The Aga Khan Rural Support Programme

Endline Study of

Advancing Gender Equality through Civil Society (AGECS) Project in Gilgit-Baltistan, Pakistan

Sub Project: Strengthening Local Capacity to Address Gender-Based Violence in (SLC-GBV) Lower and Upper Chitral.

Final Report

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Endline Study of the Advancing Gender Equality through Civil Society (AGECS) Project in Gilgit-Baltistan and Chitral, Pakistan

Between Progress and Resistance: Understanding Gender-Based Violence and Advancing Equality in Gilgit-Baltistan and Chitral

Commissioned by: Aga Khan Rural Support Programme (AKRSP)
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Abbreviation

ACCD	Advancing Canadian Champions for Development
AGECS	Advancing Gender Equality through Civil Society
AKDN	Aga Khan Development Network
AKFC	Aga Khan Foundation Canada
AKRSP	Aga Khan Rural Support Programme
BISP	Benazir Income Support Programme
CSO	Civil Society Organization
DY	DEVYIELD Consulting
ECD	Early Childhood Development
FGD	Focus Group Discussion
FIA	Federal Investigation Agency
FP	Family Planning
F4C	Foundations for Children
F4H	Foundations for Health
GAC	Global Affairs Canada
GB	Gilgit-Baltistan
GBV	Gender-Based Violence
HRCP	Human Rights Commission of Pakistan
KADO	Karakoram Area Development Organization
KII	Key Informant Interview
KP	Khyber Pakhtunkhwa
LAPH	Legal Aid and Psycho-social Help
LSO	Local Support Organizations
MoV	Means of Verification
NOC	No Objection Certificate
OPI	Organizational Performance Index
PECA	Prevention of Electronic Crimes Act
PMF	Performance Measurement Framework
SRH	Sexual and Reproductive Health
UC	Union Council

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EXECUTIVE SUMMARY

The AKF's Advancing Gender Equality through Civil Society (AGECS) initiative, implemented under the F4HE program in Gilgit-Baltistan and Chitral (GBC) by AKRSP and its partner CSOs (KADO, LAPH, SBHI), set out with a clear ambition: to strengthen women-led and gender-focused civil society organizations (CSOs) so they could play a greater role in reducing gender-based violence (GBV), advancing women's leadership, and influencing institutional responses. The endline study, conducted by DEVYIELD in 2025, offers a comprehensive reflection on progress since the inception of the project in 2022.

Using a mixed-methods approach guided by DEVYIELD's RISE framework (Rigorous, Inclusive, Systematic, Evidence-based), the study combined a household survey of 360 households, Organizational Performance Index (OPI) assessments, 22 key informant interviews, 11 focus group discussions, and administrative data from police, media and partner CSOs. Safeguarding protocols were applied throughout to ensure confidentiality and the ethical handling of sensitive GBV issues.

Findings from the Performance Monitoring Framework (PFM) outcome indicators show that the project contributed meaningfully to strengthening CSOs and enhancing women's participation in family and community life. Partner organizations demonstrated notable improvements in institutional capacity: KADO's OPI score increased from 1.69 at baseline to 3.13 at endline, LAPH's from 1.75 to 2.88, and SBHI's from 1.56 to 2.63. These gains reflected stronger institutional governance, monitoring and financial systems, and advocacy capacities, though sustainability remains uncertain given continued donor dependence.

At the household level, joint or independent decision-making by women on family planning, child health, and early childhood development rose from 55 percent to 85 percent. Focus group discussions confirmed that women are increasingly active in family discussions, although in more conservative communities men still present themselves as the final authority. Attitudinal shifts were also evident: acceptance of gender equality grew modestly, and community leaders increasingly acknowledged barriers to women's participation, though awareness did not always translate into practice.

Institutional responses to GBV, however, remain a critical weakness. Only 7 percent of survey respondents were "completely satisfied" with how police and courts handled cases. Administrative records confirm more cases are being reported—44 in Gilgit in 2024–25 compared to 24 at baseline (2022-23)—but judicial backlogs, intimidation in courts, and weak enforcement undermine resolution. Survivors and activists described humiliation at police stations and delays in court processes, while hospitals were said to lack confidential spaces and psychosocial services. Some progress toward gender-responsive court environments and facilities for women lawyers was noted, but implementation remains limited. Male police personnel often lack gender sensitization and awareness of survivor-centred case handling, and police stations still lack safe, confidential spaces for victims. Despite several sensitization sessions held in Gilgit, behavioural change remains slow. In this vacuum, CSOs stepped in to provide awareness, legal aid, and safe spaces, though their reach was uneven and, in conservative areas, sometimes contested.

Perceptions of AGECS's overall impact were positive but nuanced. Around one-third of respondents said the project made a "big difference," while nearly six in ten described "some difference." The strongest contributions were in women's household decision-making, GBV awareness & sensitization, and progress toward gender equality. Women emphasized confidence-building and improved family communication, while men highlighted awareness. District-level differences were notable: Hunza and Ghizer respondents were the most optimistic, whereas Gilgit, Nagar, and Chitral residents expressed

more cautious views. When asked about sustainability, one-third (with 27% women and 40% men) of the respondents believed changes would "definitely" continue, but most answered "maybe," reflecting concerns that progress may fade without continued support.

The study also confirmed that GBV in GBC remains a pervasive and multifaceted reality. Women and CSO activists both women and men described domestic violence, inheritance denial, mobility restrictions, early and forced marriages, and digital harassment as routine. Importantly, many of these practices were not recognized as violence at all. Men often viewed economic control and verbal humiliation as legitimate discipline rather than abuse. Elders defended inheritance denial as tradition, while women and activists described it as a clear rights violation disguised as custom. Digital harassment emerged as a particularly urgent concern, with adolescents reporting blackmail, fake accounts, and AI-generated videos. Families often responded by restricting girls' mobility rather than seeking justice, showing how new forms of GBV reinforce older patterns of control.

Underreporting was found to be widespread. Survivors confront what participants described as a "double wall"—the violence itself, followed by silencing within the family to protect honor. Reporting is stigmatized, and survivors often face retaliation. Formal institutions remain intimidating and inaccessible, leading most cases to be resolved informally through elders, jirgas, or religious leaders. While men valued these mechanisms for speed and cultural legitimacy, women and adolescents described them as unsafe and disempowering, prioritizing reconciliation over rights and often returning survivors to abusive homes.

Despite these challenges, the study identified signs of fragile progress. Women's awareness of rights has increased, particularly around inheritance and mobility. Police officers trained under AGECS, and other initiatives reported improved sensitivity, though trust in law enforcement remains low. Media coverage of GBV has expanded, creating space for public discussion, even if it also provokes resistance from conservative groups. Women's leadership in Local Support Organizations, such as in Passu and Altit, illustrates new openings for participation. Generational differences were also noted: younger men appeared more supportive of women's education and leadership, while older men resisted. Yet these gains are precarious. Digital harassment has emerged as a growing threat, and families often respond by further restricting women's opportunities, undermining progress in education and mobility. Progress also remains uneven, with urban centers showing more visible change while remote valleys lag.

A deeper pattern emerges across the survey and qualitative findings. Communities are more willing to support women in practical areas such as education, leadership, or business—domains seen as contributing to household and community welfare—than in areas tied to autonomy and authority, such as mobility, control over income, family planning decisions, or participation in community governance without male consent.

Overall, empowerment is often welcomed when it enhances family survival and productivity but resisted when it challenges patriarchal power structures. This mixed picture highlights the coexistence of progress and resistance: norms are shifting in ways that expand women's roles in public and economic life, while traditional notions of protection and authority continue to restrict their independence.

Taken together, the evidence underscores that GBV in Gilgit-Baltistan and Chitral is both cultural and structural, rooted in property relations, economic dependency, and institutional weakness. Violence extends beyond physical harm to structural practices that reproduce women's subordination while being legitimized as "tradition." Survivors often remain silent because formal systems are intimidating

and ineffective, while informal mechanisms prioritize family honor over justice. CSOs have opened vital spaces for awareness and dialogue, but their sustainability and reach are uncertain.

The study concludes that sustainable progress requires shifting the material base of women's lives—securing economic independence, enforcing inheritance and marriage laws, reforming police and courts, and embedding survivor-centred services in health and social systems. Equal attention to both prevention and response is essential for real progress. Without these systemic reforms, informal mechanisms will continue to dominate, backlash will intensify, and cycles of violence and silence will persist.

Building on these insights, future GBV efforts in Gilgit-Baltistan and Chitral should build upon the progress in raising awareness by connecting it with stronger institutional systems, survivor-centred support, and women's economic empowerment. Continued community education—alongside early prevention in families and schools, justice reforms, and long-term behaviour-change efforts—can help transform norms and strengthen protection. Together, these actions can turn growing awareness into lasting progress toward safety, dignity, and equality. The detailed recommendations presented in report are summarized here

1. Deepen systemic and institutional engagement through stronger coordination among the Women Development Department, police, health, judiciary, and social welfare institutions, supported by joint mechanisms and GBV data systems.
2. Support women's economic rights and agency by enforcing inheritance laws, simplifying land record systems, expanding livelihood opportunities, and ensuring women's equal control over income and assets.
3. Strengthen survivor-centred case management and psychosocial support through integrated referral systems, trauma-informed counselling, and community-based healing mechanisms.
4. Promote early prevention by engaging parents, teachers, and schools in nurturing empathy, equality, and non-violence in children—especially boys—from an early age.
5. Sustain awareness and foster behaviour change through long-term communication strategies that engage men, youth, and religious leaders to challenge harmful norms.
6. Enhance legal and law enforcement systems through gender-sensitive training, procedural reforms, and stronger collaboration with lawmakers and judicial actors.
7. Use data and media responsibly to strengthen case tracking, accountability, and digital safety, and to promote positive narratives on women's rights.
8. Promote inclusion and local leadership by empowering women leaders, engaging faith and community influencers, and tailoring approaches to diverse district contexts.
9. Encourage continuous learning and flexibility by embedding reflection, adaptation, and evidence-based decision-making into future programme design.

In sum, AGECS has planted seeds of change in Gilgit-Baltistan and Chitral. It strengthened CSOs, gave women greater voice in households, and raised awareness of GBV. Yet without structural reforms and redistribution of resources, these gains remain fragile. Future programs needs to treat GBV as both a cultural and structural issue, ensuring awareness is matched by material change and survivor-centered systems. Only then can fragile openings grow into sustainable pathways to equality and justice.

1. INTRODUCTION AND BACKGROUND

1.1. Introduction

The *Advancing Gender Equality through Civil Society (AGECS)* initiative, implemented under the Foundations for Health and Education (F4HE) programme in Gilgit-Baltistan and Chitral by AKRSP and partner CSOs, aims to strengthen women-led and gender-focused civil society organizations (CSOs). The initiative focuses on reducing gender-based violence (GBV), enhancing women's leadership, and promoting institutional responsiveness to gender and social barriers.

This assessment was commissioned to assess progress against key outcome indicators of the project and identify lessons to inform future programming. The study applied a mixed-methods approach, integrating quantitative and qualitative data to provide a comprehensive understanding of results and emerging trends.

To guide the reader, this report begins with an Executive Summary, which highlights the main findings, conclusions, and recommendations. It then proceeds through nine main sections. Section 1 provides the background and introduction to the AGECS initiative, its objectives, and scope. Section 2 outlines the approach and methods, including the RISE framework, data collection tools, and safeguarding protocols. Section 3 presents findings on Project Outcome Indicators (PMF), while Section 4 summarizes household survey results. Section 5 examines the capacity of community leaders and implementing partners to respond to gender and social barriers, and Section 6 reviews government capacity and responses to GBV, drawing on police, court, CSO, FIA, HRCP, and DCPU data. Section 7 synthesizes key findings across the study, Section 8 sets out the main conclusions, and Section 9 provides recommendations for future programming. Finally, a series of annexes present supporting tools, datasets, and some detailed analysis tables.

1.2. Background

Gender-based violence (GBV) and gender inequality remain persistent challenges in Gilgit-Baltistan and Chitral (GBC), where cultural norms, institutional limitations, and economic dependency continue to restrict women's participation in social and economic life. Addressing these barriers requires not only community-level engagement but also stronger, more inclusive civil society institutions capable of promoting women's rights and influencing systemic change. In this context, AGECS builds on AKRSP's longstanding experience in community-driven development and gender inclusion, working to strengthen women-led and gender-focused civil society organizations (CSOs) as catalysts for advancing gender equality and social justice in the region.

The *Foundations for Health and Empowerment (F4HE)* programme provides the overarching framework for AGECS. The Foundations for Health and Empowerment (F4HE) is a five-year program (2020–2025) funded by Global Affairs Canada (GAC) and implemented by Aga Khan Foundation (AKF C). The program seeks to improve the health, well-being, equitable development, and empowerment of women, girls, their families, and communities across five Asian countries: Afghanistan, India, the Kyrgyz Republic, Pakistan, and Tajikistan. It is implemented by AKF country units in close collaboration with other agencies of the Aga Khan Development Network (AKDN), as well as Civil Society Organizations (CSOs).

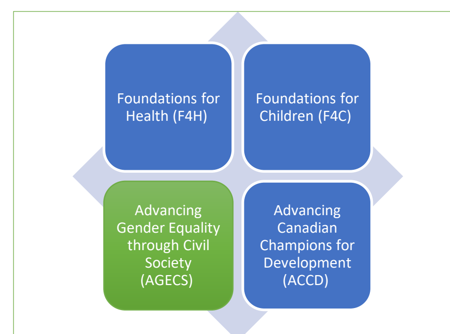


Figure 1. F4HE Components

F4HE is structured around four interrelated components:

1. **Foundations for Health (F4H):** Improving maternal, newborn, and child health by strengthening health systems and services.
2. **Foundations for Children (F4C):** Promoting early childhood development through access to quality early learning and responsive caregiving.
3. **Advancing Gender Equality through Civil Society (AGECS):** Strengthening women-led and gender-focused civil society organizations (CSOs) to address gender and social barriers and promote inclusive governance.
4. **Advancing Canadian Champions for Development (ACCD):** Engaging Canadian individuals and institutions to champion global development and gender equality.

1.3. AGECS in Pakistan

In Pakistan, the Aga Khan Rural Support Programme (AKRSP), with technical and grant management support from the Aga Khan Foundation Pakistan (AKF-P), implemented two sub-projects of the AGECS component aimed at reducing gender and social barriers that limit women's and adolescents' access to essential services through strengthened community systems, leadership, and institutional responses to GBV and inequality. These sub-projects were carried out in partnership with the following two CSOs working on gender equality and women's empowerment in Gilgit-Baltistan and Chitral (GBC). To ensure localized and context-sensitive delivery, these two civil society organizations were competitively selected to implement the AGECS sub-projects tailored to the distinct socio-cultural contexts of the region:

- **Legal Awareness Program for Human Rights (LAPH): Strengthening Local Capacity to Address Gender-Based Violence (GBV) in Chitral**: The LAPH sub-project focused on improving access to justice and institutional responses for GBV survivors in Upper and Lower Chitral. Its interventions included establishing legal aid centers, engaging lawyers, training government officials, and providing infrastructural support to facilities serving women survivors. LAPH also mobilized community groups and CSOs, strengthened GBV monitoring committees, raised awareness through legal aid clinics, and trained media professionals on responsible GBV reporting. While its greatest strengths lay in institutional and legal system strengthening, LAPH also attempted to enhance women's empowerment through awareness-raising and vocational skills training for GBV survivors.

- **Karakorum Area Development Organization (KADO): Empowering Communities to Address GBV in Gilgit-Baltistan and Upper Chitral**: The KADO sub-project placed greater emphasis on community mobilization, leadership, and social norm change. KADO implemented the project in Ghizer, Gilgit, Hunza, Nagar and Upper Chitral. Its interventions included the formation of Women Activist Forums (WAFs), training community and religious leaders, and building networks between women's groups and law enforcement agencies. KADO also worked with elected women representatives in the Gilgit-Baltistan Assembly to enhance their policy advocacy capacity, while raising awareness on women's rights and gender equality through schools, parents, teachers, and community platforms. Additionally, the sub-project engaged media stakeholders through training and developed documentaries and public service announcements (PSAs) to amplify voices for gender justice.

Both sub-projects were designed to address gender and social barriers that prevent women and adolescents from accessing essential services, including health, early childhood development, legal protection, and broader sustainable development opportunities. Together, they complemented one another: LAPH anchored legal and institutional responses for GBV survivors in Chitral, while KADO

focused on community mobilization, leadership development, and policy advocacy across Gilgit-Baltistan and Upper Chitral. Progress on the output results are presented in **Annex – 1.**

Project implementation concluded in 30th September 2025. As part of its design, AGECS required an endline study to assess the capacity and effectiveness of these sub-projects, examine their achievements and limitations, and capture community and stakeholder perceptions.

DEVYIELD was selected through a competitive bidding process in August 2025 to conduct the endline study in the target geographies of the two sub-projects (KADO and LAPH).

1.4. Objectives of the Study

The endline study is designed to generate evidence on the achievements, lessons, and future directions of the sub-projects. Specifically, it aims to:

1. **Assess the status of key outcome-level indicators** of the sub-projects at the endline, in comparison to the baseline values, and determine the degree of achievement of the endline targets, as outlined in the Performance Measurement Framework (PMF) of the project.
2. **Collect additional quantitative and qualitative data** beyond the PMF indicators to help assess the overall impact of the interventions and to strengthen the understanding of changes brought about by the sub-projects.
3. **Provide tailored recommendations for each sub-project outcome** based on the findings, including practical suggestions to strengthen Civil Society Organizations (CSOs) capacities and inform future programming.
4. **Document key lessons learned, good practices, and success stories** from the CSOs supported through the sub-projects, highlighting approaches and strategies that contributed to positive results and sustainability.
5. **Generate recommendations and lessons** from the endline process that can inform future AGECS interventions and capacity strengthening initiatives.

1.5. Scope of the Study

The scope of the endline study covered document review, quantitative and qualitative data collection, data management, and reporting according to the scope outlined in the study ToRs agreed upon in the inception period. It also entailed securing necessary approvals, coordinating with key stakeholders, and ensuring adherence to ethical standards.

- **Thematic Scope:** The study assessed outcome indicators defined in the Project Monitoring Framework (PMF), with emphasis on gender equality, women's empowerment, prevention and response to gender-based violence (GBV), and strengthening the institutional capacity of partner CSOs.
- **Geographic Scope:** The study was conducted in intervention areas of the two sub-projects implemented by LAPH and KADO, covering six districts in Gilgit-Baltistan and Chitral (Ghizer, Gilgit, Nagar, Hunza, Upper Chitral, and Lower Chitral). Within these districts, data was collected from sample Union Councils where project activities were implemented.
- **Temporal Scope:** The study captured the status of project outcomes at the conclusion of implementation (2025) and compared findings with baseline data collected in 2023 to assess changes and progress.

A detailed description of scope, responsibilities, and deliverables agreed in the inception report is provided in **Annex 2: Study Scope Matrix.**

2. APPROACH AND METHODS

The endline study applied a mixed-methods approach to generate evidence on the performance, outcomes, and impact of the AGECS sub-projects implemented by AKRSP through LAPH and KADO in Gilgit-Baltistan and Chitral. This approach combines quantitative and qualitative methods, complemented by a desk review of program documentation, to capture both measurable changes and contextual insights.

2.1. Guiding Approach: RISE

The methodology for this endline study is guided by DEVYIELD's **RISE** approach — **R**igorous, **I**nclusive, **S**ystematic, and **E**vidence-based.

- **Rigorous:** Methods are designed to align with international evaluation standards and ensure reliability, validity, and comparability with baseline assessments.
- **Inclusive:** Diverse voices are intentionally included — women, men, adolescents, community leaders, and service providers — to ensure findings reflect the perspectives of those most affected.
- **Systematic:** The study followed a stepwise process, from desk review through data collection to analysis and validation, ensuring transparency and replicability.
- **Evidence-based:** Quantitative and qualitative methods were triangulated with documentary evidence to generate actionable recommendations.

This approach helped in ensuring the endline findings are credible, context-sensitive, and useful for decision-making at both local and programmatic levels

2.2. Data Collection and Analysis Methods

The study was carried out in the following steps, each building on the previous one to ensure clarity and rigor.

2.3. Desk Review

The endline study commenced with a desk review of key documents, including project proposals, baseline and midline reports, the Performance Measurement Framework (PMF), monitoring reports, training materials, and relevant policy documents. The review served to establish benchmarks for comparison, identify data gaps, and support triangulation of findings. It also informed survey tool refinement and shaped probes for FGDs and KIIs. A list of key documents reviewed is attached in **Annex 3.**

2.4. Quantitative Data Collection and Analysis Methods

Quantitative data collection provided measurable evidence of changes in outcomes, institutional capacity, and community perceptions across the AGECS sub-projects. Two main quantitative approaches were used:

(i) Organizational Performance Index (OPI)

The OPI was used to assess the performance of LAPH and KADO across four domains—Effectiveness, Efficiency, Relevance, and Sustainability—using the standardized AKF OPI tool and guidelines.

The OPI defines eight sub-domains (two per domain), each scored on a scale of 1–4, supported by illustrative examples to ensure consistency. Table 3 presents the domains and sub-domains, while the full OPI tool is provided in **Annex 4.**

Table 1:OPI Domains and Sub-domains

Domain	Sub-domains
Effectiveness	*Results:* Measuring and analyzing outcome-level results. *Standards:* Adopting and improving sector standards.
Efficiency	*Delivery:* Planning, budgeting, and analyzing cost-efficiency. *Reach:* Using resources to expand coverage and beneficiaries.
Relevance	*Target Population:* Engaging stakeholders to ensure activities address actual needs. *Learning:* Implementing learning systems as a driver of change.
Sustainability	*Resources:* Mobilizing diverse financial and human resources. *Social Capital:* Leveraging community relationships for long-term results.

The OPI was implemented in the following six structured steps:

1. **Orientation to the tool** – DEVYIELD field team, with AKRSP support, conducted an orientation session for LAPH and KADO on the OPI purpose, domains, sub-domains, scoring scale, means of verification (MoVs), and scoring exercises.
2. **Evidence gathering and self-assessment** – Each CSO compiled MoVs (e.g., results frameworks, budgets, stakeholder engagement records) and assigned provisional scores (1–4) for each sub-domain.
3. **Validation workshops** – DEVYIELD and AKRSP M&E team organized online discussion session with each CSO teams to review evidence, discuss provisional scores, and finalize ratings against OPI criteria.
4. **Scoring and aggregation** – Sub-domain scores were averaged into domain scores, which were then aggregated to generate an overall OPI score for each CSO.
5. **Comparison with baseline** – Endline scores were compared with baseline (and midline, where available) to highlight changes in organizational performance and growth.
6. **Reporting and utilization** – Results were documented in the report, including overall and domain-specific findings, strengths, capacity gaps, and recommendations. The mandatory indicator *1200.1 (percentage of CSOs with improved OPI performance relative to baseline)* was calculated.

Each CSO also reported the value of local support mobilized (financial and in-kind), including contributions from individuals, diaspora, businesses, government, and volunteer time.

(ii) Beneficiary Surveys

The beneficiary survey measured how community knowledge, attitudes, behaviors, and access to services changed over the course of the AGECS sub-projects. It also assessed community trust in and satisfaction with CSO services. To ensure comparability, the endline used the same instruments as the baseline—a structured household survey and a Net Promoter Score (NPS) module—while making minor refinements to improve clarity and safeguarding.

Household Survey: The household survey captured data on women's roles in household decision-making, community perceptions of gender-based violence, access to legal and protection services, and changes in women's empowerment and gender equality. The questionnaire followed the same structure as the baseline, with modules covering household profiles, gender and social barriers, service access, institutional responsiveness, knowledge and attitudes, and perceptions of CSO performance. It also included a Net Promoter Score (NPS) item at the endline to measure how much trust community members placed in project implementing CSOs (KADO and LAPH) and whether they would recommend their services to others. The household survey instrument is attached as **Annex 5.**

Net Promoter Score (NPS): The NPS module asked respondents: *"On a scale of 1 to 10, how likely are you to recommend the services provided by [KADO or LAPH or SBHI] to other women, girls, and community members in need?"* Based on their answers, respondents were classified as promoters, passives, or detractors. The score was calculated as the percentage of promoters minus the percentage of detractors, producing a result on a scale from –100 to +100.

Sampling Strategy: The survey followed a stratified, three-stage cluster design consistent with the baseline. In total, 360 households were sampled across the six target districts: Ghizer, Gilgit, Hunza, Nagar, Upper Chitral, and Lower Chitral, with 60 households allocated per district. To ensure comparability, the same five union councils per district that were included at baseline were again selected at endline. Within each selected union council, one village was chosen from the lists provided by the implementing partners, resulting in 30 villages across the six project districts.

In each selected village, 12 beneficiary households were targeted for interviews. Where KADO and LAPH provided household lists, these were used to identify beneficiaries; in villages without such lists, households were selected randomly from the community. Compared to the planned allocation of 12 households per village (60 per district), a minor shortfall occurred in a few locations—for example, one household each in Taus and Pakora in Ghizer and in Shinaki in Hunza declined or were unavailable. These gaps were compensated by interviewing additional households in other villages of the same district, maintaining the intended district totals of 60 households and the overall sample of 360 households.

Table 2: District and gender wise number of sample villages and survey respondents, endline 2025

District	PSUs (villages)	Number of Respondents		Total Respondents
		Women	Men	
Ghizer	5	30	30	60
Gilgit	5	37	23	60
Hunza	5	31	29	60
Nagar	5	30	30	60
Upper Chitral	5	30	30	60
Lower Chitral	5	30	30	60

Within each household, enumerators interviewed the most informed, available, and willing adult respondent (18 years or older). The sampling strategy aimed to achieve gender balance at the village level and overall sample level, with approximately equal numbers of male and female respondents. However, because many men were absent during fieldwork due to work or travel, the final distribution included a slightly higher proportion of women (52.2 percent) compared to men (47.8 percent).

The overall sample size of 360 households was calculated using Cochran's formula with a 95% confidence level, maximum variability (p=0.5), and allowing for a margin of error of ±5.2%; at baseline, the same formula yielded 480 households, corresponding to a ±4.5% margin of error.

Overall, the main difference between the baseline and endline sampling strategies was the number of households surveyed per village—16 at baseline versus 12 at endline. This adjustment reduced the total sample size from 480 to 360 households, modestly increasing the margin of error at the district level, but still providing statistically robust estimates and ensuring methodological comparability for measuring change over time. A summary of the baseline and endline sampling structures is presented in Figure 2, while the detailed list of sample villages is provided in **Annex 6.**

Figure 2: Comparison of baseline and endline sampling design and sample sizes

Field Teams and Training: DEVYIELD recruited and deployed 24 enumerators, including 13 women and 11 men. Enumerators were selected through a structured process that emphasized local residence in the survey areas, strong proficiency in local languages, a minimum educational qualification of a Bachelor's degree, and—where possible—prior experience with field surveys. This ensured cultural sensitivity, community acceptance, and strong technical competence for data collection.

The team was organized into regional groups. In the Gilgit region, two teams were formed: one locally hired dedicated team in Ghizer and another team covering Hunza, Nagar and Gilgit. In Chitral, separate teams were formed for Upper and Lower Chitral. Each team was supervised by a dedicated field supervisor, who provided day-to-day oversight, managed logistics, and carried out on-the-spot quality assurance. The supervisors also monitored daily data submissions in KoBo, conducted spot checks, and resolved operational challenges during fieldwork. All supervisors had prior experience in survey coordination and were well equipped to ensure accuracy, efficiency, and adherence to ethical standards.

To prepare the teams, DEVYIELD organized separate two-day training sessions: one in Gilgit for the Gilgit region teams and two in Chitral (Upper and Lower) for the respective field teams. Training sessions covered survey objectives, ethical standards and safeguarding, interviewing techniques, and digital data collection using KoBo. Special emphasis was placed on ensuring sensitivity when addressing gender-based violence (GBV) and related topics. The training schedule is attached to **Annex 7.**

Box 3. Field Team at a Glance

- **24 enumerators** (13 women, 11 men), all locally recruited
- **2 supervisors** (Gilgit & Chitral) provided daily oversight and quality checks
- **Teams:** 2 in Gilgit, 2 in Chitral (Upper & Lower)
- **Training:** three 2-day sessions on ethics, safeguarding, interviewing, KoBo, and GBV sensitivity; pilot test completed

The training was delivered by a senior consultant of DEVYIELD with expertise in GBV, survey methods, and adult learning. Sessions combined interactive presentations, group discussions, role plays, and simulations. Enumerators practiced administering the household questionnaire and refined their interviewing skills through mock

exercises. Before deployment, the teams conducted a pilot test to check their understanding of the questionnaire and KoBo application. A separate pretest of the instrument was not required, as the survey adopted the baseline questionnaire, which had already been tested and validated in 2023.

Data Collection and Management: Data collection for the endline survey was conducted digitally using KoBo Collect on Android devices. The tools were pre-programmed with the names of Districts, all sampled union councils and villages, which eliminated the possibility of deviation from the agreed sampling plan. Instruments included built-in skip logic, validation checks, mandatory fields, and GPS tagging to strengthen accuracy and reliability. Enumerators submitted completed forms daily, ensuring real-time data capture and immediate monitoring by supervisors and the evaluation team. To protect confidentiality, no personal identifiers were stored within KoBo; the supervisors maintained a minimal contact list (limited to name) separately only to facilitate verification calls.

Box 4. Data Collection & Management at a Glance

- **Digital data collection** with KoBo Collect (skip logic, validation checks, GPS tagging)
- **Prefilled sample UCs, villages** in the tool; no substitutions or deviations recorded
- **Daily supervision:** supervisors checked submissions, held debriefings, and provided feedback
- **Central monitoring:** evaluation team reviewed dashboards for completeness, logic, GPS, and timestamps
- **Safeguarding protocols in place**, though not triggered during fieldwork as no respondents required referral

Team in back-office provided supportive supervision throughout the process. They monitored enumerator performance, checked submissions for completeness, and coordinated daily debriefing sessions with their teams and reported the daily progress on daily basis through WhatsApp calls and voice notes. The back-office experts reviewed the day's data quality using KoBo dashboards and shared feedback with the teams to address any gaps or errors. This cycle of daily review and corrective feedback helped maintain consistency and high standards across all districts.

The back-office team tracked incoming submissions centrally through the KoBo dashboard. They verified data for completeness, logical consistency, GPS accuracy, and time stamps. Because village names were pre-fed into the system and followed strictly, no substitutions or deviations were recorded during fieldwork.

Although this was a general perceptions survey rather than a direct GBV survivor survey, enumerators were trained in safeguarding principles, and referral pathways were in place should sensitive disclosures have arisen. In practice, no such cases were reported during fieldwork, but having the protocols in place strengthened the ethical integrity of the study.

Data Analysis: The analysis process was designed to ensure comparability with the baseline survey while maintaining rigor, transparency, and reproducibility. Before fieldwork began, the evaluation team developed a Data Analysis Plan (DAP) aligned with the baseline methodology. The DAP specified how each indicator would be measured, including clear definitions of the numerator (respondents meeting the condition) and denominator (all respondents assessed). A detailed codebook was prepared to link each survey question to its corresponding indicator, ensuring consistency and preventing drift from the baseline definitions.

As data were uploaded from KoBo each day, they were consolidated into a master dataset. The team conducted systematic quality checks, including verification of interview duration, logical flow of responses, adherence to skip patterns, and accuracy of GPS locations and timestamps. Duplicate records were removed, and any issues identified were cross-checked with field notes. Where corrections were not possible, missing values were recorded and documented in a data quality log. This process ensured that the final dataset was both clean and directly comparable to the baseline.

Box 5. Data Analysis at a Glance

- **Daily data cleaning:** Master dataset consolidated, duplicates removed, logic/skip checks, GPS/time verified
- **Descriptive analysis:** Percentages, frequencies, averages, and 95% confidence intervals reported
- **Net Promoter Score (NPS):** Promoters (9–10), Passives (7–8), Detractors (0–6), plus thematic coding of "why" responses
- **Comparison with baseline:** Percentage-point differences highlighted; "core" comparable indicators emphasized
- **Reproducibility:** Clean dataset, codebook, indicator dictionary, and scripts archived securely

The analysis remained primarily descriptive, providing clear summaries of the data. Percentages were calculated for key outcome indicators, while frequencies and cross-tabulations were used to explore patterns by district, gender and age groups. Where appropriate, averages, minimums, and maximums were also reported.

The survey also incorporated the Net Promoter Score (NPS) to assess community trust and satisfaction with CSO services. Responses were categorized into *Promoters* (scores 9–10), *Passives* (7–8), and *Detractors* (1–6). The NPS was calculated as the percentage of Promoters minus the percentage of Detractors, producing a score ranging from –100 to +100.

To assess change over time, endline findings were compared directly with baseline results. For each indicator, differences were expressed in percentage points.

The outputs of the analysis included clear, reader-friendly visuals such as bar charts, summary tables, and district disaggregation, all labelled to highlight key findings. To ensure reproducibility, the evaluation team archived the clean dataset, the codebook, the indicator dictionary, and any analysis scripts (developed in power query).

The quantitative results, disaggregated by sex, age, and geography, provide robust evidence of outcome-level change and complement the findings of the Organizational Performance Index (OPI) and qualitative research. Together, these strands of evidence allow for strong triangulation, producing a comprehensive assessment of both organizational capacity and community-level change

2.5. Qualitative Data Collection and Analysis Methods

The qualitative component was designed to complement the survey and OPI by providing depth and explanation—clarifying the "why" behind the numbers. It explored how social norms around GBV operate, what enables or hinders access to services, how empowerment is experienced in practice, and how CSO performance is perceived by diverse community stakeholders. Data collection tools were mapped to PMF indicators so that qualitative findings directly explain quantitative patterns, outliers, and unexpected results. This approach strengthened triangulation across methods and ensured that qualitative evidence contributed meaningfully to conclusions and recommendations.

Key Informant Interviews (KIIs): Semi-structured, one-on-one interviews (30–60 minutes) were conducted with purposively selected participants such as CSO leaders, police officials, lawyers, media personnel, women activists, traditional and religious leaders, and elected representatives. These informants offered diverse perspectives on GBV prevention and response, women's empowerment, institutional coordination, and community dynamics. Informed consent and confidentiality were ensured for all participants.

In the baseline, a separate survey was conducted with community leaders. For the endline, the identified KII participants were found to align with the baseline definition of community leaders. Consequently, the structured community leaders' questionnaire was embedded within the KII tool and administered alongside open-ended questions. This approach allowed for the collection of both qualitative and quantitative data on leaders' exposure to GBV-related training, their attitudes towards women's rights, perceptions of barriers to women's progress, and their capacity to promote women's empowerment. The KII tools are attached at **Annex – 8.**

Focus Group Discussions (FGDs): FGDs captured community-level experiences, shared norms, and perceptions of service access and CSO performance. Homogeneous groups of 5–6 participants were convened separately for adult women, adult men, and—in safe and appropriate contexts—adolescent girls and boys (together or separately). Discussions were conducted in local languages, lasted less than 60 minutes, and followed guides aligned with PMF indicators. Facilitators created safe environments, established ground rules, and used indirect questions and vignettes to encourage open dialogue on sensitive topics. The FGD Tools are attached at **Annex – 9.**

Sampling Strategy: The qualitative design used purposive sampling to ensure representation of diverse perspectives across all six project districts. A total of 11 Focus Group Discussions (FGDs) were conducted, engaging 104 participants (53 women and 51 men) representing adult women, adult men, and adolescent groups. For KIIs, stakeholders were selected across with representation from all the project districts, focusing on profiles that could provide the richest insights about the issue of GBV, its reason and how to responses. Recruitment also aimed for having gender balance (11 women and 11 men) and thematic saturation. Summary of the KII and FGD events is presented in Table 3.

Table 3: Summary of KII participants and FGD events

	Key Informant Interviews (KIIs)				Focus Group Discussions (FGDs)
District	Men	Women	Total	Remarks	
Ghizer	1	1	2	Elected Representative, Police Officer	Yasin Hunder (10 Participants): Mixed group of men and women, aged mid-20s to mid-40s, engaged in farming, small trade, and household work, reflecting both married adults and younger participants
Gilgit	3	2	5	Representative of Women Development Department Gilgit, Woman Police Officer, Lawyers and representative of academia	Khomar, Gilgit (10 women): Aged 23–48, with education from primary to BA, mostly engaged in business (7), along with 2 homemakers and 1 student. Danyore, Gilgit (9 women): Aged 18–40, with education from primary to BA; 2 single and 7 married, including 3 students and 6 homemakers.
Hunza	1	2	3	Representatives of CSO and media	Thol, Nagar (12 participants – 6 men, 6 women): A mixed group of students (FA–BBA), teachers,

	Key Informant Interviews (KIIs)				Focus Group Discussions (FGDs)
Nagar	1	1	2	Nambardar, NGO Representative	businessmen, and housewives aged 15–40, balancing perspectives of single youth and married adults. Sumayar, Nagar (13 participants – 9 men, 4 women): Predominantly businessmen (BA–MBA), alongside a manager, nurse, teacher, housewife, and students (FA–FAC), aged 15–45, with both single youth and married adults represented.
Lower Chitral	2	3	5	Women Activist (CSO), representative of Suicide Preventions and Gender Response Centre, Darul Aman, Media and Lawyers	Adult Men Group (8, UC Chitral-2): Farmers, shopkeepers and labors. Adult Women Group (9, UC Drosh-II): Homemakers managing childcare, farming support, and small income activities. Adolescents Group (8, UC Shoghore): Students balancing school with chores/work.
Upper Chitral	3	2	5	Social Activist, representative of district health department, education department and media	Adolescents (9, UC Charun–Bulanlasht): Students (boys and girls) combining school with domestic chores or small work, aspiring to learn despite limited opportunities. Adult Women (9, UC Yarkhoon–Brep): Homemakers focused on childcare, household tasks, farming, and small income activities with limited mobility. Adult Men (7, UC Kosht–Barumkagh): Farmers, laborers, and shopkeepers identifying as family providers and active in local community affairs.
Total	11	11	22		11 FGDs 104 Participants

Data Collection and Management: Qualitative research teams led by one of our senior team members in Gilgit-Baltistan and one in Chitral—conducted the fieldwork. Each team included a facilitator and a note-taker trained in trauma-informed practice, probing, neutrality, and safeguarding protocols. Sessions began with an explanation of study objectives, voluntary participation, confidentiality, and referral pathways. Written or verbal consent was obtained, including guardian consent and youth assent for adolescents. With permission, interviews and discussions were audio-recorded; otherwise, detailed notes were taken.

Daily debriefs were held to summarize attendance, duration, emerging themes, and any safeguarding actions. Evaluation experts monitored adherence to guides and checked for data quality. Transcripts were prepared within 24–72 hours and translated where necessary. To ensure quality, translations were reviewed by bilingual team members who cross-checked key sections to confirm accuracy and consistency with the original responses.

Data Analysis: A hybrid thematic analysis approach was applied to the Key Informant Interview (KII) and FGD data. After transcripts were reviewed and anonymized, a codebook was developed using AI-assisted tools, combining deductive codes derived from the evaluation objectives and Performance Measurement Framework (PMF) indicators with inductive codes that emerged directly from the data (for example, themes such as digital GBV).. Each transcript was systematically coded, and themes were generated by clustering related codes. To ensure rigor, findings were compared across stakeholder groups (e.g., CSOs, police, government, traditional leaders, media) and across districts to highlight both commonalities and divergences. Illustrative quotes were extracted to ground the analysis in

participants' voices. This process created a transparent, systematic, and replicable pathway from raw data to findings, increasing the credibility and trustworthiness of the results.

2.6. Research Ethics and Safeguarding

The endline study followed the Aga Khan Foundation (AKF) safeguarding framework, ensuring that all stages of design, data collection, analysis, and reporting were ethically sound, gender-sensitive, and culturally appropriate. The safeguarding approach covered risk assessment, gender-appropriate team composition, logistics and security planning, informed consent, referral pathways, data protection, and the responsible sharing of findings.

Risk Assessment and Mitigation: A written risk assessment was completed prior to fieldwork. Key risks included participant distress when discussing sensitive issues such as gender-based violence (GBV), the possibility of social backlash against women or activists, breaches of privacy, interviewer fatigue, and logistical hazards related to travel in remote and flood-affected areas. Mitigation measures included conducting interviews in private and safe spaces, assigning same-gender interviewers for sensitive discussions, offering participants the option to skip or withdraw at any time, excluding names or direct identifiers from datasets, and establishing referral pathways for disclosures. Teams also implemented daily safety briefings, conservative travel plans, real-time check-ins, and contingency arrangements for inaccessible sites.

Ethical Study Design: Data collection tools and procedures were adapted to minimize risk and ensure gender sensitivity and inclusion. Women's interviews were conducted by women enumerators, and women-only teams facilitated women's FGDs. Adolescents were engaged only in contexts where it was culturally and ethically appropriate, with guardian consent and youth assent. Sensitive questions were carefully worded to avoid re-traumatization and opt-out options were built into the guides.

Secondary Data Use: To reduce unnecessary burden on participants, secondary sources such as baseline data, PMF indicators, CSO records, government GBV statistics, and safeguarding reports were reviewed in advance. This helped sharpen the focus of primary data collection on gaps that could not be addressed otherwise.

Community Engagement. Prior to data collection, field teams, supported by AKRSP and partner CSOs, introduced the study to community leaders and participants. Teams explained the objectives, voluntary nature of participation, and how findings would be used. Suitable venues and timings were agreed with participants. High-level findings will be shared back in accessible formats to ensure transparency and accountability to communities.

Team Composition and Training. Field teams were gender-balanced, with at least two women per team. Women's interviews and FGDs were led by female staff, while male enumerators primarily engaged with men. All team members were residents with fluency in the local languages and familiarity with cultural norms. Before fieldwork, they signed AKF's Safeguarding Statement of Commitment and Code of Conduct and received tailored safeguarding training, covering ethical practice, referral protocols, and cultural sensitivity.

Logistics and Security. A detailed fieldwork logistics plan was prepared, covering routes, vehicles, communications, and contingency plans for floods, landslides, or poor network coverage. Teams followed daily go/no-go safety decisions, worked in pairs, conducted GPS/phone check-ins, and limited travel to daylight hours.

Informed Consent. All participants received a clear explanation of the study's purpose, voluntary nature, expected duration, risks, and benefits, as well as privacy protections and referral options.

Written consent was obtained for in-person sessions, while verbal consent was documented for remote interviews. For adolescents, guardian consent and youth assent were required.

Safeguarding Disclosures. A clear referral protocol was in place for participants to disclose GBV or related distress. Staff did not investigate cases but listened respectfully, documented only minimal details, and referred participants safely to local services identified through CSOs and government hotlines. Supervisors logged incidents without identifiers and reported them to the safeguarding focal point within 24 hours.

Voluntary Participation and Privacy. Participation was strictly voluntary, with no penalties for refusal and no incentives tied to answers. Only modest reimbursements were offered for FGD travel and refreshments. Interviews were conducted in private, and if privacy was compromised in a household setting, the interview was paused or rescheduled. Participants were reminded of confidentiality and its limits, especially in situations of imminent harm.

Data Protection and De-identification. No names or direct identifiers were stored in KoBo or transcripts. A separate contact list, used only for verification calls, was securely stored outside the dataset. Audio files were deleted after verified transcription, and all transcripts were anonymized (e.g., "KII—district official," "FGD—woman, Hunza").

Limitations and Reporting. The report clearly notes study limitations, including sampling error at district level, self-report bias, and flood-related access challenges.

Sharing Findings. Results will be disseminated to CSOs, communities, AKRSP, AKF, and other relevant stakeholders. All findings are presented in a way that protects confidentiality and avoids identifying individuals.

2.7. Limitations Of the Study and Challenges

Self-reporting bias: Both the household survey and the Organizational Performance Index (OPI) relied heavily on self-reported information from individuals and organizations. In particular, the household survey covered sensitive topics related to gender-based violence (GBV) and empowerment, which carry a risk of under- or over-reporting. To minimize this bias, the study team used neutral wording, ensured privacy during interviews, assigned female enumerators to interview women respondents, and emphasized respondents' right to skip or discontinue any question. The team also triangulated findings with key informant interviews (KIIs), focus group discussions (FGDs), and available administrative data. For the OPI, the risk of bias was further reduced through evidence-based self-assessments, validation meetings, and consensus scoring against objective criteria.

Representativeness: The findings are presented at the district level but are representative only of the project's intervention areas within each district—not of the entire district population. The primary sampling units (villages) were drawn specifically from geographies where the project operated.

Project closure and staff unavailability: The project's closure posed challenges in some districts, such as Ghizer, Gilgit, and Chitral, where project staff were no longer available to help identify beneficiaries. In these areas, project activities had been relatively limited, and awareness of the project among communities was low, making it difficult to trace and engage with participants.

Administrative data constraints: Accessing official records from law enforcement and the justice sector proved challenging, particularly for indicators such as *1200.3 (number of people/GBV survivors accessing courts and support services, by gender/district)* and *1210.1 (number of GBV cases reported and redressed, by gender/district)*. Barriers included the absence of systematic recordkeeping by type

of GBV, weak information management and reporting systems, limited institutional understanding of GBV, reluctance to share information, and bureaucratic delays in granting access, especially in Chitral. As a result, baseline and endline comparisons for these indicators contained gaps.

Operational access: Recent glacial lake outburst floods (GLOFs) and cloudbursts in Gilgit-Baltistan and Chitral, combined with security incidents—such as the attack on a religious cleric in Gilgit and rising tensions along the Pakistan–Afghanistan border—made some baseline villages unsafe or inaccessible. In such cases, the team replaced those villages with alternatives identified by the implementing partner. In addition, accessing key informants such as law enforcement agencies and political and religious leaders proved difficult due to security concerns, sensitivities, and competing priorities.

Questionnaire relevance for young unmarried respondents. Certain sections of the questionnaire were less applicable to young unmarried respondents. For example, questions related to contraceptive use carried cultural sensitivity and often led to incomplete or inaccurate responses. Similarly, decision-making questions on maternal and neonatal health were not relevant to this group, creating challenges in data collection and consistency.

3. FINDINGS ON PROJECT OUTCOMES (PMF INDICATORS)

This section presents the summary results of the Project Performance Measurement Framework (PMF) outcome indicators. Data is drawn from the endline household survey, Organizational Performance Index (OPI) assessments, police and CSO records, and complemented by qualitative evidence from focus group discussions (FGDs) and key informant interviews (KIIs). Summary of the PMF indicators is presented below and detailed indicators results in attached at **Annex 10.**

3.1. Organizational Performance of CSOs (Indicator 1200.1)

Indicator 1200.1: % of AKF supported CSOs with improved performance

This section provides a summary of key results from the Organizational Performance Index (OPI) assessment. A full, detailed analysis of institutional capacity-building processes, sub-domain scores, and supporting qualitative evidence is presented in Section 5.2. At baseline, all three supported CSOs (KADO, LAPH, SBHI) were operating at a foundational level of institutional maturity. By endline, all three showed measurable improvements in their OPI scores, reflecting stronger systems, policies, and capacities. KADO achieved the largest improvement, moving from 1.69 to 3.13, while LAPH rose from 1.75 to 2.88, and SBHI from 1.0 to 1.63. This indicates that sustained mentoring and capacity development inputs have contributed to enhanced governance, monitoring and evaluation systems, and standardization of practices across these organizations.

CSO leaders highlighted how institutional strengthening has enhanced credibility with donors and community members. For instance, KADO noted that hiring a dedicated M&E professional and finalizing safeguarding and climate adaptation frameworks improved their ability to track outcomes. Similarly, LAPH staff described how developing core institutional policies (e.g., HR, procurement, anti-fraud) allowed them to function more systematically and build trust with stakeholders.

Table 4: Organizational Performance of CSOs (Baseline vs. Endline OPI Scores)

Indicator	Organization	Baseline	Endline	Source
% of AKF-supported CSOs with improved performance	All CSOs	–	100% (3/3 improved)	OPI summaries (Tables 48, 51, 53)
OPI Score	KADO	1.69	3.13	Table 48
	LAPH	1.75	2.88	Table 51
	SBHI	1.00	1.63	Table 53

KADO recorded the highest and most balanced improvement among AGECS partners. The strongest gains were seen in Effectiveness, Governance, and Sustainability, reflecting the organization's transition from basic procedural compliance to a more evidence-driven, and learning based organization.

With AGECS support, KADO institutionalized safeguarding and anti-harassment policies, integrated gender analysis into planning and budgeting, and introduced a results-based Monitoring and Evaluation (M&E) framework. It also developed a comprehensive M&E manual, adopted Excel-based tracking tools, and hired a dedicated M&E professional to oversee program reporting.

"Hiring a dedicated M&E professional and finalizing safeguarding and climate adaptation frameworks improved our ability to track outcomes." — KADO Manager

KADO also enhanced its institutional standards by finalizing policies on procurement, human resources, climate adaptation, and gender equality, while achieving Pakistan Centre for Philanthropy (PCP) certification. These measures strengthened internal governance, ensured compliance with donor and national standards, and enhanced organizational accountability.

"The new policies helped us standardize how we work across departments—decisions are now guided by procedures, not personal judgment." — KADO CEO

Under the Efficiency domain, KADO introduced detailed workplans and budget tracking systems supported by regular internal reviews and board oversight. The organization now produces quarterly progress and budget utilization reports that feed into both internal decision-making and donor presentations. These tools improved planning discipline and transparency, enabling KADO to complete projects such as the UN Women and GIZ-funded initiatives on schedule and within budget.

KADO also strengthened coordination with government departments, including the Police, Health, and Women Development Departments. In partnership with the police, KADO is working to initiate a toll-free complaint mechanism to make it easier for survivors of gender-based violence to report cases safely and confidentially. These collaborations improved institutional linkages and positioned KADO as a credible civil society partner in gender equality and social protection initiatives.

In terms of Relevance and Reach, KADO expanded both its thematic and geographic footprint. It extended operations to Gilgit, Skardu, Nagar, and Ghizer, targeting over 3,000 beneficiaries through women's entrepreneurship and export development projects. The organization also continued its long-standing commitment to the inclusion of persons with disabilities and promoted digital skills and climate resilience. Its collaboration with AKAH under the Climate Action Forum in Chitral demonstrates KADO's growing ability to integrate gender, inclusion, and climate perspectives into local development agendas.

KADO's Learning capacity improved substantially. It now documents lessons systematically and shares them through reports and presentations to its Board and national and international partners. The organization's two-year learning report on the project *"Enhancing Climate Resilience through Index-Based Community Climate Insurance in Chitral"* exemplifies its shift toward reflective and adaptive management.

"Every new project now starts with lessons from the last one. That mindset didn't exist before." — *KADO PM, Hunza.*

To enhance Sustainability, KADO developed a Resource Mobilization Plan and signed multiple MoUs with partners such as the Shamani Living Trust (till 2028), Community World Service Asia (till 2026), and the International Center for Development Learning, as well as a Takaful funding agreement. It also operates a Digital Hub in Hunza, generating income through membership fees and co-working spaces. However, some of MoUs have not yet translated into consistent funding, underscoring the continued challenge of turning strategic agreements into long-term financial support.

KADO's social capital and visibility have grown significantly. Visits by ambassadors, UN representatives, and senior government officials have reinforced its credibility as a leading civil society organization in Gilgit-Baltistan. The organization has also built new alliances with Serena Hotels,

Karakoram International University, and Jazz Musafir to promote technology-based climate and skills initiatives.

Overall, these developments have made KADO more transparent, better organized, and more trusted by both donors and local partners. The improved systems have improved how the organization plans, tracks, and reports its work while embedding gender and accountability principles into daily practice. Still, KADO's leadership recognizes that sustaining these gains will require predictable funding and retention of skilled staff. Like many other CSOs in the region, it faces the risk that progress achieved under donor-funded projects may erode if financial and human resource continuity is not secured.

LAPH demonstrated institutional progress, with its overall OPI score increasing from 1.75 (2023) to 2.88 (2025). The organization made its greatest gains in the domains of Governance, Effectiveness, and Efficiency, showing a shift from a reactive, case-based approach to a structured, system-oriented organization.

At baseline, LAPH primarily tracked project outputs to meet donor reporting requirements and lacked an integrated monitoring and evaluation (M&E) framework. With AGECS support, it developed a comprehensive project monitoring framework (PMF) that now captures both output and outcome-level results. The PMF, along with the Activity Implementation Schedule (AIS) and validated attendance and photo records, improved the organization's ability to plan, monitor, and evaluate its performance across multiple projects.

Under the Governance and Effectiveness domains, LAPH introduced a set of core institutional policies—including HR, procurement, anti-fraud, and safeguarding—which standardized procedures and clarified roles and responsibilities. These changes made decision-making more transparent and predictable.

"Before, decisions depended on individuals. Now they're guided by policy and board oversight." — LAPH PM, Chitral

In terms of Efficiency, LAPH established detailed workplans and delivery mechanisms that cover all projects and align with its strategic objectives. It also strengthened coordination with the District GBV Monitoring Committees, the Police, and the Women Development Department (WDD) in both Upper and Lower Chitral. This coordination led to tangible outputs, such as a locally produced awareness video on digital violence, which was broadcast on a local cable network following committee recommendations.

LAPH's Relevance and Learning capacities also improved. The organization engaged its target population more systematically in planning and decision-making and incorporated feedback from community consultations into its projects. Regular meetings with the District Social Welfare Department helped align local GBV initiatives with LAPH's model "Awareness–Action & Response," which other local departments have expressed interest in replicating.

Under Sustainability, LAPH developed and later operationalized a resource mobilization plan, identifying priority funding needs and strategies to pursue them. Although the plan has not yet translated into significant new funding, it has helped LAPH map potential partners and diversify its fundraising outreach. The organization also strengthened its social capital by maintaining active

partnerships with institutions such as the Aga Khan Foundation, District Bar Association, Chitral University, and Department of Information and Communication Technology (DICT).

Collectively, these efforts have made LAPH more professional, accountable, and credible in the eyes of both government and community partners. Staff now follow clear standards for service delivery, document results systematically, and engage external actors in joint GBV prevention and response efforts. However, financial sustainability remains a key concern, as the organization still depends heavily on short-term donor funding. Sustaining progress will require dedicated investment in fundraising capacity and long-term mentoring to embed its new systems fully.

SBHI made modest, short-lived gains mainly in relevance and outreach, supported by AGECS training and workplans. Progress stalled after the project's premature closure. The organization's role focused on conducting vocational and livelihood trainings for women and GBV survivors in Upper and Lower Chitral. However, due to persistent coordination and management challenges with the lead partner (LAPH), only three of the seven planned trainings were completed, and the component was closed prematurely.

SBHI reported limited involvement in staffing and procurement decisions, which affected transparency and training quality. Despite repeated attempts to address these issues, communication gaps remained unresolved. The organization adopted basic workplans and recordkeeping systems and participated in safeguarding and gender training, but broader institutional gains were minimal.

Overall, SBHI's progress was constraints by weak coordination and oversight mechanisms. The experience underscores the importance of clear partner roles, transparent decision-making, and joint monitoring systems in multi-partner projects. ***"We believed in the project's vision, but partners must work together with transparency and respect." — Chairperson, SBHI, Chitral***

3.2. Women's Decision-Making Power (Indicator 1200.2)

Indicator 1200.2: % of women who made decisions alone or jointly on FP/child health/health, SRH & ECD

Survey data show a significant rise in women making decisions—alone or jointly—on family planning, child health, and use of health services for pre-natal and post-natal care, Sexual and Reproductive Health Services, and enrolment of children in Early Childhood between 2023 and 2025. Overall, women's decision-making on these issues increased from 55% at baseline to 85% at endline. Gains were strongest among younger women (18–35 years: 60% to 86%) and in Hunza (55% to 98%) and Gilgit (51% to 90%). Ghizer showed weaker improvement (52% to 61%), reflecting persistent structural barriers.

Table 5: Percentage of Women made decisions alone or jointly on FP/child health/health, SRH & ECD

Disaggregation	Baseline	Endline	Source
Total	55%	85%	Table 14
Age			
Women (18–35)	60%	86%	Table 14
Women (36–53)	47%	83%	Table 14
District			
Hunza	55%	98%	Table 14
Nagar	35%	83%	Table 14
Gilgit	51%	90%	Table 14
Ghizer	52%	61%	Table 14
Upper Chitral	71%	88%	Table 14

Across specific domains (Table 15), women's participation in decision-making improved across all four areas: family planning (57% → 80%), child health (66% → 90%), SRH (52% → 81%), and ECD (46% → 87%). These figures indicate that women are increasingly part of key household decisions that directly affect their health and their children's wellbeing. The depth of involvement also shifted: at baseline, most women described their input as equal but not decisive. By endline, the share identifying as primary or sole decision-makers increased from 19% to 33% (Table 17), showing modest but meaningful movement toward greater shared authority within families.

Qualitative evidence from FGDs reinforces these trends. In several districts, women described being more confident discussing family and health matters and more involved in practical decisions such as when to visit clinics or enroll children in preschool. In Thol Nagar (Hunza), a participant said, ***"Before, we were silent. Now we can talk to our husbands about birth spacing and when to visit the clinic."*** In Brep (Upper Chitral), another woman shared, ***"Earlier, I could not go to the hospital without permission. Now, my husband asks my opinion first."*** Similarly, a woman in Sumayar (Nagar) explained, ***"Now our children get proper vaccination and schooling because we are part of these decisions."***

Men also noted this shift. In Drosh (Lower Chitral) and Barumkagh (Upper Chitral), male participants remarked, ***"Women speak up more now and are more involved in family health matters."*** However, not all accounts were positive. In Ghizer, one man added, ***"Our local imam now talks about women's health and family rights in Friday sermons — earlier, these topics were never mentioned."*** In **Nagar**, another participant explained, ***"When religious leaders support these ideas, it becomes easier for us to let women make their own health decisions."***

However, not all accounts were positive. In Danyore (Gilgit), one woman shared, ***"I tried to end my life because I have no say in decisions. Everything in my life happens by my husband's order."*** Such contrasting views reflect the uneven nature of empowerment across the region, with women in areas still struggling to exercise full agency.

Survey data on barriers (Tables 16–22) confirm these mixed realities. Knowledge and access barriers have declined—showing the positive influence of awareness campaigns and improved health service delivery—but economic hardship, restrictive social norms, and lack of spousal support continue to limit women's autonomy. At endline, 61% of respondents cited poor economic conditions and 50% pointed to cultural or religious norms as constraints. Encouragingly, fear and stigma were reported

less frequently (13% → 6%), suggesting that women now feel safer discussing reproductive and health issues.

Across FGDs, women identified new forms of agency that were not visible before AGECS interventions. These include:

- Confidence to discuss and negotiate reproductive and child health decisions with their husbands;
- Independent use of health services, particularly among younger and educated women;
- Openness in communication with daughters about menstruation, personal safety, and marriage; and
- Collective confidence, gained from peer learning and AGECS community sessions.

In summary, women's decision-making power on family planning, child health, SRH, and ECD has expanded from limited consultation to broader shared decision-making and, in some cases, independent choices. This progress may have strengthened family wellbeing, especially in Hunza, Gilgit, and Nagar, but remains uneven in Ghizer and Chitral. Without continued engagement of men, community leaders, and local institutions, women's agency may decline over time as economic and cultural barriers persist.

3.3. Community Satisfaction with Handling of GBV Cases (Indicator 1210.1)

Indicator 1210.1: % of community members completely satisfied with handling/management of GBV cases

Despite institutional efforts, satisfaction with how GBV cases are handled remained low and even declined overall (15% to 7%). Men expressed slightly higher levels of satisfaction (21% to 11%), while women reported the lowest satisfaction (10% to 3%), reflecting continued mistrust of formal systems.

Table 6: Percent of respondents completely satisfied with handling/management of GBV Cases (Baseline Vs Endline)

Disaggregation	Baseline	Endline	Source
Total	15%	7%	Table 28
Gender			
Women	10%	3%	Table 28
Men	21%	11%	Table 28
District			
Hunza	18%	3%	Table 28
Nagar	24%	8%	Table 28
Gilgit	1%	5%	Table 28
Ghizer	24%	8%	Table 28
Upper Chitral	9%	7%	Table 28
Lower Chitral (LAPH-specific)	7%	8%	Table 28

This indicator measures the share of respondents who reported being completely satisfied with how gender-based violence (GBV) cases are handled in their community. The survey asked participants to rate their satisfaction using four options: completely dissatisfied, partially dissatisfied, satisfied, and

completely satisfied. The overall sample sizes were consistent across indicators (Baseline n = 481; Endline n = 360), but only a small proportion of respondents expressed complete satisfaction. The small figure reflects low confidence in the existing systems rather than a small or unrepresentative sample.

Survey results show a clear decline in satisfaction with GBV case management between baseline and endline. The proportion of respondents who were completely satisfied dropped from 15 percent to 7 percent, while those satisfied fell from 65 percent to 26 percent. Meanwhile, partial dissatisfaction increased from 19 percent to 42 percent, and complete dissatisfaction rose from 8 percent to 21 percent. Women's complete satisfaction declined from 10 percent to 3 percent, and men's from 21 percent to 11 percent. Declines were observed in all districts, with the largest drops in Hunza, Gilgit, and Nagar. These findings suggest that while awareness and access to information improved, confidence in institutional response and case management weakened. Respondents are more aware but also more critical of how GBV cases are managed.

The decline in satisfaction must be viewed in the context of broader shifts in awareness and perception captured in the survey. Awareness of GBV as a community problem increased from 54 percent at baseline to 90.7 percent at endline (Table 23). This sharp rise shows that community engagement and awareness efforts were effective, but also that expectations from formal systems have increased. As people became more aware of GBV and its different forms, they began to expect faster, more confidential, and more survivor-centered services. Communities also developed a broader understanding of GBV. Recognition of online and digital abuse increased by 6.5 percentage points, and sexual abuse by 2.5 percentage points, while physical abuse declined slightly and emotional or psychological abuse remained the most reported form (Table 24). This shift shows growing recognition of diverse types of violence, but it also raises expectations for institutional mechanisms that can respond to them.

Perceptions about who experiences GBV also changed over time. At baseline, 76 percent believed GBV primarily affected women, while only 23 percent thought it affected both genders. By endline, 37 percent said it affects both men and women (Table 25). This suggests that public understanding has become more inclusive, but it also means that more people now expect accessible and fair systems that serve all survivors, regardless of gender. Awareness of GBV handling mechanisms also improved. The share of respondents who said they were unsure dropped from 18 percent to 4 percent, and mentions of reporting mechanisms, awareness campaigns, and accountability initiatives increased. However, more people now believe that GBV cases are not adequately addressed—rising from 26 percent to 32 percent (Tables 26 and 27). This shows that people are now more informed but remain frustrated by inconsistent follow-up and limited survivor support. Women, in particular, reported fewer available support services and a lack of confidentiality when reporting cases.

Qualitative findings help explain these survey trends. Focus group discussions (FGDs) and key informant interviews (KIIs) show that while communities value increased awareness, many still distrust formal response mechanisms due to stigma, poor coordination, and limited confidentiality. As one civil society participant in Gilgit stated, ***"The referral system exists on paper, but there is no follow-up, no dedicated staff, no tracking."*** A woman in Ghizer said, ***"Once you go to the police, your name spreads everywhere. There is no privacy."*** Another participant from Upper Chitral noted, ***"We know now what GBV means, but reporting is another matter. Families prefer to stay silent because***

of shame." In contrast, a few positive signs emerged. Men in Ghizer observed that ***"now our Imam and elders talk about women's protection in Friday sermons. When they support it, men listen more seriously."*** Similarly, a woman in Hunza said, ***"At least now the police listen and there are women officers. Earlier we could not even enter the station."*** These quotes highlight that awareness and community dialogue have improved, but institutional follow-up and survivor protection remain weak.

The decline in satisfaction therefore reflects a gap between rising awareness and limited institutional capacity. The AGECS project helped communities recognize GBV as a collective concern and encouraged open discussion, but formal services have not yet caught up with the community's expectations. Survivors still face stigma, weak coordination among police and social services, and inconsistent follow-up. Increased understanding of GBV and its forms has led people to demand more reliable, confidential, and survivor-friendly mechanisms.

The findings suggest that progress in awareness has outpaced progress in institutional trust. Future programming should focus on strengthening confidential and survivor-centered services, improving coordination among police, health, and welfare departments, ensuring accountability and follow-up for reported cases, and sustaining engagement with men, elders, and religious leaders to reduce stigma. The AGECS project has succeeded in changing perceptions and creating space for dialogue, but lasting impact will depend on whether institutions can now respond to this heightened public awareness with effective and trustworthy action.

3.4. Formal Complaints of GBV (Indicator 1210.2 – KADO-specific)

Indicator: 1210.2: # of women filing formal complaints regarding GBV with law agencies

For KADO's districts, the number of women filing formal complaints increased from 24 at baseline to 44 at endline. The largest increases were observed in Hunza (0 to 9) and Gilgit (11 to 23). However, in Nagar no formal complaints were recorded. For Chitral we could not access the official police data. According to LAPH data in Chitral, cases filed and redressed remained high but with limited improvement. For women, cases increased from 185 (with 119 redressed) at baseline to 203 (with 127 redressed) at endline. Success rates (64% to 62%) suggest that while reporting increased, systemic constraints hinder resolution.

Table 7: Number of Formal GBV Complaints Filed by Women (KADO Areas) and cases filed and redressed (LAPH area) (Baseline Vs Endline)

District	Baseline	Endline	Source
Total	24	44	Table 56
District			
Hunza	0	9	Table 56
Nagar	0	0	Table 56
Gilgit	11	23	Table 56
Ghizer	7	12	Table 56
Upper Chitral	6	NA*	Table 56
GBV Cases Reported and Redressed (LAPH/SBHI Areas)	185 / 119 (64%)	203 / 127 (62%)	Table 57
District			
Upper Chitral	34 / 19 (56%)	59 / 29 (49%)	Table 57
Lower Chitral	151 / 100 (66%)	144 / 98 (68%)	Table 57
Note: We could not access the data recorded in police stations in Chitral.			

The uneven pattern of reported GBV cases across the six districts reflects both rising trust in formal systems and the persistence of stigma and traditional norms. In **Gilgit**, survivors reported cases through multiple stations including Danyore and City Police Station, showing broader access to law enforcement and closer coordination with the Women Development Department (WDD). A female police officer explained, ***"Now we receive more cases directly from women; they come on their own or through CSOs. Having women officers at the station has helped a lot."*** A lawyer in Gilgit added, ***"There is better awareness and more reporting, but follow-up is weak. Once a case is filed, it gets stuck between the police and courts."*** These views illustrate that although reporting has improved, slow legal processes and limited follow-through still undermine justice.

In **Hunza**, all nine cases were filed at the Women Police Station, showing the value of gender-responsive services. A CSO representative observed, ***"Awareness sessions and media coverage have encouraged women to speak up. Many cases are now discussed openly."*** Yet social pressure remains strong. A community leader explained, *"People are more aware of their rights, but they still hesitate to go to the police because they fear social backlash."* Formal reporting therefore occurs only when informal resolutions fail.

In **Nagar**, no cases were recorded, underscoring how deeply patriarchal norms and honor culture suppress reporting. A police officer acknowledged, ***"No woman has ever come to report violence here. The community believes such issues should be handled privately."*** A CSO worker added, ***"Reporting GBV is still seen as shameful; families stop women from going to the police."*** A religious leader confirmed this barrier: ***"The culture here discourages public discussion of such matters because people fear dishonor."*** These statements explain why Nagar remains an outlier with no formal complaints.

In **Ghizer**, formal complaints increased slightly from seven to twelve, distributed across Immit, Gupis, Yasin, and Phander police stations. A CSO representative said, ***"Earlier, women didn't know how or where to report. Now they come to CSOs first."*** A police officer added, ***"Women try community mediation first, and only if that fails do they approach the police."*** According to a Women Development Department official, ***"We are working with religious leaders to talk about GBV in sermons, which helps reduce stigma."*** These comments show how community engagement is gradually building bridges between informal and formal systems.

In **Chitral**, where official police data were unavailable, the Legal Aid and Human Rights Programme (LAPH) supported **203 court cases** during 2023–2025, up from 185 in 2020–2022, though the decision rate fell from 64% to 62% (Table 57; Section 6.2). A lawyer explained, ***"Women in Chitral are more aware now, but the court process is too long and expensive. That discourages them."*** A CSO representative added, ***"Families still prefer reconciliation. Reporting to police is the last resort."*** **A religious leader shared a positive shift:** ***"We now speak in Friday sermons that violence against women is wrong. This message has softened attitudes."***

Supporting data from the **FIA Cyber Wing Gilgit (2023–2025)** show **145 online-harassment complaints**, reflecting growing awareness of digital GBV (Section 6.3). Monitoring by the **Human Rights Commission of Pakistan (HRCP)** recorded cases of honor killings, forced marriage, rape, and

harassment, along with male suicides linked to social pressures (Section 6.4), demonstrating that formal complaints capture only a small fraction of incidents.

While formal reporting has grown—particularly in Gilgit, Hunza, and Ghizer—the overall progress remains gradual. Survivors continue to face social stigma, slow legal processes, and pressure for family-based reconciliation. As one lawyer summarized, ***"Proceedings involve a prolonged, public, and financially draining ordeal, so most survivors stop midway or accept reconciliation."***

Strengthening survivor-centered support, ensuring case follow-up, expanding female police staffing, and continuing to engage religious leaders are critical to translate these initial gains into sustained institutional change and confidence in justice systems.

3.5. Resource Mobilization (Indicator 1220.1)

Indicator1220.1: Monetary value of support raised from local donors by CSOs

Only KADO raised CAD 842,413 from local donors at baseline, but this fell to CAD 250,540 by endline. While KADO succeeded in signing several long-term MoUs (e.g., Shamani Living Trust, Community World Service Asia), reliance on large donor projects limited consistent local fundraising. LAPH reported that they have not mobilized any other local resource except the AGECS project. SBHI even discontinued in the middle of the project due to conflict between LAPH and SBHI on operational issues.

Table 8: Monetary Value of Support Raised from Local Donors (KADO)

Organization	Baseline	Endline	Source
KADO	CAD 842,413	CAD 250,540	Table 49
LAPH	CAD 14,912	00	Narrative in LAPH OPI section
SBHI	CAD 2,624	00	Narrative in SBHI OPI section

Discussions with KADO's management confirmed that the sharp decline mainly reflected the completion of several large, one-time projects that had generated substantial in-kind and government contributions during the baseline period. Once these projects closed, there were no comparable local or government funding streams available to replace them. Staff also noted that local philanthropy and private-sector contributions had weakened since the COVID-19 pandemic, as businesses reduced community investment budgets to stabilize their own operations.

The decline was further compounded by broader funding trends in Pakistan and the region. Donor priorities have shifted significantly since 2022, following changes in policies by major bilateral agencies such as USAID and others, who reduced or restructured their country portfolios. As a result, fewer development programs have been launched, and competition for remaining grants has intensified. This regional funding contraction has made it more difficult for mid-sized CSOs like KADO and LAPH to secure new resources, even when institutional systems and donor engagement mechanisms have improved.

Despite these challenges, KADO used the AGECS period to strengthen its internal systems. It finalized a resource mobilization plan, established donor outreach procedures, and signed multiple MoUs with private companies, trusts, and government agencies. However, these agreements have so far remained at a preliminary stage and have not yet resulted in new grants or projects. This shows that KADO's institutional capacity to engage potential donors has improved, but its ability to convert partnerships into funding remains limited.

For LAPH, the absence of additional local resource mobilization was attributed to limited staff capacity and competing implementation demands. The organization focused primarily on delivering project activities and had no dedicated resource mobilization focal point. Although it prepared a basic fundraising plan and initiated informal discussions with local partners, these efforts were still at an early stage and did not lead to tangible results.

SBHI's early withdrawal from the project prevented it from pursuing any meaningful fundraising or institutional strengthening efforts.

Overall, the decline in local fundraising across partners reflects both structural constraints in the enabling environment—such as narrow local philanthropy, dependence on short-term donor cycles, and reduced international development funding.

3.6. Net Promoter Score – Value of CSO Work (Indicator 1220.2)

Indicator 1220.2: Extent to which members value CSO work (NPS)

At endline, Net Promoter Scores (NPS) remained negative for all three CSOs, suggesting that community members hold mixed or critical views of CSOs' effectiveness. For KADO, overall NPS fell from -15 to -21, with women rating the organization slightly better (-40 to -8) but men more negatively (3 to -35). For LAPH, NPS improved slightly (-25 to -14), while SBHI's score declined (-15 to -19).

Table 9: Net Promoter Score (Value of CSO Work) - Baseline Vs Endline

Organization	Baseline	Endline	Source
KADO			Table 50
Total	-15	-21	
Female	-40	-8	
Male	3	-35	
LAPH			Table 52
Total	-25	-14	
Female	-33	-19	
Male	-18	-8	
SBHI			Table 54
Total	-15	-19	
Female	-24	-24	
Male	-9	-16	

As presented in section 5 (Table 52 -55), the NPS results show divergent patterns across the three organizations. LAPH improved overall (–49% to –28%), with particularly better perceptions in its home base of Lower Chitral, suggesting a possible link between local presence and trust. SBHI, however, saw a steep decline (–18% to –69%), likely influenced by the premature discontinuation of activities, which left communities dissatisfied. KADO recorded mixed results, improving in Hunza (–20% to +15%) where it is most active, but declining in all other districts, leading to a small overall drop (–15% to –21%). These results indicate that local presence and continuity matter for sustaining community trust and shaping perceptions.

KADO representatives noted during validation discussions that the negative NPS may not fully reflect actual community trust, because many survey respondents were non-direct beneficiaries with limited direct interaction with KADO's activities. They emphasized that the recall period between activity completion and the endline survey may have influenced perceptions. KADO recommended that future

perception assessments should primarily sample active participants such as Women Activist Forum members, trained community leaders, and police officials involved in referral coordination, to ensure that NPS results more accurately capture changes among those directly engaged.

However, the qualitative evidence confirms that these shifts in NPS scores reflect genuine changes in community perception. Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) across all districts showed that satisfaction and trust were closely tied to field visibility, communication frequency, and the availability of tangible support services from the implementing organizations. Communities consistently expressed stronger confidence in organizations that maintained a consistent field presence and provided direct engagement—such as LAPH in Lower Chitral and KADO in Hunza—compared to those with limited presence or early closure.

Importantly, while AGECS succeeded in expanding awareness of GBV and women's rights, this awareness was not matched by equivalent improvements in access to services or redress mechanisms. Earlier and later sections of this report show a marked rise in GBV awareness and recognition (Tables 23–27), but a decline in satisfaction with handling of GBV cases (Table 28). This gap between awareness and service delivery appears to have shaped community perceptions of the partner organizations. As awareness increased, so did expectations for accessible justice, psychosocial support, and protection services—yet these systems remained underdeveloped and inconsistent. Many respondents emphasized that ***"people now know more, but help is still hard to find,"*** highlighting how unmet expectations eroded trust in local institutions and, by extension, in partner organizations.

For KADO, the mixed results reflect its operational footprint. Communities in Hunza expressed high appreciation for women's empowerment and livelihood activities, where KADO's work with local communities remained strong with AGECS and other projects. However, in Ghizer, Upper Chitral, Gilgit and Nagar, reduced field-level visibility and limited engagement led to lower satisfaction. Our data collection teams observation and discussion with respondents suggest that KADO's direct presence at the grassroots level was more visible than districts like Ghizer or Upper Chitral, therefore affecting community perceptions of accessibility and responsiveness.

LAPH's modest improvement in NPS corresponds with its continued community engagement in Lower Chitral, particularly through legal aid, referrals, and awareness sessions. While respondents valued its responsiveness and trusted its intent, however, in Upper Chitral many also cited slow judicial processes and limited psychosocial support as persistent gaps. The improvement, therefore, again reflects confidence in LAPH's approach and proximity.

For SBHI, the steep decline aligns with community feedback following its early withdrawal from the project. Participants reported confusion and disappointment over incomplete activities, describing feelings of neglect and loss of trust. This decline was driven primarily by program discontinuity rather than dissatisfaction with the organization's original work.

Across partners, three factors consistently shaped community perception: (1) continuity of field presence and communication, (2) visible, depth of activities and accessible service delivery, and (3) clarity about project scope and closure. The AGECS project's heavy emphasis on awareness-raising created expectations that were not matched by equal investment in support and referral services, leading to frustration when cases were not redressed.

In summary, the decline in NPS for KADO and SBHI, and the limited improvement for LAPH, are credible reflections of communities' growing awareness and expectations amid uneven service access. While AGECS partners effectively advanced dialogue on GBV, the limited availability of survivor-centered

services and weak institutional follow-up mechanisms constrained sustained trust. For GAC reporting, these findings underscore the need to balance awareness creation with investments in accessible protection systems to ensure that perception gains translate into lasting confidence in GBV response mechanisms.

3.7. Community Leaders’ Capacity to Address Gender and Social Barriers (Indicator 1220.3 – KADO-specific proxy)

Indicator 1220.3: % of community leaders reporting increased ability to identify/respond to gender & social barriers

As shown in Table 10, the proportion of community leaders who felt *very confident* in identifying and responding to gender and social barriers increased from 35% at baseline to 50% at endline. Women leaders reported higher confidence (55%) than men (45%), reflecting both their lived experiences with gendered constraints and their direct engagement in AGECS-supported leadership activities. District-level progress was uneven: Hunza showed the strongest gains (50% → 67%), followed by Nagar (30% → 50%) and Ghizer (38% → 50%), while Gilgit and Upper Chitral recorded smaller improvements (around 40%)..

Table 10: Community Leaders’ Ability to Identify and Respond to Gender and Social Barriers (KADO Areas) - Baseline Vs Endline

Disaggregation	Baseline	Endline	Source
Total	35%	50% (n=22)	Tables 45
By Gender			
Men	33%	45% (n=11)	Tables 45
Women	42%	55% (n=11)	
By District		(n=11)	
Hunza	50%	67%	Tables 45
Nagar	30%	50%	
Gilgit	31%	40%	
Ghizer	38%	50%	
Upper Chitral	33%	40%	

Qualitative evidence from KIIs with community leaders confirms these patterns and provides context for the reported increase in confidence. Leaders in Hunza and Ghizer described new readiness to discuss issues that were previously taboo, including restrictions on women’s mobility, early marriage, and inheritance denial. A male leader from Hunza explained, ***“Earlier we avoided talking about these issues; now we know how to address them respectfully in meetings.”*** Similarly, another male leader in Ghizer noted, ***“Traditional leaders could better prevent GBV by raising awareness about harmful practices such as child marriage, inheritance denial, or restrictions on women’s mobility, and actively discouraging them.”*** These perspectives show that training and dialogue sessions have helped leaders reframe such practices as barriers to equality rather than cultural norms.

The “barriers” most frequently cited by community leaders included mobility restrictions, inheritance denial, early and forced marriage, unequal access to education and livelihoods, and limited participation of women in public decision-making. As a woman activist from Lower Chitral observed, ***“Early marriage, inheritance denial, and mobility restrictions are still treated as family matters, not***

violence. Men see these as protection, but women see them as barriers that stop them from education, healthcare, or earning."

However, despite stronger awareness, many leaders said they still face social resistance when attempting to challenge these norms. KII respondent from Nagar explained, ***"We still face community resistance when addressing inheritance or domestic control issues. People say 'this is our culture,' which makes open discussion difficult."*** Another community activist from Upper Chitral highlighted ongoing stigma, stating, ***"Families often silence survivors, fearing shame more than harm. In some valleys, even talking about GBV is considered taboo."*** These views reflect how deeply rooted traditions continue to limit leaders' ability to translate awareness into action.

Women leaders also acknowledged that although their confidence to speak up has grown, transforming awareness into influence remains constrained by backlash, lack of institutional backing, and weak follow-up mechanisms. As one local government representative from Ghizer noted, ***"In rural areas, poverty and unemployment worsen barriers. Women cannot travel to access health or legal services and depend on men who may be the ones restricting them."***

Overall, AGECS interventions have clearly strengthened community leaders' ability to identify and discuss gender and social barriers, especially in districts with sustained CSO engagement. Yet, the transformation from recognition to resolution remains limited by entrenched social norms, fear of community resistance, and uneven institutional support. Continued mentorship, dialogue with religious and traditional leaders, and stronger linkages with protection systems will be critical to sustaining progress and ensuring that awareness leads to practical, locally accepted change.

3.8. Gender Equitable Attitudes (Indicator 1230.1)

Indicator 1230.1: % of male & female community members reporting increased understanding & acceptance of gender equality / women's empowerment

The proportion of men and women expressing gender-equitable attitudes increased modestly from 72.7% to 78% overall. Women's scores rose slightly (72.8% to 78%), while men's score rose more (72.7% to 79%). Gains were strongest in Ghizer (71.5% to 87%) and Nagar (79.7% to 85%).

Table 11:Percentage of Community Members Reporting Gender-Equitable Attitudes (Baseline Vs Endline)

Disaggregation	Baseline	Endline	Source
Total	72.7%	78%	Table 32
By Gender			
Men	72.7%	79%	Table 32
Women	72.8%	78%	
By District			
Hunza	77.4%	70%	Table 32
Nagar	79.7%	85%	
Gilgit	65.5%	75%	
Ghizer	71.5%	87%	
Upper Chitral	71.6%	85%	
Lower Chitral (LAPH-specific)	57.9%	68%	

Awareness and understanding of gender equality have clearly improved. The share of people who said they were "not aware at all" of laws and policies promoting women's rights dropped from 41% at

baseline to just 15% at endline. The biggest improvements were seen in Hunza, Nagar, and Gilgit, while Upper Chitral fell behind and even lost ground (Table 29). Awareness of the term "gender-based violence (GBV)" is now widespread, rising from 39% to 94% overall. Knowledge of where to seek legal help also improved slightly, from 75% to 78% (Table 30). However, belief that better access to legal services can reduce GBV remains uneven—strong in Ghizer and both Chitrals (around 77–80%) but very low in Gilgit (22%). As one woman in Gilgit explained, ***"Before, most of us didn't know there were laws protecting women from violence. Now people at least know these exist, even if they don't fully trust the system."*** Another participant in Hunza added, ***"You hear about women's rights more often now in community meetings and on TV. It's not strange anymore to talk about gender equality."***

Attitudes and social norms have also shifted in several important areas. Victim-blaming has declined sharply: the share of people who agreed that a woman "should be blamed" if harassed while going to the market fell from 32% to 18%. The most dramatic improvements were in Hunza (61% to 17%) and Nagar (41% to 3%) (Table 31). One woman in Nagar said, ***"Earlier, if a woman was harassed, people would say she should have stayed at home. Now many say the man should be punished."*** Agreement that "violence is never acceptable" increased from 68% to 81%, and support for holding perpetrators legally accountable and for education as a tool to prevent GBV remained very high (around 89–93%) (Table 32). Participants in Lower Chitral also noted, ***"Violence in the home is less tolerated. Some people talk about it, and some community elders try to stop it instead of ignoring it."***

People are now more likely to support formal action when a woman faces repeated GBV. Support for reporting to authorities increased from 35% to 46%, while those saying "it's a family matter" dropped from 23% to 11%. The biggest progress came in Ghizer and Chitral, though Nagar moved backward (Table 33). Still, not everyone feels confident enough to act. As one man in Ghizer put it, ***"Even though men understand violence is wrong, not everyone feels brave enough to report it. They worry it will bring shame to the family."*** This helps explain why personal willingness to intervene declined overall—those who said they were **"likely or very likely to intervene"** fell from 74% to 56%, while neutral responses increased (Table 34).

Views on women's public roles are positive but still mixed. Support for women's equal opportunities in community leadership stayed very high (94% to 96%), but approval for women's participation in decision-making at all levels fell from 94% to 87%, showing hesitation to share power equally (Table 35). As a woman from Upper Chitral shared, ***"Women are taking part in meetings now. Before, men spoke for them, but now women speak for themselves."*** However, a female participant from Hunza noted, ***"Leadership by women is accepted when it helps the whole community. But when it's about politics, some families still say no."***

Communities continue to support "practical" empowerment that benefits households. The share of people who would prioritize a girl's education when resources are limited rose from 37% to 53%, and those who would support women opening a business in a male-dominated bazaar increased from 53% to 57% (Table 37). As one woman in Ghizer said, ***"Parents now want to send their daughters to good schools. They see that an educated girl supports her family better."*** However, fewer people supported women entering male-dominated professions (down from 76% to 69%) or professional sports (68% to 59%), showing discomfort with visible, public roles (Table 36). ***"When a woman opens a shop or earns her own income, the family benefits,"*** **explained a woman in Gilgit,** ***"but some men still feel insecure."***

Attitudes toward women's autonomy also improved. Support for a working woman's right to delay another child rose from 42% to 60%, while those who said she should "obey her husband and family" dropped from 20% to 16%. The biggest progress was in Ghizer (24% to 88%), while Nagar showed the

steepest decline (Table 38). A woman in Ghizer emphasized, ***"A woman should have a say in how many children to have, especially if she is working. It's her health too."*** In contrast, a man from Nagar reflected that, ***"In our area, people still think a woman must obey her husband. Slowly that thinking is changing, but not everywhere."***

However, women's political participation remains conditional. Unconditional support for a woman relative running for local office fell (63% to 26%), while conditional support—"if the family agrees"—increased (25% to 59%) (Table 39). As a woman in Hunza put it, ***"If a woman wants to contest elections, she must get permission from the family. Without that, it's difficult."*** A man in Gilgit added, ***"Women can lead, but politics brings criticism and gossip. Families don't want to face that."***

Overall, the data and community voices show steady but uneven progress. People are more aware of gender laws, more likely to reject violence and victim-blaming, and more open to women's education and livelihoods. Yet hesitation remains when empowerment challenges traditional authority or involves visible public roles like politics or sports. In short, gender equality is gaining ground, but deep-rooted norms continue to limit how far and how fast change can go. Sustained engagement with men, religious leaders, and community institutions will be essential to turning these positive attitudes into lasting behavioral change.

4. HOUSEHOLD SURVEY RESULTS

4.1. Respondents' Demographic Profile

The baseline survey included 481 households, and endline included 360 households with one respondent from each household. The demographic profile of respondents across baseline (2023) and endline (2025) shows overall comparability with some differences (Table 12).

Gender balance was consistently maintained, with women slightly more represented than men in both rounds. Married respondents formed the majority in both surveys, though their proportion declined at endline, where single respondents became more prominent. In terms of age, younger participants (18–34) dominated the baseline, whereas older adults (35+) made up a greater share in the endline.

A quarter of baseline respondents reported no or only primary education, this proportion dropped sharply at endline, where more than half of respondents had graduate or postgraduate qualifications. These variations suggest that while the two samples are broadly balanced, the endline represents a somewhat older, more educated, and less married profile compared to the baseline. District wise comparisons are presented in **Annex 11.**

Table 12: Demographic Profile of Respondents in Baseline (2023) and Endline (2025) Surveys

Category	Baseline 2023 (n=481)	Endline 2025 (n=360)	Key Observations
Gender	Women: 246 (51%) Men: 235 (49%)	Women: 188 (52%) Men: 172 (48%)	Gender balance maintained.
Age	18–34yrs: 261 (54%) 35+yrs: 219 (46%)	18–34yrs: 155 (43%) 35+yrs: 205 (57%)	Endline sample is older compared to baseline.
Education	No/Primary: 119 (25%) Secondary & Intermediate: 188 (39%) Graduate+: 174 (36%)	No/Primary: 40 (11%) Secondary & Intermediate: 126 (35%) Graduate+: 192 (54%)	Endline more respondents with higher level of education
Marital Status	Married: 357 (74%) Single: 112 (23%) Other (sep/wid): 12 (3%)	Married: 307 (62%) Single: 46 (31%) Other (sep/wid): 7 (7%)	More married respondents in both surveys

Table 13 presents the family profile of the sample respondents between baseline (2023) and endline (2025), which shows some differences in sample composition. The endline included more respondents from nuclear families (58% vs. 45%), with higher education level of any member in the family (54% graduate/postgraduate vs. 36% at baseline) and greater reliance on self-employment (34% vs. 13%). These shifts indicate a more educated and economically diversified endline sample, which should be considered when interpreting outcome changes. District wise detail profile of the sample households is presented in **Annex 12.**

Table 13: Household Profile of Respondents in Baseline (2023) and Endline (2025) Surveys

Category	Baseline 2023 (n=481)	Endline 2025 (n=360)	Observations (Proportions)
Family Type	Nuclear: 45% Joint: 55%	Nuclear: 58% Joint: 42%	Baseline: majority joint families (55%) Endline: majority nuclear families (58%)
Education (highest in household)	No/Primary: 25% Secondary & Intermediate: 39% Graduate+: 36%	No/Primary: 11% Secondary & Intermediate: 35% Graduate+: 54%	Baseline: 64% up to secondary/intermediate, 36% graduate+ Endline: 46% up to secondary/intermediate, 54% graduate+
Household Income Sources	Daily wage: 33% Salary (non-agri): 36% Business: 13% Pension: 8%	Daily wage: 15% Salary (non-agri): 35% Business: 34% Pension: 1%	Baseline: daily wage dominant (33%) Endline: business/self-employment expanded (34%), daily wage reduced (15%)

4.2. Gender and Social Barriers to Access Services

Role of Women in Decision Making on Family Planning, Child Health and Use of services (SRH, ECD)

As shown in Table 14 women's participation in decision-making on family planning, child health, SRH, and ECD services increased overall from 55% at baseline (2023) to 85% at endline (2025). District-level variation is notable: the largest gains were observed in Gilgit, Hunza, and Nagar, while Lower Chitral and Ghizer showed smaller improvements. Younger women (18–35) reported greater increases in involvement than older women (36–53). These findings indicate a broad positive trend towards women's inclusion in health and family-related decisions, though progress is uneven across districts and age groups. *Since the baseline and endline samples are not panels, these changes reflect population-level differences rather than individual trajectories.*

Table 14: % of Women Reporting made decisions alone or jointly on Family Planning, Child Health, SRH and ECD Services – Baseline (2023) and Endline (2025)

Group	Baseline (%)	Endline (%)	n (Base Line)	n (End Line)
Overall	55%	85%	245	160–188
District				
Upper Chitral	71%	88%	39–42	15–19
Lower Chitral	66%	66%	40–43	10–15
Ghizer	52%	61%	38–40	28–30
Gilgit	51%	90%	40	37
Hunza	55%	98%	40–43	31
Nagar	35%	83%	41–42	25–28
Age				
Age 18–35	60%	86%	147–153	69–74
Age 36–53	47%	83%	91–92	79–82

Table 15 compares women's decision-making at baseline (2023) and endline (2025) across the four areas: family planning, child health, sexual and reproductive health (SRH), and early childhood development (ECD).

At the overall level, women's involvement in decision-making increased across all four areas. Family planning decisions rose from 57% to 80%, child health from 66% to 90%, SRH from 52% to 81%, and ECD from 46% to 87%. This indicates that more women reported being part of these decisions at endline than at baseline.

Looking at districts, some clear differences appear. In Gilgit and Nagar, the proportions of women involved in decisions increased sharply across most areas. Hunza also showed very high endline figures across all four areas. In Ghizer, progress was strong for ECD but more limited for family planning and child health. In Lower Chitral, the results were mixed: there were increases in SRH decision-making but declines in family planning and ECD compared to baseline. Upper Chitral showed smaller changes, with already high baseline levels in some areas.

By age, younger women (18–35) reported higher involvement in decisions than older women (36–53) at baseline. However, by endline both groups showed improvement, with older women also reporting substantial increases in decision-making across areas.

In summary, the data suggests a general improvement in women's participation in household decision-making on health and education matters, though the extent of change varies by district and area of decision-making. Some of the very large differences between baseline and endline—for example, in Gilgit, Nagar, and Hunza—should be treated cautiously, as they may reflect sample variation rather than only real shifts in behavior.

Table 15: Women's Decision-Making in Family Planning, Child Health, SRH, and Early Childhood Development (ECD)

The table shows the percentage of women who reported having made a decision, either alone or jointly with others, in the last two years on:
C1.1: Contraceptive use for family planning/birth spacing
C1.2: Visiting hospital/health center for child health (pre/post-natal care, immunization)
C1.3: Visiting health services for Sexual and Reproductive Health (SRH)
C1.4: Enrolling children under five in Early Childhood Development (ECD)

Group	Time	Family Planning (C1.1)	Child Health (C1.2)	SRH Services (C1.3)	ECD Services (C1.4)	n (FP)	n (Child)	n (SRH)	n (ECD)
Overall	Baseline	56.7%	66.0%	51.5%	46.1%	245	245	239	245
	Endline	80.0%	90.3%	80.8%	86.9%	160	150	153	151
Upper Chitral	Baseline	78.6%	87.2%	59.5%	66.7%	42	39	39	42
	Endline	81.9%	96.9%	85.9%	94.8%	19	17	18	15
Lower Chitral	Baseline	70.0%	81.0%	57.5%	47.5%	40	42	40	40
	Endline	53.4%	89.9%	79.5%	39.6%	15	10	10	14
Ghizer	Baseline	55.0%	62.5%	41.0%	48.7%	40	40	38	39
	Endline	44.1%	58.6%	49.8%	91.4%	30	28	30	29
Gilgit	Baseline	52.5%	60.0%	55.0%	37.5%	40	40	40	40
	Endline	96.2%	92.2%	84.3%	88.6%	37	37	37	37
Hunza	Baseline	45.2%	55.8%	62.5%	55.8%	42	43	40	43
	Endline	100%	100%	92.5%	100%	31	31	31	31
Nagar	Baseline	39.0%	50.0%	31.6%	19.5%	41	40	42	41
	Endline	85.0%	96.2%	84.7%	84.5%	28	27	27	25
Age 18–35	Baseline	61.4%	71.9%	57.1%	48.4%	153	153	147	153

	Endline	88.1%	92.9%	77.4%	84.0%	74	71	74	69
Age 36–53	Baseline	48.9%	56.0%	42.4%	42.4%	92	91	92	92
	Endline	74.5%	88.4%	83.4%	84.6%	86	79	79	82

Table 16 shows why some of the women were not able to make decisions about family planning, child health, SRH, and ECD. Across all four areas, the most common reasons were lack of awareness, limited access to services, and cultural or social norms. At endline, reported barriers like lack of awareness and service access were higher in number compared to baseline, which may reflect women being more open in acknowledging these constraints. Spousal support and decision-making power also remained significant barriers, especially for SRH and ECD. While stigma, religious beliefs, and fear of side effects were mentioned, they were less common. These findings suggest that women's limited involvement in family and health-related decisions is driven mainly by low awareness, restricted access to services, and male-dominated household decision-making, rather than by individual unwillingness or personal attitudes of women.

Table 16: Reported Factors for Not Making Decisions on Family Planning, Child Health, SRH, and ECD (Baseline 2023 vs Endline 2025)

If you answered "No" to any of the above, what factors contributed to your not being involved in decision-making regarding family planning, child health, sexual and reproductive health (SRH), or early childhood development (ECD) services?					
Factor / Barrier	**Time**	**Family Planning (C1.1)**	**Child Health (C1.2)**	**SRH Services (C1.3)**	**ECD Services (C1.4)**
Lack of awareness	Baseline	7	7	14	6
	Endline	19	8	30	19
Cultural and social norms	Baseline	4	–	8	4
	Endline	4	6	12	–
Lack of spousal support	Baseline	2	–	2	–
	Endline	2	3	9	2
No decision-making power	Baseline	4	–	1	2
	Endline	1	–	7	7
Fear of side effects	Baseline	4	–	2	2
	Endline	7	–	–	–
Limited access/availability	Baseline	2	3	4	6
	Endline	1	9	14	12
Religious beliefs	Baseline	1	–	3	1
	Endline	1	1	–	–
Fear of stigma/judgment	Baseline	2	–	1	1
	Endline	–	1	3	–
Other reasons	Baseline	16	3	–	4
	Endline	13	8	10	6
Not relevant	Baseline	65	64	29	67
	Endline	25	–	2	–
Refused to respond	Baseline	–	–	–	1
	Endline	–	–	–	1
N	Baseline	110	77	75	94
	Endline	73	36	87	47

Table 17 provides a deeper look into *how* women are involved in decision-making across four domains: family planning, child health, sexual and reproductive health (SRH), and early childhood development (ECD). At baseline, most women reported having *equal input* alongside others in decisions (58% overall), especially in areas like family planning and SRH. However, by endline, there was a clear shift:

fewer women described their role as “equal input,” and more identified as *primary* or even *sole decision-makers*. For example, sole decision-making rose from 2% to 15% overall, with notable increases in ECD and SRH decisions. At the same time, a larger share of women also reported having only *limited input* (12% → 24%), suggesting a polarization—some women gained stronger authority, while others remained marginalized.

When compared to Table 15, which simply measured whether women were *involved at all* in household decisions, the two datasets together show both breadth and depth. Table 15 highlighted the strong overall rise in women’s participation (e.g., family planning from 57% → 80%, ECD from 46% → 87%), while Table 17 reveals *how much voice* women had within those decisions—whether equal, limited, or leading.

The district-level disaggregation in the **annex 13** adds further nuance. In Gilgit and Hunza, women increasingly moved from equal influence to taking more primary or sole decision-making roles, reflecting strengthening agency. In contrast, in Nagar and parts of Upper Chitral, women’s decision-making power either declined or remained limited, with others continuing to dominate final decisions. These variations suggest that while overall progress has been made, local cultural and social contexts still shape the *quality* of women’s agency in household decision-making.

In short, women’s participation in decision-making has grown since baseline, but the depth of their influence varies—progress is uneven, with gains in some districts and persistent barriers in others.

Table 17: Women's depth of the involvement in decision making (Baseline 2023 Vs Endline 2025)

C1.5: What is your level of involvement in decision-making regarding the following matters?					
	Family Planning Use of contraceptives	**Child Health**	**SRH services**	**Enrolling children in ECD**	**Grand Total**
Baseline 2023:					
I have equal input and influence in the decision-making process	64%	19%	67%	63%	58%
I have limited input, but others make the final decision	8%	35%	10%	7%	12%
I am not involved / Others decide for me	10%	19%	9%	9%	10%
I am the primary decision-maker but consider others’ input	17%	28%	11%	19%	17%
I am the sole decision-maker	2%	0%	4%	3%	2%
N	157	81	163	149	550
Endline 2025:					
I have equal input and influence in the decision-making process	27%	23%	18%	21%	22%
I have limited input, but others make the final decision	29%	12%	24%	26%	24%
I am not involved / Others decide for me	5%	25%	8%	3%	8%
I am the primary decision-maker but consider others’ input	24%	17%	15%	17%	18%
I am the sole decision-maker	3%	21%	15%	23%	15%
N	138	80	130	134	482

Factors Limiting Women's Access to Contraceptives, SRH, and Child Health Services

Across the study areas, women's ability to space births, use contraceptives, and access SRH and child health services is influenced by a mix of knowledge gaps, service availability, economic hardship, and socio-cultural norms. Encouragingly, knowledge and service-related barriers have eased over time, suggesting that awareness-raising and improved service delivery are having an effect. However, economic conditions remain a persistent barrier, while socio-cultural norms, fear, and stigma have become increasingly visible constraints. Moreover, family and community support plays a decisive role, often limiting women's autonomy even when services and information are available. The evidence suggests that while progress has been made in reducing structural barriers, poverty and entrenched social norms now stand as the primary obstacles to women's reproductive and health choices.

Table 18 presents district-level data on factors limiting women's ability to use contraceptives and practice birth spacing, revealing important variations across contexts. In **Upper Chitral**, lack of knowledge and poverty are key barriers, while stigma plays a smaller role. **Lower Chitral** shows stronger influence of cultural norms and service availability, alongside economic challenges. In **Ghizer**, poverty and service availability dominate, with minimal reference to stigma. **Gilgit** reflects multi-dimensional barriers—knowledge, services, stigma, and poverty all reported at medium levels. In **Hunza**, nearly all barriers are reported at medium levels, with poverty and stigma particularly strong. **Nagar** stands out with high reporting of poverty and stigma as dominant barriers. Overall, while structural barriers vary, poverty and service availability emerge as common limiting factors across most districts.

Table 18: District wise distribution of factors limiting contraceptive use and birth spacing (Endline 2025)

C1.6: To what extent do the following factors limit women's ability to space birth or use of contraceptives in your area/community?				
Factor by District	**Medium Extent**	**Small Extent**	**To a high Extent**	**N**
1. Upper Chitral				
1) Lack of information or knowledge	44.44%	33.33%	22.22%	**18**
2) Lack of availability of products and services	42.11%	26.32%	31.58%	**19**
3) Religious, cultural, or social norms and taboos	20.00%	73.33%	6.67%	**15**
5) Fear or stigma associated	23.08%	76.92%	0.00%	**13**
6) Poor economic condition	45.45%	22.73%	31.82%	**22**
2. Lower Chitral				
1) Lack of information or knowledge	43.48%	30.43%	26.09%	**23**
2) Lack of availability of products and services	15.79%	42.11%	42.11%	**19**
3) Religious, cultural, or social norms and taboos	57.14%	14.29%	28.57%	**14**
5) Fear or stigma associated	84.62%	15.38%	0.00%	**13**
6) Poor economic condition	53.33%	6.67%	40.00%	**15**
3. Ghizer				
1) Lack of information or knowledge	21.05%	78.95%	0.00%	**19**
2) Lack of availability of products and services	45.00%	55.00%	0.00%	**20**
3) Religious, cultural, or social norms and taboos	26.32%	42.11%	31.58%	**19**
5) Fear or stigma associated	35.29%	58.82%	5.88%	**17**
6) Poor economic condition	65.22%	30.43%	4.35%	**23**
4. Gilgit				
1) Lack of information or knowledge	51.35%	27.03%	21.62%	**37**

C1.6: To what extent do the following factors limit women's ability to space birth or use of contraceptives in your area/community?				
2) Lack of availability of products and services	63.89%	30.56%	5.56%	**36**
3) Religious, cultural, or social norms and taboos	50.00%	33.33%	16.67%	**30**
5) Fear or stigma associated	65.52%	27.59%	6.90%	**29**
6) Poor economic condition	51.52%	33.33%	15.15%	**33**
5. Hunza				
1) Lack of information or knowledge	70.97%	29.03%	0.00%	**31**
2) Lack of availability of products and services	54.84%	41.94%	3.23%	**31**
3) Religious, cultural, or social norms and taboos	64.52%	32.26%	3.23%	**31**
5) Fear or stigma associated	74.19%	16.13%	9.68%	**31**
6) Poor economic condition	80.65%	16.13%	3.23%	**31**
6. Nagar				
1) Lack of information or knowledge	57.89%	21.05%	21.05%	**19**
2) Lack of availability of products and services	60.00%	20.00%	20.00%	**10**
3) Religious, cultural, or social norms and taboos	57.14%	14.29%	28.57%	**7**
5) Fear or stigma associated	77.78%	11.11%	11.11%	**9**
6) Poor economic condition	85.71%	0.00%	14.29%	**7**

Table 19 compares baseline (2023) and endline (2025) results on factors limiting women's ability to space births or use contraceptives. The findings highlight shifts over time: knowledge gaps and service availability barriers declined slightly at the high-extent level, suggesting improved awareness and access. However, religious and cultural norms became more pronounced (high-barrier reporting rose from 9% to 17%), pointing to stronger visibility of social restrictions. Fear and stigma reduced significantly (13% to 6% at high level), while poverty remained persistent and even worsened as a medium-level barrier (47% to 61%). This suggests that progress in reducing informational barriers is being offset by persistent economic and cultural constraints.

Table 19: Factors limiting women's ability to space births or use contraceptives (Baseline 2023 vs. Endline 2025)

C1.6: To what extent do the following factors limit women's ability to space birth or use of contraceptives in your area/community?					
Factors		**Medium Extent**	**Small Extent**	**To a High Extent**	**n**
1. Lack of information or knowledge	Baseline	45%	37%	18%	206
	Endline	52%	35%	13%	147
2. Religious, cultural, or social norms and taboos	Baseline	47%	45%	9%	164
	Endline	50%	34%	17%	116
3. Lack of availability of products and services	Baseline	41%	36%	23%	210
	Endline	43%	38%	19%	135
4. Fear or stigma	Baseline	49%	38%	13%	188
	Endline	63%	30%	6%	112
5. Poor economic condition	Baseline	47%	31%	22%	210
	Endline	61%	20%	19%	131

Table 20 compares baseline (2023) and endline (2025) results on factors limiting women's ability to access Sexual and Reproductive Health (SRH) services. The findings show that knowledge and awareness barriers declined, with fewer women reporting them as severe, and information about

service availability also improved. However, socio-cultural and religious norms became more restrictive (high-barrier reporting rose from 7.7% to 16%), and fear and stigma worsened significantly (rising from 9% to 31% at the high-barrier level). Financial constraints and inadequate healthcare access improved slightly but remain moderate challenges. In addition, new factors assessed at endline—lack of family and community support, limited transport, and weak decision-making power—further underscore the relational and mobility barriers women face.

Table 20: Factors limiting women's access to SRH services (Baseline 2023 vs. Endline 2025)

C1.7: To what extent do the following factors limit women's ability to adopt practices or access health services for healthcare, including Sexual and Reproductive Health (SRH) services, in your local area/community?					
Factors		**Medium Extent**	**Small Extent**	**To a High Extent**	**n**
Lack of knowledge or information about the benefits and importance of SRH	Baseline	49.11%	33.04%	17.86%	224
	Endline	58.60%	34.38%	7.02%	136
Lack of information about availability of SRH Services SRH	Baseline	44.69%	37.17%	18.14%	226
	Endline	68.37%	19.61%	12.02%	138
Socio-cultural or religious norms	Baseline	49.45%	42.86%	7.69%	182
	Endline	48.77%	35.22%	16.01%	127
Lack of support from community	Endline	52.55%	34.24%	13.20%	123
Limited financial resources	Baseline	42.61%	34.35%	23.04%	230
	Endline	54.81%	27.59%	17.60%	146
Lack of support from family or spouse	Endline	59.99%	30.67%	9.34%	129
Inadequate access to healthcare facilities	Baseline	43.56%	36.44%	20.00%	225
	Endline	54.08%	29.74%	16.18%	147
Stigma and judgment	Baseline	41.21%	49.75%	9.05%	199
	Endline	40.78%	28.06%	31.16%	114
Limited decision-making power	Baseline	54.93%	35.68%	9.39%	213
	Endline	52.15%	36.62%	11.23%	151
Lack of transportation	Endline	41.13%	40.69%	18.18%	152
Limited/Unavailability of SRH specific services in the health services	Baseline	51.09%	28.82%	20.09%	229
	Endline	55.05%	27.78%	17.17%	134

Table 21 compares baseline (2023) and endline (2025) results on factors limiting women's ability to make decisions to use or access child health services. The findings show that knowledge barriers declined, with fewer women reporting them as severe (from 10.6% to 8.1%). Access-related constraints, including limited facilities, remoteness, and transportation, also improved, with transportation barriers in particular dropping sharply (from 41.5% to 17.6% at the high-barrier level). However, cultural and religious restrictions worsened significantly, with high-barrier responses doubling (from 10.9% to 22.1%). Family and community support remains critical, with moderate-level barriers increasing at endline. Overall, while physical access to child health services has improved, socio-cultural restrictions and limited decision-making power within households continue to constrain women's autonomy.

Table 21: Factors limiting women's ability to access child health services (Baseline 2023 vs. Endline 2025)

C1.8: To what extent do the following factors limit women's ability to make decisions to use or access child health services?					
Factors		**Medium Extent**	**Small Extent**	**To a high Extent**	**n**
Lack of information or knowledge	Baseline	43.78%	43.78%	10.65%	169
	Endline	59.59%	32.31%	8.10%	160
Limited access to healthcare services (Physical)	Baseline	44.01%	32.05%	22.64%	234
	Endline	49.51%	34.55%	15.93%	154
Cultural or social norms	Baseline	42.39%	47.82%	8.15%	184
	Endline	49.20%	32.45%	18.35%	138
Lack of support from family members or partner	Baseline	41.96%	36.26%	19.6%	193
	Endline	52.74%	30.35%	16.92%	136
Limited availability of services in the area	Baseline	44.97%	32.80%	20.63%	189
	Endline	52.32%	28.27%	19.41%	154
Lack of support from community	Baseline	43.40%	45.60%	8.24%	182
	Endline	49.29%	42.19%	8.51%	137
Lack of physical access/remoteness/mobility issues	Baseline	45.25%	33.18%	20.2%	232
	Endline	47.85%	31.79%	20.35%	142
Cultural or religious beliefs or restrictions	Baseline	41.60%	45.98%	10.94%	137
	Endline	36.98%	40.89%	22.13%	119
Lack of transportation or geographical barriers to access child health services	Baseline	31.35%	25.84%	41.52%	236
	Endline	54.53%	27.92%	17.55%	147
Others	Endline	45.65%	47.92%	6.43%	76

4.3. Prevalence of GBV and Its Handling

***C2 (1200.3):** % of community members satisfied with handling and management of GBV cases (by gender, district)*

Awareness of GBV as a community problem increased markedly across all districts and genders, with greater recognition of diverse forms of GBV, particularly online/digital abuse. Respondents increasingly acknowledged that GBV affects both women and men, reflecting a shift in perceptions. However, satisfaction with handling mechanisms has declined, indicating that while awareness has grown, institutional and community responses remain insufficient or inconsistent.

Perception of Prevalence of GBV

At baseline, just over half of respondents considered GBV a community problem (54%). By endline, this perception rose sharply to over 90% across almost all districts and both genders, reflecting greater awareness and recognition of GBV as a social issue. The only outlier is Lower Chitral, where perceptions remained relatively lower (69%).

Table 22: Perception of prevalence of GBV (Baseline vs Endline)

C2.1: Do you think that Gender-Based Violence is a problem in your community?								
Group	**Baseline (2023)**				**Endline (2025)**			
	Yes	**No**	**DK**	**N**	**Yes**	**No**	**DK**	**N**
Overall	54%	44%	2%	481	90.7%	8.7%	0.7%	360
Upper Chitral	51%	46%	4%	81	98.4%	0%	1.6%	60
Lower Chitral	56%	44%	0%	81	68.6%	30.5%	0.9%	60
Ghizer	84%	16%	0%	80	100%	0%	0%	60
Gilgit	18%	80%	3%	80	100%	0%	0%	60
Hunza	58%	38%	5%	80	98.3%	0%	1.7%	60
Nagar	59%	38%	3%	79	98.1%	1.9%	0%	60
Women	61%	37%	2%	246	92.9%	6.8%	0.3%	188
Men	47%	50%	3%	234	88.0%	10.9%	1.1%	172

The data presented in Table 23 highlight evolving perceptions of the forms of GBV prevalent in communities. At baseline, the most frequently cited forms were emotional/psychological abuse (27%) and physical abuse (25%), while harmful traditional practices and sexual abuse were less emphasized. By endline, emotional/psychological abuse remained the most cited form, but its relative share declined slightly (25%), sexual abuse increased by 2.5% and online/digital abuse increased by 6.5%, reflecting growing sexual and digital violence due to increased exposure and access to social media.

Physical abuse saw a relative decline (25% → 19%), which may suggest either an improvement in awareness of other forms of GBV or shifting perceptions on what is considered reportable. The broad takeaway is that perceptions of GBV are diversifying, with communities recognizing both traditional and newer forms of violence, though emotional and psychological abuse remains the most visible.

Table 23: Prevalent Forms of GBV (multi-select, Baseline vs Endline)

C2.2: Which of the following forms of GBV are commonly prevalent in your area?					
Form of GBV	**Baseline Yes (n=579)***	**% (Baseline)**	**Endline Yes (n=1,117)***	**% (Endline)**	**Δ pp**
Harmful Traditional Practices	54	9.3%	108	9.7%	+0.4
Online / Digital Abuse	68	11.8%	204	18.3%	+6.5
Economic Abuse	100	17.3%	176	15.8%	–1.5
Sexual Abuse	60	10.4%	144	12.9%	+2.5
Physical Abuse	142	24.5%	211	18.9%	–5.6
Emotional/Psychological Abuse	155	26.8%	274	24.5%	–2.3
*Denominator = total “Yes” responses (multi-select).					

Perceptions of Gendered Experience of GBV

At baseline, the overwhelming perception was that GBV primarily affects women (76%), with only 23% suggesting it affects both genders equally. By endline, there was a clear shift, with 37% reporting that both genders are affected (Table 24). This shift was particularly visible in Gilgit, Hunza, and Ghizer, where recognition of male experiences of GBV rose. However, females continue to be seen as disproportionately affected (57%), especially in Upper and Lower Chitral. The increase in acknowledgment of GBV affecting both genders suggests broader awareness campaigns and discourse may have helped communities recognize that GBV is not exclusively a women’s issue, but one that undermines the wellbeing of all genders. This evolving perception may also signal a reduction in stigma associated with reporting GBV among men.

Table 24:Perceptions of those who experience GBV more (Baseline vs Endline)

C2.3: Who experiences GBV more in your community?								
	Baseline (2023)				**Endline (2025)**			
Group	**Men**	**Women**	**Both**	**N**	**Men**	**Women**	**Both**	**n**
Overall	1.3%	75.8%	22.9%	240	5.2%	57.4%	37.4%	326
Upper Chitral	0%	87.5%	12.5%	40	0%	71.9%	28.1%	57
Lower Chitral	0%	41.9%	58.1%	43	2.8%	77.8%	19.4%	36
Ghizer	1.8%	80.0%	18.2%	55	0%	62.1%	37.9%	58
Gilgit	0%	92.9%	7.1%	14	5%	43.3%	51.7%	60
Hunza	2.3%	74.4%	23.3%	43	13.3%	40.0%	46.7%	60
Nagar	2.2%	88.9%	8.9%	45	9.1%	58.2%	32.7%	55
Women	1.5%	74.5%	24.1%	137	4%	54%	42%	174
Men	1.0%	77.7%	21.4%	103	6.6%	61.2%	32.2%	152

Availability of GBV Handling Mechanisms

Over time, more people in the community now know how cases of gender-based violence (GBV) are dealt with, and fewer say they are "unsure." Communities are starting to see more awareness campaigns, education programmes, and efforts to hold perpetrators accountable. This shows progress compared to the past, when most people felt nothing was being done.

But there are still big gaps. Many people — especially in Lower Chitral and women overall — feel that GBV cases are not handled properly and that survivors don't always get the medical, legal, or counselling support they need. In other words, while awareness has improved, the actual services to support survivors remain weak and inconsistent and overall satisfaction with how GBV cases are managed has declined over time.

According to a representative of LAPH, Lower Chitral has established a comprehensive GBV response structure, including reporting desks, legal aid services, shelter facilities, and psychosocial support. However, the endline data indicates that the presence of these mechanisms has not translated into sustained confidence among community members. Recognition of comprehensive support services in Lower Chitral declined from 41% at baseline to 20% at endline, and the share of respondents who felt that GBV cases are not adequately addressed increased sharply from 9% to 32%. Similarly, overall satisfaction with how GBV cases are managed decreased noticeably, with the proportion of respondents who were satisfied falling from 89% at baseline to 47% at endline, and dissatisfaction rising correspondingly. At the same time, the level of "unsure" responses remained relatively high (16%) at endline, suggesting that many individuals are still unclear about how to navigate available services in practice. This points to a gap not in the existence of mechanisms, but in consistent accessibility, survivor-centered response, and follow-through on case management.

The detailed results — overall, district-wise, and gender-wise — are presented in the tables below:

As presented in Table 25, at the overall sample level, the most striking change is the sharp drop in "unsure" responses (18% → 4%) in endline, reflecting greater community awareness of available mechanisms. Endline data also show the emergence of community awareness and prevention initiatives (32%), which were not identified at baseline. This results in a shift from purely reactive to more preventive approaches. However, perceptions that GBV cases are not adequately addressed increased (26% → 32%), suggesting that while awareness has improved, confidence in service adequacy remains limited. Support services (36% → 20%) declined in recognition, while reporting mechanisms (13% → 21%) gained traction, showing a trade-off between expectations of service delivery and recognition of system-level responses.

Table 25: Current Handling Mechanism for GBV (Baseline 2023 vs Endline 2025)

C2.4: How are GBV cases typically handled and redressed in your community? Select all that apply		
Handling Mechanism	**Baseline % (n=330)**	**Endline % (n=468)**
1. Comprehensive support services (medical care, counselling, legal assistance)	36%	20%
2. Adequate reporting mechanisms & helplines; LEA respond promptly	13%	21%
3. Community awareness & engagement; education for prevention & empowerment	–	32%
4. Accountability mechanisms; perpetrators held accountable, legal justice ensured	7%	10%
5. GBV cases not adequately addressed / lack of support services & awareness	26%	32%
99. Unsure / Don't know / No response	18%	4%

Presented in Table 26, District-level comparisons reveal uneven progress:

- Gilgit showed the most dramatic improvement, with "unsure" dropping from 60% at baseline to 0% at endline, and large gains in reporting (2% → 34%) and accountability (3% → 20%).
- Nagar recorded the strongest recognition of *community awareness and prevention* (55% at endline, from 0% at baseline).

Table 26: Current Handling Mechanisms for GBV by District (Baseline 2023 vs Endline 2025)

C2.4: How are GBV cases typically handled and redressed in your community? Select all that apply							
District	**Timepoint**	**Support Services**	**Reporting & Response**	**Awareness & Education**	**Accountability**	**Not Adequately Addressed**	**Unsure/Don't Know**
Overall	Baseline	36%	13%	–	7%	26%	18%
	Endline	20%	21%	32%	10%	32%	4%
By District							
Upper Chitral	Baseline	30%	30%	–	3%	33%	4%
	Endline	19%	16%	22%	11%	16%	16%
Lower Chitral	Baseline	41%	28%	–	13%	9%	9%
	Endline	20%	16%	14%	11%	32%	16%
Ghizer	Baseline	26%	13%	–	7%	44%	9%
	Endline	20%	30%	26%	4%	1%	1%
Gilgit	Baseline	25%	2%	–	3%	10%	60%
	Endline	6%	34%	27%	20%	12%	0%
Hunza	Baseline	58%	0%	–	9%	21%	12%
	Endline	22%	22%	29%	26%	2%	0%
Nagar	Baseline	49%	2%	–	7%	37%	5%
	Endline	1%	13%	55%	22%	10%	1%

- Hunza also showed major improvements in accountability (9% → 26%) and awareness (29%), reflecting active community engagement.
- Ghizer improved in reporting mechanisms (13% → 30%), but perceptions of inadequate handling plummeted (44% → 1%), showing confidence in formal redress.

- Upper Chitral showed moderate gains in awareness and accountability but retained a high share of "unsure" (16%), indicating uneven knowledge of mechanisms.
- Lower Chitral stands out negatively: those reporting "not adequately addressed" rose from 9% to 32%, suggesting declining confidence despite being a programme focus.

Overall, the shift from uncertainty to awareness is evident across districts, but Lower Chitral diverges, with more respondents perceiving GBV cases as inadequately addressed.

Gendered analysis highlights contrasting perceptions (Table 27):

- Women showed a steep decline in recognizing support services (36% → 12%), but a clear increase in accountability (7% → 20%) and prevention/awareness (26%). This suggests women are more likely to recognize systemic and preventive responses rather than direct services.
- Men reported higher recognition of support services (28%) compared to women (12%) at endline, though both genders saw declines relative to baseline.
- The share of "unsure" responses fell for both genders (women 16% → 7%; men 20% → 3%), showing clearer awareness at endline.

Although the survey did not explicitly ask for reasons behind these shifts, several plausible explanations include that awareness of GBV response structures became more defined and realistic. The most notable gender difference is that women perceive less access to services but greater awareness of accountability and prevention, while men continue to perceive support availability more strongly, possibly due to their greater interaction with public institutions..

Table 27: Current Handling Mechanisms for GBV by Gender (Baseline 2023 vs Endline 2025)

C2.4: How are GBV cases typically handled and redressed in your community? Select all that apply							
Gender	**Timepoint**	**Support Services**	**Reporting & Response**	**Awareness & Education**	**Accountability**	**Not Adequately Addressed**	**Unsure/Don't Know**
Women	Baseline	36%	13%	–	7%	26%	16%
	Endline	12%	22%	26%	20%	14%	7%
Men	Baseline	36%	13%	–	7%	26%	20%
	Endline	28%	22%	23%	13%	12%	3%
All	Baseline	36%	13%	–	7%	26%	18%
	Endline	20%	21%	32%	10%	32%	4%

Satisfaction with Handling of GBV Cases (Baseline vs Endline)

As seen in the previous section (Table 28), awareness of GBV handling mechanisms has improved, and more communities now recognize the existence of reporting, prevention, and accountability measures. However, when it comes to actual satisfaction with how GBV cases are managed, the picture is much less positive.

At the start of the project, most people said they were satisfied with how cases of gender-based violence (GBV) were being handled in their communities. About two-thirds felt satisfied with the system. By the end of the project, however, this picture had changed dramatically. Only about one in three people still felt satisfied, while most reported being dissatisfied.

The drop in satisfaction is seen across almost all districts. For example, in Hunza, only 4% of people were "completely dissatisfied" at the beginning, but by the end this had risen to more than 40%. Gilgit also shifted strongly towards dissatisfaction, while Lower Chitral and Nagar, which started with very high satisfaction levels, saw sharp declines too.

Women in particular expressed growing concern. At baseline, nearly two-thirds of women felt satisfied, but by endline this dropped to just a quarter. Men also reported lower satisfaction than before, though slightly more men than women said they remained satisfied with the handling of GBV cases.

Overall, these results show that while communities may now be more aware of reporting mechanisms and prevention efforts, people are much less confident that cases are being managed effectively and fairly. Survivors still face major gaps in medical, counselling, and legal support, and communities do not yet see consistent justice for those affected.

Table 28: Satisfaction with handling and management of GBV cases (Baseline vs Endline, Overall, by District, and by Gender)

C2.5: To what extent are you satisfied with the handling and management of GBV cases in your community?							
Category	**Timepoint**	**Completely Dissatisfied**	**Partially Dissatisfied**	**Satisfied**	**Completely Satisfied**	**Don't Know**	**n**
Overall	Baseline	8%	19%	65%	-	18%	481
	Endline	21%	42%	26%	7%	4%	360
By District							
Upper Chitral	Baseline	11%	12%	68%	-	9%	81
	Endline	8%	55%	22%	7%	8%	60
Lower Chitral	Baseline	2%	6%	89%	-	2%	81
	Endline	10%	17%	47%	8%	18%	60
Ghizer	Baseline	15%	18%	48%	-	20%	80
	Endline	22%	35%	35%	8%	0%	60
Gilgit	Baseline	8%	5%	36%	-	51%	80
	Endline	28%	53%	13%	5%	0%	60
Hunza	Baseline	4%	9%	69%	-	19%	80
	Endline	43%	43%	10%	3%	0%	60
Nagar	Baseline	9%	3%	80%	-	9%	79
	Endline	15%	48%	28%	8%	0%	60
By Gender							
Women	Baseline	8%	9%	62%	-	21%	246
	Endline	20%	49%	24%	3%	4%	188
Men	Baseline	8%	8%	69%	-	15%	234
	Endline	23%	34%	28%	11%	5%	172

4.4. Knowledge, skills and attitude among male and female community members on gender equality and women empowerment

D.1 (1230.1): *% of individuals surveyed hold gender equitable attitudes towards ending GBV*

Knowledge/awareness of women empowerment and rights related policies, laws, and regulations

Overall, awareness of government laws and policies promoting gender equality improved noticeably from baseline to endline. The share of people who said they were "not aware at all" fell sharply (from 41% to 15%), while more people reported being "quite aware" or "fully aware." District patterns vary: Hunza, Nagar, and Gilgit saw the biggest improvements, with many moving into the

"quite aware" category. By contrast, Upper Chitral is an outlier, where the proportion of people saying they were "not aware at all" increased. Women and men both showed progress, but men reported larger gains in being "quite aware," while women's improvements were more evenly spread across moderate and high awareness. The key message is that awareness of gender equality laws has improved overall, but progress is uneven, with Upper Chitral lagging.

Table 29: Awareness of government laws, regulations, or policies promoting gender equality and protecting women's rights (Overall, by District, and by Gender), Baseline (2023) vs Endline (2025)

D1.1. To what extent are you aware of the government's laws, regulations or policies that promote gender equality and protect women's rights?							
Category	**Timepoint**	**Not aware at all**	**Slightly aware**	**Moderately aware**	**Quite aware**	**Fully aware**	**N**
Overall	Baseline	41%	28%	13%	9%	9%	479
	Endline	15%	30%	18%	24%	12%	360
Upper Chitral	Baseline	17.3%	32.1%	27.2%	19.8%	3.7%	79
	Endline	33.6%	39.0%	9.9%	5.1%	12.4%	60
Lower Chitral	Baseline	4.9%	58.0%	12.3%	17.3%	7.4%	81
	Endline	15.0%	39.4%	17.6%	18.6%	9.3%	60
Ghizer	Baseline	43.8%	18.8%	7.5%	7.5%	22.5%	79
	Endline	12.9%	72.4%	10.9%	0.9%	2.9%	60
Gilgit	Baseline	36.7%	43.0%	12.7%	6.3%	1.3%	81
	Endline	3.7%	12.9%	29.5%	49.1%	4.7%	60
Nagar	Baseline	78.5%	11.4%	5.1%	0.0%	5.1%	80
	Endline	15.7%	19.2%	16.4%	30.1%	18.6%	60
Hunza	Baseline	67.1%	7.6%	11.4%	2.5%	11.4%	79
	Endline	15.6%	7.5%	21.0%	36.8%	19.1%	60
Women	Baseline	45.7%	26.1%	11.4%	10.6%	6.1%	245
	Endline	17.7%	34.6%	18.5%	14.7%	14.6%	188
Men	Baseline	36.3%	31.2%	14.1%	7.3%	11.1%	234
	Endline	13.0%	26.9%	17.0%	31.9%	8.8%	172

As shown in Table 30, there has been a major jump in awareness of the term GBV: only about 39% knew it at baseline, but by endline, over 90% across most districts and both genders reported awareness. Similarly, knowledge of where to seek legal help improved modestly (from 75% to 78% overall), with Ghizer, Gilgit, and Hunza showing the strongest progress.

However, when asked whether better access to legal services can reduce GBV, results were mixed. A majority agreed overall (57%), but support varied sharply by district—from very high in Ghizer (80%), Upper and Lower Chitral (77% each), to very low in Gilgit (22%). Women (53%) were slightly less confident than men (62%) in the role of legal services in reducing GBV.

This suggests that while awareness is now widespread, building trust in the effectiveness of legal systems remains a key challenge, especially in places like Gilgit.

Table 30: Knowledge and Awareness of GBV and Legal Help – Baseline 2023 vs Endline 2025 (Overall, District, Gender)

D1.2. Are you aware of the term Gender Based Violence (GBV)? D1.3. Do you know where to seek legal help in the case of GBV? D1.4. Do you believe easy access to legal services and courts for women can help reduce GBV cases?					
Category	Timepoint	Aware of GBV Term (Yes)	Know where to seek legal help (Yes)	Believe access to legal services reduces GBV (Yes)	**N**
Overall	Baseline	38.5%	74.6%	63%	481
	Endline	94.0%	78.0%	57%	360
Upper Chitral	Baseline	61.3%	69.1%	67%	81
	Endline	83.3%	70.0%	77%	60
Lower Chitral	Baseline	30.4%	76.5%	79%	81
	Endline	97.3%	68.0%	77%	60
Ghizer	Baseline	42.5%	72.5%	58%	80
	Endline	93.9%	85.0%	80%	60
Gilgit	Baseline	28.4%	73.8%	73%	80
	Endline	92.2%	85.0%	22%	60
Hunza	Baseline	46.3%	78.8%	50%	80
	Endline	96.2%	87.0%	47%	60
Nagar	Baseline	22.2%	77.2%	54%	79
	Endline	93.5%	75.0%	42%	60
Women	Baseline	35.0%	66.7%	65%	246
	Endline	94.2%	78.0%	53%	188
Men	Baseline	42.1%	83.0%	62%	235
	Endline	87.2%	79.0%	62%	172

Attitudes Towards Gender-Based Violence (GBV)

Understanding community attitudes is critical, since beliefs and social norms strongly influence how gender-based violence (GBV) is tolerated, prevented, or addressed. The survey asked a series of direct questions on freedom of movement for women, acceptability of domestic violence, accountability of perpetrators, and the role of education in preventing GBV. Below, results are presented from baseline and endline surveys at overall, district, and gender levels.

Data presented in Table 31 show that, over time, fewer people agree with the idea that women should be blamed if they face verbal abuse while going to the market alone. At baseline, about one-third of respondents overall agreed with this restrictive view, but by endline this had dropped to less than one-fifth. At the same time, disagreement with blaming women increased (from 58% to 68%), suggesting a gradual shift toward recognizing women's right to move freely without being held responsible for harassment.

District-level results, however, show mixed patterns. In places like Lower Chitral and Nagar, agreement with victim-blaming fell sharply, while in Upper Chitral and Ghizer it increased somewhat. Hunza, which had the highest baseline acceptance of blaming women (61%), showed a dramatic drop to 17% by endline, marking clear progress.

Gender differences are also visible. Women were more likely than men at both time points to reject the idea of blaming women, though both groups moved toward greater disagreement over time.

This means more people now believe that women should not be blamed for harassment in public spaces, although this attitude change is uneven across districts. While some communities show strong progress, others still hold onto victim-blaming views.

Table 31:Attitudes Towards Freedom of Movement of Women

D1.5: To what extent do you agree with the following statements? If a woman goes to a market alone and encounters verbal abuse from a stranger, she should be blamed for the abuse incident, as she should not go out alone and provide an opportunity for men to abuse her.					
Group	Time	Agree	Neutral	Disagree	N
Overall	Baseline	32%	10%	58%	475
	Endline	18%	15%	68%	360
Upper Chitral	Baseline	22%	26%	53%	78
	Endline	30%	8%	62%	60
Lower Chitral	Baseline	43%	25%	32%	81
	Endline	20%	22%	58%	60
Ghizer	Baseline	16%	3%	81%	80
	Endline	25%	30%	45%	60
Gilgit	Baseline	6%	6%	87%	79
	Endline	11%	11%	79%	60
Hunza	Baseline	61%	1%	38%	79
	Endline	17%	7%	77%	60
Nagar	Baseline	41%	3%	56%	78
	Endline	3%	12%	85%	60
Women	Baseline	33%	9%	58%	245
	Endline	20%	19%	61%	188
Men	Baseline	30%	12%	58%	230
	Endline	15%	11%		

The data presented in Table 32 show that community attitudes toward gender-based violence (GBV) have generally shifted in a positive direction over time. Agreement that violence in relationships is "never acceptable" increased from around two-thirds at baseline to over four-fifths at endline, with notable gains in districts such as Lower Chitral and Ghizer, where acceptance of domestic violence was previously higher. Support for holding perpetrators accountable through the justice system remained consistently high across both timepoints, with slight strengthening in some areas. Belief in education as a tool to prevent GBV was already very strong at baseline and remained high, though it dipped slightly in some districts like Hunza and Nagar, where baseline agreement was near universal.

This means more people now say violence is never acceptable, and nearly everyone continues to agree that perpetrators should face justice. These results point to encouraging progress in reshaping social norms, though they may also reflect social desirability bias—where people want to provide the "right answer" when asked directly about sensitive issues like GBV.

Table 32: Attitudes Towards Domestic Violence, Accountability of Perpetrators, and the Role of Education in Preventing GBV (Baseline 2023 vs. Endline 2025)

D1.5: To what extent do you agree with the following statements?

- **It is never acceptable for someone to use violence against their partner or spouse, regardless of the circumstances.(Agree, Disagree, Neutral)**

D1.6: How likely are you to believe or support the following statements related to gender-based violence? Please indicate your level of agreement.

- **Perpetrators of GBV should be held accountable through legal and justice system. (Very likely to believe or support, Likely to believe or support, Neutral, Unlikely to believe or support, very unlikely to believe or support, refused to respond)**
- **Educating individuals about consent and healthy relationships can help prevent GBV. (Very likely to believe or support, Likely to believe or support, Neutral, Unlikely to believe or support, very unlikely to believe or support, refused to respond)**

Group	Time	Gender-Equitable Attitudes	Violence Never Acceptable (Agree)	Perpetrators Accountable*	Education Prevents GBV*	n
Overall	Baseline	72.7%	67.6%	91%	92.5%	477
	Endline	78%	81%	92%	89%	360
Upper Chitral	Baseline	71.6%	80%	90%	97%	80
	Endline	85%	95%	93%	100%	60
Lower Chitral	Baseline	57.9%	38.8%	83%	70%	81
	Endline	68%	81.7%	98%	92%	60
Ghizer	Baseline	71.5%	46.8%	90%	95%	79
	Endline	87%	75%	92%	97%	60
Gilgit	Baseline	65.5%	62.5%	88%	96%	79
	Endline	75%	66.7%	87%	82%	60
Hunza	Baseline	77.4%	93.8%	99%	99%	80
	Endline	70%	86.7%	90%	87%	60
Nagar	Baseline	79.7%	83.5%	94%	97%	78
	Endline	85%	80%	88%	77%	60
Women	Baseline	72.8%	73.1%	89%	91%	244
	Endline	78%	79.1%	90%	89%	188
Men	Baseline	72.7%	61.9%	93%	93%	233
	Endline	79%	82.7%	93%	89%	172

Note: "Perpetrators Accountable" and "Education prevents GBV" combines respondents who answered, "Very likely to believe or support" and "Likely to believe or support."

Table 33 shows how community attitudes have shifted between baseline and endline regarding how women facing repeated gender-based violence (GBV) from their husbands should be supported.

Overall, there has been a clear move toward more formal and proactive responses. At baseline, only about one in three respondents (35%) supported encouraging women to report to authorities, but by endline this rose to nearly half (46%). At the same time, the proportion of people saying GBV is a "family matter" dropped sharply (from 23% to 11%), reflecting reduced acceptance of silence and inaction.

By district, the most notable improvements are seen in Ghizer and Lower Chitral, where support for reporting to authorities increased dramatically (Ghizer: 39% → 75%; Lower Chitral: 15% → 51%). In Upper Chitral, there was also a sharp rise (19% → 51%), and more respondents favored community intervention (26% → 34%). By contrast, Nagar shows a concerning reversal, with fewer people

endorsing formal or community action and more saying GBV is a family matter (14% → 30%). In Gilgit, attitudes became slightly more mixed, with a decline in support for reporting to authorities (48% → 39%) and a small rise in "family matter" responses. Hunza remained relatively stable, with half of respondents continuing to support legal reporting.

By gender, women showed the strongest shift toward formal reporting (26% → 53%) and community intervention (24% → 40%), while rejecting the idea that GBV is just a private matter. Men also moved toward supporting reporting (30% → 48%), but more men than women still considered GBV to be a family issue (3% vs. 0% at endline).

Overall, the results suggest growing recognition across most districts that GBV requires collective and institutional responses rather than being left to families alone. However, uneven progress across districts, especially in Nagar and Gilgit, highlights the need for continued community awareness and stronger institutional support.

Table 33: Preferred Community Responses When a Woman Faces Repeated Gender-Based Violence from Her Husband (Baseline 2023 vs Endline 2025)

D1.7. If a woman in your community experiences repeated gender-based violence from her husband, what do you believe should be the response and support provided to her?							
Group	**Time**	Support her in reporting incidents to authorities for legal protection	Community should intervene immediately for her safety and facilitation	Respect and support her choice, and only support if he asks for it.	It is a family matter and lets them solve and others should not intervene.	Connect her with local CSOs for GBV assistance	**n**
Overall	Baseline	35%	27%	11%	23%	4%	479
	Endline	46%	23%	15%	11%	5%	353
Upper Chitral	Baseline	19%	26%	15%	27%	14%	81
	Endline	51%	34%	7%	2%	7%	59
Lower Chitral	Baseline	15%	20%	16%	48%	1%	81
	Endline	51%	16%	22%	7%	4%	55
Ghizer	Baseline	39%	30%	9%	15%	6%	79
	Endline	75%	17%	7%	2%	0%	60
Gilgit	Baseline	48%	13%	21%	18%	1%	80
	Endline	39%	14%	22%	15%	10%	59
Hunza	Baseline	50%	31%	3%	14%	3%	80
	Endline	50%	30%	5%	8%	7%	60
Nagar	Baseline	40%	46%	0%	14%	0%	78
	Endline	13%	25%	27%	30%	5%	60
Women	Baseline	26%	24%	14%	21%	14%	245
	Endline	53%	40%	0%	0%	7%	188
Men	Baseline	30%	28%	15%	33%	13%	230
	Endline	48%	28%	14%	3%	7%	172

The results in Table 34 show mixed trends in people's desire to intervene or report gender-based violence when they witness it. At the overall level, there is some decline in proactive responses: in baseline, nearly three-quarters (74%) said they were either *likely* or *very likely* to intervene, but this fell to just over half (56%) at endline. Neutral responses increased significantly (from 12% to 27%), suggesting more uncertainty about taking action.

Looking at districts, Upper Chitral remained relatively strong, with nearly 70% still willing to intervene at endline, although slightly less than baseline. Lower Chitral saw a sharp drop: at baseline, two-thirds (68%) said they would intervene, but at endline this fell to half (50%), with many shifting to a neutral position. In Ghizer, willingness to intervene decreased markedly, with fewer respondents choosing “very likely” and more moving to neutral or unlikely. Gilgit also showed a clear decline: while 70% had said they were “likely” at baseline, only 38% said so at endline, and neutrality rose from 23% to 20%. Hunza showed a more balanced picture — while fewer people said “likely,” more said “very likely” at endline, keeping overall willingness steady. In Nagar, responses shifted toward “likely,” with 63% at endline compared to 57% at baseline, though fewer were “very likely.”

By gender, both women and men showed less certainty at endline. Among women, “likely” responses dropped (60% to 47%) while neutrality rose (21% to 22%). Among men, the decline was sharper: at baseline, over 70% said they were “likely” to intervene, but this fell to 35% at endline, though more moved into the “very likely” (23%) and “neutral” (31%) categories.

Overall, the findings suggest that while communities remain concerned about GBV, there is growing hesitation about taking direct action, with more respondents positioning themselves as neutral. This may reflect social desirability bias at baseline, when people gave more positive answers to appear supportive, while endline results show more cautious and realistic responses.

These patterns echo the findings from earlier sections, where support for women’s autonomy and condemnation of violence were broadly high, but willingness to translate those attitudes into consistent and proactive action remained uneven across districts and genders

Table 34:Likelihood of Intervening or Reporting if Witnessing Gender-Based Violence

D1.8. How likely are you to intervene or report if you witness gender-based violence or abuse?							
Group	Time	Very Unlikely	Unlikely	Neutral	Likely	Very Likely	n
Overall	Baseline	8.9%	5.3%	11.5%	53.0%	21.4%	476
	Endline	11%	5%	27%	40%	16%	360
Upper Chitral	Baseline	11.2%	2.5%	17.5%	63.8%	5.0%	80
	Endline	10%	5%	15%	58%	12%	60
Lower Chitral	Baseline	2.5%	8.6%	21.0%	65.4%	2.5%	81
	Endline	10%	0%	38%	37%	13%	60
Ghizer	Baseline	21.5%	6.3%	3.8%	11.4%	57.0%	79
	Endline	28%	0%	43%	18%	10%	60
Gilgit	Baseline	0.0%	3.8%	22.8%	69.6%	3.8%	79
	Endline	7%	18%	20%	38%	15%	60
Hunza	Baseline	11.4%	5.1%	2.5%	50.6%	30.4%	80
	Endline	8%	3%	22%	27%	40%	60
Nagar	Baseline	6.5%	5.2%	1.3%	57.1%	29.9%	77
	Endline	2%	3%	25%	63%	7%	60
Women	Baseline	11.0%	6.7%	20.9%	59.5%	1.9%	204
	Endline	19%	3%	22%	47%	9%	142
Men	Baseline	6.3%	3.9%	10.2%	71.5%	8.1%	272
	Endline	4%	7%	31%	35%	23%	218

1230.1: Percentage of male and female community members reporting understanding and acceptance of gender equality and women’s empowerment (by gender, district)

Table 35 shows that support for gender equality and women’s participation in leadership and decision-making is very high, but with some important nuances between baseline and endline.

At the overall level, about half of respondents (52%) at endline said gender equality is important for the progress of society, which is consistent with the baseline result (51%). However, recognition of the importance of women's leadership and decision-making opportunities increased slightly, from 94% at baseline to 96% at endline. By contrast, when asked more specifically about women's participation in decision-making at all levels, support was lower at endline (87%) compared to baseline (94%).

This pattern suggests that while gender equality as a value is widely endorsed, and there is growing acceptance of women's right to community leadership, there is still some reluctance when it comes to sharing actual decision-making power at all levels.

District-level trends confirm this. Upper Chitral, Ghizer, and Gilgit showed strong and consistent support, but Gilgit, Hunza, and especially Nagar recorded sharp drops in acceptance of women in decision-making roles at endline (e.g., in Nagar only 67% agreed, down from 77% at baseline).

Looking at gender differences, women themselves reported much higher acceptance of female leadership and decision-making roles (93% at endline) than men (80%), revealing a persistent gender gap in attitudes.

Overall, these results highlight that the principle of equality is broadly accepted but translating it into practice—particularly in decision-making at all levels—remains an ongoing challenge, shaped by cultural norms and male resistance in certain districts.

*Table 35: Perceptions of Gender Equality and Women's Role in Leadership and Decision-Making - (Percentage of respondents answering **Yes**) in Baseline 2023 and Endline 2025*

D2.1. Do you believe that gender equality is important for the progress of society?
D2.2. Do you believe *that women should have equal opportunities for community* leadership *and community decision-making?*
D2.3. Do you think women should have the same opportunities as men to participate in decision-making processes at all levels?

Group	Time	Gender Equality Important	Equal Opportunities in Community Leadership	Women in Leadership Accepted	N
Overall	Baseline	51%	94%	94%	481
	Endline	52%	96%	87%	360
Upper Chitral	Baseline	52%	99%	99%	81
	Endline	50%	95%	93%	60
Lower Chitral	Baseline	49%	95%	95%	81
	Endline	49%	97%	90%	60
Ghizer	Baseline	50%	100%	100%	80
	Endline	50%	98%	100%	60
Gilgit	Baseline	50%	99%	99%	80
	Endline	63%	95%	86%	60
Hunza	Baseline	54%	96%	96%	80
	Endline	52%	98%	86%	60
Nagar	Baseline	52%	77%	77%	79
	Endline	50%	90%	67%	60
Women	Baseline	51%	98%	98%	245
	Endline	52%	98%	93%	188
Men	Baseline	49%	91%	91%	234
	Endline	48%	93%	80%	170

Table 36 presents community attitudes towards two related issues: whether young women should be encouraged to pursue careers in male-dominated fields such as engineering or construction, and whether they should be supported if they aspire to become professional athletes in male-dominated sports like soccer.

At the overall level, support for women entering non-traditional professions remained high but slightly declined, from about **76% at baseline to 69% at endline**, with a corresponding increase in those preferring that women pursue more "traditional" female careers. By contrast, support for women aspiring to professional sports careers showed a sharper drop, from **68% at baseline to 59% at endline**, while reservations and suggestions for more "suitable" alternatives rose. This suggests that while the idea of women in professional careers is increasingly accepted, sports continue to carry greater social resistance.

District level results show considerable variation. **Hunza, Gilgit, and Ghizer** consistently reported the strongest support for women in unconventional professions, though in Gilgit support for women pursuing sports fell notably from 84% to 53%. **Lower Chitral** showed the most striking positive change for professions, with support rising from 63% to 87%, but it also showed declining support for women in sports. In **Nagar**, both indicators worsened sharply, with support for unconventional careers falling from 70% to just 37%, and sports support dropping from 33% to 27%.

Gender-wise, women expressed slightly less support than men for women pursuing non-traditional careers, and their backing declined at endline (from 71% to 65%). However, women showed stronger acceptance than men for professional sports, particularly at endline (77% vs. 70%). Men, on the other hand, remained more skeptical of women in sports, with higher proportions expressing reservations or suggesting alternatives.

Overall, the findings highlight a persistent social tension: while professional pathways outside traditional gender norms are gaining gradual acceptance, sports continue to face cultural barriers. The decline in support in some districts and among women themselves suggests that social desirability bias may be at play, with respondents keen to appear progressive in career choices but less comfortable when the issue relates to visible, public roles such as sports.

Table 36: Attitudes Towards Women Pursuing Careers in Male-Dominated Fields and Professional Sports (Baseline 2023 vs Endline 2025, by District and Gender)

D2.4: A young woman member of your family wants to pursue a career in a field traditionally dominated by men, such as engineering or construction. What do you think she should do? D2.5: A girl in your family turns out to be a good soccer player and she aspires to become a professional soccer player, a sport predominantly played by men in our society. How do you feel about her ambition? (Ask and select one relevant response)								
Group	**Time**	**I will support women in male-dominated careers**	**I will prefer women take traditional careers**	**I will support professional sports (soccer)**	**I have reservations about sports (soccer)**	**I will suggest alternative sports**	**Refused to respond**	**n**
Overall	BL	75.6%	24.4%	67.6%	11.4%	18.9%	2.1%	471
	EL	69.4%	30.6%	59.2%	18.1%	20.3%	2.5%	356
Upper Chitral	BL	65.4%	34.6%	12.9%	16.4%	29.7%	30.0%	78
	EL	62.7%	37.3%	73.3%	5.0%	21.7%	0.0%	59
Lower Chitral	BL	63.3%	36.7%	56.8%	16.1%	27.2%	0.0%	79

D2.4: A young woman member of your family wants to pursue a career in a field traditionally dominated by men, such as engineering or construction. What do you think she should do? D2.5: A girl in your family turns out to be a good soccer player and she aspires to become a professional soccer player, a sport predominantly played by men in our society. How do you feel about her ambition? (Ask and select one relevant response)								
Group	**Time**	**I will support women in male-dominated careers**	**I will prefer women take traditional careers**	**I will support professional sports (soccer)**	**I have reservations about sports (soccer)**	**I will suggest alternative sports**	**Refused to respond**	**n**
	EL	86.7%	13.3%	40.0%	21.7%	30.0%	8.3%	60
Ghizer	BL	84.8%	15.2%	85.0%	1.3%	12.5%	1.3%	79
	EL	69.0%	31.0%	86.7%	8.3%	5.0%	0.0%	58
Gilgit	BL	89.9%	10.1%	83.8%	8.8%	7.5%	0.0%	79
	EL	78.3%	21.7%	53.3%	23.3%	20.0%	3.3%	60
Hunza	BL	79.7%	20.3%	95.0%	1.3%	2.5%	1.3%	79
	EL	81.7%	18.3%	75.0%	18.3%	6.7%	0.0%	60
Nagar	BL	70.1%	29.9%	32.9%	30.4%	30.4%	6.3%	77
	EL	37.3%	62.7%	26.7%	31.7%	38.3%	3.3%	59
Women	BL	70.5%	29.5%	59.5%	33.3%	48.2%	33.3%	241
	EL	65.4%	34.6%	76.7%	13.3%	40.0%	0.0%	188
Men	BL	80.9%	19.1%	42.1%	66.7%	51.9%	66.7%	230
	EL	73.8%	26.2%	70.0%	10.0%	20.0%	16.7%	168

Table 37 compares two important attitudes: (a) prioritizing girls for better education under financial constraints, and (b) supporting women to run businesses in male-dominated spaces.

The results show that support for gender equality in education has increased over time. At baseline, just over one-third of respondents (37%) said they would prioritize sending a girl to a private school if only one child could attend. By the endline, this rose to more than half (53%), suggesting that communities are becoming more willing to invest in girls' futures even in resource-constrained households. Ghizer, Upper Chitral, and Hunza in particular show strong improvements, while Lower Chitral lags with only 28% prioritizing girls at endline. Women are slightly more supportive of prioritizing girls (54%) compared to men (51%), but both groups have moved in a positive direction.

On women's economic participation, the findings also point to gradual acceptance. At baseline, 53% of respondents said a woman should be encouraged to open her shop in the local bazaar despite male dominance. By the endline, this rose modestly to 57% overall, with men (60%) somewhat more supportive than women (55%). Ghizer and Hunza stand out with consistently high support (above 75%), while Nagar and Upper Chitral remain more conservative, with only 40% and 30% supportive at endline, respectively.

When read alongside earlier findings on freedom of movement and GBV attitudes (in earlier tables), a pattern emerges: while direct rejection of discriminatory practices (e.g., blaming women for harassment, accepting domestic violence), freedom of movement shows, role of women in decision making mixed progress, there is clearer evidence of positive change when respondents are asked about practical opportunities for women's empowerment—in education, leadership, or business. This may reflect how communities perceive women's roles as evolving in tangible areas of social and economic life, even as some traditional norms around control and protection remain deeply rooted.

The reason for this may lie in communities supporting women's education and income generation because it increases household productivity and survival. But they resist granting women independence over mobility, sexuality, and decision-making, because those spheres threaten patriarchal power on which the society still relies on.

Table 37: Attitudes Towards Equal Opportunities for Women in Education and Economic Participation in Baseline (2023) and Endline (2025)

D2.6: Imagine you have two children, a boy and a girl, and you can only afford to send one child to a well-known private school for a better-quality education. Both have equal abilities and potential. What would you do in this situation?
D2.7: One of your female household members has received business training and has a unique business idea. The suitable place to start and operate this business is a shop in the local bazaar where most of the business operators are male. What do you think she should do?

Group	Time	Prioritize Girl for Private Education	Support Woman to Open Business in Male-Dominated Bazaar	n (Education)	n (Business)
Overall	Baseline	37%	53%	479	481
	Endline	53%	57%	360	356
Upper Chitral	Baseline	20%	31%	81	81
	Endline	65%	30%	60	58
Lower Chitral	Baseline	47%	57%	81	81
	Endline	28%	57%	60	60
Ghizer	Baseline	40%	87%	80	80
	Endline	83%	87%	60	60
Gilgit	Baseline	29%	52%	80	80
	Endline	45%	50%	59	58
Hunza	Baseline	66%	75%	79	80
	Endline	62%	75%	60	60
Nagar	Baseline	23%	40%	79	79
	Endline	37%	40%	60	60
Women	Baseline	40%	52%	245	241
	Endline	54%	55%	188	187
Men	Baseline	35%	54%	234	230
	Endline	51%	60%	170	169

Note:
For education (D2.6), the table shows the percentage of respondents who said they would prioritize sending the girl to a private school if only one child could be enrolled. Other options ("prioritize boy" or "send both to a cheaper school") are not shown.
For business participation (D2.7), the table shows the percentage who said a woman should be encouraged and supported to open her business in the local bazaar, even if it is a male-dominated space. Other options ("discourage her" or "suggest alternatives") are not shown.

The survey asked respondents what should happen if a working woman with two daughters wishes to delay having another child, while her husband and family pressure her to conceive again.

The result is presented in Table 38. At baseline, views were divided: about 42% said her decision to delay should be respected, while 36% believed family planning should be a joint decision between the couple. Around 20% felt she should compromise and obey her husband and family.

By endline, support for women's autonomy had grown considerably. Six in ten respondents (60%) now supported the woman's right to delay childbearing, while only 16% thought she should obey her husband and family. Support for joint decision-making fell slightly (22%). This shows a clear shift towards recognizing women's reproductive rights and career aspirations.

District results show some variation. For example, in Ghizer, support for women's autonomy jumped from 24% to 88%, while in Nagar it dropped from 52% to 27%. Gender-wise, both men and women became more supportive of women's discretion, though women remained slightly more in favor (60% vs. 61% among men at endline).

Overall, more people now believe women should have the freedom to make decisions about when to have children, even if family expectations differ, but this varies strongly by district.

Table 38: Attitudes Towards Women's Autonomy in Family Planning in Baseline (2023) and Endline (2025)

D2.8: Your cousin got married four years ago and now has two daughters. His wife is employed in a private company and wants to focus on her career and educate the girls. She expresses her desire to delay having another child for another five years. However, her spouse and family members are pressuring her to conceive again as soon as possible, specifically hoping for a son. What are your thoughts on this situation?					
Group	Time	She should prioritize her career and personal aspirations, and her decision to delay having another child should be respected	She should compromise on her personal aspirations and obey her husband's decision to conceive another child as the family wants.	The decision on family planning should be a joint one between the couple, considering their preferences and circumstance.	N
Overall	Baseline	42%	20%	36%	469
	Endline	60%	16%	22%	359
Upper Chitral	Baseline	32%	15%	47%	76
	Endline	55%	15%	30%	60
Lower Chitral	Baseline	19%	23%	58%	81
	Endline	50%	13%	35%	60
Ghizer	Baseline	24%	19%	53%	76
	Endline	88%	2%	8%	60
Gilgit	Baseline	60%	13%	26%	79
	Endline	73%	22%	2%	60
Hunza	Baseline	65%	24%	10%	79
	Endline	68%	20%	10%	59
Nagar	Baseline	52%	27%	20%	78
	Endline	27%	25%	48%	60
Women	Baseline	45%	22%	32%	243
	Endline	60%	16%	24%	188
Men	Baseline	38%	18%	40%	226
	Endline	61%	16%	20%	171

The survey asked respondents how they would react if their aunt decided to contest the next local government elections. They could choose from three options: unconditional support, conditional support (only if the family agreed), or opposition to her participation.

Table 39 shows, at baseline, an unusually high 63% of respondents said they would unconditionally support their aunt's decision to run for election, while 25% supported her only if the family approved, and 11% opposed outright. By endline, however, only 26% reported unconditional support, while the majority (59%) said they would support her only if family consent was given, and 15% opposed it altogether.

This sharp decline in unconditional support seems unrealistic when compared with other survey findings on women's agency, mobility, and leadership. It is likely that the baseline figure was inflated

due to sampling differences, interviewer effects, or social desirability bias (respondents giving more "progressive" answers to look good). The endline data, although apparently less favorable, may reflect more realistic attitudes in the community, where women's political participation is mediated by family approval and traditional gender norms.

Table 39:Attitudes Towards Women's Political Participation in Baseline (2023) and Endline (2025)

D2.9: Your aunt has decided to contest the next local government election. What are your thoughts on her decision?					
Group	Time	Unconditional Support	Conditional Support (if Family Agrees)	No Support	n
Overall	Baseline	63%	25%	11%	474
	Endline	26%	59%	15%	350
Upper Chitral	Baseline	50%	41%	6%	79
	Endline	53%	37%	10%	59
Lower Chitral	Baseline	63%	28%	6%	80
	Endline	44%	51%	5%	57
Ghizer	Baseline	65%	18%	16%	79
	Endline	2%	95%	3%	60
Gilgit	Baseline	56%	26%	16%	79
	Endline	25%	61%	14%	56
Hunza	Baseline	75%	13%	13%	80
	Endline	2%	69%	29%	59
Nagar	Baseline	67%	22%	9%	77
	Endline	34%	39%	27%	59
Women	Baseline	63%	26%	9%	185
	Endline	63%	26%	11%	185
Men	Baseline	62%	23%	13%	165
	Endline	55%	27%	19%	165

Overall, across all attitude tables, a pattern emerges: people are more willing to endorse women's empowerment in domains that are framed as beneficial for families or communities (education, income, careers), but less willing to support women's autonomy in mobility, family planning, and politics. In other words, empowerment is often accepted when it aligns with collective welfare but resisted when it challenges traditional hierarchies of authority and control. This in fact highlights how women's labor and education are often valued for their contribution to household and economic productivity, but their autonomy in personal and political life is constrained by patriarchal power structures.

4.5. Perceptions about the Contributions, Impact, and Sustainability of the AGECS Project

In the endline survey we added the following additional perception questions about the overall impact of the project and sustainability of the benefits. The results of the survey are presented below.

Perceptions of overall difference made by AGECS

Most people agreed that the AGECS project had made a difference in their lives, households, or communities. However, the scale of change was not always described as transformative. While about one in three said the project had brought a *big difference*, the majority (six in ten) said it had made

some difference. Only a very small proportion reported no change or that things had become worse, though this sentiment was more visible in Chitral Upper and Nagar.

Gender perspectives showed some variation: men were more likely to describe AGECS as making a "big difference," while women more often said it made "some difference." District-level patterns were also uneven. In **Ghizer and Hunza**, many respondents felt the project had significantly improved their lives. By contrast, in **Gilgit, Nagar and Chitral**, most people described the change as partial or limited. These perceptions are reflected in the survey data (Table 40).

Table 40: Perceptions of Difference Made by AGECS in Endline (2025)

D3.1. Do you think the AGECS project has made any positive difference in your life, household, or community?					
Category	Yes, a big difference	Yes, some difference	No difference	Things have become worse	N
Overall	36%	59%	4.7%	0.3%	339
Men	39%	55%	5%	1%	164
Women	33%	63%	4%	0%	175
Chitral Lower	33%	63%	4%	0%	46
Chitral Upper	36%	57%	8%	0%	53
Ghizer	58%	40%	2%	0%	60
Gilgit	18%	75%	7%	0%	60
Hunza	63%	37%	0%	0%	60
Nagar	7%	83%	8%	2%	60

Areas where AGECS made a positive difference

When asked where AGECS had made the most difference, respondents most frequently pointed to women's decision-making within families, especially on family planning, child health, SRH, and early childhood development. This was the strongest and most consistent theme across districts.

Other areas mentioned included greater awareness and response to gender-based violence, progress towards gender equality and empowerment in communities, and easier access to health and SRH services. Still, not all communities experienced change equally. In Ghizer, women strongly emphasized their growing voice in decision-making, while in Nagar, women highlighted the same, but men focused more on equality at community level. In Hunza, responses were more evenly spread, showing that people recognized multiple contributions rather than one dominant area.

It is also important to note that a small number of respondents — nearly 4% overall — said they saw no difference from AGECS. These findings are summarized in Table 41.

Table 41:Areas Where AGECS Made a Positive Difference (multi-select), perceptions of respondents Endline 2025

D3.2. In which areas have the AGECS project made a positive difference?		
Area of Change	Respondents (%)	Responses (%)
Women's decision-making (family planning, child health, SRH, ECD)	79%	34% (268)
Awareness and response to GBV	55%	24% (188)
Gender equality and women's empowerment in community	49%	21% (167)
Easier access to health, SRH, or ECD services	43%	19% (147)
No difference from AGECS	3.8%	2% (13)
Other	0.6%	0.3% (2)
Total Responses	–	785

How AGECS brought about these changes

Respondents described several ways in which AGECS had influenced their lives. The most frequently cited mechanism was awareness-raising, which many felt gave them the knowledge and confidence to act differently. Alongside this, respondents spoke about building women's confidence and decision-making skills, which improved their ability to engage in household discussions and decisions.

Other mechanisms included better family communication, improved access to services, and reducing stigma or social pressure. Some participants also credited shifts in family attitudes, such as greater support from husbands or fathers, because of the project.

These responses highlight that AGECS helped some beneficiaries in shifting social norms, increasing agency, and creating space for women's voices within families and communities. However, the relative emphasis varied: women were more likely to stress confidence and communication, while men tended to highlight awareness. Survey results are presented in Table 42.

Table 42: How AGECS Brought Change (multi-select), perceptions of respondents in Endline 2025

D3.3. How did the AGECS project bring these changes?		
Mechanism of Change	Respondents (%)	Responses (%)
Awareness	31%	32% (281)
Building confidence and decision-making skills	19%	19% (169)
Improving family communication	16%	16% (138)
Making services easier to access	13%	11% (97)
Reducing stigma or social pressure	10%	10% (83)
Family attitudes	7%	8% (68)
Service providers	4%	4% (32)
Other	<1%	<1% (1)
Total Responses	–	869

Perceptions of sustainability of AGECS outcomes

When asked whether the positive changes from AGECS would continue after the project ends, most people expressed **cautious optimism** rather than certainty. About one in three respondents believed changes would "definitely" sustain, but the majority said "maybe," signalling that while they valued the progress, they were unsure if it would be sustained without continued support.

Men were more confident than women that changes would continue, while women leaned more toward uncertainty. District-level variations were also clear: people in **Hunza and Ghizer** were the most confident about sustainability, while those in **Gilgit and Nagar** expressed hesitation, often saying that continuation was possible but not guaranteed. These views are reflected in Table 43.

Table 43: Perceptions of Sustainability of AGECS Outcomes, Endline 2025

D3.4. Do you think the positive changes from the AGECS project will continue after the project ends?					
Category	Yes, definitely	Yes, maybe	No, unlikely	Don't know/unsure	N
Overall	33% (116)	60% (208)	3% (9)	4% (14)	347
Men	40%	50%	3%	7%	167
Women	27%	69%	2%	2%	180
Chitral Lower	43%	53%	0%	4%	46
Chitral Upper	27%	59%	7%	7%	53
Ghizer	42%	55%	0%	3%	60
Gilgit	13%	77%	5%	5%	60
Hunza	50%	47%	2%	2%	60
Nagar	27%	68%	2%	3%	60

Taken together, community perceptions highlight AGECS as a project that opened new spaces for women's participation and awareness of sensitive issues**,** but whose overall impact was uneven and often described as modest rather than transformative**.**

The strongest contributions were in household-level decision-making, confidence-building, and GBV awareness**,** yet most people framed these as *some difference* rather than *big difference*. In districts such as Hunza and Ghizer**,** communities were more positive, while in Gilgit, Nagar, and Chitral Upper**,** respondents expressed more limited or cautious views.

Looking ahead, perceptions of sustainability reveal fragility in the gains**.** While some communities are confident that changes will last, the majority are uncertain, reflecting concerns that progress may fade without reinforcement from families, communities, and local institutions.

Overall, AGECS is seen as having planted the seeds of social and behavioral change**,** but the survey findings suggest these seeds will need continued nurturing if they are to grow into lasting, community-owned outcomes.

5. COMMUNITY LEADERS' AND COMMUNITY STRUCTURE'S CAPACITY TO RESPOND GENDER AND SOCIAL BARRIERS

5.1. Community Leaders' capacity to identify and respond to gender and social barriers

1220.3: % of Community leaders reporting increase in ability to identify and respond to gender and social barriers (by gender, district)

Profile of Community Leaders' Survey

The endline survey engaged 22 community leaders (11 women, 11 men) from Hunza, Nagar, Gilgit, Ghizer, Lower Chitral, and Upper Chitral, representing a diverse mix of CSO representatives, police officers, lawyers, media professionals, government officials, elected representatives, and community activists. This composition ensured balanced institutional, community, and grassroots perspectives on GBV, women's empowerment, and community dynamics. The baseline included 48 respondents (36 men, 12 women). These were categorized into three groups: 26 Civil Society Leaders, 9 Traditional Leaders, and 13 Religious Leaders.

Table 44: District and Gender Wise Distribution of Community Leaders Survey sample in Baseline and Endline

District	Baseline (2023)			Baseline (2025)		
	Women	Men	Total	Women	Men	Total
Gilgit	4	9	13	2	3	5
Nagar	1	9	10	1	1	2
Chitral	3	6	9	5	5	10
Ghizer	2	6	8	1	1	2
Hunza	2	6	8	2	1	3
Total	12	36	48	11	11	22

Findings

This indicator presented here assesses the extent to which community leaders have strengthened their capacity to recognize and address gender and social barriers. It captures the proportion of leaders who self-reported an increase in their ability to identify and respond to such challenges.

The analysis draws on two distinct cohorts of purposively selected leaders in the baseline and endline. While both groups were chosen using consistent criteria (availability and basic familiarity with GBV issues), the endline cohort additionally included leaders who had taken part in project-supported training and awareness sessions.

The results in Table 45 indicate that confidence among community leaders in their ability to identify and respond to gender and social barriers has increased overall, with **35% at baseline rising to 50% at endline**. This suggests a growing self-assurance among leaders, likely reflecting the influence of AGECS trainings, exposure to CSO advocacy, and increased dialogue on gender rights.

Box 6: Progress on Indicator 1220.3 – Community Leaders' Capacity to Identify and Respond to Gender and Social Barriers

Confidence: 35% of leaders at baseline and 50% in endline reported confidence in identifying and responding gender and social barriers.

Knowledge: Share of leaders self-reporting as *knowledgeable* increased from **89.4% → 95.5%** (+6.1 pp).

Shift: Endline leaders reported stronger knowledge of GBV and laws, with no leader rating themselves "not knowledgeable."

Gender differences are evident. **Women leaders reported higher levels of confidence (55%) than men (45%)** at endline a pattern consistent with qualitative findings that women leaders are more directly aware of mobility restrictions, inheritance denial, and domestic workload issues. However, the lower confidence among men highlights the persistence of patriarchal attitudes that limit men's recognition of these issues as barriers.

District-level differences show a mixed picture:

- Hunza stands out with the strongest improvement (50% → 67%), reflecting the district's relatively enabling social context and higher concentration of CSO activities.
- Nagar also shows strong progress (30% → 50%), suggesting growing awareness despite conservative pushback noted in FGDs.
- Ghizer improved moderately (38% → 50%), while Gilgit and Upper Chitral show only small gains (31% → 40% and 33% → 40% respectively), underlining the entrenched barriers and weaker civil society presence in these areas.

Taken together, these findings suggest that while leaders' **confidence** in addressing gender and social barriers has grown, progress is uneven. Women leaders tend to be more confident, but their influence is often constrained by male-dominated structures. Geographic disparities also remain stark, with Hunza showing a stronger enabling environment compared to more conservative or resource-constrained districts.

Table 45: Perception of community leaders showing confidence level of 5 (on scale of 1-5) in identifying and responding gender and social barriers, Baseline Vs Endline

Categories	Baseline (2023)		Endline (2025)	
	(n)	% of respondent	(n)	% respondent
Overall	48	35%	22	50%
Ghizer	8	38%	2	50%
Gilgit	13	31%	7	40%
Hunza	8	50%	2	67%
Nagar	10	30%	2	50%
Chitral	9	33%	7	40%
Women	12	42%	11	55%
Men	36	33%	11	45%

Understanding of GBV issues, social barriers to women and related policies, laws, and regulations

As shown in Table 46, the 2025 cohort reported stronger knowledge compared to 2023. The share of knowledgeable leaders rose from 89.4% at baseline to 95.5% at endline, with four of the five districts reaching a full 100% knowledge score. These results suggest that leaders engaged at the endline had a more robust understanding of the barriers women face in accessing essential services and of the legal frameworks designed to protect their rights.

Table 46:Knowledge level of community Leaders on gender and social barriers in accessing services (FP, SRH, ECD)

Districts	Baseline (2023)			Endline (2025)		
	(n)	Not knowledgeable	Knowledgeable	(n)	Not knowledgeable	Knowledgeable
Overall	47	10.6%	89.4%	22	4.5%	95.5%
Ghizer	7	28.6%	71.4%	2	0%	100%
Gilgit	13	15.4%	84.6%	7	0%	100%
Hunza	8	0%	100%	2	0%	100%
Nagar	10	10%	90%	2	0%	100%
Chitral	9	0%	100%	7	14.3%	85.7%
Women	12	0%	100%	11	0%	100%
Men	35	14.3%	85.7%	11	9.1%	90.9%

Knowledge level of community leaders on different forms of GBV and Related polices, law and regulation

The endline results indicate a marked improvement in community leaders' self-reported knowledge of both diverse forms of GBV and the policies and laws promoting gender equality, compared to the baseline (2023)- Table 47.

For understanding of GBV, the proportion of leaders who felt "very" or "moderately" knowledgeable increased across all districts, while the "slightly knowledgeable" category declined. Importantly, no leader at endline reported being "not knowledgeable," whereas at baseline some districts—such as Nagar (20%) and Chitral (11%)—had leaders who admitted to no knowledge at all.

A similar shift was observed in knowledge of policies, laws, and regulations. At baseline, leaders in districts such as Gilgit (23%) and Chitral (11%) acknowledged being "not knowledgeable," but by endline this category was eliminated across all districts. The share of leaders reporting "very" knowledgeable rose, especially in Ghizer, Hunza, and Nagar, pointing to a stronger grasp of legal frameworks that protect women's rights.

Overall, these results suggest that community leaders selected in the endline reported capacity to recognize GBV and related legal protections strengthened significantly over the project period, though the degree of improvement varied across districts (e.g., Chitral showed more modest gains compared to others).

Table 47: Knowledge level of sample community leaders about forms of GBV and related polices, laws and regulations

District	Baseline (2023) Knowledgeable:				Endline (2025) Knowledgeable:			
	Very	Moderately	Slightly	Not at all	Very	Moderately	Slightly	Not at all
Understanding of diverse types of GBV:								
Ghizer	13%	25%	63%	0%	50%	50%	0%	0%
Gilgit	23%	23%	54%	0%	43%	43%	14%	0%
Hunza	25%	25%	50%	0%	50%	50%	0%	0%
Nagar	0%	50%	30%	20%	50%	50%	0%	0%
Chitral	22%	44%	22%	11%	43%	43%	14%	0%
Understanding of policies, laws, and regulations that promote gender equality								
Ghizer	25%	0%	63%	13%	50%	50%	0%	0%
Gilgit	8%	23%	46%	23%	29%	57%	14%	0%
Hunza	13%	38%	38%	13%	50%	50%	0%	0%
Nagar	30%	10%	60%	0%	50%	50%	0%	0%
Chitral	22%	44%	22%	11%	43%	43%	14%	0%

5.2. Implementing Partners (Community Structure's) Capacity to Respond to Gender and Social Barriers

E1 (1220.2): Extent to which the members of the project population value the work of CSOs (by geography) – Men and Women module (KADO, LAPH and SBHI) (Net Promoter Score)

Organizational Performance Index (OPI)

The Organizational Performance Index (OPI) was applied to assess the institutional capacity and performance of three partner civil society organizations (CSOs): the Karakoram Area Development Organization (KADO), the Legal Awareness Program for Human Rights (LAPH), and the Sadabahar Hunarmand Board for Human Rights (SBHI).

The OPI, developed by the Aga Khan Foundation (AKF), is a standardized tool that measures organizational capacity across four domains—Effectiveness, Efficiency, Relevance, and Sustainability—and eight sub-domains (two per domain). Each sub-domain is scored on a scale of 1–4. The assessment was conducted at three points in time: baseline (2023), midline (2024), and endline (2025). Full details of the tool and methodology are presented in the methodology section (Section 3).

The following sections present the performance of each CSO over this three-year period, with a focus on trends across domains, reasons for improvements or stagnation, and the broader implications for institutional maturity. Detailed results are presented in **Annex 14.**

Karakoram Area Development Organization (KADO)– OPI Results

Findings

KADO showed the strongest growth trajectory among the three CSOs, with its overall score rising from 1.69 in 2023 to 3.13 in 2025 (Table 48). This growth reflects significant advances in systems, policies, and partnerships, though challenges remain in sustaining financial inflows.

Effectiveness improved steadily, with the score rising from 1.0 in the baseline to 3.0 at the endline. At baseline, KADO's monitoring was limited to Excel-based tracking of outputs. By midline, it had developed a comprehensive Monitoring and Evaluation (M&E) manual, hired a professional M&E officer, and introduced outcome-level tracking in donor-funded projects (e.g., GIZ's climate resilience initiative and a UN Women project on women's economic empowerment). At endline, KADO presented a finalized M&E framework for its climate resilience program, demonstrating institutionalization of results-based management.

Initially, compliance was limited to donor requirements. By midline, KADO had adopted a safeguarding policy, established HR guidelines, gained PCP certification, and introduced standards for its rehabilitation center. At endline, institutional frameworks were strengthened further with adoption of climate change, gender equality, and procurement policies.

Efficiency score rose from 2.0 in the baseline to 3.0 at the endline. KADO institutionalized structured workplans, budget tracking, and routine progress reporting. Evidence included quarterly progress reports for donor-funded projects and budget tracking tools. By endline, project delivery was consistently within time and budget, and progress was reported to the Board of Directors, showing stronger internal accountability.

Relevance score increased from 2.0 in the baseline to 3.5 in the endline. KADO deepened its engagement with communities, producing needs assessments on potential products in Gilgit-Baltistan and re-engineering opportunities through digital technology. Importantly, it launched the Climate Action Forum in collaboration with AKAH in Chitral, showing participatory engagement at scale expending its operations from GB to KPK.

At baseline, documenting learning and sharing was ad hoc. By midline, KADO began documenting its learning and sharing lessons externally (e.g., presentations in Mombasa) and producing thematic assessments. By endline, it prepared a comprehensive two-year learning report on climate resilience insurance and institutionalized learning dissemination at board and partner levels.

Sustainability improved structurally from 1.5 to 3.0. At baseline, no resource mobilization plan existed. By midline, KADO piloted income-generating activities (e.g., Digital Hub memberships) and secured donor extensions. At endline, it presented a formal Resource Mobilization Plan and signed

multi-year MoUs with organizations such as Shamani Living Trust (2028), Community World Service Asia (2026), and the International Center for Development Learning.

Table 48:KADO – OPI Scores and Analysis of Change (2023–2025)

Domain	Sub-Domain	Baseline 2023	Midline 2024	Endline 2025	Analysis of Change
Effectiveness	Results	1	2	3	Comprehensive M&E system institutionalized.
	Standards	1.5	2	3	Adoption of safeguarding, HR, procurement, gender equality frameworks.
Efficiency	Delivery	2	3	3	Workplans and reporting systems institutionalized.
	Reach	2	3	3	Expanded reach to multiple districts and >3,000 beneficiaries.
Relevance	Target Population	2	2.5	3.5	Enhanced participatory planning; Climate Action Forum.
	Learning	1.5	2	3.5	Robust dissemination of learnings.
Sustainability	Resources	1.5	2.5	3	Resource mobilization plan operationalized with multi-year MOUs.
	Social Capital	2	3	3	Strong partnerships & trust at multiple levels.
Total Score	–	**1.69**	**2.50**	**3.13**	Overall improvement across all domains.

Monetary value of resource mobilization: As shown in Table 49, KADO's financial mobilization declined sharply over the three-year period, falling from **CAD 842,413 in 2023** to **CAD 250,540 in 2025**. The high baseline was driven by exceptional government allocations (CAD 165,382) and a large volume of in-kind contributions (CAD 542,400), which fell drastically to just CAD 78,111 and CAD 3,203 respectively by 2025. While this decline reflects the loss of one-off and in-kind support, the composition of contributions shifted notably. By endline, international organizations (CAD 125,409) and local businesses (CAD 43,817) had become significant contributors, pointing to greater diversification of sources compared to 2023, when government and in-kind dominated. However, despite this diversification, total inflows contracted by nearly 70% across the period. This divergence underscores that KADO's strengthened systems—resource mobilization plan, multi-year MoUs, and wider partnerships—represent institutional readiness, but they have not yet been translated into consistent or expanding revenues. Unless these agreements mature into predictable funding streams, financial sustainability remains a critical risk.

Table 49: Monetary Value of Resource mobilization Baseline 2023, Midline 2024 and Endline 2025

Type of Support	Type of Donor / Contribution	2023 (CAD)	2024 (CAD)	2025 (CAD)
Financial	Individual Givers (Local)	3,584	2,847	–
	Individual Givers (International)	17,413	36,440	–
	Individual Givers (Diaspora)	–	7,840	–
	International Organizations	–	–	125,409
	Local/National Government	165,382	171,500	78,111
	Local/National Businesses	2,657	9,800	43,817
	Local/National Foundations	110,976	240,590	–
In-Kind	Donated Goods/Materials	542,400	35,280	3,203
	Volunteer Time	–	1,103	–
Grand Total		842,413	505,400	250,540

Net Promoter Score: As presented in Table 50 the NPS for KADO declined slightly overall (–15% at baseline to –21% at endline). District-level analysis reveals divergent trends: Hunza improved significantly (–20% to +15%) and Gilgit improved modestly (–18% to –3%), while Ghizer dropped sharply (+41% to –62%) and Chitral Upper scored very low at endline (–83%). By gender, women's views improved (–40% to –8%), whereas men's NPS worsened (from slightly positive at +3% to –35%).

Table 50: Net Promoter Scores (NPS) for KADO, Baseline 2023 vs. Endline 2025

Group	Timepoint	Detractors (1–6)	Neutrals (7–8)	Promoters (9–10)	n	NPS
Overall	Baseline	48%	21%	33%	147	–15
	Endline	44%	33%	23%	264	–21
Chitral Upper	Baseline	–	–	–	0	–
	Endline	87%	8%	4%	24	–83
Ghizer	Baseline	18%	24%	59%	17	+41
	Endline	75%	11%	13%	60	–62
Gilgit	Baseline	44%	28%	26%	49	–18
	Endline	23%	59%	20%	60	–3
Hunza	Baseline	52%	18%	32%	64	–20
	Endline	26%	33%	41%	60	+15
Nagar	Baseline	65%	6%	29%	17	–36
	Endline	35%	42%	23%	60	–12
Women	Baseline	63%	14%	23%	66	–40
	Endline	34%	40%	26%	140	–8
Men	Baseline	37%	23%	40%	80	+3
	Endline	54%	26%	19%	124	–35

Legal Awareness Program for Human Rights (LAPH) – OPI Results

Findings

LAPH achieved significant progress in some areas, with its overall score increasing from 1.75 in 2023 to 2.88 in 2025 (Table 51). Gains were particularly strong in effectiveness and institutional policy development. However, efficiency improvements remained project-based, and sustainability advances did not translate into tangible funding.

Effectiveness score improved markedly from 1.0 to 3.5. At baseline, monitoring was output-focused and fragmented across projects. By midline, LAPH had developed structured PMFs and AISs, supported by evidence such as validated attendance sheets and activity reports. By endline, these were consolidated into an organization-wide framework with outcome-level reporting, moving beyond project compliance.

Initially, LAPH operated without core policies. By midline, it had introduced HR, procurement, anti-fraud, and safeguarding policies, as evidenced by training records, meeting minutes, and audit reports. Endline verification confirmed that these were operational.

Efficiency score increased only modestly, from 2.0 to 2.5. Although LAPH exceeded its outreach targets (achieving 135% of planned reach), efficiency gains were tied to project-level systems (AGECS PMFs, AISs) rather than comprehensive organizational processes.

Relevance score advanced incrementally from 2.0 to 2.75. LAPH consistently engaged communities through participatory planning, particularly via GBV monitoring committees. Evidence included

district-level meeting minutes, and proof of recommendations integrated into workplans. Learning practices also improved from foundational to semi-structure, with Board discussions and some external learning engagements.

Sustainability scores rose structurally from 2.0 to 2.5, but progress was limited. At baseline, no resource mobilization plan existed. By midline, a plan was drafted. By endline, engagement with institutional partners had begun. However, LAPH mobilized no additional financial or in-kind resources beyond CAD 14,912 at baseline. Social capital improved, with MoUs established with universities, civil society, and government bodies.

Table 51: LAPH – OPI Scores and Analysis of Change (Baseline 2023–Endline 2025)

Domain	Sub-Domain	Baseline 2023	Midline 2024	Endline 2025	Analysis of Change
Effectiveness	Results	1	3	3.5	From output-driven to consolidated results monitoring framework.
	Standards	1	3	3	Adoption of HR, procurement, anti-fraud, safeguarding policies.
Efficiency	Delivery	2	2	2.5	Improved but still project focused.
	Reach	2	2	2.5	Outreach expanded, exceeding 135% of planned targets.
Relevance	Target Population	3	3	3	Consistent participatory planning mechanisms.
	Learning	1	2	2.5	Progressed to semi-structured learning practices.
Sustainability	Resources	1	2	2.5	Resource mobilization plan operationalized.
	Social Capital	3	3	3.5	Stronger partnerships with institutions and communities.
Overall Score	–	**1.75**	**2.50**	**2.88**	Strong gains in Effectiveness and Sustainability.

Monetary value of local support mobilization: At baseline (2023), LAPH reported mobilizing modest local support equivalent to approximately CAD 14,912, primarily from a local/national foundation (CAD 12,800) and volunteer time (CAD 2,112). However, during the implementation period (2023–2025), no additional financial or in-kind contributions were reported. By endline, the organization had developed a resource mobilization plan and initiated engagement with institutional partners, but these efforts had not yet been translated into tangible resources. As such, LAPH remains largely dependent on donor-funded projects, with resource mobilization still at an early stage of development.

Net Promoter Score (NPS): The results in Table 52 show that while the NPS for LAPH remains negative overall, there is a clear improvement between baseline (–49%) and endline (–28%). At the district level, Lower Chitral improved from –33% to –20%, while Upper Chitral also showed progress from –63% to –36%, though it remains more negative. By gender, both women and men reported negative NPS, but men's perceptions improved significantly (–79% to –40%), narrowing the gender gap. Overall, these findings indicate that although detractors still outnumber promoters, perceptions of LAPH's value are shifting positively across locations and groups.

Table 52: Net Promoter Scores (NPS) for LAPH, Baseline 2023 vs. Endline 2025

Group	Timepoint	Detractors (1–6)	Neutrals (7–8)	Promoters (9–10)	n	NPS
Overall	Baseline	62%	24%	14%	37	–49%
	Endline	53%	23%	25%	120	–28%
Lower Chitral	Baseline	56%	22%	22%	18	–33%
	Endline	50%	20%	30%	60	–20%
Upper Chitral	Baseline	68%	27%	5%	19	–63%
	Endline	56%	25%	20%	60	–36%
Female	Baseline	44%	28%	28%	18	–17%
	Endline	46%	25%	30%	60	–16%
Male	Baseline	79%	21%	0%	19	–79%
	Endline	60%	20%	20%	60	–40%

Sadabahar Hunarmand Board for Human Rights (SBHI) – OPI Results

Findings

SBHI showed only modest and short-lived improvements, with its overall score rising from 1.0 in 2023 to 1.63 in 2024 and then stagnating through 2025 (Table 53). Gains were confined to project-level monitoring and outreach under the AGECS project, while relevance and sustainability remained weak. Importantly, the AGECS project was discontinued midway due to a conflict between LAPH and SBHI, which curtailed further institutional development.

Effectiveness improved marginally, with the score increasing from 1.0 at baseline to 2.0 at midline, but no further progress was recorded at endline. Gains were limited to the introduction of AGECS workplans and refresher training for master trainers, representing project-level rather than organization-wide systems. No outcome-level monitoring was developed, and organizational standards remained basic, with compliance limited to training certificates. No new frameworks or institutional policies were introduced to strengthen governance or accountability.

Efficiency score improved from 1.0 to 2.0, driven by the adoption of workplans and modest outreach expansion at the start of AGECS implementation. However, with the discontinuation of the project, these systems did not evolve beyond midline.

Relevance score remained static at 1.0 throughout the period. There was no evidence of participatory planning or institutional learning mechanisms.

Sustainability improved marginally from 1.0 to 1.5 in midline due to some donor extensions and community engagement. However, this did not progress further. SBHI reported only one in-kind contribution at baseline (CAD 2,624), with no further mobilization by 2025.

Table 53: SBHI – OPI Scores and Analysis of Change (Baseline 2023–Endline 2025)

Domain	Sub-Domain	Baseline 2023	Midline 2024	Endline 2025	Analysis of Change
Effectiveness	Results	1	2	2	Basic project-level monitoring introduced.
	Standards	1	2	2	Limited to refresher training certificates.
Efficiency	Delivery	1	2	2	Limited to workplan-based delivery.
	Reach	1	2	2	Expanded outreach in AGECS projects.
Relevance	Population	1	1	1	No structured engagement mechanisms.
	Learning	1	1	1	No learning systems developed.
Sustainability	Resources	1	1.5	1.5	No formal RM plan; donor dependency.
	SocialCapital	1	2	2	Some community partnerships developed.
Total Score	–	**1.00**	**1.63**	**1.63**	Limited progress, still at foundational level.

Monetary value of resource mobilization: At baseline (2023), SBHI reported mobilizing a limited in-kind contribution valued at approximately CAD 2,624 in the form of donated goods or materials. However, no further financial or in-kind support was mobilized during the period 2023–2025. The organization continues to rely almost entirely on donor-funded project support and has not developed or operationalized a resource mobilization strategy. This underlines a critical sustainability gap compared to peer organizations.

Net Promoter Score NPS: The NPS for SBHI worsened from baseline to endline, shifting from –18% to –69% overall (Table 54). Both districts reported more negative perceptions at endline, with Lower Chitral dropping from –20% to –64% and Upper Chitral from 0% to –69%. By gender, women's NPS fell sharply (from +8% to –58%), while men's score, though slightly improved, remained highly negative (–100% to –76%).

However, it is important to interpret these findings with caution. The baseline sample size (n) was very small (overall n=17, with some sub-groups as low as 2–4), making the scores highly sensitive to individual responses. For instance, in Upper Chitral (n=2), a single change in response would have swung the NPS by 100 points. The larger endline sample (n=120) provides more reliable estimates, but comparisons should focus on general trends rather than precise percentage differences.

Table 54: Summary of Net Promoter Scores (NPS) for SBHI, Baseline 2023 vs. Endline 2025

Group	Timepoint	Detractors (1–6)	Neutrals (7–8)	Promoters (9–10)	n	NPS
Overall	Baseline	47%	24%	29%	17	–18%
	Endline	81%	11%	12%	120	–69%
Lower Chitral	Baseline	47%	27%	27%	15	–20%
	Endline	78%	9%	14%	60	–64%
Upper Chitral	Baseline	50%	0%	50%	2	0%
	Endline	79%	11%	10%	60	–69%
Female	Baseline	31%	31%	38%	13	+8%
	Endline	73%	12%	15%	60	–58%
Male	Baseline	100%	0%	0%	4	–100%
	Endline	84%	8%	8%	60	–76%

Comparative Analysis of OPI Results

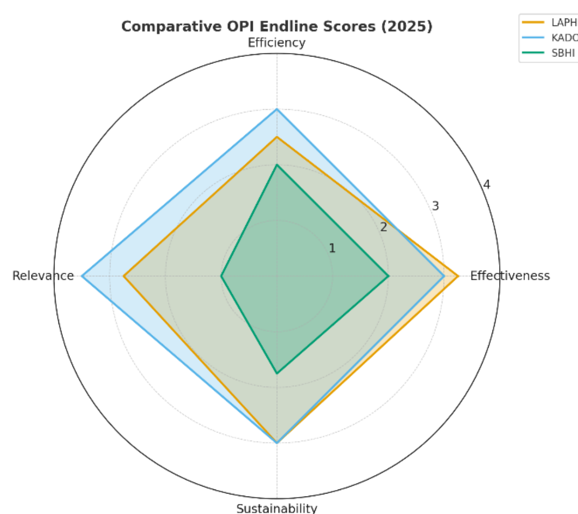
The OPI results presented in Table 55 show divergent trajectories: **KADO (1.69 → 3.13)** achieved the strongest and most balanced growth, institutionalizing delivery systems, participatory planning, and resource mobilization structures, though financial inflows declined. **LAPH (1.75 → 2.88)** made solid gains in effectiveness and strengthened its monitoring systems and adoption of organizational policies, but efficiency remained project-focused and resource mobilization outcomes lagged capacity. **SBHI (1.0 → 1.63)** recorded only modest, short-lived gains in effectiveness and efficiency, driven by the AGECS project, which was discontinued mid-way, leaving relevance and sustainability weak. Overall, KADO reached better organizational maturity, LAPH consolidated its systems with gaps in efficiency and learning, while SBHI remained at a foundational stage.

Table 55:Comparative OPI Scores (Average by Domain, 2023–2025)

Domain	LAPH (Baseline-Endline)	KADO (Baseline-Endline)	SBHI (Baseline-Endline)	Key Insights
Effectiveness	1 → 3.25	1.25 → 3.0	1 → 2	Strong gains for LAPH and KADO; SBHI remained basic.
Efficiency	2 → 2.5	2 → 3	1 → 2	KADO institutionalized delivery; LAPH exceeded outreach; SBHI modest gains.
Relevance	2 → 2.75	2 → 3.5	1 → 1	KADO achieved strongest community alignment; LAPH steady; SBHI stagnant.
Sustainability	2 → 3.0	1.75 → 3.0	1 → 1.75	LAPH and KADO diversified resources; SBHI remained weak.
Overall Score	1.75 → 2.88	1.69 → 3.13	1.0 → 1.63	KADO advanced; LAPH consolidating; SBHI foundational.

Conclusion

The OPI assessment demonstrates that while all three partner CSOs made progress between 2023 and 2025, their institutional maturity and trajectories diverged significantly.



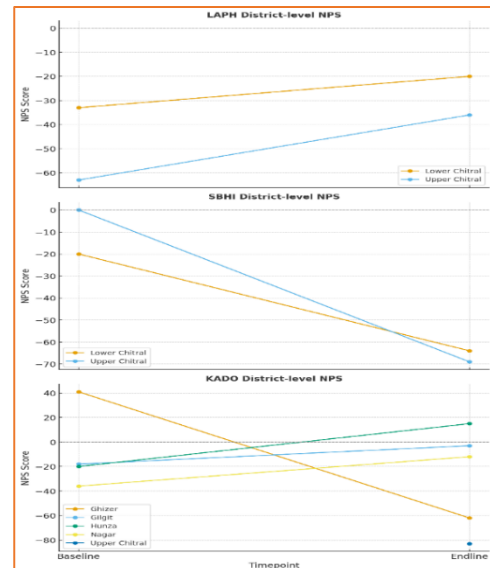
KADO achieved the strongest and most balanced growth, advancing in monitoring, governance frameworks, participatory engagement, and resource mobilization planning, though declining financial inflows raise questions about long-term resilience.

LAPH consolidated effectiveness and policy adoption, moving from project-driven systems to a more structured organization, yet its efficiency remains tied to project cycles and resource mobilization outcomes have not materialized.

SBHI showed only short-lived gains linked to the AGECS project, which was discontinued mid-way, leaving relevance, sustainability, and institutional development weak.

Overall, all three CSOs improved, their institutional maturity differs significantly. Common strengths include improved monitoring systems and stronger stakeholder engagement. Key gaps remain in sustainability planning and organisation-wide learning systems, especially for SBHI and, to a lesser degree, LAPH. LAPH requires targeted support to transition from compliance to maturity, and SBHI remains at a foundational stage requiring investment in its core systems, governance, and conflict management. A cross-cutting lesson is that partnership governance and conflict resolution mechanisms are essential to sustaining institutional development across all CSOs.

Comparative analysis of NPS



The NPS results show divergent patterns across the three organizations. LAPH improved overall (–49% to –28%), with particularly better perceptions in its home base of Lower Chitral, suggesting a possible link between local presence and trust. SBHI, however, saw a steep decline (–18% to –69%), likely influenced by the premature discontinuation of activities, which left communities dissatisfied. KADO recorded mixed results, improving in Hunza (–20% to +15%) where it is most active, but declining in other districts, leading to a small overall drop (–15% to –21%). These results indicate that local presence and continuity matter for sustaining community trust and shaping their perceptions.

Recommendations

KADO's immediate priority is to translate its MoUs and Resource Mobilization Plan into predictable and preferably unrestricted revenue streams. Without this, its strong structural advances risk being undermined by unstable funding. A secondary priority is to reinforce governance systems to ensure resilience and reduce dependence on project cycles. By consolidating its internal governance and securing stable financial flows, KADO can leverage its strong reputation, particularly in Hunza, and expand outreach into districts where perceptions remain weaker.

LAPH's most urgent need is to move from resource mobilization planning to active execution, diversifying donors and institutional partners to reduce reliance on projects. Strengthening organization-wide efficiency systems beyond project-level tools is the next priority to consolidate gains in effectiveness and sustainability.

For **SBHI**, priorities are more foundational. The most urgent actions are to develop and operationalize a basic resource mobilization strategy and to establish core M&E and learning systems. In parallel, SBHI must strengthen governance and conflict resolution mechanisms to safeguard institutional growth and prevent future project disruptions, such as the challenges faced during the discontinuation of the AGECS project following tensions between partners.

6. Government's Capacity and Respond to Gender Based Violence

This section presents reported cases of gender-based violence (GBV) and child abuse in the project districts of Gilgit, Ghizer, Hunza, and Nagar, drawing on official police records, FIA cyber wing data, HRCP monitoring, and media reports between 2023 and 2025. For Chitral we could not access the official reported cases, but it includes data from LAPH and media reports. The data highlights both the scale and complexity of violence in the region, including domestic abuse, sexual violence, harassment, forced marriage, honor killings, child exploitation, and digital harassment. While police and FIA records show increasing reliance on formal reporting channels, civil society monitoring and media reports capture incidents that often remain outside official statistics, pointing to significant underreporting and structural barriers. Together, these multiple sources provide a more comprehensive picture of the prevalence, patterns, and responses to GBV and child abuse across the districts.

6.1. GBV Cases Reported at Police Stations (Oct 2024 – Sept 2025)

Data collected from police department across the project districts (Ghizer, Gilgit, Hunza, and Nagar) for the period October 2024 to September 2025 shows a total of 44 GBV cases reported (Table 56). In The distribution of cases varies across districts, with Gilgit reporting the highest number of cases (23), followed by Ghizer (12), Hunza (9), while no GBV cases were formally reported from Nagar district during this period.

Notably, in Gilgit, cases were spread across multiple police stations, with the highest numbers in Danyore (6 cases) and City PS (5 cases). In Hunza, cases were recorded only at the Women Police Station (9 cases), while in Ghizer, Immit (4 cases), Gupis (3 cases), and Yasin/Phander (2 each) were the most affected areas.

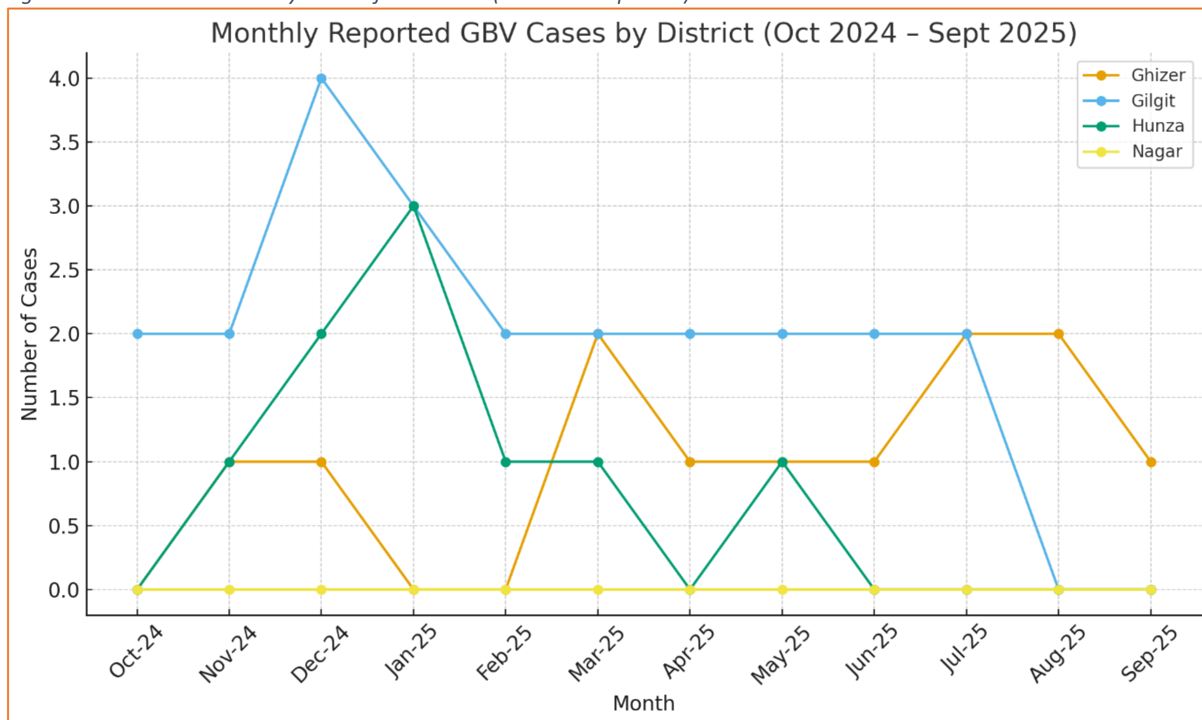
This reporting trend highlights both the growing reliance on police mechanisms for GBV redressal in certain areas and the possible underreporting or lack of access to police facilities in others (e.g., Nagar).

Table 56:Report GBV cases in police station of the project districts in Gilgit Region the year Oct 2024- Sep 2025

District	Number of Polic Station	Police Stations (PS) Reported cases	Total Cases reported in the last 12 months	Key Observations
Ghizer	8	Chatorkhand (1), Immit (4), Gupis (3), Yasin (2), Phander (2),	12	Highest cases from Immit; scattered cases across valley.
Gilgit	11	City (5), Danyore (6), Pari (4), Jutial (2), Basin (2), Juglote (1), Nomal (1), Women PS (1), Airport (1)	23	Danyore had the highest cases (6); GBV widely spread across multiple PS.
Hunza	5	Women PS only (9)	9	All cases reported at Women Police Station.
Nagar	4	No PS reported any case	0	No cases formally reported.
Grand Total	28	15 PS reported cases	44	Gilgit leads in reporting, followed by Ghizer and Hunza.
Source: District Police Offices (Gilgit, Ghizer, Nagar, Hunza)				

The monthly trend of reported GBV cases (Oct 2024–Sept 2025) presented in Figure 3 shows fluctuations, with a clear peak in December 2024 (7 cases) and another high in January 2025 (6 cases), largely driven by Gilgit and Hunza. Gilgit reported cases consistently throughout the year (23 total), while Hunza (9) and Ghizer (12) showed more sporadic reporting. In contrast, Nagar reported no cases, indicating possible underreporting. Overall, the data highlights seasonal spikes in late 2024 and early 2025, followed by lower, scattered reporting in subsequent months.

Figure 3: District wise monthly trend of GBV cases (Oct 2024-Sep 2025)



6.2. GBV Cases Supported by LAPH in Chitral (2020–2025)

Because official police data on GBV cases in Chitral was not available, this section draws on records maintained by the Legal Aid and Human Rights Programme (LAPH) (Table 57). These cases represent survivors who sought legal assistance through LAPH to file and pursue court cases.

- From Jan 2020–Dec 2022 (baseline period), a total of **185 cases** were filed, with a decision rate of **64%**.
- From Jan 2023–Aug 2025 (endline period), the number increased to **203 cases**, but the decision rate declined slightly to **62%**.
- In **Lower Chitral**, cases remained steady (151 → 144), with stable decision rates (66% → 68%).
- In **Upper Chitral**, cases rose significantly (34 → 59), but decision rates fell (56% → 49%), with a backlog of pending cases nearly doubling.

This suggests that while more survivors are using legal channels with LAPH's support, the capacity of courts to resolve cases in a timely manner remains a major challenge.

Table 57:Number of GBV Survivors Accessing Courts with LAPH Support in Chitral (Baseline: Jan 2020–Dec 2022; Endline: Jan 2023–Aug 2025)

District	Period	Cases Filed	Cases Decided	In Progress	Decision Rate
Lower Chitral	Baseline	151	100	51	66%
	Endline	144	98	46	68%
Upper Chitral	Baseline	34	19	15	56%
	Endline	59	29	30	49%
Total	Baseline	185	119	66	64%
	Endline	203	127	76	62%
Source: LAPH					

6.3. Women Harassment Complaints – FIA Cyber Wing Gilgit (2023–July 2025)

From 2023 to July 2025, the FIA Cyber Wing Gilgit registered 145 harassment complaints under PECA 2016. Of these, 33 became enquiries, 10 FIRs were filed, 11 arrests made, and 10 challans submitted to courts.

Table 58: Number of online GBV cases reported in FIA Cyber Wing Gilgit 2023-2025

Year	Complaints	Enquiries	FIRs	Arrested	Challaned
2023	75	15	4	2	4
2024	15	8	5	8	5
2025	55	10	1	1	1
Total	**145**	**33**	**10**	**11**	**10**
Source: FIA Cyber Wing Gilgit					

6.4. HRCP Gilgit Media Monitoring Cell – Reported Cases (2024–2025)

The media monitoring by Human Rights Commission of Pakistan (HRCP) Gilgit office shows that both men and women are affected by gender-based violence, but women remain the primary victims in most categories. In 2024, a total of 15 serious GBV-related cases were reported, with women experiencing incidents such as honor killings, kidnappings, child marriage, and rape, while men were more represented in suicides. By 2025, the overall number of reported cases dropped to 6, but cases of honor killings, harassment, and gang rape highlight continuing risks for women.

As shown in Table 59, the year-on-year comparison suggests fluctuations rather than a consistent decline, reflecting both the sporadic nature of media reporting and possible underreporting of cases. Importantly, the data highlights the persistence of harmful practices like honor killings and sexual violence against women, alongside issues such as male suicides linked to social pressures. These findings underline that GBV remains a systemic problem in the region, with women disproportionately exposed to severe forms of violence.

Table 59: Gender wise types of GBV cases reported in local and national media in 2024 and 2025

Category	2024			2,025		
	Male	Female	Total	Male	Female	Total
Death penalty	1	-	1	-	-	-
Honor killing	-	2	2	1	2	3
Harassment	-	-	-	-	1	1
Women kidnappings	-	1	1	-	-	-
Suicide	6	1	7	-	1	1
Child marriage	-	1	1	-	-	-
Gang rape	-	-	-	1	-	1
Rape	1	2	3	-	-	-
Grand Tota	**8**	**7**	**15**	**2**	**4**	**6**
HRCP Office Gilgit						

6.5. Selected Media-Reported Cases of Gender-Based Violence in Gilgit-Baltistan and Chitral (2023–2025)

In Table 60 we compiled selected cases of gender-based violence (GBV) reported in local, regional, and national media outlets between 2023 and 2025. These reports, while not exhaustive, provide valuable insights into the types of violence occurring in the region—ranging from honor killings, abductions, and forced marriages to harassment, sexual violence, and domestic abuse. The entries also capture broader societal responses, such as community protests, legal proceedings, and civil society advocacy, alongside institutional measures like the establishment of anti-harassment squads.

Table 60: Summary of selected GBV cases of Gilgit-Baltistan and Chitral reported in local and national media from 2023 and 2025

Date	Brief Description of Case (Location)	Source / Title/Link
Jan 31, 2023	Murder of Chitrali woman Yasmin Bibi by neighbor with an axe in Rabat, Lower Dir; protests demanded justice.	*Chitral Public Meeting Slams Brutal Killing of Woman In Lower Dir* – The Friday Times
Mar 25, 2024	Forced marriage/abduction of 13-year-old Falak Noor in Sultanabad, Gilgit; protests & court intervention.	*Protesters demand safe return of 13-year-old girl* – Voicepk / Pamir Times
Apr 2, 2024	Women's rights groups denounce GB govt stance in Falak Noor case; highlight failures in child protection.	*Falak Noor case: women's rights bodies rubbish G-B govt stance* – The High Asia
Apr 10, 2024	Analysis of inconsistencies in Falak Noor case; calls for accountability and minors' rights protection.	*Falak Noor case: a clarion call for justice and protection* – The High Asia
Jun 28, 2024	Harassment of women during Kalash Chilam Joshi festival in Chitral valleys; cultural/safety concerns raised.	*The Chitral Fairytale* – Chitral Today
Jul 2024	Rape of 13-year-old disabled girl in Yasin, Ghizer; pregnancy complications led to her death. DNA later confirmed perpetrator.	*Disabled girl's rape, death: DNA evidence leads to suspect's arrest, confession* – The News
Nov 21–22, 2024	Gilgit Police launched Anti-Harassment Squad near schools & public spaces; helpline created for complaints.	*In a significant move to tackle harassment in public spaces…* – IBEX Media
Dec 4, 2024	Women with disabilities in GB face heightened GBV risks and barriers to access support services.	*Breaking barriers: the unseen struggles of women with disabilities* – The High Asia
Mar 29, 2024	Murder of college student Inara (18) from Yasin, body found near Danyor College; protests demanded security for women.	*Suspiciously missing girl found dead in POGB; locals demand more security* – News Intervention
Apr 19, 2025	Honor killing of 17-year-old girl in Sultanabad, Gilgit; part of 18 cases reported in GB in 2024, activists demand reform.	*Pamir Times – Honor Killing Reports*
Jun 2–3, 2025	Murder of 17-year-old TikToker Sana Yousaf in Islamabad after rejecting proposals; suspect arrested, trial ongoing.	*Father of teen TikTok influencer calls for justice…* – AP / Al Jazeera
Jul 28, 2025	Domestic abuse survivor from Ayun, Chitral reunited with children after activists and police intervened.	*Chitral woman reunited with kids after escaping abusive marriage* – Chitral Today
Aug 14, 2025	Teacher in Laspur (Upper Chitral) booked for harassing 15-year-old students; elders demand strict action.	*Teacher Booked for Harassing Student in Laspur* – Chitral Today

Date	Brief Description of Case (Location)	Source / Title/Link
Aug 29, 2025	Shehla case: 22-year-old student from Upper Chitral found dead after harassment and blackmail; court denied accused's bail.	*Chitral girl's mysterious death sparks protest* – Express Tribune / Chitral Today
Aug 31, 2025	GB floods heightened GBV risks in displacement; media urged protection of vulnerable women and girls.	*G-B floods: put vulnerable segments at centre of response* – The High Asia
Sept 16, 2025	A first-year student, allegedly abducted by his friends, subjected to a brutal rape attempt. In a desperate attempt to save his dignity, he either jumped into the river to escape or was killed and thrown into it.	A Community Shaken by Tragedy -PAMIR TIMES
Dec 12, 2020	Arts and cultural events in GB highlighted violence against women in homes, workplaces, and campuses.	*Artworks highlight violence against women* – The High Asia
Oct 14, 2018	Opinion linking honor culture and patriarchal control to GBV in GB; calls for reform.	*Psychopathology and societal malaise of Gilgit-Baltistan* – The High Asia
Sources: Local and national media sites, compiled by the DEVYIELD Team		

6.6. Child Abuse Cases – District Child Protection Unit (DCPU) Gilgit (2021–Sept 2025)

Between 2021 and September 2025, the District Child Protection Unit (DCPU) Gilgit documented over 33 distinct child abuse cases involving at least 43 child victims (26 boys and 17 girls) – Table 61. These cases span a range of serious violations of children's rights, including sexual abuse, child marriage, trafficking, corporal punishment, physical violence, negligence, abduction, and suicide. In some cases, multiple children were involved (e.g., missing siblings, negligence affecting more than one child), which explains why the number of victims is higher than the number of reported cases.

Nature of Reported Cases

- Sexual abuse and exploitation formed the largest category, with cases documented across Gilgit, Ghizer, Skardu, and Diamer, affecting both boys and girls. FIRs were registered in some cases, leading to arrests and medico-legal support, but many were left at the referral stage.
- Child marriage and trafficking cases included a 15-year-old girl allegedly trafficked from Juglote to AJK and a 10-year-old boy married in Diamer under local customs.
- Missing children and abductions were repeatedly reported from Hunza and Gilgit, with some children recovered but others never traced despite extensive searches.
- Corporal punishment and physical abuse cases included children beaten by teachers in Hunza and Skardu, as well as children harmed by parents and community members.
- Child negligence cases involved children left unattended, missing siblings, or lack of parental care, including instances later resolved by recovery.
- Adolescent suicides were reported from Ghizer, where girls aged 13 and 15 took their lives due to academic failure pressures.

District-Specific Highlights

- Gilgit: Recorded the highest concentration of sexual abuse and missing child cases, including high-profile cases of kidnapping and exploitation.

- Ghizer: Reported serious sexual abuse cases (including a case where both victim and newborn died) and the two adolescent suicides linked to exam stress.
- Skardu: Notable cases for child negligence and physical abuse, as well as missing children and sexual exploitation incidents in Shigar.
- Hunza: Reported cases of corporal punishment in private schools and unresolved missing children cases, including a mentally challenged boy who was never found.
- Diamer: Unique for child marriage cases involving boys, reflecting persistence of traditional practices despite legal prohibitions.

Status of Cases

- About 70% of cases have been closed, either due to recovery of children, settlements between families, or provision of psychosocial/legal support.
- The remaining 30% were referred to relevant authorities, with limited follow-up in many instances and frequent reluctance of families to pursue legal action.
- Some cases demonstrated accountability (FIRs, arrests, medico-legal support), but overall enforcement was inconsistent.

Trends Over Time

- **2025 (Jan–Sept):** 10+ cases including sexual abuse, missing children, corporal punishment, and child marriage. Most remain under process.
- **2024:** 7 cases spanning sexual abuse, negligence, and corporal punishment. Arrests were made in some cases, but referrals were the norm.
- **2023:** 8 cases of child marriage, exploitation, and physical harm. Largely referred onward with weak follow-up.
- **2022:** 4 cases of sexual and physical abuse, most closed after legal or family responses.
- **2021:** 4 cases including sexual abuse, suicide, and molestation attempts. Closed after local/community intervention.

Table 61:Summary of Child Abuse Cases and Victims in Gilgit-Baltistan (2021–Sept 2025)

Period	Nature of Cases (examples)	Total Cases	Child Victims (Boys)	Child Victims (Girls)	Status Overview
2025 (Jan–Sept)	Child marriage (1), sexual abuse (3), missing children (4), corporal punishment (1), forced abuse (1)	10+	8	5	Most referred to Police/Departments; some closed, others pending
2024	Sexual abuse (2), corporal punishment (2), negligence (2), kidnapping (1)	7	7	3	Mixed responses: a few arrests and psychosocial support; others sent to depts

Period	Nature of Cases (examples)	Total Cases	Child Victims (Boys)	Child Victims (Girls)	Status Overview
2023	Child marriage (1), exploitation (2), physical harm (2), negligence (3)	8	6	4	Mostly referred to departments; limited follow-up documented
2022	Sexual abuse (2), physical abuse (2)	4	3	2	Cases closed with some legal action and family support
2021	Sexual abuse (1), suicide (2), molestation attempt (1)	4	2	3	Closed after local/community response; awareness sessions held in Ghizer cases
Total (2021–25)	Various forms of child abuse including sexual exploitation, child marriage, neglect, and suicides	33+	26	17	~70% cases closed, rest referred/under process; weak enforcement & follow-up
Source: District Child Protection Unit, Gilgit, summarized by DEVYIELD Team					

The DCPU Gilgit's case documentation reflects both the scale and diversity of child protection violations in Gilgit-Baltistan. However, the system relies heavily on referrals and local settlements, with weak enforcement, fragmented follow-up, and limited accountability. District-level patterns highlight sexual abuse in Gilgit, suicides in Ghizer, negligence in Skardu, corporal punishment in Hunza, and child marriages in Diamer, underscoring the urgent need for a stronger, district-tailored child protection response.

The data presented above shows that while more GBV cases are now being reported to police and other institutions, significant barriers to seeking justice and support remain. To understand how survivors actually access help in practice, and where gaps continue, we also engaged with a civil society organization currently providing frontline GBV response services in Gilgit-Baltistan.

The Family Planning Association of Pakistan (FPAP), which implements the Rehnuma Youth Program focusing on sexual and reproductive health (SRH), psychosocial counselling, and GBV prevention, particularly among youth. According to FPAP, approximately 70 percent of its services are delivered through its health facilities, while the remaining 30 percent involve community outreach and counselling support through trained counsellors and para-psychosocial workers.

FPAP works extensively with schools. Each year, the organization partners with around 10 schools, training two teachers per school in life skills and SRHR education. Approximately 60 students per school receive awareness sessions, and 20 youth peer educators are trained annually to continue outreach within their communities.

However, FPAP notes that child sexual abuse, including cases of pedophilia, is more common than official reporting suggests. Families often avoid reporting due to fear of stigma, reputational harm, pressure from relatives, and limited confidence in follow-up systems. FPAP receives more than 200 SRH and GBV-related cases each year, but only a small fraction become public due to sensitivity and privacy concerns.

Despite these efforts, several persistent challenges limit the effectiveness of GBV prevention and response. Many community members still lack awareness of what constitutes GBV, particularly in cases of emotional or sexual abuse. Reporting pathways are limited and are often not confidential or survivor-friendly. Fear of stigma and victim-blaming discourages families from seeking support. In some areas, opposition from religious and community leaders leads to misunderstandings about SRH education. Institutional response systems, including legal processes and survivor support services, remain slow, inconsistent, and difficult to navigate.

To improve outcomes, FPAP representative emphasized the need for stronger and continuous awareness programs in schools and communities; confidential and safe reporting mechanisms for survivors; and deliberate engagement with religious and community leaders to reduce resistance. Better coordination among civil society groups, health facilities, police, and legal actors is needed to ensure timely referrals and follow-up. Importantly, stakeholders stressed that awareness alone is insufficient. Sustainable improvement requires investment in survivor-centered psychosocial, legal, and protection services so that individuals who come forward can actually receive meaningful help.

6.7. Conclusion

Overall, the findings show that while formal mechanisms such as police reporting, the FIA cyber wing, and child protection units are increasingly being used, many GBV and child abuse cases continue to be identified through civil society support networks, media reports, and community-level actors. District-level variations in reporting, the persistence of honor-based violence, and the heightened vulnerability of women, girls, and children underscore the systemic nature of the issue.

The evidence also highlights that *awareness has increased faster than access to support services*. Survivors often face significant barriers in reporting GBV, including stigma, family pressure, weak confidentiality protections, slow legal processes, and limited psychosocial services. Civil society organizations such as FPAP and LAPH are filling critical gaps—particularly in counselling, court support, and youth education—but their reach remains uneven across districts.

These reported cases likely represent only a small share of the actual prevalence of GBV and child abuse in Gilgit-Baltistan and Chitral. Strengthening district-level protection systems, expanding confidential and survivor-friendly reporting pathways, improving coordination across government and civil society, and investing in sustained psychosocial, legal, and protection services are essential to ensure that increased awareness translates into meaningful access to justice and safety for survivors

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7. SYNTHESIS OF KEY FINDINGS

1. Prevalence and Forms of Gender Base Violence in the Project Districts

Across all program districts, the study respondents consistently described gender-based violence (GBV) as a persistent and multifaceted reality. Women's lives continue to be shaped by domestic violence, denial of inheritance, restrictions on mobility, early and forced marriages, and, increasingly, digital harassment. Yet what is defined and recognized as "violence" differs significantly depending on perspective. At the household level, 41% of women at baseline and 37% at endline survey reported experiencing at least one form of GBV, showing that while awareness increased, overall prevalence remained high.

Civil society organizations, activists, and lawyers were unequivocal in framing practices such as inheritance denial and mobility restrictions as clear violations of women's rights. An activist from Hunza asserted: ***"Custom cannot override women's rights—when daughters are denied land, it is violence in another form, but families pretend it is just tradition."*** Lawyers echoed this, emphasizing that even when women win inheritance cases in court, families often resist enforcement by invoking custom. A CSO participant reinforced this point: ***"There is silence where injustice is mislabeled as tradition,"*** stressing that such practices perpetuate gender inequality while being socially accepted as protection or custom. These respondents agreed that laws exist but are often undermined by cultural justifications and weak enforcement. This corresponds with survey findings, where more than 90% of respondents at endline reported awareness of GBV but only 57% believed that improved access to legal services could reduce GBV—indicating limited confidence in redressal systems.

Focus group participants reinforced these insights by describing how GBV permeates daily life. Women's groups in Khomer and Danyore explained that verbal abuse, emotional neglect, economic control, and heavy domestic workloads are normalized within families and rarely recognized as violence. One woman in Danyore shared the devastating personal impact: ***"I tried to commit suicide many times because I have no say in decisions. Everything in my life happens by my husband's order."*** For her and others, violence was not only physical but structural embedded in the denial of autonomy and decision-making power.

Men in Kosht and Lower Chitral acknowledged that overt physical violence has declined compared to the past, a trend also reflected in household survey data showing that agreement with the statement 'violence is never acceptable' increased from 68% to 81% between baseline and endline. However, they continued to justify verbal humiliation and economic restrictions as acceptable forms of discipline. As one man explained: ***"Beating may have reduced but controlling women financially or socially is still common."*** This illustrates how many men differentiate between "real" violence, which they see as physical harm, and practices they view as legitimate cultural authority.

Early and forced marriages also emerged as a widespread concern, particularly in poorer or remote valleys. In the endline survey, 27% of respondents identified early or forced marriage as the most common form of GBV in their community, compared to 18% at baseline. Families often rationalize these practices as forms of protection or economic necessity. Women in Nagar explained how early marriage curtailed their education and reinforced dependence on husbands and in-laws. These testimonies show how GBV extends beyond physical acts to include normalized practices that limit women's life choices and reinforce structural inequalities.

At the same time, not all community leaders defended such practices. While a village elder in Chitral argued that ***"Property stays within the family to protect it; this is tradition, not violence,"*** a senior

leader in Hunza offered a more progressive view, acknowledging that while customs exist, women should still receive their rights in practice. This divergence highlights how structural forms of GBV remain contested, with rights-based and custom-based perspectives in tension.

Digital harassment was identified as one of the most rapidly growing forms of GBV. Media professionals described increasing cases of online blackmail targeting adolescent girls, often resulting in families restricting the girl's mobility instead of holding perpetrators accountable. A women police officer in Gilgit explained: ***"We now receive cases of blackmail through mobile phones, especially targeting adolescent girls."*** FIA Cyber Wing data (2023–2025) recorded 145 online harassment complaints, 33 inquiries, and 10 FIRs filed in Gilgit-Baltistan alone. Education officials noted that digital harassment contributes to school dropouts and reduces access to health services, as families become more protective and restrictive.

Adolescents, particularly girls, added urgency to this issue by recounting direct experiences of digital abuse. In Chitral, teenage girls described receiving unwanted messages and being further restricted once their families found out. In Hundur, Yasin, adolescents reported even more alarming trends: ***"Fake accounts are created… AI-generated videos are spread… women and girls face online harassment which is increasing rapidly."*** For these young participants, mobile phones and the internet represent both opportunities for connection and sites of new vulnerability.

Taken together, these findings show that GBV persists not only because of entrenched practices but also because many forms are not recognized as violence at all. By reframing inheritance denial, mobility restrictions, or forced marriages as "protection" or "tradition," communities justify practices that curtail women's autonomy, restrict their mobility, and undermine their rights.

2. The challenge of no or under reporting of GBV cases

Key informant interviews and focus group discussions consistently showed that gender-based violence (GBV) remains significantly under-reported across all program districts. Participants from civil society, the police, Women Development Department (WDD), lawyers, the media, and community groups explained that while awareness of rights has improved, most cases never reach formal institutions. Official police data indicate that only 44 formal GBV complaints were filed across Gilgit, Ghizer and Hunza during the last one year with no GBV reported in Nagar districts given widespread prevalence.

Family and honor dynamics were described as the strongest barrier. Respondents explained that families discourage women from disclosing violence to protect family honor and avoid social stigma. A CSO participant summarized this as a ***"double wall—the violence itself, and then the silencing at home."*** This pattern was echoed across FGDs, where women and adolescents described silence as the socially expected response. Reporting was widely framed as "bringing shame," which shifts blame onto survivors rather than perpetrators. At endline, 64% of respondents stated that GBV cases in their communities are handled by families or jirgas, compared to just 19% who identified police or courts as the main channel—showing the continuing dominance of informal mechanisms.

Stigma and backlash were repeatedly highlighted as deterrents. Media professionals explained that when cases are reported, community narratives often accuse women of dishonoring the family instead of questioning male behavior. Adolescent boys also noted that families often respond to harassment—particularly digital harassment—by restricting girls' mobility rather than pursuing justice against perpetrators. As one boy in Yasin put it, ***"Families respond by restricting the girl, not punishing the perpetrator."***

Institutional mistrust compounded these social pressures. Lawyers described courts as intimidating and slow, with survivors frequently giving up before cases are concluded. As one informant noted, proceedings involve ***"a prolonged, public, and financially draining ordeal,"*** which discourages women from seeking legal remedies. Police officers admitted that they are usually approached only when cases spiral beyond the control of families or community elders, reflecting how informal mechanisms dominate initial resolution. In Chitral, for instance, only 62% of GBV cases filed at endline were redressed—down from 64% at baseline—highlighting limited institutional response capacity.

Lack of functional services was also identified as a critical barrier. A CSO respondent in Gilgit stated that referral pathways in Gilgit-Baltistan remain inactive and that ***"no shelter house is functional in the region—one has been under construction for years."*** Women in FGDs across Chitral and Gilgit reinforced this point, explaining that government offices and services often appear only after an incident and rarely provide safe, confidential support. Hospitals were described as lacking private consultation rooms or psychosocial counselors, which deters survivors from seeking medical care.

Economic dependence and mobility restrictions further limited options. Women in Nagar and Chitral explained that reliance on husbands or in-laws made it nearly impossible to pursue justice without risking survival. Adolescents, especially girls, highlighted how harassment often led to school dropouts because families prioritized social reputation over girls' education. The survey data show that 23% of women cited lack of spousal support and 19% cited fear of stigma as barriers to seeking help—both up from baseline.

Taken together, these findings illustrate why underreporting persists. Survivors weigh the cost-stigma, retaliation, institutional hostility, and lack of safe alternatives—against uncertain benefits. In this context, silence becomes a rational survival strategy. Even as awareness grows, the pathways to justice remain blocked by entrenched social norms and weak institutional responses

3. Pathways and Resolution

The majority of GBV cases are resolved informally through family, elderly, or religious leaders. Respondents across groups acknowledged this dominance of informal pathways, though their evaluations differed. At endline survey, 64% of respondents stated that GBV cases in their communities are handled by families or jirgas, compared to just 19% who identified police or courts as the main channel—showing the continuing dominance of informal mechanisms.

Traditional leaders defended these forums as accessible and efficient, contrasting them with formal courts that are slow and costly. Elected representatives admitted being pressured to support jirgas even when they disagreed, as refusal was perceived as ***"betraying tradition"*** .

By contrast, CSOs and women's activists criticized informal systems as biased and unsafe for survivors. ***"Jirgas prioritize reputation over safety,"*** one CSO representative argued, noting that women are often returned to unsafe homes for the sake of honor . Lawyers similarly warned that informal resolutions sometimes override state law, forcing compromises even in serious cases . In endline survey findings show that only 35% of community members believed reporting to authorities was the right response to GBV—an increase from 23% at baseline—but still far below desired levels.

Police expressed frustration at being involved only when informal forums fail: ***"People come to us only when the case is beyond control. Then they still blame us for not acting."***

The **focus group discussions** provided further nuance by showing how community members themselves navigate these pathways.

- **Adult men** often endorsed informal resolution, praising its speed and ability to protect family honor. In Lower Chitral, men emphasized that ***"elders solve cases in days, while courts take years,"*** revealing widespread mistrust of formal systems. For many, informal pathways were not only practical but also essential for preserving social cohesion.
- **Adult women** were more critical. Women in Chitral explained that ***"nearly all cases are resolved by family elders or jirgas… formal reporting is almost unheard of."*** They noted that decisions generally emphasize reconciliation and the return of women to marital homes, even in unsafe situations. Women also highlighted their lack of agency, as outcomes were typically imposed by male relatives or leaders. For many, this reliance on informal resolution perpetuates cycles of abuse and denies survivors their rights.
- **Adolescents** focused on secrecy and silence. Girls observed that families prefer to ***"solve problems quietly"*** to avoid public shame, often at the expense of safety. Boys similarly acknowledged that this culture of secrecy meant perpetrators were rarely punished, while restrictions and blame fell disproportionately on girls.

While a growing share of respondents believe GBV should be reported to authorities rather than handled privately (attitudinal change), the majority of cases continue to be resolved through family or jirga mechanisms in practice. This indicates a gap between awareness and action—communities increasingly recognize formal justice as ideal, yet rely on informal forums due to accessibility, trust, and social pressure.

Taken together, these insights underscore that informal mechanisms dominate GBV resolution because they are fast, socially legitimate, and culturally embedded. However, their reliance on honor and compromise undermines survivors' safety, reinforces gender inequality, and sustains cycles of violence. Only 11% of respondents at endline survey said "it's a family matter" when asked how GBV should be handled—down from 23% at baseline—indicating a slow shift away from purely private resolution. While men tended to defend them as effective and legitimate, women and adolescents described them as disempowering, unsafe, and a major barrier to justice.

4. **Institutional Capacity to Response and Redress GBV cases**

Across Gilgit-Baltistan and Chitral, respondents agreed that institutional mechanisms to address gender-based violence (GBV) exist on paper but remain weak, inconsistent, and often inaccessible in practice. While shelters, referral systems, police stations, courts, and hospitals are formally mandated to support survivors, both key informants and community participants stressed that these services are fragmented, under-resourced, and rarely provide meaningful protection. At endline survey, only 7% of respondents reported being "completely satisfied" with how GBV cases were handled—down from 15% at baseline—showing limited confidence in institutional mechanisms.

Shelters and referral systems were described as uneven across districts. In Lower Chitral, participants referred to the Darul Aman shelter, which has supported women over the years, though uptake remains low due to stigma, fear of retaliation, and mistrust of formal systems. In Gilgit-Baltistan, by contrast, respondents reported that referral pathways developed under earlier initiatives remain largely inactive. A Women Development Department (WDD) official acknowledged this gap, explaining: ***"The referral system exists on paper, but there is no follow-up, no dedicated staff, no tracking."*** Survey data also showed that only 12% of women and 28% of men recognized the existence

of any functional support services in their district—down sharply from 36% and 33% respectively at baseline.

Police services were seen as an area where some progress has been made. Trainings supported by civil society organizations (CSOs), including under AGECS and KADO, were credited with improving officer sensitivity. Yet major gaps persist. Survivors continue to hesitate due to the shortage of female officers and lack of confidential spaces for reporting. One police officer noted: ***"Our behavior has improved after trainings, but without female officers and safe spaces, women still hesitate to approach us."*** The establishment of a women's police station in Gilgit was welcomed, but its reach was seen as limited to urban centers. In FGDs, women described police stations as intimidating, and some recalled experiences of humiliation when attempting to file complaints. As one woman in Khomer summarized, ***"Government offices do not support women."***

Judicial processes were described by lawyers, CSOs, and community participants as slow, costly, and intimidating. Cases often take years, involve hostile cross-examinations, and rarely result in enforceable outcomes. One gender specialist gave the example of an inheritance case in which a woman won a favorable ruling, only for enforcement to be blocked by family resistance and weak administrative follow-through. These experiences reinforced the perception of courts as inaccessible and unresponsive to women's needs.

Health services also lack critical survivor-centered functions. Key informants noted that hospitals in Gilgit-Baltistan do not have psychosocial counselors or private consultation rooms, a gap that discourages survivors from seeking care. As one health official explained, ***"Hospitals have no counsellors or private rooms—survivors come once and never return."*** FGDs echoed this sentiment, with women describing health facilities as unsafe for confidential disclosure and fearing exposure to community judgment.

Awareness and outreach gaps further reduce the accessibility of services. Media representatives noted that communities are often unaware of available mechanisms, and when services are visible, mistrust undermines their use. A journalist from Hunza commented: ***"There is no proper mechanism to address gender-based violence. Organizations usually appear only after an incident occurs."*** This aligns with survey findings showing that only 20% of respondents could name any specific government or NGO-run GBV service at endline, compared to 38% at baseline.

By contrast, **civil society organizations (CSOs)** such as AKRSP, KADO, and LAPH were widely recognized across FGDs for their more effective role in raising awareness and creating safe spaces for dialogue. Women in Hunza described CSO sessions as the first time they openly discussed harassment and rights, while adolescents explained that school-based sessions gave them the language to talk about GBV. However, participants in Kosht and remote Chitral valleys highlighted that CSO reach is uneven, leaving many communities excluded. Trust in CSOs was also context dependent. In conservative areas such as Nagar and Yasin, some participants accused CSOs of promoting **"Western"** values, which reduced acceptance. Trust improved when CSOs worked with religious leaders and framed messages in faith-based language.

Taken together, these perspectives highlight a stark contrast between **state institutions** and **CSOs**. While CSOs create entry points for dialogue, awareness, and, in some areas, community-level support, the absence of functioning government services leaves survivors without viable pathways to justice or protection. Institutions are widely perceived as symbolic rather than functional survivors avoid them not out of ignorance, but because they expect them to be ineffective, intimidating, or unsafe. This

institutional gap reinforces the dominance of informal resolution mechanisms and undermines confidence in the formal system's ability to deliver justice or protection

5. **Change overtime**

Despite persistent challenges, both key informants and community members noted that some positive changes have taken place in recent years, though these shifts remain fragile, uneven, and often contested.

Awareness of rights was the most frequently cited change. Civil society actors and gender specialists emphasized that women increasingly recognize their entitlements, especially around inheritance and mobility, even though denial persists in practice. As one activist explained, ***"Women now know inheritance is a right, even if families still deny it."*** For many, this awareness represents an important first step, though participants stressed that translating knowledge into action remains difficult due to family pressure and weak enforcement. Survey data support this perception: awareness of laws and policies on gender equality improved from 59% at baseline to 85% at endline. Awareness of the term "GBV" itself increased dramatically—from 39% to 94%—indicating a major expansion in basic gender rights literacy.

Police sensitivity was another area where gradual progress was reported. Officers who had received training through AGECS and partner initiatives acknowledged that their handling of cases had improved, but they also highlighted the need for ongoing refresher sessions. A police officer in Gilgit admitted, ***"Our behavior has improved after trainings, but refresher sessions are needed."*** Community participants in FGDs confirmed that police attitudes had become "slightly more sensitive," but overall trust in police effectiveness remained low. Still, only 7% of community members said they were "completely satisfied" with how GBV cases were handled at endline—down from 15% at baseline —showing that progress in sensitivity has not yet translated into trust.

Media visibility of GBV was also identified as a change. Journalists observed that coverage of women's rights and violence has become more frequent, raising the profile of these issues in public discourse. However, they cautioned that this visibility has also provoked resistance from conservative voices. As one media respondent explained, ***"People now talk about GBV, but we also see resistance from conservative groups."*** This aligns with the finding that 78% of community members now express gender-equitable attitudes—up from 72.7% at baseline (Table 32)—yet support for women's participation in decision-making roles declined (94%→87%, Table 35), showing both progress and pushback**.**

Women's leadership provided a visible marker of transformation in some districts. Both WDD representatives and CSO respondents pointed to examples of women leading Local Support Organizations (LSOs) in Passu and Altit as milestones in women's participation in public decision-making. In FGDs, women leaders themselves highlighted these roles as evidence that change, while slow, is possible. Endline survey data also show that 85% of women reported participating—alone or jointly—in decisions related to family planning, child health, and SRH, up from 55% at baseline (Table 14), suggesting growing agency in household-level decision-making.

Generational differences were consistently noted across both KIIs and FGDs. Younger men were described as more supportive of women's participation in education, leadership, and community life, while older men often resisted these changes. Elected representatives and CSO leaders interpreted this divide as creating opportunities for gradual but meaningful shifts in social norms. In FGDs, adolescents frequently expressed that "younger men are more open-minded," reflecting the survey finding that equitable attitudes among youth (18–35 years) increased from 60% to 86%.

At the same time, **new risks have emerged**, particularly around digital spaces. Police, media respondents, and adolescents highlighted the rise of online harassment and blackmail, especially targeting adolescent girls. Families often responded by further restricting girls' mobility rather than holding perpetrators accountable, which undermined fragile gains in education and mobility. As one adolescent girl in Yasin explained, ***"Now we fear phones more than streets."*** Data from the FIA Cyber Wing Gilgit confirm 145 complaints of online harassment between 2023–2025, showing how GBV dynamics are shifting into digital spaces.

Regional differences also stood out. In urban centers such as Drosh, Chitral town, and Gilgit, participants reported a decline in extreme physical violence and greater acceptance of girls' education. By contrast, women in more remote valleys emphasized that little had changed: early marriages, mobility restrictions, and economic dependency remained entrenched.

Overall, participants agreed that change has begun, but it is fragile, uneven, and concentrated in urban and semi-urban areas with active CSO engagement and media presence. Gains in awareness, women's leadership, and modest improvements in institutional sensitivity are significant but remain vulnerable to backlash and to emerging risks such as digital harassment.

8. CONCLUSIONS

Quantitative surveys, institutional assessment and qualitative insights from key informant interviews and focus group discussions provide a sobering yet nuanced picture of gender-based violence (GBV) across Gilgit-Baltistan and Chitral. GBV is not only a matter of harmful social norms but is deeply rooted in material conditions, unequal property relations, and structural dependencies that reproduce women's subordination.

The findings confirm that GBV is pervasive, multifaceted, and sustained by the intersection of economic dependency, patriarchal control, and weak institutional accountability. Violence extends beyond physical harm to include denial of inheritance, restrictions on mobility, early and forced marriages, economic dependency, and digital harassment. These practices are frequently legitimized as "tradition" or "protection," functioning as ideological tools that obscure their role in maintaining unequal control over property, labor, and women's bodies. In this sense, the normalization of control reflects not only cultural practices but also the reproduction of patriarchal and class-based power relations.

Under-reporting of GBV remains widespread, reflecting both cultural and structural barriers. Survivors confront what participants described as a "double wall"—first the violence itself and then silencing within households and communities to protect family honor. At the institutional level, courts, police, and health systems are not simply weak but actively reproduce existing hierarchies: courts are hostile and inaccessible, police remain intimidating despite some reforms, and health facilities lack survivor-centered services. The absence of functional shelters or confidential spaces in many districts forces survivors into silence. In this context, non-reporting is not ignorance but a rational survival strategy in the face of systems designed to preserve order rather than challenge inequality.

Informal systems—families, elders, jirgas, and religious leaders—remain the dominant pathways for resolving GBV. These forums serve to protect property, preserve male authority, and maintain family honor rather than provide justice. While men defend these mechanisms as efficient and legitimate, women and adolescents emphasized that such pathways return survivors to unsafe conditions, prioritize reconciliation over rights, and reinforce secrecy. In doing so, they sustain rather than disrupt cycles of exploitation and violence.

The institutional response is largely symbolic. State mechanisms—referral pathways, police desks, and courts—exist more as instruments of legitimacy than as functional systems of protection. They preserve the appearance of reform while leaving survivors disempowered. By contrast, civil society organizations (CSOs) were recognized for raising awareness and creating safe spaces, though their reach is uneven and contested in conservative settings. Their impact illustrates that change is possible but limited without systemic transformation of state institutions and redistribution of resources.

Signs of progress, however fragile, reveal contradictions within this system. Women's increasing awareness of rights, modest improvements in police sensitivity, and greater media visibility of GBV highlight shifts in consciousness and discourse. Women's leadership in Local Support Organizations demonstrates cracks in traditional structures of authority, and generational differences suggest that younger men may be more open to gender equality than older cohorts. Yet these gains remain precarious.

New forms of violence illustrate how patriarchal control adapts to changing material conditions. The visibility of women in workplaces and adolescent girls in schools challenges traditional hierarchies but also provokes backlash through digital harassment, online blackmail, and reputational attacks. Families often respond by further restricting women's and girls' mobility, reinforcing dependency and undermining fragile progress. As one adolescent girl in Yasin noted, "Now we fear phones more than streets."

Regional inequalities further expose structural divides. In urban centers such as Chitral town, and Gilgit city, participants reported declines in extreme physical violence and increased acceptance of girls' education. In contrast, women in remote valleys emphasized that early marriages, mobility restrictions, and economic dependency remain deeply entrenched, reflecting uneven access to education, markets, and civil society presence.

In conclusion, GBV in Gilgit-Baltistan and Chitral must be understood as both a cultural and a structural problem. It is rooted in property relations, economic dependency, and institutional complicity that reproduce patriarchal authority. While awareness and modest openings for change are emerging, these remain fragile as long as material inequalities persist and state institutions function symbolically rather than substantively. Sustainable progress requires altering the material base: securing women's economic independence, enforcing inheritance and marriage laws, strengthening state accountability, and embedding survivor-centered services within institutions. Without such structural transformation, informal systems will continue to dominate, backlash will intensify, and cycles of silence and violence will persist.

9. RECOMMENDATIONS

The endline study confirms that the AGECS project contributed meaningfully to raising awareness about gender-based violence (GBV) and strengthening civil society organizations (CSOs) across Gilgit-Baltistan and Chitral. Women's participation in family and community life increased, and open conversations on gender issues became more common.

Yet the study also shows that while awareness has expanded, systemic and institutional barriers remain deeply entrenched. Many survivors continue to face stigma, limited access to justice, and uneven institutional support. Norms that tolerate control and silence persist, often justified as tradition. These realities suggest that progress against GBV must extend beyond awareness and

training—toward coordinated efforts that address the structural, institutional, and social foundations of inequality.

The following recommendations are proposed as directions for collective learning and adaptation. They are not prescriptive but aim to inspire thoughtful, context-sensitive action in future programming.

1. Deepen Systemic and Institutional Engagement: Future initiatives could build on AGECS's foundations by engaging more directly with the state systems responsible for GBV prevention and response. Strengthening coordination among the Women Development Department (WDD), police, health, social welfare, and judiciary can create more coherent and survivor-focused services.

Establishing a provincial coordination platform and a GBV information management system could help align institutional roles, track cases, and identify service gaps. Collaboration with CSOs, academia, and development partners would ensure that data informs learning and policy reform while keeping community voices central.

2. Support Women's Economic Rights and Agency: The study found that many people still view women's exclusion from inheritance, assets, and control over income as normal. To move from awareness to transformation, future programmes might link economic empowerment directly to GBV prevention.

Simplified inheritance procedures, easy access to land records, and access to legal aid could make women's rights enforceable. At the same time, livelihood, enterprise, and skills programmes that promote equal access to and control over income and productive assets can help shift household power dynamics.

Economic independence—when combined with legal awareness—reduces dependency and challenges the power and class dynamics that perpetuate GBV.

3. Strengthen Survivor-Centered Case Management and Psychosocial Support: The study highlights that survivors and those at risk of GBV continue to face fragmented support and limited trust in formal institutions. Future programmes could explore district-level Survivor-Centered Case Management Units (CMUs) under the WDD (or a suitable coordination mechanism) linking police, health, judiciary, and social welfare departments through clear referral systems.

Within these units, psychosocial support (PSS) should be a core element. Trained case workers could provide psychosocial first aid through empathy and active listening, with referrals for trauma counselling and stress management by qualified professionals.

At community level, group-based peer circles, resilience workshops, and life skills sessions can help survivors regain confidence and emotional stability. All psychosocial support should follow principles of confidentiality, safety, and respect, ensuring that survivors are treated with dignity and compassion.

Integrating psychosocial care within institutional systems can move GBV response from reactive to coordinated, survivor-centered, and healing-oriented approaches.

4. Promote Early Prevention Through Parenting and School Engagement: The findings of this and other studies show that attitudes toward gender roles begin early—in homes, schools, and community

interactions. Future programmes could engage parents, teachers, and young people as key allies in preventing GBV before it occurs.

Parenting sessions can help families reflect on how everyday practices shape power and respect at home, encouraging both mothers and fathers to raise boys and girls with empathy and equality. Partnering with schools to integrate GBV prevention, digital safety, and gender equality into lessons and extracurricular activities can foster emotional awareness and respect-based communication among children.

By combining household reflection with school-based education, programmes can nurture a generation that understands equality as a shared community value rather than a challenge to cultural identity.

5. Sustain Awareness Efforts and Foster Gradual Behavior Change: AGECS helped shift public awareness, but changing behavior and attitudes takes time. Future efforts could build on this momentum through long-term social and behavior change communication (SBCC) approaches that encourage dialogue, empathy, and collective reflection.

Engaging men, youth, and religious leaders as allies can make discussions more inclusive and credible. Storytelling, theatre, and digital media can help challenge everyday justifications for violence and promote positive role models of equality.

Monitoring shifts in community attitudes through surveys and dialogues will help keep these initiatives adaptive, responsive, and locally relevant.

6. Strengthen Legal and Law Enforcement Systems for Sustained Change: The law enforcement and justice system remains a critical bottleneck in GBV response. Survivors often face procedural delays, intimidation, and lack of sensitivity. Future programming might prioritize collaboration with law enforcement, judiciary, and lawmakers to make the justice environment more gender-responsive.

Updating training curricula for police, prosecutors, and judicial staff to include trauma-informed practices, survivor-centered interviewing, and digital harassment laws can institutionalize learning. Ongoing mentorship and peer-learning can help reinforce accountability and empathy.

Constructive engagement with the Gilgit-Baltistan Legislative Assembly (GBLA) can help review and strengthen GBV and cybercrime laws, making enforcement more survivor-friendly and accessible. Evidence-sharing and joint policy dialogues could ensure that laws reflect community realities and justice needs.

7. Use Data and Media to Advance Accountability and Public Understanding: The study found that underreporting and weak data systems are key challenges to evidence-based policymaking. Developing a unified GBV information management and case-tracking system, in partnership with police, judiciary, CSOs, and universities, can improve coordination, transparency, and service delivery.

At the same time, responsible media engagement can amplify survivor voices safely and raise awareness about available services. Partnerships with journalists and digital influencers can promote balanced coverage and positive narratives on gender equality.

As digital harassment becomes more common, digital literacy and online safety education should be integrated into community and school initiatives to ensure prevention and protection across generations.

8. Promote Inclusion, Leadership, and Local Adaptation: The study shows that progress has been uneven—districts like Hunza and Ghizer show stronger change, while Nagar and Chitral remain more resistant. Future programmes could focus on context-sensitive and inclusive strategies, encouraging local innovation and leadership.

Strengthening women's leadership within community institutions, LSOs, and governance bodies can ensure sustained participation and voice. Mentorship, training, and networking opportunities can help women move from awareness to influence and decision-making.

Engaging elders, faith leaders, and local champions can improve acceptance and make interventions more relevant and sustainable. District learning exchanges could further promote peer learning and collective ownership of equality goals.

9. Encourage Continuous Learning and Flexibility: Given the complex and evolving nature of GBV, no single model guarantees success. Embedding adaptive learning systems in future programmes—with regular reflection, joint reviews, and participatory adjustments—can make interventions more effective and responsive.

Continuous tracking both quantitative indicators (such as service use) and qualitative insights (such as survivor experiences and attitude change) will help identify what works best across different contexts.

This learning-oriented approach acknowledges that progress may be gradual but becomes durable when grounded in reflection, collaboration, and shared accountability.

In Summary, AGECS has opened vital spaces for dialogue, awareness, and inclusion in Gilgit-Baltistan and Chitral. The next phase of effort can build on these foundations by linking awareness with empowerment, institutional responsiveness, and prevention.

GBV remains a deeply social and structural issue—rooted in power, inequality, and institutional weakness. Continued collaboration between communities, civil society, and state systems can help transform today's fragile gains into lasting pathways of safety, dignity, and equality.

Table 62: Recommendations Matrix

Priority Area	Key Actions	Pathway (How It Drives Change)	Responsible Institutions
1. Deepen Systemic and Institutional Engagement (Immediate – Short Term)	• Strengthen coordination among WDD, police, health, social welfare, and judiciary for integrated GBV response.• Establish a provincial GBV coordination platform and unified information management system.	Builds a coherent and survivor-focused institutional framework by aligning mandates, improving coordination, and ensuring services are responsive and data-driven.	Women Development Department (WDD), Police, Health, Social Welfare, Judiciary, Planning & Development Dept., AKRSP, CSOs, Academia
2. Strengthen Survivor-Centered Case Management and Psychosocial Support (Immediate – Short Term)	• Establish district-level Survivor-Centered Case Management Units (CMUs) linking police, health, judiciary, and social welfare through referral systems.• Integrate psychosocial support (PSS) into GBV services, including counselling, peer-support groups, and trauma recovery activities.	Moves GBV response from reactive to coordinated and healing-oriented; improves survivor trust and well-being through confidential, empathetic, and trauma-informed care.	WDD, Health Dept., Social Welfare Dept., Police, District Administration, AKRSP, CSOs, Psychosocial Professionals
3. Support Women's Economic Rights and Agency (Short – Medium Term)	• Simplify inheritance claim procedures and digitize land records to make women's property rights enforceable.• Expand livelihood, enterprise, and skills programmes ensuring women's equal access to and control over income and assets.	Reduces economic dependency and power imbalances within households; links women's economic independence to GBV prevention and long-term resilience.	Land Revenue Dept., Judiciary, WDD, Local Government, Planning & Development Dept., AKRSP, CSOs, Financial Institutions
4. Promote Early Prevention Through Parenting and School Engagement (Short – Medium Term)	• Engage parents—especially fathers and mothers—to promote gender-equitable child-rearing and empathy-based parenting.• Integrate GBV prevention, digital literacy, and gender equality into school curricula and teacher training.	Shapes respectful attitudes and emotional awareness early in life; prevents normalization of violence by promoting equality and shared responsibility at home and in schools.	Education Dept., Teachers' Training Institutes, Parent–Teacher Associations, AKRSP, CSOs, Faith Leaders
5. Strengthen Legal and Law Enforcement Systems (Medium Term)	• Update GBV and cybercrime laws and ensure effective enforcement through policy dialogue with GBLA.• Strengthen training curricula for police, prosecutors, and judges to include trauma-informed, survivor-centered practices.	Makes justice systems more accessible, gender-responsive, and credible; ensures fair, timely, and respectful handling of GBV and digital harassment cases.	GBLA, Judiciary, Ministry of Law & Justice, Police, FIA (Cybercrime Wing), WDD, AKRSP
6. Sustain Awareness and Foster Behavior Change (Medium – Long Term)	• Implement long-term social and behavior change communication (SBCC) campaigns using storytelling, theatre, and digital media.•	Reinforces gradual shifts in attitudes, builds empathy, and normalizes equality across generations	AKRSP, CSOs, Media, Religious Leaders, Youth Networks, WDD

Priority Area	Key Actions	Pathway (How It Drives Change)	Responsible Institutions
	Engage men, youth, and religious leaders in dialogues that challenge everyday justifications for violence.	through continuous dialogue and social learning.	
7. Promote Inclusion, Leadership, and Local Adaptation (Medium – Long Term)	• Strengthen women's leadership in LSOs, cooperatives, and local governance through training and mentorship.• Encourage district-level innovation and peer-learning exchanges between communities.	Increases women's voice in decision-making, supports context-sensitive solutions, and fosters local ownership of gender-equality efforts.	Local Government, WDD, Cooperatives Dept., AKRSP, CSOs, Faith & Community Leaders
8. Use Data and Media to Advance Accountability and Public Understanding (Cross-Cutting)	• Develop a unified GBV information management system to track cases and improve coordination.• Partner with journalists and digital platforms for responsible reporting and awareness of support services.	Strengthens evidence-based planning, transparency, and informed dialogue; reduces stigma and misinformation while promoting survivor safety and media responsibility.	Planning & Development Dept., Police, Judiciary, AKRSP, Media Outlets, CSOs, Academia
9. Embed Accountability and Continuous Learning in Governance (Cross-Cutting, Long Term)	• Establish an inter-departmental GBV Accountability Taskforce for quarterly progress reviews.• Conduct annual social audits of GBV services with participation from CSOs and women's groups.• Institutionalize adaptive learning systems with regular reflection and programme adjustment.	Embeds accountability and learning into governance systems, ensuring sustained improvement and responsiveness to evolving GBV dynamics.	Provincial Govt., WDD, Planning & Development Dept., Ombudsman Offices, AKRSP, CSOs, Development Partners

10. ANNEXTURES

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ANNEX – 1: AGECS SUB-PROJECT OUTPUT INDICATORS (TARGETS &ACHIEVEMENTS

KADO- AGECS Sub-Project Output Indicator (2022-2025)					
Expected Results	Indicator	Disaggregation Categories	Project Target	Achievements	Variance
1211: Toll Free Number creat-ed and mobile app software developed to record com-plaints and report GBV cases by women in targeted project areas	1211.1: # of police staff trained to handle GBV case reports via the toll free number (by gender, district)	Total	75	27	36%
		# of men	36	11	31%
		# of women	39	16	41%
		# in Hunza District	15	3	20%
		# in Nagar District	15	2	13%
		# in Gilgit District	15	5	33%
		# in Ghizer District	15	3	20%
		# in Upper Chitral District	15	0	0%
1212: Sessions on addressing GBV cases delivered to law enforcement agencies across all targeted Ucs	1212.1: # of sessions conducted with law enforcement agencies for sensitization, better response and handling of GBV cases (by district)	Total	22	6	27%
		# in Hunza District	4	1	25%
		# in Nagar District	4	0	0%
		# in Gilgit District	4	5	125%
		# in Ghizer District	4	0	0%
		# in Upper Chitral District	6	0	0%
	1212.2: # of police personnel trained on better response and handling of GBV cases (by gender, district)	Total	240	394	164%
		# of men	50	333	666%
		# of women	190	61	32%
		# in Hunza District	40	42	105%
		# in Nagar District	40	32	80%
		# in Gilgit District	40	91	228%
		# in Ghizer District	40	65	163%
		# in Upper Chitral District	40	0	0%
1213: Networking/Trust Build-ing Sessions facilitated be-tween Police and Women's Groups across targeted dis-tricts	1213.1: # of networking/trust building ses-sions between police and women's groups conducted (by district)	Total	20	13	65%
		# in Hunza District	3	3	100%
		# in Nagar District	5	2	40%
		# in Gilgit District	5	2	40%
		# in Ghizer District	4	3	75%
		# in Upper Chitral District	3	3	100%
	1213.2: # of people participating in networking/trust building session between police and women's groups (by gender, type of stakeholder, district)	Total	415	309	74%
		# of male police officials	26	30	115%
		# of female police officials	101	53	52%
		# of women's group members	286	226	79%
		# in Hunza District	77	63	82%
		# in Nagar District	105	63	60%
		# in Gilgit District	105	48	46%
		# in Ghizer District	85	71	84%

KADO- AGECS Sub-Project Output Indicator (2022-2025)					
Expected Results	Indicator	Disaggregation Categories	Project Target	Achievements	Variance
		# in Upper Chitral District	65	64	98%
1221: Women Activist Forums (WAFs) formed at district level in targeted project areas	1221.1: # of Women Activists Forums formed (by district)	Total	8	5	63%
		# in Hunza District	2	1	50%
		# in Nagar District	1	1	100%
		# in Gilgit District	2	1	50%
		# in Ghizer District	1	1	100%
		# in Upper Chitral District	2	1	50%
	1221.2: # of women involved in the Women Activists Forums (by district)	Total	80	50	63%
		# in Hunza District	20	10	50%
		# in Nagar District	10	10	100%
		# in Gilgit District	20	10	50%
		# in Ghizer District	10	10	100%
		# in Upper Chitral District	20	10	50%
1222: Women's Leadership Conventions held in select districts for female leaders from all districts of GB and Chitral	1222.1: # of women's leadership conven-tions held	Total	6	0	0%
		# of sessions	6	0	0%
	1222.2: # of participants in women's leadership conventions (by gender)	Total	700	0	0%
		# of men	300	0	0%
		# of women	2200	0	0%
1223: Women's rights sessions conducted with tribal leaders, religious leaders, and heads of CSOs across all targeted Ucs	1223.1: # of sessions for community leaders conducted	Total	21	12	57%
		# of sessions	21	12	57%
	1223.2: # of community leaders and heads of CSOs trained (by gender)	Total	275	265	96%
		# of men	137	128	93%
		# of women	138	137	99%
1224: Policies on women's rights developed and present-ed to Elected Women Repre-sentatives of the GB Assembly	1224.1: # of Elected Women Representa-tives of the GB Assembly trained on advocacy on policy matters (by district)	Total	20	35	175%
		# in Hunza District	4	2	50%
		# in Nagar District	4	2	50%
		# in Gilgit District	4	5	125%
		# in Ghizer District	4	4	100%
		# in Upper Chitral District	4	0	0%
1225: Short documentaries produced to highlight the achievements and challenges faced by women in targeted districts	1225.1: # of short documentaries produced and disseminated	Total	18	10	56%
		# of Documentaries	18	10	56%
		Total	16	4	25%

KADO- AGECS Sub-Project Output Indicator (2022-2025)					
Expected Results	Indicator	Disaggregation Categories	Project Target	Achievements	Variance
1231: Gender equality ses-sions held with men and young boys across all targeted UCs	1231.1: # of sessions on gender equality conducted with men and young boys (by district)	# in Hunza District	0	1	#DIV/0!
		# in Nagar District	4	1	25%
		# in Gilgit District	4	1	25%
		# in Ghizer District	4	1	25%
		# in Upper Chitral District	4	0	0%
	1231.2: # of men and boys who have at-tended trainings on gender equality and addressing GBV (by age, district)	Total	300	110	37%
		# of Adults (age 20+)	210	82	39%
		# of Adolescent boys (10-19)	90	28	31%
		# in Hunza District	60	26	43%
		# in Nagar District	60	25	42%
		# in Gilgit District	60	28	47%
		# in Ghizer District	60	31	52%
		# in Upper Chitral District	60	0	0%
1232: Women's rights sessions held with women and young girls across all targeted Ucs	1232.1: # of women's rights sessions with women and young girls conducted (by district)	Total	5	5	100%
		# in Hunza District	1	1	100%
		# in Nagar District	1	1	100%
		# in Gilgit District	1	1	100%
		# in Ghizer District	1	1	100%
		# in Upper Chitral District	1	1	100%
	1232.2: # of women and girls who have at-tended women's rights sessions (by age, district)	Total	100	163	163%
		# of Adults (age 20+)	70	71	101%
		# of Adolescent girls (10-19)	30	92	307%
		# in Hunza District	20	25	125%
		# in Nagar District	20	33	165%
		# in Gilgit District	20	37	185%
		# in Ghizer District	20	40	200%
		# in Upper Chitral District	20	28	140%
1233: Sessions on the gender-neutral upbringing of adoles-cents held with parents and teachers of ECD children across targeted districts	1233.1: # of parents who have attended sessions on the gender-neutral up-bringing of adolescents (by gender, age, district)	Total	228	250	110%
		# of men	128	98	77%
		# of women	100	152	152%
		# in Hunza District	40	72	180%
		# in Nagar District	40	48	120%
		# in Gilgit District	54	55	102%
		# in Ghizer District	40	43	108%
		# in Upper Chitral District	54	32	59%
	1233.2: # of teachers who have attended sessions on the gender-neutral up-bringing of	Total	100	115	115%
		# of men	50	0	0%
		# of women	50	115	230%
		# in Hunza District	20	20	100%

KADO- AGECS Sub-Project Output Indicator (2022-2025)					
Expected Results	Indicator	Disaggregation Categories	Project Target	Achievements	Variance
	adolescents (by gender, district)	# in Nagar District	20	21	105%
		# in Gilgit District	20	19	95%
		# in Ghizer District	20	32	160%
		# in Upper Chitral District	20	23	115%
1234: Mental health sessions held with men and women across targeted districts	1234.1: Number of sessions conducted on mental health awareness (by dis-trict)	Total	21	14	67%
		# in Hunza District	4	5	125%
		# in Nagar District	5	2	40%
		# in Gilgit District	4	3	75%
		# in Ghizer District	5	2	40%
		# in Upper Chitral District	3	2	67%
	1234.2: # of people participating in mental health awareness sessions (by gender, age, district)	Total	300	#VALUE!	#VALUE!
		# of men	149	144	97%
		# of women	151	179	119%
		# in Hunza District	60	150	250%
		# in Nagar District	60	51	85%
		# in Gilgit District	60	66	110%
		# in Ghizer District	60	56	93%
		# in Upper Chitral District	60	88	147%
1235: Training modules and a toolkit on women's rights de-veloped for men and women residing in targeted Ucs	1235.1: # of training manuals/booklets and other communication content pro-duced and disseminated (by district)	Total	14000	9500	68%
		# in Hunza District	2800	1900	68%
		# in Nagar District	2800	1900	68%
		# in Gilgit District	2800	1900	68%
		# in Ghizer District	2800	1900	68%
		# in Upper Chitral District	2800	1900	68%
1236: Public service messages on women's rights and GBV developed and aired on media platforms	1236.1: # of Public Service Messages developed and aired	Total	100	47	47%
		# of Messages	100	47	47%
	1236.2: # of media persons trained on re-sponsible reporting of GBV cases and the promotion and advocacy of equal rights of women (by gender)	Total	100	82	82%
		# of men	50	55	110%
		# of women	50	27	54%

LAPH- AGECS Sub-Project Output Indicator (2022-2025)					
Expected Results	Indicator	Disaggregation Categories	Project Target	Achievements	Variance
1211 Legal Aid Centers established in target districts to provide legal consultation and support court cases of GBV survivors.	# of Legal Aid Centres established	Total	3	3	100%
	# of lawyers engaged to provide legal consultation and support court cases of GBV survivors (by gender)	Total	100	93	93%
		# of men	90	90	100%
		# of women	10	3	30%
	# of people who have benefitted from legal aid desks (by gender, age, district)	Total	2250	2581	115%
		# of men (20+)	480	526	110%
		# of women (20+)	1440	1451	101%
		# of adolescent boys (10-19)	170	252	148%
		# of adolescent girls (10-19)	160	352	220%
		# in Upper Chitral	1125	970	86%
		# in Lower Chitral	1125	1147	102%
1212 Institutions/groups formed for the redressal and reporting of GBV cases at community level.	# of local institutional groups/forums/committees formed (by district)	Total	38	38	100%
		# in Upper Chitral	19	18	95%
		# in Lower Chitral	19	20	105%
	# of members of groups formed for the redressal and reporting of GBV cases at community level (by gender, district)	Total	570	667	117%
		# of men	190	298	157%
		# of women	380	369	97%
		# in Upper Chitral	285	293	103%
		# in Lower Chitral	285	339	119%
1213 District-level GBV Monitoring Committees formed with members of the District Administration, CSOs and Communities.	# of District Level Monitoring Committees established (by district)	Total	2	2	100%
		# in Upper Chitral	1	1	100%
		# in Lower Chitral	1	1	100%
	# of members of District Level Monitoring Committees (by gender, district)	Total	30	42	140%
		# of men	20	31	155%
		# of women	10	11	110%
		# in Upper Chitral	15	20	133%
		# in Lower Chitral	15	22	147%
1221 Capacity strengthening support provided to local Community Groups/CSOs on identifying, handling and referring GBV cases.	# of individuals from LSOs/Women Groups/CSOs trained to identify, handle and report cases (by gender, district)	Total	178	230	129%
		# of men	100	69	69%
		# of women	78	161	206%
		# in Upper Chitral	65	89	137%
		# in Lower Chitral	65	90	138%
	# of LSOs/Women Groups/CSOs provided with institutional support for reporting GBV cases (by district)	Total	14	14	100%
		# in Upper Chitral	7	7	100%
		# in Lower Chitral	7	7	100%
1222 Training provided to Government Department staff	# of trainings conducted on improved services for GBV survivors (by district)	Total	6	6	100%
		# in Upper Chitral	3	3	100%
		# in Lower Chitral	3	3	100%

LAPH- AGECS Sub-Project Output Indicator (2022-2025)					
Expected Results	Indicator	Disaggregation Categories	Project Target	Achievements	Variance
on improved services for GBV survivors in target districts.	# of government officials/staff trained (by gender, district)	Total	144	172	119%
		# of men	43	78	181%
		# of women	101	94	93%
		# in Upper Chitral	72	74	103%
		# in Lower Chitral	72	73	101%
1223 Infrastructural improvements provided to women's facilities that support GBV survivors in target districts	# of facilities provided with infrastructure improvements (by district)	Total	5	5	100%
		# in Upper Chitral	3	2	67%
		# in Lower Chitral	2	3	150%
1224 Training and capacity support provided to local media staff on the appropriate reporting of GBV cases in the media.	# of media training events conducted (by district)	Total	4	4	100%
		# in Upper Chitral	2	2	100%
		# in Lower Chitral	2	2	100%
	# of media persons trained on reporting on GBV (by gender, district)	Total	50	49	98%
		# of men	45	41	91%
		# of women	5	8	160%
		# in Upper Chitral	25	29	116%
		# in Lower Chitral	25	20	80%
1231 Awareness-raising activities conducted in local communities on basic human rights and basic legal rights.	# of awareness sessions/legal aid clinics conducted at village level (by district)	Total	52	52	100%
		# in Upper Chitral	26	26	100%
		# in Lower Chitral	26	26	100%
	# of people reached by awareness-raising activities (by gender, age, district)	Total	2080	2909	140%
		# of men (20+)	464	473	102%
		# of women (20+)	1406	1741	124%
		# of adolescent boys (10-19)	101	112	111%
		# of adolescent girls (10-19)	109	583	535%
		# in Upper Chitral	1040	1551	149%
		# in Lower Chitral	1040	1358	131%
1232 Awareness sessions held for students in target districts on basic human rights and gender-based harassment.	# of awareness sessions/events conducted for students on human rights and gender equality (by type of event)	Total	34	32	94%
		# of Sessions	30	29	97%
		# of Sport galas	4	3	75%
	# of students attending awareness sessions on human rights and gender equality (by gender, age, district)	Total	3300	3617	110%
		# of men (20+)	196	240	122%
		# of women (20+)	654	529	81%
		# of adolescent boys (10-19)	744	819	110%
		# of adolescent girls (10-19)	1706	2029	119%

LAPH- AGECS Sub-Project Output Indicator (2022-2025)					
Expected Results	Indicator	Disaggregation Categories	Project Target	Achievements	Variance
		# in Upper Chitral	1650	1897	115%
		# in Lower Chitral	1650	1720	104%
1233 Training on vocational skills provided to women who have experienced GBV in target communities.	# of trainings or other capacity building activities conducted on vocational skills (by district)	Total	10	3	30%
		# in Upper Chitral	5	1	20%
		# in Lower Chitral	5	2	40%
	# of women benefitting from employment-related capacity building activities (by district)	Total	294	72	24%
		# in Upper Chitral	147	25	17%
		# in Lower Chitral	147	47	32%

ANNEX – 2: STUDY SCOPE MATRIX

Activity	Description	Responsibility	Deliverable
1. Document Review	Review project proposals, PMF, CSO progress reports, Endline Survey Guidelines (AKRSP/AKFC), baseline reports, and other relevant materials (see Annex 5 for full list).	AKRSP: Share all required documents. DY: Review and synthesize key findings. KADO/LAPH: Provide project-specific reports/records.	Document review summary (to inform inception report and triangulation of findings)
2. Inception Meetings	Hold meetings with AKRSP/AKFC and sub-project partners (LAPH, KADO) to validate objectives, methodology, and work plan.	AKRSP: Facilitate and coordinate meetings. DY: Present proposed methodology and tools. KADO/LAPH: Provide contextual inputs and feedback.	Agreed study plan and refined methodology
3. Inception Report	Prepare and submit an inception report covering objectives, methodology, timeline, data tools, consent forms, and analysis plan.	DY: Draft and finalize inception report. AKRSP: Review and provide feedback. KADO/LAPH: Validate feasibility of field activities.	Inception Report
4. Securing Approvals	No Objection Certificates (NOCs) before fieldwork.	DY: Lead process of obtaining approvals. AKRSP: Provide institutional support and coordination, letter of introduction. KADO/LAPH: Facilitate local permissions where required.	NOC documents
5.Organizational Performance Index (OPI) Assessment	Assess the institutional performance of partner CSOs (LAPH and KADO) using the OPI framework. Endline scores will be compared against baseline scores to determine changes in organizational performance. The percentage of CSOs with improved OPI scores will be calculated to align with donor indicators.	KADO and LAPH: Lead the self-assessment process by reviewing evidence and assigning scores for each sub-domain. Compile supporting documentation (means of verification). Participate actively in the validation workshop. DY: Explains the methodology, ensures consistency with OPI guidelines. Conducts quality assurance and ensures scoring is evidence-based. Aggregates scores into domain/overall OPI and conducts the comparative analysis (Endline vs Baseline/Midline).	Completed OPI assessments, domain/sub-domain scores, overall OPI score, and comparative analysis (Endline vs. Baseline).

Activity	Description	Responsibility	Deliverable
		AKRSP: Provides baseline OPI data and tools.	
6. Quantitative Data Collection	Conduct community surveys and document reviews, collecting demographic data (age, gender, education) and outcome indicators as per PMF.	DY: Design survey, train and supervise enumerators, ensure quality control. KADO/LAPH: Facilitate community entry and mobilization. AKRSP: Oversee compliance with standards.	Clean quantitative dataset
7. Qualitative Data Collection	Conduct KIIs and FGDs with stakeholders and beneficiaries.	DY: Develop guides, train facilitators, and conduct/oversee FGDs and KIIs. KADO/LAPH: Facilitate identification and mobilization of respondents and schedule meetings. AKRSP: Provide oversight and technical guidance.	Transcripts/field notes, qualitative dataset
8. Government Records Review	Coordinate with authorities to gather official records on GBV cases reported and addressed.	DY: Lead data collection and validation. AKRSP: Provide institutional backing and letters of introduction. KADO/LAPH: Support access to local government offices.	Dataset/summary of GBV records
9. Qualitative Data Collection	Conduct KIIs and FGDs with stakeholders and beneficiaries.	DY: Develop guides, train facilitators, and conduct/oversee FGDs and KIIs. KADO/LAPH: Facilitate identification and mobilization of respondents and schedule meetings. AKRSP: Provide oversight and technical guidance.	Transcripts/field notes, qualitative dataset
10. Data Management and Analysis	Ensure quality assurance, cleaning, management, and analysis of quantitative and qualitative data.	DY: Manage and analyze all data.	Data analysis report (for final report)
11. Final Endline Report	Prepare and submit the final report with findings, conclusions, lessons learned, and recommendations.	DY: Draft final report and finalise the report incorporating comments and feedback of AKRSP/KADO/LAPH AKRSP: Review, provide technical comments, and ensure donor compliance. KADO/LAPH: Contribute lessons learned, success stories, and contextual insights.	Final Endline Report

ANNEX 3– LIST OF DOCUMENTS RECEIVED AND REVIEWED

S.#	Document Type	Source
1	Project Proposals with budget	AKRSP,KADO, LAPH
2	Performance Monitoring Framework (PMF)	AKRSP, KADO, LAPH
3	Progress Reports (Narrative and financial)	KADO, LAPH
4	Baseline Study Report	AKRSP
5	Baseline Data Set with identification of sample and variables	AKRSP
6	Baseline/Monitoring Data Collection Tools	AKRSP
7	Monitoring Databases (quant/qual)	AKRSP
8	Organizational Performance Index (OPI) Records	AKRSP/AKFC
9	Net Promoter Score (NPS) Data	AKRSP/AKFC
10	Government Records on GBV Cases	Government Departments
11	Endline Survey Methodolgy Guidelines	AKRSP/AKFC
12	Endline Inception report templet	AKRSP/AKFC
13	Endline report templet	AKRSP/AKFC
14	Endline report Annex 4 Mandatory indicators (Excel sheet)	AKRSP/AKFC
15	Endline Data collector Training (PPT)	AKRSP/AKFC
16	Media Report on GBV cases	Internet/HRCP

ANNEX – 4: OPI TOOL

OPI Tool.xlsx

ANNEX 5: AGECS ENDLINE SURVEY - HOUSEHOLD SURVEY QUESTIONNAIRE

Informed Consent Form

Introduction

Great according to local context, my name is ____________________. I am part of a survey team from the DEVYIELD Consulting Firm who have been hired by the Aga Khan Rural Support Programme (AKRSP). We are conducting a survey in your community to better understand the current situation regarding decision-making in health and family matters, gender equality, social barriers, and how communities handle and respond to gender-based violence (GBV).

Your household was randomly selected, and we would like to hear the views of both men and women in your community. This will help AKRSP improve its programmes for the benefit of the community.

Participation

- Your participation in this survey is completely voluntary.
- You may refuse to participate, skip any question, or stop the interview at any time without giving a reason.
- The interview will take about 30–45 minutes.

Confidentiality

- All the information you share will remain confidential and anonymous.
- Your name will not appear in any reports.
- Results will only be presented in summary form so no individual can be identified.

Risks and Benefits

- Some questions may feel sensitive, especially those related to family decisions or Gender Based Violence. You may skip any question if you feel uncomfortable.
- While there are no direct benefits for you from this survey, your responses will help improve services and programmes in your community.

Support / Referrals

If you or someone in your family needs legal, financial, psychosocial, or other support, we can provide contact information for organizations and services in your area (e.g., LAPH, KADO, SBHI, AKRSP). [Insert Contact Person & Phone Number].

Consent Statement

Do you have any questions about the survey before deciding?

1. If **18+ and literate**:
   Would you be willing to participate in this survey and give your consent?

- Yes → Please sign below
- No → End interview

Participant's Consent:
I have read (or been read) the information above. I understand the purpose of the study, that my participation is voluntary. I consent freely to take part in this survey.

Name of Participant: __________________________
Signature/Thumbprint: _________________________
Date: ____ / ____ / ______

2. If **participant is not-literate or under 18**:
   A witness, chosen by the participant and not linked to the research team, must confirm consent.

Witness Statement:
I confirm that the consent form was read accurately to the participant, they had the chance to ask questions, and they freely gave consent.

Name of Witness: __________________________
Signature/Thumbprint: _________________________
Date: ____ / ____ / ______

Enumerator Declaration

I confirm that I explained the survey clearly, answered all questions, and obtained voluntary consent without any pressure.

Name of Enumerator: __________________________
Signature: _________________________
Date: ____ / ____ / ______

MODULE 1 BASIC INFORMATION: (PREFED)

Household ID								
Province		*Select One*	*1 GB*	*2 KP*				
District*		*Select One**	***1***	***2***	***3***	***4***	***5***	***6***
UC Code**		*Select One*	***1***	***2***	***3***	***4***	***5***	***6***
Village Code***			***1***		***2***		***3***	

** 1 = Ghizer, 2 = Gilgit, 3 = Hunza, 4 = Nager, 5 = Upper Chitral, 6 = Lower Chitral,*
*** 1 =*
**** 1 = -----, 2 = ……………………., 3 = …………………*

Date of Interview (DD/MM/YYYY)		***Language of Interview***	*1. Shina* *2. Balti* *2 Burushaski* *3 Khowar* *4. Wakhi* *5 Gujiri*	*6 Pashto* *98 Other*
Interviewer Name		***Interviewer ID***		
Supervisor Name		***Supervisor ID***		

Respondent ID			
Gender of respondent	*1 Men*	*2 Women*	*3 Adolescent Girl (10-19 years of age)*
Age of respondent is 18 or above	*1. Yes* *2. No (End the interview)*		

MODULE-A. RESPONDENT IDENTIFICATION

No.	Question	Instructions	Response Category/Codes
A1	*How old are you?*	*Write age in years*	*Enter Age __________* *99 Don't Know/No response*
A2	*What is your current marital status?*	*Tick one relevant option*	*1. Single* *2. Married* *3. Separated* *4. Widowed* *99. No response*
A3	*Are you currently a parent or primary guardian of a child?*	*Tick one relevant option*	*Yes* *No*
A4	*What do you consider your literacy level to be?*	*Tick one relevant option*	*1. Cannot read or write* *2. Can read only* *3. Can read and write* *99. No response*
A5	*What was the highest level of education you completed?*	*Tick one relevant option*	*1. No education* *2. Primary* *3. Middle* *4. Secondary/Matric* *5. Intermediate* *6. Technical/Vocational* *7. Graduate/general* *8. Graduate/Professional* *9. Master and above* *10. Madrasa* *98.Other (Specify)* *99. Don't Know/No Response*

MODULE-B. HOUSEHOLD IDENTIFICATION

(A household is defined as a group of people who live and eat together under one roof. Please exclude the household members who may live outside of the house or country for work.)

No.	Question	Instructions	Response Category/Codes	
B1	*What is the family type of household?*	*Tick one relevant option*	*Nuclear family (only parents and their children)* *Joint family (extended family)*	
B2	*What is the gender of household head?*	*Tick one relevant option*	*1. Female* *Male*	
B3	*Are you head of Household?*		*1. Yes (go to B5)* *2. No (go to B4))*	
B4	*What is the relationship of the respondent to the household head?*	*Tick one relevant option*	*1. Husband/Wife* *2. Mother/Father* *3. Brother/Sister* *4. Brother/Sister-in-law* *5. Father or Mother-in-law* *6. Son/Daughter* *98. Other (Specify)* *99. No response*	
B5	*How many members are in your family?*	*Write numbers (0,1,2, 3....) in each cell)*	***Female***	***Male***
			>18 yrs	*>18 yrs*
			< 18 yrs	*< 18 yrs*

B6	*What is the ownership status of your house?*	*Tick one relevant option*	*1. Own house* *2. Shared house (Family house)* *3. Rented house* *4. Other (specify)_________*
B7	*What was the highest level of education any member of your household completed?*	*Tick one relevant option*	*1. No education* *2. Primary* *3. Middle* *4. Secondary/Matric* *5. Intermediate* *6. Technical/Vocational* *7. Graduate/general* *8. Graduate/Professional* *9. Master and above* *10. Madrasa* *98.Other (Specify)* *99. Don't Know/No Response*
B8	*What is the main source of household income?*	*Tick one relevant option*	*1.Daily Wage (Agricultural)* *2. Daily Wage (Non-Agricultural)* *3. Crop production and livestock* *4. Salary (Non-Agricultural)* *5. Self-employed/ business* *6. Property* *7. Pension* *8. Remittance* *9. Social Welfare such as BISP/Zakat* *10. None* *11. Other (Specify) ___________*
B9	*Do your household have access to following facilities?*	*Tick all that apply (multiple options can be selected)*	*1. Clean water* *2. Gas* *3. Electricity* *4. School Madrassa* *5. Health facility/Clinic* *6. Telephone/Mobile* *7. Internet* *8. Radio* *9. TV* *10. Legal services* *11. None*

MODULE-C (1200): REDUCED GENDER AND SOCIAL BARRIERS TO UTILIZATION AND UPTAKE OF HEALTH, EARLY CHILDHOOD DEVELOPMENT AND OTHER SUSTAINABLE DEVELOPMENT SERVICES AND PRACTICES IN SELECTED AREAS OF ASIA BY WOMEN, GIRLS, ADOLESCENTS, MEN, AND BOYS

***C.1 (1200.2)**: % of women (18-49 years) who made decisions alone or jointly on matters related to family planning, child health and use of health, SRH and ECD services (by district)*

C1.1: Have you made a decision, either alone or jointly with others regarding the use of contraceptives for family planning /space births during the last 2 years?

کیا آپ نے گزشتہ 2 سالوں کے دوران خاندانی منصوبہ بندی کے لیے مانع حمل ادویات کے استعمال کے بارے میں اکیلے یا کسی دوسرے کے ساتھ مل کر کوئی فیصلہ کیا ہے؟

1. Yes (Skip to C1.2)
2. No
97. Not relevant (Skip to C1.2)
99. Refused to Respond (Skip to C1.2)

C.1a. If No, What factors contribute to your decision not to make use of family planning services? Tick all that apply (multiple options can be selected). Do not prompt. After answering, ask "are there any other reasons? (Ask, do not prompt) اگر نہیں تو

خاندانی منصوبہ بندی کی خدمات کو استعمال نہ کرنے کے کیا وجوہات ہیں؟

1. Lack of awareness	**آگاہی میں کمی**
2. Cultural and social norms	**سماجی اور ثقفتی روائیں**
3. Lack of spousal support	**خاوند کا ساتھ نہ دینا**
4. No decision-making power to use the modern method	**فیصلہ کرنا میرے اختیا میں نہیں**
5. Limited access and availability of the services	**سروس کی عدم دستیابی یا پہنچ سے دوری**
6. Fear of side effects	**استعمال سے قصان ہونے کا خوف**
7. Religious beliefs	**مذہبی عقائد**
8. Fear of Stigma or Judgment	**معاشرے میں بدنامیٔ۔ لوگ کیا کہیں گے۔**
9. Others	**دوسرے وجوہات**
97. Not applicable	**یہ سوال متعلق نہیں**
99. Refused to respond	**جواب نہیں دیا**

C1.2: Have you made a decision, either alone or jointly with others regarding visiting hospital/health center for child health such as pre-natal and post-natal care or immunization ***during the last 2 years?***

ک کیا آپ نے گزشتہ 2 سالوں کے دوران بچوں کی صحت کی دیکھ بال جیسے کہ قبل از پیدائش اور بعد از پیدائش کی دیکھ بھال یا حفاظتی ٹیکوں کے لیے ہسپتال/صحت مرکز جانے کے حوالے سے اکیلے یا کسی کے مشورے سے فیصلہ کیا ہے؟

1. Yes (Skip to C1.3)
2. No
97. Not applicable (Skip to C1.3)
99. Refused to Respond (Skip to C1.3)

C1.2a. If No, what factors contribute to your decision not to not use Child health services? (Ask, do not prompt). Do not prompt. After answering, ask "are there any other reasons? (Ask, do not prompt)

اگر نہیں تو فیصلہ نہ کرنے کی کیا وجوہات ہیں؟

اشارہ نہ کریں۔ جواب دینے کے بعد، پوچھیں "کیا کوئی اور وجوہات ہیں؟

1. Lack of awareness	**آگاہی میں کمی**
2. Cultural and social norms	**سماجی اور ثقفتی روائیں**
3. Lack of spousal support	**خاوند کا ساتھ نہ دینا**
4. Limited access and availability of the services	**سروس کی عدم دستیابی یا پہنچ سے دوری**
5. Religious beliefs	**مذہبی عقائد**
6. Fear of Stigma or Judgment	**معاشرے میں بدنامیٔ۔ لوگ کیا کہیں گے۔**
8. Others	**دوسرے وجوہات**
97. Not applicable	**یہ سوال متعلق نہیں**
99. Refused to respond	**جواب نہیں دیا**

C1.3: Have you made a decision, either alone or jointly with others regarding visiting health service(s) or consult a heath professional for Sexual and Reproductive Health (SRH) such as sexual and reproductive health counselling, pregnancy, infertility, contraception, disorders related to reproductive events etc. during the last 2 years?

کیا آپ نے پچھلے دو سالوں کے دوران جنسی اور تولیدی صحت جیسا کہ حمل، بانجھ پن، خاندنی منصوب بندی، تولیدی امراض سے متعلق کسی صحت کے پیشہ ور یا ڈاکٹر سے مشورہ لینے کے حوالے سے اکیلے یا کسی اور کے ساتھ مل کر کوئی فیصلہ لیا ہے؟

1. Yes (Skip to C1.4)
2. No
97. Not applicable (Skip to C1.4)
99. Refused to Respond (Skip to C1.4)

C.1.3.a. If No, what factors contribute to your decision not to make use of Sexual and Reproductive Health (SRH) services? Do not prompt. After answering, ask "are there any other reasons? (Ask, do not prompt).

اگر جنسی اور تولیدی صحت کی خدمات کو استعمال نہ کرنے کے فیصلے فیصلہ نہیں کی ہو تو یہ بتائیں کہ وہ کون سے عوامل ہیں جوان اشارہ نہ کریں۔ جواب دینے کے بعد، پوچھیں "کیا کوئی خدمات یا سہولیات سے استفادہ حاصل کرنے کے فیصلوں پر اثر انداز ہوئی ہیں؟ اور وجوہات ہیں؟

1. Lack of awareness about the importance and benefits of SRH practices and services	**آگاہی میں کمی**

2. Cultural and social norms	سماجی اور ثقفتی روائیں
3. Lack of spousal support	خاوند کا ساتھ نہ دینا
4. No decision-making power to use SRH Services	فیصلہ کرنا میرے اختیا میں نہیں
5. Limited access and availability of the services	سروس کی عدم دستیابی یا پہنچ سے دوری
6. Religious beliefs	مذہبی عقائد
7. Fear of Stigma or Judgment	معاشرے میں بدنامیٔ۔ لوگ کیا کہیں گے۔
8. Others	دوسرے وجوہات
97. Not applicable	یہ سوال متعلق نہیں
99. Refused to respond	جواب نہیں دیا

C1.4: Have you made a decision, either alone or jointly with others regarding enrolling your child/children under five years in Early Childhood Development (ECD) service
کیا آپ نے ارلی چائلڈ ہڈ ڈیولپمنٹ سروس میں اپنے پانچ سال سے کم عمر کے بچے/بچوں کو اندراج کرنے کے بارے میں یا تو اکیلے یا دوسروں کے ساتھ مشترکہ طور پر کوئی فیصلہ کیا ہے؟
1. Yes (Skip to C1.5)
2. No
97. Not relevant (Skip to C1.5)
99. Refused to Respond (Skip to C1.5)
C1.4a. If No, what factors contribute to your decision not to enroll Early Childhood Development (ECD) service? Do not prompt. After answering, ask "are there any other reasons? (Ask, do not prompt)
ابتدائی چائلڈ ہڈ ڈیولپمنٹ سروس میں اندراج نہ کرنے کے آپ کے فیصلے میں کون سے عوامل کارفرما ہیں؟ اشارہ نہ کریں۔ جواب دینے کے بعد، پوچھیں "کیا کوئی اور وجوہات ہیں؟

1. Lack of awareness about the importance and benefits of ECD services	آ ای سی ڈی خدمات کی اہمیت اور فوائد کے بارے میں آگاہی کا فقدان
2. Cultural and social norms	سماجی اور ثقفتی روائیں
3. Lack of spousal support	خاوند کا ساتھ نہ دینا
4. No decision-making power to use related to early child education and development	فیصلہ کرنا میرے اختیا میں نہیں
5. Limited access and availability of the services	سروس کی عدم دستیابی یا پہنچ سے دوری
6. Religious beliefs	مذہبی عقائد
7. Fear of Stigma or Judgment	معاشرے میں بدنامیٔ۔ لوگ کیا کہیں گے۔
8. Others	دوسرے وجوہات
97. Not applicable	یہ سوال متعلق نہیں
99. Refused to respond	جواب نہیں دیا

C1.5: What is the level position (level of involvement) in decision-making regarding each of the following matters? Please select the option that best represents respondent's situation. Select "Not Applicable" for options that are not relevant to the respondent. مندرجہ ذیل معاملات میں سے ہر ایک کے بارے میں فیصلہ سازی میں آپ کس حد تک شامل ہوتے ہیں؟	1. I am not involved/Others decide for me فیصلہ سازی میں میرا کوئی کردار نہیں 2. I have limited input, but others make the final decision فیصلہ کرنے میں میرا بہت محدود کردار ہے 3. I have equal input and influence in the decision-making process فیصلہ سازی میں میرا بھرپور کردار ہے اور میں فیصلہ پہ اثر انداز ہوسکتی ہوں 4. I am the primary decision-maker but consider others' input میں خود ہی فیصلہ کرتی ہوں لیکن دوسروں کے مشورے بھی شامل ہوتے ہیں 5. I am the sole decision-maker میں تن تنہا فیصلہ کرتی ہوں 97) Not Applicable یہ عوامل مجھ سے متعلق نہیں 99. Did not Respond جواب نہیں دیا۔

1. Use of contraceptives to space births پیدائش کے وقفے کے لیے مانع حمل ادویات کا استعمال	1	2	3	4	5	97	99
2. To visit hospital/health centre for child health as anti-natal and post-natal care or immunization بچوں کی صحت کے لیے ہسپتال/صحت کے مرکز کا دورہ اینٹی نٹل اور پوسٹ نیٹل کیئر یا امیونائزیشن کے طور پر کرنا	1	2	3	4	5	97	99
3. To visit health service(s) or consult a heath professional for Sexual and Reproductive Health (SRH) other than family planning such as counselling on healthy physical relationship with husband, pregnancy, menstruation, infertility, contraception, disorders related to reproductive events etc. صحت کی خدمات (سروسز) کا دورہ کرنا یا خاندانی تعلقات کے علاوہ جنسی اور تولیدی صحت (SRH) کے لیے صحت کے پیشہ ور سے مشورہ کرنا جیسے کہ شوہر کے ساتھ صحت مند جسمانی تعلق، حمل، حیض، بانجھ پن، مانع حمل، تولیدی واقعات سے متعلق عوارض وغیرہ۔	1	2	3	4	5	97	99
4. Enrolling your child/Children under five years in Early Childhood Development (ECD) service سروس میں پانچ سال سے کم عمر کے اپنے بچے/بچوں کا (ECD) ارلی چائلڈ ہڈ ڈویلپمنٹ داخلہ	1	2	3	4	5	97	99

C1.6: To what extent do the following factors limit women's ability to space birth or use of contraceptives in your area/community? (Select all that apply). **مندرجہ ذیل عوامل آپ کے علاقے/کمیونٹی میں خواتین کی خلائی پیدائش یا مانع حمل ادویات کے استعمال کو کس حد تک محدود کرتے ہیں؟**	*1. Not at All* *2. Small Extent* *3. Medium Extent* *4. To a high Extent* *99. Did not respond*			
1) Lack of information or knowledge such as importance and benefits of family planning various methods used for family planning/contraceptives **معلومات یا علم کی کمی جیسے خاندانی منصوبہ بندی کی اہمیت اور فوائد خاندانی منصوبہ بندی/ مانع حمل ادویات کے لیے استعمال کیے جانے والے مختلف طریقے**	*1*	*2*	*3*	*4*	*99*
2) Lack of availability of products and services related to family planning/ use of contraceptives **خاندانی منصوبہ بندی/ مانع حمل ادویات کے استعمال سے متعلق مصنوعات اور خدمات کی دستیابی کا فقدان**	*1*	*2*	*3*	*4*	*99*
3) Religious, cultural, or social norms and taboos **مذہبی، ثقافتی یا سماجی اصول اور ممنوعات**	*1*	*2*	*3*	*4*	*99*
5) Fear or stigma associated with seeking family planning or use of contraceptives **خاندانی منصوبہ بندی کی تلاش یا مانع حمل ادویات کے استعمال سے وابستہ خوف یا بدنما داغ**	*1*	*2*	*3*	*4*	*99*
6) Poor economic condition of the Household **گھر کی خراب معاشی حالت**					

C1.7: To what extent do the following factors limit women's ability adopt practices or access health services for healthcare, including Sexual and Reproductive Health (SRH) services, in your local area/community? درجہ ذیل عوامل آپ کے علاقے یا کمیونٹی میں خواتین کی جنسی اور تولیدی صحت کی بہتر طریقوں کو اپنانے یا اان سے متعلقہ خدمات تک رسائی کی کس حد تک محدود کرتی ہیں؟	1. Not at All 2. Small Extent 3. Medium Extent 4. To a high Extent 99. Did not respond				
1. Lack of knowledge or information about the benefits and importance of SRH SRH کے فوائد اور اہمیت کے بارے میں علم یا معلومات کی کمی	1	2	3	4	99
2. Lack of information about availability of SRH Services SRH خدمات کی دستیابی کے بارے میں معلومات کا فقدان	1	2	3	4	99
3. Socio-cultural or religious norms and expectations سماجی ثقافتی یا مذہبی اصول اور توقعات	1	2	3	4	99

4. Lack of support from community کمیونٹی کی طرف سے حمایت کا فقدان	1	2	3	4	99
5. Limited financial resources محدود مالی وسائل	1	2	3	4	99
6. Lack of support from family or spouse خاندان یا شریک حیات کی طرف سے تعاون کی کمی	1	2	3	4	99
7. Inadequate access to healthcare facilities صحت کی سہولیات تک ناکافی رسائی	1	2	3	4	99
8. Stigma and judgment معاشرے میں بدنامی۔ لوگ کیا کہیں گے۔	1	2	3	4	99
9. Limited decision-making power فیصلہ سازی کی محدود طاقت	1	2	3	4	99
10. Lack of transportation ٹرانسپورٹ سروس کا فقدان					
11. Limited/Unavailability of SRH specific services in the health services صحت کی خدمات میں مخصوص جنسی اور تولیدی صحت کی خدمات کی محدود/غیر دستیابی۔	1	2	3	4	99

C1.8: To what extent do the following factors limit women's ability to decision making to access services for health using child health services? (Select all that apply) **درج ذیل عوامل کس حد تک خواتین کی بچوں کی صحت کی صحت کے لیے صحت کی خدمات تک رسائی کے بارے میں فیصلے کرنے کی صلاحیت کو محدود کرتے ہیں؟**	*1. Not at All* *2. Small Extent* *3. Medium Extent* *4. To a high Extent* *99. Did not respond*				
1) Lack of information or knowledge **معلومات یا علم کی کمی**	*1*	*2*	*3*	*4*	*99*
2) Limited-access to healthcare services (Physical) **صحت کی دیکھ بھال کی خدمات تک محدود رسائی**	*1*	*2*	*3*	*4*	*99*
3) Cultural or social norms **ثقافتی یا سماجی اصول**	*1*	*2*	*3*	*4*	*99*
4) Lack of support from family members or partner **خاندان کے افراد یا ساتھی کی طرف سے تعاون کی کمی**	*1*	*2*	*3*	*4*	*99*
5) Limited availability of services in the area **علاقے میں خدمات کی محدود دستیابی**	*1*	*2*	*3*	*4*	*99*
6) Lack of support from community **کمیونٹی کی طرف سے حمایت کا فقدان**	*1*	*2*	*3*	*4*	*99*
7) Lack of physical access/remoteness/mobility issues **/ رسائی کی کمی / دور دراز** **نقل و حرکت کے مسائل**	*1*	*2*	*3*	*4*	*99*
8) Cultural or religious beliefs or restrictions **ثقافتی یا مذہبی عقائد یا پابندیاں**	*1*	*2*	*3*	*4*	*99*
9) Lack of transportation or geographical barriers to access child health services **بچوں کی صحت کی خدمات تک رسائی میں نقل و حمل یا جغرافیائی رکاوٹوں کا فقدان**	*1*	*2*	*3*	*4*	*99*
98) Others **دوسرے**	*1*	*2*	*3*	*4*	*99*

C2 (1200.3): *% of community members satisfied with handling and management of GBV cases (by gender, district)* ***– Men and Women module.***

No.	Question		Response Category/Code
C2.1	Do you think that GBV is a problem in your community? کیا آپ کو لگتا ہے کہ صنفی بنیاد پر تشدد آپ کے علاقے میں ایک مسئلہ ہے؟	Tick one relevant option	1. Yes 2. No Skip to C2.4 99. Don't Know Skip to C2.4
C2.2	Which of the following forms of GBV do you believe are commonly prevalent in your area?	Tick all that apply (multiple options can be selected). Do not prompt. After answered,	1. Physical abuse 2. Sexual abuse 3. Emotional/Psychological abuse

	آپ کے خیال میں صنفی بنیاد پر تشدد کی درج ذیل میں سے کون سی شکل آپ کے علاقے میں عام طور پر پائی جاتی ہے؟	ask "are there any other reasons?"	4. Economic abuse 5. Online or Digital abuse 6.Harmful Traditional Practices: 98. Other (Specify) 99. Don't Know/No Response
C2.3	In your observation which gender do you believe faces the highest number of GBV cases in your area? آپ کے مشاہدے میں آپ کو لگتا ہے کہ آپ کے علاقے میں جی بی وی کیسز کی سب سے زیادہ تعداد کس جنس کو درپیش ہے؟	Tick one relevant option	Females Males Both genders equally 99. Unsure/Don't know/No Response

C2.4. How are GBV cases typically handled and redressed in your community? (Select all that apply)

آپ کی کمیونٹی میں صنفی بنیاد پر تشدد کے معاملات کو عام طور پر کیسے نمٹا جاتا ہے اور ان کا ازالہ کیا جاتا ہے؟ (وہ سب سلیکٹ کریں جو مناسب ہے(

1. Comprehensive support services are provided to survivors, including medical care, counseling, and legal assistance. *2. Adequate reporting mechanisms and helplines are in place, and law enforcement agencies respond promptly and effectively.* *3. There is community awareness and engagement to prevent GBV, and educational programs are conducted to promote gender equality and women's empowerment.* *4. There are initiatives to hold perpetrators accountable, and legal measures are taken to ensure justice for survivors.* *5. GBV cases are not adequately addressed, and there is a lack of support services and awareness.* *99 Unsure/Don't know/No Response*	1.زندہ بچ جانے والوں کو جامع امدادی خدمات فراہم کی جاتی ہیں، بشمول طبی دیکھ بھال، مشاورت، اور قانونی مدد۔ 2.مناسب رپورٹنگ میکانزم اور ہیلپ لائنز موجود ہیں، اور قانون نافذ کرنے والے ادارے فوری اور مؤثر طریقے سے جواب دیتے ہیں۔ 3. GBVکو روکنے کے لیے کمیونٹی بیداری اور مشغولیت ہے، اور صنفی مساوات اور خواتین کو بااختیار بنانے کے لیے تعلیمی پروگرام منعقد کیے جاتے ہیں۔ 1. قصورواروں کو جوابدہ بنانے کے لیے اقدامات کیے گئے ہیں، اور لواحقین کے لیے انصاف کو یقینی بنانے کے لیے قانونی اقدامات کیے گئے ہیں۔ .2 5. GBV کے معاملات کو مناسب طریقے سے حل نہیں کیا جاتا ہے، اور امدادی خدمات اور بیداری کی کمی ہے۔ 99.غیر یقینی/معلوم نہیں/کوئی جواب نہیں۔

C2.5. To what extent are you satisfied with the handling and management of GBV cases in your community?
آپ اپنی کمیونٹی میں صنفی بنیاد پر تشدد کے معاملات کو سنبھالنے اور ان کے انتظام سے کس حد تک مطمئن ہیں؟
1. Completely Dissatisfied
2. Partially dissatisfied
3. Satisfied
4. Completely satisfied
99. Don't Know

MODULE-D (1230): ENHANCED KNOWLEDGE, SKILSS AND ATTITUDE AMONGE MALE AND FEMALE COMMUNITY MEMBERS ON GENDER EQUALITY AND WOMEN EMPOWERMENT

D.1 (1230.1):** % of individual surveyed that hold gender equitable attitudes towards ending GBV – **Men and Women module

D1.1	To what extent are you aware of the government's laws, regulations or policies that promote gender equality and protect women's rights? آپ حکومت کے قوانین، ضوابط یا پالیسیوں سے کس حد تک واقف ہیں جو صنفی مساوات کو فروغ دیتے ہیں اور خواتین کے حقوق کا تحفظ کرتے ہیں؟	*Tick one relevant option*	*1. Not aware at all* ☐ *2. Slightly aware* ☐ 3. *Moderately aware* ☐ 4. *Quite aware* ☐ 5. *Fully aware* ☐ *99.Not Response* ☐

D1.2	*Are you aware of the term Gender Based Violence (GBV)?* کیا آپ صنفی بنیاد پر تشدد (GBV) کی اصطلاح سے واقف ہیں؟	*Pic one relevant option*	1. Yes 2. No
D1.3	*Do you know where to seek legal help in the case of GBV?* کیا آپ جانتے ہیں کہ GBV کی صورت میں قانونی مدد کہاں سے حاصل کی جائے؟	*Pic one relevant option*	*1. Yes* *2. No*
D1.4	*Do you believe easy access to legal services and courts for women can help reduce GBV cases?* کیا آپ کو یقین ہے کہ خواتین کے لیے قانونی خدمات اور عدالتوں تک آسان رسائی سے GBV کے مقدمات کو کم کرنے میں مدد مل سکتی ہے؟	*Pic one relevant option*	*1. yes* *2. No* *3. May be*

D1.5: To what extent do you agree with the following statements?

1) If a woman goes to a market alone and encounters verbal abuse from a stranger, she should be blamed for the abuse incident, as she should not go out alone and provide an opportunity for men to abuse her. اگر کوئی عورت بازار میں اکیلی جاتی ہے اور اسے کسی اجنبی کی زبانی بدسلوکی کا سامنا کرنا پڑتا ہے تو اسے زیادتی کے واقعے کا ذمہ دار ٹھہرایا جانا چاہیے کیونکہ اسے اکیلے باہر نہیں جانا چاہیے اور مردوں کو اس کے ساتھ زیادتی کا موقع فراہم نہیں کرنا چاہیے۔	*Select one relevant*	1. Agree 2. Neutral 3. Disagree 99. Refused to Respond
2) It is never acceptable for someone to use violence against their partner or spouse, regardless of the circumstances. حالات سے قطع نظر کسی کے لیے اپنے ساتھی یا شریک حیات کے خلاف تشدد کا استعمال کرنا کبھی بھی قابل قبول نہیں ہے۔	*Select one relevant*	1. Agree 2. Neutral 3. Disagree 99. Refused to Respond

D1.6: How likely are you to believe or support the following statements related to gender-based violence? Please indicate your level of agreement. (Select one relevant)

1) Perpetrators of gender-based violence should be held accountable through legal and justice system صنفی بنیاد پر تشدد کے مرتکب افراد کو قانونی اور انصاف کے نظام کے ذریعے جوابدہ ہونا چاہیے۔	*1. Very likely to believe or support* *2. Likely to believe or support* *3. Neutral* *4. Unlikely to believe or support* *5. Very unlikely to believe or support* *99. Refused to respond*
2) Educating individuals about consent and healthy relationships can help prevent gender-based violence افراد کو رضامندی اور صحت مند تعلقات کے بارے میں تعلیم دینے سے صنفی بنیاد پر تشدد کو روکنے میں مدد مل سکتی ہے۔	*1. Very likely to believe or support* *2. Likely to believe or support* *3. Neutral* *4. Unlikely to believe or support* *5. Very unlikely to believe or support* *99. Refused to respond*

D1.7: If a woman in your community experiences repeated gender-based violence from her husband, what do you believe should be the response and support provided to her? (Ask and select one relevant response).

اگر آپ کی کمیونٹی میں کوئی عورت اپنے شوہر کی طرف سے بار بار صنفی بنیاد پر تشدد کا سامنا کرتی ہے، تو آپ کے خیال میں اسے کیا مدد فراہم کی جانی چاہیے؟ (ایک متعلقہ جواب پوچھیں اور منتخب کریں)۔

1. She should be encouraged and supported to report the incidents to the appropriate authorities and seek legal protection against her husband. 2. The community should intervene and provide immediate support to ensure her safety, while also facilitating access to counseling and support services. 3. It is her decision to make whether to report the incidents or seek help, and she should be respected and supported regardless of her choice. 4. It is a family matter and let them solve and others should not intervene. Others should intervene at a level to make the husband understand and if he does not listen leave the leave the matter to their own. 5. She should be connected with local support organizations specializing in gender-based violence to receive comprehensive assistance and guidance. 99. Refused to respond	**1.**اسے متعلقہ حکام کو واقعات کی اطلاع دینے اور اپنے شوہر کے خلاف قانونی تحفظ حاصل کرنے کے لیے حوصلہ افزائی اور حمایت کی جانی چاہیے۔ **2.**کمیونٹی کو مداخلت کرنی چاہیے اور اس کی حفاظت کو یقینی بنانے کے لیے فوری مدد فراہم کرنی چاہیے، جبکہ مشاورت اور معاون خدمات تک رسائی کو بھی آسان بنانا چاہیے۔ **3.**یہ اس کا فیصلہ ہے کہ آیا واقعات کی اطلاع دینی ہے یا مدد طلب کرنا ہے، اور اس کی پسند سے قطع نظر اس کا احترام اور حمایت کی جانی چاہیے۔ **4.**یہ خاندانی معاملہ ہے اسے حل کرنے دیں اور دوسروں کو مداخلت نہیں کرنی چاہیے۔ دوسرے کو چاہیے کہ شوہر کو سمجھانے کے لیے مداخلت کریں اور اگر وہ نہ مانے تو معاملہ ان پر چھوڑ دیں۔ **5.**اسے جامع مدد اور رہنمائی حاصل کرنے کے لیے صنفی بنیاد پر تشدد میں مہارت رکھنے والی مقامی امدادی تنظیموں سے منسلک ہونا چاہیے۔ **99.**جواب دینے سے انکار کر دیا۔

D1.8	How likely are you to intervene or report if you witness gender-based violence or abuse? اگر آپ صنفی بنیاد پر تشدد یا بدسلوکی کا مشاہدہ کرتے ہیں تو آپ کے مداخلت یا رپورٹ کرنے کا کتنا امکان ہے؟	*Tick one relevant option*	*1. Very unlikely* *2. Unlikely* *3. Neutral* *4. Likely* *5. Very likely* *99 Not Response*

D2: 1230.1: Percentage of male and female community members reporting understanding and acceptance of gender equality and women's empowerment (by gender, district) ***Men and Women module***

D2.1	Do you believe that gender equality is important for the progress of society? کیا آپ سمجھتے ہیں کہ صنفی مساوات معاشرے کی ترقی کے لیے اہم ہے؟	*Tick one relevant option*	*Yes* *No* *99. No Response*
D2.2	*Do you* believe *that women should have equal opportunities for community* leadership *and community decision-making?* کیا آپ اس بات پر یقین رکھتے ہیں کہ خواتین کو کمیونٹی کی قیادت اور کمیونٹی فیصلہ سازی کے لیے مساوی مواقع ملنے چاہئیں؟	*Tick one relevant option*	*Yes* *No* *No Response*
D2.3	*In your opinion, do you think women should have the same opportunities as men to participate in decision-making processes at all levels?* آپ کی رائے میں، کیا آپ سمجھتے ہیں کہ خواتین کو ہر سطح پر فیصلہ سازی کے عمل میں حصہ لینے کے لیے مردوں کے برابر مواقع ملنے چاہئیں؟		*Yes* *No* *No Response*

D2.4: A young woman member of your family wants to pursue a career in a field traditionally dominated by men, such as engineering or construction. What do you think she should do? (Ask and select one relevant response)

آپ کے خاندان کی ایک نوجوان خاتون رکن ایسے شعبے میں اپنا کیریئر بنانا چاہتی ہے جو روایتی طور پر مردوں کے زیر تسلط ہے، جیسے انجینئرنگ یا تعمیرات۔ آپ کے خیال میں اسے کیا کرنا چاہیے؟ (ایک متعلقہ جواب پوچھیں اور منتخب کریں)

1. She should follow her passion and pursue the career she desires, regardless of gender norms *2. She should consider more traditionally female-oriented careers, as they may be more suitable for women* *99. Refused to respond* *D2.5: A girl in your family turns out to be a good soccer player and she aspires to become a professional soccer player, a sport predominantly played by men in our society. How do you feel about her ambition? (Ask and select one relevant response)* *1. I fully support and encourage her to pursue her ambition as a professional soccer player, regardless of societal gender norms.* *2. I have reservations about her choice of becoming a professional soccer player and believe she should consider more "suitable" options for women.* *3. She should explore other alternatives or sports that are more traditionally associated with women rather than pursuing soccer.* *99. Refused to respond*	**1 .اسے اپنے جذبے کی پیروی کرنی چاہیے اور صنفی اصولوں سے قطع نظر اپنے کیرئیر کو آگے بڑھانا چاہیے** **2 .اسے روایتی طور پر خواتین پر مبنی کیریئر پر غور کرنا چاہیے، کیونکہ وہ خواتین کے لیے زیادہ موزوں ہو سکتے ہیں۔** **99 .جواب دینے سے انکار کر دیا۔** **D2.5: آپ کے خاندان کی ایک لڑکی فٹ بال کی اچھی کھلاڑی نکلی ہے اور وہ ایک پیشہ ور فٹ بال کھلاڑی بننے کی خواہش رکھتی ہے، یہ کھیل ہمارے معاشرے میں زیادہ تر مرد کھیلتے ہیں۔ آپ اس کی خواہش کے بارے میں کیسا محسوس کرتے ہیں؟ (ایک متعلقہ جواب پوچھیں اور منتخب کریں(** **1 .میں اس کی مکمل حمایت کرتا ہوں اور اس کی حوصلہ افزائی کرتا ہوں کہ وہ ایک پیشہ ور فٹ بال کھلاڑی کے طور پر سماجی جنس کے اصولوں سے قطع نظر اپنے عزائم کو آگے بڑھائے۔** **2 .مجھے اس کے پیشہ ور فٹ بال کھلاڑی بننے کے انتخاب کے بارے میں تحفظات ہیں اور مجھے یقین ہے کہ اسے خواتین کے لیے مزید "مناسب" اختیارات پر غور کرنا چاہیے۔** **3 .اسے دوسرے متبادلات یا کھیلوں کو تلاش کرنا چاہیے جو فٹ بال کو آگے بڑھانے کے بجائے روایتی طور پر خواتین سے جڑے ہوئے ہوں۔** **99 .جواب دینے سے انکار کر دیا۔**

D2.6: Imagine you have two children, a boy, and a girl, and you can only afford to send one child to a well-known private school for a better-quality education. Both have equal abilities and potential. What would you do in this situation? (Ask and select one relevant response)

D2.6: تصور کریں کہ آپ کے دو بچے ہیں، ایک لڑکا اور ایک لڑکی، اور آپ صرف ایک بچے کو بہتر معیار کی تعلیم کے لیے کسی معروف پرائیویٹ اسکول میں بھیجنے کے متحمل ہوسکتے ہیں۔ دونوں میں یکساں صلاحیتیں اور صلاحیتیں ہیں۔ اس صورت حال میں آپ کیا کریں گے؟ (ایک متعلقہ جواب پوچھیں اور منتخب کریں***)***

1. I would prioritize sending the boy to the private school because traditionally boys have more opportunities and responsibilities in society. *2. I would prioritize sending the girl to the private school to empower her and provide equal opportunities for her future.* *3. Since I cannot afford this school for both of them, I will explore alternative options (relatively less known) which I can afford for both of them* *99. Refused to respond* *D2.7: One of your female household members has received business training and has a unique business idea. The suitable place to start and operate this business is a shop in the local bazaar where most of the business operators are male. What do you think she should do? (Ask and select one relevant response).* *1. She should be encouraged and supported in pursuing her business idea and opening the shop in the local bazaar, regardless of traditional gender roles.*	**.**میں لڑکے کو پرائیویٹ اسکول بھیجنے کو ترجیح دوں گا کیونکہ روایتی طور پر لڑکوں کو معاشرے میں زیادہ مواقع اور ذمہ داریاں حاصل ہوتی ہیں۔ ***.2***میں لڑکی کو بااختیار بنانے اور اس کے مستقبل کے لیے مساوی مواقع فراہم کرنے کے لیے اسے نجی اسکول بھیجنے کو ترجیح دوں گا۔ ***.3***چونکہ میں ان دونوں کے لیے اس اسکول کا متحمل نہیں ہو سکتا، اس لیے میں متبادل اختیارات تلاش کروں گا (جو نسبتاً کم معلوم ہیں) جو میں ان دونوں کے لیے برداشت کر سکتا ہوں۔ ***.99***جواب دینے سے انکار کر دیا۔ ***D2.7:***آپ کے گھریلو ممبران میں سے ایک نے کاروباری تربیت حاصل کی ہے اور اس کے پاس ایک منفرد کاروباری خیال ہے۔ اس کاروبار کو شروع کرنے اور چلانے کے لیے مناسب جگہ مقامی بازار میں ایک دکان ہے جہاں زیادہ تر کاروبار چلانے والے مرد ہیں۔ آپ کے خیال میں اسے کیا کرنا چاہیے؟ (ایک متعلقہ جواب پوچھیں اور منتخب کریں)۔

2. She should be discouraged from pursuing the business idea and directed towards more "appropriate" roles for women in the household or community. *3. She should explore other alternatives or locations for the business idea that are more aligned with societal expectations for women.* *99. Refuse to respond*	***1.***روایتی صنفی کرداروں سے قطع نظر اپنے کاروباری خیال کو آگے بڑھانے اور مقامی بازار میں دکان کھولنے میں اس کی حوصلہ افزائی اور حمایت کی جانی چاہیے۔ ***2.***اسے کاروباری خیال کی پیروی کرنے سے حوصلہ شکنی کی جانی چاہیے اور اسے گھر یا کمیونٹی میں خواتین کے لیے مزید "مناسب" کرداروں کی طرف ہدایت دی جانی چاہیے۔ ***3.***اسے کاروباری خیال کے لیے دیگر متبادلات یا مقامات کی تلاش کرنی چاہیے جو خواتین کے لیے سماجی توقعات کے ساتھ زیادہ ہم آہنگ ہوں۔ ***99.***جواب دینے سے انکار

D2. 8: Your cousin got married four years ago and now has two daughters. His wife is employed in a private company and wants to focus on her career and educate the girls. She expresses her desire to delay having another child for another five years. However, her spouse and family members are pressuring her to conceive again as soon as possible, specifically hoping for a son. What are your thoughts on this situation? (Ask and select one relevant response)

آپ کے کزن کی شادی چار سال پہلے ہوئی تھی اور اب ان کی دو بیٹیاں ہیں۔ اس کی بیوی ایک پرائیویٹ کمپنی میں ملازم ہے اور وہ اپنے کیریئر پر توجہ دینا اور لڑکیوں کو تعلیم دینا چاہتی ہے۔ وہ ایک اور بچہ پیدا کرنے میں مزید پانچ سال تاخیر کرنے کی خواہش کا اظہار کرتی ہے۔ تاہم، اس کی شریک حیات اور خاندان کے افراد اس پر جتنی جلدی ممکن ہو دوبارہ حاملہ ہونے کے لیے دباؤ ڈال رہے ہیں، (خاص طور پر بیٹے کی امید میں۔ اس صورتحال پر آپ کے کیا خیالات ہیں؟ (ایک متعلقہ جواب پوچھیں اور منتخب کریں

1. She should have the freedom to prioritize her career and personal aspirations, and her decision to delay having another child should be respected. *2. She should compromise on her personal aspiration and obey the decision of husband and respect family's desire and conceive another child as they want* *3. The decision regarding family planning should be a joint one between the couple, taking into account their individual preferences and circumstances.* *99. Refused to respond.*	*1.***اسے اپنے کیریئر اور ذاتی خواہشات کو ترجیح دینے کی آزادی ہونی چاہیے، اور دوسرے بچے کی پیدائش میں تاخیر کے اس کے فیصلے کا احترام کیا جانا چاہیے۔** *2.***اسے اپنی ذاتی خواہش پر سمجھوتہ کرنا چاہیے اور شوہر کے فیصلے پر عمل کرنا چاہیے اور خاندان کی خواہش کا احترام کرنا چاہیے اور جیسا وہ چاہتے ہیں دوسرے بچے کو حاملہ کرنا چاہیے۔** *3.***خاندانی منصوبہ بندی کے بارے میں فیصلہ جوڑے کے درمیان ان کی انفرادی ترجیحات اور حالات کو مدنظر رکھتے ہوئے مشترکہ ہونا چاہیے۔** *99.***جواب دینے سے انکار کر دیا۔**

D2.9: Your aunt has decided to contest the next local government election? What are your thoughts on her decision? (Ask and select one relevant response)

:D2.9آپ کی خالہ نے اگلا بلدیاتی الیکشن لڑنے کا فیصلہ کیا ہے؟ اس کے فیصلے پر آپ کے کیا خیالات ہیں؟ (ایک متعلقہ جواب پوچھیں اور منتخب کریں(

1. I will her decision of taking part in political activities and contesting the election. 2. I will only support her if she has taken the decision in consultation with uncle and other family members 3. I have reservations about her decision to enter politics and believe women should focus on other roles in society. 99. Refused to respond.	**.1میں اس کے سیاسی سرگرمیوں میں حصہ لینے اور الیکشن لڑنے کا فیصلہ کروں گا۔** **.2میں اس کی حمایت صرف اس صورت میں کروں گا جب اس نے چچا اور خاندان کے دیگر افراد کی مشاورت سے فیصلہ کیا ہو۔** **.3مجھے ان کے سیاست میں آنے کے فیصلے پر تحفظات ہیں اور مجھے یقین ہے کہ خواتین کو معاشرے میں دیگر کرداروں پر توجہ دینی چاہیے۔** **.99جواب دینے سے انکار کر دیا۔**

D3: Perceptions about the contributions of AGECS Project Impact and Sustainability

D3.1. Do you think the AGECS project has made any positive difference in your life, household, or community?

کیا آپ سمجھتے ہیں کہ اے جی ای سی ایس پراجیکٹ نے آپ کی زندگی، گھرانے یا کمیونٹی میں کوئی مثبت فرق ڈالا ہے؟

(Single choice)

1. Yes, a big difference
2. Yes, some difference
3. No difference
4. Things have become worse
97. Not applicable
99.Refused to respond

D3.2. In which areas has the AGECS project made a positive difference?
آپ کے خیال میں اے جی ای سی ایس پراجیکٹ نے کن شعبوں میں مثبت فرق ڈالا ہے؟
(Multiple choice, tick all that apply)

1. Women’s decision-making (family planning, child health, SRH, ECD)
2. Easier access to health, SRH, or ECD services
3. Awareness and response to GBV
4. Gender equality and women’s empowerment in community
5. No difference from AGECS
9.Other (please specify)
97. Not applicable
99.Refused to respond

D3.3. How did the AGECS project bring these changes?
آپ کے خیال میں اے جی ای سی ایس پراجیکٹ نے یہ تبدیلیاں کیسے لائیں؟
(Multiple choice, tick all that apply)

1. By giving me more knowledge/awareness
2. By building my confidence and decision-making skills
3. By improving communication in my family
4. By making services easier to access
5. By reducing stigma or social pressure
6. By changing community/family attitudes
7. By increasing support from leaders/service providers
9.Other (please specify)
97. Not applicable
99.Refused to respond

D3.4. Do you think the positive changes from the AGECS project will continue after the project ends?
کیا آپ سمجھتے ہیں کہ اے جی ای سی ایس پراجیکٹ کی مثبت تبدیلیاں پراجیکٹ کے ختم ہونے کے بعد بھی جاری رہیں گی؟
(Single choice)

1. Yes, definitely
2. Yes, maybe
3. No, unlikely
4. Don’t know/unsure
97. Not applicable
99.Refused to respond

Module-E (1220). Enhanced ability of local Community strucutres, Instiutions, and leaders to identify and respond to gender and social barriers through transformative action

E1 (1220.2): Extent to which the members of the project population value the work of CSOs (by geography) – Men and Women module (KADO, LAPH and SBHI)
(Net Promoter Score)

E1.1. (If Chitral Region) Are you familiar with LAPH and its work?
1. Yes (Go to D1.2)
2. No (Skip to E1)

E1.2. (If Chitral) Are you familiar with SBHI and its work?
1. Yes (Go to D1.3)
2. No (Skip to E1)

E1.3. (If Gilgit Region or UC Laspur and Yarkhun of Chitral Upper). Are you familiar with Karakorum Area Development Organization (KADO) and its work?
1. Yes (Go to D1.4)
2. No (Skip to E1)

E1.4: On a scale of 1 to 10, to what extent do you value the work of LAPH?

1	2	3	4	5	6	7	8	9	10

E1.5: On a scale of 1 to 10, to what extent do you value the work of SBHI?

1	2	3	4	5	6	7	8	9	10

E1.6: On a scale of 1 to 10, to what extent do you value the work of KADO?

1	2	3	4	5	6	7	8	9	10

ANNEX 6: LIST OF SAMPLE VILLAGES FOR THE BASELINE AND ENDLINE SURVEY

District	Union Councils	Name of Villages (Baseline)	Name of Villages (Endline)	Sample HHs (Baseline)	Sample HHs (Endline)
Ghizer	Chatorkhand	Chatorkhand	Chatokhand	16	12
	Chatorkhand	Dain	Pakora	16	12
	Imit	Sultanabad	Bilhanz	16	12
	Hunder Silgan	Hundur	Hundur	16	12
	Sultanabad Tause	Tause	Tause	16	12
Gilgit	Gilgit MC	Gilgit Proper	Khomar	16	12
	Danyore	Sultanabad	Danyore	16	12
	Gilgit MC	Jagir Basin	Zulfiqarabad	16	12
	Nomal	Nomal	Nomal	16	12
	Rahimabad	Juglote/Guro	Rahimabad	16	12
Hunza	Gojal 2	Sost (Afiyatabad)	Sost	16	12
	Gojal 1	Khudaabad	Passu	16	12
	Gojal 1	Gulmit	Gulmit	16	12
	Altit	Altit	Altit	16	12
	Shinaki	Khanabad	Nasirabad	16	12
Nagar	Hoper	Hakalshal	Hoper(thol)	16	12
	Hoper	Hisper	Buladas	16	12
	Hoper	Ratal	Akberabad	16	12
	Sumayar	Chalat Paeen	Sumayar	16	12
	Shain Bar	Askurdass	Asqurdas	16	12
Chitral Upper	Charun	Charun	Bulan Lasht	16	12
	Kosht	Drunghgh	Barumkagh	16	12
	Laspure	Raman	Awi	16	12
	Mastuj	Parkusap	Parwak	16	12
	Yarkhoon	Brep	Chapali	16	12
Chtral Lower	Chitral-2	Lasht See	Dankarikan Deh	16	12
	Ayun	Burun	Muldeh Ayun	16	12
	Lotkoh	Bashqir Payeen	Birzeen	16	12
	Shoghore	Momi	Kassat	16	12
	Drosh-2	Kuru	Shahnigar	16	12
	Total			480	360

ANNEX 7: TRAINING SCHEDULE FOR DATA COLLECTION TEAMS

Session	Topic	Objective	Method
Day 1: Orientation, Ethics, and Tools			
1	Welcome, introductions, objectives	Build rapport and set expectations	Icebreakers, group discussion
2	Overview of AGECS Programme & Endline Survey	Clarify purpose and linkages to baseline	Presentation, Q&A
3	Ethical considerations & safeguarding	Understand informed consent, confidentiality, referral pathways	Case studies, role play
4	Understanding GBV and sensitive issues	Build sensitivity to gender and cultural dynamics	Group work, discussion
5	Household survey tool walkthrough	Familiarise with modules, skip logic, question flow	Instrument review, Q&A
6	Digital data collection (ODK/KoBo)	Train on device use, data entry, saving/submitting	Hands-on practice
Day 2: Applied Practice and Simulation			
1	Interview techniques (probing, neutrality, rapport)	Strengthen interviewing skills	Role plays, peer feedback
2	Sampling and respondent selection	Standardise procedures for household, KII, FGD respondents	Practical exercises
3	Mock household survey	Simulate real interviews for accuracy	Role plays, trainer feedback
4	KIIs and FGDs: purpose, roles, facilitation	Build skills in qualitative data collection	Demonstration, Q&A
5	Mock KIIs and FGDs	Practice facilitation, probing, and note-taking	Simulation, feedback
6	Field protocols and logistics	Clarify roles, daily reporting, and coordination	Plenary discussion
7	Wrap-up and evaluation	Consolidate learning and assess readiness	Reflection, Q&A

ANNEX – 8: KII GUIDES – AGECS ENDLINE SURVEY

Participant Information

- Name of participant: _________Type/designation of participant: ______Sex: _______
- Date of interview: ________Name of interviewer: ___________Venue of interview: ________

Informed Consent

(Greet according to local culture/tradition)
My name is __________________, and I am part of the research team from DEVYIELD Consulting Firm, working with the Aga Khan Rural Support Programme (AKRSP) for the AGECS Endline Study.
We are speaking with key community members like you to understand issues around health and family decision-making, gender equality, social barriers, and how communities handle and respond to gender-based violence (GBV).

- Participation is voluntary.
- You may skip any question or stop the interview at any time.
- Everything you share will remain confidential and anonymous; your name will not appear in any report.
- The discussion will last about 30–45 minutes.
- While there are no direct benefits, your views will help AKRSP and partners improve future programmes.

Audio-recording: To ensure accuracy, we would like to record this interview. The recording will remain confidential and be deleted after analysis. If you do not agree, we will only take written notes.
Consent Questions:

1. Do you agree to participate in this interview?
    - Yes → Proceed
    - No → Thank them and end interview
2. Do you agree to have this interview audio-recorded?
    - Yes → Start recording
    - No → Proceed with note-taking only

GBV Clarification for Participants

"Before we begin, I want to clarify what we mean by Gender-Based Violence (GBV):
GBV refers to harmful acts done to someone because of their gender. This includes:

- Physical violence (hitting, slapping, beating)
- Sexual violence (harassment, assault, rape)
- Emotional/psychological abuse (threats, humiliation, control)
- Economic violence (blocking access to money, jobs, or independence)
- Harmful traditional practices (child marriage, forced marriage, honour-related violence)
- Online/digital violence (harassment, cyberbullying, non-consensual photo sharing)

In some communities, these are often seen as 'family matters' and not considered violence. For this study, we would like to understand your views and experiences on these issues."

Opening Question

- Please tell us about your role and the organizations/institutions/communities you are associated with.

Main Questions & Probes

Q1. Understanding GBV in Local Context

- Which forms of GBV are recognised as violence here, and which are treated as normal/family matters?
    - Probe: Are early marriage, inheritance denial, or mobility restrictions seen as GBV?

- Probe: Do men and women see these differently?

Q2. Gender and Social Barriers

- What are the main barriers women, girls, and GBV survivors face in accessing services (health, ECD, legal, protection)?
  - Probe: Examples you have seen?
  - Probe: Differences rural vs. urban, adolescents vs. adults?
  - Probe: Are services absent, or present but underused?
  - Probe: How do poverty/unemployment worsen barriers?

Q3. Underreporting of Cases

- Why do many GBV cases remain hidden or unreported?
  - Probe: Stigma, family honour, retaliation, costs?
  - Probe: Are adolescents less likely to report than adults?

Q4. Nature and Scale of GBV

- How do you see GBV trends in your area (increasing, decreasing, changing)?
  - Probe: Compared to 2–3 years ago, has reporting changed? Why?
  - Probe: Which forms are most common now (domestic, economic, workplace, online)?
  - Probe: New risks (social media, migration, disasters)?
  - Probe: Who are the most vulnerable groups?

Q5. Informal vs. Formal Handling of Cases

- How are GBV cases usually resolved in your community?
  - Probe: Role of jirgas, elders, religious leaders?
  - Probe: When do they refer cases to police/CSOs? Why/why not?

Q6. Institutional Challenges

- What challenges do institutions (police, courts, CSOs) face in dealing with hidden or culturally normalised GBV cases?
  - Probe: Lack of training? Weak survivor protection? Political pressure?

Q7. Role of KADO, LAPH, AKRSP

- How effective have CSOs been in addressing GBV and gender barriers?
  - Probe: Which interventions worked well? Where are gaps?
  - Probe: Do communities trust them? Why/why not?
  - Probe: How effective is coordination with government/police?

Q8. Institutional Coordination

- How do police, courts, CSOs, religious and traditional leaders coordinate in GBV cases?
  - Probe: What referral mechanisms exist? Are they effective?
  - Probe: Do survivors feel satisfied with this collaboration?

Q9. Perceptions of Change

- Compared to 2–3 years ago, have community attitudes or reporting changed?
  - Probe: Has CSO, media, or religious messaging influenced this?
  - Probe: Are men and boys more engaged now?

Q10. Recommendations

- What would make it easier for survivors to report and access justice?
  - Probe: Better-trained police, more women officers, faster courts?
  - Probe: Stronger CSO presence, school/media awareness, legal reforms?

Stakeholder-Specific Questions

1. CSO Leadership (KADO, LAPH, AKRSP)

- How has AGECS support strengthened your capacity and partnerships?
- Which training, tools, or systems improved most?
- What challenges affect sustainability (funding, staff, political issues)?
- How do you measure community trust in your work?

- What strategies can sustain services post-AGECS?

2. Police (Station Heads/Staff)

- What is the current volume and type of GBV cases?
- What prevents survivors from filing complaints?
- How do police coordinate with CSOs and legal aid?
- What resources or training do you need?
- Has trust between survivors and police changed? Why?

3. Lawyers / Legal Aid Providers

- What types of GBV cases reach you most?
- What challenges do survivors face in accessing justice?
- How effective are legal aid mechanisms?
- How do you coordinate with police/CSOs?
- What reforms would improve justice delivery?

4. Women Activists

- What barriers do women and girls face most?
- How do women mobilise for support?
- Have attitudes in the community shifted?
- Are grassroots groups sustainable?
- What risks do activists face?

5. Media Persons

- How is GBV covered in your media (sensitive/responsible)?
- What role does media play in prevention/awareness?
- What constraints exist in reporting?
- How effective are partnerships with CSOs?
- What more can media do to change attitudes?

6. Traditional Leaders

- How are GBV cases resolved in customary systems?
- When do you refer cases to formal systems? Why/why not?
- Have community expectations changed?
- What risks do you face in handling cases?
- How could traditional leaders better prevent GBV?

7. Religious Leaders

- How do you address GBV in sermons/gatherings?
- Which messages have been most effective?
- Are women/girls now seeking your support?
- What support do you need to improve your role?

8. Elected Representatives

- What laws/policies exist on GBV? Are they effective?
- What is your role in budgeting and oversight?
- How do you coordinate with police, courts, CSOs?
- What are the biggest funding/service gaps?

- What political/institutional changes are needed?

KII PARTICIPENTS GENDER AND GBV CAPAICTY CHECKLIST

MODULE-A. TRAINING

A3	*Have you received any formal training or education on gender empowerment, GBV and women rights?*	*Tick one relevant option*	*1. Yes* *2. No*
A4	*If yes, please specify the type of training or support you have received.*		
A5	*Have you received any formal training or education on addressing GBV issues?*	*Tick one relevant option*	*1. Yes* *2. No*
A5	*In your opinion, do you think addressing gender and social barriers faced by women is an important issue for your community?*	*Tick one relevant option*	*1. Yes* *2. No*

MODULE B: (1220.3): *% of community leaders reporting increase in ability to identify and respond to gender and social barriers (by gender, district)*

A2.1: Do you support the following statements? (Ask for responses by reading out each statement).	*1) Yes* *2) No* *99. Did not respond*		
1) Women should be involved in household decisions about marriage, health, education, personal finance and other spheres of life.	*1*	*2*	*99*
2) Women should have equal share of productive assets of the family and have freedom to use as they want	*1*	*2*	*99*
3) Women should have the right to set their own life goals and priorities	*1*	*2*	*99*
4) Women should have access to education, training and other opportunities to gain skills and self-confidence	*1*	*2*	*99*
5) Women should have freedom and opportunities to engage in paid work/jobs	*1*	*2*	*99*
6) Promoting women's participation in household decisions about marriage, health, education, personal finances and other spheres of life	*1*	*2*	*99*
7) Women should be allowed to take leadership roles in community institutions and politics	*1*	*2*	*99*
8) Promoting women's ability to set their own goals and priorities	*1*	*2*	*99*
9) Awareness should be created against the discrimination of women including early marriage, suicide and mental health, taboos around female childbirth, domestic violence and workplace discrimination	*1*	*2*	*99*

A3: How knowledgeable are you with regards to the following?	*1) Very knowledgeable* *2) Moderately knowledgeable* *3) Slightly knowledgeable* *4) Not knowledgeable at all* *99. Did not respond*				
1) Various types of sexual and Gender based Violence (SGBV) against women?	*1*	*2*	*3*	*4*	*99*
2) Gender and social barriers faced by women in accessing services family planning, child health care, SRH and ECD service.	*1*	*2*	*3*	*4*	*99*

4) Government's laws, regulations or policies that promote gender equality and protect women's rights?	*1*	*2*	*3*	*4*	*99*

A4.: Do you think it is part of your role in your sphere/context as a local leader to help promote women's empowerment?

- Yes____
- No_____ (End the interview)
- Don't Know

A5	*How confident do you feel in your ability to identify gender and social barriers faced by women? Please rate your confidence level on a scale of 1 to 5, where 1 represents "Not confident at all" and 5 represents "Very confident."*	*1*	*2*	*3*	*4*	*5*

Closing (all KIIs)

- Is there anything else you would like to add about how GBV and gender equality can be better addressed in your community?

DATA COLLECTION FROM POLICES STATIONS

Data Collection Approach: A letter/application requesting the required information will be issued to the concerned DPO at each district to provide the desired required information. The letter will be will also attached a supplementary letter by AKRSP confirming the commissioning of the study. Similarly, the templated will be provided along with the letter. After that, the relevant policies station will be followed up and support to get the required information.

MODULE A: (1200): 1200 REDUCED GENDER AND SOCIAL BARRIERS TO UTILIZATION AND UPTAKE OF HEALTH, EARLY CHILD-HOOD DEVELOPMENT, AND OTHER SUSTAINABLE DEVELOPMENT SERVICES AND PRACTICES IN SELECT AREAS OF ASIA BY WOMEN AND GIRLS, ADOLESCENTS, MEN, AND BOYS

Gender-Based Violence (GBV) refers to any form of violence or harmful behavior that is primarily committed against an individual based on their gender, typically targeting women and girls. However, it is important to note that GBV can also affect individuals of any gender identity. Gender-Based Violence encompasses various forms of violence, including:

- ***Physical Violence:*** *This involves any form of physical harm or force, such as hitting, slapping, kicking, or restraining someone against their will.*
- ***Sexual Violence:*** *It includes acts of sexual assault, rape, sexual harassment, coercion, and any non-consensual sexual activity.*
- ***Emotional or Psychological Violence:*** *This refers to behaviors that cause emotional or psychological harm, such as verbal abuse, intimidation, humiliation, or controlling behaviors.*
- ***Economic Violence:*** *It involves the deprivation or control of financial resources, limiting someone's access to money, employment opportunities, or economic independence.*
- ***Harmful Traditional Practices:*** *Some harmful practices rooted in tradition or cultural beliefs can cause physical, psychological, such as forced marriage, or honor killings.*
- ***Online or Digital Violence:*** *With the rise of technology and the internet, GBV can also occur in the form of online harassment, cyberbullying, stalking, or the distribution of non-consensual intimate images etc.*

MOUDULE A1: # OF GBV CASES REPORTED AND REDRESSED (BY GENDER, DISTRICT) ***(LAPH ONLY)***

A1.1: During the last year how many GBV cases are reported in your police satiation? Please provide data for each police station.

District Name	*Police Station Name*	*Month 01*	*Month 02*	*Month 03*	*Month 04*	*Month 05*	*Month 06*	*Month 07*	*Month 08*	*Month 09*	*Month 10*	*Month 11*	*Month 12*

WHAT ARE MAIN FORMS OF GBV CASES REPORTED? IF POSSIBLE INDICATE NUMBERS BY FORMS?

MODULE- B (1210): INCREASED EQUITABLE ACCESS TO LEGAL SERVICES FOR ADDRESSING GBV CASES IN TARGET DISTRICTS

B1 (1210.1): Number of women filing formal complaints regarding GBV with law agencies (by district) ***(KADO ONLY) – (Data will be gathered from Police stations)***

B1.1: During the last year, how many women cases of Gender Based Violence (GBV) reported in the district. Please provide data for each police station.

Name of District.	*Police Station Name*	*Month 01*	*Month 02*	*Month 03*	*Month 04*	*Month 05*	*Month 06*	*Month 07*	*Month 08*	*Month 09*	*Month 10*	*Month 11*	*Month 12*

WHAT ARE MAIN FORMS OF GBV CASES REPORTED? IF POSSIBLE INDICATE NUMBERS BY FORMS?

10.1.

ANNEX – 9: FGD GUIDE – AGECS ENDLINE SURVEY

Participant & Session Information

- FGD Group: (Adult women / Adult men / Adolescent girls & boys joint group)
- Location (village/district): __________Date: __________Facilitator(s): _____________
- Note-taker(s): __________________________ Duration: 1 hour

Informed Consent (to be read aloud)

Informed Consent

(Greet according to local culture/tradition)

My name is __________________, and I am part of the research team from DEVYIELD Consulting Firm, working with the Aga Khan Rural Support Programme (AKRSP) for the AGECS Endline Study.

We are speaking with key community members like you to understand issues around health and family decision-making, gender equality, social barriers, and how communities handle and respond to gender-based violence (GBV).

- Participation is voluntary.
- You may skip any question or stop the interview at any time.
- Everything you share will remain confidential and anonymous; your name will not appear in any report.
- The discussion will last about 50–60 minutes.
- While there are no direct benefits, your views will help AKRSP and partners improve future programmes.

Audio-recording: To ensure accuracy, we would like to record this interview. The recording will remain confidential and be deleted after analysis. If you do not agree, we will only take written notes.

Consent Questions:

3. Do you agree to participate in this interview?
   - Yes → Proceed
   - No → Thank them and end interview
4. Do you agree to have this interview audio-recorded?
   - Yes → Start recording
   - No → Proceed with note-taking only

GBV Clarification for Participants

"Before we begin, I want to clarify what we mean by Gender-Based Violence (GBV): GBV refers to harmful acts done to someone because of their gender. This includes:

- Physical violence (hitting, slapping, beating)
- Sexual violence (harassment, assault, rape)
- Emotional/psychological abuse (threats, humiliation, control)
- Economic violence (blocking access to money, jobs, or independence)
- Harmful traditional practices (child marriage, forced marriage, honour-related violence)
- Online/digital violence (harassment, cyberbullying, non-consensual photo sharing)

In some communities, these are often seen as 'family matters' and not considered violence. For this study, we would like to understand your views and experiences on these issues."

Opening Question

- Ask everyone to introduce themselves. Please tell us about yourself and your role in the community.

FGD Questions

Core Discussion Framework (all groups)

Part 1: Understanding Gender and Social Barriers

- What are the main challenges faced by women, girls, and GBV survivors in your community?
- Which forms of GBV are recognised as violence, and which are treated as "normal" family issues?

- Why do you think many GBV cases remain hidden or unreported?

Part 2: Nature and Scale of GBV

- Compared to 2–3 years ago, has GBV increased, decreased, or changed form in your community?
- Who are the most vulnerable groups (e.g., young girls, married women, minorities, adolescents)?
- How are cases usually handled – through elders, religious leaders, or formal institutions?

Part 3: Institutions and CSOs

- How effective have KADO, LAPH, and AKRSP been in addressing these issues?
- Do communities trust them? Why or why not?
- How well do they coordinate with police, courts, and government?

Part 4: Perceptions of Change

- Have attitudes toward women's rights and GBV changed in the past 2–3 years?
- Are men and boys more engaged now?
- Has media, religious messaging, or CSO outreach influenced these changes?

Part 5: Recommendations and Sustainability

- What can be done to improve prevention, reporting, and redressal of GBV?
- What role should CSOs, police, religious/traditional leaders play?
- How can these changes be sustained after AGECS ends?

Group-Specific Modules

Group 1: Adult Women (18+)

1. Understanding the Issues
    - What are the main problems women face in daily life (health, childcare, family planning, education, safety)?
    - How common is GBV in this community? What forms do you see most often?
2. Causes of the Problems
    - Why do these barriers exist (traditions, family restrictions, poverty, lack of awareness/services)?
3. Coping and Responses
    - How do women usually handle these challenges? Who do they turn to?
    - What prevents women from getting help?
4. CSOs' Effectiveness & Sustainability
    - How have CSOs (KADO, LAPH, AKRSP) helped? Which activities were most useful?
    - Have these changes made a lasting difference? What's needed for sustainability?

Group 2: Adult Men (18+)

1. Understanding the Issues
    - How do men in this community see women's roles in decision-making, health, and education?
    - Is GBV a problem here? Which forms are most common?
2. Causes of the Problems
    - Why do men use violence or exclude women from decisions? (Norms, power, stress, poverty, peer pressure)
3. Coping and Responses
    - How do men usually respond when they see or hear about GBV?
    - What role should men play in supporting survivors?
4. CSOs' Effectiveness & Sustainability
    - How useful are CSO activities (awareness, legal support, livelihood)?
    - Can these efforts continue after the project ends? What would help sustain them?

Group 3: Adolescent Girls & Boys (10–19)

(Separate groups if joint discussion is not safe)

1. Understanding the Issues
    - What challenges do young people face in school, at home, or in the community?
    - Do you feel safe in your community? Why or why not?
2. Causes of the Problems
    - Why do these challenges exist for youth? (Gender expectations, bullying, lack of opportunities)

3. Coping and Responses
    - If a young person faces violence or discrimination, where can they go for help?
    - What makes it hard for youth to seek help?
4. CSOs' Effectiveness & Sustainability
    - Have you seen or joined CSO activities (campaigns, trainings)? What did you learn?
    - Do you think these activities will continue to help young people in the future? How?

Closing

- Is there anything else you would like to add that we did not discuss today?
- Thank participants sincerely, remind them their input is confidential, and explain that their views will help improve future programmes.

FGD Attendance Sheet – AGECS Endline Study

FGD Group (e.g., Adult Women / Adult Men / Adolescents):_________Location (Village / UC / District): ____

Date: ____ / ____ / ______ Facilitator Name: ________Note-taker Name: ________________________

Participants' Information:

No.	Full Name	Sex (M/F)	Age	Marital Status	Education Level	Occupation	Contact (optional)	Signature / Thumbprint
1								

Guidelines for FGD and KII Facilitators & Note-takers

AGECS Endline Study – DEVYIELD / AKRSP

1. Preparation

- Review tools in advance (FGD/KII guide, consent forms, attendance sheet).
- Set up venue: quiet, private, comfortable seating (circle for FGDs).
- Assign roles: one facilitator (leads discussion), one note-taker (captures responses verbatim and observations).

2. Informed Consent

- Clearly explain the purpose, duration, and voluntary nature of participation.
- Emphasize confidentiality: no names will be shared in reports.
- Obtain verbal or written consent (and audio-recording consent if applicable).

3. Facilitating FGDs

- Start with introductions and an icebreaker to make participants comfortable.
- Ask open-ended questions first, then probe for depth (why/how).
- Encourage participation from everyone (not only vocal participants).
- Be neutral: do not show agreement/disagreement with responses.
- Manage time: keep the discussion within the planned 1.5–2 hours.

4. Conducting KIIs

- Treat as a respectful conversation rather than a formal interview.
- Follow the question guide, but allow flexibility for deeper insights.
- Probe for examples: "Can you give an example?" / "How was this handled?"
- Be mindful of the power/status of informants (police, leaders, etc.).

5. Note-taking

- Capture key points verbatim (use participant quotes when possible).
- Note non-verbal cues (tone, hesitation, group reactions).
- Record participant numbers/roles, not names (e.g., Woman 1, Youth 2, Police Officer).
- For FGDs, note if certain participants dominate or if disagreements emerge.

6. Safeguarding & Sensitivity

- If sensitive issues (e.g., GBV) cause discomfort, allow participants to skip or pause.
- Stop the discussion if anyone feels unsafe or distressed.
- Provide referral information for support services if needed as mentioned in the consent form.

7. Closing

- Summarize key points to participants and thank them for their time.
- Remind them that their input will help improve programmes.

ANNEX – 10: PMF INDICATORS FOR KADO AND LAPH

PFM INDICATORS OF KADO (BASELINE 2022/23 - ENDLINE 2025)

OUTCOME INDICATORS	DISAGGREGATED INDICATORS	BASELINE	ENDLINE	Source ENDLINE Report (Table)
1200.1: % of AKF supported CSOs with improved performance	% of CSOs with an improved score	—	100%	OPI summaries (Tables 48, 51, 53)
	OPI Score for KADO	1.69	3.13	Table 48
1200.2: % of women who made decisions alone or jointly on FP/child health/health, SRH & ECD	Total	55%	85%	Table 14.
	% of women (age 18–35)	60%	86%	Table 14.
	% of women (age 36–53)	47%	83%	Table 14.
	% in Hunza	55%	98%	Table 14.
	% in Nagar	35%	83%	Table 14.
	% in Gilgit	51%	90%	Table 14.
	% in Ghizer	52%	61%	Table 14.
	% in Upper Chitral	71%	88%	Table 14.
1210.1: % of community members *completely satisfied* with handling/management of GBV cases	Total	15%	7%	Table 28. AND PFM FOR BASELINE
	% of Women	10%	3%	Table 28. AND PFM FOR BASELINE
	% of Men	21%	11%	Table 28. AND PFM FOR BASELINE
	% in Hunza	18%	3%	Table 28. AND PFM FOR BASELINE
	% in Nagar	24%	8%	Table 28. AND PFM FOR BASELINE
	% in Gilgit	1%	5%	Table 28. AND PFM FOR BASELINE
	% in Ghizer	24%	8%	Table 28. AND PFM FOR BASELINE
	% in Upper Chitral	9%	7%	Table 28. AND PFM FOR BASELINE
1210.2: # of women filing formal complaints re: GBV with law agencies	Total	24	44	ENDLINE: Police-registered GBV cases (all survivors) Oct 2024–Sept 2025 total 44: Hunza 9, Gilgit 23, Ghizer 12, Nagar 0 (proxy for formal complaints). Table 56. BASELINE: PFM
	# in Hunza District	0	9	
	# in Nagar District	0	0	
	# in Gilgit District	11	23	
	# in Ghizer District	7	12	
	# in Upper Chitral District	6	NA	
1220.1: Monetary value of support raised from local donors by CSOs	Total value raised by KADO	CAD 842,413	CAD 250,540	Table 49.
1220.2: Extent to which members value CSO work (NPS)	Net Promoter Score – KADO (Total)	-15	-21	Table 50.
	Female NPS	-40	-8	Table 50.

PFM INDICATORS OF KADO (BASELINE 2022/23 - ENDLINE 2025)

OUTCOME INDICATORS	DISAGGREGATED INDICATORS	BASELINE	ENDLINE	Source ENDLINE Report (Table)
	Male NPS	3	-35	Table 50.
1220.3: % of community leaders reporting increased ability to identify/respond to gender & social barriers	Total	35%	50%	Table 45
	% of men			
	% of women	33%	45%	
	% in Hunza District	42%	55%	
	% in Nagar District			
	% in Gilgit District	50%	67%	
	% in Ghizer District	30%	50%	
	% in Upper Chitral District	31%	40%	
1230.1: % of male & female community members reporting ↑ understanding & acceptance of gender equality / women's empowerment	Total (Gender-Equitable Attitudes)	72.70%	78%	Table 32
	% of Men	72.70%	79%	Table 32
	% of Women	72.80%	78%	Table 32
	% in Hunza	77.40%	70%	Table 32
	% in Nagar	79.70%	85%	Table 32
	% in Gilgit	65.50%	75%	Table 32
	% in Ghizer	71.50%	87%	Table 32
	% in Upper Chitral	71.60%	85%	Table 32

PFM INDICATORS OF LAPH (BASELINE 2022/23 - ENDLINE 2025)

Outcome Indicators	Disaggregated Indicators	Baseline	Endline	Source (Report Table)
% of AKF supported CSOs with improved performance	% of CSOs with an improved score	–	100% (3/3 CSOs improved)	OPI summaries (Tables 48, 51, 53)
	OPI Score for LAPH	1.75	2.88	Table 51
	OPI Score for SBHI	1	1.63	Table 53
# of GBV cases reported and redressed (by gender, district)	Total (Filed / Decided)	185 / 119 (64%)	203 / 127 (62%)	Table 57
	# of Men	–	–	DEALING WITH ONLY WOMEN CASES
	# of Women	185 / 119 (64%)	203 / 127 (62%)	ALL WOMEN
	# in Upper Chitral	34 / 19 (56%)	59 / 29 (49%)	Table 57
	# in Lower Chitral	151 / 100 (66%)	144 / 98 (68%)	Table 57
% of people satisfied with handling/management of GBV cases	Total	8%	7%	Table 28 AND PFM (BASELINE)
	% of Men	4%	11%	Table 28 AND PFM (BASELINE)
	% of Women	12%	3%	Table 28 AND PFM (BASELINE)
	% in Upper Chitral	9%	7%	Table 28 AND PFM (BASELINE)
	% in Lower Chitral	7%	8%	Table 28 AND PFM (BASELINE)
# of people/GBV survivors accessing courts for justice & support services	Total (women's legal cases filed)	185	203	Table 57
	# of Men	~~NA~~	N/A	DEALING WITH ONLY WOMEN CASES
	# of Women	185	203	Table 57
	# in Upper Chitral	34	59	Table 57
	# in Lower Chitral	151	144	Table 57
Monetary value of support raised from local donors by CSOs	Total (all CSOs)	CAD 17536	0	
	Value for LAPH	CAD 14,912	–	No funds mobilized
	Value for SBHI	CAD 2,624	–	Not reported
1220.2: Extent to which members value CSOs' work (Net Promoter Score)	LAPH – Total	-25	-14	Table 52
	Female (LAPH)	-33	-19	Table 52
	Male (LAPH)	-18	-8	Table 52
	SBHI – Total	-15	-19	Table 54
	Female (SBHI)	-24	-24	Table 54
	Male (SBHI)	-9	-16	Table 54
% of individuals holding gender equitable attitudes towards ending GBV	Total	72.70%	78%	Table 32
	% of Men	72.70%	79%	Table 32
	% of Women	72.80%	78%	Table 32
	% in Upper Chitral	71.60%	85%	Table 32
	% in Lower Chitral	57.90%	68%	Table 32

ANNEX 11: DEMOGRAPHIC PROFILE OF SAMPLE RESPONDENTS IN BASELINE (2023) AND ENDLINE (2025)

Districts	Lower Chitral		Upper Chitral		Ghizer		Gilgit		Hunza		Nagar		Grand Total	
Categories	2023	2025	2023	2025	2023	2025	2023	2025	2023	2025	2023	2025	2023	2025
Gender														
Female	40	30	42	30	40	30	40	37	43	31	41	30	188	246
Male	41	30	39	30	40	30	40	23	37	29	38	30	172	235
Grand Total	81	60	81	60	80	60	80	60	80	60	79	60	360	481
Age														
18-34	32	32	28	22	46	21	49	24	43	21	63	35	155	261
35 and above	47	28	52	38	34	39	31	36	37	39	16	25	205	219
Grand Total	81	60	80	60	80	60	80	60	80	60	79	60	360	480
Education														
No education	21	3	30	3	15	5	7	4	6	3	13	0	18	92
Primary	4	1	2	6	6	11	5	3	8	1	2	0	22	27
Middle	12	3	5	5	6	6	4	2	15	2	10	4	22	52
Secondary/Matric	16	10	18	18	14	14	11	8	10	7	16	2	59	85
Intermediate	16	13	15	11	19	11	15	10	17	13	21	9	67	103
Graduate/general	10	8	4	7	10	7	15	8	13	16	7	18	64	59
Graduate/Professional		7		2	6	2	13	12	4	12	2	16	51	25
Master and above	2	14	7	6	3	4	7	11	6	4	8	8	47	33
Technical/Vocational		0		2	1	0	2	1	1	2		3	8	4
Madrasa		1		0		0	1	1		0		0	2	1
Marital Status														
Single	5	26	8	16	17	0	25	2	26	1	31	1	46	112
Married	75	34	69	42	62	60	54	55	51	59	46	57	307	357
Separated		0		0		0	1	2	1	0		1	3	2
Widowed	1	0	4	2	1	0		1	2	0	2	1	4	10

ANNEX 12: FAMILY PROFILE OF THE SAMPLE SURVEY HOUSEHOLDS

	Ghizer		Gilgit		Hunza		Lower Chitral		Nagar		Upper Chitral		Grand Total	
Family Profile	2023	2025	2023	2025	2023	2025	2023	2025	2023	2025	2023	2025	2023	2025
Family Type														
Overall	**80**	**60**	**80**	**60**	**80**	**60**	**81**	**60**	**79**	**60**	**81**	**60**	**481**	**360**
Nuclear family (only parents and their children)	35	40	40	30	45	36	37	39	24	19	33	44	214	208
Joint family (extended family	45	20	40	30	35	24	44	21	55	41	48	16	267	152
Highest level of education any member of your household completed														
No education		1	2	0	1	1	5	0	4	0	1	0	13	2
Primary	2	3	3	3	1	0	2	0	2	0		0	10	6
Middle	3	4	4	2	3	1	10	2	5	6	1	1	26	16
Secondary/Matric	9	5	4	2	1	10	15	6	10	5	16	11	55	39
Intermediate	21	15	14	9	15	12	21	9	15	4	22	16	108	65
Technical/Vocational	2	1	1	1		1		1		0	1	1	4	5
Graduate/general	17	14	22	12	14	15	16	15	13	17	15	6	97	79
Graduate/Professional	5	9	15	10	9	11	3	11	10	13	3	13	45	67
Master and above	21	8	15	20	36	9	9	16	20	15	22	12	123	80
Madrassa		0				0		0		0		0	0	0
Household Income Source														
Daily Wage (Agricultural)	6	1	1	1	12	6	32	6	18	1	10	0	79	15
Daily Wage (Non-Agricultural)	18	9	3	5	3	1	15	10	9	0	31	13	79	38
Crop production and livestock	2	4	1	3		6	1	2	3	1	1	3	8	19
Salary (Non-Agricultural)	37	16	49	23	37	10	23	27	17	27	12	24	175	127
Self-employed/ business	5	26	18	25	13	32	8	5	13	27	5	9	62	124
Property		4	1	3		3		7		3		9	1	29
Pension	12	0	3	0		1	2	0	2	1	20	0	39	2
Social Welfare such as BISP/Zakat		0		0	1	1		0		0		1	1	2
Other		0	4	0	14	0		3	17	0	2	1	37	4

ANNEX 13: DISTRICT WISE DISTRIBUTION OF THE WOMEN'S ROLE IN DECISION MAKING BASELINE AND ENDLINE

	% Upper Chitral		% Upper Chitral		% Ghizer		% Gilgit		% Hunza		% Nagar		#	#
	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL	BL	EL
1. Use of contraceptives	35	22	36	11	28	29	28	42	29	32	24	**26**	**180**	**162**
I am not involved or Others decide for me		17%		0%		33%		50%		0%		0%		6
I am the primary decision-maker but consider others' input	25.70%	20%	47.20%	5%	3.57%	0%	7.14%	27%	0.00%	29%	0.00%	20%		41
I am the sole decision-maker	8.57%		16.60%		0.00%		0.00%		0.00%		0.00%			
I have equal input and influence in the decision-making process	62.80%	9%	19.40%	6%	96.40%	9%	89.20%	34%	82.70%	19%	83.30%	22%		67
I have limited input, but others make the final decision	2.85%	15%	16.60%	10%	0.00%	44%	3.57%	10%	17.20%	15%	16.60%	6%		48
To visit hospital/health centre		**21**		**9**		**28**		**46**		**32**		**25**		**161**
I am not involved or Others decide for me		0%		0%		20%		60%		20%		0%		5
I am the primary decision-maker but consider others' input		18%		2%		2%		29%		33%		16%		45
I am the sole decision-maker		0%		0%		0%		0%		0%		100%		1
I have equal input and influence in the decision-making process		10%		4%		10%		40%		15%		19%		67
I have limited input, but others make the final decision		14%		12%		44%		7%		14%		9%		43
To visit health service(s) or consult a heath professional	39	25	39	12	32	31	31	45	29	32	24	29	194	**174**
I am not involved or Others decide for me		11%		11%		33%		44%		0%		0%		9
I am the primary decision-maker but consider others' input	18%	16%	21%	5%	9%	7%	10%	20%	0%	36%	0%	16%		44
I am the sole decision-maker	8%	0%	8%	0%	3%	0%	0%	25%	0%	25%	0%	50%		4
I have equal input and influence in the decision-making process	67%	12%	54%	4%	81%	7%	84%	39%	83%	16%	71%	22%		69

	% Upper Chitral		% Upper Chitral		% Ghizer		% Gilgit		% Hunza		% Nagar		#	#
	BL	**EL**	**BL**	**EL**	**BL**	**EL**	**BL**	**EL**	**BL**	**EL**	**BL**	**EL**	**BL**	**EL**
I have limited input, but others make the final decision	8%	19%	18%	13%	6%	42%	6%	8%	17%	8%	29%	10%		48
4. Enrolling your child/Children	34	21	32	7	31	29	25	45	28	32	22	25	172	**158**
I am not involved or Others decide for me		17%		0%		33%		50%		0%		0%		6
I am the primary decision-maker but consider others' input	18%	12%	59%	3%	16%	3%	16%	36%	0%	36%	0%	9%		33
I am the sole decision-maker	3%	17%	6%	0%	3%	0%	0%	50%	4%	17%	0%	17%		6
I have equal input and influence in the decision-making process	74%	16%	25%	1%	74%	7%	80%	35%	86%	17%	64%	23%		69
I have limited input, but others make the final decision	6%	9%	9%	11%	6%	48%	4%	7%	11%	14%	36%	11%		44

ANNEX -14: OPI SCORE DETAILS

A. *Karakuram Area Devlopment Organization (KADO)*												
	Baseline (2023)				**Midline (2024)**				**Endline (2025)**			
Domain	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted/Remarks**	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted/Remarks**	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted/Remarks**
Effectiveness	1	Results	1	M&E manual; Excel tracking sheets	2	Results	2	M&E manual; Excel tracking; M&E Professional hired; PMFs with outcome targets (GIZ, UN Women); Baseline report (Climate Adaptation & Resilience); Draft strategic document	3	Results	3	M&E manual; Excel tracking; M&E Professional; M&E Framework (Chitral project); Progress & budget reports; Completion reports
	1.5	Standards	1	Exploring standards; PCP certification in process		Standards	2	Safeguarding Policy; Communication Strategy; HR Policy; PCP certification; Donor/AKRSP guidelines	3	Standards	3	Safeguarding, gender equality & climate change frameworks; Procurement framework
Efficiency	2	Delivery	2	Workplan with roles/timelines; Assessment reports	3	Delivery	3	Workplan & budget; Quarterly progress reports (UN Women, GIZ); Budget tracking sheets	3	Delivery	3	Workplan & budget; Periodic progress & budget utilization reports; Board presentations; Completion reports
	2	Reach	2	M&E framework; AKF tools		Reach	3	M&E framework; Agreement with GoGB (women's empowerment project – Gilgit); Export Development Fund	3	Reach	3	Same as midline; Expanded outreach confirmed

	A. *Karakuram Area Devlopment Organization (KADO)*											
	Baseline (2023)				**Midline (2024)**				**Endline (2025)**			
Domain	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted/Remarks**	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted/Remarks**	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted/Remarks**
								project (Skardu, Nagar, Gilgit, Ghizer)				
Relevance	2	Target population	2	Needs assessments; Focus on people with disabilities	2.5	Target population	3	Assessments (digital economy, product development); Climate Action Forum with AKAH	3.5	Target population	3	Same as midline; Stakeholder engagement records
	1.5	Learning	2	Market need assessments; Digital hub model		Learning	2	Assessment reports; Presentation (Mambasa)	3.5	Learning	4	Two-year learning report (Climate Insurance project); Assessment reports; Board presentations
Sustainability	1.5	Resources	1	Funding proposals; Donor applications	2.5	Resources	2	Digital Hub membership fees; Donor engagement (GIZ, UN Women, AKRSP, AGECs, MoC); I Care Foundation support	3	Resources	3	Resource Mobilization Plan; MOUs (Shamani Living Trust, Takaful, Community World Service Asia, ICDL)
	2	Social Capital	2	Recognition by PM of Pakistan; UN agency visits; AKF leadership		Social Capital	3	Visits by ambassadors (Portugal, Poland); MOUs (Serena Hotels, KIU, Jazz Musafir)	3	Social Capital	3	Networks with communities, government, private sector, CSOs
Total Average Scores		1.69				2.50				3.13		

A. *Legal Awareness Program for Human Rights (LAPH)*												
	Baseline (2023)				Midline (2024)				Endline (2025)			
Domain	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted**	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted**	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted**
Effectiveness	1	Results	1	Project-specific monitoring tools; Donor/government compliance reports	3	Results	3	AGECS PMF; AIS; Attendance sheets & pictures	3.25	Results	3.5	Updated PMF & AIS; Consolidated progress reports; Attendance sheets & pictures
		Standards	1	Donor/government compliance only		Standards	3	Staff training reports; Policies (HR, procurement, anti-fraud); Meeting minutes; Audit report		Standards	3	Institutional policies; Capacity-building records; Audit reports
Efficiency	2	Delivery	2	Project-specific workplans	2	Delivery	2	PMF, AIS of AGECS	2.5	Delivery	2.5	Updated project online PMF and AIS records/data
		Reach	2	Beneficiary database (30,000 reached)		Reach	2	Defined target population		Reach	2.5	PMF reach data (135% of target achieved)
Relevance	2	Target population	3	Stakeholder consultation records	2.5	Target population	3	GBV committee meeting minutes; Video on digital violence	2.75	Target population	3	GBV committee minutes; Integration of recommendations in workplan
		Learning	1	Acknowledged gaps; OPI notes		Learning	2	BoD meeting minutes (challenges discussed)		Learning	2.5	DSWD minutes; DSWD intent to replicate AGECS model
Sustainability	2	Resources	1	Reliance on donor funding; No RM strategy	2.5	Resources	2	Resource mobilization plan	3	Resources	2.5	Operationalized RM plan; Donor/partner engagement
		Social Capital	3	MOUs (AKF, DICT, Chitral Univ., District Bar Association)		Social Capital	3	Same as baseline		Social Capital	3.5	Active engagement with CSOs, community structures, govt departments
Total Average Score	1.75				2.50				2.88			

B. *Sadabahar Hunarmand Woman Community Citizen Board (SBHI)*												
	Baseline (2023)				Midline (2024)				Endline (2025)			
Domain	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted/Remarks**	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted/Remarks**	**Domain Score**	**Sub-Domain**	**Sub-Domain Score**	**Means of verification submitted/Remarks**
Effectiveness	1	Results	1	Not Available	2	Results	2	AGECs Workplan	2	Results	2	AGECs Workplan
		Standards	1	Not Available		Standards	2	Refresher Training certificates of SBHI's master trainers		Standards	2	Refresher Training certificates of SBHI's master trainers
Efficiency	1	Delivery	1	Not Available	2	Delivery	2	AGECs Workplan	2	Delivery	2	AGECs Workplan
		Reach	1	Not Available		Reach	2	AGECs Workplan		Reach	2	AGECs Workplan
Relevance	1	Target population	1	Not Available	1	Target population	1	Not Available	1	Target population	1	Not Available
		Learning	1	Not Available		Learning	1	Not Available		Learning	1	Not Available
Sustainability	1	Resources	1	Not Available	1.5	Resources	1	Not Available	1.5	Resources	1	Not Available
		Social Capital	1	Not Available		Social Capital	2	Not Available		Social Capital	2	Not Available
Total Average Score	1				1.625				1.63			