FOCUS GROUP DISCUSSIONS (FGD)

What: Focus Group Discussions (FGD) consist of dialogues between 6-10 people, guided by a facilitator. The purpose of these dialogues is to obtain in-depth information on the participants perceptions or experiences with a particular topic/range of topics. For GBV, FGDs are particularly helpful as the sensitive topic can be introduced and talked about in non-direct ways, which helps gain understanding on the perception and potential GBV risks. FGDs are recommended to use in any sector, as it is a prime opportunity to gather different groups of people to hear their voices and opinions. Whereas other data collection techniques often reflect voices of men, with FGDs humanitarian actors can choose participants from different sex and age groups, and thus reflect the voices of women and girls in a safe environment.

Type of data that can be collected: FGDs lend themselves to collect data on *all aspects* of the AAAQ framework. The availability of services can be discussed beyond the quantitative number of facilities, services, or goods available. Accessibility can be discussed in more ways to really gain an understanding of what peoples' (or different groups') barriers to services or goods may be. Acceptability and quality can be discussed more in-depth. *Safety perceptions and GBV risks* can be discussed in an FGD. Rather than obtaining a quantitative measure on safety ('do you feel safe? Yes/no') people can go into depth on why the affected community may not feel safe accessing a good or service, what their challenges may be, and what potential solutions can be implemented.

In general, even if quantitative studies are available (e.g. from large-scale key informant interviews or household surveys), it is helpful to supplement with Focus Group Discussions as the qualitative information can provide more in-depth understand of the risks that women and girls may face.

Analysis

FGDs generate a wealth of *qualitative* data. Ensure that you have tools in place to process this data, such as a matrix built in Excel. Especially when having done multiple FGDs, look for recurrent themes or topics in participants' answers.

Do's and don't's

Set up:

- Inform relevant leaders/authorities of the FGDs
- Work together with a GBV specialist to review the questions asked
- Ensure you have a private and closed off space when holding FGDs
- Have facilitators/enumerators and notetakers of the same sex as participants

During:

- Establish some ground rules (e.g. let each other finish speaking)
- Do not ask participants direct questions on GBV (e.g. 'have you experienced GBV?')
- When probing for GBV risks, ask participants general questions, such as 'why would someone in your community feel unsafe accessing XYZ service?'
- Use recall periods (recognizable timeframes) when asking questions, particularly when collecting data at different points in time

- Be mindful of the mix of participants. There are instances where participants may be uncomfortable sharing information. For example, younger women may feel uncomfortable sharing their opinions when there are older women present in the FGD.
- See to it that everyone has a chance to discuss and talk. Manage instances where one or some individuals dominate the conversation
- Notetaking should focus both on verbal expressions as well as non-verbal behavior

After:

- Allow for participants to ask questions
- Write down full notes on FGD right after it took place
- Ensure follow up to participants

Additional resources: Consulting with women and girls for GBV risk mitigation

What type of information do you need for GBV risk analysis?

The indicator matrix include list of indicators, data collection methods and sample questions that you can use in your assessment. Broadly the following type of information is needed to analyze GBV risks in your sector[1]:

1. Barriers to accessing services
2. Safety perceptions of women and girls
3. Contextual information
4. Other information such as coping mechanisms

All these types of information are related to each other and some indicators could be categorized to all three types of information. That is why it is critical to triangulate different data to identify risk factors related to your sector and as needed to conduct additional data collection activities such as Focus Group Discussions to supplement more information to unpack risk factors into programmable level data. This means that for most indicators listed, there are *quantitative* (for example, household surveys or key informant interviews) and *qualitative* ways (for example, FGD) listed to obtain data. However, keep in mind that discussions with women and girls are key to including their voices and opinions and are always key to provide more in-depth understanding.

Indicators to measure GBV risks may not always be easy to identify, or it may not always be obvious how an indicator can help measure GBV risk. This is why the indicator matrix also has a 'rationale' column, where the reasons for including the indicator and how it may link to GBV are listed.

1. Barriers to accessing services

The indicators in the matrix are categorized according to the Availability, Accessibility, Acceptability and Quality (AAAQ) framework. Typically, people in humanitarian situations face barriers to information, services and goods. The barriers are often divided into four to five different categories. In GBV risk mitigation, we work with the AAAQ framework: availability, accessibility, acceptability, and quality. The four identified barriers consist of larger categories that can contain different barriers. For example, 'accessibility' barriers can exist of physical constraints (e.g. a broken bridge or flooded road), economic constraints (no income or price inflation), or safety (checkpoints or armed attacks on the route).

[1] Classification adapted from the Harvard Humanitarian Initiative (HHI) and UNICEF project on measuring GBV risk mitigation

Availability refers to the actual presence of goods, services, facilities, and infrastructures in the location of concern through all forms of domestic production (e.g. farming), trade (e.g. commercial imports), stock (e.g. food reserve, contingency stocks, etc.), and transfer (aid or subsidies or free services) by a third party (the national government, local authorities or humanitarian actors).
Accessibility refers to people's ability to obtain and benefit from goods and services, including those offered by humanitarian agencies. It often concerns the physical location of services (distance, road access, bridges, etc.), but can also be influenced by purchasing power, social discrimination, special vulnerabilities, or security issues that constrain movements.
Acceptability refers to whether the provision of goods and services is done in a respectful manner, and mindful of the culture of individuals, minorities, peoples and communities.
Quality refers to the degree of excellence, benefits or satisfaction that one can enjoy when consuming a good or a service. Quality may depend on the number of people with the required skills and knowledge to perform a given service or produce a good but is also influenced by the reliability (consistency of quality over time), diversity and safety of the provided service or good (i.e. water quality, sterilization of medical tools, pharmaceuticals, etc.). It is important to stress that affected populations may have a different perception of quality compared to humanitarian agencies.

Source: Basic Needs Assessment Toolbox, Okular Analytics & Save the Children

The barriers above contribute to programming not reaching its goal of decreasing humanitarian needs, but can also contribute to increasing the likelihood of GBV. This is why good programming across all sectors consists of a barrier analysis that is done from a gender-lens, as barriers to accessing goods and services can be, and often are, gender-based. For example, the need for a husband's approval to leave the house is a very common barrier for women and children in accessing nutrition services in a very patriarchal community. Due to this barrier, women and their children may not be able to access nutrition services even if they need it. Sometimes, women may take a risk to access services without their husband's approval. As a result, they might face domestic violence at home. For more examples of barriers per sector, see Annex 3.

The indicators that measure barriers are referred to as 'AAAQ'.

2. Reported safety perception of women and girls

In addition to barriers, how safe women and girls feel accessing a facility or services can help identify the overall level of risk in your sector. "Feeling safe" is of course based on perception, yet this can still help inform whether women and girls feel comfortable using services and whether they are likely to use them based on perceived risk. Measuring this requires a careful approach to data collection and analysis in order to better understand why women and girls may not feel safe accessing goods or services. Questions should be framed carefully, to focus on risks in services rather than 'general' protection risks that may occur in the environment. In addition, measuring safety is not always straightforward and some questions may work better than others (e.g. starting with "do you fear…?" rather than "do you feel safe…?"). Generally, the best way to collect this information is through consultations, specifically focus group discussions. Adding this type of data collection is best done in collaboration with GBV specialists.

These indicators are referred to as "safety perception" in the indicator matrix.

3. Contextual indicators

Contextual indicators are those that are key to understand more of the context surrounding GBV risks, for example gender dynamics and norms. These contextual indicators will help to better understand barriers to services and safety perceptions of women and girls, and are part of any gender analysis.

4. Other information e.g. coping mechanisms

Some of the information that is already being collected in sectors can be useful to incorporate into GBV risk analysis. For example, coping strategies can which in turn can increase the risk of exposure to GBV. For example, a lack of food can lead to different coping mechanisms – one of which could be engagement in survival sex, which comes with different GBV risks. These indicators can be combined with other data points to help overall analysis.

The indicators related to other information are categorized as "Other" in the indicator matrix.

Integrating a GBV lens into needs assessment and needs identification

The common data collection techniques used to obtain data for GBV risk analysis in a humanitarian setting (key informant interviews, household surveys, focus group discussions, safety audit), lend themselves for obtaining data on different aspects of the AAAQ framework. Finding risks in your sector can be done through using these different data collecting techniques. There is usually no *one size fits all* indicator to collect information on GBV risks. Instead, combining multiple indicators and triangulating data to find potential barriers to accessing services and GBV risks is recommended. In addition, **consultations with women and girls (e.g. FGDs), particularly on access barriers and potential risks are highly recommended at every stage of the programme cycle. Not only does this allow women and girls to voice their opinions, it can lead to finding access barriers and solutions that we sometimes do not think of. Consulting with women and girls will therefore lead to better and safer programming, as well as the reduction of GBV risks.** Read more below on how the different techniques can inform different aspects on the framework.

There are several steps to take to gather information on GBV risks in your sector. The steps are adapted from the HPC guidance and JIAF Guidance.

Step 1: Planning and design

Go through the indicators for your sector, define your information needs and review the indicators.

Step 2: Data collection and collation

List all assessments including sectoral and multisectoral assessments available, as well as other sources and surveys. Conduct a secondary data review based on all sectoral and multisectoral assessments, as well assessments conducted in other sectors that may contain information on the indicators.

From there, define what information is missing (information gaps), and which indicators you want to collect through primary data collection. Set up primary data collection exercise. Then Identify data collection methods and questions for each indicator. In the indicator matrix, questions per data collection method are already listed.

These GBV risk mitigation indicators can be integrated into your sectoral assessments, or you could choose to do a specific assessment on GBV risk mitigation in your sector. In addition, GBV risk mitigation indicators can also be integrated into multi-sectoral needs assessments.

Whichever approach chosen, we do always recommend to supplement any data collection with **consultations, with women and girls,** in particular **Focus Group Discussions.** While all data collection techniques are valid, they do often reflect a male perspective (e.g. a key informant or head of household is often male). Focus Group Discussions with women and girls on the other hand, allow for them to voice their opinions and views on many issues, including safety and accessibility of goods and services in all sectors. This will give key insight into GBV risks and what (they think) can be done to mitigate them.

When setting up an assessment/data collection exercise please keep in mind some of the following overarching things:

- Female enumerators: Topics can be sensitive. To include voices of women and girls through for example consultations, it is recommendable to have female enumerators.
- Do not single out GBV survivors as participants for any data collection exercise. In other words, do not hold expert key informant interviews specifically/exclusively with survivors, or do not have a Focus Group Discussion solely with GBV survivors.
- For all data collection: train enumerators/facilitators in how to respond to GBV disclosures in the event this happens.
- Referrals: ensure your enumerators are trained on knowing how to respond to incidents of GBV should a survivor disclose to them.
- Do not include direct questions on GBV to participants in any needs assessment, regardless of data collection technique. In other words, do not ask people after direct experiences of GBV (e.g. "have you ever been raped?").
- For examples on good and safe to use questions, consult the indicator matrix.

Step 3: (Joint) analysis
Once all data has been collected, analyze both primary and secondary data to identify the barriers, safety perceptions, and other information to define what GBV risks exist in your sector. Analysis can be done jointly with GBV colleagues. Within your sector, you can also discuss measures that can be taken to mitigate GBV risks.

Step 4: Validation
Present output and validate your findings within your sector. In the case of consulting communities, ensure to feed back to them as well. When sharing findings, pay close attention to data protection and once again ensure that everything is anonymized and cannot lead to identification of anyone who has participated in data collection.