MULTI-COUNTRY REAL TIME EVALUATION OF UNICEF GENDER-BASED VIOLENCE IN EMERGENCIES PROGRAMMES

PAKISTAN COUNTRY REPORT

CHILD PROTECTION SECTION
PROGRAMME DIVISION
July 2016
MULTI-COUNTRY REAL TIME EVALUATION OF UNICEF GENDER-BASED VIOLENCE IN EMERGENCIES PROGRAMME

PAKISTAN COUNTRY REPORT
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This report for Pakistan is one of seven country evaluations which form part of the Multi-Country Real Time Evaluation of UNICEF Gender-based Violence in Emergencies Programmes global evaluation. The Pakistan country report was prepared by Vine Management Consulting Ltd, an independent company recruited by the Child Protection Section of Programme Division to conduct this evaluation. A five-person internal UNICEF Evaluation Management Group was responsible for the management of this evaluation including inputs to quality assurance.

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The Evaluation Management Group whose responsibilities have included supervising and guiding the evaluation team in each step of the process; reviewing, commenting and approving the evaluation deliverables; approving the final report and supporting dissemination and management response process is comprised of Mendy Marsh, GBViE Specialist, CPS, Krishna Belbase, Senior Evaluation Specialist, Evaluation Office, Jennifer Keane, CP Specialist on Knowledge, Planning and Evidence, and Laili Irani, Senior Adviser, Gender & Evaluation, Gender Section and Sophie Read-Hamilton, GBViE Consultant with the CPS.
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<tr>
<td>ARC</td>
<td>American Refugee Committee</td>
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<tr>
<td>AoR</td>
<td>Area of Responsibility (global sub-cluster of the Global Protection Cluster)</td>
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<tr>
<td>C4D</td>
<td>Communication for Development</td>
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<tr>
<td>CAT</td>
<td>Convention against Torture and other cruel, inhumane and degrading treatment and punishment</td>
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<td>CCCs</td>
<td>UNICEF Core Commitments for Children in Humanitarian Action</td>
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<td>CFS</td>
<td>Child Friendly Space</td>
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<td>CGPA</td>
<td>Centre for Governance and Public Accountability</td>
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<td>CP</td>
<td>Child Protection</td>
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<td>CPC</td>
<td>Child Protection Committee</td>
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<td>CPCA</td>
<td>Contingency Programme Cooperation Agreement</td>
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<td>CPiE</td>
<td>Child Protection in Emergencies</td>
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<td>CPD</td>
<td>Country Programme Document</td>
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<td>CPS</td>
<td>Child Protection Section, Programme Division, UNICEF New York</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>DV</td>
<td>Domestic Violence</td>
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<td>EIE</td>
<td>Education in Emergencies</td>
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<td>EMG</td>
<td>Evaluation Management Group</td>
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<td>ERG</td>
<td>Evaluation Reference Group</td>
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<td>FATA</td>
<td>Federally Administered Tribal Areas</td>
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<td>FDMA</td>
<td>FATA Disaster Management Agency</td>
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<td>GBV</td>
<td>Gender-based Violence</td>
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<td>GBViE</td>
<td>Gender-based Violence in Emergencies</td>
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<td>GCC</td>
<td>Gender and Child Cells</td>
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<td>GoP</td>
<td>Government of Pakistan</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<td>HNO</td>
<td>Humanitarian Needs Overview</td>
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<td>HSP</td>
<td>Humanitarian Strategic Plan</td>
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<td>Inter-Agency Standing Committee</td>
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<td>ICCPR</td>
<td>International Convention on Civil and Political Rights</td>
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<td>International Convention on Economic, Social, and Cultural Rights</td>
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<tr>
<td>ICT</td>
<td>Islamabad Capital Territory</td>
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<tr>
<td>IDP</td>
<td>Internal Displaced Person</td>
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<tr>
<td>IEC</td>
<td>Information, Education &amp; Communication</td>
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<tr>
<td>INEE</td>
<td>Inter-Agency Network for Education in Emergencies</td>
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<td>INGAD</td>
<td>Inter-Agency Gender and Development Group</td>
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<tr>
<td>INGO</td>
<td>International Non-Government Organization</td>
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<tr>
<td>IP</td>
<td>Implementing Partner</td>
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<tr>
<td>IPV</td>
<td>Intimate Partner Violence</td>
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<tr>
<td>KP</td>
<td>Kyber Pakhtunkhwa</td>
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<tr>
<td>L3</td>
<td>Level 3 Emergency</td>
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<tr>
<td>LNGO</td>
<td>Local Non-Government Organization</td>
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<tr>
<td>MHM</td>
<td>Menstrual hygiene management</td>
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<tr>
<td>MISP</td>
<td>Minimum initial services package</td>
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<tr>
<td>MoNHSR&amp;C</td>
<td>Ministry of national health services, regulations, and coordination</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MoSW</td>
<td>Ministry of Social Welfare</td>
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<td>MoU</td>
<td>Memorandum of Understanding</td>
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<td>NDMA</td>
<td>National Disaster Management Agency</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
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<tr>
<td>NOC</td>
<td>No Objection Certificate</td>
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<tr>
<td>NCSW</td>
<td>National Commission for the Status of Women</td>
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<td>PAK</td>
<td>Pakistan-administered Kashmir</td>
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<td>PCA</td>
<td>UNICEF Programme Cooperation Agreement</td>
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<tr>
<td>PCO</td>
<td>Pakistan Country Office</td>
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<tr>
<td>PDMA</td>
<td>Provincial Disaster Management Agency</td>
</tr>
<tr>
<td>PLaCES</td>
<td>Protection learning and community emergency services</td>
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<tr>
<td>PMER</td>
<td>Planning, monitoring, evaluation and research</td>
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<tr>
<td>PSEA</td>
<td>Protection from Sexual Exploitation and Abuse</td>
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<tr>
<td>PSS</td>
<td>Psycho-social Support</td>
</tr>
<tr>
<td>RC/HC</td>
<td>Resident Coordinator/Humanitarian Coordinator</td>
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<tr>
<td>REGA</td>
<td>Regional Emergency GBV Advisor</td>
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<td>RO</td>
<td>Regional Office</td>
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<td>ROSA</td>
<td>Regional Office for South Asia</td>
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<tr>
<td>RRT</td>
<td>Rapid Response Team</td>
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<tr>
<td>RTE</td>
<td>Real Time Evaluation</td>
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<tr>
<td>SC</td>
<td>Sub-Cluster</td>
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<tr>
<td>SEA</td>
<td>Sexual Exploitation and Abuse</td>
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<td>SGBV</td>
<td>Sexual and Gender-based Violence</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
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<tr>
<td>TLC</td>
<td>Temporary Operating Centre</td>
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<tr>
<td>ToC</td>
<td>Theory of Change</td>
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<tr>
<td>TPM</td>
<td>Third Party Monitoring</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNHCR</td>
<td>United Nations Refugee Agency</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>VAW</td>
<td>Violence against Women</td>
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<tr>
<td>WFHS</td>
<td>Women Friendly Health Spaces</td>
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<td>WFS</td>
<td>Women Friendly Spaces</td>
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EXECUTIVE SUMMARY

The Child Protection Section of UNICEF’s Programme Division, New York, is undertaking a multi-country real time evaluation of UNICEF’s Gender-based Violence in Emergencies (GBViE) programming with the overall purpose of strengthening UNICEF’s current and future GBViE programming based on real time learning. The core of the evaluation is seven real time evaluations (RTE) which are being conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic and a brief study of the GBViE programme the Democratic Republic of Congo conducted by telephone.

This report presents the findings, conclusions and recommendations of the mission conducted in Pakistan, between 24th January and 6th February 2016.

CONTEXT

Pakistan is classified by the World Bank as a lower middle income country, and ranks 147 out of 188 countries in the Human Development Index (HDI) and 121 in the gender inequality-adjusted HDI. Pakistan ranks 144 out of 145 in the World Economic Forum gender gap report (2015); second to last ahead of Yemen.\(^1\)

In 2011, sweeping political reform in Pakistan in the form of the 18th Amendment to the Constitution introduced political devolution, giving provincial governments a significant degree of autonomy. Pakistan is now divided into four provinces: Baluchistan, Kyber Pakhtunkhwa (KP), Punjab, and Sindh; the Islamabad Capital Territory; the Federally Administered Tribal Areas (FATA); and Pakistan-administered Kashmir (PAK). This has created challenges for UNICEF and other humanitarian and development actors in that it requires separate engagement with government at the federal, provincial and district levels. Further, gaps in technical capacity within sub-national government departments hinder effective service delivery. It is considered by some partners that women’s empowerment has been the greatest casualty of devolution because the lack of a federal ‘anchor’ on equality issues has weakened advocacy as the four provincial ‘highways’ are semi-autonomous.

GBV is rife in Pakistan, with women and girls suffering from many types of GBV that are prevalent the world over (e.g. sexual violence, domestic violence, child marriage, etc.), as well as additional context-specific forms of GBV. The generally low status of women and girls and the prevalence of GBV has been exacerbated in KP/FATA by the chronic complex emergency. National response services for GBV survivors are very limited. Sexual violence against boys is also a problem in Pakistan in general, and in the emergency response, and is being addressed by the Child Protection Section in the Pakistan Country Office (PCO).

CONCLUSIONS

1. The child protection (CP) focus in the Pakistan Country Office (PCO) is on protecting children against all forms of violence within the framework of the Sustainable Development Goals 5 and 16.\(^2\) The PCO approach is to address GBV, both for emergency and regular programming, within its broader support

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\(^1\) The gender inequality adjusted HDI ranks across three dimensions - health, empowerment, and the labour market: whereas the World Economic Forum global gender gap report ranks across four areas – the economy, politics, health, and education. Hence the difference in ranking.

\(^2\) Ie, Gender equality and empowerment of women and girls (5) and promoting just, peaceful and inclusive societies (16).
to the development and implementation of a legal framework for child protection, (including case management and a referral system) which is also aimed at supporting service providers to deliver tailored protective services, including in the emergency/humanitarian context. Apart from this, specialised GBViE programming (as described in the corporate Theory of Change) is not a current focus of the UNICEF response.³

2. A lack of clarity among many Pakistan Country Office (PCO) staff at all levels of UNICEF’s mandate, definition, and global responsibilities regarding GBViE, has been a significant constraint in the development of clear GBV objectives across UNICEF Pakistan’s humanitarian response. Addressing this lack of clarity will be important as the process of preparing the new Country Programme Document (CPD) begins in early 2017.

3. There are very significant cultural, legal and social challenges in tackling GBV for girls and women within Pakistan. Added to this, there are very significant challenges in implementing effective GBViE (and any humanitarian) programming in KP and FATA, including very significant security and access constraints for both international and national UNICEF staff and partners; very limited numbers of female professionals⁴ working in KP/FATA restricting service provision for girls and women;⁵ the generally poor quality of implementing partners in that part of the country; and the challenges associated with monitoring both programme quality and programme results. All these contribute to the lack of effectiveness of GBViE (and CP) programming through the Protective Learning and Community Emergency Services (PLaCES) model, which is the main modus operandi for UNICEF CP/GBV emergency response programming.⁶

4. With the exception of the systems building focus in the CP programme, integration of GBV and GBViE across other UNICEF sections is limited, as other UNICEF section response programmes (ie WASH, education, health and CP) have not set out to mitigate risks of GBV, and any contributions to GBV risk mitigation (eg delaying the age of marriage by encouraging children to stay longer in schools) are incidental rather being explicit programme objectives. This is largely due to a lack of understanding of UNICEF’s mandate for GBV as a lifesaving element of humanitarian response, lack of knowledge of the recommendations in the 2005 and 2015 IASC GBViE Guidelines, and a lack of specialist GBViE capacity within the CO.

5. UNICEF’s approach in leveraging its position as a trusted partner of the Government of Pakistan (GoP), to advocate with the Government to align its legal framework and child protection systems with international standards and good practice is positive.⁷ Addressing GBV risks inherently involves addressing some of the specific needs of different target beneficiary groups. Therefore, the evaluation team consider that addressing GBV as a higher priority across UNICEF’s humanitarian response would, therefore, contribute materially to progress on other UNICEF commitments, including the human

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³ The language of ‘gender’ and ‘GBV’ can often elicit pushback from authorities, whereas they are supportive of initiatives which are addressing ‘violence against children’ and which address Sustainable Development Goals 5 and 16 which include
⁴ Both medical professionals and those qualified to offer psycho-social support.
⁵ Given the cultural prohibitions on girls and women meeting men outside their families.
⁶ Following a recent assessment (conducting by the CP Chief since the evaluation mission), a decision has been taken to modify the model for the on-going protracted emergency in KP/FATA. This will focus on providing support to the GoP/FATA Disaster Management Agency (FDMA) to provide mobile protective services to children, families and communities on their own involvement in their personal safety as well as for mine risk education and birth registration. See further discussion on this in sections 3.2.2 and 4.2.
⁷ Including by leveraging the Gender Scheme of Preferences as part of international trade agreements with the European Union. (See below, section 3.3.2 for more details/discussion of advocacy on the Gender Scheme of Preferences.)
rights based approach, programming in line with the equity approach and also to the quality of other sector programmes and the overall effectiveness.

6. GBV sector coordination is poor, with no effective GBV sub-cluster (SC) in Peshawar and therefore no coordinated GBViE response as part of the humanitarian action. Despite UNICEF having co-led the cluster when it was first activated in 2010-2011, and still being a member of the SC; UNICEF staff in Peshawar and Islamabad are generally not aware that a GBV SC exists, or that they are a member of it. The situation is compounded nationally by the existence of a number of interagency groups with different and somewhat overlapping foci, and led by different agencies. This means there is no clear, coordinated, leadership for the GBV sector to address GBV and to advocate as a body with national authorities for a legal framework to be put into place which is aligned with international good practice on GBV. Given that UNICEF is co-lead at a global level for GBV, the agency has responsibilities, even in countries where it does not (co-)lead the national/sub-national coordination mechanisms for ensuring a strong, coordinated response.

7. The lack of GBV prioritisation in the regular programme means that there is limited capacity to build on for emergency response. GBV is not a stand-alone priority for the PCO within the regular CP programme. This means there is no focus on GBV-specific preparedness, and that the low levels of existing services for GBV survivors and those at risk are not being strengthened before emergencies compound the situation. The challenges of scaling up GBViE in Pakistan is compounded by the reticence of the GoP to request international assistance for emergency response, which restricts humanitarian space for international actors to provide services to augment national systems. The CP team are addressing the gap in provision of GBV among other CP services and systems through their systems approach, but this will take time to put in place, and for the implementation of the frameworks to become effective. While CP is working with the Disaster Management Agencies and other line departments to strengthen their disaster risk reduction capacities for child protection (including VAC and using a gender lens), the pervasiveness of GBV in Pakistan and its negative impact on communities and individuals’ abilities to recover from crisis, would indicate that the programming would be more effective if a higher priority was placed on establishing and strengthening GBViE prevention and response. The CP team has developed a number of good working partnerships with key counterparts in the government to deliver on the CP mandate. Building on these partnerships to strengthen GBV prevention and response as one priority of regular programming would provide a more substantive foundation for mounting a more comprehensive GBV response in the context of the cyclical emergencies to which Pakistan is subject.

8. There are entry points in existing CO programmes and operations which could be leveraged to address GBV as part of the regular programme and operations as well as setting the foundation to be able to expand GBViE risk mitigation speedily in future emergencies. These include:

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8 The evaluation team acknowledges the different perspective from which the CP team is approaching GBV. However, this conclusion is written reflecting the framework of the wider evaluation which, itself, is aligned with the corporate approach to GBV as a standalone priority, albeit housed within the CP programme.

9 Given that there are no headquarters resources for GBV except in emergencies (ie one GBViE Specialist in the Child Protection Section of the Programme Division in New York) this is not unusual. However, it has serious consequences for having a foundation of capacity, partnerships and programmes on which to build an emergency response speedily and effectively.

10 It is widely acknowledged that levels of GBV rise in all crises, in all countries.
Incorporating explicit GBV risk mitigation activities into current WASH programming to reduce open defecation and to provide separate latrines for boys and girls in schools;

Expanding the appropriate use of the innovative communication media already being used by the Pakistan Country Office as part of their Communication for Development (C4D) work to transmit appropriate and culturally sensitive messages about GBV prevention and information on services;

Revising the Emergency Preparedness and Response Plans such that they all include GBV risk mitigation actions using the practical recommendations in the 2015 IASC GBViE Guidelines;

Including an introduction to GBV into existing trainings conducted as part of signing Contingency Partner Cooperation Agreements (CPCA) with IPs;

Including an introduction to GBV routinely in training opportunities for emergency capacity strengthening such as the ongoing training being conducted by the Asian Disaster Preparedness Centre for the National Disaster Management Centre. Training modules could be developed with support from the GBViE Specialist in New York.

9. There is a dearth of evidence in general on GBV in Pakistan which could be used to inform UNICEF’s GBViE programming. In addition, monitoring of existing protection projects is weak because of the poor calibre of implementing partners in KP/FATA, and while third party monitoring (TPM) is practical in that it goes some way to addressing access issues for UNICEF staff in KP/FATA, the current TPMs have no training in protection and work with checklists which provide only basic information. In preparation for the forthcoming discussions on the new CPD, collating what evidence there is to inform these discussions for GBViE will mean that decisions are taken in the light of the best information possible. (And, as CP systems are implemented, increasing amounts of information will be available to augment what is currently available).

RECOMMENDATIONS

Recommendation 1 is foundational to all other recommendations and needs to be addressed as soon as possible.

Recommendation 1: Ensure that all UNICEF staff are fully conversant with, and have clarity on, UNICEF’s global corporate commitments to GBViE and existing good practice programme guidance for specialised and integrated GBViE programming within UNICEF.

a. PCO CP Section should engage with the CPS in New York to clarify and agree GBV priorities within the CP programme for Pakistan and agree what technical support is needed to design and implement the agreed activities, and how that can be accessed by the PCO.

b. Once agreement has been reached, and with Child Protection Section (CPS, HQ) support, arrange training for all staff on UNICEF global corporate commitments to GBVE to ensure all staff are fully aware of UNICEF’s agency-wide responsibilities as a key part of all emergency response.

c. Provide training for PCO senior management, Gender Advisor, and CP team on the minimum comprehensive GBViE response as articulated within the Resource Pack, and ensure that this is a strategic consideration when engaging with both the Protection Cluster and the GBV SC;

d. Roll out the 2015 IASC GBViE Guidelines with CPS (HQ) and Regional Office (RO) support for UNICEF and other international GBV actors in Pakistan. Ensure that all UNICEF teams are aware of the actions and resources to support integrating GBViE across their section’s emergency programme. (The training could be led either by the GBViE Specialist from CPS, HQ; or a trained consultant; or the

11 The PCO signs these CPCA pre-crisis, and they can be activated within 24 hours if a crisis happens to facilitate a very speedy response.
Gender Advisor if she has been fully trained on the 2015 IASC GBViE Guidelines). Ensure that all UNICEF section annual plans/monitoring frameworks include at least 1 GBViE specific indicator as part of their monitoring framework for the emergency response. Appoint GBV focal points in all Sections.

**Lead Responsibility:** CP Chief lead with support from Gender Focal Point, Representative and Deputy Representative and Chiefs of Sections  
**When:** As soon as possible (2016)

**Recommendation 2:** Recruit a GBViE specialist(s) at a sufficiently senior level (P3 minimum) to lead the PCO prioritisation of GBViE within the wider UNICEF emergency response (and GBV in regular programming) including both specialised and integrated programming.

a. Create the GBV sub-unit within the CP team but with very clear linkages with the Gender Advisor.

b. The GBViE budget should be clearly delineated and ring-fenced as a % of the Child Protection in Emergencies (CPiE) budget. As necessary, additional funds for GBV programming should be raised. (A number of humanitarian donors which prioritise either GBV or violence against women and girls (i.e. UKAid, USAID, ECHO) have indicated in global interviews that that they have funding to allocate for well-designed GBV programmes which can demonstrate results).

**Lead Responsibility:** CP Chief  
**When:** to be budgeted for in new CPD

**Recommendation 3:** UNICEF Pakistan should engage with the GBV Sub-Cluster leadership, to ensure that it functions as an effective coordination mechanism for GBViE response in KP/FATA. Notwithstanding the lack of a national GBV SC, UNICEF should take a lead and ensure a coordinated response to GBViE among GBV actors in Islamabad.

1. Engage proactively with UNFPA to revitalise the GBV SC in Peshawar (including considering re-engaging as co-chair of the GBV SC in Peshawar) with the aim of having an effective coordinating body which leads on developing a clear strategy for GBV as part of the humanitarian response.  
   **Lead Responsibility:** allocated CP officer/GBViE Specialists once recruited  
   **When:** 2016

2. Develop a clear GBV SC strategy which has the agreement of all key GBV actors. The strategy should clarify for members of the SC (and with their agreement) their respective areas of programme and geographic focus and complementarity to ensure that the assessed needs are addressed.  
   **Lead Responsibility:** allocated CP officer/GBViE Specialists once recruited  
   **When:** 2016

3. Engage with key national and international actors to create and support effective functioning of one national level coordination mechanism for GBV to fulfil the function of the several current mechanisms. UNICEF should maximise its comparative advantages (size, presence in-country before, during and after emergencies, existing relationship with the government etc.), and take a leadership role (either formally or informally) to ensure that the existing national level GBViE coordination mechanisms work together collaboratively, to develop standards and guidance for emergency response in the Pakistan context and strengthen the sector overall.  
   **Lead Responsibility:** allocated CP officer/GBViE Specialists once recruited  
   **When:** 2017

4. Lead/ensure development of strategy with the Disaster Management Agencies (DMAs) at all levels to ensure integration of GBViE as a priority of their emergency response. As a key deliverable of the
strengthened coordination mechanism, in line with the CCPD of UNICEF, UNFPA and UNDP and working closely with the DMAs, ensure the development of a GBViE-sector strategy, with associated action plan, outlining effective working plan for engagement with the NDMA, PDMAs, and FDMAs in provinces likely to suffer from cyclical emergencies. The strategy should outline how GBViE policies, funding, action plans, and staff training will be supported throughout all DMAs. This strategy/action plan will clarify roles and responsibilities of different actors, and include targets and activities with associated indicators and timeframes for GBViE integration in DMAs.

**Lead Responsibility:** GBViE Specialists supported by CP Chief and senior PCO staff.

**When:** 2017

5 Develop a GBV sector advocacy strategy. As a key deliverable of the strengthened coordination mechanism, and in line with the GBV SC (Recommendation 2b) and the CCPD of UNICEF, UNFPA and UNDP and key GBV national actors (e.g. MoSW, the National Commission on the Status of Women), UNICEF Pakistan should lead/support the development of a joint GBViE advocacy strategy with clear goals in terms of policies, service delivery and legal framework for the provinces cyclically affected by emergencies. The strategy and associated action plan will clarify roles and responsibilities of different actors (international and national), and include targets and activities with associated indicators and timeframes for realisation of the strategy objectives in partnership with MoSW and other counterparts.

**Lead Responsibility:** GBViE Specialists supported by allocated CP officer and CP Chief and senior PCO staff.

**When:** 2017

**Recommendation 4:** Assume a strategic national leadership role in collection, analysis and utilisation of GBViE evidence and data to inform development of a strategy, dedicated sector programming and effective advocacy to prevent and respond to GBV.

a. Collate existing evidence on GBV in Pakistan in both crisis and non-crisis settings. This could be done either in partnership with national and international actors, or by UNICEF using a consultant. This would include a review of any existing documentation on the nature and extent of GBV (as reported) in different parts of the country, and of social norms and attitudes which underpin the current levels of GBV, as well as conducting original research. A study of this nature will be politically sensitive but is a necessary pre-requisite to designing and implementing specific GBV interventions in both regular and emergency programmes which tackle issues and attitudes and will inform the GBV Theory of Change (see recommendation 8), the GBV strategy and the GBV element of the new Country Programme Document (CPD).

**Lead Responsibility:** Gender Advisor

**When:** 2016

b. Strengthen monitoring of GBViE interventions, to provide evidence of programme quality and programme results which can be used to inform policy and programmes. This will include training for implementing partners on quality monitoring techniques which are appropriate for collection, storage and sharing of GBV data. Field visits by UNICEF staff should conducted regularly (as regularly as Non-Objection Certificates can be obtained), and qualitative methods including collecting beneficiary feedback, regularly used to augment quantitative data collection. Action points from monitoring reports need to be followed up speedily. (Third Party Monitoring is not appropriate for GBV programming because of the sensitivity of data to be collected, and the requirements for TPM to

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12 While the team have been made aware since the evaluation mission that the study on violence against women commissioned by the National Commission on the Status of Women is not now going ahead, collating the evidence which is available on GBV in Pakistan is still important so that decisions on how to address GBV in the new CPD are based on the most up to date and comprehensive information base.
understand fully the elements and manner of implementation which ensure quality GBV programming).

**Lead Responsibility:** Chief Child Protection  
**When:** 2016/2017 ongoing

c. In collaboration with other members of the GBVIMS global Steering Committee, lead on strategising for the activation of GBVIMS in Pakistan within the next three years.  
**Lead Responsibility:** GBVIE Specialists, allocated CP officer  
**When:** By end 2018

**Recommendation 5: Revisit PLaCES as a flagship GBVIE intervention to ensure that the model is appropriate for KP/FATA, and will meet the objective of providing effective integrated GBVIE prevention and response for women and girls as a reality in the areas of humanitarian response.**

a. Review the design and implementation of current PLaCES projects in the areas of emergency response to ensure that GBVIE prevention and response can be delivered as part of the safe space model. If the security and access issues are insurmountable, revise the model so that GBVIE prevention and response can be delivered in KP/FATA; including key programme elements such psychosocial support (PSS) and other minimum and expanded actions recommended with the UNICEF Resource Pack.

b. Working closely with UN Women and UNFPA who currently provide case management and GBVIE services to some extent, work to ensure that service provision for survivors of GBV is available to women and girls in KP/FATA by international partners if not national partners. UNICEF staff and IPs should be capacitated to ensure that clear referral pathways to these services are known and survivors referred with appropriate case management procedures.

c. Communicate GBV Standard Operating Procedures, currently being used by UNFPA and UN Women, to UNICEF staff and IPs so that they are fully aware of good survivor-centred practice for GBV programming.  
**Lead Responsibility:** CP Chief, GBVIE Specialists  
**When:** 2016

**Recommendation 6: Maximise opportunities to integrate GBVIE across other sections of the emergency response and regular programme, leveraging existing entry points by re-visiting existing programmes using a GBV lens.** Protection gains which are currently implicit should be strengthened and expanded by making GBV risk mitigation a stated objective which is explicitly monitored and reported upon. For example:

a. The planned WASH study on open defecation should include collection of data specifically on current levels and the nature of GBV risk associated with open defecation, and in what ways WASH programming will contribute to risk mitigation of GBV by addressing these. The findings should be used both programmatically in relevant WASH interventions (UNICEF and sector-wide, using Cluster leadership influence) and for advocacy both in Pakistan and regionally.  
**Lead Responsibility:** allocated CP officer, GBVIE specialists and WASH allocated GBV focal point  
**When:** 2016-2017

b. The PCO is already using innovative communication channels as part of the Communication for Development (C4D) programming. Building on the work already being done and using social media and radio and TV soaps, develop and disseminate messaging to promote social norms change around GBV prevention and attitudes, as well as information on availability of services drawing on good practice of what has worked in other settings for GBVIE using C4D. All such communication should be line with good practice on the confidentiality and security of survivors and service providers.  
**Lead Responsibility:** allocated CP officer, GBVIE specialists and C4D Specialist
c. UNICEF-partnered training opportunities for emergency capacity strengthening, such as the on-going training being conducted by the Asian Disaster Preparedness Centre for NDMA should routinely include a GBViE module. Support to develop training material can be provided by CPS (HQ) or the RO.

**Lead Responsibility:** GBViE specialists, staff-member liaising with the ADPC

**When:** 2016-2017

**Recommendation 7:** IPs should be routinely trained on GBViE concepts and good practice for programming on GBViE and for the collection, storage, analysis and sharing of GBV-related data

a. Routinely incorporate GBViE training and monitoring indicators into the process and format for all Contingency Partner Cooperation Agreements (CPCAs) which are signed annually. All CPCAs should be revised to ensure GBViE mainstreaming / risk reduction are incorporated through all programmes implemented in emergency response in line with the recommendations for each sector in the 2015 IASC GBViE Guidelines.

**Recommendation 8:** The preparation for the new CPD (from 2018) should include development of a GBViE strategy and tools to ensure that GBViE is a key priority within all emergency response for the PCO.

a. Develop a GBViE PCO Theory of Change (ToC) which is aligned with corporate commitments and the UNICEF corporate ToC in the Resource Pack, contextualised for Pakistan. The ToC should cover all elements and components of a holistic response, demonstrating clearly how the intended interventions will achieve the desired results. Findings from the study conducted on GBV (recommendation 4) should inform the detailed design and selection of interventions included in the ToC to ensure it is relevant for the specifics of the context. This is particularly important relating to addressing social norms which underlie high levels of GBV. Ensure focus and language within the ToC systematically includes women as well as girls, as per UNICEF global corporate GBV commitments. (Interventions to address sexual violence against boys should be included in the CP programme.)

**Lead Responsibility:** CP Chief with support from Gender Focal Point, CP Team

**When:** 2017, for inclusion in the CPD

b. Develop a GBViE Strategy for the PCO based on the PCO ToC and the GBV SC strategy, which specifies which interventions will be prioritised and also how these will be implemented in ways which are culturally appropriate for the particular communities (ie obtaining agreement of community leaders/decision makers so that the interventions have their support.) The strategy and accompanying action plan will set out how different actors contribute to the desired results at all levels in emergency response.

**Lead Responsibility:** CP Chief

**When:** to be budgeted for in new CPD
1 INTRODUCTION

1.1 UNICEF’s Approach to GBViE

UNICEF defines Gender-based Violence (GBV) as an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.\(^{13}\) This definition draws on UNICEF’s core mission to protect the health and well-being of children and women and its mandate to support states and other duty bearers, civil society and communities to prevent violence against children and women in emergencies, and to ensure availability of appropriate systems and services for children and women survivors.

UNICEF is committed to providing comprehensive and coordinated programming across sectors to address the rights and needs of children and women holistically, leveraging UNICEF’s leadership and programming across humanitarian response, especially in Child Protection (CP), Education, Health, HIV/AIDS, Nutrition, and WASH sectors. In addition to a programme response, UNICEF is global co-lead of the GBV Area of Responsibility (AoR), part of the Global Protection Cluster, with associated responsibilities for coordination and as a provider of last resort.

The Theory of Change (ToC) for UNICEF GBViE programming (see below) has been developed by the evaluation team and the Child Protection Section (CPS) Gender-based Violence in Emergencies (GBViE) Specialist based on the Resource Pack and other UNICEF GBViE guidance and strategies. The ToC was used to inform the evaluation approach and tools and is discussed during country evaluations with CO colleagues. As relevant the ToC will be updated to reflect evaluation findings.

1.2 Impact of Armed Conflict and Natural Disasters on GBV

GBV occurs in all societies in the world. However, conflict situations and disasters typically intensify many forms of GBV with which children and women live, even in times of peace and stability. Tensions at household level can increase intimate partner violence (IPV) and other forms of domestic violence (DV). The pervasive impunity which characterizes conflict settings can exacerbate sexual violence, including its use as a weapon of war. Poverty, displacement and increased dependency resulting from crises may increase the risk for women and girls of being forced or coerced to engage in sex in return for safe passage, food, shelter or other resources.\(^{14}\) Insufficient security in camps and informal settlements increases the risk of sexual and physical assault, as well as trafficking.

Immediate consequences of GBV include acute and chronic health problems. In humanitarian settings, where community support systems and formal health and psychosocial services are often severely compromised, the results can be even more profound than in peacetime. GBV affects survivors and limits the ability of entire societies to heal from conflict. At the same time that GBV increases costs to public health and social welfare systems, it decreases women and children’s abilities to participate in social and economic recovery. While the primary responsibility to ensure people are protected from violence

\(^{13}\) UNICEF programmes to address GBViE generally focus on the rights and needs of women and girls given their high vulnerability to violence rooted in systemic gender-based inequality in all societies and the importance of developing targeted programming to address violence against them. While prioritizing the protection of women and girls within UNICEF’s GBViE programmes, UNICEF’s CP programmes may target specific protection-related rights and needs of boy survivors and those at risk, promoting their access to care and support.

### PROBLEM: GBV is exacerbated in an emergency environment (women and girls are more vulnerable to GBV in an emergency)

**DRIVERS:** Conflict drives violence against women and girls; social systems break down; existing power imbalances increase vulnerability and lack of information for women and girls; inadequate care and support is limited.

### SUPER IMPACT: Women and girls are able to access their rights and live with equal value and dignity to men

### IMPACT: Improve the safety and wellbeing of women and girls in emergencies

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<th>OUTCOMES</th>
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<td>THE LIKELIHOOD OF GBV OCCURRING IS REDUCED</td>
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- **Ongoing response and recovery:** Sector programmes mitigate risk and build resistance to GBV. Women and girls are meaningfully engaged in humanitarian programming; violations of IHL are identified and actions taken to address them.
- **Immediate:** Humanitarian actors recognize the urgency of addressing GBV; GBV risks, vulnerabilities, and threats are identified and action taken to address them; resources and services are available taken to meet women and girls' specific safety, dignity and protection needs.

| SURVIVORS BENEFIT FROM APPROPRIATE CARE |

- **Ongoing response and recovery:** Women and girls are safely accessing appropriate and coordinated response services; referral systems in place for all GBV survivors; coverage and quality of services strengthened; actions taken to improve access to services.
- **Immediate:** Life-saving services are put in place (health, psychological, safety) and communities are informed about them.

| CONDITIONS THAT FOSTER GBV ARE TRANSFORMED |

- **Ongoing response and recovery that starts through the laws and policies that promote women and girls' rights are implemented; relevant social norms that promote equality, safety and dignity begin to take hold; communities are taking action to prevent violence against women and girls; women are empowered.**

### STRATEGIC INTERVENTIONS

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<th>MITIGATE RISKS</th>
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<td>Advocate for prioritization of GBV</td>
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<td>Implement and monitor essential actions outlined in the IASC GBV Guidelines across clusters/sectors</td>
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<th>BUILD RESILIENCE</th>
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<tr>
<td>Community safety assessments</td>
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<td>Distribute dignity kits</td>
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<td>Establish safe spaces</td>
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<td>Integrate GBV into DRR efforts</td>
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<th>PROMOTE ACCOUNTABILITY</th>
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<tr>
<td>Monitor CRSV</td>
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<td>Engage and advocate with duty bearers to comply with IHL</td>
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<td>Advocate for PSEA</td>
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<th>PROVIDE QUALITY SERVICES TO SURVIVORS</th>
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<td>Make health, psychological, and safety services available</td>
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<td>Identify and addressing barriers to accessing services</td>
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<td>Strengthen quality of available services</td>
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<td>Publicize information about availability and benefits of services</td>
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<tr>
<td>Establish/strengthen referral systems, including for victims of PSEA</td>
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### BARRIERS

- Lack of technical capacity
- Questioning the need to fund GBV
- Lack of financial and human resources
- Lack of technical expertise

### UNICEF ACTIONS

- Leverage resources and supplies (procuring PEP kits, dignity kits, donor support)
- Promote accountability for PSEA
- Develop capacity
- Provide TA across sectors and clusters
- Promote GBV Guidelines and upload standards across all sectors
- Facilitate knowledge generation and exchange
- Coordinate humanitarian actors (at national and sub-national level)
- Advocate across humanitarian system (to ensure prioritization of and action around GBV prevention and response)

### SUPPORT ACTIONS

- Take on responsibilities when government cannot
- Advocate for and monitor compliance with international laws and norms
- Advocacy and technical support for enactment and enforcement of appropriate laws, policies, and protocols
- Leverage connections
- Fund services and programmes
- Develop capacity

### SUPPORT AGENCY ACTIONS

- Promote accountability for PSEA
- Fund programmes/guarantees
- Develop capacity
- Providing TA to enhance programme quality
- Promote GBV Guidelines and upload standards across all sectors
- Facilitate knowledge and learning exchange
- Support CIVL SOCIETY to address GBV

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This facilitates strategic interventions in the following areas
rests with the State, humanitarian actors play an important role in supporting measures to prevent and respond to GBV.

The consequences of exposure to violence are as extensive as the scope of violence itself, in terms of the myriad acute and chronic health problems that accompany many types of GBV, and because victimization can increase risk of future ill-health for survivors. In humanitarian settings, where community support systems as well as formal health and psychosocial services are often severely compromised, the consequences of violence can be even more profound than in peacetime.

The extent and impact of GBV not only affects survivors, it also limits the ability of entire societies to heal from conflict. Violence may affect child survival and development, raising infant mortality rates, lowering birth weights and affecting school participation. GBV can limit women’s access to reproductive health services including family planning, leading to unwanted pregnancies and unsafe abortions, and increasing women’s risk of HIV infection. At the same time that GBV increases costs to public health and social welfare systems, it decreases women and children’s abilities to participate in social and economic recovery.

While the primary responsibility to ensure people are protected from violence rests with the State, humanitarian actors play an important role in supporting measures to prevent and respond to GBV. According to the IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action, 2015, (‘2015 IASC GBV Guidelines’) “All humanitarian actors must be aware of the risk of GBV and—acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their areas of operation” (p 14). This responsibility is supported by a framework that encompasses international and national law, UN Security Council Resolutions, Humanitarian Principles and Humanitarian Standards and Guidelines.

1.3 Background to the GBViE Evaluation

In the past decade, UNICEF has been at the forefront of efforts to prevent and respond to GBV in emergencies, both globally and at country level. UNICEF HQ is committed to supporting Regional and Country Offices (ROs/COs) to continue to deliver on UNICEF’s mandate to protect children and women from GBV through consistent and effective GBV prevention and response in emergencies. The Child Protection in Emergencies Team (CPiE), is currently developing a range of resources for COs to use for designing, monitoring and evaluating stand-alone GBV programmes and improved integration of GBV prevention and response across all sectors of UNICEF’s humanitarian response, in line with the Core Commitment’s for Children (CCCs) and other humanitarian standards. This includes the development of the new UNICEF GBViE Programme Resource Pack (‘Resource Pack’).

To facilitate continuous learning and improvement within UNICEF’s ongoing GBV response in emergency-affected countries and to inform the development of the Resource Pack, the CPiE Team of the CPS, in collaboration with ROs and COs, is undertaking this multi-country evaluation of UNICEF’s GBViE programming.

The evaluation is being conducted between November 2015 and July 2016.
2 EVALUATION SCOPE AND METHODOLOGY

2.1 Purpose and Objectives
The overall purpose of the multi-country GBViE evaluation is to strengthen UNICEF’s current and future GBViE programming based on real time learning.

The objectives are to:
1. Assess GBViE programming in UNICEF country programmes using standard criteria for evaluating humanitarian action to generate learning that informs future UNICEF GBViE programming.
3. Develop a real-time GBViE programming evaluation methodology that can be used by UNICEF and other GBViE actors.
4. Develop recommendations to help UNICEF operationalise its organizational commitments to GBViE at HQ, regional and country levels.

This evaluation assesses UNICEF’s programming response to GBV in seven current emergencies against standard criteria for evaluating humanitarian action, namely: relevance, effectiveness, connectedness/sustainability, coordination, coverage and efficiency. Evaluation questions to be addressed under each of these criteria are included in Annex 1.

For this RTE, guidance on good programming practice from two documents is being used as the benchmarks on which UNICEF GBViE programmes should be modelled, representing current thinking on best practice for GBViE programming for specialised and integrated programming respectively:

(i) The GBViE Programme Resource Pack (the ‘Resource Pack’) currently being developed by the Child Protection Section of Programme Division, (CPS) provides detailed guidance for conducting assessments and designing and implementing specialised GBV programmes relevant to UNICEF’s operations. The Resource Pack (due to be finalized in 2016) includes information and resources for implementing a minimum package of essential services for GBV protection and response in the aftermath of an emergency or population displacement. It also contains guidance for expanded programming to strengthen structures, systems and services and institutionalize prevention, protection and response to GBV during ongoing response and throughout recovery.

(ii) The recently launched IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action, 2015, (‘2015 IASC GBV Guidelines’) provides detailed guidance and good practice

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15 To clarify programming terms being used in the evaluation as well as the nature of GBViE programmes to be evaluated: ‘GBV specific programmes’ are understood to be:
(a) Multi-sectoral response and referral services for survivors focusing on health care; security (including safe spaces) and psychosocial support (including within schools);
(b) Dignity kits (distributed by Child Protection (CP) and Water, Sanitation and Hygiene (WASH) teams or just CP teams), economic strengthening for adolescent girls, community based protection activities;
(c) Prevention programming including work on social norms, economic and social empowerment of women and girls, legal and policy reforms.

‘Integrated’ programming refers to the mainstreaming of GBV prevention and risk mitigation approaches/activities across other sectors.

2.2 Evaluation Focus and Scope
The evaluation includes data gathering at global, regional and country levels.

The core of the evaluation is seven real time evaluations (RTEs) which are being conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic, with missions lasting one to two weeks each. The primary focus of the evaluation is on learning:

- To promote learning in each of the RTE COs on how existing programmes can be enhanced in the light of good and emergent practice as captured in the 2015 IASC GBV Guidelines and in the Resource Pack; and,
- To promote learning at HQ and ROs through the CO reports and the final evaluation, as well as short case studies of good practice and a detailed comparative review of three GBVIE specific interventions across three to four of the mission countries which will inform the development of the GBVIE Resource Pack.

To provide an overall picture of UNICEF’s GBVIE programming, a mapping exercise will be conducted by electronic survey of 39 UNICEF COs which are reporting against corporate targeted priorities within the Gender Action Plan (GAP).

Implementing Partners
Any evaluation of UNICEF programming means, de facto, an evaluation of the programming of their implementing partners (IPs). The country missions will clarify UNICEF’s role vis-à-vis their IPs and how these roles may differ in different contexts and in different types of emergencies. This will include clarification of the nature of support UNICEF staff are offering their partners, (national and international); and how UNICEF staff are overseeing partnerships and ensuring programme quality.

GBV Sub-clusters
The evaluation will not include an assessment of the global GBV Area of Responsibility (AoR), or of country level GBV sub-clusters (or other GBV coordination mechanisms) per se, as it is focused on the GBV programming function of UNICEF. It will, however, consider the extent/nature of UNICEF’s programming contribution in realizing sub-cluster strategy/plans for addressing identified gaps/priorities, and will address how the agency has added value to the whole GBV response (including leadership and advocacy activities) within the CO and across the response as a whole.

GBV and Sexual Exploitation and Abuse (SEA)
The evaluation ToR doesn’t specifically include SEA within the scope of this evaluation. However, in the light of the recent report on the UN response to allegations of SEA in CAR, several donor interviewees have indicated that UNICEF, in common with all UN agencies, needs to have clear policies and guidelines

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16 The length of each mission is dependent on the extent of the GBV programme and access to programme areas. The mission in Somalia was longer than the others, being 15 working days.
17 An evaluation of the coordination function was not included in the ToR. Additionally, the UNICEF, via the Cluster Management Unit of UNICEF EMOPS and UNFPA HQ are undertaking a Review of the GBV AoR leadership function.
in place to implement the UN Secretary-General’s October 2003 bulletin: *Special Measures to Protect from Sexual Exploitation and Abuse.* The evaluation scope will therefore include questions on the existence of protection from SEA (PSEA) policies and action plans, and familiarity with them by CO staff, and whether victims of SEA are referred to for care and support services.

**Audience**

The primary audience for the evaluation findings and collated good practice is the CPS, (who commissioned the evaluation and will use the findings to inform future priorities as well as the GBViE Resource Pack). Findings will also be used by GBV specialists, CP specialists and Gender Advisors in Regional and Country Offices (CO) who are implementing, managing and providing support to GBV programmes. The secondary audience includes other sectors and UNICEF senior management at headquarters (HQ), Regional Offices (RO) and COs.

Given the paucity of evaluations on GBViE programming, it is hoped that the final evaluation report will also be of interest and use to non-UNICEF actors implementing and/or resourcing GBViE programmes.

**2.3 Methodology**

The evaluation is based on collection and analysis of primary and secondary data. Data collection includes document review (at global level and for each mission country); key informant interviews (KII) with stakeholders at global, regional and country levels; focus group discussions (FGDs) with programme beneficiaries in country; and field observation by the evaluation team. As a learning tool for country office personnel, staff are being asked to assess their programming against good practice checklists based on the 2015 IASC GBV Guidelines and the Resource Pack that were distributed prior to and during the field trips. National consultants are recruited to support the evaluations in each country to ensure that approaches and tools used are culturally sensitive and appropriate, and to support the team with language translation.

The evaluation team are visiting a selection of projects in each mission country to make field observations, interview IP staff and conduct FGDs with different groups of beneficiaries. Criteria have been developed for the selection of projects to be visited, but, in practice, final decisions have been taken by the CO evaluation focal point and CP Chief in advance of the evaluation team mission in light of accessibility, willingness of IPs to host visits and arrange FGDs, those projects with the most learning potential, and safety of beneficiaries, in-country staff and partners and the evaluation team.

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19 ST/SGB/2003/13, 9 October 2003

20 UNICEF and all other protection actors are obliged to mainstream prevention of GBV within all programmes. Along with mainstreaming GBV prevention, UNICEF also delivers targeted programming where possible to address identified risk factors for GBV. All of these efforts will contribute to protection against SEA.

21 SEA committed by UN/UNICEF staff or related personnel against any persons of concern is based on abuse of power and—in the case of women and girls, who are the primary victims of SEA—gender inequality and gender discrimination. The SG’s Bulletin requires that all humanitarian personnel ensure action is taken to prevent SEA in their areas of operation, and report it when they observe any risks or abusive behaviour. PSEA should link with GBV programming to ensure survivors’ rights are respected and to improve victim assistance and the development of community-based complaints mechanisms. SEA agency focal points should link with GBV actors to develop referral systems that support survivor-centred care. While CP and GBV staff in UNICEF country programmes should know and promote the key principles and standards of conduct outlined in the Secretary-General’s Bulletin, the accountability for PSEA lies with senior management (Country Representatives) and human resources (Heads of Human Resource Departments). The IASC GBV Guidelines fully support the mandate of the SG’s Bulletin and provide several recommendations within each sector guidance chapter on programming that mitigates SEA, including incorporating PSEA strategies into agency policies and community outreach.

22 Including both self-reported data by mission CO staff and data gathered by the evaluation team.
Tools developed by the evaluation team guide country mission preparation and data collection and analysis. These tools were reviewed the Evaluation Management and Reference Groups and were tested and refined during the first two missions. The final versions of the evaluation tools will be included in the Resource Pack to support future GBViE evaluations.

In line with RTE methodology, a workshop is held at the end of each country mission to share and validate the initial findings and reflect, with CO colleagues, about how the findings can be used to enhance GVBiE programming in that setting.

A country mission report, based on the workshop presentation and discussion is drafted by the evaluation team, and reviewed by the CO and the Evaluation Management Group. The findings section of the country mission reports addresses the evaluation questions relating to each of the evaluation criteria. The seven country mission reports will inform the final, overall evaluation report.

2.4 Evaluation Management

The evaluation has been commissioned by the Child Protection Section (CPS) of UNICEF Programme Division, who also selected the case study countries and has closely overseen the process throughout.

An internal, five-person UNICEF Evaluation Management Group (EMG) has been formed with responsibility for daily management of the evaluation including supervision of the evaluation team, review of all products (Inception Report, tools, workplan, country and final reports, coordinate with the Evaluation Reference Group (ERG) and disseminate the final evaluation findings). This Evaluation Management Group is comprised of Mendy Marsh, GBViE Specialist, CPS, Krishna Belbase, Senior Evaluation Specialist, Evaluation Office, Jennifer Keane, CP Specialist on Knowledge, Planning and Evidence, and Laili Irani, Senior Adviser, Gender & Evaluation, Gender Section and Sophie Read-Hamilton, GBViE Consultant with the CPS.

The ERG is composed of internal and external experts who provide quality oversight to the evaluation. The ERG includes the following individuals: Mary Ellsberg, Director, Global Women’s Institute at George Washington University; Mazeda Hossain, Social Epidemiologist, London School of Hygiene and Tropical Medicine (LSHTM); Jina Krause-Vilman, Senior Area Practice Lead, Refugees, Gender and Livelihoods, Near East Foundation; Maha Muna, Regional Gender Advisor, UNICEF CEE-CIS; Michael Copland, Regional Child Protection Advisor, UNICEF ESARO; Laurent Chapuis, Regional Child Protection Advisor, UNICEF MENARO; and Kate Alley, Emergency Specialist: Assessment, Planning, Monitoring and Evaluation, Humanitarian Policy Section, UNICEF EMOPS. Responsibilities include reviewing and commenting on the Inception Report, two early country reports and the draft final report, and sharing the final report with partners and networks. ERG responsibilities include reviewing and commenting on the Inception Report, two early country reports and the draft final report, and sharing the final report with partners and networks.
3 PAKISTAN MISSION OVERVIEW

3.1 Mission Overview
The country mission to Pakistan was conducted between the 25th January and the 5th February by two international consultants, supported by two national consultants. The evaluation team met with key informants in Islamabad and visited KP province where UNICEF has its only current emergency response23 in Pakistan. The final workshop was attended by 17 UNICEF staff members including the Deputy Representative and five Chiefs of Sections, and the two national consultants.

3.1.1 Data Collection
A country document review was compiled by the evaluation team before the mission, to provide background on the Pakistan and CO contexts as well as the emergency response and the current GBViE programme. During the mission additional documentation was received from the country office (CO).24

A total of 70 interviews (51% female, 49% male) were conducted with UNICEF staff and partners in Islamabad and Peshawar, with government, UN agencies, INGOs, civil society organisations (CSOs)/Implementing Partners (IPs). The team also attended and discussed lessons learned on GBViE programming in Pakistan at a meeting of the Inter-Agency Gender and Development (INGAD) Group, which includes agency and donor members. Nine Focus Group Discussions (FGDs) were conducted with host and displaced populations in and around Bannu town, with women, men, adolescent and youth females and adolescent and youth males (in separate FGDs). FGD sites and participants were selected by the CO and implementing partners (IPs) following discussions with the evaluation team during the preparations for the mission.

All these data sources have informed this country report.

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF staff</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
<tr>
<td>Government</td>
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<td>3</td>
<td>5</td>
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<tr>
<td>UN Agencies</td>
<td>6</td>
<td>4</td>
<td>10</td>
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<tr>
<td>INGO/CSO/Academic/Other</td>
<td>8</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total KII</strong></td>
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<td><strong>34</strong></td>
<td><strong>70</strong></td>
</tr>
<tr>
<td>FGD – adult female</td>
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<td>48</td>
</tr>
<tr>
<td>FGD – adult male</td>
<td></td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>FGD – adolescent female (15-24)</td>
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<td></td>
<td>11</td>
</tr>
<tr>
<td>FGD – adolescent male (15-24)*</td>
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<td>26</td>
</tr>
<tr>
<td><strong>Total FGD and KII</strong></td>
<td><strong>95</strong></td>
<td><strong>92</strong></td>
<td><strong>187</strong></td>
</tr>
</tbody>
</table>

* The male “adolescent” groups in Pakistan consisted of unmarried males of varying ages

3.1.2 Limitations
Limitations of this mission included: (1) no individual interviews with donors (who were unavailable for interview, despite several requests) although there were representatives from Japan, Canada, Australia, Sweden and Norway at the INGAD meeting; (2) the team was unable to visit one planned evaluation site as No Objection Certificates (NOCs) were not received for a visit to Jalozai Camp meaning no camps were

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23 KP hosts IDPs from FATA as well as Afghan refugees; it is the only province in Pakistan where UNICEF and other UN partners are currently implementing an emergency response and where Clusters and Sub-Clusters are active at the provincial level.

24 See Annex 4 for bibliography
included in field visits;^25 (3) FGD were conducted with heavy military protection in the near vicinity which was provided by the Government of Pakistan (GoP) which is mandatory for travel to Bannu town and the surrounding areas making it very unlikely that ‘open and honest’ opinions were shared during the FGDs.\^26

3.2 Country Overview

3.2.1 Country Context

Pakistan is a South Asian country bordering India (with whom Pakistan has a disputed territory claim over Kashmir), Afghanistan, Iran and China, with the Arabian Sea to the south. It is the 6\textsuperscript{th} most populous country in the world with an estimated population of 196 million people.\^27

Pakistan is marked by stark regional disparities, with diverse languages and sub-cultures between and within the provinces and territories. Notwithstanding these differences, cultural attitudes are overwhelmingly conservative, with pronounced gender inequality in all areas of Pakistan. While there are highly educated and competent women who hold high office in politics and professions, the majority of women and girls are marginalized in the formal economy and decision making structures, and face difficulties accessing education, health, other basic services, and the justice systems.

Classified by the World Bank as a lower middle income country, Pakistan ranks 147 out of 188 countries in the Human Development Index (HDI). It ranks 121 in the gender inequality-adjusted HDI, and 144 out of 145 in the World Economic Forum gender gap report (2015), coming in second to last only ahead of Yemen.\^28

Pakistan has 80 million children, of whom almost 7 million of primary school age, are out of school (Pakistan has the second largest number of children out of school in the world).\^29 10 million boys and 8.1 million girls enrol at primary level. This drops to one million boys and 700,000 girls at higher secondary level.\^30 Pakistan is one of the two remaining countries in the world with endemic polio, with the Federally Administered Tribal Areas (FATA) being a key reservoir for the disease.\^31 3.3 million children\^32 and 2.2 million pregnant and lactating women are malnourished.

Pakistan was created out of the partition of the Indian subcontinent in 1947. Initially geographically divided into two parts, the East Wing split in 1971 to become Bangladesh. Pakistan is now divided into

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\^25 In Pakistan NOCs issued by the government are required for visits to certain areas and often not issued. Despite PCO submitting a request for this travel, NOCs for Jalozai Camp were not issued and only NOCs for visit to Bannu town were provided by the government, restricting movement and the scope of the field work.

\^26 The military surrounded PLaCES sites and other locations where men and boys were participants, and were in the area but not immediately surrounding locations where females were participants (given the cultural restraints on non-family males and females not being in the same immediate vicinity).

\^27 2016 Humanitarian Needs Overview. UNICEF CPD 203-2017 puts the population at 177 million (based on earlier data sets)

\^28 The gender inequality adjusted HDI ranks across three dimensions - health, empowerment, and the labour market: whereas the World Economic Forum global gender gap report ranks across four areas – the economy, politics, health, and education. Hence the difference in ranking.

\^29 Pakistan One United Nations Programme. 2013-2017 p2. However, 7 million is a debatable figure, as it does not include those children not registered at birth and therefore not counted in official figures.


\^31 The other country is Afghanistan and endemic polio is restricted to a small area straddling the border between Pakistan and Afghanistan

\^32 1.6 million boys and 1.6 million girls
four provinces: Baluchistan, Kyber Pakhtunkhwa (KP), Punjab, and Sindh; the Islamabad Capital Territory; the Federally Administered Tribal Areas (FATA); and Pakistan-administered Kashmir (PAK).

In 2011, sweeping political reform in the form of the 18th Amendment to the Constitution introduced political devolution, giving provincial governments a significant degree of autonomy. This devolution has resulted in the necessity for international agencies to engage separately with provinces with government at federal, provincial and district levels. Gaps in technical capacity within sub-national government departments hinder effective service delivery, and it is thought by some that, post-devolution, the greatest casualty was women’s empowerment because the lack of a federal ‘anchor’ on equality issues weakened advocacy as the four provincial ‘highways’ went in different directions.\(^\text{33}\)

In general, the Ministry of Social Welfare (MoSW) is the key government lead agency for women and children’s protection and the main counterpart for GBV programming. However, it is widely considered to be one of the weaker government ministries in most provinces.

Pakistan is signatory to several international covenants\(^\text{34}\) on human rights and has comprehensive legal coverage for the protection of the marginalized groups including women, children and minorities. Since the 18th Amendment, the KP government has made significant progress in terms of legislation for various human rights issues and several Pakistani laws have been extended to FATA. However, an appropriate implementation machinery is lacking.

### 3.2.2 GBV Context

GBV is rife in Pakistan. While there have been civil society organisations focused on women’s rights and gender equality for a number of years, a comprehensive picture of prevalence, types of violence and the differences between provinces is not clear. “...despite attention, serious efforts and research on violence against women over the recent years, some key concerns have remain(ed) unaddressed: there is a significant data deficit which can aid in building a holistic understanding on the scope and extent of the issue, and on women’s experiences of violence.”\(^\text{35}\)

Despite limited documented evidence, it is clear that Pakistani women and girls often suffer severe limitations on their movement and mobility, as well as restricted access to education and vocational activities, and high levels and widespread acceptance of domestic violence and child marriage.\(^\text{36}\) In addition to types of GBV that are prevalent the world over (e.g. sexual violence, domestic violence, child marriage etc.), in Pakistan women and girls are also victims of context-specific forms of GBV, such as swara / vani or watta satta (girls given as brides for the settlement of debts or as a form of compensation),

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\(^{33}\) INGAD meeting  
\(^{35}\) Foreward to Standardized Indicators on Violence Against Women in Pakistan, National Commission on the Status of Women Pakistan, September 2015  
\(^{36}\) This extends to all areas of life: FGD with adult women in the host communities in Bannu reported that if women go out of their homes they should be accompanied by a male family member, if not an adult then a male child. (FGD, Bannu, 3\(^{rd}\) Feb 2016)
marriage to the Koran, and honour killings. Current child marriage rates in Pakistan are estimated at 21% of girls married by the age of 18 and 3% of girls married by the age of 15.\(^{37}\)

In areas of displacement, women and girls cannot leave their homes without being in the presence of a male relative and/or observing purdah.\(^{38}\) Women who hold senior jobs are often expected to revert to traditional patriarchal relationships within the family. The evaluation team were told that married women are sometimes discriminated against in recruitments, with reservations coming from both employers and their families.\(^{39}\)

The low status of women and girls and the prevalence of GBV has been exacerbated by the chronic complex emergency in KP and FATA, and the numerous natural disasters in Pakistan. National response services for GBV survivors are woefully inadequate. Survivors of GBV do not speak out for many reasons including restricted mobility, fear, risk of ongoing violence (e.g. honour killings and reprisals), shame, social stigma/exclusion, acceptance of GBV as normal, very few services for survivors with limited awareness of which do exist, and a legal system which is dysfunctional and unresponsive to those survivors who do seek legal redress.\(^{40}\) There is widespread denial of GBV. A protection cluster survey of returnees reported that 99% of mostly male respondents claimed GBV was not an issue.\(^{41}\) This situation is worse during emergencies: “GBV is side-lined and people don’t want to report incidents”.\(^{42}\) Women’s shelters (Dar-Ul-Aman) exist in most provinces, but these are few and provide a very poor level of care – with women often referred to as “inmates” and having their mobility restricted and rights’ violated.\(^{43}\)

During the FGDs, only one adult woman openly disclosed domestic violence within her home by her husband.\(^{45}\) Other women reported that men did not beat their wives so much anymore, a result of (men’s) better education. Given the high incidence of GBV, this view is likely due to the normalisation of domestic violence within Pakistani communities, and the rapid nature of the RTE FGD methodology which allowed only a short time for discussion of the highly sensitive subject of GBV. FGD participants (male and female) confirmed that very few girls attend school past primary level, unlike boys, because of the perceived dangers when travelling further to middle schools. Girls must travel separately from boys, which is expensive, and parents are afraid that girls will be harassed.\(^{46}\) Some FGD participants (adolescent males and females) said that more girls are subject to child marriage earlier due to the displacement. These marriages are designed to secure economic / financial and physical protection for the girls, all of which are compromised by displacement.

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\(^{37}\) UNICEF SoWC Report 2015

\(^{38}\) NB the concept of using the veil to be completely covered as a protection measure indicates the existence of fear, that if they do not observe purdah, they will be inviting unwanted attention.

\(^{39}\) Employers with concerns with a lack of flexibility due to family responsibilities and families with the fear that with economic independence will come a challenge to traditional family roles and power structures.

\(^{40}\) UNICEF and other KII, and lack of knowledge of existing services confirmed by FGDs in Bannu

\(^{41}\) Protection Cluster Quarterly Bulletin Oct-Dec 2015

\(^{42}\) KII respondent

\(^{43}\) The Humanitarian Strategic Plan Objectives, Indicators & Targets states that there are 9 districts in the areas which the plan targets which have ‘functioning GBV referral and service mechanisms in place’ but the interviewees consistently reported a real lack of functioning services.

\(^{44}\) UN Women KII

\(^{45}\) The FGD methodology did not ask intrusive or personal questions about participants own circumstances; but in one FGD a woman volunteered this information.

\(^{46}\) One FGD young woman from the host community had persuaded her husband to let her return to school after marriage, and had completed Grade 12 despite having two children, but this is very rare.
Displaced women and girls in Bannu said that their movements were more restricted since displacement, with their families afraid that local male youths and IDP males might harm them.\footnote{An opinion which the evaluation team met frequently during the mission from beneficiaries, UN colleagues and other NGO interviewees was that protection risks were seen as being from people outside the family. Women and girls are seen as being 'protected' by being kept at home. (KII, FGDs)} Notably, some host community adult women FGD participants reported that women are ‘stronger’\footnote{Which they explained as having more influence on decision-making.} now than previously in the home relative to men; which was confirmed by adult male FGD participants. “We don’t like it, but they are!”\footnote{FGD discussions with adult men and women (separately) 3rd Feb 2016 in Bannu.}

In some parts of Pakistan (particularly in tribal areas), abusive sexual relations between men and young boys are relatively common, and widely considered to be culturally acceptable. Throughout Pakistan, boys, especially male child labourers, are particularly vulnerable to sexual abuse, given the limited protection systems. While there have been a few high profile media cases involving sexual abuse of boys, in general the dysfunctionality/ineffectiveness of the criminal justice sector and stigma of reporting incidents means that survivors do not come forward and for boys, issues of sexual violence against them are even less discussed than GBV against women and girls. While sexual violence against boys is a significant issue in some parts of Pakistan, it does not constitute the ‘structural’ nature of GBV against women and girls who have very limited forms of redress (within families, within religious courts, within the legal systems) in a strongly patriarchal society where the power balance is so strongly in the hands of males. Boys who have been sexually abused need to receive appropriate services, but programming on GBV against women and girls needs to focus on addressing the structural issues as well as the socio-cultural attitudes which underpin the high levels of GBV in Pakistan.\footnote{It should be noted that the CP team of the PCO does not agree with this view.}

In the eyes of Pashtun informants, the cultural protection mechanisms, which involve women and girls always being accompanied by males outside the home offer them better protection than in other areas of the country.\footnote{Pashtun are the ethnic community historically living in south-eastern Afghanistan and north-western (FATA) Pakistan; they are traditionally pastoral nomads: One respondent reported that there is less GBV outside of homes within Pashtun communities because men caught 'hassling' women and girls would be beaten. (UNICEF and UN partner KII, Peshawar)} In other areas – particularly cities and more urban areas – the GBV risks for women and girls outside of the home remain pervasive. A number of gang rapes have been reported against women who have left their homes to defecate in different areas of Pakistan.\footnote{KII UNICEF Peshawar}

Pakistan’s constitution and national and provincial\footnote{Relevant provincial laws include: (i) The KP Establishment of Commission on Status of Women Act, 2009; (ii) The Khyber Pakhtunkhwa Enforcement of Women Ownership Rights Act, 2012; (iii) The Khyber Pakhtunkhwa Promotion, Protection and Enforcement of Human Rights Act, 2014; and, (iv) The Khyber Pakhtunkhwa Maternity Benefit Act, 2015.} laws provide for some women’s rights, legal protection, and legal safeguards and a number of new laws have been passed in recent years: the Child Marriage Restraint Act, 2014 in Sindh (raising the marriage age for girls from 16 to 18), and the Protection of Women against Violence Bill in Punjab 2015, which was finally passed in February 2016 by the Punjab Assembly after considerable opposition.\footnote{However, condemnation as "un-Islamic" and "blasphemous" of a bill to raise the marriage age for girls in Islamabad to 18, by the Council of Islamic Ideology, caused it to be dropped by the legislature in January 2016. The bill would have imposed harsher penalties on those who arrange child marriages, and raised the legal age of marriage for girls from 16 to 18. (Al Jazeera blog: Child Marriage: Despite a minor setback there is progress on child marriage, 22 Jan 2016)} The GoP has recently decided to amend rape and honour killing laws in the next joint session of Parliament, motivated by the showing of an Oscar-winning documentary:

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\footnotesize

47 An opinion which the evaluation team met frequently during the mission from beneficiaries, UN colleagues and other NGO interviewees was that protection risks were seen as being from people outside the family. Women and girls are seen as being ‘protected’ by being kept at home. (KII, FGDs)

48 Which they explained as having more influence on decision-making.

49 FGD discussions with adult men and women (separately) 3rd Feb 2016 in Bannu.

50 It should be noted that the CP team of the PCO does not agree with this view.

51 Pashtun are the ethnic community historically living in south-eastern Afghanistan and north-western (FATA) Pakistan; they are traditionally pastoral nomads: One respondent reported that there is less GBV outside of homes within Pashtun communities because men caught 'hassling' women and girls would be beaten. (UNICEF and UN partner KII, Peshawar)

52 KII UNICEF Peshawar


54 However, condemnation as “un-Islamic” and “blasphemous” of a bill to raise the marriage age for girls in Islamabad to 18, by the Council of Islamic Ideology, caused it to be dropped by the legislature in January 2016. The bill would have imposed harsher penalties on those who arrange child marriages, and raised the legal age of marriage for girls from 16 to 18. (Al Jazeera blog: Child Marriage: Despite a minor setback there is progress on child marriage, 22 Jan 2016)
'A girl in the River: Price of Forgiveness’. While these laws signal progress, their implementation is not systematic. For example, the Child Marriage Restraint Act includes no provision to nullify child marriages which do take place. However, the legal framework provides an entry point for advocacy on GBV and child rights, as Pakistan wishes to be seen as a progressive society.

Women and girls in FATA are denied their most basic constitutional rights under the colonial-era Frontier Crimes Regulation 1901 that governs the region. There are no family courts in FATA, so legal jurisdiction in family matters is exercised through jirgas (traditional courts made up of a council of male elders), which have been criticized for not being competent, neutral, or just.

3.2.3 General and GBV-specific Humanitarian Response

Pakistan is a context of a “challenging security situation and multiple crises”. It ranks among the top 10 countries in the world in terms of vulnerability to the impacts of climate change. Floods in 2010 affected more than 18 million people and caused an estimated USD 10 billion in damage. In addition to the vulnerability to climate change, Pakistan is host to the largest protracted refugee population in the world with 1.7 million registered Afghan refugees and an estimated further million unregistered.

According to the 2016 Humanitarian Needs Overview (HNO), of a total population of 196 million, 12.3 million people in Pakistan require humanitarian assistance and 3.5 million people were affected by natural disasters in 2015. More than 5 million people have been displaced from FATA and Khyber Pakhtunkhwa (KP) since 2008. Most Internally Displaced Persons (IDPs) live in informal settlements and host communities in KP and lack access to adequate housing, sanitation, electricity supply, schools, hospitals, and protection services.

600,000 IDPs returned to FATA during 2015 and the GoP has plans to facilitate the return of all IDPs and to start rebuilding communities in host and return areas. However, people are returning to severely damaged infrastructure and minimal or no access to health and education services, safe drinking water, or opportunities to re-establish livelihoods. Pressing protection issues include the dearth of female doctors and teachers in FATA, leaving women and girls with no access to health and education services, and women and children with limited access to humanitarian assistance, basic services, civil documentation, psychosocial support, or protective spaces.

55 The Express Tribune, December 17th, 2011.
56 Centre for Governance and Public Accountability (CGPA), State of Implementation of Laws Extended to Federally Administered Areas (FATA), October 2015, pp. 10-11
57 CPD 2013-2017
58 UNDP http://www.pk.undp.org/content/pakistan/en/home/countryinfo/
59 ibid
60 CPD 2013-2017
61 Of which 53 million are men, 48 million are women, 49 million are boys and 46 million are girls
62 Of which 1.8 million are men, 3.8 million are women, 3.4 million are boys and 3.2 million are girls
63 Since 2010, over 37 million people have been affected by floods which destroyed or damaged more than 3 million homes, and displaced more than 17 million people. In 2015 1.6 million people were affected by flooding
64 The Afghan/Pakistan earthquake left 272 dead, 2,000 injured and damaged more than 25,000 homes
65 2016 HNO for Pakistan
66 As of September 2015 an estimated 14,600 IDPs were living in three camps managed by the humanitarian community (Jalozai, Togh Sarai and New Durrani). In addition, the GoP runs Baka Khel camp, hosting 12,800 IDPs, and 8,100 people live in twelve spontaneous settlements in Bannu.
67 127,000 women, 149,000 men, 149,000 girls and 175,000 boys (UNHCR Sept 2015, IDP statistics)
68 Originally the date set for all IDPs to be repatriated was end 2016, but this has been revised.
69 An estimated 17% of IDPs are not registered and are therefore not officially recognized as IDPs. A national ID card is a pre-requisite to receiving government and humanitarian assistance including monthly food distributions and cash transfers. Females are much less likely to have ID cards than males.
Disaster management authorities at national, provincial and district levels have primary responsibility to coordinate each line department’s response to disasters. Significant improvements in capacity in recent years mean that the GoP can respond adequately to medium level crises. The government’s reticence to request international humanitarian assistance for all but the largest emergencies restricts the humanitarian space for international agencies.

Gender and Child Cells (GCC) were established in 2013 in the National Disaster Management Authority (NDMA), Provincial Disaster Management Authority (PDMAs) and FATA Disaster Management Authority (FDMA). The NDMA developed National Policy Guidelines on Vulnerable Groups in Disasters to be implemented through the GCCs. While the FDMA GCC’s engagement with protection actors was praised by interviewees, GCC staff have been funded externally by UNICEF and UN Women since their establishment, suggesting a lack of prioritisation of women and children’s emergency protection needs by the GoP. Additionally, the GCCs are relatively ineffective, as they have confused their mandate and engaged in service delivery rather than focusing on their primary coordination function.

The Standard Operating Procedures (SOPs) for GBViE response, developed by the GBV sub-cluster (SC) in 2011, have still not been endorsed nationally; again indicating that GBV is considered a low priority nationally as part of emergency response. However, they are being used by UNFPA and UN Women.

The GBV SC was first formally activated in Islamabad in 2010, with provincial GBV SC coordinators in place by January 2011. Initially UNICEF and UNFPA co-led the sub-cluster. However, in January 2011, UNICEF withdrew from leadership, citing as the reason heavy responsibilities leading four other clusters. Currently, the cluster system is only active at the provincial level in KP/FATA. Having a provincial cluster when the national cluster is not activated creates challenges. UNHCR leads the protection cluster, UNICEF chairs the CP SC, and UNFPA chairs the GBV SC. The CP and GBV SCs have worked closely together intermittently in the past, developing joint assessment tools and plans. However, at the time of the evaluation mission, the GBV SC in Peshawar had not met for the last six months, in part because the UNFPA GBV SC coordinator was based in Islamabad while the SC functioned in Peshawar, and capacities within UNFPA are stretched. In the 2015 Humanitarian Strategic Plan (HSP), GBV was severely under-funded with only USD 584,301 confirmed funding from a total budget of USD 3.5 million. Funding challenges for the sector have severely limited the strengthening of essential GBV services.

The 2016 HSP includes strategic objectives for CP and GBV SCs which directly and indirectly address GBViE: CP SC strategic objectives include the establishment of protection spaces and services in host and return areas; the establishment of information desks at embarkation points for returnees with the objective of helping women and children access services and monitor their needs; and the active promotion of CP mainstreaming using the Minimum Initial Service Package (MISP). GBV SC strategic objectives in the HSP include targeting 243,000 people as direct beneficiaries for GBV prevention and response; providing safe access to life-saving multi-sectoral GBV response services and prevention activities for IDPs, which will also indirectly benefit host communities. Seven districts/agencies in KP and five in FATA are being

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70 UNFPA KII
71 USD16,063,390 was requested overall, of which $3,314,645 was received for the Strategic Plan as a whole.
72 Within the One UN Plan for Pakistan (2013-2017), Strategic Priority Areas 4 and 5 also indirectly focus on issues relating to GBV prevention and elements of response: SPA 4: Strengthened governance and social cohesion (which include outcomes relating to the rule of law to provide improved safety and security including measures to address transnational crime and trafficking); and SPA 5: Gender equality and social justice
prioritized. Response services aim to improve multi-sectoral services,\textsuperscript{73} incident referral and reporting mechanisms to address GBV.

In addition to the GBV SC, there are a number of other gender/GBV coordination mechanisms which are led by national and international actors, suggesting some degree of duplication. Mechanisms include the SGBV Working Group (led by American Refugee Committee (ARC) and UNHCR), the Gender and Humanitarian Task Force, (led by UN Women, covering GBV) and the National Commission for the Status of Women (NCSW).\textsuperscript{74} This duplication of coordination mechanisms is complicated by a lack of clarity/agreement on what GBV is among national actors, community members\textsuperscript{75} and UN staff, including UNICEF Pakistan (symptomatic, in the case of UNICEF, of the lack of clarity within UNICEF as a whole).

\subsection*{3.3 UNICEF GBV Programme}

Neither GBV nor GBViE are Pakistan Country Office (PCO) priorities. UNICEF, UNDP, and UNFPA have a common country programme document (CCPD) 2013-2017 in order to promote UN coherence and strengthen effective support to the GoP. This is a second generation CCPD.\textsuperscript{76} The CCPD focuses “particularly on key areas for which the three organizations have recognized mandates and proven competitive advantages”.\textsuperscript{77} The CCPD aims to maximize the three organizations’ relevant contributions to the six strategic priority areas identified in the One UN Programme.\textsuperscript{78} The UNICEF results framework with targets and indicators references GBV only peripherally under Priority Area 5, Ensuring gender equality and social justice, with only Outcome 5.1 referencing CEDAW.

GBViE related activities are currently only being implemented in KP/FATA\textsuperscript{79} and are very limited.

UNICEF is implementing a number of CP interventions as part of the regular programme which aim to contribute, in the long term, to enhancing national services for GBV survivors (children and women) and which, it is anticipated, will support more effective GBViE response for future emergencies. The WASH, Health and Education sectors contribute to GBViE risk mitigation to a very limited degree. Currently, none of the UNICEF sectors except CP (to a very limited extent) have GBV risk mitigation as an explicit programme result.

\subsubsection*{3.3.1 GBViE Specific Programmes}

The evaluation team recognise that, when the PLaCES model was developed, it was done so as a holistic, multi-sectoral approach aimed at offering services and creating an environment to improve the safety, health and wellbeing of children, adolescents and women, including assistance and awareness-raising on

\textsuperscript{73} Including psychosocial support and counselling, case management, health services, safety/security, legal assistance and reintegration support for GBV survivors.

\textsuperscript{74} The National Commission on the Status of Women (NCSW) was planning to conduct a survey on prevalence of Violence Against Women (VAW) based on standardized indicators on violence against women (VAW) in Pakistan: \url{http://www.ncsw.gov.pk/previewpublication/36} at the time of the evaluation mission. However, this will now be conducted in Punjab rather than nationally.

\textsuperscript{75} FGD members considered GBV to be violence perpetrated by strangers outside the home.

\textsuperscript{76} Pakistan was one of the eight pilot countries for the original One UN Programme approach, 2009-2012 - UNICEF CCPD 2013-2017

\textsuperscript{77} CCP 2013-2017

\textsuperscript{78} (1) vulnerable and marginalised populations have equitable access to and use of services; (2) inclusive economic growth through the development of sustainable livelihoods; (3) increased resilience to disasters, crises, and external shocks; (4) strengthened governance and social cohesion; (5) gender equality and social justice; and (6) food and nutrition security for the most vulnerable groups

\textsuperscript{79} UNICEF provides assistance primarily to IDPs in camps and those returning home, with limited assistance provided to host families, (UNICEF Annual Report for Pakistan, 2014)
However, currently there is, essentially no GBV specific programming being implemented as part of the PCO emergency response. PLaCES programmes include some awareness-raising, but are described as part of the CP programme in CO reports, and do not reference GBV specifically, hence its description below under child protection.

3.3.2 Integrated GBViE Programming

Child Protection

Violence against children is a high priority for the CP team in Pakistan CO. The CP section is focused on supporting the provincial and federal government to establish CP systems and structures which will function to provide effective referral and protective services for children suffering all types of abuse and violence. This includes GBV which is wholly integrated within the CP programme. In the context of Pakistan, the language of ‘addressing abuse and violence against children’ has the support of provincial and federal governments, whereas the language of ‘GBV’ does not. The PCO is addressing these issues within the context of SDG 5 (Achieve gender equality and empower all women and girls) and 16 (Promote just, peaceful and inclusive societies), which have the support of the Government of Pakistan. This approach is aligned with the IASC GBV Guidelines recommendations for integration of GBV across CP programming.

The PCO CP team’s position is that, given scarce resources, (i) UNICEF’s focus needs to be on children (girls and boys) rather than a focus on women and girls (which is UNFPA and UN Women’s focus in Pakistan); and (ii) that the focus needs to remain on strengthening government systems to provide effective and widely accessible protective services to children (which will therefore be available for women to access as well) rather than standalone GBV interventions.

CP Legislative/Service Framework:

A major focus of the CP team’s regular programming in Pakistan is supporting national and provincial governments to build a comprehensive child protection system including a functioning case management and referral system and service provision for child survivors, and those at risk of violence, abuse and neglect (including GBV). This, the team believes in the context in Pakistan where acknowledgement of GBV and therefore provision of services for survivors is negligible, is the necessary first step to putting in place GBV services, and will also provide a system for addressing GBViE in future emergencies.

CP is supporting provincial governments to draft and endorse legislation mandating the development of quality CP systems. The legislation will also provide for the establishment of an oversight mechanism within government to ensure that implementation of the laws is systematic rather than, as now, being dependent on the decisions of individual officials. To address this issue, the CP Chief has been working closely with several provincial governments to develop legislation. Currently a technically sound bill has

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80 PLaCES Concept Note, UNICEF Pakistan, February 2012
81 Given the real time focus of this evaluation, the team reviewed current not past programming.
82 In the Regional Emergency GBV Advisor’s (REGA) mission report, 2014, it was noted that the PLaCES sites visited by the REGA (in southern Sindh and Jalozi Camp) appeared to be implementing a ‘very simple’ model, with no dedicated actions relating to GBV. The report included one UNICEF- specific recommendation that the implementation of the PLaCES model should be enhanced to address GBV specifically.
83 Within the PCO, discussions on ‘GBV’ are acceptable. With national actors, using ‘safety, protection, dignity of women and girls’ is more acceptable, or VAC for children.
84 CP section KII
85 The 2013 CP Unit Assessment Report found that only 5% of CP cases were being reported (95% of the cases reported to CP Units relating to social welfare), and that the referral system was ineffective with a lack of case management and follow up on cases. (Power point presentation to the Government of Gilgit Baltistan: Public Child Protection System, October 2015)
been approved by the Minister for Human Rights in Islamabad Capital Territory, hopefully to be passed this year, which would mean that it might be extended to FATA as a federal statute. A bill for Baluchistan will also be enacted during 2016. The CP section is aiming to support reform of the existing CP Act in KP during 2016. The legal framework, once in place at provincial level, will ensure a more effective delivery of case management and referral services in support of strengthened access to available services for CP and GBV survivors. This is a long term plan, and, in the opinion of the Chief, CP, is likely not to be functional at any level until 2017. As part of this focus, the CP team is engaged in supporting multi-sectoral care of children; training CP actors; monitoring and addressing risks; children and armed conflict; children in conflict with the law and supporting the development and implementation of relevant policies.

The CP section also supports the provincial Social Welfare Department in KP in the delivery of their substantive CPIE mandate together with supporting PDMA with their coordination mandate. The CP section supported the GoP to establish Gender and Child Cells (GCCs) in 2013 by funding the staff within these cells. These cells provide women and children protection desks at embarkation points for displaced populations returning to FATA and are also responsible for other vulnerability gaps such as disability. However the GoP Return and Rehabilitation Strategy (supported by UNDP) does not include gender or GBV and therefore the influence of the GCC within the return strategy is limited.

Protective Learning and Community Emergency Services (PLaCES):
The PCO developed the flagship PLaCES model following the 2011 flooding to address the need for more interaction and complementarity of services to address safety, health and wellbeing of children, adolescents and women, including CP, education, health, and nutrition interventions. The model promotes co-location and closer collaboration between services offered previously at Temporary Learning Centres (TLCs), Child Friendly Spaces (CFss) and Women Friendly Spaces (WFss). As KP/FATA is currently the only area of the country where humanitarian response is being provided, PLaCES are currently only operational in KP/FATA. The GBVIE element of the PLaCES model aims to promote a protective and stimulating environment for women and adolescent girls and boys through community-organized, structured, age- and gender-appropriate activities, relief services and interventions in one location, creating private spaces for women and adolescent girls to be able to discuss and address prevention and response to GBVIE. Within PLaCES, men are engaged through Child Protection Committees (CPCs) as community volunteers and change agents.

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86 The bill already passed in KP (2010) requires some revision to ensure that it is in line with international standards and law.
87 One important ethical concern when undertaking community mobilization related to GBV is to ensure the availability of services for any survivor who may come forward during the mobilization process.
88 As part of ensuring progress on legal frameworks, the CP section are advocating using the leverage of the Gender Scheme of Preferences under the trading agreement between Pakistan and the European Union. Under this scheme, countries have preferential trading status with the European Union, but this is conditional on meaningful implementation of the human rights treaties already ratified by the government. In the case of Pakistan this is 27 treaties, including on child protection and gender equality. Pakistan was admitted to this scheme in 2011 and there is considerable political will to show progress in line with the treaty terms. Countries have been excluded from the treaty in recent years for not meeting the conditions. The Chief Minister of Punjab and the Prime Minister have commercial backgrounds, and so are keen to have access to the EU market. Sri Lanka was excluded for not meeting treaty conditions last year, so they are aware that the conditions will be upheld. (KII, CP section)
89 UNICEF KII
90 KII, GCC
91 KII, RC, KII, GCC
The PLaCES model represented a significant advance on more traditional CFSSs which tend to focus on younger children. PLaCES aimed to allow increased access particularly for adolescents, whilst ensuring maximisation of a protective space for all girls, boys, and women in those areas where it was implemented following the severe flooding of 2011.

At the time of the evaluation mission, UNICEF was implementing four CPIE projects, all of which focused on establishing PLaCES through which outreach services and community-based social structures were to be established, including CPCs and Adolescent Groups, aiming to strengthen the protective environment including existing protection mechanisms and other social justice structures and services for children which have been undermined. 50 PLaCES were operational, all in KP/FATA. Numbers attending PLaCES reported in the Protection Cluster quarterly report (October-December 2015) as part of the CP response were 25,157 girls, 30,708 boys, and 15,264 women. However, these figures differed from those reported by the PCO at: 55,978 “children and caregivers” accessing PLaCES in 2015 (18,852 girls, 22,695 boys, and 14,431 women).

**IKEA Foundation Regional Adolescent Programme:**
Regionally, one of the CP priorities is child marriage. Pakistan is one of three countries implementing the regional programme, as part of the regular programme outside the humanitarian response. The project: *Improving adolescents’ lives in South Asia – A multi-country project to reduce the vulnerability of adolescents and increase their autonomy over decisions impacting their lives in Afghanistan, India and Pakistan*, is funded by the IKEA Foundation programme. The project will target adolescents in four districts of Punjab and Sindh provinces. The areas of adolescence which will be addressed include child marriage, sexual and reproductive health and prevailing attitudes condoning domestic violence and abuse. In addition to adolescents themselves, the project aims to mobilize community members, families and socio-cultural influences to address these issues. A baseline study was conducted in January 2016 and the project document is being revised in the light of these findings.

**Training of CPIE/GBVIE specialists**
Recently, supported by UNICEF, the FDMA GCC and the University of Peshawar signed a Memorandum of Understanding (MOU) to develop and incorporate courses on CP and GBV within the University curriculum, including a six-month diploma course. This aims to address the chronic shortage of trained CP and GBV professionals within Pakistan who are equipped to engage in regular and emergency CP and GBV prevention and response. The MOU has not yet been actioned.

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92 UNICEF KII
93 Since the evaluation mission, the PLaCES model is in process of revision to make it more appropriate for the protracted emergency. Mobile services will provide training for children, families and communities to build knowledge and understanding on how to take responsibility for their personal safety, as well as raising awareness on other CP issues (birth registration, land mine education etc). Various different media will be used (video, puppets, games, toys etc). Staff will be trained to refer children and women from the communities visited to appropriate services. The present static PLaCES projects will continue for the currently agreed duration and will be phased out and replaced by the mobile model. (KII CP Chief)
94 20 in Bannu District; 15 in North Waziristan Agency; and 15 in Kurram Agency
95 Protection Cluster quarterly report October-December 2015
97 UNICEF Regional Office of South Asia (ROSA)
98 This project is being implemented across Pakistan, Afghanistan and India with a total target of 3.5 million beneficiaries (direct and indirect) in Pakistan. The project started in January 2015 although Year 1 was planning and baseline so no results are available. Furthermore, it is not an emergency response programme and it is not being implemented in KP.
Education
One focus of the UNICEF Education in Emergency (EiE) intervention is to encourage more displaced girls to attend schools. While remaining in school is believed to contribute to lower rates of child marriage for girls, this aim is not explicit in the EiE programme. The education programme uses the INEE (Inter-Agency Network for Education in Emergencies) guidance for protection standards rather than the GBV Guidelines. The INEE Guidelines focus on physical safety eg building boundary walls, rather than protection from GBV.99

Health
UNICEF Health Section, in coordination with UNFPA, have supported the Ministry of National Health Services, Regulations & Coordination (MoNHSR&C) in conducting training for health staff across disaster-prone districts in 2015, on various subjects including the Minimum Initial Service Package (MISP) for reproductive health which includes training on some actions to prevent and respond to GBV.100

WASH
WASH is implementing emergency interventions in host communities, camps, embarkation points for return, and returnee areas which include siting male and female washrooms separately and taking into account sub-tribal cultural requirements of women not encountering men outside of their family or tribe, and locks fitted on the inside of latrine doors.101

In the regular programme, the provision of separate WASH facilities for girls in schools is a CO WASH priority, with the aim of supporting more girls to remain in school past primary level, linked to reducing child marriage.

A Regional Office (RO) and CO WASH priority for regular programming is to combat open defecation through the provision of more latrines. A CO study on the correlation between reductions in open defecation and GBV incidence was planned but has been put on hold.102

3.3.3 Programme Funding
In 2015 PCO had an allocated budget of USD 132 million, of which USD 94 million (71%) was spent.103
In total PCO humanitarian expenditure was USD 16.45 million of which CP received USD 0.72 million (4%).104 There are no figures for expenditure on GBV, as no dedicated programmes were implemented.

4 EVALUATION FINDINGS
The section on evaluation findings addresses the evaluation questions related to the respective evaluation criteria in the ToR and Inception Report.

99 UNICEF Education KII
100 MISP is a set of priority actions to be implemented at the onset of a crisis, and scaled up throughout protracted crisis and recovery to prevent ill-health and death associated with reproductive health. MISP includes prevention and actions to manage the consequences of sexual violence. (Minimum Initial Service Package for Reproductive Health: A Distance Learning Module, WRC, published September 2006, revised February 2011)
101 UNICEF KII
102 UNICEF KII; the respondent believed the study had been put on hold due to a broader-based study being planned but had no further information
103 UNICEF COAR 2015: note, UNICEF COAR summary document (finalised) provides a figure of $124 million (94%) spent. However, UNICEF COAR additional one page Financial Resources provides a figure of $94 million (71%) spent together with the other financial data included in this report.
104 ibid
4.1 Relevance

Alignment of UNICEF programming with assessed needs of beneficiaries (which may change over time), good GBViE programme practice and relevant UNICEF strategies and policies.

Alignment with assessed needs

The UNICEF CCPD is aligned with national development priorities reflected in the Pakistan Framework for Economic Growth and in the One United Nations Programme. Within this framework, UNDP, UNFPA and UNICEF work closely together, and collaborate with the rest of the United Nations country team and other development partners to provide coherent and complementary policy and institutional support to the GoP.

Despite the widespread and entrenched nature of GBV within Pakistan, addressing GBV is not a CO priority for UNICEF’s emergency or regular programming. As noted above, the focus of the CP section is on building a legislative framework in the different provinces for CP which is aligned with international good practice for CP. This is seen as the first step, and will incorporate some provision of GBV services for survivors. Once this framework is in place, the team consider that GBV can be tackled more comprehensively.

The level of CO understanding of GBV is generally weak.\(^{105}\) The COAR 2015 does not reference GBV\(^{106}\) at all (GBV is not a listed acronym). PLaCES is referred to exclusively as a CP intervention with no reference to women in the Executive Summary or the CP Section programme outline – “In response to the on-going humanitarian crisis in KP and FATA, the programme partnered with CSOs to effectively deliver the Protective Learning and Community Emergency Services (PLaCES) model in hard-to-reach areas of northwest Pakistan to support affected children’s access to protective services.”\(^{107}\) This lack of focus on GBViE translates into an absence of questions relating to GBV being included in UNICEF sector needs assessments, and the absence of a discussion of GBV risks, and how to prevent, mitigate and response to GBV issues in programme plans.

GBV integration across UNICEF sections

In the EiE programme in KP/FATA for displaced children attending schools, UNICEF is committed to encouraging them to remain in education for longer than they otherwise would in their home areas, providing a safe environment for those attending school and, it is hoped, delaying the age at which girls are married. However, 2015 results state that 52,796 children and adolescents (figure not sex disaggregated) accessed education services in KP and FATA out of 0.5 million which is the education sector target.\(^{108}\)\(^ {109}\) The EiE programmes have been developed with reference to the Inter-Agency Network for Education in Emergencies (INEE) gender standards. There is no reference to either the 2005 or 2015 IASC GBViE Guidelines for integrating GBViE.\(^ {110}\) FGD participants of all ages agreed that sending girls to secondary schools was very problematic because of the need for them to travel separately from males (even their brothers) which was agreed to be too expensive for all but a very few families.

\(^{105}\) UNICEF KII\(s\)

\(^{106}\) UNICEF COAR 2015

\(^{107}\) ibid

\(^{108}\) ibid

\(^{109}\) Humanitarian Needs Overview 2016

\(^{110}\) UNICEF Education KII\(s\)
The education section in Islamabad had attended training on the 2015 IASC GBViE Guidelines and said they would like to replicate this for the Education Cluster in Peshawar.\textsuperscript{111} However, no action has been taken on this.

3,525 health staff have been trained in disaster prone areas by UNICEF, UNFPA and the Ministry of National Health Services, Regulations & Coordination (MoNHSR&C), including training on the MISP, which is one recommendation included in the health thematic area guidelines (TAG) of the 2015 IASC GBViE Guidelines.\textsuperscript{112, 113} However, the PCO health programme does not address GBV explicitly at all.

As with the EiE programme, the WASH emergency response includes activities which contribute to GBViE risk mitigation, although this is not an explicit objective of the WASH response. Actions such as segregated wash rooms and locks inside latrines are understood by the WASH team as being good practice in terms of cultural sensitivity rather than relating to mitigating risks of GBV. However, the programmes have been flexible in terms of responding to beneficiary needs. For example, female latrines in Jalozai refugee camp\textsuperscript{114} were initially sited near the road. After consultation with women and girls, it became clear that it was difficult for them to access these because they might be seen by men who are not members of their family, so UNICEF re-sited the latrines to a more appropriate location.\textsuperscript{115} The regular WASH programme focus also includes menstrual hygiene management (MHM) for girls in schools.\textsuperscript{116}

\textbf{Lack of clarity on GBV and UNICEF’s commitments}

Overall, there is a real lack of clarity on what GBV is, among many staff in the PCO, in all sections and at all levels. Gender appears to be quite well understood, but few staff understood the differences between gender and GBV.\textsuperscript{117} Several interviewees asked what GBV is during interviews, none were aware of UNICEF’s definition of GBV or the agency’s mandate and responsibilities with reference to GBViE except some members of the CP team. Staff reference GBV, if at all, through Gender Marker tip sheets.\textsuperscript{118} There is almost universal agreement within the CO that there is a need for much greater clarity at all levels of UNICEF on how corporate commitments and responsibilities should be interpreted in terms of foci for advocacy, priority themes, and standard programmes. However, a newly appointed Gender Advisor had arrived in the PCO the week before the evaluation mission, reflecting a resolve to strengthen programming on gender equality within the PCO.

\textbf{Theory of Change}

There is no regional or country-specific GBViE ToC. As there are no targeted GBV interventions in the humanitarian response being implemented by UNICEF, the three core roles are not being addressed, namely: (i) Strengthening humanitarian action on GBV; (ii) supporting the state and other duty-bearers to uphold responsibilities to address GBV; (iii) supporting civil society to address GBV. Similarly, there are no targeted GBV interventions at the strategic intervention level. The only intervention which is explicitly

\footnotesize\textsuperscript{111} As national clusters are not currently active in Islamabad. Only KP provincial clusters are active.

\footnotesize\textsuperscript{112} UNICEF COAR 2015 – for number of staff; COAR does not reference MISP; UNICEF and MoNHSRC KIIs referenced MISP

\footnotesize\textsuperscript{113} UNFPA and WHO conduct SPRINT training with the MoNHSR&C, but not UNICEF. SPRINT was designed to address gaps in the implementation of MISP and trains humanitarian workers to deal with pregnancy, childbirth, reproductive health, and the aftermath of rape and violence. (http://www.ippf-sprint.org/aboutus/)

\footnotesize\textsuperscript{114} The evaluation team was scheduled to visit Jalozai Camp but the Government did not issue an NOC and therefore the visit could not take place

\footnotesize\textsuperscript{115} UNICEF KII

\footnotesize\textsuperscript{116} UNICEF KII and COAR 2015; neither KII nor COAR provided figures for numbers reached.

\footnotesize\textsuperscript{117} UNICEF KIIs

\footnotesize\textsuperscript{118} PCAs include a commitment by IPs to having gender balanced teams (although this is often not achievable within the context of KP/FATA (UNICEF KIIs)}
linked to GBV is the EiE aim of encouraging girls to remain in school longer to delay the age of marriage, and as figures above show, only 1/10th of IDP children and adolescents of both sexes enrolled in primary school in FATA. Any risk mitigation results within the WASH programme (ie siting latrines where women will use them – see above) are not aimed at mitigating risks of GBV. As far as the team are aware, no community safety assessments are being conducted relating to GBV, dignity kit distribution is done by UNFPA, and there is no targeted advocacy by the PCO with duty bearers relating to GBV. UNICEF is not supporting provision of services for GBV survivor except through their support for developing CP systems, and is not addressing the social norms which underlie the very high levels of GBV against women and girls.

Cultural Relevance
As a general point of relevance for GBV programming in Pakistan, and considering the extreme cultural and religious sensitivity around discussing GBV issues within Pakistan, a number of national informants stressed that it is imperative that any GBV intervention is designed in a way which is contextually appropriate, both in terms of the intervention per se and the medium of its delivery. For example, approaching male tribal leaders among displaced people and using their own traditional community meeting structures, or using language which supports widely held religious views (such as the Koran’s teaching regarding the protection of vulnerable persons) was described as a way to gain community leaders’ buy-in and support for projects which target the female members of their community.

4.2 Effectiveness
The extent to which the programme/activity is achieving or is likely to achieve its stated purposes, on the basis of outputs delivered.

There is universal agreement that delivering good protection programmes and monitoring their effectiveness is extremely difficult in KP/FATA areas of displacement and return, due to serious challenges over security, access and generally poor quality of potential IPs.\textsuperscript{119} The PLaCES model, as it was being implemented, was not effective in delivering GBViE (and CP) programmes.\textsuperscript{120}

Improved access to GBV services
The PLaCES were not providing services as planned due to both contextual challenges and also very limited capacity of IPs in the area. There is very limited access for UNICEF staff (national and international) and IPs to the areas where the emergency response is most needed because of ongoing military activities and resultant restrictions on movement.\textsuperscript{121} In addition, the capacity of IPs working in KP/FATA is generally low, lacking the technical skills to deal with more complex components of the model, so they focus on more superficial activities.\textsuperscript{122} Challenges related to monitoring (see further discussion below) also mean that there is very limited data on programme effectiveness/quality/progress on desired results is difficult to establish.\textsuperscript{123} All of this is compounded by the very limited numbers of protection professionals, (psychosocial counsellors, medical professionals and teachers) who are willing to work in KP/FATA, with very few women among them.\textsuperscript{124} Given that women and girls cannot meet with male service providers,

\textsuperscript{119}This is not a UNICEF-specific issue and is on the HCT agenda to try and find a system-wide solution.

\textsuperscript{120}As noted above, since the evaluation mission an assessment of the PLaCES model has concluded that, in the KP/FATA context, static services provision is not effective given the serious constraints on security/access for UNICEF staff, partners, and the quality of IPs available (see further discussion below). Hence the revision of the model. this

\textsuperscript{121}Non-Objection Certificates had to be obtained for movements in the areas from the Government.

\textsuperscript{122}Protection Cluster partner KII

\textsuperscript{123}Since the evaluation mission, the Chief CP visited the PLaCES and was ‘very disappointed.’

\textsuperscript{124}Cultural restrictions on women’s movement in this very conservative part of Pakistan make it extremely difficult for women to work professionally, especially in the areas of displacement and particularly in the areas of return. The CP Chief is aware of around 300 qualified psychologists operating in KP/FATA, but no figures are available for how many of these are women.
the dearth of female professionals significantly limits service provision for girls and women. Psycho-social support (PSS) is being offered in some PLaCES including by a few female psychosocial counsellors, but, given the lack of any reliable monitoring (see below discussion on evidence), the evaluation couldn’t establish whether any of this was provided to survivors of GBV. Case management is not being offered through PLaCES.

**GBV prevention and risk mitigation**

The protection activities delivered through PLaCES in KP/FATA focus on discussion and awareness-raising, and some PSS, which is mainly for boys (given the shortage of female professionals). While raising awareness of GBV in societies where it is not recognised and spoken about is important, the programming appeared to be extremely basic in part because of the extreme sensitivities around protection issues, and – as discussed below – the PCO have no way of assessing the quality of this element of the programme, or whether it is making any difference to the beneficiaries, because of shortcomings in the monitoring systems.

Male FGD IDP participants reported that they are happy for their children to attend the PLaCES in Bannu, as long as the discussions and information shared are aligned with teachings from the Koran (they cited the messaging about not engaging in drugs). By contrast, in the adult women’s FGD among the same IDP community, one participant said that there was nowhere she could go for assistance for domestic violence, and no services. This was despite the fact that the FGD was being conducted next door to the PLaCES site – in which the FGDs for men and adolescent boys were being held. The same group of women were adamant that the PLaCES next door was for men and adolescent boys, and this was confirmed by the IP staff, clearly highlighting a confusion in implementation, and who also reported that a PLaCES would be opening shortly for women and adolescent girls. Adolescent girls from the host community had never heard of PLaCES. This strongly indicates that messaging about the target group and aim of PLaCES is not being effectively conveyed within this community.

Over the longer term, there is scope for closer engagement between Communication for Development (C4D) and GBV as part of broader prevention programming to address social norms and behaviours which accept present levels of GBV. UNICEF Pakistan is already using some innovative communication

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125 This is, indeed, surprising, as men are not the target beneficiaries of PLaCES. The Concept Note states that: “The main participants and beneficiaries in PLaCES are girls and boys, female and male adolescents up to 18 years old, and women... PLaCES also encourage the engagement of men through Child Protection Committees (as community volunteers) and as change agents, where men reflect on harmful practices against children and women and promote positive, alternative behaviour.” (PLaCES Concept Note, UNICEF Pakistan, February 2012)

126 FGDs were organised by IP and – remotely – UNICEF CP staff in Peshawar before the evaluation visit took place following conversations between the focal point and evaluation team in preparation for the mission: whilst all participants were beneficiaries of UNICEF emergency programme interventions, none of the women or girls participating had received services through the PLaCES. The female participants had had contact with PLaCES through their sons who participated. However, according to UNICEF COAR 2015 figures, women and children are accessing services through PLaCES (see Section 4.5, Coverage)

127 For example, developing a series of messages on GBV prevention and information on service provision provided confidentiality could be assured; or by developing radio programmes/soaps on issues related to GBV (learning from experience in other countries – eg South Sudan where radio broadcasts on family issues such as polygamy/supporting girls to finish secondary school) have been developed as part of the global Peacebuilding, Education and Advocacy programme.
media channels within other country programmes. However, these would need to be developed after careful assessments to ensure that media are used which will reach the target beneficiaries.\textsuperscript{128,129}

**Clarity of programme objectives**

There are no clearly articulated GBV related programme objectives for PLaCES in KP/FATA; and on a recent visit to the PLaCES in KP/FATA, the Chief, CP was ‘disappointed’ with the project performance. The CP team consider that the static model of PLaCES, while appropriate in the early stages of emergency relief, is less appropriate for a protracted emergency where there are serious access constraints for implementers (IP and UNICEF staff) and for beneficiaries to access the PLaCES – hence the change to a mobile model in KP/FATA.\textsuperscript{130}

**Capturing and use of programme results**

Monitoring has been an area of comparative weakness within UNICEF Pakistan. This is recognised by the recently arrived Chief of Planning, Monitoring, Evaluation and Reporting (PMER) and strengthening monitoring systems is now a PMER priority for the country programme as a whole.\textsuperscript{131}

Due to the difficulty of access for UN staff members, and to some extent national staff, to many parts of KP/FATA,\textsuperscript{132} and the lack of skilled IPs, the PCO uses Third Party Monitoring (TPM). While this can be a good solution in situations of very restricted access, in KP/FATA, it is mostly a ‘tick box’ exercise and provides little real information on the quality of services being delivered. Additionally, the third party field monitors have no technical skills to assess whether programmes are appropriate in terms of good protection programming, and do not report on whether activities are being implemented according to agreed work plans.\textsuperscript{133}

The TPM reports do not provide numbers of services or participants. The reports summarise the number of sites visited (eg for the March 2016 report, 109 Education sites, 16 CP sites, and 11 Nutrition sites) and the number of ‘High risk gaps’ and ‘Low risk gaps’ identified.\textsuperscript{134} High risk gaps for CP PLaCES included comments for different sites such as “No activity were found, and also no staff member present” and “Today was adolescent committee meeting in plan but meeting was not conducted and the CPF response

\textsuperscript{128} Research conducted on the potential of U-report as part of the baseline study of the IKEA funded programming on adolescents in Pakistan found that very low levels of adolescents/young people who are not from privileged groups have access to mobile phones in Pakistan. Of this low number, only a fraction are girls (0.002%), so as tools to report on or influence those most at risk of GBV, the reach of mobile phones is limited. However, UNICEF could draw on its experience other C4D media to engage with young people on attitudes and social norms which normalise GBV and to challenge them.\textsuperscript{129} The C4D team is currently one international staff member.

The original design was implemented in the 2011 floods in Sindh and Province where both access and local capacity are much higher; there are many more service providers available (including female service providers) for a genuine case management system and referral pathway to be implemented; and there is less cultural rigidity of restriction on women and girls’ behaviour and mobility than there is within the displaced Pashtun communities in KP/FATA.

\textsuperscript{130} It should be noted that the original design was implemented in the 2011 floods in Sindh and Province where both access and local capacity are much higher; there are many more service providers available (including female service providers) for a genuine case management system and referral pathway to be implemented; and there is less cultural rigidity of restriction on women and girls’ behaviour and mobility than there is within the displaced Pashtun communities in KP/FATA.

\textsuperscript{131} UNICEF PMER KII

\textsuperscript{132} All UN staff members, but national and international, require a Government-issued NOC (No Objection – to travel – Certificate). There are many challenges with the issuance of these NOCs, with many Islamabad and Peshawar-based staff reporting that they have not been able to visit displacement project sites for more than six months; and few staff having ever visited any of the returnee sites in FATA – UNICEF KIIs. Reportedly, the challenges relating to difficulties of accessing project areas have been discussed on several occasions by the HCT, but without any agreement being reached on how they can be addressed.

\textsuperscript{133} UNICEF, UNFPA, Protection Cluster KIIs

\textsuperscript{134} TPM Report March 2016- which included 52 high risk gaps and 93 low risk gaps across the three sectors
that committees were not formed”. All TPM responses to these gaps were that “Debriefing with partner held and issues will be resolved” but it is unclear as to how these issues are followed up on a monthly basis by PCO.

Leadership contribution
GBViE is not a focus of advocacy for UNICEF Pakistan, outside the support to provincial governments to establish effective legal and service frameworks for CP. Advocacy on GBV is a challenge in Pakistan, given the hostile attitudes of conservative groups to issues which challenge the status quo, in particular issues relating to women’s equality and empowerment. For example, the National Commission on the Status of Women in Pakistan was planning the first nationwide survey on violence against women and adolescent girls, with support from with UNDP, UNFPA, and UNICEF at the time of the evaluation mission. Subsequently, the team has been informed that the survey will be conducted in the Punjab rather than nationally.

The evaluation team noted that, at the INGAD meeting, donors who are normally strong advocates for gender equality and addressing GBViE appeared reticent to engage in Pakistan because of the ‘push back’ they expected from Government. However, given the pervasiveness of the issue, and the negative impact GBV has on equity, human rights, community recovery and long term development, real clarity on how UNICEF’s can integrate GBV across the whole emergency response through all sections would support a much more effective programme, albeit approached in programming which is more acceptable to the government and cultural guardians. The CP programme of support for legal frameworks and systems is one approach which could be strengthened and replicated across all sections.

4.3 Efficiency
Measure of outputs versus inputs in terms of having appropriate levels of financial and human resource capacity in place, both within UNICEF and via implementing partners, and how well these have been used to generate outputs.

Funding and Human Resources
In 2015 PCO had an allocated budget of USD 132 million, of which USD 94 million (71%) was spent. “In the context of a changing humanitarian situation, UNICEF increased development expenditures significantly relative to 2014, while humanitarian expenditures fell to almost half.”

In total the humanitarian expenditure was $16.45 million of which CP received 0.72 million (4%).

There are no GBViE staff within PCO and no GBViE budget.

135 IPs reported that, because of the security situation in which the Pakistan army will inform communities and IPs at short notice that military operations will be taking place, so they either have to leave the area or cannot implement the programme for the period of the operation, programmes are sometimes halted or interrupted.
136 UNICEF COAR 2015: note, UNICEF COAR summary document (finalised) provides a figure of $124 million (94%) spent. However, UNICEF COAR additional one page Financial Resources provides a figure of $94 million (71%) spent together with the other financial data included in this report.
137 Ibid
**Value for money**
The cost of establishing and implementing PLaCES has previously been estimated at $11 per capita, 138, 139, 140 However, these figures do not relate to the current PLaCES being implemented in KP/FATA which is an entirely different context, and are therefore not indicative of current costs.

One of the rationales for the revision of the current, static PLaCES model is that it is a waste of resources, and that the mobile model will deliver far better value for money in the context of the protracted emergency in the context of KP/FATA.

### 4.4 Sustainability / Connectedness

*To what extent emergency response activities take into account and support a longer-term approach, including in connection with UNICEF’s regular development programming.*

**Linking emergency and longer-term programming**

UNICEF are supporting the various levels of Disaster Management Agencies (at national, provincial and district level), including the FATA Disaster Management Agency (FDMA)141 within the current emergency response, including funding the Gender and Child Cells to fulfil their coordination mandate, and – going forward - will work with FDMA and the Department of Social Welfare in FATA to deliver the mobile PLaCES model.

However, in terms of sustainable programming for GBV *per se*, at the time of the evaluation mission, there were few indications of sustainability and connectedness in terms of GBV focused programming, either within UNICEF’s programming or through previous UNICEF contributions to the wider GBVIE response. The PLaCES model was developed with the aim of incorporating elements of sustainability.142 However, in the current response, PLaCES are not functioning effectively in KP/FATA (as discussed above). Even in other parts of Pakistan, where PLaCES was implemented in Sindh and Punjab following the major floods of 2011 and 2012, these had closed down with the cessation of UNICEF funding. Whether there have been any lasting changes in attitudes for those who participated in PLaCES programming when it was operational in Sindh and Punjab, no assessments have been made.

The mobile model currently being developed appears, in theory, to be more appropriate and therefore sustainable to the context in KP/FATA. Part of the revised focus is on supporting the Government of FATA143 to deliver the services, (as they control access to these militarised areas of the country), with the objective that they will, eventually, take over full responsibility for the provision of these services. As the

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138 According to a Lessons Learned from PLaCES report, 2012 – unseen, referenced in February 2014 UNICEF are Study on UNICEF's integrated approach to programming in humanitarian action. It was not possible to verify this figure of $11 per capita and PCO has no current unit cost for the PLaCES intervention

139 According to a 2013 lessons-learned paper on PLaCES (Lessons Learned from Protective Learning and Community Emergency Services (PLaCES), 2012), the approach has proven cost effective in Sindh with more women and children being reached, using limited funds, than would have been possible outside of PLaCES

140 Cost effectiveness and efficiency were one of the objectives of the PLaCES implemented in Sindh and Punjab with 90% of TLCs were established within PLaCES during the 2011 floods, thus ensuring cost-sharing between CP and Education and making the best use out of the space (CPiE Evaluation April 2013)

141 The DMAs are responsible for leading on the coordination of emergency response

142 According to the concept note, PLaCES are designed ‘to travel with their communities’ as they return home, through the existence of Child Protection Committees and Adolescent Groups which, it was hoped, would continue to promote the attitudes and learning gained by IDPs while they were displaced, when they return to their original communities.

143 As the revised model will be rolled out first in FATA, but this would be the focus in other parts of the country where thisx mobile model was used.
Government of FATA already has systems in place to monitor provincial government activities, the focus on supporting them is also designed to strengthen programme monitoring for mobile PLaCES. The revised model for protracted emergencies will incorporate training on monitoring, including developing monitoring templates which will also be aligned with CP data systems more generally.

Currently, the PCO conducts no capacity building on GBViE, although the recently signed MOU with the University of Peshawar is promising. GBViE training could, however, be included routinely in a number of existing partnership arrangements: eg as a matter of routine with all IPs signing PCAs; and as one element of Contingency Programme Cooperation Agreements (CPCA) which are signed with CSO and NGO partners and can be activated within 24 hours in the event of a disaster. (These agreements are valid for one year, renewable, which is means there is immediate capacity for emergency response - a good preparedness practice). PCO, in partnership with the Asian Disaster Preparedness Centre, conduct training for NDMA annually. Currently the training includes no GBViE, but a GBViE module could be included.

UNICEF’s current response projects in return areas include the stated aim to strengthen awareness of CPC and adolescent group members to recognise possible CP cases/incidents and refer these to PLaCES projects and CP Units. The projects also aim to build capacities and networks between relevant government departments and NGOs, political administration and partners’ groups, including the Protection Cluster and the CP and GBV SCs; and to mobilize duty-bearers, rights holders, relevant stakeholders and influential individuals. However, given the lack of reliable monitoring evidence, it is not possible to assess how effectively these elements of the projects are being implemented or whether they include any aspects of GBViE. Again, no specific GBViE capacity development is included in the design of these projects.

Partnerships with civil society and government
The Peshawar GCC, supported by UNICEF, has recently signed a MoU with the University of Peshawar to include GBV and CPIE in various courses, including a six-month diploma course for development students.

The Gender and Child Cells in the national, provincial and FATA disaster management agencies were funded by UN Women and are now being funded by UNICEF. The GCCs have potential as partners for GBV coordination but their mandate is not operational.

4.5 Coordination
The extent/nature of UNICEF CO programming contribution to realizing GBV-sector strategies/plans/priorities and how UNICEF has added value to/been affected by the GBV sector response within the CO and across the response as a whole.

The activation of the first GBV SC in 2010 jointly by UNICEF and UNFPA created a space to discuss GBViE as a regular part of the humanitarian response for the first time, including within the GoP. In the words of a previous GBV SC coordinator: “Back in 2010 we couldn’t even talk about [GBV] with Government, but now we can.” This space has remained, in part due to the continued nominal existence of the GBV SC in Peshawar, although – as discussed above – the means of addressing GBV need to be culturally sensitive.

UNICEF’s added value to the GBV sector
Currently, there is extremely limited coordination on GBViE between UNICEF and other partners, and within UNICEF amongst programme sections. Since UNICEF’s withdrawal from SC co-leadership, and although UNICEF technically remains a member of the sub-national GBV SC, there has been very limited

144 UNICEF CP KIIs
engagement by UNICEF staff in the GBV SC mechanism. Various PCO staff in Islamabad and in Peshawar were not aware that there was an active GBV SC, despite the fact that there are UNFPA GBV Coordinator positions in Islamabad and Peshawar (dual role positions). Many UNICEF staff were not aware that UNICEF co-led the GBV SC at the global level, or that UNICEF has organisational commitments to address GBV. They considered that “GBViE is solely a UNFPA mandate.”

The Protection Cluster Coordinator reported that the CP and GBV SCs had worked closely with the Protection Cluster in the early years of the response, citing a joint proposal between UNICEF and UNFPA submitted to address GBV and CP issues in Bannu. (Although, once funding was received, activities were implemented separately.) There is no coordination between the two SC now. CP and GBV SCs did report jointly on 4Ws until 2015; however because of major delays in submitting data from the GBV SC to the Protection Cluster, and a general deterioration of relationships, GBV SC, CP SC, and the Protection Cluster will all be reporting separately on 4Ws against the humanitarian plan in 2016.

UNICEF is perceived by other protection actors as focusing entirely on CP rather than GBV, and child survivors cannot yet be referred to appropriate services in a coordinated manner because no system exists yet to do this. In certain areas within refugee camps UNICEF PlACES and UN Women and UNFPA joint WFSs exist virtually next door, but there is no coordination of activities between them.

Complicating the situation further, there is general confusion around GBV coordination within Pakistan. The official GBV SC currently exists only in Peshawar, led by UNFPA. However, there is a national SGBV WG in Islamabad, led by UNHCR and American Refugee Committee (ARC). The purpose of this WG is purportedly different from the SC in that it focuses on new policy and research, although this was contradicted by the GBV SC Coordinator who believed the SGBV WG under ARC and UNHCR focused solely on refugees. UNICEF is a member of this SGBV WG, although, to date, no specific achievements have been reported.

Observations made in the 2014 Regional Emergency GBV Advisor (REGA) mission report on the need for strong support among GBV SC members for sustained advocacy, mobilization of funding and promoting long term response service provision have not been acted on given the virtual cessation of SC activity. The report states that “The complexity of the response in KP/FATA requires GBV programmes and coordination which responds to ongoing displacement and returns, needs of IDPs in host communities, a longer term approach, and greater engagement with the development sector to address unmet pre-existing needs and vulnerabilities.” This analysis remains pertinent, two years on, and is being addressed to some extent through the CP team’s work on supporting the government to put a sustainable system for CP in place.

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145 UNICEF and GBV SC member and coordinator KIIs
146 UNICEF KIIs
147 UNICEF KIIs
148 Protection Cluster Coordinator KII
149 Protection Cluster and GBV SC member and coordinator KIIs
150 WFS were renamed ‘Women Facilitation Centres’ by the Secretary for Social Welfare & Women’s Empowerment KP as the translation of WFS into Pashtun has negative connotations. UN Women led WFS provided women with PSS and caretakers were trained in first aid psychosocial support. UNFPA led WFS focused on reproductive health (RH) and PSS. Referrals were made between the UN Women and UNFPA WFS. Interestingly, the men in Jalozai refugee camp protested when contraceptive/RH services were discontinued in the camp. They had had no awareness of them before this service.
151 This is perhaps because ARC’s current KP/FATA project focuses on refugees.
152 REGAs are inter-agency GBViE Advisors which are based with the UNFPA ROs and whose support can be requested for short mission by the inter-agency coordination mechanism for the GBV sector.
While the scope of this evaluation does not include an evaluation of the GBV SC function, it is of note that the REGA mission in 2014 recommended holding a joint workshop between SC partners to agree an action plan for GBViE response, relating specifically to a need to establish or revise: (i) incident reporting forms; (ii) information sharing protocols; (iii) mapping and assessment of services; (iv) other Information Management (IM) tools; (v) development of key messages; and (vi) guidelines/minimum standards for women and girls safe spaces. At the time of this evaluation mission, UNICEF was not engaged in any of these activities. The Protection Cluster quarterly report October-December 2015 references UNICEF and PLaCES squarely under CP, and UNFPA Women Friendly Health Spaces (WFHS), UNFPA Women Protection Desks, UNFPA mobile protection desks, and UNFPA dignity kits under GBV.

4.6 Coverage
The extent of UNICEF’s programming reach (geographic and numerical) compared with the needs of those at risk of or affected by GBV as assessed by UNICEF and/or the GBV sector as a whole. Given the lack of evidence, it is impossible to have any clarity on the extent and coverage of GBViE interventions. UNICEF reported 55,978 “children and caregivers” accessing PLaCES in 2015 (18,852 girls, 22,695 boys, and 14,431 women). There is no data available for how these numbers compare with the need, or to any particular demographic gaps. An absence of age and sex disaggregation in these figures means it is also impossible to see how many adolescents are attending PLaCES. Once the law is reformed and implemented in KP, and developed in FATA, a CPIMS system will be established.

There current PLaCes are in Bannu District, North Waziristan Agency and Kurram Agency. These areas were identified as being high need areas in the inter-cluster assessments which were conducted in September 2015 by health, education, WASH, shelter and protection because of the level of destruction of infrastructure as a result of military action.

5 PROTECTION OF SEXUAL EXPLOITATION AND ABUSE (PSEA)
Most UNICEF staff questioned were generally aware of PSEA and believed procedures to be in place, none outlined what the procedures were, had had any specific training, or were aware of any cases being reported either within UNICEF or more broadly within the humanitarian system.

IOM has provided training on PSEA, though not to UNICEF staff, and UN Women are currently advocating for more focus on PSEA. The RC quoted other UN and INGO staff as reportedly saying “this is not Africa” in response to any PSEA discussion, and several UNICEF staff reported that SEA was not an issue in Pakistan.

There has been no PSEA focal point in PCO until January 2016 when the new Gender Advisor arrived and was allocated the role.

154 COAR 2015
155 These figures do not align with the 3 month figures provided in the Protection Cluster quarterly report October-December 2015 for UNICEF PLaCES as part of the CP response, and a different figure is given in the CP Section of the COAR (55, 292 – not disaggregated) than in the Summary Results Section of the report, as provided above.
156 RC Office KII
157 ibid
158 UNICEF KII
CONCLUSIONS

1. The child protection (CP) focus in the Pakistan Country Office (PCO) is on protecting children against all forms of violence within the framework of the Sustainable Development Goals 5 and 16. The PCO approach is to address GBV, both for emergency and regular programming, within its broader support to the development and implementation of a legal framework for child protection, including case management and a referral system, which is also aimed at supporting service providers to deliver tailored protective services, including in the emergency/humanitarian context. Apart from this, specialised GBViE programming (as described in the corporate Theory of Change) is not a current focus of the UNICEF response.

2. A lack of clarity among many Pakistan Country Office (PCO) staff at all levels of UNICEF’s mandate, definition, and global responsibilities regarding GBViE, has been a significant constraint in the development of clear GBV objectives across UNICEF Pakistan’s humanitarian response. Addressing this lack of clarity will be important as the process of preparing the new Country Programme Document (CPD) begins in early 2017.

3. There are very significant cultural, legal, and social challenges in tackling GBV for girls and women within Pakistan. Added to this, there are very significant challenges in implementing effective GBViE (and any humanitarian) programming in KP and FATA including very significant security and access constraints for both international and national UNICEF staff and partners; very limited numbers of female professionals working in KP/FATA restricting service provision for girls and women; the generally poor quality of implementing partners in that part of the country; and the challenges associated with monitoring both programme quality and programme results. All these contribute to the lack of effectiveness of GBViE (and CP) programming through the Protective Learning and Community Emergency Services (PLaCES), model which is the main modus operandi for UNICEF CP/GBV emergency response programming.

4. With the exception of the systems building focus in the CP programme, integration of GBV and GBViE across other UNICEF sections is limited, as other UNICEF section response programmes (i.e., WASH, education, health, and CP) have not set out to mitigate risks of GBV, and any contributions to GBV risk mitigation (e.g., delaying the age of marriage by encouraging children to stay longer in schools) are incidental rather than explicit programme objectives. This is largely due to a lack of understanding of UNICEF’s mandate for GBV as a lifesaving element of humanitarian response, lack of knowledge of the recommendations in the 2005 and 2015 IASC GBViE Guidelines, and a lack of specialist GBViE capacity within the CO.

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159 I.e., Gender equality and empowerment of women and girls (5) and promoting just, peaceful and inclusive societies (16).
160 The language of ‘gender’ and ‘GBV’ can often elicit pushback from authorities, whereas they are supportive of initiatives which are addressing ‘violence against children’ and which address Sustainable Development Goals 5 and 16 which include
161 Both medical professionals and those qualified to offer psycho-social support.
162 Given the cultural prohibitions on girls and women meeting men outside their families.
163 Following a recent assessment (conducted by the CP Chief since the evaluation mission), a decision has been taken to modify the model for the on-going protracted emergency in KP/FATA. This will focus on providing support to the GoP/FATA Disaster Management Agency (FDMA) to provide mobile protective services to children, families, and communities on their own involvement in their personal safety as well as for mine risk education and birth registration. See further discussion on this in sections 3.2.2 and 4.2.
5. UNICEF’s approach in leveraging its position as a trusted partner of the Government of Pakistan (GoP), to advocate with the Government to align its legal framework and child protection systems with international standards and good practice is positive. However, the evaluation team consider that addressing GBV as higher priority across UNICEF’s humanitarian response would contribute materially to progress on other UNICEF commitments including the human rights based approach, programming in line with the equity approach and also to the quality of other section programmes and the overall effectiveness of the humanitarian response (as addressing GBV risks inherently involves addressing some of the specific needs of different target beneficiary groups.)

6. GBV sector coordination is poor, with no effective GBV sub-cluster in Peshawar and therefore no coordinated GBViE response as part of the humanitarian action. Despite UNICEF having co-led the cluster when it was first activated in 2010-2011, and still being a member of the SC; UNICEF staff in Peshawar and Islamabad are generally not aware that a GBV SC exists, or that they are a member of it. The situation is compounded nationally by the existence of a number of interagency groups with different and somewhat overlapping foci, and led by different agencies. This means there is no clear, coordinated, leadership for the GBV sector which can work together to address GBV and to advocate as a body with national authorities for a legal framework to be put into place which is aligned with international good practice on GBV. It also means that those actors providing GBV prevention and response are not acting as part of an overall GBV strategy for the sector. Given that UNICEF is co-lead at a global level for GBV, the agency has responsibilities, even in countries where it does not (co-)lead the national/sub-national coordination mechanisms for ensuring a strong, coordinated response.

7. The lack of GBV prioritisation in the regular programme means that there is limited capacity to build on for emergency response. GBV is not a stand-alone priority for the PCO within the regular CP programme. This means there is no focus on GBV-specific preparedness, and that the low levels of existing services for GBV survivors and those at risk are not being strengthened before emergencies compound the situation. The challenges of scaling up GBViE in Pakistan is compounded by the reticence of the GoP to request international assistance for emergency response, which restricts humanitarian space for international actors to provide services to augment national systems. The CP team are addressing the gap in provision of GBV among other CP services and systems through their systems approach, but this will take time to put in place and for the implementation of the frameworks to become effective. While CP is working with the Disaster Management Agencies and other line departments to strengthen their disaster risk reduction capacities for child protection (including VAC and using a gender lens), the pervasiveness of GBV in Pakistan and its negative impact on communities and individuals’ abilities to recover from crisis, would indicate that the programming would be more effective if a higher priority was placed on establishing and strengthening GBViE prevention and response. The CP team has developed a number of good working partnerships with key counterparts in the government to deliver on the CP mandate. Building on these to strengthen GBV prevention and response as one priority of regular programming would provide a more

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164 Including by leveraging the Gender Scheme of Preferences as part of international trade agreements with the European Union. (See below, section 3.3.2 for more details/discussion of advocacy on the Gender Scheme of Preferences.)

165 The evaluation team acknowledges the different perspective from which the CP team is approaching GBV. However, this conclusion is written reflecting the framework of the wider evaluation which, itself, is aligned with the corporate approach to GBV as a standalone priority, albeit housed within the CP programme.

166 Given that there are no headquarters resources for GBV except in emergencies (ie one GBViE Specialist in the Child Protection Section of the Programme Division in New York) this is not unusual. However, it has serious consequences for having a foundation of capacity, partnerships and programmes on which to build an emergency response speedily and effectively.

167 It is widely acknowledged that levels of GBV rise in all crises, in all countries.
substantive foundation for mounting a more comprehensive GBV response in the context of the cyclical emergencies to which Pakistan is subject.

8. There are entry points in existing CO programmes and operations which could be leveraged to address GBV as part of the regular programme and operations as well as setting the foundation to be able to expand GBViE risk mitigation speedily in future emergencies. These include:

- Incorporating explicit GBV risk mitigation activities into current WASH programming to reduce open defecation and to provide separate latrines for boys and girls in schools;
- Expanding the appropriate use of the innovative communication media already being used by the Pakistan Country Office as part of their Communication for Development (C4D) work to transmit appropriate and culturally sensitive messages about GBV prevention and information on services;
- Revising the Emergency Preparedness and Response Plans such that they all include GBV risk mitigation actions using the practical recommendations in the 2015 IASC GBViE Guidelines;
- Including an introduction to GBV routinely into the existing training associated with the Contingency Partner Cooperation Agreements with IPs which are signed to enable very fast activation in emergency settings;
- Including an introduction to GBV routinely in training opportunities for emergency capacity strengthening such as the ongoing training being conducted by the Asian Disaster preparedness Centre for the National Disaster Management Centre. Training modules could be developed with support from the GBViE Specialist in New York.

9. There is a dearth of evidence available to the PCO to inform GBViE programming, and monitoring of existing protection projects is very weak because of the poor calibre of implementing partners in KP/FATA and the use of third party monitors who have no training in protection and work with checklists which provide only basic information. While evidence is scarce currently, collating what knowledge of GBV there is will provide an informed basis for any future programming, and the evidence can be expanded as the CP system becomes increasingly effective.

7 RECOMMENDATIONS

Recommendation 1 is foundational to all other recommendations and needs to be addressed as soon as possible.

Recommendation 1: Ensure that all UNICEF staff are fully conversant with, and have clarity on, UNICEF’s global corporate commitments to GBVE and existing good practice programme guidance for specialised and integrated GBViE programming within UNICEF.

e. PCO CP Section should engage with the CPS in New York to clarify and agree GBV priorities within the CP programme for Pakistan and agree what technical support is needed to design and implement the agreed activities, and how that can be accessed by the PCO.

f. Once agreement has been reached, and with Child Protection Section (CPS, HQ) support, arrange training for all staff on UNICEF global corporate commitments to GBVE to ensure all staff are fully aware of UNICEF’s agency-wide responsibilities as a key part of all emergency response.

g. Provide training for PCO senior management, Gender Advisor, and CP team on the minimum comprehensive GBViE response as articulated within the Resource Pack, and ensure that this is a strategic consideration when engaging with both the Protection Cluster and the GBV SC;

h. Roll out the 2015 IASC GBViE Guidelines with CPS (HQ) and Regional Office (RO) support for UNICEF and other international GBV actors in Pakistan. Ensure that all UNICEF teams are aware of the actions
and resources to support integrating GBViE across their section’s emergency programme. (The training could be led either by the GBViE Specialist from CPS, HQ; or a trained consultant; or the Gender Advisor if she has been fully trained on the 2015 IASC GBViE Guidelines). Ensure that all UNICEF section annual plans/monitoring frameworks include at least 1 GBViE specific indicator as part of their monitoring framework for the emergency response. Appoint GBV focal points in all Sections.

**Lead Responsibility:** CP Chief lead with support from Gender Focal Point, Representative and Deputy Representative and Chiefs of Sections  
**When:** As soon as possible (2016)

**Recommendation 2:** Recruit a GBViE specialist(s) at a sufficiently senior level (P3 minimum) to lead the PCO prioritisation of GBViE within the wider UNICEF emergency response (and GBV in regular programming) including both specialised and integrated programming.

a. Create the GBV sub-unit within the CP team but with very clear linkages with the Gender Advisor.  
b. The GBViE budget should be clearly delineated and ring-fenced as a % of the Child Protection in Emergencies (CPIE) budget. As necessary, additional funds for GBV programming should be raised. (A number of humanitarian donors which prioritise either GBV or violence against women and girls (i.e. UKAid, USAID, ECHO) have indicated in global interviews that that they have funding to allocate for well-designed GBV programmes which can demonstrate results).

**Lead Responsibility:** CP Chief  
**When:** to be budgeted for in new CPD

**Recommendation 3:** UNICEF Pakistan should engage with the GBV SC leadership, to ensure that it functions as an effective coordination mechanism for GBViE response in KP/FATA. Notwithstanding the lack of a national GBV SC, UNICEF should take a lead and ensure a coordinated response to GBViE among GBV actors in Islamabad.

6 Engage proactively with UNFPA to revitalise the GBV SC in Peshawar (including considering re-engaging as co-chair of the GBV SC in Peshawar) with the aim of having an effective coordinating body which leads on developing a clear strategy for GBV as part of the humanitarian response.

**Lead Responsibility:** allocated CP officer/GBViE Specialists once recruited  
**When:** 2016

7 Develop a clear GBV SC strategy which has the agreement of all key GBV actors. The strategy should clarify for members of the SC (and with their agreement) their respective areas of programme and geographic focus and complementarity to ensure that the assessed needs are addressed.

**Lead Responsibility:** allocated CP officer/GBViE Specialists once recruited  
**When:** 2016

8 Engage with key national and international actors to create and support effective functioning of a national level coordination mechanism for GBViE. UNICEF should maximise its comparative advantages (size, presence in-country before, during and after emergencies, existing relationship with the government etc.), and take a leadership role (either formally or informally) to ensure that the existing national level GBViE coordination mechanisms work together collaboratively, to develop standards and guidance for emergency response in the Pakistan context and strengthen the sector overall.

**Lead Responsibility:** allocated CP officer/GBViE Specialists once recruited  
**When:** 2017
9 Lead/ensure development of strategy with the Disaster Management Agencies (DMAs) at all levels to ensure integration of GBViE as a priority of their emergency response. As a key deliverable of the strengthened coordination mechanism, in line with the CCPD of UNICEF, UNFPA and UNDP and working closely with the DMAs, ensure the development of a GBViE-sector strategy, with associated action plan, outlining effective working plan for engagement with the NDMA, PDMAs, and FDMAs in provinces likely to suffer from cyclical emergencies. The strategy should outline how GBViE policies, funding, action plans, and staff training will be supported throughout all DMAs. This strategy/action plan will clarify roles and responsibilities of different actors, and include targets and activities with associated indicators and timeframes for GBViE integration in DMAs.

**Lead Responsibility:** GBViE Specialists supported by CP Chief and senior PCO staff.

**When:** 2017

10 Develop a GBV sector advocacy strategy. As a key deliverable of the strengthened coordination mechanism, and in line with the GBV SC (Recommendation 2b) and the CCPD of UNICEF, UNFPA and UNDP and key GBV national actors (e.g. MoSW, the National Commission on the Status of Women), UNICEF Pakistan should lead/support the development of a joint GBViE advocacy strategy with clear goals in terms of policies, service delivery and legal framework for the provinces cyclically affected by emergencies. The strategy and associated action plan will clarify roles and responsibilities of different actors (international and national), and include targets and activities with associated indicators and timeframes for realisation of the strategy objectives in partnership with MoSW and other counterparts.

**Lead Responsibility:** GBViE Specialists supported by allocated CP officer and CP Chief and senior PCO staff.

**When:** 2017

**Recommendation 4:** Assume a strategic national leadership role in collection, analysis and utilisation of GBViE evidence and data to inform development of a strategy, dedicated sector programming and effective advocacy to prevent and respond to GBV.

d. Collate existing evidence on GBV in Pakistan in both crisis and non-crisis settings. This could be done either in partnership with national and international actors, or by UNICEF using a consultant. This would include a review of any existing documentation on the nature and extent of GBV (as reported) in different parts of the country, and of social norms and attitudes which underpin the current levels of GBV, as well as conducting original research. A study of this nature will be politically sensitive but is a necessary pre-requisite to designing and implementing specific GBV interventions in both regular and emergency programmes which tackle issues and attitudes and will inform the GBV Theory of Change (see recommendation 8), the GBV strategy and the GBV element of the new Country Programme Document (CPD).

168 **Lead Responsibility:** Gender Advisor

**When:** 2016

e. Strengthen monitoring of GBViE interventions, to provide evidence of programme quality and programme results which can be used to inform policy and programmes. This will include training for implementing partners on quality monitoring techniques which are appropriate for collection, storage and sharing of GBV data. Field visits by UNICEF staff should conducted regularly (as regularly as Non-Objective Certificates can be obtained), and qualitative methods including collecting beneficiary feedback, regularly used to augment quantitative data collection. Action points from monitoring reports need to be followed up speedily. (Third Party Monitoring is not appropriate for GBV)

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168 While the team have been made aware since the evaluation mission that the study on violence against women commissioned by the National Commission on the Status of Women is not now going ahead, collating the evidence which is available on GBV in Pakistan is still important so that decisions on how to address GBV in the new CPD are based on the most up to date and comprehensive information base.
programming because of the sensitivity of data to be collected, and the requirements for TPM to understand fully the elements and manner of implementation which ensure quality GBV programming).

Lead Responsibility: Chief Child Protection
When: 2016/2017 ongoing

f. In collaboration with other members of the GBVIMS global Steering Committee, lead on strategising for the activation of GBVIMS in Pakistan within the next three years.

Lead Responsibility: GBViE Specialists, allocated CP officer
When: By end 2018

Recommendation 5: Revisit PLaCES as a flagship GBViE intervention to ensure that the model is appropriate for KP/FATA, and will meet the objective of providing effective integrated GBViE prevention and response for women and girls as a reality in the areas of humanitarian response.

a. Review design and implementation of current PLaCES projects in the areas of emergency response to ensure that GBViE prevention and response can be delivered as part of the safe space model. If the security and access issues are insurmountable, revise the model so that GBViE prevention and response can be delivered in KP/FATA; including key programme elements such psychosocial support (PSS) and other minimum and expanded actions recommended with the UNICEF Resource Pack.

b. Working closely with UN Women and UNFPA who currently provide case management and GBViE services to some extent, work to ensure that service provision for survivors of GBV is available to women and girls in KP/FATA by international partners if not national partners. UNICEF staff and IPs should be capacitated to ensure that clear referral pathways to these services are known and survivors referred with appropriate case management procedures.

c. Communicate GBV Standard Operating Procedures, currently being used by UNFPA and UN Women, to UNICEF staff and IPs so that they are fully aware of good survivor-centred practice for GBV programming.

Lead Responsibility: CP Chief, GBViE Specialists
When: 2016

Recommendation 6: Maximise opportunities to integrate GBViE across other sections of the emergency response and regular programme, leveraging existing entry points by re-visiting existing programmes using a GBV lens. Protection gains which are currently implicit should be strengthened and expanded by making GBV risk mitigation a stated objective which is explicitly monitored and reported upon. For example:

b. The planned WASH study on open defecation should include collection of data specifically on current levels and the nature of GBV risk associated with open defecation, and in what ways WASH programming will contribute to risk mitigation of GBV by addressing these. The findings should be used both programmatically in relevant WASH interventions (UNICEF and sector-wide, using Cluster leadership influence) and for advocacy both in Pakistan and regionally.

Lead Responsibility: allocated CP officer, GBViE specialists and WASH allocated GBV focal point
When: 2016-2017

b. The PCO is already using innovative communication channels as part of the Communication for Development (C4D) programming. Building on the work already being done and using social media and radio and TV soaps, develop and disseminate messaging to promote social norms change around GBV prevention and attitudes, as well as information on availability of services drawing on good practice of what has worked in other settings for GBViE using C4D. All such communication should be line with good practice on the confidentiality and security of survivors and service providers.
**Lead Responsibility:** allocated CP officer, GBViE specialists and C4D Specialist  
**When:** 2016-2017  

- UNICEF-partnered training opportunities for emergency capacity strengthening, such as the on-going training being conducted by the Asian Disaster Preparedness Centre for NDMA should routinely include a GBViE module. Support to develop training material can be provided by CPS (HQ) or the RO.  
**Lead Responsibility:** GBViE specialists, staff-member liaising with the ADPC  
**When:** 2016-2017  

**Recommendation 7:** IPs should be routinely trained on GBViE concepts and good practice for programming on GBViE and for the collection, storage, analysis and sharing of GBV-related data  

a. Routinely incorporate GBViE training and monitoring indicators into the process and format for all Contingency Partner Cooperation Agreements (CPCAs) which are signed annually. All CPCAs should be revised to ensure GBViE mainstreaming / risk reduction are incorporated through all programmes implemented in emergency response in line with the recommendations for each sector in the 2015 IASC GBViE Guidelines.  

**Recommendation 8:** The preparation for the new CPD (post 2017) should include development of a GBViE strategy and tools to ensure that GBViE is a key priority within all emergency response for the PCO.  

a. Develop a GBViE PCO Theory of Change (ToC) which is aligned with corporate commitments and the UNICEF corporate ToC in the Resource Pack and is also contextualised for Pakistan. The ToC should cover all elements and components of a holistic response, demonstrating clearly how the intended interventions will achieve the desired results. Findings from the study conducted on GBV (recommendation 4) should inform the detailed design and selection of interventions included in the ToC to ensure it is relevant for the specifics of the context. This is particularly important relating to addressing social norms which underlie high levels of GBV. Ensure focus and language within the ToC systematically includes women as well as girls, as per UNICEF global corporate GBV commitments. (Interventions to address sexual violence against boys should be included in the CP programme.)  
**Lead Responsibility:** CP Chief with support from Gender Focal Point, CP Team  
**When:** 2017, for inclusion in the CPD  

b. Develop a GBViE Strategy for the PCO based on the PCO ToC and the GBV SC strategy, which specifies which interventions will be prioritised and also how these will be implemented in ways which are culturally appropriate for the particular communities (ie obtaining agreement of community leaders/decision makers so that the interventions have their support.) The strategy and accompanying action plan will set out how different actors contribute to the desired results at all levels in emergency response.  
**Lead Responsibility:** CP Chief  
**When:** to be budgeted for in new CPD
Annex 1: Evaluation Questions

Relevance
1. To what extent is UNICEF GBVIE programming for care, support, protection, and risk reduction based on:
   a. assessed needs and data analysis? (Are the different needs of needs of women, adolescents, and children considered separately?)
   b. established good practice for GBVIE service provision, risk reduction and prevention? (Is UNICEF employing the most appropriate strategies to ensure further violence is reduced and survivors provided with appropriate services and support?)
2. To what extent has risk reduction been integrated into other UNICEF sector programmes?
3. To what extent do GBVIE programmes adapt to changing needs, and how well are the changing needs documented?
4. How well have views of survivors and other high risk groups (adolescent girls, women, children) been reflected in programme assessment, design, implementation and monitoring? (covers AAP)
5. Are programmes built on a clear Theory of Change for GBVIE programming? To what extent is this consistent with a corporate/regional Theory of Change and with UNICEF standards and guidelines expressed through the CCCs or elsewhere?)
6. To what extent has a HRBA been taken in design, implementation, and monitoring of GBVIE programming?

Effectiveness
7. To what extent have UNICEF GBVIE programmes improved survivors' access to quality, life-saving, multi-sectoral services for care and support?
8. How quickly has UNICEF been able to establish services at the scale required?
9. To what extent has the programme contributed to preventing and mitigating risks of GBV for women, adolescents and children?
10. Are programme objectives clear and specific for different GBVIE areas of programming? How far have programme objectives been achieved / likely to be achieved?
11. Which have been the most/least effective programmes? Why?
12. How systematically have results been captured/used/learned from?
13. How and how effectively has 1) UNICEF leadership and 2) technical support from HQ, regional and country levels contributed to the effectiveness of UNICEF GBVIE programming? Including ensuring that GBVIE is included in the earliest response strategies and funding priorities?

Connectedness and Sustainability
14. How, and how effectively does UNICEF GBVIE programme design and implementation link emergency programming with UNICEF’s longer-term programming to prevent and respond to GBV? Is UNICEF’s approach to GBVIE built into its conceptualisation and implementation of sustainable resilience programming?
15. How effectively have partnerships with civil society and government been built to address planned GBVIE outcomes?
16. How and to what extent has the capacity of local and national partners been strengthened through the programme?
17. To what extent has UNICEF’s internal and external advocacy contributed to improved GBV response and prevention? (Including clarifying UNICEF’s specific programme and leadership roles?)

Coordination
18. To what extent are programmes consistent with good practice (Resource Pack and revised GBVIE Guidelines)
19. Does/how does UNICEF add value to the GBVIE response (through leadership, standard setting, coordination)?
# Annex 2: Interviews/Workshops participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Position</th>
<th>M/F</th>
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</thead>
<tbody>
<tr>
<td>Cris Munduate</td>
<td>UNICEF SMT</td>
<td>Deputy Representative</td>
<td>F</td>
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<tr>
<td>Sarah Coleman</td>
<td>UNICEF CP</td>
<td>Chief, Child Protection</td>
<td>F</td>
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<tr>
<td>Mannan Rana</td>
<td>UNICEF CP</td>
<td>Child Protection Specialist</td>
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<td>Federica Di Stefano</td>
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<td>Child Protection Specialist</td>
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<tr>
<td>Farrah Ilyas</td>
<td>UNICEF CP</td>
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<td>Peta-Gaye Bookall</td>
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<td>Rahama Rihood Mohammed</td>
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<td>John Ekaju</td>
<td>UNICEF Education</td>
<td>Education Specialist, OIC Education Section</td>
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<td>Yasir Arafat</td>
<td>UNICEF Education</td>
<td>IM Officer, Education Cluster</td>
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<tr>
<td>Ehsan Ullah</td>
<td>UNICEF Education</td>
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<tr>
<td>Sadaf Zulfiqar</td>
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<td>Ivan Amezquita</td>
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<td>Shaheen Hussain</td>
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<td>Mussarrad Youssuf</td>
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<tr>
<td>Tania Goldner</td>
<td>UNICEF Health</td>
<td>Chief Health</td>
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<td>Dr Samia Rizwan</td>
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<td>Dr Samia Hashim</td>
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<td>Nutrition Specialist and Emergency Focal Point</td>
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<td>Dr Nashmia Mahmood</td>
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<td>Salman Hussain</td>
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<td>Neil Buhne</td>
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<td>Kay Schwendnger</td>
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<td>Hadia Nusrat</td>
<td>Resident Coordinators Office</td>
<td>Inter-Agency Gender Equality Advisor, HCT, UNWOMEN</td>
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<tr>
<td>Graciela van der Poel</td>
<td>UNFPA</td>
<td>GBViE Specialist and GBV SC Coordinator</td>
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<tr>
<td>Farid Gul</td>
<td>UNFPA</td>
<td>Head Peshawar Officer</td>
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<tr>
<td>Devanna de la Puente</td>
<td>GBV AoR</td>
<td>Former RRT and REGA and GBV SC Coordinator</td>
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<td>Yasmin Jaswal</td>
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<td>WLSR Officer</td>
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<td>Syed Wajid</td>
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<td>Jolanda van Dijk</td>
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<td>Imran Ullah</td>
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<td>Dr Samra Mazhar</td>
<td>Ministry of Health</td>
<td>Deputy Director, Ministry of NHSR&amp;C</td>
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<tr>
<td>Dr Amen ul Haq</td>
<td>MoH/Lady Health Worker</td>
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<td>Mr Khalid</td>
<td>MoH/Lady Health Worker</td>
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<td>Jawad Ullah</td>
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<td>Dr Arslan Marlik</td>
<td>ARC</td>
<td>Programme Coordinator, ISB</td>
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<td>Sabeeena Gul</td>
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<td>Ambreen Banori</td>
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<td>Aftab Ismail Khan</td>
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<td>Mr Zia Ul Haq</td>
<td>Pakistan Village Development Programme (PVDP), Bannu</td>
<td>Programme Director</td>
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<td>Mr Noor Khan</td>
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<tr>
<td>Muhammad Abbas</td>
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<td>Team Leader</td>
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<tr>
<td>Mr. Salman</td>
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<td>SABAWON, Bannu</td>
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## Annex 3: Mission Itinerary

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<tr>
<th>Time</th>
<th>Monday 25th Jan</th>
<th>Tuesday 26th Jan</th>
<th>Wednesday 27th Jan</th>
<th>Thursday 28th Jan</th>
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<td>9am</td>
<td>Arrive, to Guest House Meeting with Chief, CP Meeting with GBVIE Specialist Meeting with Comms</td>
<td>Sarah Coleman, CP Chief</td>
<td>Joh Ejaku, Education Ehsan Ullah, Education Yasir Arafat, Education</td>
<td>Timothy Grieve WASH Chief; Kiran Qazi, WASH GBVIE Focal Point Asiya Ashraf Chaudry, WASH</td>
<td>Travel to Peshawar</td>
<td>Training of National Consultants</td>
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<td>10am</td>
<td>Team Security Briefing</td>
<td>Tania Goldner, Health Chief;</td>
<td>Dr Samra Mazhar Deputy Director MinNHSR&amp;C</td>
<td>UN Women Fareeha Ummar and Yasmin</td>
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<tr>
<td>11am</td>
<td></td>
<td>Dr Nashmia Mahmood, Health GBVIE Focal Point</td>
<td></td>
<td>Dr Wassaf WASH</td>
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<td>12pm</td>
<td></td>
<td>Melanie Galvin, Nutrition Chief Dr Wisal Khan GBVIE Focal Point</td>
<td></td>
<td>Protection Cluster Jawad Ullah Jolanda Van Dijk</td>
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<td>1pm</td>
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<td>Dep Representative, Cris Munduate</td>
<td>Mussarat Youssuf, PMER</td>
<td>Hadia Nusrat Interagency Gender Equality Advisor for Humanitarian Country Team (UN Women)</td>
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<tr>
<td>2pm</td>
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<td>Rahma Rihood Mohamed, Chief, Field Operations Masooma Qazilash, Emergency Officer</td>
<td>INGAD meeting</td>
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<td>3pm</td>
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<td>UN Women</td>
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<td>4pm</td>
<td>Meeting with Peta-Gaye Bookall, CP Officer</td>
<td>RCH / HC</td>
<td>CP Section Sarah Coleman Manna Rana Farrah Illyas Federia Di Stefano Pete-Gaye Bookall</td>
<td>Travel to Islamabad</td>
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<tr>
<td>9am</td>
<td>Travel to Peshawar: KP security briefing</td>
<td>Travel to Bannu</td>
<td>Travel to Bannu</td>
<td>Travel to Islamabad</td>
<td>Final Findings Workshop</td>
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<td>10am</td>
<td>FDMA Shama Asad</td>
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<td>Bannu FGDs</td>
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<td>11am</td>
<td>GBV Sub Cluster lead Farid Gul</td>
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<td>MinNHSR&amp;C – Lady Health Worker Programme Dr Fahim Hussai</td>
<td>Bannu FGDs</td>
<td>Workshop prep</td>
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<td>Nisar Khan Education, Nosheen Khan Health</td>
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<td>Travel to Karak</td>
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<td>PRSP Ms Ambreen Banori</td>
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<td>5 pm</td>
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Annex 4: Bibliography

*IASC Guidelines for Integrating Gender-based Violence in Humanitarian Action, 2015*
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