

Gap Analysis and Proposed Disability-Inclusive Referral Pathways

Strengthened Institutional Capacities and Community-Based
Mechanisms to Advance Gender Equality in Balochistan

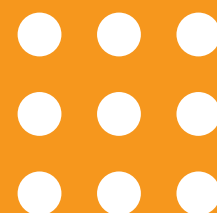


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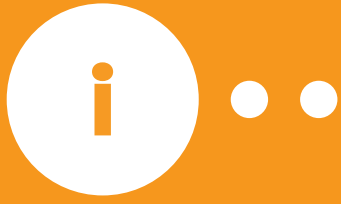
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LIST OF ACRONYMS



LIST OF ACRONYMS

CRPD

Convention on the Rights of
Persons with Disabilities

ESP

Essential Services Package

FGD

Focus Group Discussion

GBV

Gender-Based Violence

HIV

Human Immunodeficiency
Virus

KII

Key Informant Interview

OPD

Organization of Persons with Disabilities

PSEA

Prevention of Sexual Exploitation and Abuse

PWDs

Persons with Disabilities

SEA

Sexual Exploitation and
Abuse

SH

Sexual Harassment

SOPs

Standard Operating
Procedures

SRH

Sexual and Reproductive
Health

STEP

Special Talent Exchange
Program

STI

Sexually Transmitted Infection

UNFPA

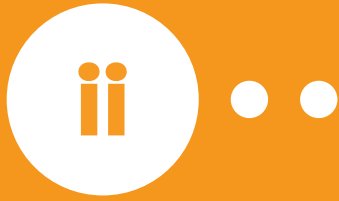
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EXECUTIVE SUMMARY



Introduction and Background

This report presents the findings of the assignment on reviewing, updating, and disseminating disability inclusive GBV referral pathways in Balochistan, implemented by STEP in partnership with UNFPA and Social Welfare and Human Rights Department. The study builds on desk research, institutional mapping, field consultations, and analysis of existing tools to identify barriers, gaps, and opportunities for strengthening referral mechanisms. It emphasizes survivor centered and disability inclusive practices, in line with the UN Essential Services Package (ESP) and national policy frameworks.

The project responds to the persistent gaps in GBV service provision in Balochistan, where women and girls with disabilities face multiple layers of exclusion. Despite legal frameworks and international commitments, referral mechanisms remain fragmented and inaccessible. STEP, supported by UNFPA, has taken the lead in creating a coordinated and inclusive pathway that connects government institutions, CSOs, and OPDs under a unified approach.

Objectives, Framework and Methodology

The consultancy was guided by the objective of reviewing and updating referral mechanisms to ensure inclusivity and stronger coordination among service providers. The framework applied a rights based and survivor centered lens, with a focus on accessibility and accountability. The methodology included desk review, key informant interviews, institutional mapping, multi stakeholder consultations, and a gap analysis using the Availability, Accessibility, Acceptability, and Quality (AAAQ) framework.

Key Findings:

The findings highlight that Balochistan's GBV referral pathways remain fragmented, under-resourced, and insufficiently disability-inclusive.



Existing Referral Practices

- Domestic violence remains the most common GBV case, often linked to drug addiction and unemployment. Police and health services mostly handle physical assaults, while shelters host women escaping family violence or forced marriages. Workplace harassment and denial of rights are reported mainly through CSOs.
- Referral decisions are largely need-based and ad hoc. Health facilities escalate severe cases to higher hospitals, police refer survivors to shelters and legal aid, while psychosocial officers and CSOs rely on informal networks, outdated directories, and digital tools like the Humqadam app.
- Standardized SOPs are absent across institutions. Police and shelters follow medico-legal and judicial steps rather than survivor-centered approaches. Most CSOs admit duplication of tools and limited coordination.
- Coordination is fragmented and informal, with actors relying on personal contacts and parallel systems, resulting in duplication and inefficiencies.



Accessibility and Disability Inclusion

- Survivors with disabilities are underserved and often invisible in the system. Only psychosocial officers and some CSOs reported direct engagement with survivors with visual, hearing, and intellectual disabilities.
- Barriers include survivors' dependence on family escorts, inaccessible infrastructure (lack of ramps, private spaces, interpreters, Braille), and absence of disability-sensitive procedures. Shelters lack capacity for cases of intellectual disability, while police and hospitals lack interpreters and accessible complaint mechanisms.
- Staff training on disability inclusion is scarce. Most frontline workers rely on experience rather than structured capacity building.



Capacity and Knowledge Gaps

- Frontline staff across health, police, and shelters lack skills in disability-sensitive case management, survivor-centered communication, and psychosocial support.
- Referral tools exist but are fragmented, outdated, or duplicated across organizations (SPO, BRSP, Shirkat Gah, HRCP). A single, unified, disability-inclusive directory is missing.
- Persistent misconceptions and biases—such as victim-blaming and underestimating risks for women with intellectual disabilities—compound systemic exclusion.



Coordination and Follow-Up

- Coordination is irregular and depends on individual relationships. Police engage hospitals for medico-legal referrals; shelters link mainly with courts; CSOs maintain stronger ties with WDD, SW and HRD, and other CSOs.
- Feedback loops are almost non-existent. Survivors are often “lost” after referral, with no systematic case follow-up between institutions.

Conclusion:

The study finds that GBV referral pathways in Balochistan are fragmented, inconsistent, and largely inaccessible, especially for women and girls with disabilities. Domestic violence remains the most reported form of GBV, but survivors face systemic barriers due to the absence of standardized protocols, weak coordination, duplication of tools, and limited staff capacity. Accessibility challenges such as lack of ramps, interpreters, and confidential spaces combined with misconceptions and biases among service providers, further exclude persons with disabilities. Coordination is mostly informal, with little follow-up or accountability, causing many survivors to be lost in the system. These gaps underscore the urgent need for a unified, survivor-centered, and disability-inclusive referral mechanism supported by trained staff, accessible infrastructure, and institutionalized coordination.

Recommendations:

-  Standardize referral practices through disability-inclusive SOPs, uniform intake forms, formal MOUs, and case-tracking systems.
-  Enhance accessibility by conducting audits, upgrading infrastructure (ramps, signage, private rooms), and introducing communication aids (interpreters, Braille, pictorial/audio guides).
-  Leverage technology by expanding digital platforms (e.g., Humqadam App) with disability-friendly features and offline access.
-  Build staff capacity with regular, on-site training in survivor-centered communication, psychosocial case management, and disability-sensitive GBV response.
-  Consolidate tools into a single provincial referral directory, available in multiple accessible formats.
-  Address misconceptions and biases through sensitization campaigns for frontline workers and communities.
-  Strengthen coordination by establishing a provincial referral forum led by WDD/SW&HRD with CSOs and OPDs' participation.
-  Institutionalize follow-up via focal persons in hospitals, police, and shelters, supported by feedback loops and digitized case-tracking systems.
-  Ensure accountability through regular inter-agency coordination meetings to review and update referral pathways.

Proposed Referral Pathways

Developed in direct response to field-identified gaps, the pathways are aligned with the UNFPA Essential Services Package (ESP) while grounded in provincial realities. The model places the Special Talent Exchange Program (STEP) at the heart of coordination, serving as a hub to consolidate efforts across government, civil society, helplines, and development partners. Through this role, STEP ensures that survivors, particularly women and girls with disabilities are not lost in the system but instead supported through a coherent, accountable, and accessible framework. At the core of the mechanism are **seven functional pillars** that collectively address systemic weaknesses:



Outreach to Persons with Disabilities through OPDs to identify and guide marginalized survivors into the pathway.



Awareness and Sensitization campaigns targeting communities, institutions, and leaders to reduce stigma and normalize GBV reporting.



Psychosocial Support delivered by STEP officers and partners to provide trauma-informed counseling and emotional care.



Accessibility Improvements including audits, infrastructure upgrades, interpreters, Braille, pictorial formats, and user-friendly digital tools.



Legal, Medico-Legal, and Protection Services integrating disability-sensitive justice and health responses through partnerships with police, courts, shelters, and legal aid providers.



Data and Evidence-Based Policy Advocacy to document barriers, inform reforms, and integrate disability inclusion into GBV policies and budgets.



Reintegration through vocational training, livelihood initiatives, and peer-support groups, enabling survivors to rebuild their lives with dignity and independence.

The referral pathways bring together a wide network of actors: government institutions such as the Social Welfare, Women Development, Health, and Police departments; protection and shelter services including Dar-ul-Amans; helplines and digital platforms such as Rescue 1122, Police Helpline 1089, and the Women Safety App; civil society actors like Aurat Foundation, Shirkat Gah, SPO, and HRCF; Organizations of persons with disabilities; and international partners, with UNFPA providing technical support and provincial coordination.

Capacity Building and Dissemination Plan

A structured capacity building plan was designed to ensure sustainability of the pathway. Training modules will cover disability inclusive GBV response, referral SOPs, psychosocial support, and coordination. Orientation sessions will be delivered to government institutions, CSOs, OPDs, and legal actors. Knowledge sharing will include community dialogues, awareness materials, and digital dissemination. Continuous support will be provided through refresher training, technical backstopping, and peer learning platforms.

1 ..

INTRODUCTION AND BACKGROUND





1.

Introduction and Background

1.1

Special Talent Exchange Program (STEP) – Organizational Introduction

Special Talent Exchange Program (STEP) is a non-profit NGO registered since 1997 under the Voluntary Social Welfare Agencies Ordinance 1961. STEP works nationally with government, civil society, and international partners to advance the rights of persons with disabilities and expand their access to inclusive and gender-sensitive services. With over two decades of experience, STEP has pioneered disability inclusion in humanitarian and development programming in Pakistan. For this project, STEP brings its strong networks of Organizations of Persons with Disabilities (OPDs), technical expertise in accessibility, and proven experience in building institutional capacities for inclusion.

1.2

Project Context

Gender-based violence (GBV) remains one of the most pressing human rights challenges in Pakistan, affecting women and girls across socioeconomic, cultural, and geographic divides. The Pakistan Demographic and Health Survey (2017–18) reported that nearly one in three women had experienced physical or sexual violence in their lifetime, with rural women more likely to be affected than those in urban areas. In Balochistan, where poverty, conflict, and weak governance exacerbate social vulnerabilities, the risks are even more pronounced. Women and girls in the province face layered disadvantages due to cultural barriers, inadequate institutional responsiveness, and limited access to justice and protection services.

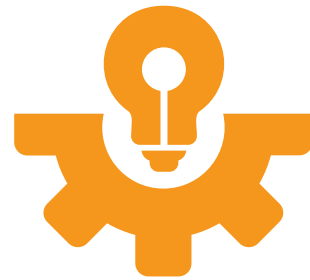
For women and girls with disabilities, the risks are intensified. They are more likely to face violence within households, remain invisible in public protection systems, and encounter structural exclusion when attempting to access services. Field consultations conducted during this study highlighted that survivors with disabilities often cannot report cases confidentially because they depend on family escorts, while health facilities, police stations, and shelters frequently lack even the most basic accessibility features such as ramps, interpreters, or private reporting rooms. The absence of disability-sensitive protocols within these institutions compounds survivors' vulnerability, often leaving them without meaningful redress.

Pakistan has taken important steps at the policy level by enacting pro-women legislation and ratifying international commitments such as the Convention on the Rights of Persons with Disabilities (CRPD). Despite these advances, the translation of commitments into practice remains uneven. Referral systems, in particular, suffer from fragmentation, duplication, and weak inter-agency coordination. Multiple organizations including SPO, BRSP, Aurat Foundation, Shirkat Gah, and HRCP have developed resource directories or digital tools, such as mobile applications and helplines, but these efforts are often outdated, lack disability inclusion, and are not integrated into a coherent framework. This results in survivors navigating a patchwork of services with no assurance of continuity, confidentiality, or accessibility.

It is within this broader national and provincial context that the initiative “Review, Update, and Dissemination of Disability-Inclusive Referral Pathways” has been launched by the Special Talent Exchange Program (STEP) in collaboration with the United Nations Population Fund (UNFPA) and Social Welfare and Human Rights Department, Government of Balochistan. . The project aligns with ongoing national and international commitments by aiming to review existing referral systems, identify service and accessibility gaps, and develop a unified, disability-inclusive referral mechanism for Balochistan. In doing so, it seeks not only to strengthen institutional capacities but also to ensure that GBV survivors with disabilities are able to access protection, health care, psychosocial support, and justice services in a dignified, timely, and coordinated manner.

2 ..

OBJECTIVES, FRAMEWORK AND METHODOLOGY





2.

Objectives, Framework and Methodology

2.1

Objectives (As Explained in TORs)

The overall objective of this consultancy is to review existing referral mechanisms, assess their inclusivity, and strengthen coordination among service providers to ensure they are accessible and responsive to the diverse needs of persons with disabilities.

The consultant will be responsible to:



Review existing referral pathways and services for persons with disabilities in the province.



Identify gaps, barriers, and challenges in access and inclusion.



Update referral pathways to reflect disability-inclusive approaches.



Develop user-friendly referral tools and materials.



Disseminate updated referral pathways to key stakeholders through orientation sessions and information materials.



Coordinate with relevant stakeholders.



Hand over all the material, ensuring confidentiality.

The study is structured around a rights-based, inclusive, and survivor-centered framework that integrates the principles of accessibility, accountability, and inter-agency coordination. It draws upon national policies, international conventions such as the Convention on the Rights of Persons with Disabilities (CRPD), and global guidance including the UNFPA Essential Services Package (ESP) for survivors of GBV. The framework is both analytical and operational, enabling a systematic review of existing referral pathways while offering practical mechanisms for their improvement and dissemination.

2.2.1 - Analytical Components



The consultancy employs a phased, participatory, and inclusive methodology designed to assess, revise, and disseminate disability-inclusive GBV referral pathways in Balochistan.

Table: Step-by-step methodology

Step	Description
Step 1: Desk Review and Orientation	Comprehensive review of referral tools, service mapping reports, and policy frameworks (including the ESP and CRPD) provided the baseline understanding and identified gaps.
Step 2: Institutional Mapping and Consultations	Mapping documented service providers across health, police, legal aid, shelters, helplines, and social protection sectors. Key Informant Interviews (KIs) with institutional representatives explored referral practices and disability inclusion. A multi-stakeholder consultation brought together government, CSOs, and OPDs to validate findings and identify coordination gaps.
Step 3: Gap Analysis	Using the AAAQ framework, the study assessed availability, accessibility, acceptability, and quality of services. Critical gaps identified included physical inaccessibility of health and police facilities, lack of psychosocial staff in shelters, reliance on family escorts, duplication of referral directories, and absence of disability-inclusive SOPs. Geographic disparities were also noted, with Quetta comparatively better served than rural districts.
Step 4: Drafting the Pathways and Referral Mechanism	Building on the gap analysis, updated survivor-centered referral pathways were designed to clarify steps for both immediate and non-immediate GBV cases, emphasizing informed consent, confidentiality, accessibility, and inter-agency coordination.
Step 5: Development of Accessible Tools and Referral Directory	Tools such as flowcharts, directories, and guidance notes were developed in accessible formats (large print, simple text, pictorial versions) for both survivors and frontline service providers.
Step 6: Capacity Building Plan	A comprehensive training and dissemination plan was prepared to build institutional capacities, focusing on health staff, police officers, and shelter managers, while leveraging CSO and OPD networks for awareness and outreach.
Step 7: Reporting and Handover	All materials, including referral tools and training content, will be compiled in accessible formats and handed over to STEP, with confidentiality and ownership safeguards.

In this phase, a detailed mapping exercise was undertaken to identify existing GBV service providers across Balochistan, including actors from the health sector, police, legal aid bodies, shelters, helplines, social protection programs, and civil society organizations. The mapping documented the scope of services, referral responsibilities, geographic coverage, and current provisions for disability inclusion. It also captured institutional realities such as resource gaps, reliance on informal coordination mechanisms, and duplication of referral tools across organizations.

To supplement the mapping, primary data collection was carried out through both individual and group consultations.



Key Informant Interviews (KIIs):

Semi-structured interviews were conducted with hospital administrators, police officers, legal aid providers, shelter managers, psychosocial officers, helpline operators, and civil society representatives. These discussions revealed, for instance, that basic health units (e.g., Nawan Killi) provide first aid but lack structured referral pathways for survivors with disabilities; police stations in Quetta are central to case registration but remain inaccessible due to the absence of ramps, interpreters, and standardized disability-sensitive protocols; and Dar-ul-Amans provide basic shelter but face serious shortages of psychosocial staff and legal advisors. CSOs such as SPO, Aurat Foundation, Shirkat Gah, and HRCP highlighted duplication of referral directories and digital platforms, which are outdated or not disability-inclusive, limiting their practical use for survivors and providers. Organizations of Persons with Disabilities (OPDs), such as TSO–ILC Quetta, shared the exclusion of PWD data in government systems (e.g., NADRA) and the absence of rehabilitation services, despite the strong linkage between drug abuse and GBV in communities.



Group Consultations:

In addition to KIIs, a multi-stakeholder consultation brought together representatives from government departments (e.g., Social Welfare Department, Women Development Department, Police, Health), civil society organizations, OPDs, and frontline service providers. This collective forum surfaced cross-cutting barriers such as cultural taboos, over-dependence on family escorts that compromise confidentiality, institutional insensitivity, and the lack of disability-friendly infrastructure. It also highlighted shared challenges, including fragmentation of referral systems, limited awareness of existing helplines and apps in rural areas, and weak coordination between government and CSOs. Opportunities for improvement were also identified, such as leveraging Shirkat Gah’s Humqadam App to expand digital outreach, consolidating SPO and BRSP directories into a unified provincial referral directory, and strengthening STEP’s role as a coordinating hub for disability-inclusive referral pathways.

Both KIIs and group consultations were guided by standardized consultation tools and ensured representation from both urban and rural contexts. The insights generated not only validated the findings of the desk review but also exposed critical service delivery gaps particularly the absence of psychosocial staff in shelters, lack of training among police and health workers, and the duplication of resource directories without disability inclusion. These findings directly inform the gap analysis and provide the evidence base for designing practical, survivor-centered, and disability-inclusive referral pathways for the province.

Table: Stakeholders engaged through individual and group KIs

Stakeholder Type	Respondents	Role in Referral Mechanism
Psychosocial Officers	Saima & Maria (STEP)	Provide psychosocial support, assess survivor needs, coordinate referrals with OPDs and NGOs
Health Facilities	BHU Nawan Killi (Dr. Shahzaib Shah, Khadija)	Provide first aid, medical support, and refer survivors to DHQ/Civil Hospital
Police	Quetta Women Police Station (Zarghoona)	Case registration, survivor protection, coordination with hospitals and shelters
Shelter Homes	Dar-ul-Aman (Madam Asia)	Provide temporary protection, basic accommodation, and coordinate with judiciary and health services
Civil Society Organizations (CSOs)	SPO, Aurat Foundation, Shirkat Gah, HRCP	Develop referral directories, legal aid, advocacy, awareness campaigns, digital tools (apps)
Organizations of Persons with Disabilities (OPDs)	TSO-ILC Quetta	Advocate for PWD inclusion, provide education and social work for excluded children
Human Rights Bodies	HRCP Quetta	Operate complaint cell, provide legal aid, advocate for survivors' rights
Community Representatives	Caregivers, survivors, volunteers	First point of contact, provide immediate support, link survivors to services
Government Departments	WDD, SWD, Health, Police, Judiciary	Policy oversight, service provision, coordination
Supporting Agencies	UNFPA	Technical assistance, convening coordination, alignment with global frameworks (ESP, CRPD)

1

Inception Report– Methodology, tools, and work plan

2

Draft Disability-Inclusive Referral Pathways– Updated process flows and survivor-centered mechanisms

3

Accessible Referral Directory of Services– Validated directory with disability inclusion features

4

Final Report and Referral Pathway Package– Consolidated final report, flowcharts, tools, and recommendations

3 ..

REFERRAL SYSTEM ASSESSMENT AND GAP ANALYSIS





3.

Referral System Assessment and Gap Analysis

3.1

Key Findings

3.1.1 - Understanding Existing Referral Practices



Types of GBV Cases Reported:

Domestic violence is the most common form of GBV across institutions, particularly linked to drug addiction and unemployment in communities. Police and health services mainly encounter physical assault cases, while shelters host women escaping family violence or forced marriages. HRCP and Aurat Foundation additionally handle workplace harassment and denial of rights cases. Acid attacks are rare in the Balochistan context.



Steps Followed When Survivors Seek Support:

Health facilities such as BHUs provide first aid and refer complex cases to district or civil hospitals. Police follow FIR registration, protection, and medico-legal referral procedures. Shelters like Dar-ul-Aman require survivors to undergo medico-legal and judicial steps before admission. Psychosocial officers at STEP engage in initial assessments and connect survivors to OPDs for specialized support. HRCP registers cases via phone, WhatsApp, or in-person visits and links survivors to legal aid services.



Informal Referral Pathways and Decision-Making:

Referrals are made according to survivors' immediate needs. BHUs send serious cases to higher-level hospitals, while police direct survivors toward shelters and legal aid depending on the nature of the case. Psychosocial officers rely on informal MOUs with OPDs and lawyers to secure specialized support. CSOs like Shirkat Gah and Aurat Foundation use their directories, mobile apps, and facilitation desks to guide survivors, though they admit coordination gaps.



Use of SOPs and Protocols:

Standardized referral protocols are largely absent. Police lack disability-inclusive SOPs, while Dar-ul-Aman operates under judicial and medico-legal requirements rather than survivor-centered procedures. Psychosocial officers apply past manuals but highlight gaps in consistency across institutions. Shirkat Gah's Humqadam app digitizes referral options but is not officially endorsed as a standard protocol.



Coordination and Partnerships:

Coordination mechanisms are mostly informal. Psychosocial officers have MOUs with OPDs and lawyers; shelters collaborate with courts and hospitals; and police link with hospitals for medico-legal processes but have weak connections to helplines. HRCP maintains strong coordination with WDD, SWD, and CSOs. SPO and BRSP have developed separate directories, creating duplication, while UNFPA's provincial sub-working group was noted as a potential platform to harmonize efforts.

Table: Existing Referral Practices across Institutions

Institution Type	Common GBV Cases	Steps Followed	Referral Practices	Coordination & SOPs
Health Facilities (BHUs, Hospitals)	Mostly domestic violence; visible injuries	Provide first aid; refer severe cases to DHQ/ Civil Hospital	Referrals based on case severity	No disability-inclusive SOPs; limited coordination with police & hospitals
Police (Quetta Women Police Station)	Mainly physical assault cases	Register FIRs, provide protection, refer for medico-legal	Refer to hospitals, shelters, legal aid	No disability-sensitive SOPs; weak links with helplines
Shelters (Dar-ul-Aman)	Family violence, forced marriages; refugee women	Admission only after medico-legal and judicial steps	Referral decisions tied to courts	Operate on judicial/ medical rules; no NGO partnerships
Psychosocial Officers (STEP)	Family violence, cyber crimes, disability-linked cases	Assess needs, provide counseling, connect to NGOs	Rely on informal MOUs with OPDs, CSOs, lawyers	Use informal manuals; ad hoc coordination
CSOs (SPO, Aurat, Shirkat Gah, HRCP)	Domestic violence, harassment, denial of rights	Register complaints, provide legal aid, use facilitation desks	Referrals through directories and partner networks	Tools outdated/ duplicated; no unified SOPs
OPDs (TSO-ILC Quetta)	Not direct GBV projects; engage vulnerable PWDs	Provide education/ social work, awareness	Recommend multi-stakeholder referral pathways	No referral protocols; weak government links
HRCP Complaint Cell	Domestic violence, workplace harassment, denial of rights	Register cases via phone/WhatsApp or in-person	Refer to lawyers, courts, police, shelters	Strong CSO/ government links; no disability-specific SOPs

3.1.2 - Accessibility and Inclusion for Persons with Disabilities



Experience with Survivors with Disabilities:

Institutions varied in the extent of their engagement with GBV survivors with disabilities. Psychosocial officers at STEP, many of whom are PWDs themselves, reported direct cases involving women with physical, visual, hearing, and intellectual disabilities. BHUs and hospitals rarely identified GBV cases among PWDs, though they acknowledged treating women with visible injuries who may also have underlying disabilities. Police officers in Quetta recognized that survivors with mobility, hearing, and visual impairments face greater difficulties in filing complaints. OPDs such as TSO-ILC emphasized that although they are not running GBV projects directly, they frequently encounter women and children with disabilities vulnerable to violence.



Challenges in Responding to Needs:

Across institutions, the most cited challenge was survivors' dependency on family escorts, which compromises confidentiality and limits disclosure. Health staff noted their own lack of sensitivity and expressed fears of backlash if they facilitated survivors' legal claims. Police officers admitted that inaccessible forms, lack of interpreters, and absence of ramps made reporting especially difficult for PWDs. Dar-ul-Aman shelters identified intellectual disability as a particularly difficult area, as staff lacked both training and resources to manage cases safely. OPDs highlighted structural barriers, such as NADRA's unwillingness to share PWD data, which obstructs survivor identification and case tracking.



Availability of Disability Accommodations:

Disability accommodations were found to be minimal or non-existent in most institutions. BHUs and police stations lacked ramps, private reporting rooms, Braille materials, or sign language interpreters. Shelters provided only basic accommodation and food, with no specialized support facilities for survivors with mobility or sensory impairments. CSO innovations such as Shirkat Gah's Humqadam App and Aurat Foundation's facilitation desks provide digital or desk-based support but are not yet designed with disability-friendly interfaces.



Staff Training on Disability-Inclusive Approaches:

Very few frontline staff reported receiving any structured training on disability inclusion in GBV response. STEP psychosocial officers had prior exposure through projects in Punjab and KP and had received limited training on supporting survivors with visual, hearing, and intellectual disabilities. Police officers and health workers acknowledged a lack of training opportunities, and shelter staff relied heavily on long service experience rather than formal capacity building. HRCP and Aurat Foundation staff had some exposure to disability awareness through broader human rights training, but this did not extend to survivor-centered GBV case management.



Communication with Survivors with Disabilities:

Effective communication with survivors who have hearing, visual, or cognitive impairments was identified as a major gap. No interpreters, pictorial guidance, or audio-assisted tools were reported at police stations, hospitals, or shelters. Survivors were often forced to rely on family members or caregivers to interpret, which undermines confidentiality and increases risks of coercion. STEP officers attempted to bridge this gap by drawing on OPDs and informal networks, but they too faced resource constraints. OPDs confirmed that without institutional provision of communication aids, survivors with disabilities remain effectively excluded from the system.

Table: Accessibility and Inclusion of GBV Survivors with Disabilities Across Key Institutions

Institution Type	Experience with PWD Survivors	Main Challenges	Accommodations & Training
Health Facilities	Rarely identified explicitly; mostly domestic violence cases	Survivors rely on family escorts; staff fear backlash	No ramps or private spaces; no disability training
Police	Some cases with mobility, hearing, visual impairments	Inaccessible forms; no ramps/interpreters	No SOPs; no disability-sensitive training
Shelters (Dar-ul-Aman)	Women and girls, some with disabilities; refugee cases	Entry tied to medico-legal orders; no psychosocial/legal staff	Only basic support; no disability facilities or training
Psychosocial Officers (STEP)	Direct work with survivors with physical, visual, hearing, intellectual disabilities	Across all institutions, the absence of coordinated disability-inclusive referral pathways and communication supports (sign language, Braille, assistive technology) leaves survivors without continuous or accessible care.	Some prior training; rely on OPDs for support
CSOs (SPO, AF, SG, HRCP)	Some direct cases; use of directories/apps	Duplication of tools; limited disability focus	Apps/desks exist but not disability-friendly; limited staff training
OPDs (TSO-ILC Quetta)	Work with PWDs and vulnerable children	No data sharing from NADRA; no rehab programs	Basic awareness; no formal accommodations
HRCP Complaint Cell	GBV-related rights cases, some involving PWDs	FIR barriers; limited outreach beyond Quetta	No disability-specific adaptations; general rights training only

3.1.3 - Capacity and Knowledge Gaps



Knowledge and Skills Needed:

Frontline staff across health, police, and shelters consistently highlighted the need for specialized training in handling cases involving survivors with disabilities. Health workers requested practical skills for supporting survivors with mobility, hearing, and visual impairments, along with guidance on how to link them to medico-legal services. Police officers emphasized the importance of training in disability sensitivity, survivor-centered case management, and communication with PWDs. Shelter staff identified a gap in knowledge for working with survivors with intellectual disabilities and stressed the need for psychosocial case management skills.



Referral Tools in Use:

Several organizations rely on referral tools, but these remain fragmented. SPO's referral directory (2019–20) exists but is outdated and not disability-inclusive. BRSP has developed a separate resource list, and Shirkat Gah digitized its resource directory into the Humqadam App. HRCP maintains a complaint cell directory for legal and referral contacts. However, duplication and overlap across these tools lead to confusion, and frontline actors lack a single, unified and accessible directory. Psychosocial officers at STEP continue to rely on informal MOUs with OPDs and NGOs instead of standardized referral directories.



Training and Guidance Needs:

Respondents strongly favored regular, structured training and guidance on disability-inclusive GBV response. Health and police staff requested on-site orientation sessions rather than external workshops due to workload constraints. Shelters highlighted the need for case management training conducted at their facilities. CSOs and OPDs stressed the value of capacity building on survivor-centered communication, accessibility audits, and inter-agency coordination. All actors agreed that technical guidance, refresher trainings, and orientation on the updated referral pathways would improve cooperation across the system.

3.1.4 - Misconceptions and Biases: Findings revealed that misconceptions about disability and GBV persist among frontline staff. Some health workers expressed victim-blaming attitudes, suggesting that women could “avoid violence” by adjusting their behavior, while others underestimated the risks of sexual harassment faced by women with intellectual disabilities. Police and shelter staff often assumed that survivors with disabilities could not navigate the system independently, reinforcing dependence on caregivers. These biases not only undermine survivor dignity but also perpetuate systemic exclusion, making disability-sensitive training and awareness an urgent need.

Coordination and Follow-Up



Frequency of Coordination:

Coordination among service providers in Balochistan is irregular and largely dependent on individual relationships rather than institutionalized mechanisms. Psychosocial officers noted that they coordinate with OPDs and NGOs on a case-by-case basis, often through informal MOUs. Police stations coordinate with hospitals for medico-legal referrals but have weak engagement with helplines. Shelters interact with courts and health facilities but not with NGOs, while CSOs such as HRCP, Aurat Foundation, and Shirkat Gah maintain stronger, though fragmented, coordination with government departments and each other.



Feedback Loops and Follow-Up:

Formal feedback mechanisms after referrals are almost entirely absent. Health staff typically lose contact with survivors once cases are referred to district hospitals. Police rarely follow up after sending survivors to shelters or legal aid. At Dar-ul-Aman, survivor information is reported to magistrates and commissioners, but there is no systematic feedback on case outcomes. Psychosocial officers at STEP attempt follow-up through direct survivor contact, but resource constraints limit this practice. CSOs such as HRCP provide some continuity by monitoring legal aid cases, but they too lack structured feedback systems with other institutions.



Challenges in Making and Receiving Referrals:

The biggest challenges identified include duplication and inconsistency of referral directories, weak communication channels between government departments and CSOs, and lack of disability-inclusive SOPs. Survivors’ reliance on family escorts also undermines confidential referrals, as sensitive information is often filtered through family members. Police reported budget constraints and absence of training as barriers to effective coordination, while shelters highlighted their inability to collaborate with NGOs due to bureaucratic restrictions. OPDs stressed that without data sharing from NADRA or integration into provincial coordination systems, survivors with disabilities remain invisible in referral flows.

Table: Coordination and Follow up Across Institutions

Institution Type	Frequency of Coordination	Key Challenges
Health Facilities (BHUs, Hospitals)	Occasional coordination with DHQ/Civil Hospitals for referrals	Survivors lost the track in system; lack of structured referral pathways
Police (Quetta Women Police Station)	Coordinate with hospitals for medico-legal support; weak links with helplines	No disability-inclusive SOPs; budget and training gaps

Shelters (Dar-ul-Aman)	Regular coordination with courts and hospitals; little engagement with NGOs	Referrals tied to judicial/medical approvals; staff lack tools
Psychosocial Officers (STEP)	Frequent coordination with OPDs and NGOs through informal MOUs	Dependence on external actors; lack of standardized referral tools and fragmented referrals
CSOs (HRCP, Aurat Foundation, Shirkat Gah, SPO)	Active coordination with WDD, SWD, and partner CSOs, but fragmented	Duplication of directories; lack of unified provincial mechanism
OPDs (TSO-ILC Quetta)	Limited direct coordination; advocate for multi-stakeholder pathways	Excluded from government data; NADRA not sharing PWD information

3.2

Conclusion

The findings reveal that the referral landscape in Balochistan is fragmented, inconsistent, and largely inaccessible for women and girls with disabilities. While domestic violence remains the most reported form of GBV, the systems in place to support survivors are constrained by the absence of standardized protocols, weak coordination, duplication of tools, and limited staff capacity. Survivors with disabilities are particularly marginalized, as physical infrastructure, communication methods, and institutional attitudes fail to meet their needs. Informal arrangements and ad hoc practices may provide short-term relief but do not ensure accountability, sustainability, or survivor-centered outcomes. These systemic weaknesses underline the urgent need for a unified, disability-inclusive referral pathway, one that integrates health, police, shelters, legal aid, and civil society into a coordinated framework, supported by accessible tools, trained staff, and institutional ownership.

Based on analysis framework, specific conclusion for each segment is as follows:



Existing Referral Practices:

The field consultations highlighted that GBV service provision in Balochistan remains fragmented and inconsistent across institutions. Domestic violence emerged as the most common form of GBV, often driven by drug addiction and unemployment, while cases of workplace harassment and denial of rights were also documented by civil society organizations. Although health facilities, police, shelters, psychosocial officers, and CSOs all play a role in responding to survivors, their approaches remain reactive and largely guided by institutional limitations rather than survivor-centered protocols. Referral pathways are often determined by immediate needs, but the absence of standardized SOPs, especially those inclusive of disability, results in ad hoc responses. Coordination, where it exists, is typically informal, with duplication of directories further complicating survivors' navigation of the system.



Accessibility and Inclusion for Persons with Disabilities:

Accessibility for survivors with disabilities remains minimal across all service providers. While psychosocial officers at STEP and some OPDs have direct experience supporting women with physical, visual, hearing, and intellectual disabilities, most health facilities and police stations rarely identify or respond effectively to survivors with disabilities. Structural barriers such as lack of ramps, interpreters, or private reporting spaces severely limit access, while dependency on family escorts compromises confidentiality. Staff across institutions acknowledged their lack of disability-specific training, and survivors with cognitive or intellectual disabilities were noted as particularly vulnerable. Without interpreters, pictorial tools, or alternative communication methods, survivors with disabilities remain largely excluded from the referral system.



Capacity and Knowledge Gaps:

Capacity constraints are evident across all frontline institutions. Health workers, police officers, and shelter staff expressed a strong need for specialized training in disability-sensitive GBV response, yet opportunities for such capacity building remain scarce. The referral tools currently in use such as SPO's outdated directory, BRSP's resource lists, and Shirkat Gah's Humqadam app are fragmented, overlapping, and not adapted for disability inclusion. Psychosocial officers rely heavily on informal MOUs with OPDs and NGOs, which undermines consistency. Misconceptions among staff further exacerbate these challenges; in some cases, survivors were blamed for violence or perceived as incapable of navigating services independently, reinforcing stigma and systemic exclusion.



Coordination and Follow-Up:

Coordination between institutions is irregular and heavily reliant on personal relationships rather than institutional mechanisms. While some coordination exists such as between police and hospitals for medico-legal cases or between shelters and courts for survivor admission there is little integration across the wider system. Formal feedback loops are almost entirely absent, with most institutions losing contact with survivors once a referral is made. Survivors often fall through the cracks due to weak follow-up, duplication of directories, and lack of standardized referral tools. Barriers such as reliance on family escorts, bureaucratic restrictions on NGO collaboration, and exclusion of PWD data from government systems further fragment the referral landscape. Without a unified, disability-inclusive provincial mechanism, survivors especially those with disabilities remain underserved and at risk of exclusion.

3.3

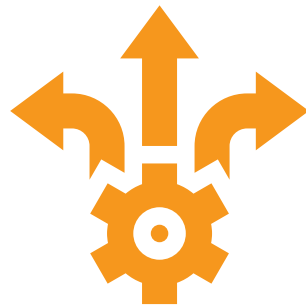
Recommendations

The consultations reveal that while institutions across Balochistan are engaged in GBV response, the absence of standardized protocols, weak coordination, poor accessibility, and limited staff capacity hinder effective service delivery. Survivors with disabilities are disproportionately excluded due to infrastructural, procedural, and attitudinal barriers. To address these gaps, the following recommendations are structured around four core components of referral practices, accessibility, capacity, and coordination detailing the priority actions and identifying lead actors for implementation.

Component	Recommendation	Actionable Steps	Lead Actors
Strengthening Referral Practices	Standardize and formalize referral mechanisms to ensure survivor-centered responses across all institutions.	• Develop and endorse SOPs with disability-inclusive provisions. • Establish uniform intake and referral forms across sectors. • Formalize partnerships through MOUs between government departments, CSOs, and OPDs. • Introduce case-tracking systems to monitor referrals and outcomes.	WDD, SWD, Health Dept., Police, CSOs, OPDs
Enhancing Accessibility and Inclusion	Ensure physical, procedural, and communication accessibility for survivors with disabilities.	• Conduct accessibility audits and implement upgrades (ramps, signage, private spaces). • Provide communication aids (interpreters, Braille, pictorial guides, audio tools). • Expand digital platforms (e.g., Humqadam App) with disability-friendly features and offline access. • Establish confidential communication protocols to reduce reliance on family escorts.	Health Dept., Police, Shelter Management, CSOs (Shirkat Gah, Aurat Foundation), OPDs
Building Capacity and Addressing Knowledge Gaps	Equip frontline workers with skills, tools, and attitudes needed to respond to survivors with disabilities.	• Deliver regular, on-site training for health, police, and shelter staff. • Integrate survivor-centered communication and psychosocial case management into curricula. • Consolidate referral directories into a single provincial directory, accessible in multiple formats. • Provide refresher trainings and orientation sessions on updated referral tools. • Conduct sensitization campaigns to address misconceptions and biases.	STEP, UNFPA, Health Dept., Police Training Academies, Shelter Homes, CSOs
Improving Coordination and Follow-Up	Move from ad hoc to system-driven coordination with clear feedback loops and accountability.	• Establish a provincial GBV referral coordination forum led by WDD/SWD with CSOs and OPDs participation. • Create formal feedback loops for tracking referrals and outcomes. • Appoint focal persons in hospitals, police, and shelters to manage referrals. • Digitize referral systems with shared directories and secure case-tracking platforms. • Hold regular inter-agency coordination meetings to review and update referral pathways.	WDD, SWD, Health Dept., Police, Judiciary, CSOs, UNFPA

4 ..

PROPOSED REFERRAL PATHWAYS





4.

Proposed Referral Pathways

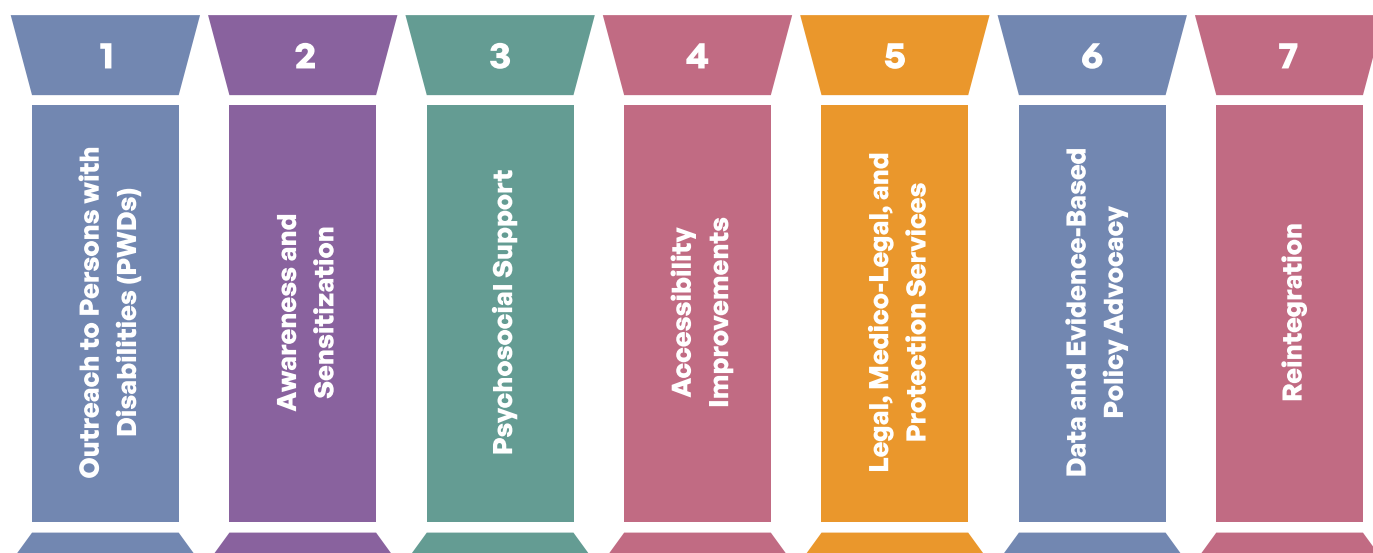
The proposed referral pathways are developed in direct response to the gaps identified through field consultations and the recommended actions outlined in the preceding section. They are designed to create a unified, survivor-centered, and disability-inclusive framework that addresses fragmentation, duplication, and institutional insensitivity. By aligning the pathways with international standards such as the UNFPA Essential Services Package (ESP) and with provincial realities, the model seeks to improve both the quality and inclusivity of GBV services across Balochistan.

4.1

Pillars of Pathways

At the heart of the referral mechanism is STEP as the Coordination Hub. Rather than allowing helplines, directories, government departments, and CSOs to continue working in parallel, STEP will serve as the anchor that consolidates these fragmented efforts into a unified disability-inclusive referral pathway. Through its psychosocial officers, networks with OPDs, and partnership with UNFPA, STEP is positioned to coordinate information sharing, track referrals, and ensure that survivors are not lost between institutions. This central logic will enable referrals to be consistent, survivor-centered, and accessible to persons with disabilities, ensuring both accountability and quality assurance.

4.1.1 - Functional Streams (Seven Pillars)



1

Outreach to Persons with Disabilities (PWDs):

The first pillar emphasizes proactive outreach to women and girls with disabilities, who often remain invisible in mainstream GBV programming. This outreach will be led by local inclusive organizations such as OPDs and OPDs, which are trusted in their communities and understand the unique barriers faced by PWDs. Through door-to-door awareness, engagement with caregivers, and community mobilization, survivors with disabilities will be identified and guided into the referral pathway. This approach ensures that the most marginalized survivors are not left behind.

2

Awareness and Sensitization

The second pillar seeks to address entrenched stigma, cultural barriers, and lack of knowledge that prevent survivors from accessing services. Joint campaigns with CSOs, government departments, and service providers will focus on both community-level sensitization and institutional awareness. Activities will include media campaigns, workshops with police and health staff including lady health workers, and engagement with community leaders such as teachers, elders, and religious figures. By normalizing conversations around GBV and disability, these efforts will foster a more enabling environment where survivors feel safe to seek help.

3

Psychosocial Support

The third pillar strengthens psychosocial support, which was consistently identified in field consultations as a major gap. STEP psychosocial officers, trained in disability-inclusive approaches, will provide direct counseling to survivors through both in-person sessions and phone-based support. Where needed, referrals will be made to specialized partners including OPDs and CSOs engaged to counter all forms of violence against GBV. This stream ensures that survivors have access to emotional and psychological care, which is often the first step toward healing and empowerment, and reduces reliance solely on medical or legal pathways.

4

Accessibility Improvements

The fourth pillar addresses the structural barriers that prevent PWDs from accessing services. Accessibility audits of hospitals, police stations, shelters, and helplines will identify gaps such as the absence of ramps, lack of private reporting rooms, communication gaps faced by persons with hearing disability or inaccessible complaint systems. STEP, together with OPDs, will advocate with government departments for disability-friendly infrastructure upgrades and service adaptations including provision of text service for deaf persons. This includes sign language interpretation, Braille or pictorial formats, and user-friendly mobile platforms. Such improvements will transform service points into spaces where survivors with disabilities can participate with dignity.

Legal, Medico-Legal, and Protection Services

The fifth pillar focuses on ensuring survivors' access to justice, protection, and medical care. Through partnerships with Aurat Foundation, Shirkat Gah, SPO, HRCP, bar councils, and police stations, survivors will be referred for legal advice, medico-legal certification, and representation in court. Police will play a central role in registering cases and providing protection, while shelters will safeguard survivors awaiting judicial outcomes. The referral pathway will integrate disability-sensitive protocols at each step, ensuring that survivors with disabilities are not excluded from legal and protective remedies.

Data and Evidence-Based Policy Advocacy

The sixth pillar highlights the importance of using data to drive change and addresses the critical gap in collecting disability-disaggregated data across the institutions. STEP will systematically collect and analyze referral data to document barriers, service uptake, and outcomes for survivors with disabilities. This evidence will be used for policy advocacy at both provincial and national levels, ensuring that GBV frameworks integrate disability inclusion. Partnerships with UNFPA and provincial working groups will amplify these findings, supporting reforms in policies, SOPs, and budgets that institutionalize disability-sensitive GBV response mechanisms.

Reintegration

The final pillar ensures that survivors are not only protected in the short term but are also supported to rebuild their lives. Reintegration activities will include linking survivors to vocational training, livelihood initiatives, and peer-support groups. Survivors will be connected back to their communities in a safe and empowering way, reducing the risk of re-victimization and dependence. Livelihood opportunities such as home-based tailoring, handicrafts, or digital work will give survivors the means to achieve economic independence and restore their dignity.

4.2

Types of Institutions to be engaged

The proposed referral pathways are designed to operate as an interconnected system of institutions, each contributing to one or more of the seven functional pillars. Their collaboration is essential to ensure survivors of GBV particularly women and girls with disabilities receive timely, accessible, and comprehensive support. Rather than operating in silos, these institutions will be connected through STEP as the central coordination hub, ensuring that referrals are survivor-centered and disability-inclusive.



A. Government Institutions

The **Social Welfare and Human Rights Department** will oversee Dar-ul-Amans, crisis centers, child protection units and provide policy leadership, ensuring that inter-agency GBV response is coordinated at the provincial level.

The **Health Department**, through hospitals and BHUs, will provide medico-legal care, mental health services, and reproductive health support contributing directly to the pillars of Psychosocial Support, Accessibility Improvements, and Legal/Medico-Legal Services.

The **Police** play a critical role in Legal and Protection Services by registering cases, offering survivor protection, and linking survivors to courts and shelters.

Similarly, **Legal Aid Committees and Bar Councils** will provide representation and advice, advancing both the Legal and Reintegration pillars by helping survivors secure free legal service, justice and re-establish their lives.



B. Protection and Shelter Services

Dar-ul-Amans and Crisis Centers remain a cornerstone of the referral system, providing immediate protection and psychosocial support, while linking survivors to health and legal services. Their role is vital in the Psychosocial Support and Reintegration pillars, as survivors often transition from shelters back to communities with ongoing support.



C. Helplines and Digital Platforms

Helplines such as Rescue 1122, the GBV Helpline 1089, Police helpline 15, MOHR helpline 1099 and the Balochistan Women Safety App represent critical first points of contact for survivors. However, field consultations revealed that these platforms are not disability-inclusive. By aligning them with STEP's unified referral pathway, they can become integral to the Outreach and Awareness pillars, while also feeding into Data and Policy Advocacy. Table 1 below summarizes existing helplines and digital platforms, their gaps, and potential for alignment with STEP.



D. Civil Society and Community Actors

Civil society organizations and Organizations of persons with disabilities (OPDs) are essential to ensuring community outreach, disability inclusion, and survivor accompaniment. OPDs will directly strengthen Outreach to PWDs and Accessibility Improvements, while CSOs such as Aurat Foundation, Shirkat Gah, HRCP, and SPO bring strong networks for Awareness & Sensitization and Legal Support. Community-based workers such as lady health workers and volunteers will also contribute to Outreach and Referral Initiation by acting as the first link between survivors and formal services.



E. Psychosocial Case Workers and Project Staff

STEP's psychosocial officers and partner staff will play a direct role in Psychosocial Support, Referral Management, and Reintegration. By bridging survivors with other institutions, they ensure that the referral pathway remains survivor-centered, responsive, and accountable.



F. Development Partners

UNFPA will provide technical assistance, quality assurance, and ensure alignment with the UN Essential Services Package (ESP), while convening provincial coordination through its Sub-Working Group. This role connects strongly with the Data and Policy Advocacy pillar and supports the institutionalization of disability-inclusive pathways within provincial and national frameworks.

4.3

Procedures for immediate and non-immediate GBV cases

Psychosocial officers serve as the entry point into the referral pathway, particularly for women and girls with disabilities who approach them for support. Their role is to carefully assess each case, obtain informed consent, ensure confidentiality, and guide survivors through the most appropriate services available in Balochistan. The procedures vary depending on whether the case is immediate (requiring urgent medical, legal, or protection services) or non-immediate (requiring psychosocial counseling, legal advice, or advocacy over time). Each pathway involves step-by-step actions communication, safety planning, documentation, and referral while incorporating disability-specific considerations to ensure accessibility and dignity. The scenarios below illustrate how different types of cases may be handled and highlight the institutions likely to be involved in each referral, ensuring that survivors receive timely, coordinated, and survivor-centered support.

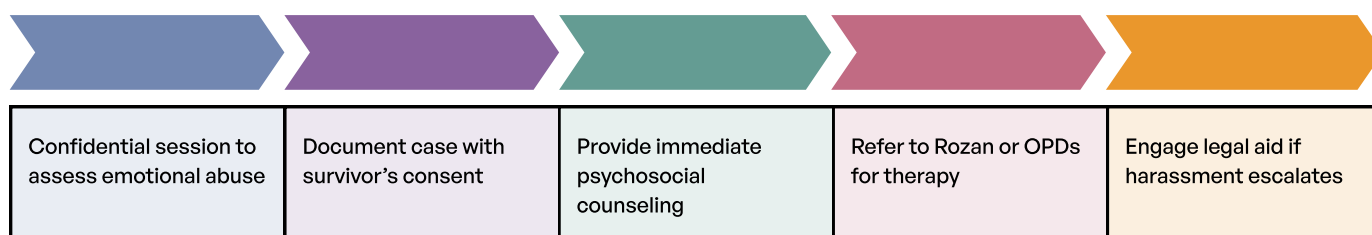
Table: Procedures of common scenarios of immediate and non-immediate GBV cases

Scenario	Procedures (Step-by-Step Flow)	Disability-Specific Considerations	Institutions Likely to be Involved
1. Mental torture or harassment from family/in-laws	- Confidential session to assess emotional abuse. - Document case with consent. - Provide immediate psychosocial counseling. - Refer to OPDs or partner CSOs for therapy; legal aid engaged if harassment escalates.	- Use accessible counseling tools (sign language, easy-to-read material). - Ensure survivor, not caregiver, provides consent.	STEP Psychosocial Officers, Aurat Foundation, Shirkat Gah, SPO, OPDs, Legal Aid Committees
2. Physical torture from family/in-laws	- Assess safety and obtain consent. - Refer to hospital for treatment and medico-legal exam. - Engage police for FIR if survivor agrees. - Offer Dar-ul-Aman shelter for protection.	- Arrange accessible transport (wheelchair support, escort if needed). - Provide an interpreter for hearing/visual impairments.	Health Dept. (BHUs/DHQs), Police, Dar-ul-Aman, Legal Aid Committees
3. Support from Police for FIR	- Survivor discloses need for formal complaint. - Officer explains the FIR process and documents consent. - Survivor accompanied to police station for FIR registration. - Case linked with medico-legal services if needed.	- Ensure accessible police stations (ramps, interpreters). - Survivor's testimony recorded directly, not via caregivers.	Police Stations, Women Police, Health Dept. (Medico-legal units), Legal Aid Committees
4. Support from Dar-ul-Aman for Protection/Shelter	- The survivor requests safe accommodation. - The officer documents consent and assesses safety needs. - Referral initiated through SWD for admission. - The survivor was accompanied to shelter and connected to psychosocial/legal services.	- Ensure shelter has accessible entry/rooms. - Survivors supported with sign language, personal assistance, or mobility support as required.	SWD, Dar-ul-Aman, Police (escort if needed), STEP Psychosocial Officers
5. Need support for divorce	- Explain the legal process clearly. - Document case with survivor's consent. - Refer to Bar Councils/Legal Aid Committees for representation. - Continue psychosocial support.	- Simplify legal jargon into plain language. - Ensure access to interpreters and large-print documentation.	Legal Aid Committees, Bar Councils, Family Courts, HRCP
6. Need support to prevent divorce	- Provide counseling to assess survivor's wishes. - Refer to legal aid and mediation mechanisms. - Engage WDD/family courts to protect survivor's rights.	- The survivor consulted directly, not through family. - Confidential meetings to ensure autonomy.	Legal Aid Committees, Family Courts, WDD
7. Prevent early child marriage	- Document risk and survivor's wishes. - Immediately refer to police and child protection units. - Engage SWD/legal aid for court intervention. - Mobilize CSOs for awareness in the community.	- Ensure child survivors with disabilities are accompanied by OPDs during police or court visits. - Provide guardian support only with survivor consents.	Police, SWD, Child Protection Units, CSOs, Legal Aid Committees

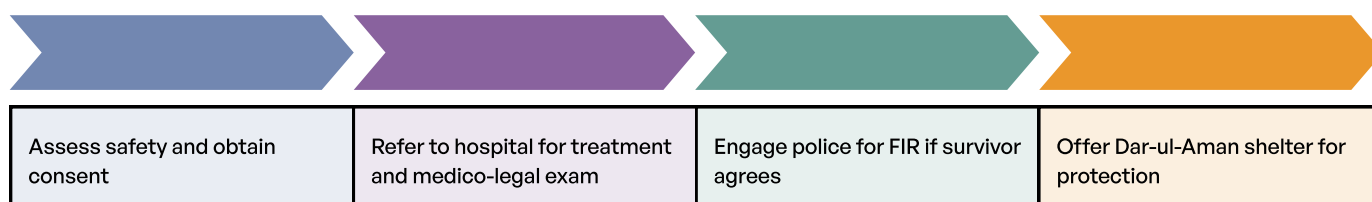
8. Sexual harassment at workplace	- Confidentially document cases with survivor's consent. - Refer to the Ombudsperson Office for redressal. - Provide psychosocial counseling and HRCP legal support. - Maintain survivor confidentiality at all stages.	- Interpreter for survivors with hearing disabilities. - Secure communication channels (written, pictorial, audio).	Ombudsperson Office, HRCP, Aurat Foundation, Legal Aid Committees
9. Protecting right to education	- Document case with survivor's consent. - Refer to Education Dept. and OPDs for advocacy with consent - Link with CSOs for policy follow-up. - Offer psychosocial support if discrimination causes trauma.	- Highlight accessibility needs (ramps, assistive devices). - Advocate for inclusive learning materials (Braille, large print).	Education Dept., OPDs, CSOs (SPO, Shirkat Gah), HRCP
10. Property inheritance	- Document survivor's claim and consent. - Refer case to Legal Aid Committees/ HRCP for proceedings. - Provide counseling and follow-up to track progress.	- Support with simplified legal paperwork. - Provide sign language interpreters or scribes if required.	Legal Aid Committees, HRCP, Judiciary
11. Registration with NADRA	- Document survivor's needs (CNIC, disability certificate). - Refer to NADRA offices with CSO/OPD support. - Engage SWD for endorsement if needed. - Advocate with NADRA for service accessibility.	- Push for disability-sensitive counters and priority processing. - Provide escorts for survivors with mobility impairments.	NADRA, SWD, OPDs, CSOs (Aurat Foundation, Shirkat Gah)

Diagrammatic Flow of Common Scenarios for Immediate and Non-Immediate GBV Cases

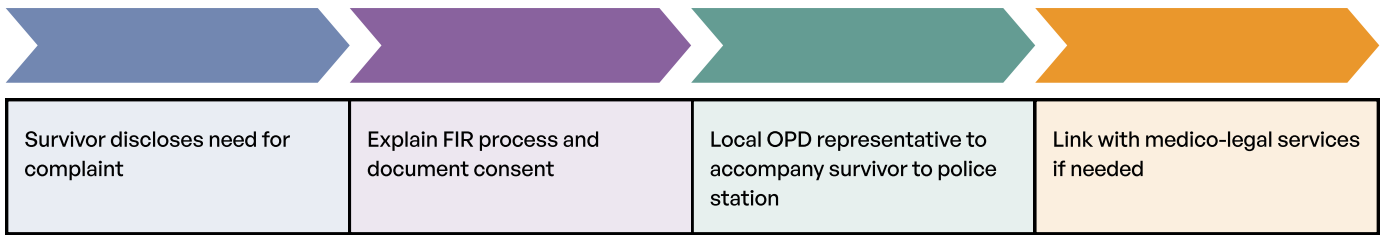
Mental Torture / Harassment from Family



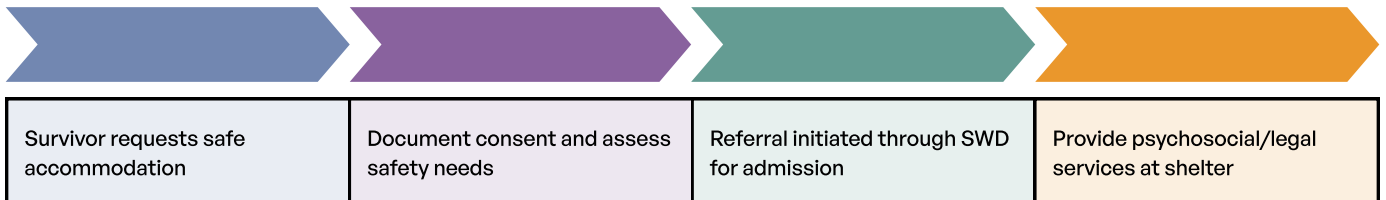
Physical Torture from Family



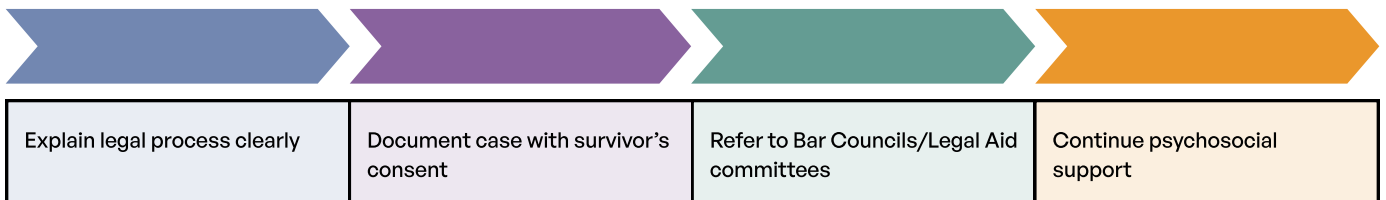
Support from Police for FIR Registration



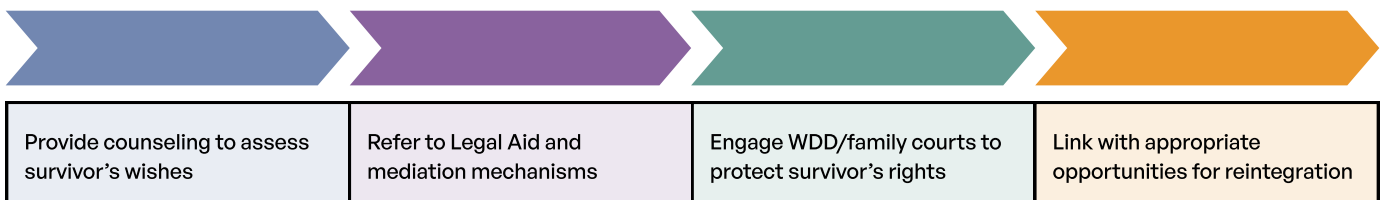
Support from Dar-ul-Aman for Shelter



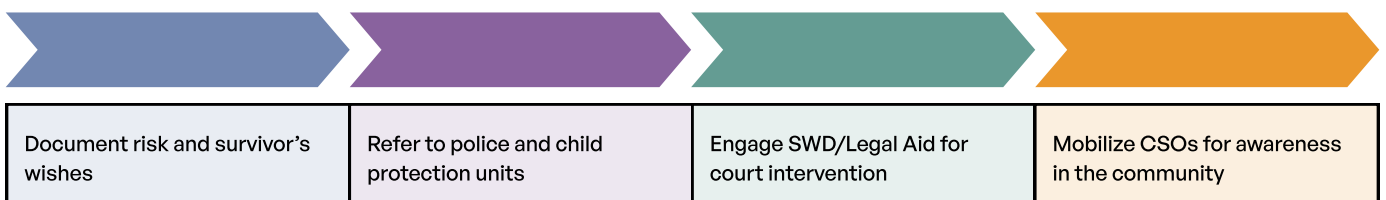
Need Support for Divorce



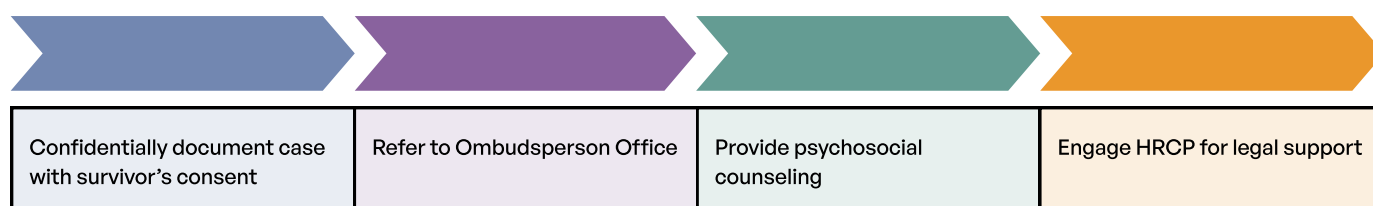
Need Support to prevent Divorce



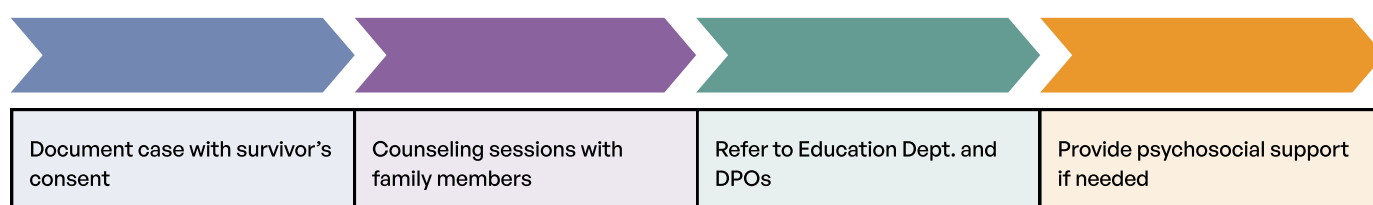
Prevent Early Child Marriage



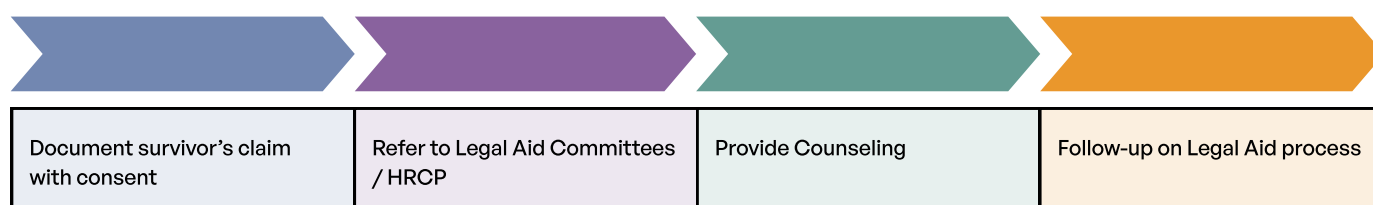
Harassment at Workplace¹



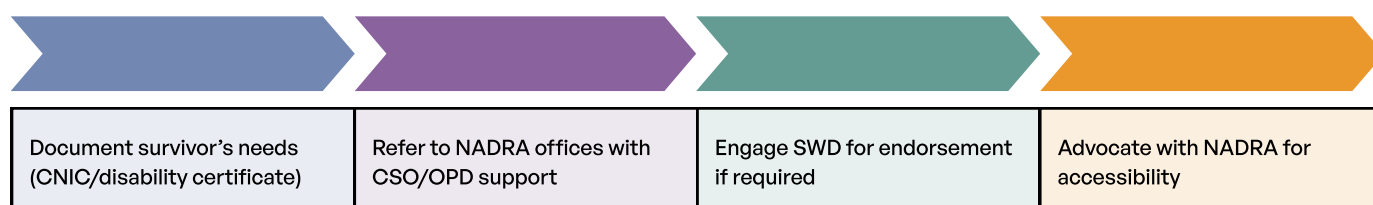
Protecting Right to Education



Property Inheritance Cases



Acquisition of CNIC from NADRA



4.4

Role of Helplines and Resource Directories

In some cases, survivors may directly approach service providers or helplines without first contacting a psychosocial officer. Platforms such as Rescue 1122, Police Helpline 1089, HRCP Complaint Cell, NCHR, or the Humqadam App act as important first entry points into the referral system. Similarly, survivors may access services through the referral directory maintained and updated by STEP in coordination with SPO, BRSP, Aurat Foundation, or HRCP. This ensures that even when entry points vary, survivors are not lost in the system and continue to receive disability-inclusive, survivor-centered assistance across all pillars of the pathway.

[1] The pathway will be followed in the absence or ineffectiveness of the Prevention of Sexual Exploitation and Abuse (PSEA) Committee at the workplace.

Table: Helplines & Digital Platforms in Balochistan

Helpline / Platform	Owner / Operator	Coverage & Services	Gaps / Challenges	Potential for STEP
Rescue 1122	Govt. of Balochistan	Emergency response, GBV-related calls	Limited disability-sensitive protocols	Advocate for PWD training modules and accessible call handling including text service for deaf people.
GBV Helpline 1089	WDD Balochistan	GBV Case reporting and initial response	Weak survivor-centered approach, no disability accommodations	Collaborate to develop disability-inclusive SOPs
Police Helpline - 15	Balochistan Police Department	Provides rapid police response to emergency calls by dispatching trained personnel to the incident location	Limited disability-sensitive protocols	Collaborate to develop disability-inclusive SOPs
Balochistan Women Safety App	Govt. of Balochistan	Live chat, location sharing, emergency alerts	Awareness gaps, no disability-friendly design	Support adaptation into accessible formats for PWDs
HRCP Complaint Cell (0306-2946125)	Human Rights Commission of Pakistan	GBV and human rights complaints via call/ WhatsApp	Limited coverage beyond Quetta	STEP can connect rural OPDs to HRCP complaint system
NCHR Complaint Cell (081-2869053)	National Commission for Human Rights	GBV/human rights complaints via call/ email	Low awareness in rural areas	Promote through OPDs and integrate into STEP's unified directory
Ombudsperson Office (081-2829894)	Ombudsperson Punjab / Quetta Office	Workplace harassment complaints	Limited visibility and survivor awareness	STEP can link OPDs for workplace harassment redressal
Health Minister Complaint Cell (1129 / 081-9211592)	Health Department Balochistan	Complaints on health services	Not GBV-specific, no disability focus	Advocate for integration with GBV health response
Humqadam Mobile App	Shirkat Gah	GBV response guide, referral directory, laws, helplines	Limited disability features, limited rural outreach	Collaborate to add PWD-specific services, expand outreach

Table: Resource Directory Initiatives

Directory / Initiative	Owner / Operator	Coverage & Services	Gaps / Challenges	Potential for STEP
SPO Referral Directory (2019–20)	SPO (Strengthening Participatory Organization)	9 districts, updated every 6 months	Outdated, overlaps with BRSP	STEP can align SPO's updates with disability-inclusive data
BRSP Resource Directory	Balochistan Rural Support Program	Covers multiple districts	Duplication with SPO, limited PWD scope	STEP can negotiate integration with OPDs' info
Aurat Foundation Desks	Aurat Foundation + WDD	Gender facilitation desks, legal advice, referrals	Not standardized as a directory	STEP can consolidate into provincial framework
Shirkat Gah Resource Directory (Humqadam App)	Shirkat Gah	Digitalized and regularly updated	Limited to app users, not widely known in rural Balochistan	STEP can partner to add OPDs and PWD-specific referrals
HRCP Complaint Cell Directory	HRCP Quetta	Legal and referral contacts	Not disability-specific, urban centric	STEP can extend outreach to rural OPDs
UNFPA Provincial Sub-Working Group	UNFPA	Coordination of referral directories across partners	Duplication persists, no single unified directory	STEP can propose leading the consolidation process

4.5

Operational Guidelines for STEP Teams (For Field and psychosocial officers)

The following operational guidelines are designed to help STEP field and psychosocial officers provide survivor-centered, disability-inclusive support during the implementation of referral pathways. Each sub-section outlines how officers should act in practice to ensure consistency, dignity, and accountability across all cases.

A

Survivor-Centered Approach

Every engagement with a survivor must begin by prioritizing her safety, dignity, confidentiality, and autonomy. Officers should first create a private and safe space where the survivor feels comfortable to speak. Survivors must always be asked for their informed consent before any information is documented, shared, or forwarded to another institution. Consent should be obtained in clear, simple terms and repeated at each stage of the referral process. Importantly, officers must always address survivors directly, not through family members or caregivers, unless the survivor specifically requests such involvement.

B**Case Identification and First Contact**

Psychosocial officers may identify survivors during outreach activities, awareness sessions, or through self-referrals. At the first point of contact, they should use communication methods suited to the survivor's needs, such as sign language, pictorial guides, or large-print materials. Officers must ensure privacy and a non-judgmental environment so survivors feel safe to disclose sensitive information. Where needed, survivors should be reassured that their concerns will be treated with confidentiality and respect.

C**Case Documentation**

Each case must be documented using STEP's standardized intake form, which includes details about the type of GBV experienced, the survivor's needs, and disability-specific considerations. Officers should explain the purpose of documentation to the survivor and only proceed after securing consent. Where survivors have visual, hearing, or cognitive impairments, the form should be presented in accessible formats, such as easy-to-read or large-print versions. All records must be stored securely, with no case details shared without the survivor's explicit permission.

D**Communication Protocols**

Clear and accessible communication is a cornerstone of effective case management. Officers should use the communication method preferred by the survivor, whether that is verbal, written, sign language, SMS, or pictorial tools. Information about referral options should be explained in simple and survivor-friendly language, avoiding legal or medical jargon. Survivors must always be given the opportunity to ask questions, and officers should confirm that the survivor fully understands the steps being proposed.

E**Safety Planning**

As part of case assessment, officers must evaluate whether the survivor faces immediate risks such as life-threatening violence, forced marriage, or sexual assault. If so, an urgent safety plan should be developed. This may include arranging safe transport, securing admission into a Dar-ul-Aman shelter, or requesting a police escort. For survivors with disabilities, safety planning must also take into account their mobility, communication, and personal assistance needs, ensuring that emergency responses are accessible and practical.

F**Referral Procedures**

When making referrals, officers should follow the pathways outlined in Section 4.3, distinguishing between immediate and non-immediate cases. Survivors should never be left to navigate the system alone; officers must facilitate the process by directly contacting the referral institution, introducing the case, and if necessary, accompanying the survivor. To ensure smooth referrals, officers should maintain up-to-date contact lists of focal persons in hospitals, police stations, shelters, legal aid bodies, and OPDs, so survivors can be connected without delay.



Coordination with Institutions

Officers are expected to maintain close working relationships with local service providers. This includes regular communication with government departments, CSOs, OPDs, and helplines. Where survivors directly access institutions through helplines or mobile applications, psychosocial officers must follow up to ensure these cases are documented and reintegrated into STEP's pathway. By acting as a bridge between survivors and service providers, officers help strengthen trust and reduce duplication across the system.

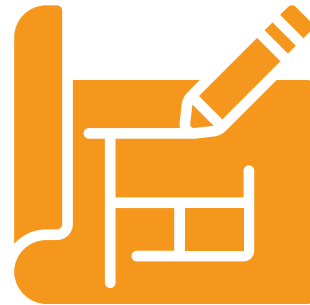


Psychosocial Support and Follow-Up

Beyond referrals, officers must provide ongoing psychosocial support to survivors. This begins with immediate counseling to help them cope with trauma and continues with regular follow-up sessions throughout their recovery journey. Officers should monitor whether survivors receive the services they were referred to and intervene if gaps arise. Survivors should also be encouraged to join peer-support groups, where they can connect with others, reduce isolation, and build resilience for long-term reintegration.

5 ..

CAPACITY BUILDING AND DISSEMINATION PLAN





5.

Capacity Building and Dissemination Plan

The effectiveness of the referral pathway depends on the ability of institutions and service providers to adopt disability-inclusive, survivor-centered practices. To achieve this, STEP will implement a structured plan that combines training content development, orientation sessions, and knowledge-sharing activities. The table below summarizes the key elements of this plan, highlighting the target groups, focus areas, and activities.

Table: Capacity Building and Dissemination Plan

Component	Target Group	Focus Areas	Activities
Training Content Development	Psychosocial officers, health staff, police, shelter managers, legal aid providers	Disability-inclusive GBV response, referral SOPs, psychosocial first aid, legal/protection frameworks, coordination and case tracking	Develop training modules in accessible formats (large print, pictorial, easy-to-read, audio-visual); translate into Urdu
Orientation Sessions	Government staff (Health, Police, SWD, WDD, NADRA), CSOs, OPDs, legal/protection actors	Practical application of referral pathways and survivor-centered approaches	Conduct provincial and district-level orientations with simulations and case studies; organize joint sessions for multi-stakeholder coordination
Knowledge-Sharing & Dissemination	CSOs, OPDs, community leaders, OPDs, service providers, survivors	Expanding awareness and ensuring referral information reaches frontline providers and communities	Distribute referral directories, posters, flyers; conduct community dialogues; organize provincial learning events
Continuous Capacity Support	Psychosocial officers, service providers across sectors, CSOs/OPDs	Sustaining skills and institutional learning beyond one-off trainings	Deliver refresher trainings every six months; provide technical backstopping; conduct accessibility audits; set up peer-learning platforms



MONITORING AND QUALITY ASSURANCE





6.

Monitoring and Quality Assurance

Ensuring that the referral pathways remain functional, survivor centered, and disability inclusive requires a strong monitoring and quality assurance framework. This framework will allow STEP and its partners to track the uptake of referral tools, assess their effectiveness, gather feedback from survivors and service providers, and make improvements based on field realities.

6.1

Regular Monitoring of Referral Tools and Effectiveness of Support

STEP will regularly monitor how referral directories, flowcharts, intake forms, and SOPs are being used by psychosocial officers and external institutions. Psychosocial officers will keep a record of the number of cases referred through the updated tools, with data disaggregated by type of service such as health, police, shelter, or legal aid, and by disability category. Partner institutions including health facilities, police stations, and Dar-ul-Amans will also be requested to share data on the cases referred using the pathway. This information will be consolidated by STEP's coordination hub in order to identify trends, geographic gaps, and areas where the tools are underutilized.

6.2

Feedback from Survivors and Service Providers

Feedback loops are essential to ensure that referral pathways meet the needs of survivors and are practical for institutions to implement. Survivors will be invited, with their consent, to provide confidential feedback to psychosocial officers after they have accessed services. This will cover the referral process, accessibility, and the quality of support received. Service providers such as hospitals, police, shelters, and legal aid bodies will also be engaged in structured feedback sessions to assess the ease of using referral tools and to highlight operational challenges. In addition, community level input will be collected with the support of OPDs and CSOs, particularly from women and girls with disabilities, to ensure that the pathway reflects lived realities.

Quality assurance will be built into the system through a series of ongoing measures. STEP will organize quarterly review meetings with key stakeholders to analyze monitoring data and feedback, identifying successes as well as bottlenecks. Random case audits will be carried out by the coordination team to verify whether referral protocols were followed and whether survivors received timely and appropriate support. Accessibility audits of hospitals, police stations, and shelters will be conducted annually to track progress on disability friendly improvements and to identify new gaps. Based on these monitoring findings, targeted refresher trainings will be offered to institutions facing difficulties in implementing referral protocols. Lessons learned from field implementation will be documented and incorporated into updated versions of referral directories, SOPs, and training content, creating a cycle of adaptive learning.



TOOLS AND RESOURCES FOR REFERRAL SUPPORT





7.

Tools and Resources for Referral Support

7.1

Consolidated Resource Directory

While several organizations in Balochistan (SPO, BRSP, Aurat Foundation, Shirkat Gah, HRCP) have developed referral directories or digital tools, these remain fragmented, outdated, and inconsistent in coverage. STEP, leveraging its coordination mandate under the UNFPA-supported initiative, has consolidated these parallel resources into a single, disability-inclusive referral directory.

The consolidated directory compiles updated information on institutions from select districts, ensuring that survivors and service providers have reliable contacts across health, police, shelter, legal aid, psychosocial, and community-based actors. The directory is produced in accessible formats (print, large font, Braille, pictorial guides, and digital apps with offline access) to meet the needs of both survivors and frontline workers.

By harmonizing multiple resources into one provincial tool, STEP reduces duplication, prevents survivors from being “lost” between systems, and strengthens coordinated action among referral partners.

7.2

Coordination Mechanism between Referral Partners

A coordinated and structured mechanism is essential for ensuring survivors are not lost in fragmented systems. In Balochistan, coordination has often been informal and reliant on personal contacts. To institutionalize this process, the project strengthens collaboration through the following arrangement:



Provincial Technical Working Group (TWG):

Serving as the apex coordination forum, the TWG—led by the Social Welfare Department (SWD) and UNFPA with participation from WDD, Health, Police, Judiciary, CSOs, and OPDs—provides strategic oversight. It reviews provincial-level progress, endorses referral protocols, and ensures alignment with the UN Essential Services Package (ESP).



District-Level Institutions:

At the operational level, district committees and service providers (police stations, hospitals, Dar-ul-Amans, legal aid bodies) implement the referral pathways. The TWG plays a facilitative role, monitoring performance, identifying gaps, and guiding these institutions to improve survivor-centered responses.

7.3

Registration of survivors, profiling and data tracking mechanisms



Standardized Intake Forms:

STEP has developed accessible forms capturing type of GBV, survivor's needs, disability profile, and consent. These forms are available in simple text, large print, pictorial formats, and digital versions.



Survivor Profiling:

Profiles capture demographics, type of disability (if any), nature of violence, immediate needs, and referral history. Survivors are always engaged directly in this process, not through caregivers, unless explicitly requested.



Data Tracking:

- **Case Tracking System:** Digitized and secure system to follow survivors through health, police, shelter, and legal processes.
- **Focal Persons:** Assigned in hospitals, police stations, shelters, and CSOs to update referral outcomes.



Monitoring & Learning:

Aggregated data informs evidence-based advocacy and continuous improvement of pathways. Survivors' feedback on accessibility and dignity of services is systematically collected to refine tools.

ANNEX - A

Resource Directory

ANNEX - B

Uniform Intake Form for GBV Referral Pathways

Section A: Survivor Identification (Confidential)

Field	Response
Case ID (Unique No.)	
Date of Intake	
Survivor's Name / Initials	
Age	
Gender	☐ Female ☐ Male ☐ Other
CNIC/Disability Certificate (if available)	
Contact Details	Phone: Address:
Disability Profile	☐ None ☐ Visual ☐ Hearing ☐ Mobility ☐ Intellectual/Psychosocial ☐ Other:

Section B: Incident Details

Field	Response
Type of Violence Experienced	☐ Physical ☐ Sexual ☐ Economic ☐ Emotional/Psychological ☐ Other:
Date/Time of Incident	
Location of Incident (Village/District)	
Perpetrator Relationship	☐ Spouse ☐ Parent/In-law ☐ Relative ☐ Employer ☐ Community member ☐ Relative ☐ Stranger ☐ Other:
Immediate Safety Risks	(Threats, unsafe home, suicidal risk, etc.)

Section C: Survivor's Needs & Consent

Field	Details
Immediate Needs Identified (tick all that apply):	☐ Medical ☐ Shelter ☐ Psychosocial Counseling ☐ Legal Aid ☐ Police Protection ☐ Economic Support ☐ Other: _____
Consent for Documentation	☐ Yes ☐ No (Explain purpose clearly in simple language / accessible format).
Consent for Referrals	☐ Yes ☐ No Survivor selects which services are acceptable.
Preferred Communication Method	☐ Verbal ☐ Written ☐ Sign Language ☐ SMS/Text ☐ Pictorial Tools ☐ Other: _____

Section D: Services Provided by STEP Team at First Contact

Field	Details
Immediate Action Taken	(E.g., first aid, psychosocial counseling, safe space provided).
Referrals Initiated	List services contacted (Hospital, Police, Legal Aid, Shelter, OPDs, Helplines).
Name of Contact Person / Institution	
Safety Plan Developed	☐ Yes ☐ No (Summarize steps: e.g., safe transport, shelter referral, police escort).

Section E: Follow-Up and Closure

Field	Details
Follow-Up Schedule	Date & Mode (phone/visit).
Feedback from Survivor	Survivor's views on accessibility, dignity, and responsiveness.
Case Status	☐ Open ☐ Closed (Closed only when survivor confirms services received).
STEP Officer Completing Form	Name: _____ Designation: _____ Signature: _____

Section F: STEP Officer Details

Field	Details
Name of Officer	
Designation	
Date of Completion	
Signature	

Guidelines for STEP Staff:

-  Always address the survivor directly, not through caregivers, unless survivor explicitly requests.
-  Obtain consent at every stage.
-  Use accessible formats: large print, pictorial aids, or interpreters if needed.
-  Store forms securely and submit digital entries into STEP's central case tracking system within 24 hours.
-  Never share information without survivor's explicit permission.

ANNEX - C

Key Consultation Questions by Stakeholder Type

1. Health Facilities (Hospitals, BHUs, RHUs)

Thematic Area	Key Questions
Referral Practices	1. What types of GBV cases do you commonly receive at your facility? 2. What is the process for handling survivors especially in terms of triage, documentation, and referrals? 3. How do you refer survivors for legal aid, shelter, or psychosocial support?
Accessibility & Inclusion	4. What arrangements exist at your facility to accommodate persons with disabilities (e.g., ramps, signage, interpreters)? 5. Do health staff receive any training in working with GBV survivors with disabilities? 6. Are medical/legal services accessible and affordable for PWDs?
Capacity & Coordination	7. What support or training would enhance your ability to respond to GBV cases involving PWDs? 8. Do you coordinate with the police or shelter homes for medico-legal processes?
Suggestions	9. What improvements could help make referral processes more inclusive and efficient for survivors with disabilities?

2. Police Stations / Law Enforcement

Thematic Area	Key Questions
Referral Practices	1. What is your standard procedure when a GBV survivor reports a case? 2. How do you determine if and when a case is referred to shelter, health, or legal services?
Accessibility & Inclusion	3. Are there disability-sensitive procedures in place (e.g., sign language, ramps, caregiver support)? 4. How do you ensure the safety and privacy of GBV survivors with disabilities?
Coordination	5. Do you have formal partnerships with Dar-ul-Amans, hospitals, or legal aid bodies for case referrals? 6. What documentation or protocols do you follow for referral?
Suggestions	7. What gaps or barriers do you observe in handling cases of survivors with disabilities? 8. How could referral communication be improved across agencies?

3. Legal Aid Bodies / Bar Councils / Courts

Thematic Area	Key Questions
Referral Practices	1. What legal support is provided to GBV survivors and how are cases processed? 2. How are referrals made between police, legal aid, and courts?
Accessibility & Inclusion	3. Are your premises and services accessible for PWDs (e.g., physical access, language support)? 4. Have you dealt with GBV survivors with disabilities? What challenges arose?
Coordination	5. Are there specific referral protocols with police and shelters? 6. Do legal aid officers receive any training on working with PWDs?
Suggestions	7. What legal or procedural changes are needed to ensure timely and disability-sensitive justice access?

4. Shelter Homes / Dar-ul-Amans / Crisis Centers

Thematic Area	Key Questions
Referral Practices	1. What is the process for admitting a GBV survivor to your facility? 2. Do you receive referrals directly from police, hospitals, or helplines?
Accessibility & Inclusion	3. Are your facilities physically and socially accessible to persons with disabilities? 4. What support is provided to survivors with disabilities (e.g., caregivers, mobility aids)?
Coordination	5. Do you coordinate with other actors (legal, police, health) for case follow-up? 6. What challenges do you face in cross-agency referrals, especially involving PWDs?
Suggestions	7. What can be improved in the referral and support process for PWD survivors?

5. Helplines (Govt & NGO-run)

Thematic Area	Key Questions
Referral Practices	1. What categories of calls do you receive (GBV, disability, health, legal)? 2. What is your process for making referrals after receiving a GBV-related call?
Accessibility & Inclusion	3. Are your helplines accessible to persons with hearing/speech impairments (e.g., text/SMS-based services)? 4. How do you ensure confidentiality and safety during calls from vulnerable groups?
Coordination	5. What is the referral mechanism with other service providers? 6. Do you maintain updated contact lists or directories of services?
Suggestions	7. What digital or technical tools could improve your outreach and referral quality?

6. Organizations of Persons with Disabilities (OPDs)

Thematic Area	Key Questions
Experience & Inclusion	1. Have you engaged with GBV survivors with disabilities? What types of support were needed? 2. What gaps do you observe in service access for survivors with disabilities?
Advocacy & Partnerships	3. Do you partner with government institutions (e.g., Social Welfare, Health, Police)? 4. Are you involved in any awareness, training, or accessibility improvement activities?
Recommendations	5. What systemic changes would improve the referral process for persons with disabilities? 6. How can OPDs better support frontline responders?

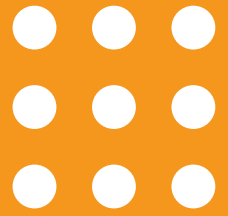
7. Psychosocial Case Workers / Field Teams (STEP)

Thematic Area	Key Questions
Practice & Procedures	1. What are the current steps you follow when managing a GBV case? 2. How do you assess the needs of survivors with disabilities?
Tools & Gaps	3. Do you use any standard referral forms or flowcharts? 4. What challenges do you face in communicating with survivors who have hearing, visual, or cognitive disabilities?
Capacity Needs	5. What kind of training or tools would help improve your work? 6. Are you able to follow up on referrals and provide feedback?
Suggestions	7. What would make the referral system easier and more efficient for your day-to-day case management?

Combined Questions for Inter-Agency Group Consultations

These questions are intended for joint sessions involving multiple actors (e.g., validation meetings, inter-agency working groups):

Thematic Area	Key Questions
System Functioning	1. What are the key strengths of the current GBV referral system? 2. Where are the most common breakdowns in referral linkages?
Disability Inclusion	3. What are the major accessibility barriers for PWDs across services? 4. How can we ensure referrals are made safely and respectfully for survivors with disabilities?
Tools & Coordination	5. What types of tools (directories, flowcharts, SOPs) would improve coordination? 6. Are there any existing coordination committees that could take ownership of updated referral systems?
Sustainability	7. What would help institutionalize a disability-inclusive referral mechanism across sectors? 8. How can we build accountability and feedback loops into the referral process?



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