of the current report. However there is a strong need to examine the services available for GBV victims residing in rural areas. Although the information received in Jalalabad suggests that women suffering from GBV in the rural areas have very limited access to any services a careful examination of rural context can produce valuable data on the institutions and mechanisms that have a potential of reaching out to GBV victims. This information could be then used by the government and development agencies in determining the strategies for strengthening GBV response in rural Nangarhar and other rural areas with higher security risk.
- **Need to increase awareness of the connection between GBV and women's health issues among the healthcare professionals.** This was specifically pronounced in the

interviews conducted with healthcare staff in the Jalalabad regional hospital, but was relevant for majority of respondents from the healthcare sector. There is a need for awareness raising program specifically targeting healthcare staff and presenting elaborate information on the detrimental effect of GBV (specifically domestic violence) on the health of all family members.

- ***Needs of Forensic Medicine Unit.*** *The work of Forensic Medicine Unit is very important for the quality of investigations involving GBV. The Unit is also providing valuable service for GBV victims who approach it directly (examination of physical injuries provides evidence used in court proceedings on divorces). FMU faces a number of challenges that should be addressed in order to strengthen its capacity to assist individual GBV victims, the police and the Prosecutor's Office. The FMU lacks equipment for advanced forensic examination. The Unit needs a car in order to promptly arrive at crime scenes. FMU's work is affected by the lack of coordination between agencies requesting forensic examinations. There is a need for:*
 - *more specific information request forms;*
 - *better mechanisms of information sharing between the agencies that in order to avoid double examination requests;*
 - *age determination procedure needs more detailed regulation with rules and procedures clear to all parties involved;*

2 Community Based Structures

Involvement in GBV response

Health Shura in Zarinabad district, Jalalabad City.

- **Structure, functions and services provided to GBV victims.** The Health Shura of the Basic Health Center in Zarinabad consists of 16 members (8 men and 8 women). Shura includes two Community Health Workers. As in several other occasions throughout the assessment mission the female members of the Health Shura were not present at the meeting. The Shura serves as a bridge between the BHC and the community it serves. The spread of malaria and high rate of maternal mortality are among the most serious health issues that concern community members. The BHC and Health Shura work together to strengthen awareness of maternal health issues in Zarinabad. According to the respondents, this joint effort resulted in the decreased rate of maternal mortality in the community. Due to cultural restrictions on women's mobility in the public space women in Zarinabad have very limited access to the healthcare facilities. Shura members suggested that an ambulance car could provide a solution for women with serious health problems who can't leave the houses. They also stressed the importance of raising awareness about the negative impact of early marriages and baad on the women's and children's health.
- **Benefits and challenges of working with Health Shura.** The members of Shura were reluctant to discuss the cases of family violence and emphasized that the incidence of early marriages and baad is low in their community. According to the respondents, in Zarinabad family abuse, although prevalent in the past, currently does not happen very often. The members of Shura viewed family violence within the framework of dispute resolution. They related that family violence situations are successfully resolved by the

traditional dispute resolution mechanisms (normally, the council of elders, jirga). 80 percent are solved by jirga and 20 percent (“criminal or complicated cases”) are reported to police⁴¹. Similar to the situation in Bamyan, the Shura members in Jalalabad considered violence against women within the families or even within the community a matter best solved through mediation by informal justice mechanisms.

Health Shura: needs and challenges in assisting GBV victims

The discussions held with health shura in Zarinabad revealed some challenges that were similar to the situation in Bamyan: reluctance to discuss the presence of GBV in the community, the hierarchical power structure within the Shura, the perception of GBV within the dispute resolution framework. However the analysis of the discussion also revealed that unlike Shura members in Bamyan, the Zarinabad Shura was keen on continuing raising awareness of the negative health consequences of GBV among the religious leaders and jirga members. The impact of security situation on the work of Shuras in various areas of Nangarhar and the influence of main socio economic and cultural characteristics of communities on the formulation of Shuras’ agenda in its relation to women’s issues are important topics in need of further examination.

⁴¹ This estimate matches the one given by professor Bidar of Afghanistan Independent Human Rights Commission.

3. LAW ENFORCEMENT

3.1 Police: the Human Rights Department and the Family Response Unit.

Involvement in GBV response

The assessment team interviewed the Head of Human Rights Department and the Head of Family Response Unit (FRU) in the main office of Nangarhar Provincial Police Department. Both police officers were eager to discuss the challenges faced by police department in the processing of GBV cases.

- **Structure, functions and services to GBV victims.** Jalalabad City has a total of 15 police posts⁴². Provincial police force includes 25 female police officers. In 2011 the regular police force in the province received support from several hundred of locally deployed police officers⁴³. The main office of the Provincial Police Department is situated in Jalalabad. Family Response Unit was established in 2008 and operates under the Head of the Human Rights Department. FRU has three staff members, all men. The absence of female officers in FRU has a detrimental effect on the work of the unit. Women are very reluctant to share GBV related problems with male officers. All attempts to hire female officers to work in FRU failed. According to respondents, educated women are not interested in joining police force. Work in a predominantly male environment and high risks involved in being a police officer in this volatile region stop many women from applying for a job with police department.
- **Access to services.** Due to explosive security situation and high probability of armed attacks on police offices the access to the police headquarters in Jalalabad is very restricted. FRU has its own small reception room however the Unit does not have special days or hours assigned for receiving visitors. There is no procedure to ensure easier access to the Unit by female visitors.

⁴² Information received through oral communication with the staff of the provincial Police Department.

⁴³ 800-strong local police force deployed in Nangarhar, 8 June 2011, Pajhwok Afghan News, <http://www.pajhwok.com/en/2011/06/08/800-strong-local-police-force-deployed-nangarhar> (last accessed on November 29, 2011)

- **Security situation and its impact on police investigation of GBV cases.** The pressure of operating under security threat experienced by the police force shifts the investigation of GBV cases to the margins of the police agenda. The respondents confirmed that in many cases (especially outside of Jalalabad City) the intervention of the police officers in the situations involving family violence may jeopardize the fragile foundations of cooperation between the local communities and the police. The respondents confirmed that the majority of GBV cases is resolved through the community based dispute resolution mechanisms.
- **Processing GBV cases.** All cases entering the Provincial Police Department are first directed to the Human Rights Department. It is worth noting that the majority of GBV cases are reported to the police by victims or their family members (sometimes, victim and her caretaker). Filing a complaint with the police department in Jalalabad is relatively easy, compared to the circuitous procedure applied in Bamyan. People can submit their complaints directly to the provincial police department or local police post. Physical violence by a family member is by far the most common type of GBV reported to the police. When the case enters police department it is classified as either “civil” (*huquqi*) or “criminal” (*jezai*). Head of the Human Rights Department related that the Department conducts preliminary investigation for civil GBV cases, while the Criminal Investigations Department (CID) deals with criminal cases. The Human Rights Department, according to the respondents, still monitors the processing of criminal GBV cases in CID because “they involve the violation of human rights”. The cases are registered and the information regarding the case is recorded in the Incident Registration Form (Form N 1). However, the police department does not have a single database of all GBV cases registered by the police. As a result, it some cases are registered twice: with Human Rights Department and the Criminal Investigation Department. The Head of Human Rights department stressed that there is a pressing need to create common data base of GBV cases for the police. He suggested that, the data base should be maintained and operated by the Human Rights Department and should be open for all police departments.

The interviews confirmed that security situation in many provincial districts limits the opportunities for law enforcement bodies to address GBV. The Head of the Human Rights Department also stressed, that police lacks sufficient capacity to reach out to the communities in order to conduct preliminary investigation of GBV cases, hold perpetrators responsible and establish the rule of law. The lack of female police officers still presents one of the main challenges for preliminary investigation of GBV related crimes. Police women are crucial in communicating with female victims and witnesses during preliminary investigation. The access to private houses is also much easier for female police officers. The women currently employed in Nangarhar police are not trained to perform the investigation of GBV cases.

- **Referral.** The regional Department of Woman's Affairs (DOWA) and the regional branch of Afghanistan Independent Human Rights Commission (AIHRC) are referring cases to the police. However the situation with the health facilities is "a one-way road": while the police department refers GBV victims to the healthcare facilities for treatment and examination, the healthcare facilities never refer patients suffering from GBV to the police and do not report the GBV cases to the police department. This statement confirmed the findings from the healthcare facilities in Jalalabad and nearby rural area: the healthcare staff is never referring patients (even those that are clearly in danger) to police. Healthcare facilities do not have any written policy requiring this type of referral or information sharing. by the forensic medicine unit (in the provincial hospital)
- **"Reconciliation approach" to GBV cases.** The FRU as well as the Human Rights Department try to reconcile the victim and the perpetrator before moving to preliminary investigation. The reconciliation process involves conversations with victim, her family members and perpetrator. The conversations first are conducted separately and later the parties are brought together for a joint meeting. FRU uses a "letter of commitment" (a written promise to not use violence again, signed by the perpetrator) as a way to stop the abusive behavior. The assessment found that this way of resolving family violence cases is a common pattern widely used by police, NGOs and DOWA in Bamyán and Jalalabad. It does not have any legal foundation and the efficiency of this mechanism is difficult to assess because there does not seem to be any monitoring of cases

“resolved” in the department. The “reconciliatory approach” regardless of the intentions of the mediators supports the idea of the impunity of violence perpetrator.

- **SOPs, guidelines and procedures.** The Department does not have written policies and procedures regulating the screening and processing of GBV cases. The respondents emphasized the need for SOPs regulating the processing of GBV cases and specific training for police officers on the processing GBV cases. They also stressed the importance of developing common procedures for information sharing and coordination between the police, Prosecutor’s Office and courts.
- **Coordination with other agencies.** The coordination in processing GBV cases between the police, the Prosecutor’s office and the courts is in a need of improvement. Respondents believed that the primary courts and sometimes the prosecutor’s office are delaying the processing of GBV cases. People approach the Human Rights Department with complaints regarding what they describe as the deliberate delaying of investigation or court decisions on GBV cases. The courts and prosecutor’s office, according to the respondents, sometimes fail to refer people to the police (some people first approach the courts or the prosecutor’s office). The staff members of these agencies sometimes discourage the citizens from requesting police investigation, alleging that it is too long and complicated. This practice, as suggested by the respondents, may be a way of extracting bribes from the parties involved in GBV related cases.
- **Implementation of EVAW Law.** Both respondents were fully aware of the EVAW Law and referred to it during the interviews. According to the information received from one of the respondents the judges in the province often do not use EVAW Law and resort to previous legislation that stipulates a milder punishment for violence perpetrators.

Police: needs and challenges in providing services for GBV victims

- **Challenge: restricted access to services.** *Due to ever worsening security situation the access of visitors to the Police Department in Jalalabad City is very restricted. The FRU does not have special days or hours assigned for receiving visitors and there is no procedure in place to ensure easier access to the Unit by female visitors. Thus it is*

important to arrange special access channel for female visitors to FRU (special hours, clear and easy procedure, separate reception room).

- **Challenge: the investigation of GBV cases is at the margins of police agenda.** *The politics of non-interference in the community and family affairs involving GBV is perceived by local police members as a way to secure some level of cooperation from the local communities. It is necessary to develop interventions and mechanisms that would promote the perception of GBV investigations as a service delivered by police to local communities.*
- **Challenge: police officers do not always distinguish between the protection of human rights and dispute resolution in treatment of GBV cases..** *The police officers interviewed for the assessment regularly used “reconciliation” approach while dealing with GBV cases. The reconciliation is achieved through meditation between the victim and the perpetrator. This approach serves to maintain impunity of GBV perpetrators. There is a strong need for training specifically geared at police officers and focused on explaining the duties of law enforcement in relation to GBV.*
- **Need to examine the impact of reconciliation practice** *on the lives of GBV victims. The police department currently has no mechanism for the monitoring the situation in the period after “reconciliation”.*
- **Need to strengthen cooperation with community based structures.** *The worsening security situation in the province provides a difficult environment for building trust between the police force and local communities. The police officers in the province are frequently becoming a target of armed attacks. In this situation the ability of the police to protect GBV victims, hold perpetrators responsible and establish the rule of law heavily depends on the strong capacity of the police force (trained officers, efficient involvement of female police officers, clear policies and procedures and necessary equipment) and its*

ability to work closely and efficiently with the community based dispute resolution mechanisms.

- **Need to elaborate existing procedures and create new policies regarding the processing of GBV cases.** The provincial Police Department does not have written policies and procedures regulating the processing of GBV cases. The Head of Human Rights Department and the Head of FRU emphasized the need for SOPs regulating the processing of GBV cases and specific training for police officers on processing GBV cases.
- **Need to establish a common database of GBV cases in the Provincial Police Department.** The absence of common database of GBV cases results in confusion and double case registration. It also slows down the information sharing process. The common data base established and maintained by the FRU or the Human Rights Department and open to all police departments will increase the efficiency of case investigation process and allow for better data collection on GBV related crime.
- **Need for better information sharing between the agencies.** The information sharing between the agencies requires more elaborate and comprehensive procedures and tools. Current mechanism of information sharing (standard letters requesting information from the health facilities or the information requests directed from the Prosecutor's office and the court to the police) fail to facilitate specific, detailed and structured communication. This failure results in waste of time and efforts of the officers responsible for the investigation of GBV cases. The information accumulated through these tools is incomplete and does not produce comprehensive case record, which adds to the time spent in further investigation of the case by agencies other than police. In addition the incomplete or inconsistent case records do not allow for tracing the history of abuse if the violence is perpetrated repeatedly by the same perpetrator or towards the same victim.
- **Need for improved coordination with the healthcare facilities.** Majority of the healthcare facilities do not report GBV cases to the police and do not refer victims of

gender based abuse to the police department. There is a need for detailed procedures regulating the coordination and information sharing between the police and the healthcare facilities.

- ***Need to recruit and train female police officers.*** *The respondents stressed that female police officers play vital role in dealing with victims and female witnesses of GBV. There is a strong need for female police officers trained in processing GBV cases and interviewing the victims and witnesses of GBV.*

4. JUDICIARY

4.1 Provincial Prosecutor's Office

Involvement in GBV response

.The mission team met with the Chief Prosecutor of Nangarhar province in his office in Jalalabad City.

- **Structure, function and services provided to GBV victims.** The local departments of the Prosecutor's Office are operating in each of 22 provincial districts. The Prosecutor's office conducts main investigation of the cases involving GBV and presents the results of the investigation to the court. The Office receives cases from the police together with the outcomes of preliminary case investigation. The respondent complained about small budgetary allocations for the Public Prosecutor's Office that result in the lack of well-trained professionals and scarce resources. The prosecutor's office is seriously understaffed in terms of female lawyers (two vacant positions in the Office were filled by female lawyers, who later resigned). Low salaries, working in predominantly male environment and high security risks stop many women from applying to the positions in the Office. The restrictions applied by the families also play an important role. Currently there are no female staff members working in the office. According to the respondent, that creates serious obstacles in working with female witnesses.
- **Access to services:** The access to the office in Jalalabad is limited by a security system, however visitors are able to enter the building. The assessment team observed a considerable number of visitors waiting in the corridors and the hall of the venue.
- **Processing GBV cases.** According to the respondent, the Prosecutor's Office almost never receives direct complaints involving GBV⁴⁴. All cases arrive from the police department after undergoing preliminary investigation. The Prosecutor's Office uses Form N1 (similar to the Form used by the police) to register the case details. The Office has 15 days to complete the investigation, after which the prosecutor makes an

⁴⁴ That contradicts the opinion expressed by the respondents in the Police Department, who suggested that people approach the Prosecutor's Office and sometimes are being discouraged there from filing official complaint with the police.

indictment and the case is transferred to court. The processing of GBV cases is often interrupted because the plaintiffs withdraw their complaints. The respondent related that in a typical case battered wife would withdraw her complaint against husband. After that the prosecutor stops pursuing the case, based on Article 40 of EVAW Law. The assessment demonstrated that the staff of the Prosecutor's Office, similar to police, routinely applies the "reconciliation" approach to family violence. The office does not have any regulations or procedures regulating, how and on which grounds should the reconciliation take place. The office does not have any mechanisms for monitoring the situation in reconciled families. The assessment found that the staff of the Prosecutor's Office needs training on processing of GBV cases, however due to heavy work load they would prefer short-term training program.

- **Referral.** The Prosecutor's Office receives almost all of its GBV cases from police. The Office refers GBV victims to the Forensic Medicine Unit for forensic examination.
- **Implementation of EVAW Law.** The Chief Prosecutor related that the implementation of EVAW Law is burdened by a number of contradictions between the Law and the Constitution of Afghanistan. He has commented on specific articles that in his opinion contradict the Constitution and are in a need of revision. As one of the examples he referred to the Article 43 of the EVAW Law ("The punishments of the convicts of crimes of violence shall not be postponed, pardoned or mitigated.") as contradicting the Article 64, paragraph 16 of the Constitution, that grants the President a right to issue pardon. The right to receive compensation from the perpetrator granted to the victim by the EVAW Law (Article 42), according to the respondent, comes into the contradiction with Sharia and Penal Code⁴⁵. The staff of the Prosecutor's Office did not receive training on the implementation of EVAW Law and did not have an opportunity to discuss their concerns with other agencies involved in the implementation of the Law.
- **Working with communities.** The Prosecutor's Office does not engage in any joint activities with community based structures to address GBV.

⁴⁵ According to the Article 44 of the EVAW Law the provisions of the law if contradicted with provision(s) of other laws should prevail.

- **SOPs, guidelines, procedures.** The Office does not have written SOPs regulating the processing of GBV cases. The Office staff routinely works with community members in the course of primary investigation however the officers do not seek cooperation of local community based groups. The respondents confirmed that vast majority of GBV cases is resolved within the communities and do not reach the Prosecutor's Office, however the Office does not have any programs aimed at strengthening relations with these structures.
- **Coordination with other agencies.** The Prosecutor's Office participates in the activity of recently created coordination mechanism that involves the prosecutor's office, courts and police. The monthly meetings bring together police officers, judges and prosecutors to discuss coordination in their daily work. The mechanism is regulated by the protocol recently signed by all parties⁴⁶. The respondent communicated that the quality of investigation of GBV cases was undermined by a low capacity of the healthcare facilities. When asked to examine GBV victim the healthcare facilities often provided inaccurate and incomplete information. He also related that the results of examination provided by the FMU are often delayed and inaccurate. The delay in examination of the victims results in the loss of important evidence and complicates the investigation. The respondent specifically stressed the importance of accurate determination of victims' age for the investigation of GBV cases. According to him, some healthcare professionals deliberately conceal young age of GBV victims in their accounts of examination results.

Prosecutor's Office: needs and challenges in providing services to GBV victims.

- ***Need to recruit and train female professionals in the Prosecutor's Office.*** *The dearth of female professionals in the Prosecutor's Office creates challenges in working with female victims and witnesses and collecting evidence in private houses.*

⁴⁶ The coordinating body and the protocol were never mentioned by respondents in the police, Family Court or Appeal Court. It might well be that at this stage the coordinating activities engage only the highest levels in bureaucratic hierarchy of respective agencies.

- **Need to strengthen coordination and information exchange with the healthcare facilities.** *The quality of investigation suffers from the poor coordination with the healthcare facilities. The information provided by the healthcare facilities is often incomplete and sometimes inaccurate. The procedure of requesting information does not include the comprehensive form that would ensure the provision of structured, standardized and detailed data. This problem should be addressed through the introduction of better information sharing mechanism and clear procedures regulating the terms of information exchange between the agencies.*
- **Need to remove the gaps in coordination with Forensic Medicine Unit.** *The coordination with FMU needs to be based on more detailed procedure in order to avoid gaps in communication (specifically regarding the forensic examination of the victims of rape and the procedure of age determination). There is a need in joint discussion of mutual expectations, timeframe and rules of information exchange.*
- **Need for SOPs, guidelines and protocols.** *There are no written policies or procedures in place to regulate the treatment of GBV cases. The general procedures that are currently used do not address the gaps in coordination and information sharing. The procedures do not require specific steps to ensure coordination with other agencies and do not take into consideration the safety of individuals involved in GBV cases.*
- **Need to examine the impact of the reconciliatory approach to family violence on GBV victims.** *The option to reconcile and drop the charges is offered by the prosecutor's office staff to parties involved in GBV case. The impact of this practice on the security and well-being of the victim is unclear and requires further examination. It is also unclear how the parties determine conditions for reconciliation. However its beyond doubt that the reconciliation of the parties in the cases involving GBV, regardless of its outcomes or the good intentions of the mediating body, generates and secures the public belief in the impunity of violence perpetrators. The practice of "reconciling" the parties is not complemented by any monitoring mechanism that would allow preventing the violence from resuming or holding the violence perpetrator responsible for breaking the agreement.*

- ***Need to strengthen the awareness and support open discussion on the implementation of ERAW Law.*** The assessment revealed that the staff of the Prosecutor's Office was not trained on the implementation of ERAW Law in their routine work. At the same time, according to the respondent, certain provisions of the Law raise concerns among the staff. These concerns should be voiced out in the open discussion. There is a need for educational and training materials presenting clear and relevant information about the Law and its relevance for the investigation of GBV.

"I am worried about the security of the judges here. They do not have transportation, they do not have guards however every day they publicly make decisions that may upset people with strong criminal connections"- respondent in one of the courts in Jalalabad City.

4.2 Courts

Involvement in GBV response

The assessment team visited the Jalalabad City Family Court and the provincial Appeal Court. The team interviewed 3 officials of Jalalabad City Family Court and the Chief of the provincial Appeal Court.

- **Structure, functions and services provided to GBV victims.** The Family Court receives large portion of cases involving GBV. The court has 8 staff members: 3 judges and 5 administrative staff members. One of the judges is female. The court also invites to the sessions the defense lawyers provided by HAWCA and DOWA. The Appeal Court has female specialist in Sharia Law: 4 female staff members that graduated from Sharia Department.
- **Access to services.** The access to the building is restricted by a strong security system. The parties to the case as well as witnesses and experts are summoned to the court to participate in the court sessions.
- **Processing of GBV cases.** All cases entering the court fall into two categories: the civil (huquqi) cases are processed in the Family Court while the criminal (jezai) cases are referred to the Prosecutor's office and then sent to the Primary Criminal Court. In 2011 (first 8 months) the Family Court received 81 case involving GBV. 41 of these cases were submitted by the Prosecutor's Office while 40 were referred by DOWA and AIHRC. The Family Court mostly receives cases involving physical violence by family member. All information regarding the case (statements of the suspect, accused, victim, witnesses and experts) is compiled in the case file. The recordings of court proceedings are made by a court clerk and added to a case file. If there is a relevant request on the side of the victim she is offered an assistance of a defense lawyer. The defense lawyers are mostly provided by the international or local non-governmental organizations and sometimes by a Ministry of Justice. The cases are registered in a registration book. The respondents outlined their vision of the main problems encountered by the courts in Nangarhar in processing the cases that involve gender based violence. Security of judges was listed as an important factor that frequently impacts the decisions on GBV cases. Judges are under considerable pressure from the families and influential community members (or

community groups). This is specifically relevant for the judges in rural areas of the province. In some parts of Nangarhar the judges are scared to make decisions that would upset influential local Taliban supporters. Some judges have been known to receive threats from parties involved in sexual assault cases.

- **Referral.** The Family Court refers GBV victims to the Forensic Medicine Unit for examination. The respondents in the Appeal Court however pointed out that the Unit staff is “producing different examination results depending on how wealthy the patient is”⁴⁷. The Court staff related that they sometimes assist GBV victims in applying for free legal counsel. However that only happens if victim requests the assistance of a defense lawyer. Obviously many GBV victims are unaware of their right to seek free legal assistance. The interviews conducted by the assessment team with the prosecutor and court officials revealed that the victims do not routinely receive information regarding free legal counsel.
- **Implementation of EAW Law.** As other member of judiciary interviewed in Jalalabad Family Court officials voiced their concerns regarding the problems with the implementation of EAW Law. The respondents mentioned the Articles 43 and 44 as “contradicting the Constitution and the Sharia”. They also suggested that in the case of family violence the punitive measures stipulated by EAW Law may cause the victims to resort to a milder punishment assigned by the community dispute resolution mechanisms⁴⁸. A suggested that joint training on the implementation of EAW Law for the police, Prosecutor’s office and judges would be a good step in capacity building and coordination.
- **Working with communities.** The Courts are not involved in any activities with community based structures.
- **SOPs, guidelines and protocols.** The Courts do not have any SOPs, guidelines or protocols regulating the processing of cases that involve GBV. The questioning of victims that suffered from physical, sexual or other type of violence does not rely on any guidelines that take into consideration psychological trauma received by the victim and

⁴⁷ This opinion was completely opposite to the positive evaluation given to FMU’s work by the Family Court officials.

⁴⁸ The respondent in the police department made similar, albeit more vague statement, suggesting that the punishment stipulated by EAW Law for wife battering is very strict.

cultural stigma often involved in the disclosure of violence. There are no procedures in place to ensure security and protect the reputation of GBV victims and witnesses.

- **Coordination with other agencies.** The Family Courts work closely with the Forensic Medicine Unit. The Family Court officials described the quality of information provided by the Unit as “accurate and complete” (the respondent in the Appeal Court had very different opinion). Overall, however, the court officials were not satisfied with the level of expertise in the healthcare facilities. The weak capacity of healthcare staff makes using them as witnesses in the court trial of GBV cases fairly difficult. The respondents also mentioned the delays in case investigation caused by police and the prosecutor’s office and the pitfalls in the flow of communication between these agencies that result in inability to compile full information regarding GBV cases.

Courts: needs and challenges in providing services to GBV victims.

- **Challenge: unstable security situation and high level of criminal activity in some parts of the province.** *In the environment characterized by weak security and high level of criminal activity, the judges conduct their daily work under considerable pressure. The adjudication delivered in this environment may be easily influenced by various power holders or simply the judges’ fear of retaliation on the side of the accused or his family members.*
- **Need to strengthen the awareness and support open discussion on the implementation of EVAW Law.** *The assessment revealed that Court officials did not receive training on the implementation of EVAW Law. Some provisions of the Law raise concerns and questions among the Court staff. These concerns should be shared in open discussion. There is a need for educational and training materials presenting clear and relevant information about the Law and its relevance for the court trial of GBV cases. The workshops bringing together judges, prosecutors and police force members would be beneficial for the development of such materials.*
- **Need for more specific procedures regulating the communication between the Courts and FMU.** *Assessment found that court employees hold conflicting opinions*

regarding the service delivered by FMU. At the same time FMU staff complained about pressures received from various agencies involved in trial and investigation of GBV cases. The detailed procedures that address the concerns and incorporate the requirements of all sides may bring some positive changes to currently strained relations.

- ***Need for SOPs, guidelines and protocols regulating the processing of GBV cases.***
The courts in Jalalabad currently do not have any SOPs regulating the treatment of individuals subjected to GBV or the witnesses in the cases that involve GBV. There is a strong need for the guidelines that will regulate the treatment of GBV victims at all stages of trial procedure. The guidelines should take into consideration a psychological trauma received by victims and cultural stigma often involved in the disclosure of violence. It is necessary to develop procedures ensuring security and protecting reputation of GBV victims and witnesses.
- ***Need for regulations ensuring better coordination and information sharing with other agencies.***
The existing procedures allow for gaps in coordination and information sharing with the prosecutor's office, police and healthcare facilities. There is a need for detailed and comprehensive information request forms that will generate consistent and comprehensive body of information regarding the case.

5. DEPARTMENT OF WOMEN'S AFFAIRS (DOWA)

Involvement in GBV response

The assessment team interviewed the Head of the provincial department of the Ministry of Women's Affairs and the head of DOWA's legal department, in DOWA's office in Jalalabad City. Throughout the meeting the Head of DOWA was open and willing to discuss the situation with GBV in the province and the obstacles confronted by DOWA in its efforts to coordinate GBV response.

- **Structure, functions and services provided to GBV victims.** DOWA is a regional branch of the Ministry of Women's Affairs. The office of DOWA in Jalalabad City oversees the activities in four eastern provinces (Nangarhar, Nuristan, Laghman and Kunar). The Department is responsible for the implementation of state policy in the area of women's rights and coordination of efforts among all agencies involved in GBV response. Two departments of DOWA are mainly involved in assisting GBV victims. Legal department is in charge of registering all GBV related complaints submitted to DOWA. Education department is responsible for awareness raising and educational efforts aiming to combat GBV. DOWA is one of the main entry points for the victims of GBV in four provinces. According to the respondents, cultural restrictions on disclosing violence in the communities across the whole region are very strong. Major flow of GBV cases that enter DOWA comes from Nangarhar province (mostly from Jalalabad and the nearby areas). Cases from neighboring provinces are rare. Majority of visitors submitting GBV related complaint reside in urban areas. Women in the rural areas contact the Department very rarely. The respondents attributed it to limited mobility of rural women. They also brought up rural women's lack of decision making power in the family and community. Small number of visitors from the rural areas may also be a result of dangerous security situation, scarce resources, authority of local community based dispute resolution mechanisms and mistrust of state agencies. Since the beginning of 2011 DOWA received 70 complaints concerning gender based abuse with physical violence by family member (typically husband and/or mother in law) being the most commonly reported form of GBV, followed by deprivation from food and shelter, denial of divorce right and termination of engagement.

- **Access to services.** The access to services is unrestricted.
- **Processing of GBV cases.** Women come to DOWA to request assistance, justice and protection from violence. The visitors are first directed to the legal department. The legal department registers all GBV cases that come to organization and decides on which course of action to take. Options include:
 - resolving the issue through mediation at DOWA
 - sending the case to the Prosecutor's Office or to the court

At first DOWA staff tries to resolve the case through mediation (for example, convincing the perpetrator and other family members that violent behavior should stop). DOWA sometimes cooperates with provincial Police Department to bring violence perpetrator to the office. In the course of mediation DOWA's staff requests that both victim and perpetrator sign the "agreement letter" (agreeing that violence should stop). Each side then receives a copy of agreement letter. The original letter stays with DOWA and is added to the case file. The letter is submitted to the court if the perpetrator continues violent acts. If sides can't reach an agreement, the legal department refers victim to the prosecutor's office or the court with a letter from DOWA. DOWA then monitors the case in the prosecutor's office and the court.

- **Referral.** Majority of GBV cases enter the Department directly. Small share of cases is referred to DOWA by the AIHRC. DOWA's staff refers victims to healthcare facilities for treatment. Depending on circumstance of every individual case, the Department refers women to police, Prosecutor's Office or court. The Department provides GBV victims with official letter to the respective agency. The Department works closely with several international and local organizations to provide women subjected to gender based abuse with free legal assistance. Victims are provided with the assistance of defense lawyers from the following NGOs (International Legal Foundation, Legal Aid Organization of Afghanistan, Women for Women and).
- **SOPs, guidelines and protocols.** The registration form and the standard letter are the only elements of SOP currently used by DOWA in the course of processing GBV cases.

- **Coordination with other agencies.** The respondents related that main obstacles in assisting the victims of violence come from the lack of coordination between the agencies. This problem persists despite the fact that there are 3 coordination mechanisms currently operating on the provincial level.
1. The ERAW Commission is in charge of monitoring and coordinating the implementation of ERAW Law. Commission meets once a month and is chaired by the provincial Governor. DOWA facilitates the meetings⁴⁹ and submits monthly reports to the Commission members (PPHD, Department of Education, Department of Social Affairs, Department of Culture, AIHRC, Provincial Police Department, legal NGOs and the local branch of the Ministry of National Security) and the central office of the MOWA in Kabul. The efficiency of Commission's operations is seriously undermined by low-profile representation of the member agencies: top level officials do not normally attend the meetings. As a result the discussion taking place at the meetings do not have strong effect on internal operations of the member agencies.
 2. Case Coordination Commission (CCC) is focusing on coordination of efforts in addressing selected GBV cases. The Commission meets monthly and is chaired by DOWA.
 3. GBV Case Task Force meets monthly to address the challenges faced by organizations working in the area of GBV. Members of Task Force include UNHCR, UNICEF, UNAMA, AIHRC, Police Department, Women for Afghan Women, Da Qanoon Gushtonky, ILF, HAWCA, AWN, IMC)

Poor mechanism of information sharing presents another problem for the building of coordinated response to GBV. DOWA is currently working with IMC and UNHCR to create a computerized database of GBV cases.

⁴⁹ According to the respondents, DOWA initially was responsible for chaired the Commission, however later the responsibility was transferred to the Governor's office in order to strengthen the status of the Commission.

DOWA: needs and challenges in providing services for GBV victims.

- **Need to introduce SOPs regulating the screening and processing of GBV cases.** *As the provincial branch of leading government agency responsible for the promotion of women's rights the Department receives a considerable number of complaints from women suffering from all types of discrimination. However women are often reluctant to disclose violence especially when committed by a family member. The reporting of sexual violence is even more difficult. The ability of the agency's staff to identify GBV cases and encourage women to disclose the abuse is crucial for expanding DOWA's assistance to GBV victims. The Department needs SOPs regulating the screening and processing of GBV cases. DOWA staff could benefit from the training focusing on the development and implementation of such procedures.*
- **Need to introduce new approach to coordination.** *Despite the presence of three bodies responsible for building coordination between the agencies involved in GBV response, the respondents identified lack of coordination as the main obstacle in addressing violence. Clearly, there is a need for a new approach to coordination. The findings of the Assessment demonstrate that the top down coordination effort, albeit sometimes successful in addressing GBV cases on an ad hoc basis, is not efficient in bringing change to the routine operations of the agencies. The changes should be introduced on an institutional level and should affect the rules and regulations governing the daily practices of the relevant agencies. DOWA should facilitate the process of incorporating specific steps that ensure coordination in the procedures that regulate the treatment of GBV cases by all agencies.*
- **Need to develop better mechanism of information sharing.** *The Assessment found that although DOWA maintains the data base of GBV cases other agencies do not have access to this information. The Department needs a policy regulating the information sharing on GBV cases. DOWA also needs tools that will facilitate the prompt and efficient information exchange among the agencies working on specific cases. The tools should also incorporate strong mechanisms protecting the security and dignity of GBV victims.*

- ***Need to facilitate open discussion regarding the implementation of the ERAW Law among the members of the judiciary.*** The Assessment findings demonstrate that the members of the judiciary have certain concerns and questions regarding the implementation of ERAW Law. Open discussion of these concerns is necessary in order to ensure the consistent implementation of ERAW Law in the judicial process. As a leading state agency responsible for promoting ERAW Law and the facilitator of ERAW Law Commission in the province DOWA have opportunity to develop specific projects that will engage prosecutors, judges and defense lawyers in productive discussions regarding implementation of ERAW Law.
- ***Need to reach out to the communities in rural areas.*** The delivery of assistance to GBV victims residing in rural areas remains one of the main challenges for DOWA. There is a pressing need to develop specific mechanisms that will increase the opportunities for rural residents to access DOWA (through field visits, informational campaigns and cooperation with local community based structures).
- ***Need to examine the effects of “reconciliation approach” and build the sound system for monitoring reprisals of violence in “reconciled” cases.*** DOWA’s staff routinely employs the reconciliation approach in addressing GBV cases. However the Department does not have written procedures regulating the monitoring of reconciled cases. Thus DOWA does not have a mechanism capable of detecting the reprisals of violence as well as other consequences of the “reconciliation approach” for the well-being of the victims.
- ***Need for expanding the services that offer long-term and short term shelter to the victims of GBV.*** The city has only one safe house/shelter (the Reference Center managed by DOWA and the Ministry of Internal Affairs). Wide spectrum of the facilities rendering long and short-term shelter to GBV victims is necessary in order to provide people suffering from GBV with a choice of assistance that suits individual needs.

AFGHANISTAN INDEPENDENT HUMAN RIGHTS COMMISSION (AIHRC).

Involvement in GBV response

Mission team members interviewed the Director and staff of AIHRC's regional office.

- **Structure, functions and services provided to GBV victims.** Established in 2002 under the article 58 of the Constitution of Afghanistan AIHRC is an independent body responsible for monitoring, promotion and protection of human rights in Afghanistan as well as investigation of human rights violations. Activities of the regional office cover 4 eastern provinces (Nangarhar, Nuristan, Laghman and Kunar). The office consists of 6 units. The Women Rights Support Unit and Monitoring and Investigation Unit are responsible for monitoring and addressing the violations of women's rights. The respondent related that, based on UNDP's recent research, in last 4 years the use of informal justice mechanisms decreased from 90% to 80% of all cases. Important factor behind this decrease is extensive awareness campaign conducted by AIHRC and other organizations. AIHRC works with different segments of population to explain the role of formal justice system in the protection of human rights (including the human rights violations based on gender identity). AIHRC needs female trainers to reach out to women residing in rural areas. Awareness raising constitutes another area of AIHRC's activities connected to GBV response. The organizations conducts meetings with various constituencies addressing GBV related issues (Women's rights in Islam, Women's rights in national legislation, Negative outcomes of traditional practices, Women's economic and social participation).
- **Access to services:** AIHRC's office is open for visitors. AIHRC also conducts regular field visits. In the course of the field visits trained AIHRC staff is registering violations of human rights, including GBV.
- **Processing of GBV cases.** On average AIHRC receives 10-30 GBV related cases per month. 90% of GBV cases enter AIHRC directly (women come alone or with their family members), the rest are referred by other organizations/agencies. Physical violence by

family member (the largest share of all GBV cases), deprivation from food and shelter, deprivation from inheritance (miras) and early marriage are among most commonly reported GBV types. The incidence of bad is decreasing. The office uses a case registration form and case management form to record information on individual cases. AIHRC staff also takes case registration forms with them to the field sessions so that they could register GBV incidents right in remote rural areas.

- **Referral.** AIHRC refers GBV victims to DOWA, police department, prosecutor's office, healthcare facilities and NGOs.
- **Working with communities.** AIHRC works with local communities extensively. One of the challenges in relating to local community members comes from the shortage of female trainers. While male trainers have easier time communicating with power holders (normally, all men) within rural communities, female trainers can reach out directly to women living in rural areas. Women trainers are more welcome to enter the private space of family houses and can talk to both women and children.

“There is a huge difference in the level of public awareness between rural and urban areas. People in many rural settlements do not know where they can complain about family violence. Security situation makes it very difficult to reach out to the communities in certain areas” – respondent in AIHRC, Jalalabad City.

- **SOPs, guidelines and protocols.** The organization has a strong system of case registration and reporting. The procedures are not specifically designed for the processing of GBV cases. AIHRC does not have guidelines regulating the treatment of individuals subjected to GBV. AIHRC staff needs specific training on working with people suffering from gender based abuse.

- **Coordination with other agencies.** The respondent had no complaints regarding the coordination with police, prosecutor's office, courts and FMU. However he brought up the issue of poor information sharing mechanism. On several occasions AIHRC encountered the problem of poor communication between the agencies working in the area of GBV elimination. Many offices fail to share information with each other. AIHRC participates in all 3 coordination mechanisms that work in the area of GBV response in Nangarhar: EVAW Commission, Women's Working Group⁵⁰ (geared at supporting DOWA's work in the area of women's rights) and the GBV Case Task Force of GBV sub-cluster (the group for information sharing and coordination among agencies working on the elimination of GBV). The members of GBV sub-cluster consider the absence of common data-base of GBV cases one of the major obstacles for coordination. GBV sub-cluster made a decision to create common database however at the time of the interview the work on the database has not yet started. At the moment each organization, according to the respondent, maintains its own system of recording GBV cases and if someone needs external source of information on the case "nobody knows where to go".

AIHRC: needs and challenges in providing services to GBV victims.

- **Challenge: security threats** *present serious challenge for AIHRC's activities. It prevents the organization from expanding its reach to many rural areas in the East. On the other hand, volatile security situation and presence of multiple sources of power prevent people from openly communicating their concerns.*
- **Shortage of female trainers.** *Female trainers are instrumental for reaching out to women in rural areas. AIHRC's activities could largely benefit from the program that seeks, recruits and educates female trainers.*

⁵⁰ This body seems to be the same as the Case Coordination Commission mentioned by the respondents from DOWA.

- ***Need for guidelines regulating the interaction with people subjected to GBV.*** AIHRC receives considerable number of complaints from GBV victims. AIHRC's service to GBV victims could benefit from the guidelines stipulating the principles of interaction with people subjected to traumatic experience of gender based abuse.
- ***Need for SOPs regulating the coordination and sharing of information with other agencies involved in GBV response.*** The internal procedures of AIHRC will probably be altered to accommodate the use of common data base as soon as this project is complete. However there is a need for broader set of procedures covering the coordination in screening of GBV cases, formulating and responding to information requests, referrals and joint awareness raising projects in the area of GBV response.

6. Non-governmental organizations (NGOs) providing services to GBV victims.

7.1 Humanitarian Assistance for Women and Children of Afghanistan (HAWCA)

Involvement in GBV response

The Assessment team interviewed the Head of HAWCA's Regional Office, two defense lawyers and one psychosocial counselor working with GBV victims.

- **Structure, functions and services provided to GBV victims.** HAWCA is a national NGO working in the area of women's rights and GBV elimination. The organization runs shelters in various parts of Afghanistan, provides legal assistance to women suffering from abuse and conducts programs to promote the awareness of women's rights. The office in Jalalabad City, established on March 17, 2001, covers four provinces of the Eastern region. The regional office works both in the field of legal assistance to GBV victims (the Center for Legal assistance to GBV victims) and human rights education. The Center for Legal assistance to GBV victims is focusing its work on civil cases that involve violence against women and children. Starting from 2001 till March of 2011 the center's lawyers helped women and girls subjected to violence in 25 cases submitted to Primary Court and seven cases submitted to Juvenile Court.
- **Access to services.** The office is located in a gated private house. The access is guarded in order to protect the staff from possible personal attacks. The staff members related that they regularly receive threats from violence perpetrators or upset family members of violence victims.
- **Processing GBV cases.** Women, suffering from GBV sometimes approach the Center directly. However the majority of GBV cases enter the Center through DOWA and AIHRC. The respondents also explained that small number of cases was directed to the Center by the Reference Center in Jalalabad. Among women seeking legal assistance from the Center, the victims of physical violence by a family member constituted the

largest group, followed by women subjected to bad (traditional practice that uses marriage to stop/resolve community feud). Information on every GBV case that entered the Legal Center was recorded in the case registration form. There was also a case history form filled by the Center's psychosocial counselors that worked with the clients subjected to GBV. The regional office used the forms provided by HAWCA's headquarters in Kabul and followed similar procedures. Each case was assigned a separate file that contained all information submitted to the court. The information was stored and updated within the computerized database. According to respondents, whenever possible they tried to protect the victim and stop violence through mediation and psychosocial counseling. However, if this approach does not help and the victim wishes to start legal process the defense lawyers give her necessary assistance. The Center employs two female lawyers. According to the Regional Director of HAWCA, at the time of the interview the Legal Center was working on two GBV cases.

- **Referral.** The Legal Center receives cases from DOWA, AIHRC and the Reference Center. Small number of cases enters the Center directly. The organization refers GBV cases to the Prosecutor's Office and courts. Sometimes the Center sends women to the healthcare facilities for treatment. If a client can't go back to her family due to a risk of continued severe violence the Center directs her to the shelter (Reference Center).
- **Problems in defending GBV victims .** The respondents outlined their vision of the main problems in assisting GBV victims based on the years of hands-on experience in defending women exposed to various types of gender based violence.
 - Judges often discourage the victims from using free legal assistance. Several women reported that the judges recommended them to avoid applying for the assistance of the Legal Center, because it will make the case trial more lengthy and complicated. The respondents believe that this is done because the involvement of the lawyers protects the client and shuts down some avenues for corruption in courts.
 - Police is very reluctant to interfere in GBV related situations in rural areas with high security risks. The security situation in these areas is very fragile and police force members do not feel that they have enough authority to operate there. So NGOs and

lawyers assisting victims that come from these areas can't rely on police for the protection.

- “Reconciliation approach” has negative impact on women, victims of violence. The “agreement letters” used by the courts⁵¹ as a way of stopping family violence proved to be a weak mechanism that often leaves women helpless and vulnerable in a situation of continued abuse.
- Accusation of zina as an instrument of manipulation and intimidation of violence victims and witnesses. The runaway or raped girls that are accused of zina represent one of the most difficult cases for legal defense, according to the respondents. According to respondents, qualifying the act of violence as zina allows judges to distribute the responsibility for committing crime between both parties (the victim of violence and its perpetrator). Judges were also reported to encourage the victim to drop the charges and marry the violence perpetrator. The threat of being qualified as having committed zina is a strong instrument of pressure that forces many women and girls to drop the charges. Same threat is regularly used against runaway girls by family members and violence perpetrators. It is also sometimes used against those who provide help and shelter for runaway girls.
- Age determination procedure is a subject to frequent manipulation and presents a recurring problem for defense lawyers. Since so many women and girls do not possess of personal identification document (tazkira), the task of determining victim's age falls upon the Forensic Medicine Unit. By stating that the victim is older than 18 the doctors conducting forensic examination are able to help violence perpetrator in avoiding more severe punishment.
- Problems of working in predominantly male professional environment. The respondents feel that often they are “not taken seriously, because of being women and working for NGO”.
- The lack of female professionals in the police force and prosecutor's office creates obstacles for the investigation. The police officers and employees of the Prosecutor's Office have a hard time establishing good communication with female victims and witnesses.

⁵¹ The Assessment found that this method is also used by police, Prosecutor's Office and DOWA.

- **Working with communities.** The Legal Center organizes legal literacy classes for community members.
- **SOPs, guidelines and protocols.** The organization uses SOPs provided by the head office in Kabul. The Legal Center does not have guidelines on the treatment of GBV victims. The staff of the Legal Center did not receive any specific training on working with victims of GBV.
- **Coordination with other agencies.** HAWCA is a member of regional CCC. The lawyers are working closely with both the Prosecutor's Office and the Forensic Medicine Unit. However the government agencies frequently neglect to share information regarding the case (such as transfer of cases to other districts, case related information or decisions) with the defense lawyers. It also happens that the defense lawyers from several NGOs start working on one case without sharing information or coordinating their efforts. Respondents explained that procedures that require transparency with regard to case processing and information sharing in state agencies would assist the protection of victims' rights.

7.2. Reference Center in Jalalabad City

Involvement in GBV response

- **Structure, functions and services provided to GBV victims.** The Reference Center for women, victims of violence was established in 2007 by DOWA and the Ministry of Internal Affairs. The Center is funded by UN WOMEN⁵². Since January 2011 the Center hosted 52 women. Most of the women that stayed in the facility suffered from physical violence perpetrated by family member. The respondent suggested that due to the efforts of the Center the number of cases involving self-immolation and suicide attempts “decreased to zero, but used to be 60%-80%”. It is unclear whether the statement is based on the Center’s records, the provincial data, the city data or the respondent’s personal observations.
- **Access to services.** The respondent related that women are mostly sent to the Center by the police department or DOWA, rarely by AIHRC.⁵³
- **Processing GBV cases.** The center does not accept women involved in criminal cases. Clients are only supposed to spend 24 hours in the Center. However in some cases police (the Human Rights department or Family Response Unit) can send a written request to keep the client for a longer period of time (even up to 6-8 months).
- **SOPs, guidelines and protocols.** The Center has TOR, that was not available for the Assessment team. According to the respondent, the facility uses the registration form to record the case details. She could not share the form. The Center’s staff initially received training on the processing of GBV cases. However, at present, due to a high staff turnover the employees of the Reference Center are not trained on the processing of GBV cases. The facility does not have any guidelines regulating the treatment of women subjected to GBV.

7.3 Legal Aid Organization of Afghanistan (LOAO)

⁵² The assessment team’s request to visit the Reference Center was declined. The team interviewed the Center’s manager in UNICEF’s Guesthouse in Jalalabad (the office was kindly provided by UNICEF staff).

⁵³ Later in the same interview the respondent mentioned that women come to the shelter directly, although not many people know where the Center is located.

Involvement in GBV response

- **Structure, functions and services provided to GBV victims.** LOAO is a non-governmental organization working in 22 provinces of Afghanistan to promote the access to justice and strengthen the rule of law through provision of legal aid services for underprivileged individuals, especially women and children. The assessment team interviewed the Head of regional office, LOAO in his office in Jalalabad City. The organization does not specifically focus its activities in the area of GBV. LOAO provides free legal assistance to men, women and children that can't afford hiring a defense lawyer. Thus GBV cases constitute only a portion of all cases processed by LOAO. The office was established in 2008 and covers all eastern provinces.
- **Access to services.** The office is open to visitors 5 days a week.
- **Processing of cases.** Most cases enter LOAO through the request for defense lawyer sent by the police department, Prosecutor's Office and courts. Sometimes the cases are discovered by the monitoring officer visiting prisons. The organization encountered certain difficulties while working in rural areas. The difficulties stem from the volatile security situation, weakness of law enforcement and judiciary mechanisms in these areas and the lack of the respect for the state laws among general population.
- **Working with communities.** The organization does not have any activities in the field of GBV response that involve local community based structures.
- **SOPs, guidelines and protocols.** LOAO does not have a special registration form for GBV cases and does not have any specific procedures regulating the processing of GBV cases. The respondent emphasized that LOAO would be interested in receiving training for defense lawyers on the processing of GBV cases.
- **Implementation of EVAW Law.** The organization's lawyers use EVAW Law in their routine work on GBV cases.

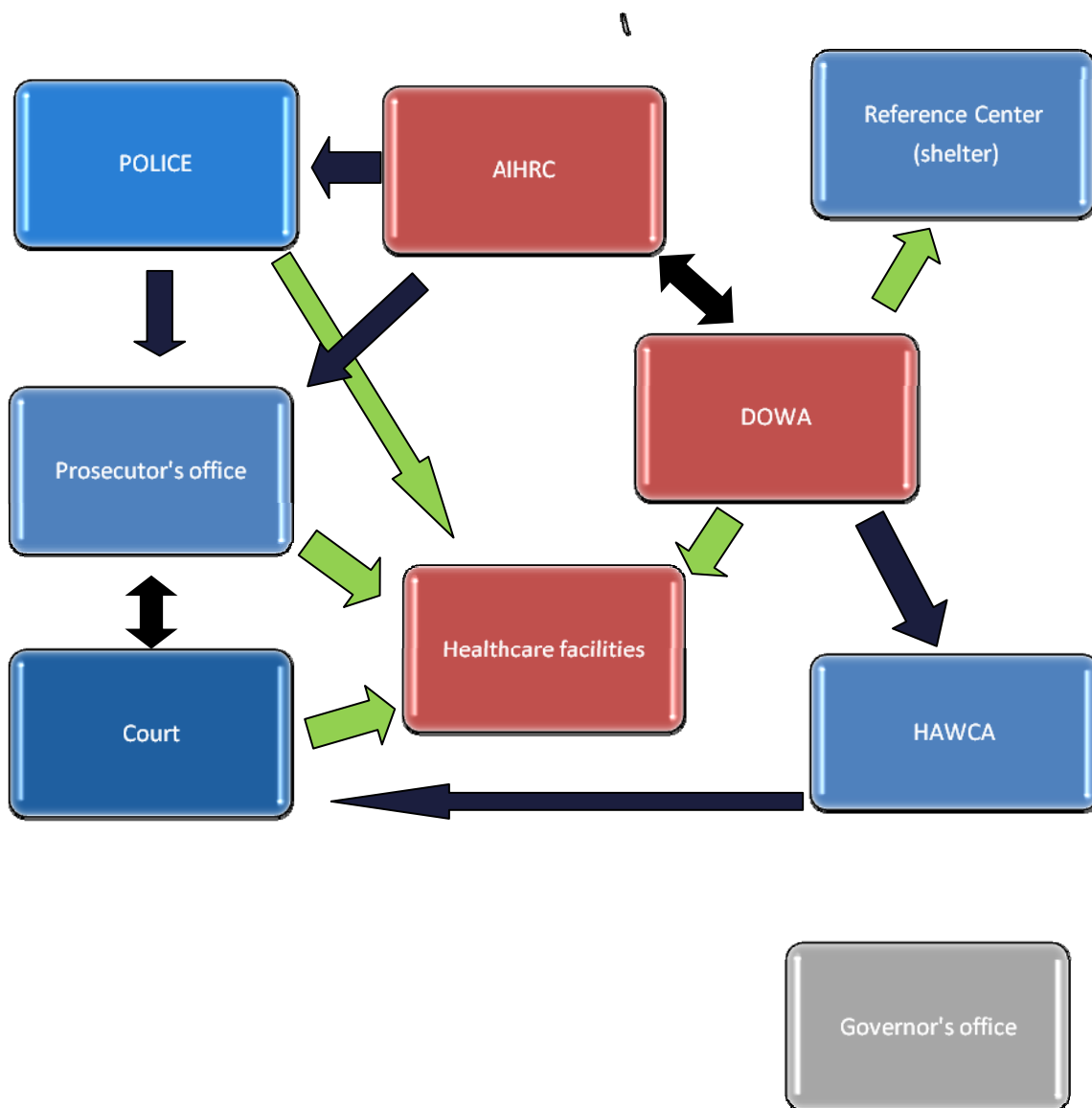
- **Coordination with other agencies.** LOAO does not have problems with obtaining case related information from the relevant government agencies. The organization has frequent contacts with UNAMA and AIHRC sharing information on GBV cases.

NGOs: needs and challenges in providing services for GBV victims

- **Challenge: high risk security environment and weakness of law enforcement bodies** in certain rural areas make the activities of NGO's particularly difficult and renders NGO employees vulnerable to possible backlashes from the violence perpetrators or families of GBV victims.
- **Challenge: working in male dominated environment** of law enforcement and judiciary bodies presents several challenges for female defense lawyers. The employees of these state agencies could benefit from training on gender sensitivity in professional environment.
- **Need to reach out to GBV victims at early stages of legal process.** The assessment revealed that many GBV victims are not receiving information about the free legal assistance available for them. There is a need to develop clear procedure that would ensure that GBV victims receive information about free legal assistance services available for them. The reference to free legal help should be a part of step-by-step procedure of processing GBV case in police, prosecutor's office and court.
- **Need to establish the standards for information sharing between the state agencies involved in investigation and trial of GBV cases and the defense lawyers.** It is also necessary to specify the format and procedure that regulate the information exchange without jeopardizing the safety of the victims.
- **Need for better coordination between organizations providing free legal assistance to GBV victims.** In order to avoid the duplication of efforts of the defense lawyers working on specific GBV cases in uncoordinated manner the organizations providing legal assistance should create common mechanism for information sharing and coordination (for example, bi-weekly meetings, or mailing list).

- ***Need for capacity building in the area of interaction with GBV victims.*** *Many respondents working for NGOs require training on the interaction with GBV victims. LOAO expressed particular interest in such training for the defense lawyers working with GBV cases.*

JALALABAD. GBV RESPONSE: MAIN SERVICE PROVIDERS.



- Entry points for GBV victims.
- ➔ Two-directional movement of cases
- ➔ Single-directional movement of cases and information

CHAPTER 4: KABUL PROVINCE

Kabul City profile⁵⁴

Kabul is a capital and largest city of Islamic Republic of Afghanistan, country's economic and cultural center. Located in the eastern central part of the country Kabul is also the capital of Kabul province. The city is divided into 18 districts. According to some estimates the population of Kabul province is 4 million people of which 3.5 million reside in the capital⁵⁵. However



Map of Kabul Province

other estimates place the population of Kabul at 4.5 million based on the assessment of the city's triple population growth since 2001⁵⁶. In a last decade, a number of socio-economic developments, including the perils of continuing armed conflicts, economic devastation, lack of basic infrastructure in many rural areas and large groups of returnees seeking the opportunity to settle in the cities, resulted in unprecedented rural-urban migration into the capital⁵⁷. Among many ethnic groups residing in the city the largest are Tadjiks and Pashtuns. Large scale urbanization created new type of urban community, less tied to traditional forms of collectivity and rigid power structures. The rapid growth of Kabul's population led to proliferation of illegal settlements, put enormous burden on capital's already insufficient infrastructure and dramatically increased demand for basic services.

⁵⁴ The profile uses information from the Statistical Year book 2010-2011, prepared by Afghanistan's Central Statistics Organization, Afghanistan National Risk and Vulnerability Study 2007-08, Provincial Development Plan, and Kabul Provincial Profile prepared by the Ministry of Rural Rehabilitation and Development (MRRD), 2007.

⁵⁵ Kabul provincial profile, <http://www.undp.org.af/publications/RRERS/Kabul%20Provincial%20Profile.pdf>

⁵⁶ Setchell, Charles A., Luther, Caroline N., Kabul, Afghanistan: a case study in responding to urban displacement, Humanitarian Exchange Magazine, Issue 45, December 2009, <http://www.odihpn.org/report.asp?id=3053>

⁵⁷ Ibid.

Large part of the capital's infrastructure was destroyed during wars in 1979-2001. However in the last decade the city witnessed certain improvements in urban infrastructure. 71% of all households in Kabul use safe drinking water and have access to electricity⁵⁸. These indicators decrease for rural areas surrounding the capital.

Kabul province has best access to health services in all Afghanistan. The city has 93 healthcare facilities, including 23 Basic Health Centers, 23 Comprehensive Health Centers, 3 District Hospitals, 22 Specialized Hospitals and 4 Mobile Clinics⁵⁹. Compared to the rest of the country Kabul offers good opportunities for education with 9 universities, dozens of public schools, vocational programs and training courses provided by international organizations. The literacy rate for both men and women in the capital is considerably higher than in the rest of the country, two thirds of all men and half of all women in Kabul are literate⁶⁰. However the population of unauthorized settlements (68 percent of Kabul's population) does not have access to clean water, electricity, basic healthcare and educational facilities.

Security situation in the city has been consistently explosive in the last two years with armed attacks sometimes unfolding in the areas close to important public landmarks and government buildings⁶¹.

⁵⁸Kabul provincial profile, prepared by the Ministry of Rural Rehabilitation and Development, <http://www.mrrd-nabdp.org/Provincial%20Profiles/Kabul%20PDP%20Provincial%20profile.pdf> (last accessed on November 30, 2011)

⁵⁹ Healthcare Information Management System (HIMS), 2010

⁶⁰ Afghanistan Policy Page, Afghanistan Congressional Communications Hub, March, 2010, <http://newstrategicsecurityinitiative.org/wp-content/uploads/2010/01/P17-Afghan-Policy-Page-Province-Profile-Kabul.pdf> (last accessed on November 30, 2011)

⁶¹ Regional Command Capital, Institute for the Study of War, <http://www.understandingwar.org/region/regional-command-capital>

ASSESSMENT FINDINGS: KABUL CITY

1. Healthcare sector

Involvement in GBV response

a) Medium size HF. Level: Secondary Care Service.

Comprehensive Health Center (CHC) in Kabul.

- **Structure, functions and services provided to GBV victims.** Located in the 9th district of Kabul, away from the busy city center CHC started as a facility exclusively providing services for mothers and children. Later the facility changed its profile to fit the requirements of Basic Package of Health Services. However to this day women and children constitute the majority of CHC's patients. The Center has 13 staff members⁶², including two doctors and one midwife. On average the facility serves 200-250 patients monthly delivering pre and post-natal, gynecological and pediatric care. According to the Head of the CHC, the facility receives considerable number of female patients suffering from physical violence perpetrated by a family member (most often husband or mother-in-law). The Head of the CHC demonstrated a high level of awareness regarding GBV and its impact on women's health. She worked in the area of combating VAW and participated in training programs on gender, human rights and the rights of the victims of human trafficking.
- **Access to services.** CHC is easy to access, however the capacity of the facility does not match public demand. The assessment team observed long lines of women and children waiting for the appointment.
- **Processing GBV cases.** Some patients come to the Center with the complaints about injuries caused by family violence. Others initially do not mention GBV but relate to the doctors a range of other health issues. According to the Head of CHC,

⁶² According to BPHS standards CHC should have 17-18 staff members.

she normally asks women probing questions to determine whether the health problems are caused by violence. After identifying the case of violence she often refers the patient to one of the NGOs providing legal assistance. She established this procedure based on her own initiative, knowledge and personal contacts. All patients arriving to the Center are registered through the standard procedure. The facility does not have a special registration or reporting procedure for the patients disclosing GBV.

- **Referral.** CHC rarely receives cases from the police (the respondent could recall only two cases). CHC staff is not required by any rules or regulations to report GBV cases to the police or refer GBV patients to any other agency outside the healthcare system. The doctors often refer women to two local NGOs that render legal assistance to the victims of violence. The NGOs, in turn, refer women in need of medical assistance to CHC.
- **Working with communities.** CHC staff has regular meetings with Health Shura representing the “neighborhood”⁶³. Shura members support CHC’s efforts to help the patients subjected to violence by family member. The members of the Shura include a lawyer, a teacher and *vakil-i-ghuzar*. The head of local NGO that provides legal assistance to CHC’s patients is also a member of the Health Shura.
- **SOPs, guidelines, procedures.** The facility does not have any written guidelines on the treatment and referral of GBV victims. The actions of the staff are based on professional experience, knowledge received through training and genuine desire to help female patients suffering from GBV.
- **Coordination with other agencies.** Coordination with other agencies is not regulated by any formal agreements and is not incorporated in the internal operational procedures of

⁶³ The respondent could not provide a clear definition of “neighborhood” and described it as “people living in the area near CHC”.

CHC. However the facility maintains good working relations with two NGOs located in the neighborhood. The relationship is based solely on the personal contacts and initiative of the Head of CHC and presents a good example of efficient informal cooperation in the absence of formal coordination framework. As opposed to the staff in small and medium HF in rural areas CHC employees in Kabul were not scared to ask the patients about GBV experience and refer them to NGOs for legal assistance. This suggests fundamentally different relation between the facility and the community it serves. Massive flow of migrants pouring into Kabul is often accompanied by the collapse of traditional forms of collectivity (extended families, qawms). New urban communities are characterized by considerably weaker social ties and less rigid power structures. In this type of urban environment the healthcare staff gains higher level of independence in decision making. Compared to similar HFs in the rural areas, doctors and midwives in the city also seem more confident in the ability of the state institutions to protect their security. This sense of security makes the healthcare staff more open to identifying GBV and assisting GBV victims.

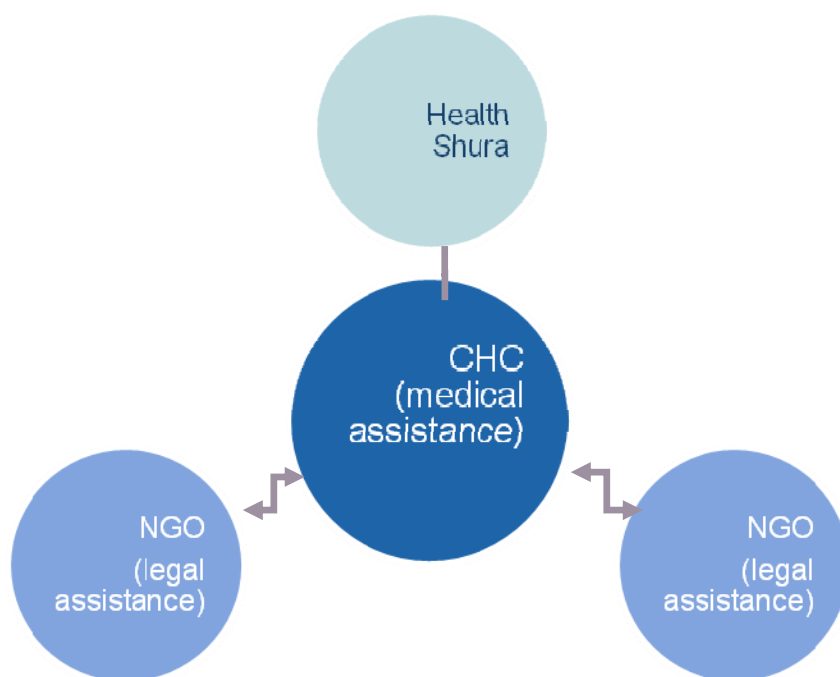


Figure. Informal coordination model, CHC, Kabul.

b) Large size HF in Kabul. Level: tertiary healthcare services.

Rabia Balkhi Hospital, Stomatological Hospital and Istiqlal Hospital.

- **Structure, functions and services provided for GBV victims.** All three HFs host psychosocial and health support program implemented by the Afghanistan Medica, local non-governmental organization established in 2000. The program was established three years ago and provided training on the screening, processing, treatment and referral of the patients subjected to GBV to 35 healthcare professionals (hospital doctors, nurses and midwives). The program also established a full-time presence of psychosocial counselors in the HFs.
- **Access to services.** The HFs are open to general public. The psychosocial counselors receive the patients in a separate room⁶⁴, the arrangement that allows to keep the meeting confidential and helps to protect the patients' security.
- **Processing GBV cases.** Upon identifying possible GBV issue the hospital doctors refer patient to psychosocial counselor. The counselors are based in the hospitals and receive patients every day of the week. Physical violence by a family member and rape are among most common GBV types treated by the counselors. The counselors assist patients who request legal assistance by referring them to Afghanistan Medica's legal department. The procedure is facilitated through the use of internal referral sheet. The defense lawyers employed by Afghanistan Medica proceed with the case updating the counselors on the progress at weekly meetings. The counselors mostly keep in touch with the patients via phone connection. attitude of hospital doctors

⁶⁴ The information about the separate room for psychosocial counseling was confirmed for Rabia Balkhi Hospital.

- **Referral.** The cases are mostly referred to the counselors by hospital doctors, who register the referral. Some patients are sent in by the police, Juvenile Rehabilitation Unit and prisons. The cases referred by the police normally come with the letter containing requests for medical examination. The hospital doctors do not send the patients to any other agency and do not report GBV to outside agencies.
- **Working with communities.** The organization runs six counseling Centers for GBV Survivors that in addition to counseling provide literacy and vocational training for women. The organization does not work with community based structures.
- **SOPs, guidelines and protocols.** The counselors use questionnaires' and case history forms to record information. The forms are normally filled after the meeting with the patient and stored in the office. The counselors store case information in the database developed by Afghanistan Medica.
- **Coordination with other agencies.** The hospitals are not directly involved in any coordinating bodies. Istiqlal Hospital has an agreement with AIHRC on the referral of GBV victims. According to the information received from respondents in AIHRC the number of referrals from the hospital is rather small. The coordination between the hospitals and other agencies is enacted through Afghanistan Medica's membership in Cooperation and Coordination Commission, ERAW Commission, Health Cluster and Child Protection Action Network. However the procedures followed by psychosocial counselors do not incorporate the elements facilitating routine coordination with other agencies.

Healthcare facilities: needs and challenges in providing services for GBV victims

- **Challenge: cultural restrictions on disclosing family abuse or other types of GBV.** *Family restrictions on women's access to public health and cultural stigma of revealing the exposure to GBV were less pronounced in the responses of healthcare professionals in Kabul, than in Bamyan and Nangarhar. However these factors were still mentioned as important for the delivery of services to GBV victims. Stigma of revealing the violence perpetrated by one's family member is specifically strong and women attending doctors are more reluctant to disclose GBV perpetuated by a family member.*
- **Need to introduce mechanisms to strengthen the involvement of HF in overall referral and reporting network.** *In Kabul, similar to situation in Bamyan and Nangarhar, the HF at the moment present an impasse in the referral and reporting network that connects other agencies working in the field of GBV response in the province. However the developments in Kabul indicate certain positive changes in this area. The assessment identified at least two HFs that were involved in coordination with agencies outside the healthcare sector. However in majority of HFs the reporting of GBV is not required by any rules or regulations and neither is the assistance to the GBV victims in the form of information sharing or referrals. Subsequently, the patients subjected to GBV are deprived of opportunity to benefit from services provided by other agencies. Involvement in the referral and reporting network should be strengthened through the introduction of SOPs that incorporate referral and reporting of GBV victims in the routine operations of the HFs.*
- **Lack of personnel trained to identify, treat and refer the patients suffering from GBV** *is a problem for both large and small HF in Kabul. Although training opportunities in the capital are much more diverse compared to the provinces there still is a dearth of training programs specifically focusing on screening, processing and referral of GBV patients in HFs.*
- **Need for the guidelines outlining ethical rules and safety precautions for treatment of GBV victims in the HFs.** *The HFs examined by the Assessment did not have*

guidelines stipulating ethical rules and safety precautions important for dealing with people subjected to gender based abuse. However, according to the information related by respondents the attitude of healthcare professionals has a strong impact on patient's decision to disclose GBV. Judgmental or even hostile treatment by the healthcare professionals often prevents women from disclosing GBV. Specific regulations ensuring that the disclosure of GBV will not jeopardize victim's security and further aggravate her (his) frustration are crucial for the improvement of healthcare sector's response to GBV.

- ***Need to develop SOPs regulating identification, treatment and referral of GBV patients in the healthcare facilities.*** *The healthcare facilities in Kabul do not have SOPs that regulate identification, treatment and referral of GBV patients. SOPs that include modules for various levels of HF and low/high security risk areas are essential for strengthening institutional involvement in service provision to GBV victims.*
- ***Need to examine the services and possibilities in the rural areas.*** *The examination of the service available for GBV victims in the rural areas outside the capital has fallen outside of the scope of the current report. However there is a strong need to examine the services available for GBV victims residing in rural areas around the capital. Combination of rural context and the proximity of the capital may have specific effects on the attitude of the healthcare staff, GBV victims and local communities towards healthcare based GBV interventions.*
- ***Need to increase awareness of the connection between GBV and women's health issues among the healthcare professionals.*** *The respondents were concerned that healthcare staff for the most part does not draw connection between GBV and women's health issues. Awareness raising programs specifically targeting healthcare staff should present comprehensive information on the detrimental effect of GBV (specifically domestic violence) on the health of women and children.*

2. COMMUNITY BASED STRUCTURES

Health Shura , Bibi Mahro sector, district 9 of Kabul

Involvement in GBV response

The Health Shura of Comprehensive Health Center (CHC) in Bibi Mahro had among its members several community elders, community leaders and *wakil-i-ghuzar*. The sector of Bibi Mahro is located in the 9th district of Kabul. District 9 has total population of more than 40000 people. CHC receives 200-250 patients per day. All patients in the health facility are women and children. Shura members were keen to raise issues pertaining to the quality of healthcare services delivered by the Center. They related, that insufficient supply of medicines and lack of necessary medical equipment create problems for healthcare service delivery in the village. Respondents stated that most common types of GBV in Bibi Mahro are related to exchange of brides (*bada*), early and forced marriages.

The information related by Shura members, suggests that situations involving GBV are most often solved (or contained) within families. Family members are adamant at concealing the situation that involves GBV as long as possible and are embarrassed when information transpires outside of close family circle. However if family cannot address the issue, situation is submitted to the council of community elders and to *wakil-e-ghuzar* (elected community representative). According to respondents, *Wakile ghuzar* normally does not like any outside interference into the community affairs. He encourages the residents to approach him or community elders for mediation. Applying to elders' *shura* (council) even in one of the neighboring sectors may cost the applicant and his family good relations with *wakile ghuzar*. If one of the parties is not satisfied with the outcome of informal adjudication or the *shura* members are not willing to make decision on the case, the residents submit cases to local police department.

Information related by *shura* members in Bibi Mahro confirmed the challenges identified by the Assessment for cooperation with community based structures in Bamyan and Nangarhar.

3. LAW ENFORCEMENT

3.1. Police

Involvement in GBV response

Criminal Investigation Department and Family Response Unit of District 10, Kabul

- **Structure, functions and services provided for GBV victims.** The Family Response Unit was established in the Police Department of district N 10 in 2005. The Unit currently has only one employee and is understaffed. The FRU is functioning as a part of the Criminal Investigation Department (CID). GBV cases received by CID mostly involve physical violence perpetrated by a family member. The FRU receives a large number of cases involving women and girls escaping home as a result of physical or psychological violence. Police very rarely receives complaints regarding sexual violence. According to the respondents since the disclosure of sexual violence stigmatizes the victim it is normally concealed by the victim or her family.
- **Access to services.** The visitors can submit their complaints to the district police department any time throughout the working week.
- **Processing GBV cases.** Overall, the procedure established in the district Police Department in Kabul is similar to the one followed by the police departments in Bamyan and Nangarhar. Visitors submit complaints to the office of the district Department Chief. The office then sends criminal cases to the CID and legal cases to FRU. CID conducts preliminary investigation and transfers the cases to Prosecutor's Office. FRU registers information on all in-coming cases. The Unit first tries to "reconcile" victim and perpetrator of violence. If the parties agree on "reconciliation" terms the case is closed. The FRU employs the practice of obtaining a letter of commitment from the perpetrator or family and community members guaranteeing security of GBV victim. However if mediation does not yield results the FRU transfers cases to the Prosecutor's Office. Although the FRU tries to monitor GBV cases after they enter the Prosecutor's Office obtaining information from the Prosecutor's Office presents considerable challenge.

- **Referral.** Both the CID and the FRU refer cases to the healthcare facilities for medical examination, however police never receives GBV cases from the healthcare sector. The referral to shelter is facilitated through MOWA. Although opportunity to stay in the shelter is important for women who are scared to return home, the duration of stay is sometimes not long enough for those who have trouble rebuilding relations with their families⁶⁵.
- **Working with communities.** Community elders, according to FRU employee, have a strong influence on plaintiff's decision to withdraw the complaint. On several occasions they engaged in mediation and requested for the case to be resolved through the community based informal justice mechanisms. The FRU granted them the opportunity, however requested a letter of commitment and followed up with the victim to ensure her safety.
- **SOPs, guidelines and protocols.** The CID and the FRU do not have specific SOPs regulating the processing of GBV cases. The FRU has a form (Ezarat) for recording information regarding the victim and the details of the case.
- **Coordination with other agencies.** Coordination with other agencies (specifically the Prosecutor's Office) suffers from gaps in the procedures regulating information exchange. There is no coordination with NGOs providing legal assistance.

⁶⁵ Since living on their own is for the most part not culturally accepted option for women in Afghanistan, reintegration into family and community is crucial for women leaving the shelter.

Police: needs and challenges in providing services to GBV victims.

- **Challenge: police officers do not always distinguish between the protection of human rights and dispute resolution in treatment of GBV cases..** Police officers interviewed for the assessment regularly used “reconciliation” approach while dealing with GBV cases. The reconciliation is achieved through mediation between the victim and the perpetrator. This approach serves to maintain impunity of GBV perpetrators. Police officers need be trained on the duties of law enforcement in response to GBV.
- **Need to examine the impact of reconciliation practice** on the lives of GBV victims. The police department currently has no mechanism for monitoring the situation in the period after “reconciliation”.
- **Need to elaborate existing procedures and create new policies regarding the processing of GBV cases.** District Police Department does not have written policies and procedures specifically designed for processing of GBV cases. Improved quality of services for GBV victims requires SOPs that regulate processing of GBV cases and coordination between various agencies helping GBV victims.
- **Need to establish a common database of GBV cases in the district Police Department.** Currently the district police department does not have a database of GBV cases open to all department members. The absence of common database of GBV cases results in confusion and double case registration. It also slows down the information sharing process. The common data base established and maintained by the FRU and open to all police departments will increase the efficiency of case investigation and allow for better data collection on GBV related crime.
- **Need for better information sharing between the agencies.** Obtaining information from the Prosecutor’s Office presented a challenge for the FRU staff. Information sharing between the agencies requires more elaborate and comprehensive procedures

and tools. Current mechanism of information sharing (standard letters requesting information from the health facilities or the information requests directed to the Prosecutor's Office) fails to facilitate specific, detailed and structured communication.

- **Need for improved coordination with the healthcare facilities.** Majority of the healthcare facilities do not report GBV cases to the police and do not refer victims of gender based abuse to the police department. In order to improve the quality of services to GBV victims both agencies need detailed procedures regulating the coordination and information sharing between the police and the healthcare facilities.
- **Need to recruit and train female police officers.** The emphasized the difficulties faced by female police officers working in predominantly male environment of law enforcement bodies. Professional interactions with the colleagues are sometimes marred by gender stereotypes and patronizing attitude. Same is relevant for interaction with the judiciary. However the assessment demonstrated that both police and Prosecutor's Office require female staff members in order to build better communication with female GBV victims and witnesses. Increase in the number of female police officers will help women to overcome the burden of gender stereotyping and will serve to improve the quality of police work.

4.JUDICIARY

4.1. Violence Against Women Unit, General Attorney's Office

Involvement in GBV response

- **Structure, functions and services provided for GBV victims.** Violence Against Women (VAW) unit within the Attorney General's office was established with the support of International Development Law Organization (IDLO). The unit, which includes nine female prosecutors, is responsible for enforcing EVAW Law through building cooperation with victim service organizations and advocates in order to identify victims and coordinate case referrals with healthcare, educational and other government agencies. The Unit receives, on average, 10 cases per day, mostly physical violence committed by a family member and forced marriage.
- **Access to services.** The office is open for visitors every day of the working week.
- **Processing GBV cases.** The Unit receives the majority of GBV cases from the police. Sometimes GBV victims approach the Unit directly, or are referred through MOWA and the AIHRC. Case information is recorded and stored in a database. The Unit conducts primary case investigation of GBV cases and provides GBV victims with free legal defense. In situations when the plaintiff decides to withdraw the complaint VAW Unit requests written agreement and stops the investigation.
- **Referral.** The police, MOWA and the AIHRC refer GBV cases to the VAW Unit. The Unit refers some GBV victims to healthcare facilities for medical examination.
- **SOPs, guidelines and protocols.** The Unit does not have SOPs regulating the processing and treatment of GBV cases.
- **Coordination with other agencies.** The information that the Unit receives from the healthcare facilities is frequently insufficient and unclear. The cooperation with police departments suffers from the gaps in information sharing. Information produced by preliminary investigation is not always sufficiently specific and delays in referring GBV cases from police to the Unit sometimes result in the loss of valuable evidence.

4.2. Supreme Court

Involvement in GBV response

- **Structure, functions and services provided for GBV victims.** According to the article 117 of the Constitution of Afghanistan, the Supreme Court as the highest judicial branch of the government is heading the judiciary power. The Supreme Court is headed by the chief of Supreme Court. The Supreme Court is comprised of the High Council, general administration directorate, General Department of Islamic Verdict and a number of divisions (civil, commercial, general criminal, public and military crimes and crimes against public security and interest). The assessment team member interviewed the administrative officer of the Court.
- **Access to services.** The visitors can access the Supreme Court's office however most of GBV cases is submitted to the Court by the Prosecutor's Offices.
- **Processing GBV cases.** In 2010 the Supreme Court received 100 cases involving violence against women. In the first two quarters of 2011 the number of such cases already exceeded 150 (mostly physical violence, kidnapping and divorce complications). The respondent explained this surge by the population's increased awareness of VAW. Certain rise in public confidence in the ability of judicial system to address the issues of VAW may have also played a positive role. Vast majority of cases arrives from the Prosecutor's Office. The information delivered by the Prosecutor's Office is not always sufficiently specific and comprehensive. For example, the cases involving burning are sometimes presented by prosecutors as self-immolation without clear supporting evidence. The administrative division of the Supreme Court identifies individual cases as criminal or civil and forwards cases to respective courts (General Criminal or Civil Court).
- **Implementation of ERAW Law.** The respondent voiced concern related to certain articles of the ERAW Law that he describes as "unclear". These concerns were shared by his colleagues and were outlined in the letter sent by the Supreme Court to the ERAW Commission. In its response the Commission related that the Law was not finalized yet. This information suggests that at the moment the ERAW Law is not fully used by the courts.

- **Working with communities.** As all other member of judiciary the respondent confirmed that the bulk of GBV cases is not reaching the national judiciary system and is processed by the community based informal justice mechanisms. However there is no nation-wide program bridging the efforts of formal and informal justice mechanisms in addressing the cases that involve gender based abuse.
- **SOPs, guidelines and protocols.** The processing of GBV cases is not subject to any specific regulations.
- **Coordination with other agencies.** The Supreme Court is a signatory for the coordination and support protocol for assisting GBV victims (in the safe-house run by HAWCA). Other parties to the protocol include MOWA, the Ministry of Public Health, the Ministry of Justice, NGO Humanitarian Assistance for Women and Children of Afghanistan (HAWCA) and AIHRC.

Judiciary: needs and challenges in providing services to GBV victims.

Challenge: gaps in information sharing between police, Family Violence Unit in the General Attorney's Office and healthcare facilities regarding GBV cases.

- **Need to strengthen coordination and information exchange between the Family Violence Unit, police and healthcare facilities.** Respondents in Family Violence Unit related that the quality of primary investigation of GBV cases suffers from poor coordination with the healthcare facilities. The information provided by the healthcare facilities is often incomplete and sometimes inaccurate. Similar to situation in Bamyan and Nangarhar sometimes the delays in preliminary investigation of GBV cases by police lead to loss of important evidence. This problem should be addressed through the introduction of better coordination and information sharing mechanism including SOPs regulating the terms and practices of information exchange between the agencies.
- **Need for SOPs, guidelines and protocols on processing and referring GBV cases.** There are no written policies or procedures in place to regulate the treatment of GBV cases in Family Violence Unit. General procedures that are currently used do not address the gaps in coordination and information sharing. Current procedures do not incorporate specific steps to ensure coordination with other agencies and do not take into consideration the safety of individuals involved in GBV cases.
- **Challenge: situations involving GBV are mostly resolved by community based informal justice mechanism.** Thus violence perpetrators avoid the punishment stipulated by Afghanistan's legislation and the victims of violence do not receive protection and justice guaranteed by national laws. Judiciary members in Kabul as well as in Bamyan and Nangarhar are fully aware of this fact. Nation-wide program bridging the efforts of formal and informal justice mechanisms is necessary for establishing the rule of law and delivering protection and justice to GBV victims.
- **Need to strengthen the awareness and support open discussion on the implementation of ERAW Law.** Assessment revealed that Court officials have certain concerns regarding the implementation of ERAW Law. Some provisions of the Law were described by the respondents as "unclear". These concerns should be shared in open discussion. There is also a need for educational and training materials presenting clear

and relevant information about the Law and its relevance for the court trial of GBV cases. The workshops bringing together judges, prosecutors and police force members would be beneficial for the development of such materials.

5. The MINISTRY OF WOMEN'S AFFAIRS (MOWA)

Involvement in GBV response

- **Structure, functions and services provided for GBV victims.** The Ministry of Women's Affairs is the main state agency responsible for the implementation of state policy in the area of women's rights. MOWA implements state policies aimed at securing and expanding legal rights of women and ensuring the rule of law in all areas related to women's political, social and economic participation. MOWA was established in 2004 by the decision of the Cabinet of Ministers. The Ministry consists of 9 central and 34 provincial departments.
- **Access to services.** The access to the Ministry's office is unrestricted for the visitors.
- **Processing GBV cases.** Majority of GBV cases enters the Ministry through its Legal Department. The department has 15 staff members that are responsible for registration of cases, maintaining of the database and monitoring of GBV cases in police, prosecutor's offices and courts. Women subjected to violence approach the Department directly. Some cases are sent to MOWA by police, AIHRC, NGOs and Family Violence Unit of the General Attorney's Office. All cases entering the Legal Department are registered. The department staff records case details in case registration form. The Department maintains database of all GBV cases registered by MOWA, however the database is not computerized yet. The head office also receives information on GBV cases from all provincial offices. The information is stored in the database and analyzed in monthly reports issued by the Legal Department. A number of GBV related complaints is settled down in MOWA's office and is not referred to any other agency. The Ministry's staff uses mediation to reconcile the victim and the perpetrator of violence. The office does not have a written procedure regulating the follow-up on "reconciled" GBV cases.
- **Referral.** MOWA receives GBV cases from AIHRC, police, NGOs and General Attorney's office. The Ministry very rarely receives any cases referred by healthcare facilities. MOWA refers women subjected to gender based violence to the police (criminal cases). The legal cases are sent directly to courts. If there are reasons to believe that going back home may put women under considerably security risk,

MOWA refers to the shelter (run by HAWCA, local NGO). Overall, all shelter related referrals by police or Family Violence Unit are conducted through MOWA.

- **Working with communities.** MOWA runs advocacy initiatives and educational campaigns that target urban and rural communities. The messages delivered by the campaigns include the issues related to GBV and its negative impact.
- **SOPs, guidelines and protocols.** MOWA has regulations that apply to the registration and processing of GBV cases. The Ministry worked jointly with the Asia Foundation to develop a form for recording GBV case information.
- **Coordination with other agencies.** MOWA facilitates the activity of several inter-agency mechanisms responsible for ensuring efficient cooperation between main service providers (CCC) and promotion of EVAW Law (EVAW Commission). The respondents related that coordinating the efforts of key service providers through inter-agency mechanism is easier in the capital compared to the provinces.

MOWA: needs and challenges in providing services to GBV victims.

- ***Need to introduce SOPs regulating the screening and processing of GBV cases.*** *As the leading government agency responsible for the promotion of women's rights MOWA receives a considerable number of complaints from women suffering from discrimination. However women are often reluctant to disclose violence especially when committed by a family member. The reporting of sexual violence is even more difficult. The ability of the agency's staff to identify GBV cases and encourage women to disclose the abuse is crucial for expanding MOWA's assistance to GBV victims. The Ministry needs SOPs regulating the screening and processing of GBV cases. MOWA's staff could benefit from the training focusing on the development and implementation of such procedures.*
- ***Need to introduce new approach to coordination.*** *Despite the presence of several bodies responsible for building coordination between the agencies involved in GBV response, the respondents identified lack of coordination as the main obstacle in addressing violence. Clearly, there is a need for new approach to coordination. The*

findings of the Assessment demonstrate that the top down coordination effort, albeit successful in addressing GBV cases on an ad hoc basis, is not efficient in bringing change to the routine operations of the agencies. The changes should be introduced on an institutional level and should affect the rules and regulations governing the daily practices of the relevant agencies. MOWA should facilitate the process of incorporating specific steps that ensure coordination in the procedures that regulate the treatment of GBV cases by all agencies.

- ***Need to develop better mechanism of information sharing.*** *The Assessment found that although MOWA maintains the data base of GBV cases other agencies do not have access to this information. The Ministry needs a policy regulating the information sharing on GBV cases. MOWA also needs tools that will facilitate the prompt and efficient information exchange among the agencies working on specific cases. The tools should also incorporate strong mechanisms protecting the security and dignity of GBV victims.*
- ***Need to reach out to the communities in rural areas.*** *The delivery of assistance to GBV victims residing in rural areas across the country remains one of the main challenges for MOWA. There is a pressing need to develop specific mechanisms that will increase the opportunities for rural residents subjected to GBV to access MOWA (through field visits, informational campaigns and cooperation with local community based structures).*
- ***Need to examine the effects of “reconciliation approach” and build the sound system for monitoring reprisals of violence in “reconciled” cases.*** *MOWA’s staff employs the “reconciliation approach” in addressing GBV cases. However the Ministry does not have written procedures regulating the monitoring of reconciled cases. Thus the Ministry does not have a mechanism capable of detecting the reprisals of violence as well as other consequences of the “reconciliation approach” for the well-being of the victims.*

6. AFGHANISTAN INDEPENDENT HUMAN RIGHTS COMMISSION

6.1. The Head Office of the Afghanistan Independent Human Rights Commission.

Involvement in GBV response

- **Structure, functions and services provided for GBV victims.** In accordance with article 58 of the Constitution, Afghanistan Independent Human Rights Commission (AIHRC) is Afghanistan's national human rights institution responsible for promoting, protecting and monitoring human rights in the country. AIHRC has six program units:
 - Human Rights Education Unit
 - Women's Rights Unit
 - Child Rights Unit
 - Persons with Disabilities Unit
 - Monitoring and Investigation Unit
 - Transitional Justice Unit

The AIHRC has 8 regional offices that submit monthly reports to the headquarters on the situation with human rights in respective regions. Women's Rights Unit (WRU) of AIHRC organizes its operations around five priority areas: education, leadership, monitoring and investigation, advocacy and empowerment.

- **Access to services.** The office is open for the visitors 6 days of the week from 07:00 to 16:30. On Thursday the office is closed but the staff can be reached through the phone (contact phone number is displayed on all promotional material distributed by WRU). The GBV cases that reach the Commission mostly involve physical violence by a family member and sexual violence.

- **Processing GBV cases.** AIHRC's Monitoring and Investigation Unit identifies large share of human rights violations related to gender based abuse in the course of routine monitoring conducted in courts, prisons, police and safe houses (shelters). GBV victims also approach AIHRC directly, often accompanied by family members. The Commission registers cases and stores information in computerized database. The AIHRC staff then monitors each case throughout police investigation, primary investigation by Prosecutor's Offices and court proceedings. The AIHRC officers notify respective agencies if human rights of GBV victims are violated in the process of investigation or adjudication.
- **Referral.** The Commission refers GBV cases to police, Prosecutor Offices, Family Violence Unit in General Attorney's Office and MOWA. The office in Kabul refers some GBV victims to the healthcare facilities for medical treatment. AIHRC signed an agreement with Istiqlal Hospital in Kabul on referral of GBV cases however the flow of cases from the hospital is still rather weak.
- **Working with communities.** AIHRC includes the messages concerning GBV in its meetings with local communities.
- **SOPs, guidelines and protocols.** The Commission has SOPs regulating the recording and processing of human rights violations. The office uses case recording form to collect information on GBV cases and stores case details in the computerized data base.
- **Coordination with other agencies.** The AIHRC is a member of EVAW Commission. Overall, the office does not encounter problems in coordinating efforts and exchanging information with police, prosecutors and MOWA. AIHRC signed Memorandums of Understanding with the Ministry of Internal Affairs, Ministry of Education, Ministry of Public Health and Ministry of Social Labor, however at this point the agencies do not have specific procedures that facilitate coordination in daily operations. The head office developed close cooperation with the media and regularly conducts media campaigns on women's rights and VAW.

AIHRC: needs and challenges in providing services to GBV victims.

- **Need to introduce coordination and information exchange on GBV cases into the routine procedures of AIHRC.** At the moment AIHRC's coordination with other agencies working in the field of GBV interventions is facilitated through participation in inter-agency coordination structures. However the Assessment revealed that coordination through these structures tends to focus on specific cases rather than the creation of interlocking procedures that ensure coordination on a daily basis. AIHRC's involvement in coordinated response could largely benefit from the introduction of specific procedures that ensure and regulate coordination and information exchange with other agencies in the course of routine services to GBV victims.
- **Need to recruit more female trainers.** Female trainers are instrumental for reaching out to women in rural areas. AIHRC's activities could largely benefit from the program that recruits and educates female trainers.
- **Need for guidelines regulating the interaction with people subjected to GBV.** AIHRC receives considerable number of complaints from GBV victims. Some approach the office directly others are identified through the monitoring of courts, prisons and other facilities. Interaction with GBV victims in a wide range of contexts calls for specific precautions protecting security of the victim. AIHRC's service to GBV victims could benefit from the ethical guidelines stipulating the principles of interaction with people subjected to traumatic experience of gender based abuse. The organization also needs to introduce safety guidelines stipulating specific steps to be followed by AIHRC staff in order to protect the safety of GBV victims.
- **Need for SOPs regulating the coordination and sharing of information with other agencies involved in GBV response.** There is a need for broader set of procedures covering the coordination in screening of GBV cases, formulating and responding to information requests, referrals and joint awareness raising projects in the area of GBV response.

7. NON GOVERNMENTAL ORGANIZATIONS

7.1. Legal and Cultural Services for Women and Children of Afghanistan (LCSWCA)

Involvement in GBV response

- **Structure, functions and services provided for GBV victims.** Located in XX district of Kabul LCSWCA is a non-governmental organization providing legal assistance to GBV victims. Together with the Comprehensive Health Center and local Health Shura LCSWCA formed small informal community network helping GBV victims in the xx district of Kabul. LCSWCA works in Kabul , Balkh and Badakhshan provinces rendering legal assistance to disempowered population groups, training female police officers and running projects on electoral rights. In Kabul and Badakhshan the organization provides free legal consultation to women and girls subjected to GBV.
- **Access to services.** The office of LCSWCA is located in the private house and is easy to access, for those visitors who already know the address. Otherwise the venue looks like one of many private houses located in a quiet back street. The LCSWCA staff explained that this lack of visibility helps them to protect security of GBV victims that use LCSWCA's legal assistance.
- **Processing GBV cases.** Majority of cases come to the organization from the CHC. Small number of women approaches the office of LCSWCA directly. The organization mainly receives cases involving physical violence by a family member. All cases entering LCSWCA go through the registration procedure. Information on each case is then filed and later given to the defense lawyer assigned to the case. However before transferring the case to defense lawyer LCSWCA tries to discuss the case with community elders. The respondents related that they try to engage community elders in defending the rights of GBV victim and use the authority of community *shura* to protect the victim. If mediation does not yield results LCSWCA either hires independent defense lawyers for the case or refers GBV victim to one of the organizations rendering free legal assistance. The defense lawyers then assist clients throughout the investigation and court proceedings.
- **Referral.** LCSWCA receives GBV cases from the healthcare facility and refers them to defense lawyers or other NGOs providing free legal assistance.

- **Working with communities.** The organization runs small projects on legal education for communities in Kabul and Badakhshan. These activities involve cooperation with elders shuras in some communities. The deputy head of LCSWCA is also a member of Health Shura of CHC in the Bibi Mahro sector of the district N 9.
- **SOPs, guidelines and protocols.** The organization does not have SOPs, guidelines or protocols regulating the treatment of GBV victims and the processing of GBV cases.
- **Coordination with other agencies.** LCSWCA mainly coordinates its activities with CHC and local Health Shura. The organization also works closely with some legal NGOs to coordinate efforts in assisting GBV victims.

7.2 Humanitarian Assistance for Women and Children of Afghanistan (HAWCA)

Involvement in GBV response

- **Structure, function and services provided to GBV victims.** Established in January of 1999 in Peshawar (Pakistan) by a group of young Afghan activists HAWCA started by organizing educational and vocational programs for women and children in refugee communities. After the demise of Taliban government the organization moved its operations to Afghanistan. In 2004 HAWCA started its first safe house in Afghanistan. Currently the organization runs a safe-house in Kabul and three Legal Centers (Kabul, Herat and Jalalabad). While safe houses provide shelter, meals and legal education for women, the Centers render free legal assistance to GBV victims and organize legal literacy classes for women and girls. In Kabul HAWCA's office helps GBV victims who require safe housing as well as those in need of legal assistance. The organization employs social worker, case worker and legal advisor. The cases entering the organization mainly involve physical violence by a family member, baad, badal, forced marriage and running away from home.
- **Access to services.** The entrance to HAWCA's office is gated and guarded.

- **Processing GBV cases.** All cases entering HAWCA go through the registration procedure. HAWCA's social worker examines the case to establish whether it is necessary to place the client in the shelter. The organization requires all potential safe-house residents to first register with the Legal Department of MOWA. The information on the case is routinely delivered to MOWA by HAWCA's social worker and/or legal advisor. The organization uses a set of forms (Client Registration Form, Client Assessment Form, Client Progress Form) to record case related information. If the organization encounters criminal case involving GBV the staff informs MOWA and General Attorney's office. HAWCA works closely with the Ministry of Interior and the General Attorney's office to determine the best route for specific GBV cases within the law enforcement and judiciary system. The respondents related that working directly with the higher ranks of the respective ministries is much easier than approaching local police departments or prosecutor's offices.
- **Referrals.** MOWA, General Attorney's Office, police departments, AIHRC and sometimes healthcare facilities refer GBV cases to HAWCA. The organization refers criminal cases to MOWA and General Attorney's Office. Sometimes HAWCA refers GBV victims to specific healthcare facilities (all - hospitals) for medical treatment. The respondents explained that they work with hospitals that can provide some level of protection and confidentiality. The social worker normally accompanies women to the HF.
- **Working with communities.** HAWCA's Legal Center has established community based groups where the defense lawyers meet with the families of GBV victims, community elders and local religious leaders to provide information on national laws concerning GBV and human rights. Sometimes community groups refer GBV cases to HAWCA and the defense lawyers provide free consultations on child custody, marital law and divorce.
- **SOPs, guidelines and protocols.** The organization currently is engaged in developing SOPs for the shelter. HAWCA uses a set of forms and procedures to ensure the registration and management of GBV cases.

- **Coordination with other agencies.** HAWCA engages in coordinated interventions through two separate mechanisms. The organization has the protocol of cooperation for the safe-house signed with MOWA, General Attorney's Office, the Ministry of Internal Affairs, Supreme Court and the Ministry of Public Health. According to this agreement government agencies support the shelter in assisting GBV victims. For example, the Ministry of Public Health should assist in provision of fast and safe medical treatment for GBV victims. The Ministry of Internal Affairs should provide protection for the shelter run by HAWCA. HAWCA also participates in the inter-agency coordinating bodies, such as Coordination and Cooperation Commission and the Commission on Shelters (established in 2007 and was active for 9 months).

7.3 Safe-house (HAWCA)

Involvement in GBV response

- **Structure, functions and services provided to GBV victims.** The safe-house for GBV victims run by HAWCA has a capacity for accommodating 40 residents. On average, the safe-house accommodates 90 clients in the course of a year. The staff of the facility includes manager, social worker, trainer and a case worker. Apart from protection, accommodation and meals the safe-house offers literacy courses, legal education, classes on women's rights in Islam and in national legislation. Women residing in the safe house receive basic medical treatment from a doctor who attends the safe house regularly. For more complicated health issues the facility provides transportation to specific healthcare facility. The residents are normally accompanied by the social worker.
- **Access to services.** The location of the safe-house is kept confidential in order to guarantee security of residents and staff members.
- **Processing GBV cases.** All women requesting safe-house residence are first interviewed by HAWCA's social worker. The social worker determines whether individual was indeed subjected to GBV and needs to be placed in the safe-house. Before entering the facility GBV victims are registered by MOWA. In the safe-house GBV victims relate their story to the case worker. The case worker records all case details and files all case related information. If GBV victim requests legal assistance the case information may be shared with the defense lawyer. The defense lawyer then follows-up with the case all throughout the investigation and court proceedings. After the verdict is issued respective court notifies MOWA. MOWA sends information about the court decision to the safe-house. Sometimes safe-house residents stay in the facility for extended periods of time waiting for court decision on divorce. The respondents mentioned cases that lasted for up to 3 years.
- **Release from the safe-house and re-integration into the society.** Release from the shelter and re-integration of GBV victim into the society present serious challenges for the safe-house management and the residents of the facility. Some women do not want to go back to their families and communities. However, courts

frequently rule that divorced women should be released from the safe-house into the custody of male relatives. However this option can put women in a position of complete dependence on family members. Cultural expectations limit the opportunities for women who do not want to re-unite with their spouses or rush into new marriage. HAWCA discussed with court judges the importance of allowing adult women to be released from the shelter without falling under the custody of family members. However the issue is still unresolved. Negative public perception of safe-houses adds to societal pressure endured by women released from the safe-house. The personnel of the facility also reported feeling the pressure of negative public attitude towards the safe-house.

“Women that are staying here face strong cultural stigma. People who work here also feel this negative public attitude, sometimes even from their own relatives.” – safe -house employee, Kabul

- **Referral.** MOWA, AIHRC, Ministry of Internal Affairs and other NGOs refer GBV victims to the safe-house. MOWA registers every person entering the facility. The referral to healthcare facility works well only if the patient has letter from MOWA. The safe-house management was planning to issue a special card for each safe-house resident to assist GBV victims with receiving prompt medical examination.
- **Working with communities.** The safe-house keeps its location confidential and does not engage in any joint activities with local community members.
- **Coordination with other agencies.** The facility benefits from coordinated assistance on the side of the state agencies that signed the shelter protocol. However not all participating agencies fulfill the commitments stipulated by the protocol. The coordination still heavily depends on personal connections and communication. Within this type of coordination, movement of human resources within partner agencies frequently results in the loss of personal connections and weakening of support.

7.4 Afghan Women's Skill Development Center

Involvement in GBV response

- **Structure, functions and services provided to GBV victims.** Afghan women skill development center is a non-profit, non-governmental organization, established in 1999 by a group of Afghan women. The organization conducts activities in the following areas: literacy and income generation, vocational training, promotion of women's rights, legal assistance to women and children, victims of human trafficking and peace building. The Center established committees for legal defense of women in 14 districts of Kabul. The organization currently runs two shelters, of which one is transitional and the other one permanent. The capacity of the permanent shelter is 15 – 20 people, however at times the shelter hosted more than 20 residents. The transit shelter can accommodate up to 15 residents. Apart from protection, accommodation and meals permanent shelter offers the residents vocational training, literacy and computer classes. The facility has its own library.
- **Access to services.** The location of the shelter is confidential.
- **Processing GBV case.** Afghan Women's Skill Development Center conducts case registration for all shelter residents. The facility provides women with a defense lawyer. The information is not stored in computerized form. The Center does not have GBV IMS tools to store and analyze information on GBV cases.
- **Referrals.** The shelter receives cases from MOWA, police department, AIHRC and its own legal defense committees. The shelter refers GBV victims to defense lawyers for free legal assistance.
- **Working with communities.** The Center maintains close ties with local communities across the city through its legal defense centers operating in 14 districts of Kabul.
- **SOPs, guidelines and protocols.** The organization does not have specific procedures, guidelines or protocols regulating the treatment of GBV victims.

- **Coordination with other agencies.** The Center signed protocols of cooperation with MOWA and the Ministry of Justice on all activities concerning the shelter. The Center also participates in the Coordination and Cooperation Commission and EVAW Commission.

NGOs: needs and challenges in providing services to GBV victims.

- ***Need to reach out to the residents of illegal settlements.*** *The rapid growth of Kabul's population resulted in the increase of illegal settlements. The residents of these settlements are subject to a range of hazards, including various forms of interpersonal violence. The presence of law enforcement in illegal settlements is minimal. Without access to basic healthcare and educational facilities women and children subjected to violence in these communities do not have opportunities to seek protection and assistance from state and non-state agencies. The actors working in the field of GBV response in Kabul should bring relevant services to the residents of these impoverished and disenfranchised communities.*
- ***Need to expand the number of facilities that provide similar services to the population in the rural areas.*** *The city with population that tripled in size since 2001 and according to some estimates totals 4.5 million people requires much higher number of shelter facilities than what is currently available. The situation also calls for a variety of facilities offering services that would range between full-time residence and short term assistance (for example, crisis centers or family counseling groups).*
- ***Need for more elaborate guidelines regulating the treatment of GBV victims and coordination with other agencies.*** *Assessment found that some NGOs examined in the capital do not have ethical guidelines, safety guidelines and written procedures that stipulate the rules for interviewing and treating GBV victims. There are no rules and*

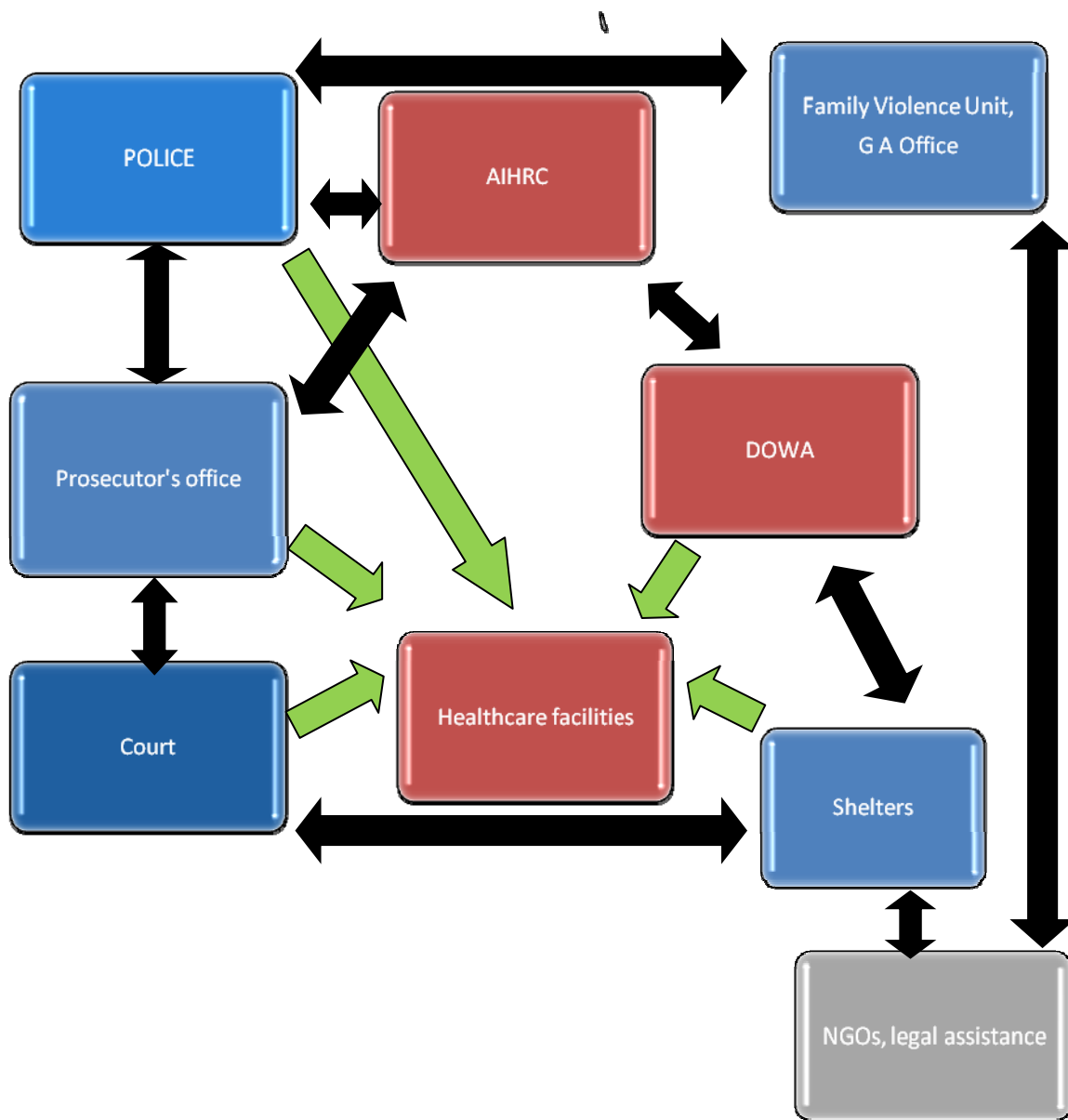
regulations regarding the procedures for “reconciliation” and release of the shelter residents, as well as the guarantees of their safety.

- **Need to determine and establish standard requirements for running safe-house or shelter for GBV victims.** Assessment found that safe-house and shelter facilities in the capital and , based on information provided by some respondents, in the rest of the country are not legally bound to meet standard set of requirements. This results in loose standards of operations and poor service provision. Some facilities called “shelters” engage in highly questionable activities exploiting vulnerability of GBV victims and contributing to already negative public perception of shelter services. There is a clear need for state regulations regarding the standard requirements for starting and running shelter type facilities.
- **Challenge of re-integrating shelter residents into families and communities.** The stigma carried by many victims who dared to disclose their experience of abuse is intensified when they leave their homes to reside in the shelter. Thus shelter residents often have to deal with the double burden of accusations and threats caused by the fact that they spoke publicly about GBV and stayed outside of their family home. Re-integrating women into their families and communities is a difficult task that requires joint efforts of government agencies, shelter workers and authority figures within the respective communities. There is a need for special programs addressing the issue of re-integration and protection of released shelter residents.
- **Need to build the capacities that increase the empowerment and protection of women.** Giving the shelter residents a set of skills that will allow them to achieve some level of economic independence and increase their ability to protect themselves and their children is crucial for their well-being outside of the shelter walls. It is important to support the shelter in equipping the women with the skills that will be relevant for their individual circumstances.
- **Need to establish the standards for information sharing between the state agencies involved in investigation and trial of GBV cases and the defense lawyers.**

It is also necessary to specify the format and procedures that regulate the information exchange without jeopardizing the safety of the victims.

- ***Need for better coordination among NGOs providing services to GBV victims.***
Currently a number of NGOs provides legal assistance and shelter services to GBV victims in Kabul. Each organization maintains its own pool of data on GBV cases. Information exchange between the NGOs is limited. In order to avoid the duplication of efforts, share experience and benefit from expertise and information accumulated by NGOs working in the same area organizations should establish common mechanism for information sharing and coordination (for example, bi-weekly meetings, Internet forum or mailing list).

KABUL, GBV RESPONSE: MAIN SERVICE PROVIDERS.



Entry points for GBV victims.



Two-directional movement of cases



Single-directional movement of cases and information

CONCLUSIONS AND RECOMMENDATIONS

The data accumulated and analyzed in the course of this assessment provided important insights into the interactions between state agencies and individuals subjected to non-state generated interpersonal violence in Afghanistan. In all locations examined by the Assessment, the majority of GBV victims mentioned in the interviews were women and girls.

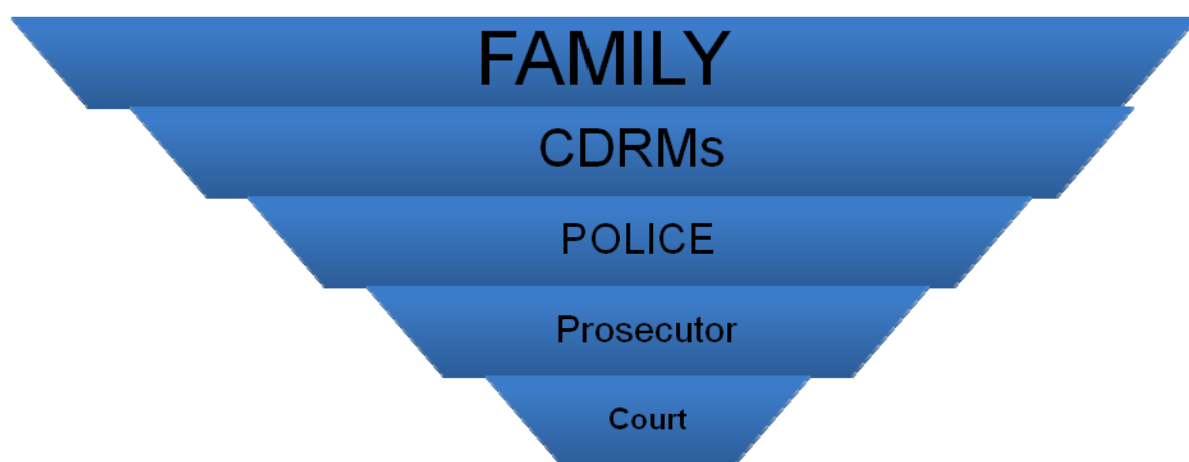
The plight of Afghanistan's female population is described in a considerable number of studies, reports, articles and documentaries. The narrative frequently used by the authors powerfully connects the image of the generalized "Afghan woman" with numerous situations of violence, depicting her as an object of psychological intimidation, sexual and physical abuse or societal pressure. In this narrative, submission to external force becomes the defining characteristic of Afghan women. One of the main findings generated by the current study comes in direct contradiction with this captivating image.

The Assessment demonstrated that despite numerous pressures and barriers, some Afghan women subjected to violence find the strength and courage to disclose GBV and seek and, at times, demand assistance, justice and protection from violence. In a socio-cultural environment that puts serious restrictions on women's mobility in public space, some women still manage to access and use services provided by state and non-state actors.

The barriers encountered by those who seek assistance from state and non-state agencies engaged in GBV response fall under several categories: economic, social, cultural and organizational. The Assessment found that for many women in rural areas the mere attempt at reaching a local healthcare facility, police department, NGO or the office of MOWA requires considerable investment of time and resources. In all areas examined by the assessment, cultural norms put severe restrictions on women's and girls' accessing and using services for GBV victims. The majority of female residents in rural and urban areas do not have resources, freedom to travel and the time necessary for visiting several agencies and navigating the bureaucratic system in order to find solutions for their problems.

Overall, the cultural norms in most areas prevent women from disclosing violence outside the family circle. However, the research conducted in several provinces suggests that women subjected to violence have some opportunities to negotiate their interests and seek

protection and justice using the structures of power and sources of authority in family and community⁶⁶. Some women resort to male relatives and elders within extended family circle. Quite often the next step involves bringing the issue of violence to the attention of community based dispute resolution mechanisms (CDRMs) that often suggest solutions at the expense of the interests of women and girls. According to the estimates received from various sources in the course of the assessment mission, CDRM's resolve 80% of all GBV cases leaving 20% for the formal state justice system. That estimate may overlook the fact that a large share of situations involving family violence is resolved inside the family circle. The data accumulated by the Assessment generates the following basic distribution of GBV cases across the structures that provide (or claim to provide) some kind of resolution.



Local health facilities are the most convenient entry point for the victims of violence who are seeking help. However families' control over women's health stops many women in rural areas from accessing Basic or Comprehensive Health Centers. The attitude of healthcare staff presents another important barrier for GBV victims looking for assistance. The Assessment found that healthcare staff in small (primary healthcare service) and some medium healthcare facilities in the rural areas is scared to identify GBV or assist GBV victims. Both in rural and urban areas families and communities often reject the outside interference in the GBV related situations. The proximity (both physical and social) to the

⁶⁶ Deborah J. Smith and Shelly Manallan, , Community Based Dispute Resolution Process in Bamyan Province, Afghanistan Research and Evaluation Unit, Case Study Series, 2009; Rebecca Gang, Community Based Dispute Resolution Process in Kabul City, Afghanistan Research and Evaluation Unit, Case Study Series, 2011; Deborah J. Smith, Community Based Dispute Resolution Process in Nangarhar Province, Afghanistan Research and Evaluation Unit, Case Study Series, 2009.

community makes the HF staff particularly vulnerable to the threats and pressure coming from victims' family members or community leaders. This factor carries even more weight for the staff in remote locations, separated from the nearest law enforcement and other government offices by miles of bad roads.

In Afghanistan the risks for the security of healthcare providers engaged in GBV response present an important challenge for building efficient GBV response system. The mechanisms reducing these risks and strengthening the safety of the healthcare providers should be built into the system of GBV response. The data collected by the Assessment suggested that coordinated multi-sectoral system of GBV response has a potential of addressing the security problem and increasing the protection of all parties engaged in assisting GBV victims.

Delivery of services to the victims of gender based violence is marred by miscommunication, poor coordination, low capacity of service providers, flaws in organization and attitudinal challenges. The interviews with state actors from a variety of public sectors revealed that they very rarely imagine the involvement of their respective agencies in GBV response as a part of a coordinated effort expanding across several public sectors. State agencies working in the field of GBV response do not have policies that reflect multi-sectoral approach to providing assistance, treatment, protection and justice to people suffering from gender based abuse.

On the level of organizational structure most service providers do not have units responsible for addressing special needs of GBV victims. The agencies do not develop inter-departmental programs or projects custom-made to strengthen the involvement in GBV response.

The capacity of agencies to address situations involving GBV and help GBV victims is thoroughly limited by the shortage of trained female professionals. Healthcare facilities lack female midwives and doctors, which stops many female patients from using healthcare services. Interviews conducted by the Assessment team with police officers and Prosecutor's office reveal that the dearth of female professionals has a negative effect on the quality of investigation and often make it difficult to access private houses and talk to female victims and witnesses.

On the level of access to services, the majority of actors working in the area of GBV response does not promote the services among target population groups. The interviews with state and non-state actors in all locations examined by the Assessment demonstrated that service providers place the responsibility for starting the interaction solely on the beneficiaries. In the remote areas of the country, where women's ability to travel and use financial resources for personal needs is very limited, this means that women subjected to violence in the family or community have small chances to access healthcare or a law enforcement agencies.

None of the state agencies examined by the Assessment made special arrangements to provide GBV victims with easy and safe access to service providers. The offices of state agencies (healthcare facilities, police, Prosecutor's Offices, courts) do not have procedures facilitating a "fast track" for the visitors suffering from gender based violence.

The processing of GBV cases in all agencies examined by the Assessment suffered from the lack of regulation and exhibited numerous gaps and inconsistencies. In all locations, healthcare facilities, MOWA offices and AIHRC offices served as entry points for the violence victims. Police departments also functioned as entry points in every location except for Bamyan city.

The assessment found that healthcare facilities in rural and urban areas are often the only chance for GBV victims to seek assistance and protection outside of family circle. However, the ability of primary level healthcare facilities to serve as an entry point for GBV victims is seriously undermined by the lack of necessary skills and knowledge among healthcare providers and the healthcare staff's vulnerability to pressures from local communities. The staff members in secondary and tertiary level HFs were much less affected by societal pressure. The healthcare staff in Kabul seemed to be most open to identifying GBV and helping the victims. However all across urban and rural facilities the lack of necessary skills and knowledge among healthcare staff presented a serious obstacle for delivery of services to patients suffering from GBV.

On the level of intra-agency procedures, the Assessment found that the majority of agencies working in the field of GBV response in piloted areas did not have SOPs, on:

- screening of GBV cases

- registration of GBV cases
- progress monitoring of cases
- referral of GBV cases
- follow-up on the cases
- internal reporting of GBV cases
- Information Management Systems for storing and analyzing information on GBV

On the level of intra-agency procedures the Assessment also found that majority of agencies working in the field of GBV response in piloted areas did not have guidelines on:

- ethical treatment of GBV victims
- protection of GBV victims' safety

The introduction of clear, detailed and consistent procedures in the operations of key agencies providing services for GBV victims will increase the efficiency and accessibility of services. It will also assist in decreasing the level of corruption in the process of service provision through establishing transparency and accountability.

One of the important findings produced by the Assessment relates to the common use of **“reconciliation approach” in treatment of GBV cases by the majority of state agencies**. The approach is routinely used by the police officers, MOWA officials, the staff of Prosecutor's Offices and courts. The assessment revealed that the parties involved in GBV related incident(s) are offered the opportunity to reconcile and not proceed with official investigation. Thus the number of criminal cases involving GBV that enters the system through the police department is normally larger than the number that makes it to the Prosecutor's office, and the latter is larger than the number of cases eventually submitted by the prosecutors to the courts. The respondents explain these attempts to reconcile the parties by the desire to protect the parties involved in the case from engaging in lengthy and costly court proceedings and prevent the dissolution of families. This practice routinely generates the situation where state institutions responsible for the protection of victims or

impartial investigation of crimes assume a mediatory and reconciliatory function. This function in Afghanistan was traditionally performed by the community-based dispute resolution mechanisms. Reconciliation of victim and perpetrator, regardless of its outcomes or the good intentions of the mediating body, generates and secures the impunity of violence perpetrators.

The Assessment revealed that the majority of agencies using the “reconciliation approach” do not routinely monitor “reconciled” cases. Thus, the mediating body does not carry any responsibility for monitoring the adherence of the parties to the promises made in the course of reconciliation. This arrangement differs considerably from the practices of CDRMs. Members of *shura* or *jirga*, normally residents of the same community, have numerous ways of monitoring the situation and ensuring the compliance of the parties to the commitments that they made.

Some prosecutors and judges, interviewed in the course of data collection, voiced **concerns and questions regarding specific provisions of the EVAW Law**. The respondents mentioned the Articles 43 and 44 as “contradicting the Constitution and the Sharia”. They also suggested that in the case of family violence the punitive measures stipulated by EVAW Law may cause the victims to resort to a milder punishment assigned by the community dispute resolution mechanisms. These concerns should be voiced out in open discussion. There is a need for educational and training materials presenting clear and relevant information about the Law and its relevance for the investigation of GBV. Joint training on the implementation of the EVAW Law for the police, Prosecutor’s office and judges would be a good step in capacity building and coordination.

With regard to referral of GBV cases the Assessment findings demonstrate that state and non-state agencies use various procedures for referral of GBV victims. However, the referral networks in Bamyan, Nangarhar and Kabul suffer from a number of problems. The referral of GBV cases in Bamyan was affected by a complex centralized structure of GBV response specific to Bamyan. All elements of this structure were strongly tied to the Governor’s office that served as a hub for defining and channeling GBV related complaints. The structure limited the number of entry points available for GBV victims and generated a circuitous and

lengthy route for GBV victims seeking protection, assistance and justice: The referral network in Nangarhar was not centralized but suffered a range of problems linked to weak communication and dis-coordination.

The Assessment found that healthcare facilities in all areas examined present an impasse in the referral and reporting network that connects agencies working in the field of GBV response. Neither the reporting of GBV in healthcare facilities is required by any rules or regulations nor is the assistance to the GBV victims in the form of information sharing or referrals. As a result, the staff of the HF is not reporting or recording any gender based violence. GBV victims attending the HF are not given any options for referral or offered any information on where to seek help. The isolation of the healthcare facilities from the rest of the agencies providing services to GBV victims is more pronounced in the provinces (Bamyan and Nangarhar) than the capital.

The Assessment revealed that **engaging communities** in cooperation or even productive dialogue presents one of the primary challenges for state and non-state agencies involved in GBV response. Part of the problem lies in issues pertaining to the distribution of power between the agencies and informal sources of authority. The tension between the central government and local power structures is common for many aspects of state building in Afghanistan. The local power structures that maintained order and social cohesion all through the times of war are often adamant in protecting this order from what they see as external interference. However, the tension between the state agencies and informal local authorities in addressing GBV is sometimes also generated by fundamentally different approaches to GBV.

The Assessment focused on examining the attitude of health *shuras* towards the issue of GBV and the interaction between the healthcare facilities and health *shuras* with regard to healthcare assistance to GBV victims. The discussions held with health *shuras* elucidated both the strengths and weaknesses of this mechanism for the cause of building an efficient coordinated response to GBV. In all locations examined by the Assessment among all respondents health *shura* members were most reluctant to discuss the subject of violence

against women. They insisted that these problems did not exist in their community, or were rare and successfully resolved by the traditional dispute resolution mechanisms. *Shura* members considered violence against women the matter best solved through mediation. The interviews with police officers, prosecutors and judges demonstrated that this approach to violence is characteristic for most of community based structures.

Community-based resolution mechanisms are geared toward maintaining the peace and social cohesion within communities. However, these important factors are often directly linked to the preservation of the existing power balance in the community, which is often done at the expense of disempowered groups. Thus, on many occasions the resolutions provided by CDRMs do not give priority to the security and well-being of GBV victims and do not serve the goal of maintaining the rule of law in relation to GBV. Obviously the system of power distribution in the communities across the country is not standard or unchanging. However, the difference in approaches to GBV resolution is an important factor that affects the relations between the power holders within communities and the state and non-state agencies working in the field of GBV response. These differences should be bridged through engaging diverse community based structures (CDRMs, women's *shuras*, teacher's *shuras*, health *shuras*) in advocacy and educational campaigns addressing the roots and consequences of GBV for individuals, families and communities.

On the level of coordination, the Assessment found that respondents in all locations identify weak coordination between agencies delivering services to GBV victims as one of the principal obstacles in their daily operations. Police officers, the staff of Prosecutor's office and courts repeatedly expressed frustration over delayed, incomplete and inaccurate communication on GBV cases. The dissatisfaction with outcomes of medical examination provided by healthcare facilities was among the most common problems identified by the Assessment.

The coordination of agencies working in GBV response operates through a range of mechanisms. The creation of inter-agency structures represented one the most common approaches to the issue of coordination in the area of GBV response. Cooperation and Coordination Commission, GBV Task Force, ERAW Commission present examples of inter-agency mechanism widely employed in three provinces examined by the Assessment.

Despite the differences in the mandate and structure these mechanisms are based on a certain common set of ideas and practices. Some of these mechanisms are persistent in addressing individual cases of GBV, and sometimes successfully resolve difficult cases protecting safety and bringing justice to GBV victims. However, in some of the meetings as related by respondents, the names of victims, perpetrators, and witnesses are publicly announced, which jeopardizes the safety of victims and witnesses and can add to cultural stigmatization of GBV victims. The sheer volume of complaints about the lack of coordination recorded in the course of the Assessment signals certain problems in the way the mechanisms address the issue of coordination.

The majority of respondents dissatisfied with the work of inter-agency structures emphasized weak or low-profile representation of certain state agencies in coordinating bodies. The analysis of the Assessment data suggests that the problem with this type of structures lies much deeper. The coordination of efforts in inter-agency structures is not supplemented by changes in internal policies and procedures of participating agencies. Coordination and information exchange are not incorporated in the routine operations of participating agencies. Subsequently the issue of coordination depends solely on the commitment of key decision makers in specific agencies. The transfer of responsibilities among officials responsible for participation in the inter-agency commission or change in priorities of individuals in decision making positions can immediately affect the agency's involvement in coordinating body. Thus, the main problem lies in the approach to the coordination rather than the commitment of the participating agencies.

The Assessment found that there is a persistent need for a new approach to coordination. The findings demonstrate that the top down coordination effort, albeit successful in addressing GBV cases on an ad hoc basis, is not efficient in bringing change to the routine operations of the agencies. The steps securing coordination and communication should be introduced on an institutional level and should affect the rules and regulations governing the daily practices of the relevant agencies.

RECOMMENDATIONS

Building the comprehensive, responsive and professional system of services for GBV victims in Afghanistan should involve interventions in the following **general areas**:

- introduction of service hubs;
- strengthening the involvement of the healthcare sector in general referral and information sharing network;
- transformation of the existing system of multi-agency coordination in GBV response;
- introduction of policies, SOPs and tools for detection/screening, processing and referral of GBV cases in all key sectors (healthcare, police, judiciary, MOWA, NGOs);
- building the capacity of service providers in all key sectors;
- advocacy and educational efforts for raising awareness of the negative impact of GBV on the lives of individuals, families and communities. The efforts should target diverse community based structures (CDRMs, women's *shuras*, health *shuras*, teachers' *shuras*).

Recommendations for immediate implementation (next 4-6 months)

Recommendations for immediate implementation involve the following steps:

1. Based on the Assessment findings develop **a concept paper** outlining a strategic vision for addressing the problems in service provision revealed by the Assessment in three pilot areas. The paper should offer solutions for major gaps, challenges and needs in coordinated GBV response.
2. Develop general **concept model** of coordinated multi-agency response to GBV. The model should cover all key sectors providing services to GBV victims, respond to existing challenges and present mechanisms for securing efficient service provision. The Model should feature main actors, entry points, service hubs, referral paths and information sharing channels.

3. Based on **general concept model** develop **regional models** of coordinated GBV response that will reflect specific challenges and opportunities in each of the pilot areas.
4. Conduct meetings with key stake-holders to receive feedback on a general concept model of coordinated response to GBV in three pilot areas.

Recommendations for long-term implementation (next 12 -36 months)

The measures geared towards strengthening GBV response should unfold in several directions.

1. *Based on the feedback from the key stake-holders prepare Action Plans for introducing Coordinated Response to GBV in three pilot areas in Bamyan, Nangarhar and Kabul.*
2. *Develop best practice SOPs, guidelines and protocols for the agencies that are part of coordinated response.*
 - 2.1. Develop and introduce to personnel of all key sectors the ethical guidelines of treatment of GBV victims.
 - 2.2.. Develop and introduce to personnel of all key sectors the guidelines securing protection of safety of GBV victims.
 - 2.3. Develop and introduce to personnel of all key sectors the necessary tools (protocols, check lists, referral maps, forms and data collection tools) facilitating and regulating the GBV case management on the level of routine procedures.
 - 2.4. Develop and introduce to personnel of all key sectors the necessary tools (protocols, check lists, referral maps, forms) facilitating and regulating on the level of routine procedures coordination and information sharing in the area of GBV response.
 - 2.5. Develop and introduce to personnel of all key sectors the tools for monitoring and evaluation of services provided to GBV victims and coordination between key actors.
 - 2.6. Introduce all the necessary tools and procedures in a single reader friendly CR (Coordinated Response) Implementation Package for each key sector.
3. *Enhance the capacity of service providers to deliver coordinated response to GBV.*

- 3.1. Develop Training Manuals for the CR Implementation Packages and organize training courses for the staff of the key agencies in three pilot areas (healthcare facilities, MOWA, police department, Prosecutor's Office, primary courts, NGOs, shelters and AIHRC) The training modules should be based on the findings of the assessment and provide the participants with basic knowledge of CR and practical skills necessary for the implementation of relevant SOPs, guidelines and tools included in the CR Implementation Package. Each training course should include a module addressing the general concepts and principles of CR and providing the participants with the birds-eye view of the whole system of coordinated response.
- 3.2. Conduct joint training on the implementation of EVAW Law for police officers, Prosecutor's Office staff and court judges.
- 3.3. Develop Training Manual on CR to GBV for the community based groups. The Training Manual should be based on the findings of the assessment and provide the participants with culturally sensitive information on the impact of GBV and general overview of coordinated multi-agency response to GBV. The training should specifically focus on the role of community based structures in preventing GBV and supporting public services provided to GBV victims by state and non-state agencies.
- 3.4. Develop a Training Module and conduct training on the development and maintaining of Information Management System (IMS) for registering, storing, analyzing and sharing information on GBV cases for the personnel of all key agencies in all pilot areas.
4. *Introduce advocacy for institutional and attitudinal change.*
 - 4.1. Organize series of workshops and seminars to present the findings of provincial assessments and facilitate open and inclusive discussion with all stake-holders involved in the development of GBV response on a district level in all pilot areas.
 - 4.2. Relying on the feedback received from the discussions, prepare and distribute a set of awareness raising and educational materials highlighting assessment findings and advocating for institutional and attitudinal changes necessary for building strong coordinated community response to GBV.

- 4.3. Alongside the general advocacy and educational materials, develop and distribute a separate set of advocacy and educational materials custom-made for each sector involved in GBV response (healthcare, community based structures, police, Prosecutor's Office, courts, NGO, DOWA, AIHRC).
5. *Operationalization of coordinated response to GBV in all three pilot areas*
 - 5.1. Operationalize the Concept Models of coordinated response GBV in all pilot areas. The choice of pilot areas should reflect the sensitivity of Concept Models to the diversity of socio-economic and cultural contexts, as well as the difference in security situations between various parts of Afghanistan.
 - 5.2. Support the operationalization of a GBV Information Management System and data collection mechanisms in all key agencies delivering services to the victims of gender based abuse.
6. *Introduce Monitoring and Evaluation into the CR to GBV*
 - 6.1 Conduct regular progress Assessments using the data generated through the monitoring and evaluation mechanism incorporated into the CR Implementation Package.
7. *Continue research in the area of service provision for GBV victims through the series of research papers.*
 - 7.1 Conduct a qualitative survey among a selected group of GBV victims on the practices of service provision (Service provision in the area of GBV response: victims' perspective).
 - 7.2 Conduct in-depth research of the Impact of the "reconciliation approach" on the safety and well-being of GBV victims.
 - 7.3 Conduct qualitative research on the role of zina accusation and virginity tests in processing, investigation and trial of GBV cases.

On the national level.

1. *Continue and expand the examination of services provided to GBV victims in various parts of the country (including the areas populated by the Kuchi minority).*
 - 1.1. Conduct assessments collecting and analyzing data on service provision to GBV victims across the country.
 - 1.2. Based on the findings of the assessments in various parts of Afghanistan, develop a National Report on the Service Provision to the Victims of Gender Based Violence: gaps, needs and challenges.
 - 1.3. Conduct a qualitative survey among selected group of GBV victims on the practices of service provision.
2. *Develop a strategic vision for addressing the problems in service provision revealed by the assessments across the country.*
 - 2.1 Based on the consolidated conclusions and recommendations outlined in the National Report on Service Provision to the Victims of Gender Based Violence, develop a National Policy and Action Plan on Coordinated Response to GBV. The Policy and Action Plan should identify the main goals and objectives, identify timeframe, indicators and implementing agencies for the building of CR and outline general directions for future work.
 - 2.2 Together with key stake-holders, relying on the findings of the assessment across the country and in line with National Policy, develop several Concept Models of CR for various settings (urban/rural, high/low security risk).
3. *Institutional change*
 - 3.1. Within the existing GBV inter-agency coordinating structure (for example ERAW Commission or CCC) establish CR Working group that would include a highly positioned representation from agencies involved in implementation of CR according to the National

Policy and Action Plan. The CR Working Group will supervise and support the activities related to the implementation of the National Policy and Action Plan.

4. Capacity building

4.1. Train the staff of key agencies involved in delivering services to violence victims. The training should be based on the findings of the assessment and provide participants with basic knowledge of CR and practical skills necessary for the implementation of relevant SOPs, guidelines and tools included in the CR Implementation Package.

4.3. Conduct training on the development and maintaining of IMS for registering, storing, analyzing and sharing information on GBV cases for the personnel of all key agencies. .

5. Advocacy for institutional and attitudinal change.

5.1. Organize workshops and seminars to present the findings of provincial assessments and National Report and facilitate open and inclusive discussion with all stake-holders involved in the development of GBV response.

5.2. Relying on the feedback received from the discussions, prepare and distribute a set of awareness raising and educational materials highlighting the National Report findings, and advocating for institutional and attitudinal changes necessary for building a strong coordinated response to GBV.

5.3. Alongside the general advocacy and educational materials, develop and distribute a separate set of advocacy and educational materials custom-made for each sector involved in GBV response (healthcare, community based structures, police, Prosecutor's Office, courts, NGO, DOWA, AIHRC).

5.4. Develop training tools and conduct Training on GBV sensitization and CR for the key staff of all agencies working in the area of GBV response.

6. Operationalization of Coordinated Response to GBV

6.1. Operationalize the Concept Models of CR and CR Implementation Package in new set of pilot areas across the country. The choice of pilot areas should reflect the sensitivity of Concept Models to the diversity of socio-economic and cultural context as well as the difference in security situation between various parts of Afghanistan.

6.2. Support the operationalization of a GBV Information Management System and data collection mechanisms in all key agencies delivering services to the victims of gender based abuse.

7. Monitoring and Evaluation

Conduct regular progress Assessments using the data generated through the monitoring and evaluation mechanism incorporated into the CR Implementation Package.

LIST OF ABBREVIATIONS

BHC – Basic Health Center

CHC – Comprehensive Health Center

CID – Criminal Investigation Department

DATC- Drug Addicted Treatment Center

DH- District Hospital

DOWA – Department of Women’s Affairs

FRU – Family Response Unit

FVU – Family Violence Unit

HIMS – Healthcare Information Management System

HP – Health Post

MOWA – Ministry of Women’s Affairs

PH- Provincial Hospital

PPHD – Provincial Public Health Directorate

RH- Regional Hospital

SH- Specialize Hospital

SHC- Sub Health Center

