GBV+HIV

A Baselne Survey Report

Prepared By:
Asifa Khnum
Dec 2013

LIST OF ACRONYMS

FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HRCP	Human Rights Commission of Pakistan
AIDS	Acquired Immune Deficiency Syndrome
SEHER	Society for Empowering Human Resource
SGBV	Sexual and Gender-Based Violence
STIs	Sexually Transmitted Infections
SPSS	Statistical Package for Social Science
GBV	Gender Base Violence
UNHCR	United Nation's High Commission for Refugees
UC	Union Council
WFS	Women friendly spaces

Contents

List of Acronyms	2
Contents	3
Acknowledgment	4
Executive Summary	5
Rationale	8
Baseline Survey	10
Baseline Findings	11
Marriage Situations	15
Literacy and Knowledge	18
Impact of GBV-HIV/AIDS	21
Working Women	22
Focus Groups Discussions	24
Conclusion	25
Recommendation	25

Acknowledgement

My first and foremost thanks goes to the women and men of the community, staff of field partner organization (SEHER), and individuals for their time and willingness in sharing their views openly. The insights drawn have gone a long way in the compilation of this Baseline Survey report.

I further thank the US Consulate General Islamabad for facilitating the Survey process. I would like to thank the SEHER team, Executive Director; Mr. Abdul Wadood, Project Manager, Mr. Rizwan Kasi, trainers, social mobilizers and other staff members for their time, views, comments and help in setting up schedules with stakeholders and community. The hospitality extended during the entire evaluation process by SEHER in Quetta respectively is acknowledged and appreciated.

Asifa Khanum

Consultant for Project Baseline Survey

December 2013

Executive Summary

The baseline survey design was bordered with the cautiousness that the study would provide evidentiary record of residential information, sources of household livelihood, state of primary health care, existence of sexual and gender based violence, and information about affairs related to abuses in project areas with the specific purpose of providing a stratum for designing corresponding strategies for efficient, effective and result oriented project implementation interventions.

Data collected through household interviews and focus group discussions provided an unmeasured amount of qualitative and quantitative information, which can be used in number of ways for understanding different dimensions of complexities and insufficiencies of people living in selected communities. However, this report is confined to what has determined as being of unmediated relevance to the purpose of baseline survey. Data was collected from selected pockets of Kharotabad and Ghousabad union councils in Quetta district.

A total of 600 questionnaires were covered during baseline survey. 360 were filled for every single woman and 240 for Men in both union councils Kharotabad and Ghausabad. The purpose was to record specific information related to UCs as well as to enhance the overall sample size for household survey. Two focus group discussions per union council separately with male and female community members were carried out for collecting desired representative information. Data management and analysis was carried out in SPSS (Statistical Program for Social Sciences).

According to survey, around 23% percent in Kharotabad and around 55 percent respondents residing in Ghousabad clusters mapped by the project are refugees. Most of women between 15 to 49 years are married, illiterate, and housewives. Nearly 75 percent male respondents of household survey are illiterate, 48 percent are labourer/daily wagers, 24 percent are self employed and 17 percent are unemployed. Average family size per household is 10, where as average number of boys per family is 3 and girls is 2. Average family size of refugees is 10 and local comprises of 8 individuals.

Around 59 percent in Kharotabad and 48 percent in Ghousabad families lives in their own houses. Nearly 67 percent local inhabitants have their own houses and 69.1 percent of refugees are residing in rented houses.

About 60 percent households in both districts are made of mud (Kharotabad: 62.4%, Ghousabad: 56.3%). Majority of houses have open space, separate room for kitchen, and toilet inside house.

Insufficient arrangement of water supply is common in both UCs. The issue is severe in Ghousabad where inside resource of water is available in only 15 percent houses. This scarcity of water is considered by community as one of the core reasons behind failure in maintaining desired cleanliness and obtaining minimal hygienic environment and in houses. About 82 percent of refugee dwellings do not have source of water available inside house however this is 59 percent in case of locals. The reason could be difference in managing water in houses possessed by the owner and ignorance of landlord in rented house as nearly 69 percent refugees live in rented houses.
Most of the households are living in poverty with an income less than Rs. 10,000 per month (Kharotabad: 83.9%, Ghousabad: 61.2%) which is less than 117.4 US dollars a month i.e. approximately 1.17 dollars per person per month. Nearly 62.5 percent of refugees are earning less than Rs. 5000 per month compare to 47.6 percent of locals.

Only 12.8 percent respondents have access or control over domestic financial resources. There is no difference between percentage of households of respondents of refugees (12.6%) and locals (12.8%) where women have access or control to cash or financial resources.

There are 28 percent households (Kharotabad: 19.4%, Ghousabad: 36.4%) where women are contributing in overall household income; out of which 68 percent are earning through embroidery. More refugee women (39.8%) are contributing in household income compare to locals (22.2%). The reason could be their less average income and limited financial resources than local population.

Average 50 percent of both refugee and local families are suffering from material deficiency. Merely 9.8 percent households have saving in cash which in 70 percent cases is less than Rs. 2000. A total of 33.1 percent families meet their incidental expenses by taking loan.

Nearly half respondents mentioned that women are not allowed to go out on their own to meet their relative. This restriction is less in Kharotabad (41%) and they face fewer problems than Ghousabad (58.3%) where women face more problems in their mobility. Forced to act immoral is little more in Ghousabad than Kharotabad and rate of reporting of these acts is higher in Ghousabad. 37.6 percent refuges respondents consider themselves free for independent mobility and 58.4 percent locals consider that they can go out to meet their friends and relatives. Similarly, 53.1 percent refugee women noticed problem when they go out and 60.2 percent local respondents considers the same.

About 3.4 percent respondents admitted that they have ever been insulted in street, public transport or public places. Similarly, 3.8 percent disclosed that someone ever stolen bags, wallet, jewellery etc. by force. Nearly 3.8 percent respondents share that someone ever forced them to undergo or perform any immoral act, out of which 57.1 percent reported to someone about the incident.

More respondents in Kharotabad (9.9%) than Ghousabad (4.9%) have childhood or teenage memory of their serious conflict with parents at home and 7.6 percent noticed tension between mother and father or seen physical violence at home.

Women in general have complaint of domestic violence. They are not supposed to involve anyone for support as this is considered a domestic problem eventuated between husband and wife. According to 55 percent respondents, they have heard about domestic violence or law for violence against women. There is no significant difference in refugee (55.1%) and local (57.0%) respondents regarding hearing about the laws.

Habitual use of addictives amongst any family member was denied by 59.1 percent household survey respondents but focus group discussion participants showed their concern about the escalating use of heroin, hash and cocaine use in community especially amongst male youth.

Both union councils are deprived of basic health care facilities. Thy have no public hospital and testing laboratory at walking distance. Utilization of allopathic healthcare facilities in case of any ailment was mentioned by 74.3 percent households (Kharotabad: 70.9%, Ghousabad: 77.6%). Little more refugee community (77.0%) is utilizing nearby allopathic health care facility than the local residents (73.4%). In traditional households, women are not authoritative to take decisions of any kind and same is true in case of deciding for the healthcare matters of family. Husbands (77.6%) or father or father in law (26.4%), are mentioned as key decision makers for seeking health care in households. Almost 85.4 percent of households have single decision maker which is dominantly a male head of household.

According to 17.1 percent respondents (Kharotabad: 12.9%, Ghousabad: 21.2%), someone in their household had health problem during last one month that made someone unable to work or go to school for at least one week.

Respondents in both communities by and large are aware of basic precautionary measure for keeping themselves healthy but they lack medical treatment facilities in their respective areas, scarcity of financial resources to meet their requirements, accessibility of water and sanitation facilities and more precisely access to information about the consequences of ill-health practices.

Precautionary measures can avoid chances of HIV/ AIDS is known to nearly 44% in Ghousabad and 33% in Kharotabad. Nearly the same percentage of respondents in Kharotabad but 32% in Ghousabad consider that an infected person can transmit HIV/AIDS to another person by meeting, shaking hand or living with him/ her. A person can be infected by shaving razor is known to a very fraction (13 to 20%) of respondents.

Immunization status of children under 5 years at surveyed households depicted that only 21.4 percent households have all their children immunized. Refugees in both union councils are little more conscious of immunization of their children under 5 years than local families. This is due to the fact that 28.3 percent refugee respondents and 51.6 percent local respondents mentioned that none of the children under 5 years in their families is vaccinated.

According to survey respondents, the most common disease in both union councils is malaria (Kharotabad: 45.1%, Ghousabad: 50.9%). This is interesting to know that close to 60 percent of respondents are aware that a person can be infected by mosquito bits and nearly 66 percent households are using mosquito safety nets

for their protection. Tuberculosis, diarrhea and hepatitis are prevalent in Kharotabad and tuberculosis, diarrhea and hepatitis are common in Ghousabad. This is easy to conclude from diseases patterns that unhealthy environment, unsafe drinking water and risky eating habits are deteriorating health of inhabitants of both communities.

Nearly 29.6 percent heard about fatal diseases. More rrefugee respondents (44.9%) have heard about fetal diseases than local respondents (20.9%).

Safe motherhood practices paved its way in community with the provision of training to traditional birth attendants. Available trained human resource is not enough at all to meet prenatal, natal and post natal requirements of every pregnant mother.

Family planning is not an appreciated idea to limit family size in households of both union councils. A small percentage (Kharotabad: 32% and Ghousabad: 16%) of respondents admitted that they heard about family planning, out of which nearly 46 percent heard about tables/ pills for birth control. About 19.7 percent refugee and 25.2 percent local respondents heard about contraception. Few traditional and indigenous methods shared by women during discussion are quite injurious and risky for the health of women. A small number of women do adopt these methods on their own secretly from their husbands.

Right of an adolescent girl to keep her medical information confidential is favoured by around 10 percent respondents. However, majority don't know about the rightness of this practice. Nearly 14.1 percent refugee and 7.8 percent local respondents are in favor of keeping her medical information confidential from close family members.

There is no methodological gender differences with regard to the types of abuses perpetrated on women, girls and boys that may have been witnessed, observed or heard about by the respondents. Physical, sexual and verbal violence are commonly perpetrated followed by mental/ psychological, and labor abuses. Males compare to female respondents in Kharotabad are slightly better aware of types of abuses on women, girls and young boys, where as this is opposite in Ghousabad. Home is considered as a place where these abuses occurs the most by around 70 percent respondents. Deprivation in economic necessitation, social oppression, cultural restrictions and stint values are actual causes for the occurrences of abuses. Domestic abuses on women are mainly affecting them mentally and psychologically. Almost half of male and female respondents were unable to share types of changes occurred in women who survived abuses. Change in behavior is less recognized than mental stress as a change for the worst in surviving women.

Although more female than males are in favor of contacting police or court for justice, but on an overall basis more than half of the respondents do not assent this option. More refugee male (22.4%) and female(44.8%) respondents are in favor of an idea that women should contact police or court for justice than local male (16.7%) and female (36.4%) respondents.

Keeping in view the existing demographic, socio-economic and health status of refugee and local inhabitants in Kharotabad and Ghousabad, a serious multifaceted long term and highly effective strategic planning is strongly recommended for sustainable change in selected union councils.

Rationale

Pakistan has been a host to the world's largest refugee population. A lot of Afghan refugee population has been living in Pakistan for nearly three decades. According to a report by Human Rights Commission of Pakistan (HRCP)[1]: 'There is no provision in the Constitution of Pakistan for refuges or displaced population and no laws specifically protecting refuges and little understanding among the police or the judiciary about refugee law. Refugees are largely viewed as illegal migrants here for economic reasons instead of fleeing persecution and a lack of security back home'.

Due to prolonged period of stay of Afghan refugees in Pakistan, many young Afghans have been born here and quite a few even married into local population. The UNHCR and other NGOs have been making efforts to facilitate Afghan refugees residing in the specific refugee camps or settled with local communities for ensuring better living opportunities for them. There are many spheres which need attention in order to improve the status of Afghan refugees, amongst them is the matter of sexual and gender-based violence (SGBV). Number of initiatives has been taken by UNHCR, SGBV networks, and local organizations, which were mostly limited to data collection or camps-based health interventions, ignoring other issues such as psychological support, economic empowerment and legal aspects. More comprehensive attempts are expected from states, international and national organizations, and civil society to work with an aim of transforming SGBV from unmentionable to an accepted dilemma. To prevent its causes and to address it as a foremost health and human concern, it is important to understand factors contributing in violence, abuse and discrimination against vulnerable and weak segments of the society. These include: i) the social fabric of society, cultural and religious interpretations and practices, which consider women and children and of that matter refugees and minorities in subordinate position, and ii) mostly women and children are 'non-productive' or 'non-earning members' of the family due to which they have no say in the decision making at family level, which contributes incidences of violence against them.

Introduction

The project developed in partnership with US Embassy in Pakistan, SEHER's project titled "GBV-HIV/AIDS" The project launched in October 2013 in two union councils (UCs) i.e. Kharotabad and Ghousabad in Quetta district, and will be continued till September 2014, this project is aimed to target refugee and non-refugee women in selected UCs however their male counterparts as well as lawyers; doctors; media personnel; and personnel from law enforcing agencies were included as integral components for addressing the issue of GBV- HIV/AIDS in its entirety.

Violation against one individual is violation of the complete humanity. The women in our society are deprived of their basic rights of the life especially in the tribal society of Baluchistan where domestic violence is a common practice of the society. The women are always threatened of abuse, abduction, honor killing, sexual assault, acid throwing and murder.

Currently the efforts to address HIV/AIDS and GBV mainly operate in isolation to each other. Many of the HIV/AIDS organizations have little understanding of gender based violence they have little awareness what responses are in place and which key players may be a source of information and support.
A significant gap in which is felt in the province is the lack of mental health programs and trained human resource to implement such programs. There was a strong perception that counseling for victims of violence were inadequate. Additionally there is little information or support provided to think through and plan for the consequences of GBV for HIV/AIDS and vice versa.

There is growing evidence from different countries that gender based violence can increase the risk of HIV/AIDS. Researchers, focusing on understanding the explosion of the HIV/AIDS epidemic among women and girls, have highlighted how sexual coercion and fear of violence limit women's ability to negotiate safe sex behaviors, access services, and/or adopt practices to prevent mother to child transmission.

Women are lacking behind in all segments of the society especially in education where there are very low number of females getting higher education in the province. Education enlightened the minds of the individuals and make them sense to choose what is right and what is wrong.

Women are not aware of their rights which were provided to them by the religion and law of the county, due to which women are more exposed to violence in our society. Moreover gender discrimination and violence is common in the province and it became acceptable among the families. Women are also unaware of the high risk diseases i.e. HIV AIDS, Hepatitis and other STI (sexually transmitted Infections), their causes and ways to prevent it.

Unregistered medical practitioners and mid wives in these areas are also the main source of the spread of diseases among the women and men in the community. Used syringes and other instruments are responsible to spread the STI's, Hepatitis and even HIV/AIDS viruses from one patient to other, which is then transferred to male or female during the sexual relations.

Forced sex or rape directly increases the risk of HIV through physical trauma, especially for young girls.
Both issues are addressed in a vertical manner, with little cross dialogue between the two professional communities or little integration of messages that reinforce programs mutually. While some progress is being made separately on ending violence against women and stemming the spread of HIV/AIDS, national and international efforts would be vastly more effective if they addressed the interconnectedness between the two pandemics.

Lack of opportunities in education, skills and health for the women also make them more vulnerable to Gender based violence in the province. Many women headed households in the area are compel to do prostitution for income generation and earning livelihood for their families. There is no such program which not only works for the skill development of the women to empower them but also create awareness among common masses about HIV/AIDS.
There is significant amount of knowledge lacking about safe sex in the community, as in some cases the male counterparts of the families have sexual relations with other females and even with other males during which they do not care about the safe ways of sex. When these male have developed sexual relations with their wives the diseases transferred from them to their wives. There is a dire need to address the issue and spread awareness among the community regarding safe sex methods in order to reduce the cases of STIs.

Baseline Survey

OBJECTIVE

The overall purpose of baseline study is to record and document the existing level of awareness of Afghan refugees and their host communities on health issues, GBV-HIV/AIDS, legal and medical services to GBV-AIDS survivors, and assessing their access to primary health care facilities in Kharotabad and Ghousabad; Quetta district, Balochistan. On the basis of which, project will devise corresponding strategies for effective and result oriented implementation plan.

METHODOLOGY

Methodology derived for carrying out baseline study survey focused on collecting quantitative and qualitative data through survey and focus group discussions from selected union councils.

Survey

Current Project is on its initial stage GBV-HIV/AIDS project implemented in Kharotabad and Ghousabad due to which project has certain understanding about selected communities, therefore it was decided to limit the boundary of household survey to clusters selected by the project team for project interventions in both union councils.

Sampling:

Selected communities and limited timeframe for implementation of the project, it was decided to limit survey to 300 individuals per union council as per plan. Every 10th household was contacted through systematic sampling in selected clusters[2] in each UC; which were identified by project team for project interventions. First household in each cluster was identified in consultation of local community; which directed them on moving within a cluster for counting of every 10th household and guided in the area for completing the target sample size. Following is the list of clusters in Kharotabad and Ghousabad which were visited for household survey:

i. Clusters in Kharotabad:
   Hanan Masjid, Aryana afghan hotel, haji fateh khan, and moulana abdul ghani
ii. Clusters in Ghousabad:
   Bahauddin chowk, katchi abadi, rehmaniya masjid, and khilji market.

Data collection format:

A data collection instrument was developed for covering 600 Individuals i.e. 300 per union council in order to collect details about households, state of livelihood, knowledge; perceptions; and practices about sexual and gender based violence, and access to primary health care facilities. Questionnaire primarily covering quantitative side of baseline survey through direct household interviews was finalized by SEHER. Questionnaire comprising of 2 major sections had different parts:
Male Questionnaires
Female Questionnaires

Respondents:

Survey questionnaire was designed for Men and Women separately which is consist of many parts like: Education, health, GBV, HIV/AIDS and its impact on life etc.

Focus Group Discussions (FGDs):

Due to cultural norms discussions were arranged separately for males and females in each union council. The overall purpose was to understand and document community dynamics with special reference to health, women empowerment, sexual and gender based violence, education, and other social and cultural aspects that are dominating their current lifestyle. Participants of female FGDs included housewives and students. Similarly, participants in FGDs for males were government servants, private employees, shopkeepers, social and political activists, town committee members, president anjuman-e- tajran (president of merchants' association), teachers, students, drivers and self employed.

Data collected on household survey questionnaire was entered, cleaned and analyzed in version 21 of Statistical Package for Social Science (SPSS).

The baseline conducted in Oct-Nov2013

Baseline Findings

Primary data from selected union councils was collected through focus group discussions and direct interviews of 640 respondents. The purpose was to understand the overall existing situation of both union councils with regard to residential status, household livelihood, gender-based violence, HIV/AIDS and primary health care facilities.

Personal information:

A total of 600 individuals from Kharotabad and 300 from Ghousabad were covered during Baseline survey. The first part of a questionnaire starts with personal information like name, age, marital status, UCs, age of marriage etc. all the statistics in frequency is given below in which you can find complete information associated to the personal information of individuals.

No of Men beneficiaries in both UC

	Frequency	Percent	Valid Percent	Cumulative Percent
Kharotabad	120	50.0	50.0	50.0
Ghousabad	120	50.0	50.0	100.0
Total	240	100.0	100.0	

As it is stated above the number of men respondents are 240 in which 120 are from the following UC,s, in the same way 360 women respondents from both UC,s

No of Women beneficiaries in both UC

		Frequency	Percent	Valid Percent	Cumulative Percent
UC	Kharotabad	180	50	50.0	50.0
	Ghousabad	180	50	50.0	100.0
	Total	360	100	100.0	

Age of Men Beneficiaries in UCs

		Frequency	Percent	Valid Percent	Cumulative Percent
Age	15-20 years	53	22.1	22.1	22.1
	21-25 years	76	31.7	31.7	53.8
	26-30 years	39	16.3	16.3	70.0
	31-35 years	22	9.2	9.2	79.2
	36-40 years	23	9.6	9.6	88.8
	45-50 years	27	11.3	11.3	100.0
	Total	240	100.0	100.0	

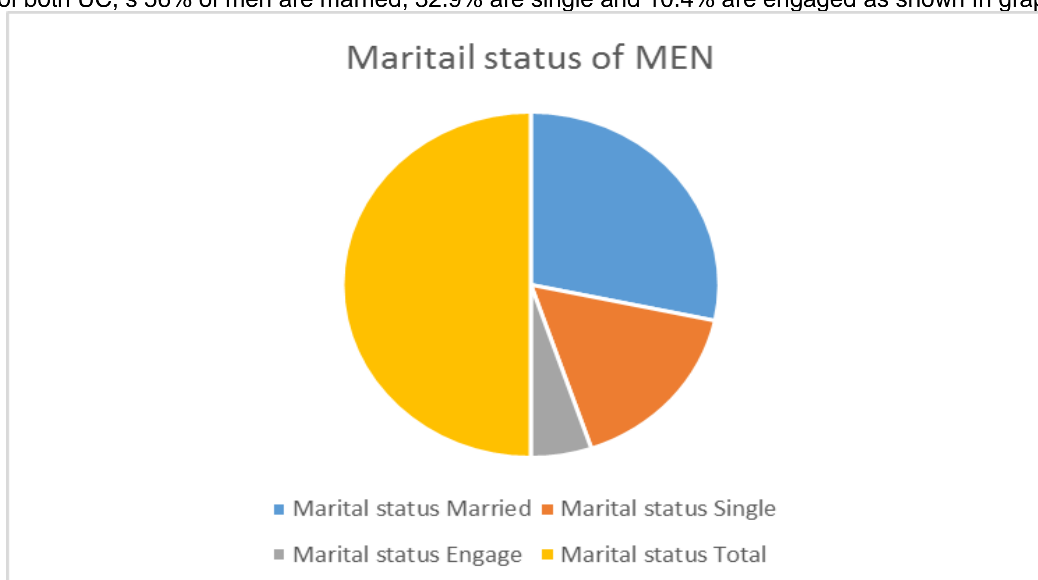
The above table is the frequency table of age of the male beneficiaries, in which 22.1% are of 15 to 20 years, 31.7% are 21 to 25 years, 16.3% are 26 to 30 years, 9.2% are 31 to 35 years, 9.6% are 36 to 40 years, and 11.3% are 45 to 50 years.

Age of Women beneficiaries in UCs

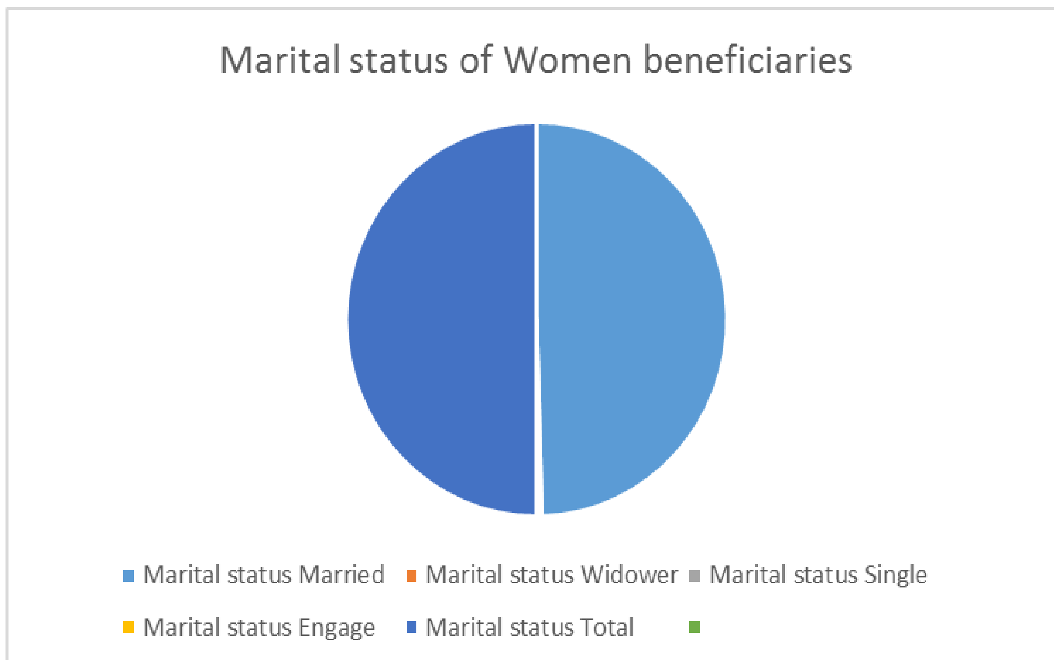
		Frequency	Percent	Valid Percent	Cumulative Percent
Age	15-20 years	2	.5	.6	.6
	21-25 years	47	12.4	13.1	13.6
	26-30 years	25	5.6	5.8	15.0
	31-35 years	89	23.4	24.7	39.7
	36-40 years	77	20.3	21.4	61.1
	41-44 years	88	23.2	24.4	85.6
	45-50	52	13.7	14.4	100.0
	Total	360	100	100.0	

Above table consist of age of the women beneficiaries in both UC, s Kharotabad and Ghausabad. In this survey we target different ages in order to analyze to community deeply, the targeted age of beneficiaries are between 15 to 50 years, in which 0.5% are 15 to 20 years, 12.4% are 21 to 25 years, 3.6% are 26 to 30 years, 23.4% are 31 to 35 years, 20.3% are 36 to 40 years, 23.2% are 41 to 44 years, and 13.7 are of the age of 45 to 50.

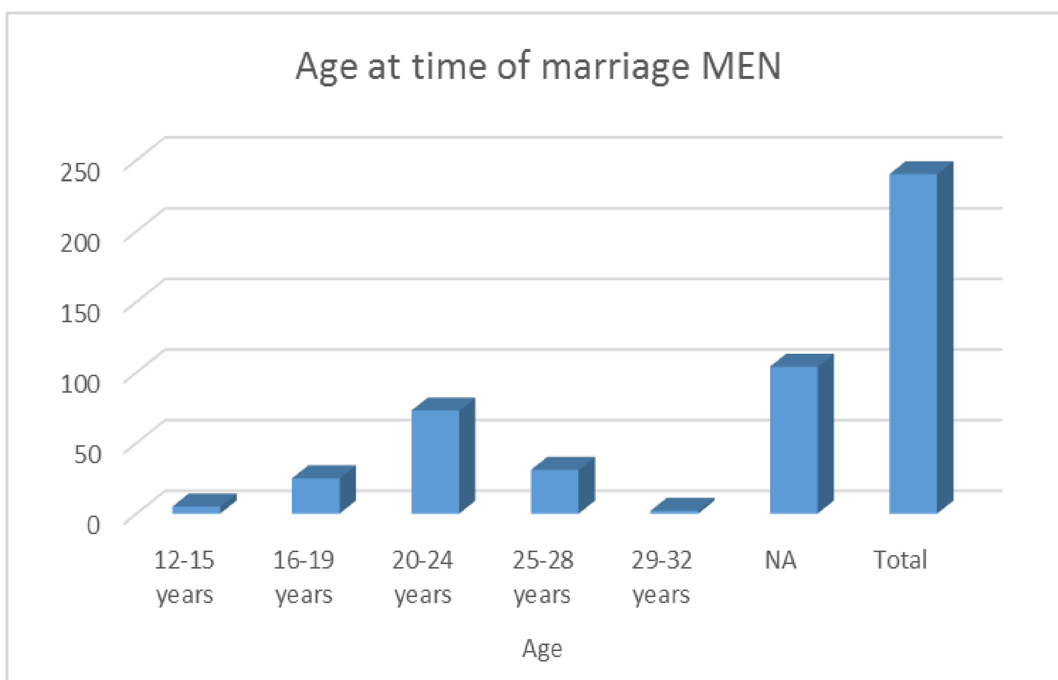
In total of both UC, s 56% of men are married, 32.9% are single and 10.4% are engaged as shown In graph below.



Graph below are the marital status of women beneficiaries Most of the women are married because of early marriages, marriages in early age are sort of tradition in this community, where 98.8% women beneficiaries are married and 1.2% are widower, single or engaged



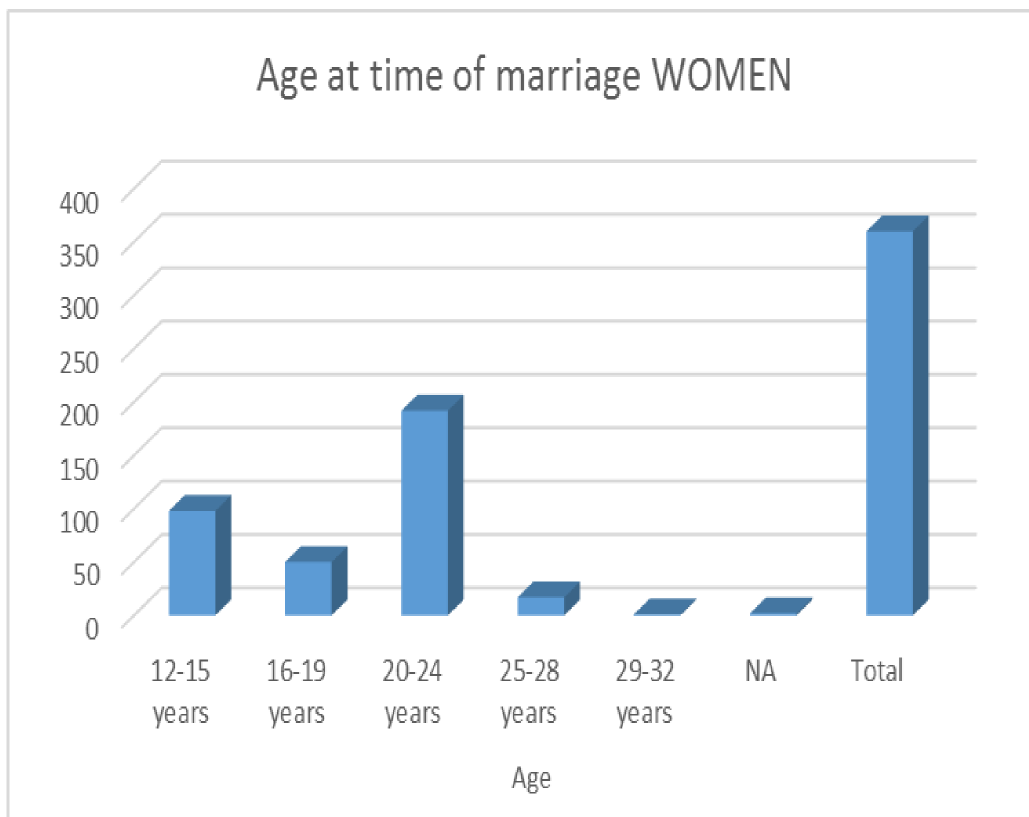
Below is graph of men beneficiaries in which age at the time of their marriages are shown most of the men get married in the age of 20-25 as it is explained above about early marriages, where 2.1% get married in the age of 12 to 15 years, 10.4% are in 16 to 19 years, 12.9% in 25 to 28 years and 0.8% in 28 to 32 years.



Age at time of marriage women

		Frequency	Percent	Valid Percent	Cumulative Percent
Age	12-15 years	98	25.8	27.2	27.2
	16-19 years	50	13.2	13.9	41.1
	20-24 years	192	50.5	53.3	94.4
	25-28 years	17	4.5	4.7	99.2
	29-32 years	1	.3	.3	99.4
	NA	2	.5	.6	100.0
	Total	360	100	100.0	

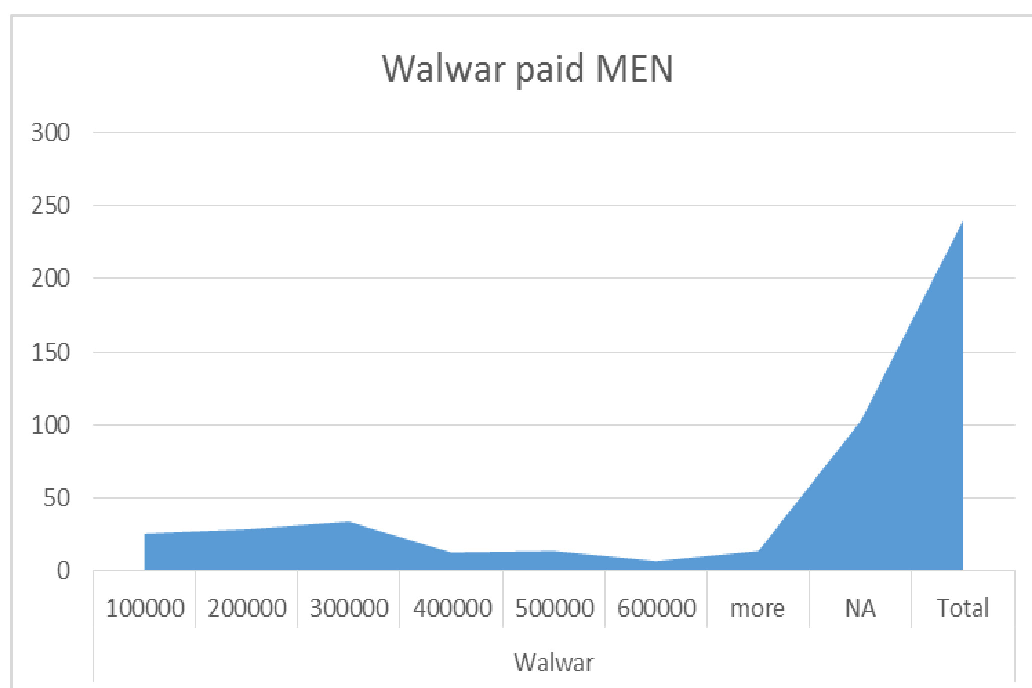
As you can see in the graph below women got early marriages (12-24 years), where 0.3% in 25+ years of age.



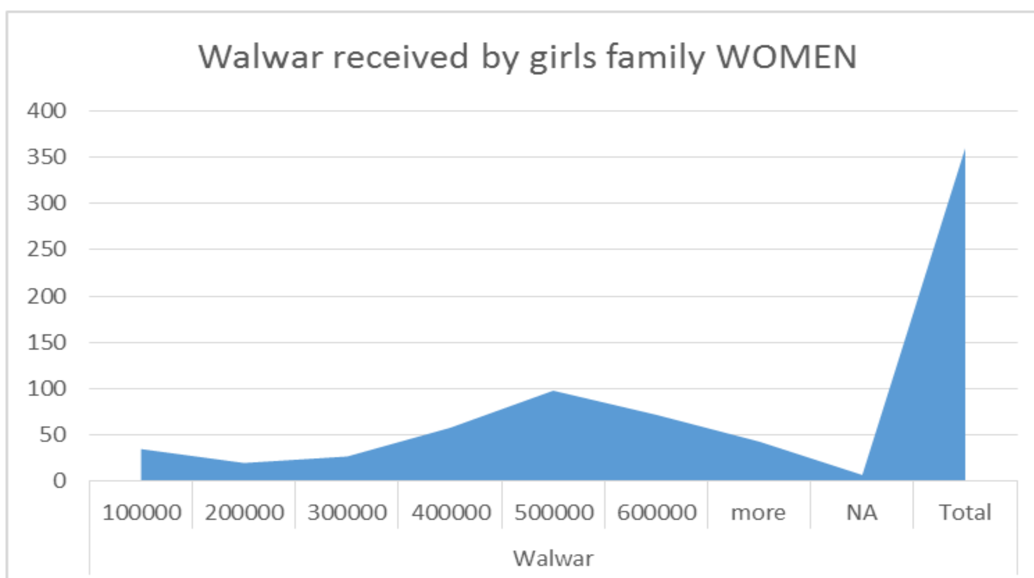
Marriage situations

Usually in this communities we find some hurdles in their marriage situations, Men offers “Walvar” amount in cash to girls family for getting married. This is the second part of questionnaire, In this part "walwar” is an important factor in order to find a reason of multi sexual relations and GBV, because this is the main reason paying a huge amount of money for marriages in this poor community, some of them are not able to pay for this then they switch to multi sexual relations without any precautions, and on other side girl after getting married face lot of problems and taunts from in-laws related to “Walwar” paid, which leads to GBV.

In the graph below the the amount paid for getting married is mentioned, in this case NA may be single individuals or exchange marriages, where 10.8% of men paid around 100000 rupees, 12.1% paid around 200000 rupees, 14.2% paid around 300000 rupees, 5.4% paid around 400000 rupees, 5.8% paid around 500000 rupees, 2.9% paid around 600000, and 5.8% paid 700000 to 1500000 rupees, this is the main reason of domestic violence on women in this community, for the reason of amount most of the women suffer after their marriages.



Graph below shows the demanded amount or received amount by the family of a girl, 9.2% of families demanded or received amount around 100000 rupees, 5.3% around 200000 rupees, 7.1% around 300000 rupees, 15.3% around 400000 rupees, 25.8% around 500000 rupees, 18.9% around 600000 rupees, where 11.3% demanded or received amount around 700000 to 2000000 rupees.



These two tables below shows the GBV- HIV cases in targeted community

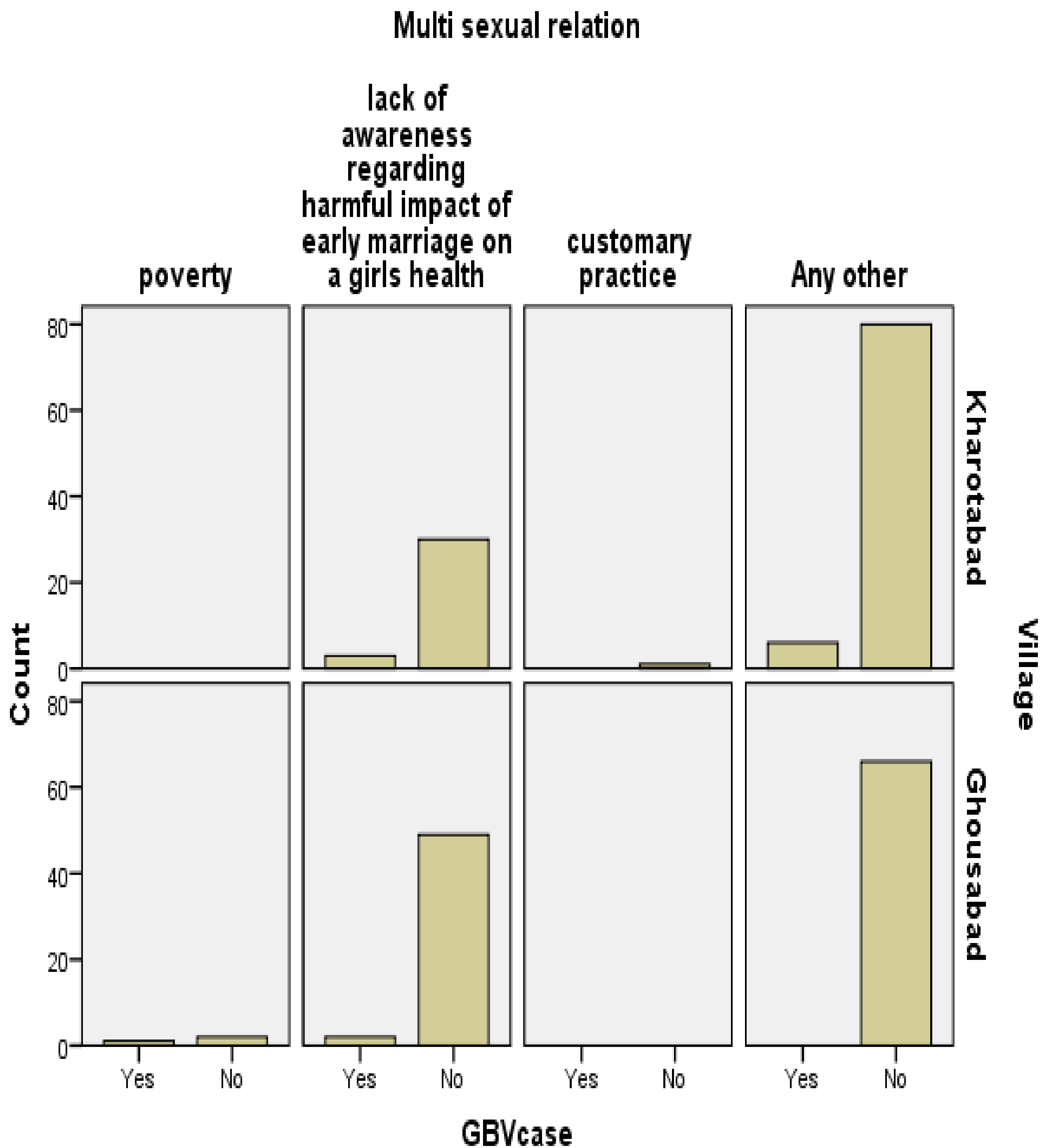
GBV-HIV/AIDS case in community MEN

		Frequency	Percent	Valid Percent	Cumulative Percent
GBV-HIV/AIDS	Yes	12	5.0	5.0	5.0
	No	228	95.0	95.0	100.0
	Total	240	100.0	100.0	

GBV-HIV/AIDS case in community WOMEN

		Frequency	Percent	Valid Percent	Cumulative Percent
GBV-HIV/AIDS	Yes	135	35.5	37.5	37.5
	No	224	58.9	62.2	99.7
	Total	360	100	100.0	

The cases varies in men and women because most of the men don't accept that there is any HIV-GBV case, especially GBV in more clear words domestic violence case. 5.0% HIV-GBV cases identified via men survey or interviews, where via women more cases are identified around 35.5%, where most of the cases are identified in UC Kharotabad as you can see in graph below.



GBV-HIV cases (MEN)

Literacy and knowledge

Third part of questionnaire is about literacy and knowledge; in this case most of individuals have not sufficient knowledge related to many things like GBV, HIV/AIDS etc. So in order to provide them a sufficient knowledge SEHER added this part in questionnaire, most of the cases were found during baseline that most of the families don't take consent from women in family issues.

Literacy in Men

		Frequency	Percent	Valid Percent	Cumulative Percent
Literacy	Yes	132	55.0	55.0	55.0
	No	108	45.0	45.0	100.0
	Total	240	100.0	100.0	

55% of men are literate in the targeted community, here literate can be 1st standard or 1 years of schooling, and 45.5% of men never seen school in their life not only for a
Day, where 0.4% of men have 0 to 2 years of schooling, 6.7% have 3 to 4 years of schooling, 9.6% have 5 to 6 years, 7.5% have 7 to 8, where 17.1% have more years of schooling like 10th standard or more.

Years of schooling MEN

		Frequency	Percent	Valid Percent	Cumulative Percent
Years of schooling	0+ to 2 years of schooling	1	.4	.4	.4
	2+ to 4 years of schooling	16	6.7	6.7	7.1
	4+ to 6 years of schooling	23	9.6	9.6	16.7
	6+ to 8 years of schooling	18	7.5	7.5	24.2
	8+ years of schooling	34	14.2	14.2	38.3
	more	41	17.1	17.1	55.4
	NA	107	44.6	44.6	100.0
	Total	240	100.0	100.0	

NA is number of not educated individual

In below graph you can see the reason that why most of the people in this community are illiterate, where most of illiterate people suffer from poverty, 12.5% have no interest in education, where in rare cases protection issues take place around 0.4%

Reason for no education MEN

		Frequency	Percent	Valid Percent	Cumulative Percent
Reason for no education	Poverty	78	32.5	32.5	32.5
	Lack of interest	30	12.5	12.5	45.0
	culture	2	.8	.8	45.8
	protection issues	1	.4	.4	46.3
	NA	128	53.3	53.3	99.6
	others	1	.4	.4	100.0
	Total	240	100.0	100.0	

NA is number of educated individuals

Consent of women in family issues MEN

		Frequency	Percent	Valid Percent	Cumulative Percent
Consent of women	Yes	162	67.5	67.5	67.5
	No	78	32.5	32.5	100.0
	Total	240	100.0	100.0	

Women rights to education MEN

		Frequency	Percent	Valid Percent	Cumulative Percent
Women right to educate	strongly agreed (SA)	34	14.2	14.2	14.2
	agreed (A)	153	63.8	63.8	77.9
	disagreed (D)	45	18.8	18.8	96.7
	strongly disagreed (SD)	8	3.3	3.3	100.0
	Total	240	100.0	100.0	

Literacy WOMEN

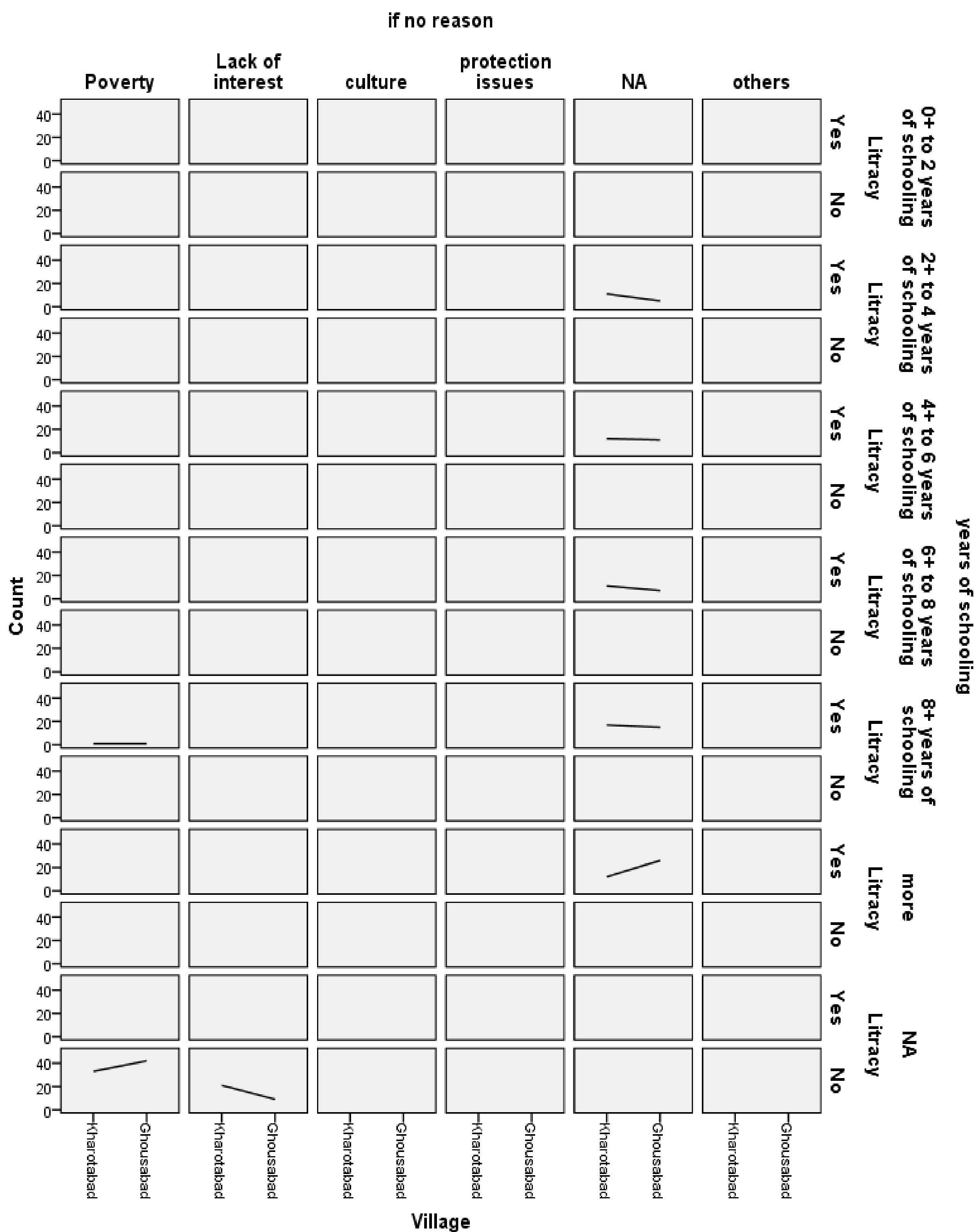
		Frequency	Percent	Valid Percent	Cumulative Percent
Literacy	No	360	100	100.0	100.0
	Yes	0	0		
	Total	380	100.0		

Reason of no education

		Frequency	Percent	Valid Percent	Cumulative Percent
Reason	Poverty	210	62	62	58.3
	culture	150	38	38	100.0
	Total	360	100	100.0	

Consent of women

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	85	23.6	23.6	23.6
	No	275	76.4	76.4	100.0
	Total	360	100	100.0	


if no reason
Poverty
Lack of interest
culture
protection issues
NA
others
Count
40
20
0
Yes
No
Litracy
0+ to 2 years of schooling
2+ to 4 years of schooling
4+ to 6 years of schooling
6+ to 8 years of schooling
8+ years of schooling
more
NA
years of schooling
Kharotabad
Ghousabad
Village

Impact of GBV-HIV/AIDS

4th and final part of questionnaire is impact and response of GBV-HIV/AIDS on the life of individual and how community reacts on this situation, most of the cases we have found leads to depression which means that there must be some factors forcing victim to set into this state.

Impact of GBV-HIV/AIDS MEN

		Frequency	Percent	Valid Percent	Cumulative Percent
Impact of GBV-HIV	depression	36	15.0	15.0	15.0
	anxiety and nervousness	74	30.8	30.8	45.8
	Sleeping disorder	27	11.3	11.3	57.1
	having suicidal tendencies	6	2.5	2.5	59.6
	Miscarriages	6	2.5	2.5	62.1
	Limited to homes	90	37.5	37.5	99.6
	NA	1	.4	.4	100.0
	Total	240	100.0	100.0	

Impact of GBV-HIV/AIDS WOMEN

		Frequency	Percent	Valid Percent	Cumulative Percent
Impact of GBV-HIV	depression	90	23.7	25.0	25.0
	anxiety and nervousness	73	19.2	20.3	45.3
	Sleeping disorder	43	11.3	11.9	57.2
	having suicidal tendencies	22	5.8	6.1	63.3
	Miscarriages	28	7.4	7.8	71.1
	Limited to homes	104	27.4	28.9	100.0
	Total	360	94.7	100.0	

Response of Family and community with victim MEN

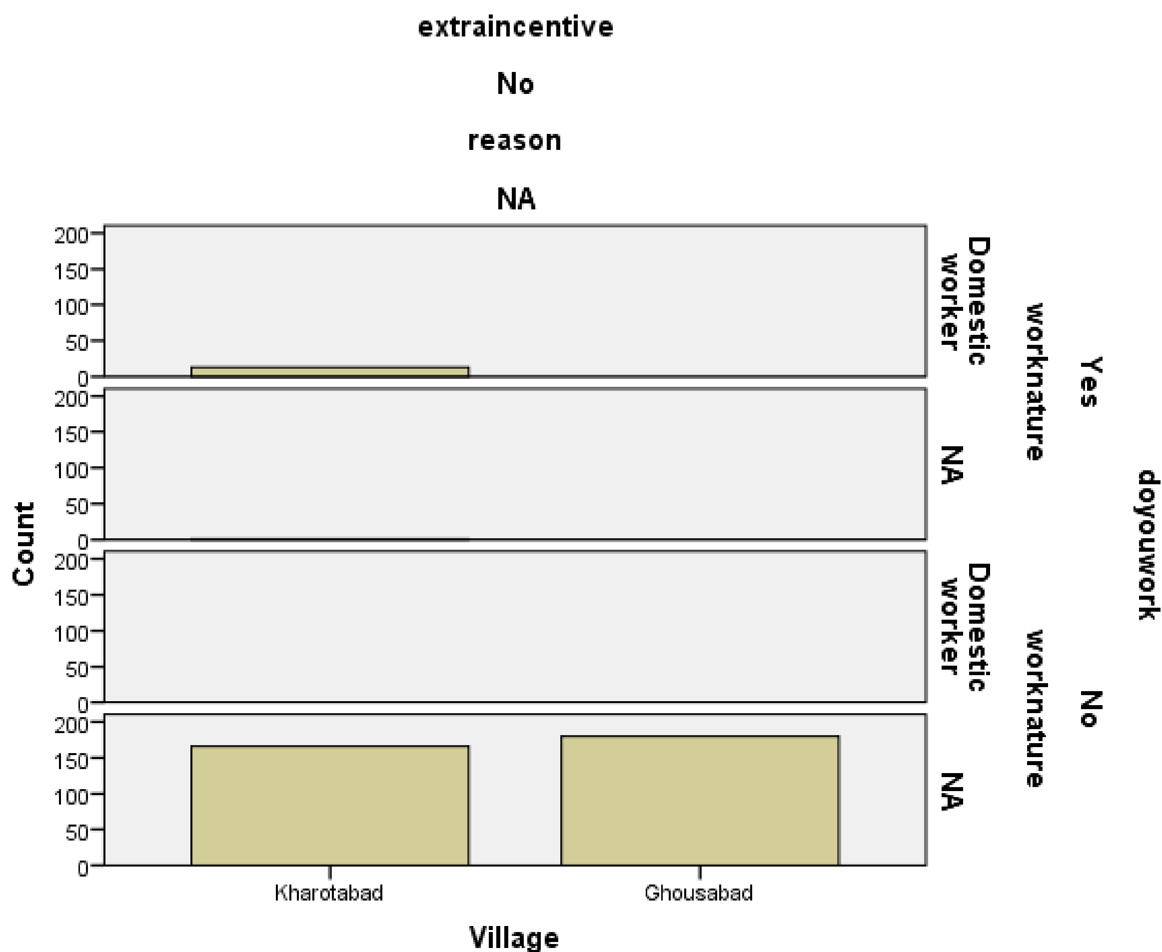
		Frequency	Percent	Valid Percent	Cumulative Percent
Response	sympathizing with survivor	80	33.3	33.3	33.3
	counseling with survivor	58	24.2	24.2	57.5
	Ignoring the survivor	6	2.5	2.5	60.0
	victimizing the survivor	2	.8	.8	60.8
	tack any action to protect	28	11.7	11.7	72.5
	countering violence	65	27.1	27.1	99.6
	NA	1	.4	.4	100.0
	Total	240	100.0	100.0	

Response of Family and community with victim WOMEN

		Frequency	Percent	Valid Percent	Cumulative Percent
Response	sympathizing with survivor	89	23.4	24.7	24.7
	counseling with survivor	71	18.7	19.7	44.4
	Ignoring the survivor	5	1.3	1.4	45.8
	victimizing the survivor	1	.3	.3	46.1
	tack any action to protect	72	18.9	20.0	66.1
	countering violence	122	32.1	33.9	100.0
	Total	360	94.7	100.0	

Working women:

This part of questionnaire is only included in Women Questionnaire, in which SEHER decided to analyze the employment and empowerment state of a women in targeted UC, s, but the situation is quite serious after analyzing the life of a women in targeted area, most of the women do not allowed to go to school, workplace etc. the figures in frequencies is given below



This graph and table below represents the work status of women, where 90.1% do not work or did not allowed to work, and 3.7% are domestic workers.

Do you work (WOMEN)

		Frequency	Percent	Valid Percent	Cumulative Percent
Do you work	Yes	14	3.7	3.9	3.9
	No	346	91.1	96.1	100.0
	Total	360	94.7	100.0	
			100.0		

As we can see that 96% women in both UCs do not work or may not be allowed to work outside. Just 3.9% of women work, see the table below to find the work nature of 3.9% of women.

(If yes)Work nature

		Frequency	Percent	Valid Percent	Cumulative Percent
Work nature	Domestic worker	13	3.4	3.6	3.6
	NA	347	91.3	96.4	100.0
	Total	360	94.7	100.0	
			100.0		

The remaining are domestic workers (House hold earner i.e. embroidery), below figure have frequencies of discussions of issues with families which is the main component of locking down women inside the house.

Discuss with family on protection issues

		Frequency	Percent	Valid Percent	Cumulative Percent
Discuss	No	340	94.7	100.0	100.0
	Yes	20	5.3		
Total		360	100.0		

And below is the reason of 94% of women that why they do not discuss the protection issues. They do not discuss protection issues because of the reaction of the family, as it is analyzed that 39.7% are afraid of family reaction, 33.9% did not discuss because they will not allowed them to go outside for education or workplace, and 20.3% did not discuss fir some other reasons.

(If No) why

		Frequency	Percent	Valid Percent	Cumulative Percent
why	Afraid of family reaction	151	39.7	41.9	41.9
	family not allow to work	129	33.9	35.8	77.8
	Others	77	20.3	21.4	99.2
	Total	360	94.7	100.0	
			100.0		

Focus Group Discussions

6 FGD's have been done out of which 4 are with women and 2 with men community members. The selected FGD, s participants were teachers, community members, shopkeepers, housewives etc. All FGD, s were interactive sessions in which the main topic was HIV/AIDS and GBV. Session starts with the introduction and aim of project, and some knowledge sharing related to GBV-HIV. FGD, s are conducted in both targeted area Kharotabad and Ghausabad. The response of community members were the same as in baseline questionnaires, which is already discussed in details with statistics. Below pictures are attached of FGDs.

Male FGD in Ghausabad

Male FGD in Kharotabad

Female FGD in Ghausabad

Female FGD in Kharotabad

Conclusion

The overall result of baseline come out with a deep acquaintance of targeted area, the individuals and about their knowledge level particularly in the GBV-HIV/AIDS perspective and what kind of GBV related issues persist among the targeted population. The initial facts about the gender inequality and the poor status of women are visible in the data consequence obtained during the baseline study.

Social abuses particularly against women i.e. early marriages, walwa etc are common practices in the project target community and the religious tremendous belief persist in numerous strong forms which are used against women in the name of so-called religious/cultural honor. The mobility of women is restricted and they have access only at the source which is not deemed to dire for them by their male dominant family members. The basic literacy not only among women but in male members of the community is much low causing the community remains backward and sightless from the development world and life standard.

The GBV issues are much common among the communities of both at Ghausabad and Kharotabad whereas they are more exposed to HIV risk factor than any other population group due to zero awareness about HIV and AIDS.

The strategy should be developed against the findings of the baseline to address the GBV-HIV issues through the project cycle.

Recommendations

- WFS's are recommended to empower the women and promote lively skills trainings to prevent HIV/AIDS in order to aware communities and to share lifesaving knowledge.
- The Skill enhancement activities should be launched at each cluster of the targeted areas as they have lack of education as well as the employment opportunities in Government and private sectors.
- They Community of Ghausabad and Kharotabad are mainly illiterate and have very low literacy particularly among women, the adult literacy is recommended to provide the basic education to the men and women of the communities.
- The health facilities are not available for the targeted population nearby and they have some unpracticed quacks on pity self made clinic, where they are exposed to receive infections via unprofessional surgical and medical treatment, it is recommended to adopt the quality health practices at their areas or nearby, the local quacks may be given trainings on safe medical practices to minimize the risk factor.
- The social-economic situation of the people at the targeted areas is very poor and the male part of population is only considered for earning purpose where as the women are bounded to their homes and do the house works only, some of the women who have some skills i.e. tailoring, embroidery, they impart somehow in the total earnings of the family, where as the women and girls who intend to learn any skill face, the lack of opportunities where they may learn some skill enhancement trainings. It is recommended to provide the targeted population with easy access to skill centers where they learn the different skills as of their tendency free of cost.
- Gender based violence is common due to lack of awareness and education regarding women rights, child rights. It is recommended to raise the voice among the community regarding human rights, particularly women's and child's rights at the targeted areas through the help of Islamic teachings.