UNHCR
The UN Refugee Agency

2022

PARTICIPATORY ASSESSMENT REPORT – PAKISTAN

ACKNOWLEDGMENTS

This report provides findings of the participatory assessment conducted with refugees and host communities in Pakistan. Focus group discussions and interviews were held with 2,204 Afghan girls and boys, women and men across 11 thematic areas, in 45 locations throughout Balochistan, Islamabad Capital Territory, Khyber Pakhtunkhwa, Punjab and Sindh provinces, as well as semi-structured discussions with Somali youth and elders in Islamabad Capital Territory.

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COVER PHOTOGRAPH:
UNHCR & partners conducted a participatory assessment in the Al Asif Square in Karachi © UNHCR/Asif Shahzad

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AFGHANISTAN
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Punjab
Chaman
Loralai
Quetta
PAKISTAN
Dalbandin
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Balochistan
Sukkur
REPUBLIC ISLAMIC OF IRAN
Sindh
Hyderabad
Karachi
INDIA
Arabian Sea
UNHCR Country Office
UNHCR Sub-Office
UNHCR Field Unit
Refugee Location
Refugee Settlement
Refugee Urban Location
Crossing point
National capital
Provincial border
Line of Control as promulgated in the 1972 SIMLA Agreement Jammu Kashmir
International Boundary
Province
District
100km
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.
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Refugee women during a session of the participatory assessment in Rawalpindi, Punjab © UNHCR

1. Introduction

The **2022 Participatory Assessment (PA)** exercise was the first to take place since the hiatus in the in-person consultations caused by the onset of COVID-19 pandemic. The Participatory Assessment was carried out by **UNHCR in collaboration with partner organizations, other UN agencies and programmes, and government counterparts**.

Between August and October 2022, multifunctional teams conducted close to **200 focus group discussions (FGDs)** and **50 key informant interviews (KIIs)** with **2,204 Afghan girls** and **boys, women** and **men** across 11 thematic areas, in 45 locations throughout **Balochistan, Islamabad Capital Territory, Khyber Pakhtunkhwa, Punjab and Sindh**, as well as semi-structured discussions with Somali youth and elders in Islamabad Capital Territory.

Purposive sampling was used to select participants for both, FGDs and KIIs to ensure adequate representation in terms of age, gender, ethnic background, and meaningful participation by persons with specific needs.

This document includes a description of the methodology employed and individual sections for each thematic area with detailed analysis and sector specific recommendations.

2. Methodology

The assessment was conducted following a qualitative methodology including a desk review of existing documents and assessments, FGDs and key informant KIIs, and semi-structured discussions. Data collection took place between August and October 2022.

Enumerators and facilitators who collected the data were trained on ethical standards, confidentiality, consent, selection of participants, group dynamics, facilitation of discussions and conducting interviews. Systematization and prioritization forms, adapted from The UNHCR Tool for Participatory Assessment in Operations, were the main tools used for data collection.

Findings were consolidated into separate area reports by each sub-office (**Country Office Islamabad, Sub-office Peshawar, Sub-office Quetta**) before being synthesized into this report.

2.1 Locations and number of FGDs and KIIs:

Locations by Sub-Office	PoCs in AoR[1]	Context	FGD	KII interviews
Islamabad Rawalpindi Mianwali (RV Kot Chandana) Karachi	313,986	Urban RV	**24**	**8**
Peshawar urban and RV Naguman Kababyan, Nowshera (Akora Khattak) Charsadda (Utmanzai) Mardan Urban and RV Bagicha, Jalala Mansehra Chitral (Kalkattak) Bannu (Bizen Khel)	692,662	Urban RV	**54**	**15**
Quetta urban and RV Mohammad Kheil Pishin (Surkhab, Saranan) Chagai (Chagai. Lejay Karez, Posti) Killa Saifullah (Malgagai) Loralai (Ghazgai Minara, Kotwai, Zar Karez)	328,553	Urban Rural RV	**120**	**27**

[1] *Overview of Refugee and Asylum-Seekers Population, UNHCR Pakistan, September 2022. Figure includes Proof of Registration (POR) card holders, UNHCR registered asylum-seekers and mandate refugees.*

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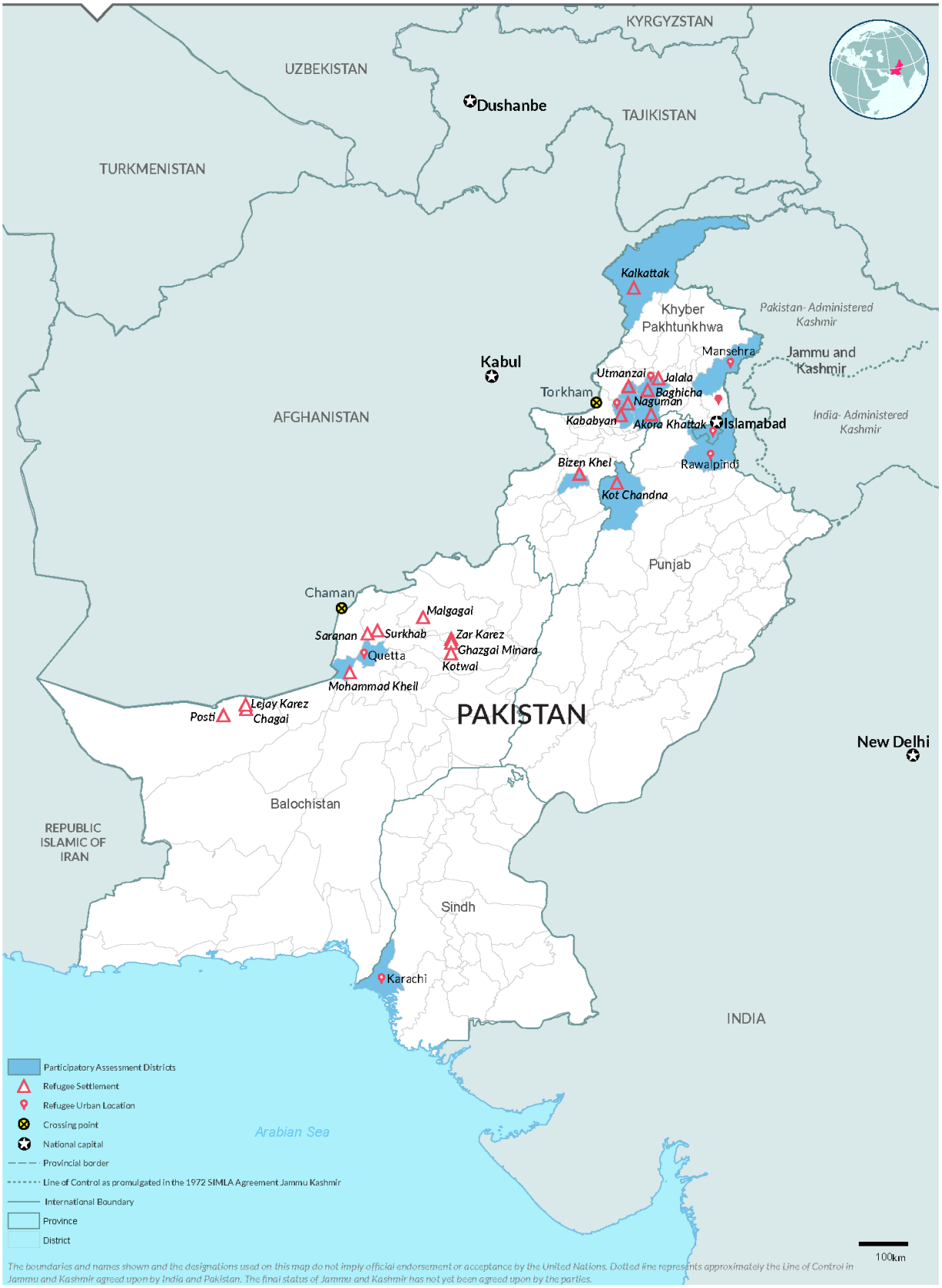
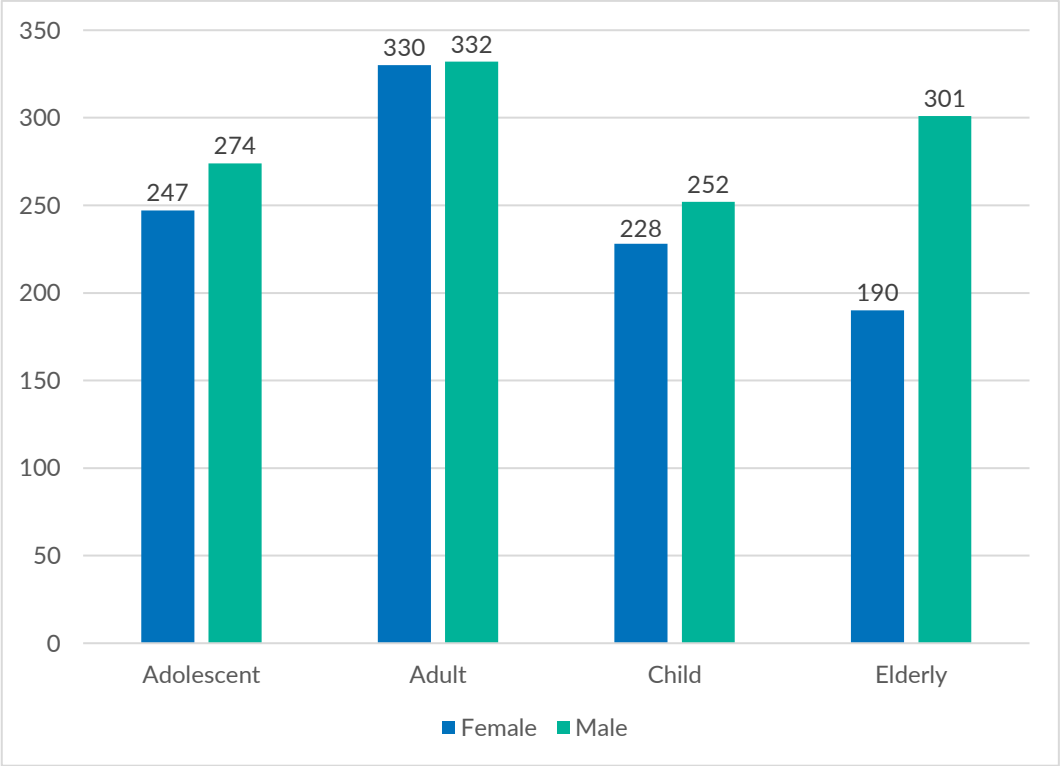
PAKISTAN
Participatory Assessment Exercise Districts
October 2022



Printing date: 24 Oct 2022 **Sources:** UNHCR, UNHCS **Author:** UNHCR - HQ Geneva **Feedback:** zahoor@unhcr.org **Filename: UNHCR PA Exercise**

UNHCR & partners conducted a participatory assessment with men in the Al Asif Square in Karachi
© UNHCR/Asif Shahzad

2.2 Age and gender breakdown of participants



2.3 Focus group discussions

FGDs provide in-depth information on the perceptions and experiences of a selected group of individuals. The FGDs conducted for the Participatory Assessment provide information on the protection situation of and access to services for women, men, girls and boys of diverse backgrounds from urban and rural areas and Refugee villages across the country as well as their capacities and suggested solutions.

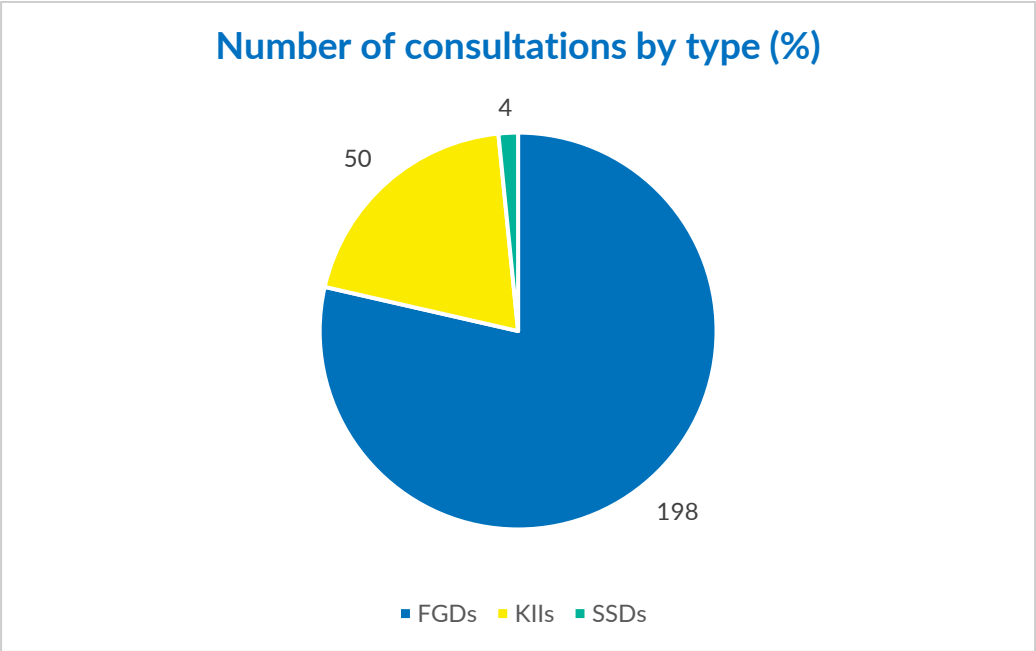
The FGDs targeted women, men, girls and boys aged between 10-13 (children), 14-17 (adolescents), 18-59 (adults) and 60+ (elderly) years, including ethnic minorities and persons with disabilities. Throughout Pakistan, **a total of 198 FGDs were conducted with 2154 individuals across all age groups**.

2.4 Key Informant interviews (KIIs)

KIIs are qualitative interviews with people who have particularly informed perspectives on specific types of populations or aspects of service delivery. **The KIIs for this Participatory Assessment targeted persons with disabilities as well as their immediate family/caregivers.**

2.5 Semi-structured discussions

Semi-structured discussions are conducted with a small number of people in an informal and conversational way by using open-ended questions. **For the purposes of this Participatory Assessment, SSDs were limited to the Somali community residing in Islamabad,** given the relatively small size of this population.



Afghan refugee children drawing during the session of the participatory assessment in Al Asif Square in Karachi, Sindh.
© UNHCR/Asif Shahzad

3. Thematic analysis

3.1 Child protection

All groups surveyed – men and women, children as well as the elderly – expressed concerns regarding the protection environment for children. Overall, across all geographic areas and contexts, **child labour** and **early marriage** were commonly mentioned by refugee communities as the most salient threats to children's physical and psychosocial wellbeing. Communities attributed these issues to poverty, caused by refugees' lack of access to sufficient livelihoods and right to work, as well as (in the case of child marriage) cultural norms and customs that encourage parents to marry off their girls at a young age (further elaborated in **Gender-Based Violence**).

A high number of children, particularly in KP and Balochistan, were found to be engaged in labor in order to support their families financially. Common types/settings of child labor included agricultural labor, garbage collection and scrap picking, working in market stalls, auto-mechanic shops, or in the restaurant/hospitality sector. In many of these settings, such as when working with heavy machinery or hazardous materials, or when roaming the streets unaccompanied, children reported being exposed to harm, exploitation and/or abuse.

In some communities, the widespread availability and use of drugs was brought up as a risk factor for adolescents, either in the form of **exposure or addiction to drugs, harassment or abduction** by drug dealers/gangs.

Both boys and girls mentioned as a key issue the **lack of safe, age-appropriate recreational spaces** where they could interact with their peers. In the case of girls, this negatively impacted their **mental health**, as they are often confined to their homes, resulting in feelings of disempowerment, loneliness, and stress.

Children with disabilities reported a larger magnitude of harassment, bullying and neglect not only outside the home i.e. schools but also at home.

RECOMMENDATIONS

- *Expand and support child-friendly spaces (CFS) in urban, rural and RV locations.*
- *Strengthen partnerships with parents, children and community leaders to raise community awareness on child protection issues (child rights, adverse effects of child labor, corporal punishment and early marriage).*
- *Engage operational partners with relevant expertise to raise awareness of communities, especially children and parents, on substance abuse.*
- *Engage with Law Enforcement Agencies in high-risk urban areas where violent crime is affecting refugee communities.*
- *Provide or continue investment in extracurricular activities, including sports events, especially for girls, to meaningfully engage children and contribute to their psychosocial and physical wellbeing.*
- *Establish and develop child clubs to provide space for healthy peer interactions and support.*

3.2 Education

Education was commonly mentioned by many groups as a key priority; almost all communities reported having some access to education, whether public, private or non-formal (neighbourhood schools established by Afghan communities and following the Afghan curriculum). However, access to quality education, and access to education beyond the primary level, was seen as severely limited in the majority of areas and communities surveyed.

From the children surveyed, physical and administrative barriers emerged as challenges to education. Many communities were found as having few or no schools in their vicinity, leading to lengthy and often dangerous journeys to school. For those who do have a school physically within reach, families faced enrolment issues due to a lack of documents (such as a “Form B” or “NOC”).

Where schools were accessible, the **quality of education** was mentioned as a **key deterrent**. Schools in RVs throughout KP, Punjab, and Balochistan were reported to be suffering from a lack of resources and crumbling infrastructure, overcrowded classrooms (sometimes up to 60 students).

Some groups of children reported the perception of high rates of teacher absenteeism and frequent use of corporal punishment as key factors that resulted in high rates of school dropout in their community.

Refugee communities surveyed were found to have challenges accessing education beyond primary level (grade 5). Lack of availability of secondary and tertiary educational institutions in their area, as well as cost of attendance, were mentioned as the causes.

Girls were found to be significantly less likely than boys to receive education – in families with multiple children and limited resources, boys' education tended to be prioritized over girls', due to cultural and community norms dictating that girls should be kept at home, engaged in domestic chores and/or married.

PROBLEMS IN SCHOOLS

- ⊗ Overcrowding in classrooms
- ⊗ Run-down/hazardous classrooms and buildings
- ⊗ Lack of clean drinking water and sanitation facilities
- ⊗ Underqualified teachers
- ⊗ Language barrier with teachers
- ⊗ Use of corporal punishment
- ⊗ Short supply of scholastic materials
- ⊗ Lack of security on the way to/at school

Children with special education needs reported significant barriers to attending school, due to peer victimization, lack of trained teachers and/or inclusive curricula and systems specialized to their needs.

RECOMMENDATIONS

- *Expand cash assistance programmes to support enrolment and retention of students in primary and secondary education, especially girls.*
- *Expand alternative learning programmes, including at-home learning programmes and accelerated learning programmes, particularly for girls.*
- *Assess the accessibility of schools and learning environment for refugee children, particularly children with special education needs.*
- *Improve existing educational infrastructure including WASH and exploring opportunities to expand secondary education services in the absence of public education facilities in RVs.*
- *Support community-led initiatives to mitigate protection risks experienced en route to schools.*
- *Expand tertiary education support programmes such as DAFI; increase community awareness of these programmes including eligibility criteria and application process.*

Afghan refugee girls during a session of the participatory assessment in Khyber-Pakhtunkhwa. © UNHCR

3.3 Legal and physical protection

The reported access to rights varied significantly between geographic areas, sometimes even within the same province.

Most individuals consulted through this exercise were Proof of Registration (PoR) card holders. The PoR card, the identification card issued by the National Database and Registration Authority (NADRA) to Afghan refugees, is the document that affords the higher level of protection and access to rights for refugees in Pakistan – these include **the right to freedom of movement within Pakistan, access to banking, telecommunication services and education, and the right to rent residential property**.

However, PoR cardholders reported facing multiple challenges accessing theses rights. Some reported being unable to open **bank accounts** or register **SIM cards** in their own name, often resorting to borrowing the identity of a Pakistani citizen to access such services. Refugees holding PoR cards reported that they face challenges while **using road for inter-city/province travel.** More specifically, they reported having experienced harassment and/or extortion by the police or private transportation providers when traveling between cities or provinces. **Booking accommodation such as guest houses or hotels also remains a challenge,** as reported by some respondents.

The lack of the formal **right to work** was mentioned by all surveyed groups (PoR cardholder or otherwise) as a key issue and priority (**Livelihoods**).

Crucially, the PoR card does not afford the **right to own land/property**. Refugees across Pakistan reported issues such as evictions (**Shelter**), and or exploitative sharecropping arrangements.

Some communities reported that law enforcement agencies routinely conduct search operations and arbitrarily detain refugees, regardless of their documentation status, and families often do not have access to detainees and are unaware of the charges. There were reports of **refoulement** of newly arrived Afghans who did not have any documentation.

Communities in urban areas were more likely to state that they generally felt unsafe, and stated they avoided certain areas known for their high prevalence of street crimes. Communities are unlikely to seek help from Law Enforcement Agencies in such instances due to lack of confidence in their support.

Due to their comparatively higher presence in public spaces outside the home (for work, school, or community participation), **men** were more likely than women to hold their own identity documentation (PoR card). However, this increased presence outside the home also made them more vulnerable to arrest, police harassment or deportation. Due to cultural practices and gender roles that limit women's exposure to the outside world, refugee women were less likely to hold their own identity documentation.

RECOMMENDATIONS

- *Advocate with national authorities for refugees to have secure Housing, Land and Property rights.*
- *Advocate with national authorities for a more systematic implementation of existing rights to services for PoR cardholders, such as the right to open bank accounts and register SIM cards.*
- *Continue to sensitize communities on their rights and providers of legal assistance to increase awareness on how and when to access legal and protection services.*
- *Continue building capacity of law enforcement agencies on refugee protection.*

3.4 Community-based complaint mechanism (CBCM)

While some refugee communities know how to directly contact UNHCR or partners to lodge a complaint, **many did not have awareness of the existing complaint and feedback channels**. This was particularly pertinent for rural female groups who lack literacy skills and access to communication devices such as personal phones.

Many refugees stated that their **sole channel of two-way communication with UNHCR was via a trusted elder or focal point in the community**. However, this was seen to cause **"gate-keeping"** in the community; some refugees complained that leaders purposefully keep information to themselves or their relatives in an attempt to monopolizing access to information.

> **Quotes from the field**
>
> *"Because our men do not like it, we do not have mobiles."*

Refugees in most communities stated their preferred method of communication with UNHCR was through in-person consultations, with their next preference being via telephone. Some refugees also indicated their preference for WhatsApp, particularly audio messages.

Refugees also criticized that their feedback to organizations was **not addressed** in a timely manner, if at all, and asked for more physical presence by organizations in their communities. Additionally, refugees were not always aware of the services available to them, nor the differences between various partner organizations/service providers. Therefore, they asked for organizations to better display/communicate their services and eligibility criteria.

RECOMMENDATIONS

- *Increase outreach and information dissemination on UNHCR and partner community-based complaints mechanisms.*
- *Expand the use of alternative channels of CBCM (such as WhatsApp) that are more equitable and easily accessible for communities.*
- *Assess current CBCM's accessibility and effectiveness, particularly for persons with specific needs and women and girls.*
- *Increase the number of face-to-face meetings between refugee communities and UNHCR/partners, particularly with PWSNs and marginalized communities.*
- *Targeted recruitment of female Outreach Volunteers (OVs).*

3.5 Women's participation and empowerment

In all Afghan communities surveyed, women's participation in decision-making and the status of women in general was found to be greatly **diminished**. Women and men of all age groups affirmed that women and girls had **little to no voice** in making important household or community-level decisions, let alone decisions pertaining to their own lives, such as when or whom to marry. There were also widespread reports of gender-based discrimination, starting from birth.

Quotes from the field

"Some people are not happy when a girl is born. They prefer sons over daughters… and give less food to their daughters than they give to their sons."

Women are often explicitly **denied or discouraged from pursuing an education** or **assuming any role** other than a wife and a mother; as school-based education is seen as irrelevant for such a role, girls are often not given any opportunity to attend school, or only allowed to attend school before becoming engaged.

The main causes identified behind the issue of gender disparity **were long-standing and widely held socio-cultural beliefs, customs and community structures that favor men and devalue women.** In the male groups surveyed, men stated that men and women should rightly be relegated to their proper roles and separate spheres of living and influence, which for men was outside the home, while for women was within the home. They did not perceive any issue with this, nor any power imbalance between women and men. Customs such as walwar, or "bride price", the widespread practice of marrying off a daughter at a price, underscore the lower status of girls and women. Lastly, traditional community leaders such as elders and community decision-making bodies (Jirga) are almost exclusively male.

In contrast to the men, girls and women across all locations showed high awareness and a keen understanding of the power imbalance between women and men. They believed that men seek to monopolize and maintain power and influence, and do not want this to change. This finding coincided with the boys' groups.

RECOMMENDATIONS

- *Identify influential community representatives as agents of social and behavioural change and advocacy for women's inclusion and empowerment.*
- *Sensitize and raise awareness of communities including elders, men, and boys, on issues of early marriage and girls' right to education.*
- *Increase access to livelihood skills training programmes for women.*
- *Support the development of women's community structures (such as a women's advisory council)*
- *Support the establishment of safe spaces (women's communal places).*
- *Raise awareness on gender equality and women's rights through community dialogue.*

3.6 Gender-based violence (GBV)

Refugees across all populations and geographic areas highlighted that they are at risk of various forms of violence from their own families, communities, and sometimes host communities. In almost all communities, **harmful traditions and cultural norms** were found to pose serious protection concerns for women and girls, often putting them in at disproportionately **higher risk of harm, exploitation, abuse and/or lack of access to basic rights**.

Most mentioned harmful practices/forms of violence across communities included early and forced marriages, *walwar*[2], the restriction on the freedom of movement and access to basic rights such as health care or education, as well as daily harassment when out in public, such as going to and from the school or market.

Girls and women stated that according to cultural norms, they were married off by their male family members in return for a girl from another family (exchange marriage) or to maintain the family inheritance (widows being forced to marry their late husband's brother). In multiple communities, there were reports of girls given as compensation to settle a debt or a feud.

COMMON FORMS OF GBV

- Forced marriage
- Child/early marriage
- Wife inheritance
- Denial of access to basic services and/or resources
- Domestic violence
- Phycological abuse
- Street harassment
- Sexual violence

Afghan refugee women and girls during a session of the participatory assessment in Khyber-Pakhtunkhwa.

[2] *Practice of the groom or his family to pay the bride's family a substantial sum of money – so-called "bride price"*

Focus group discussions with women and men confirmed the prevalence of **domestic violence** in many refugee communities. Men further stated that the **psychological stress** and anger resulting from their lack of rights and uncertain futures played a part in their use of violence against their wives and children.

Quotes from the field

"Husbands ..... they also get angry when food is not cooked well."

In most groups, girls and women stated they **had little to no awareness of any organization** or public institutions (police, hospital) that may help survivors of GBV, or what **services** were available.

Another barrier to seeking help for survivors is the **cultural stigma** attached to speaking out against perpetrators, or even disclosing experiences of gender-based violence. This was especially the case when the perpetrator is within one's own family, such as the husband.

Women stated **their own families are not supportive** in cases of domestic violence; as a family's honour is often tied to her husband's, disclosing family matters is seen as disgraceful and shameful for both the woman and her husband, which **discourages** many girls and women experiencing domestic violence from speaking out or seeking support, let alone hold the perpetrator accountable.

Quotes from the field

"Whenever I go outside, my neighbour tells my father that he should not allow his daughter to go outside. Men outside the family also suggest to my father to beat me because I go outside of the house."

BARRIERS TO REPORT AND SEEK HELP

- ⊗ Stigma attached to victims/survivors
- ⊗ Family is the perpetrator
- ⊗ Low awareness of services, support available for GBV survivors
- ⊗ Engrained beliefs/cultural or traditional practices that perpetuate or normalize gender inequality and/or GBV

Traditions and gender-based norms that disproportionately disempower women and dictate that women must obey the male head of their household were seen to further foster an environment that tacitly endorses domestic violence behind closed doors as a valid form of control and discipline, while further deterring survivors or bystanders from reporting or seeking help.

Also observed from the female participants was a sense of **"feeling stuck"** and **helpless** to change their situation; some elderly women stated that Islamic law dictated their duty to cover themselves properly and obey their men. Some girls and women disclosed that while they wished to break free from such restrictive traditions and norms, they were also fearful of the **public shaming and stigma** attached to diversions from conventional behaviour. In this way, cultural norms were seen to have a powerful influence on the minds and views of individual members of communities, thus perpetuating and sustaining the status quo.

RECOMMENDATIONS

- *Assess the efficiency of existing UNHCR and partner GBV reporting and referral mechanisms.*
- *Strengthen GBV reporting structures and referral mechanisms by making use of the existing community structures (e.g. elders) and developing new ones (women's advisory council or specialized OVs).*
- *Ensure gender parity and presence of female staff during field visits, consultations and at the protection counselling desks.*
- *Engage men and boys as well as influential community members in GBV social and behavioural communication sessions.*
- *Develop capacity of community members on psychological first aid (PFA) and community-based mental health and psychosocial support (MHPSS).*
- *Ensure access to psychosocial counselling for GBV survivors and women and girls in general.*
- *Increase sensitization and awareness in the refugee and host communities on the risks of GBV, its effects on individuals and the importance of reporting GBV.*

3.7 Health

Across all locations, access to healthcare was seen to be a **key priority for communities**. The refugee community accesses health services through Basic Health Units (BHUs) in Refugee Villages where such facilities are present, and otherwise public and private clinics and hospitals (with some limitations). The most reported ailments across population groups across locations are **acute infectious diseases** such as malaria, skin diseases, diarrhea, tuberculosis and upper respiratory tract infection, as well as **chronic conditions** such as liver and kidney issues, hepatitis, hypertension, diabetes, and cancer.

The reported causes of the health problems are common among women and men of different ages and population groups. These include **poor hygiene and sanitation, lack of safe drinking water and poor water supply from existing sources**, especially in the refugee villages or urban slum areas. Poor waste management was also seen to contribute to the spread of diseases in some urban areas. Refugees living in Balochistan and some areas of KP stated that the tough climate and environmental conditions of the region exacerbated their health issues.

Refugee women, men, girls and boys of different backgrounds face various barriers to access healthcare. Those living in Refugee Villages with BHUs stated that these **facilities tended to be poorly equipped and out of stock of basic medicine**. In addition, women and girls in some RVs reported issues with accessing the BHU due to the **lack of a female doctor**. For urban refugees, most are able to access government hospitals, but there were some reports of **hospitals refusing treatment to refugees**, as they did not recognize the PoR card as a valid form of documentation.

Even those refugees who are able to access healthcare facilities face financial challenges in seeking **tertiary care for serious medical conditions** or **emergencies**, as both public and private hospitals charge fees that are too onerous for the refugees. As there is no public or private assistance available for medical treatment for refugees, many simply forego treatment, while some communities were found to address this issue by raising collective funds to support vulnerable families' medical treatment.

In addition, elderly women and men, as well as refugees living in rural and urban periphery areas mentioned the **long distances to health facilities** and the **lack of available transportation options** as barriers to accessing healthcare.

Maternal and gynaecological health care was mentioned as a major gap and a priority in many communities. For complicated or high-risk pregnancies, healthcare providers particularly in the private sector were reported to deny care at times or charge prohibitive fees, leaving many women without access to vital care.

BARRIERS TO HEALTH CARE

Urban/rural

- ⊗ Long/expensive journeys to facilities
- ⊗ High cost of treatment

Refugee villages

- ⊗ No facility
- ⊗ Poor quality of care available at BHUs
- ⊗ Lack of female doctors at BHUs

Refugees with physical disabilities expressed that they faced barriers in accessing health care due to their **conditions and mobility issues**. They were not able to afford the **cost of assistive devices** such as wheelchairs and hearing aids.

MENTAL HEALTH

Mental health issues were widely reported in all communities surveyed – these included **depression, chronic stress, anger and insomnia**. In men these were attributed to the lack of access to livelihoods, while for women stressors identified were gender-based discrimination and violence and restrictions on access to rights and freedom of movement.

Barriers to proper diagnosis and treatment included **stigmatization of mental health in general, low awareness, lack of relevant providers in the area, or cost**. Mental health was found to be rarely discussed openly, and communities were likely to address psychological distress using spiritual and folk knowledge, cultural or spiritual healing practices or consulting religious leaders.

RECOMMENDATIONS

- *Raise community awareness on health-related concerns, particularly on hygiene and mental health.*
- *Strengthen referral pathways with public healthcare providers for persons with health needs and disabilities.*
- *Provide transportation assistance for PWSNs with medical conditions to facilitate access to healthcare facilities.*
- *Explore further areas where RAHA (or RAHA-like) interventions in refugee-populated areas would improve access and availability of health services.*
- *Ensure presence of female staff at RV BHUs.*
- *Increase access to professional psychologists, counsellors, and mental healthcare providers.*
- *Mobilize health partners (in certain areas) to provide primary health care services, including mobile health services.*
- *Increase support for maternal and reproductive healthcare.*
- *Continue advocacy with individual healthcare providers to extend care and services to refugees.*
- *Continue advocacy for the inclusion of persons of concern in the national healthcare system, including social health protection programme.*

3.8 Livelihoods

The overwhelming majority of groups surveyed – regardless of context – reported **barriers to access livelihoods**. A main factor in this is refugees' **lack of legal right to work** in Pakistan, which relegates them to low-paying, unskilled labor, which can be dangerous and exploitative, as well as trapping them in a cycle of poverty in the long term. Some refugees who were engaged in an informal sector reported they are often exploited by the employers, who pay less than the minimum wages, besides this, there is no legal support available for refugees to protect their employment rights.

Communities also reported that they did not have access to **vocational training programs** that would allow them to access higher-paying jobs in the informal sector, while even those who have skills and entrepreneurial ambitions reported being unable to do so due to the **lack of seed money and access to financial services**.

Further, **gender norms** that prohibit women from contributing to income generation – typically, in Afghan communities, only men are allowed to engage in work outside the home – can pose a burden for households with many dependents and only a single male provider, or at times none. This also feeds into other issues such as early marriage and child labor as girls become a financial burden to families, while boys are forced to work to support the family. **Women with sewing or handicraft skills** reported that they were unable to translate their abilities into income due to a **lack of market linkages**.

Due to limited livelihood opportunities, some refugee women, men, adolescent girls and boys were seen to adopt **negative coping strategies and behaviours**. These included **substance abuse and domestic violence** for men, and for women, **survival sex**.

RECOMMENDATIONS

- *Continue to assess the impact of current livelihoods interventions and identify gaps where programming requires further strengthening.*
- *Expand market-based vocational training and skills development opportunities, particularly for adolescents/youth.*
- *Explore the provision of start-up capital grants for refugee entrepreneurs.*
- *Continue to support Community-Led Initiatives, particularly skills development and income-generating initiatives.*
- *Advocate for the inclusion of refugees in national economic empowerment initiatives.*

3.9 Wash, Sanitation and Hygiene (WASH)

In all of the provinces, refugee women, men, girls and boys reported having **insufficient access to clean good quality water and sanitation**, which was seen to be linked with **poor health outcomes**. The majority of communities indicated that they have sufficient access to latrines, but improper or insufficient waste management systems.

The reported key challenges included **inadequacy of water sources, frequent loadshedding** and in some cases, **distance** between dwellings and water sources. Groups throughout all provinces reported a **scarcity of water for domestic use and drinking**, as water supply might be limited or unreliable. Communities without these sources were compelled to rely on **water tankers**, which are a drain on limited financial resources.

In some RVs, where water sources (wells and other water points) were far away, it was left up to the **girls and women to fetch water on foot**, which places them at risk of harassment and violence.

Key problems with water quality and sanitation were **contamination of water sources, lack of health and hygiene awareness** and improper **waste management**. Refugees in some urban areas mentioned that their water sources are close to **sewers** and **septic tanks** which then **contaminate the water**. They also stated there is **lack of awareness** among the refugees regarding hygiene that also contributed to **health and sanitation problems**. In addition, many refugees stated not to have the resources or willingness to use public or private services for waste management.

RECOMMENDATIONS

- *Enhance awareness on hygiene and sanitation.*
- *Support water management committees at the RV or settlement level and provide training on water supply system management that includes maintenance and repair of the existing water sources, water pipes and boreholes.*
- *Advocate with national authorities on inclusion of RVs and refugee settlements in national water and waste management systems.*

3.10 Energy

Across the country, refugees were seen to be **facing challenges to accessing safe, reliable and affordable sources of energy**. Refugees in most urban areas appear to rely on **gas** and/or **electricity**, while those living in rural or RV contexts without these sources reported using **firewood** or other **flammable materials** (such as garbage). The usage of these was also attributed to **respiratory health issues** in some households.

The rising **costs of various types of energy** was found to be a common issue across the country: refugees expressed concerns over the **high electricity bills**, as well as the **cost of firewood**. There were also reports of **unreliable power supply** due to low gas pressure or frequent power cuts. The refugees also pointed out that due to the use of **illegal connections**, or kunda, by some community members, others in the neighbourhood experience more frequent load shedding.

Afghan refugee boys during a session of the participatory assessment in Kot Chandana Refugee Village in Mianwali, Punjab. © UNHCR.

When asked, refugees from Balochistan, KP and Punjab indicated their preference for **solar energy sources**.

RECOMMENDATIONS

- *Increase RVs' access to sustainable energy sources.*
- *Support renewable/clean energy access for RVs, refugee homes, schools, water source points and communal places to reduce communities' dependence on high-cost energy sources.*
- *Advocate with national authorities for the inclusion of RVs in national utility systems.*

3.11 Shelter

Many refugee women, men, girls and boys of various ages across settlements reported **problems with access to safe, stable and secure shelter**.

Against the backdrop of rising inflation and climate change, the majority of refugees across the country were found to be spending a major part of their earnings on rent and/or shelter repair. Due to the **lack of right to own land or construct permanent dwellings,** refugees in Pakistan for the most part live in **rented houses** (urban) or self-constructed structures (rural and RV).

In urban areas, the ongoing **economic crisis and inflated rent prices** have created a significant housing challenge for refugees. In addition, the landlords are reportedly reluctant to rent land and/or housing to Afghans, who therefore have to move places frequently. In rural and RV areas, refugees' houses are **vulnerable to damage and have a tendency to collapse** from rain, storm, and flash floods, and do not adequately protect them from harsh weather, often causing physical ailments.

In the absence of the formal right to own land/housing, some refugees were found to have traditionally developed **informal arrangements with landowners** who lease their land to refugees. However, such arrangements are not documented, exposing refugees to possible exploitation, fraud and forced evictions.

RECOMMENDATIONS

- *Advocate with national authorities for refugees to have secure housing, land and property rights.*
- *Provide high-quality, weatherproof, durable building materials to refugees in rural and RV settings.*
- *Increase access to livelihoods for refugees to improve their ability to rent or build better homes.*

Afghan refugee boys during a session of the participatory assessment in Katwai Refugee Village in Loralai, Balochistan. © UNHCR

Findings of Consultations with Specific Groups

3.12 Persons with Disabilities (PWDs)

Key informant interviews conducted with **persons with disabilities** (sensory impairment, mental disabilities, physical disabilities) and their caregivers indicated greater exposure to protection risks as well as higher barriers to accessing services for these individuals. While the same issues were reported by the general population as well, it was noted that the risks and restrictions to access were elevated for persons with disabilities.

In all locations, children with disabilities reported **harassment** and **bullying** from peers, as well as **exploitation** in some locations. Parents of children with disabilities reported keeping their children mostly at home due to the **lack of safe spaces** for children and **heightened threats** (violence, abduction) for children with impairments.

Children and adults alike reported **social isolation and discrimination** on the basis of their disability, with many being considered "useless" or a burden on their caregivers and communities. They reported being marginalized and voiceless when it came to **community decision-making**. Children with disabilities also reported significant **barriers to attending school**, due to the lack of trained teachers and/or inclusive curricula and systems specialized to their needs.

With regard to health, there were reported **difficulties in accessing healthcare facilities** due to their **limited mobility and/or communication barriers with hospital staff**. Key informants stated they were unable to purchase **assistive devices** such as hearing aids and wheelchairs due to the high cost of such items.

Adults with disabilities mostly did not have access to their own **mobile devices**, which in combination with sensory impairments or limited mobility left them largely **unable to access Community-Based Complaints Mechanisms (CBCM)** such as Helplines, email, or in-person appointments for protection counselling.

Adult individuals prioritized **livelihoods** (access to specialized livelihoods skills training courses), and **CBCM** (access to UNHCR and partners). Children prioritized **education** (provision of special education, including sign language classes), **accessibility/mobility training**, as well as **safe spaces** for peer **interaction and play**.

RECOMMENDATIONS

- *Increase awareness of community members on disabilities and the rights of persons with disabilities.*
- *Increase capacity of teachers, school management and caregivers by providing inclusive education training.*
- *Introduce child specific CBCM mechanisms in schools and other spaces for children.*
- *Provide special education equipment, materials and safe spaces at key community-based locations such as communal places and Refugee Village schools.*
- *Provide assistive devices to PWDs.*
- *Advocate for inclusion of PWDs in community structures.*
- *Provide transportation assistance for PWDs to access healthcare.*
- *Adapt UNHCR and partner CBCM channels as well as informational materials to improve accessibility for persons with sensory impairments.*
- *Advocate for inclusion of refugees in government programmes providing support to people living with disabilities, particularly in the sectors of education and health.*

3.13 Somali refugee community

Somali refugees represent the largest group among the non-Afghan asylum-seekers and refugees registered with UNHCR in Pakistan.

During the semi-structured discussions with Somali female and male youth and community leaders (elders), participants overwhelmingly prioritized documentation, access to rights and services, health, access to CBCM, and physical protection/security as their priority issues. Despite their challenges, the Somali community were seen to have adopted community-based measures to address many of these issues themselves.

Men and women stated that they face significant barriers in accessing healthcare due to high **cost** and **perceived discrimination** by healthcare providers and hospital staff as well as **language barriers**. Somali men and women stated that this has adversely affected their health and wellbeing, as many live without sustainable livelihoods and cannot afford medical expenses, or even the transportation cost to go to the hospital. While the community tackles this issue to a limited extent via an informal local (sometimes inter-city) **community fund**, they stated that many individuals with specific needs (such as persons with disabilities) are effectively left **without access to essential healthcare**.

Community informants stated that Somali boys and male adolescents were often targets of **police harassment, detention and arbitrary arrest**. The community often supports each other by fundraising to pay **bail charges for release**. A common thread throughout the discussions were reported feelings and perceptions of **marginalization, discrimination, and exclusion from services**. A common feeling of UNHCR and partner organizations prioritizing Afghan refugees while overlooking other refugees who are less in numbers has been expressed during the discussions.

RECOMMENDATIONS

- *Improve communication with the community by scheduling consistent consultations between UNHCR and community members.*
- *Strengthen communication with the community through expanding interpretation services in Somali/Arabic through training community focal points.*
- *Sensitize and raise awareness with UNHCR and partner staff on the importance of including all refugees in access to services.*
- *Facilitation of a legal camp for the Somali community to mitigate arbitrary arrest/detention and further strengthen access to legal assistance.*
- *Facilitate community dialogues between Somali and host communities.*
- *Conduct community sensitization on access to legal structures and conflict resolution.*

4. Participating partners

Government of Pakistan

Commissionerate for Afghan Refugees (C/CAR)

UN Agencies

Food and Agriculture Organization (FAO)
International Organization for Migration (IOM)
United Nations Children's Fund (UNICEF)
United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)

NGOs

Drugs And Narcotics Educational Services For Humanity (DANESH)
Frontier Primary Health Care (FPHC)
Hashoo Foundation
Initiative for Development and Empowerment Axis (IDEA)
Innovative Development Organization (IDO)
Inspire Pakistan
International Rescue Committee (IRC)
Khwendo Kor (KK)
Mercy Corps International (MCI)
Pathfinder International
Peoples Primary Healthcare Initiative (PPHI) Balochistan
Society for Human Rights and Prisoners' Aid (SHARP)
Society for Community Support to Primary Education, Balochistan (SCSPEB)
Society For Empowering Human Resources (SEHER)
Sarhad Rural Support Programme (SRSP)
Taraqee Foundation (TF)
Tameer-e-Khalq Foundation (TKF)
Water, Environment & Sanitation Society, Pakistan (WESS)

5. Acronyms

BHU	Basic Health Unit
CBCM	Community-based complaints mechanisms
GBV	Gender-based violence
KP	Khyber Pakhtunkhwa
NADRA	National Database and Registration Authority
OV	Outreach Volunteers
PoR	Proof of Registration
PWD	Persons with Disabilities
RAHA	Refugee-Affected and Hosting Areas
RV	Refugee Village
WASH	Water, Sanitation and Hygiene

PARTICIPATORY ASSESSMENT REPORT 2022

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