KEY INFORMANT INTERVIEWS

What: A key informant interview is often done with a structured or semi-structured questionnaire. KIIs can give both quantitative and qualitative data. A key informant interview can be done with experts (e.g. humanitarian staff) or members of the community (e.g. community leaders). Sometimes, key informant interviews are done in a more targeted manner for programme evaluation (e.g. a key informant interview with a service user).

When integrating into large-scale data collection exercises such as DTM, keep in mind that key informants are mostly done with members of the community/affected population.

Type of data that can be collected: Key informants lend themselves for obtaining data on most aspects of the AAAQ framework. However, most key informant interviews that take place on a large scale will be collected in a quantitative way (i.e. structured interviews with set answer options). Thus, although you will have questions on e.g. 'accessibility' your answers will be limited to set options such as facility X is 'accessible' or 'not accessible'. Questions should therefore be carefully thought through to ensure that the data collected yields a useful response. For *safety perceptions and GBV risks,* this is also an issue as you may generate questions with answers of 'very safe' 'safe' 'not very safe' 'unsafe'. In general, avoid putting in questions that probe for GBV risks.

Do's and don't's

- Train enumerators on referral pathways
- Ensure a private space when interviewing people
- Use recall periods (recognizable timeframes) when asking questions, particularly when collecting data at different points in time
- Do not include direct questions on GBV. For example, do not include questions on whether someone experienced GBV, or knows someone who experienced GBV, etc.
    - If a female KII is interviewed, she could be experiencing trauma or harm from this question. It could be unsafe for her to answer
    - If a male KII is interviewed, they could be experiencing trauma or be offended or suspicious by the question

Integrating into multi-sectoral assessments:[1] *DTM*

IOM's Displacement Tracking Matrix (DTM) is a large-scale multi-sectoral assessment where clusters usually have the possibility to feed in indicators and questions. As such, it is often used to inform the HNO. There are resources available on integrating GBV risk mitigation indicators ('proxy indicators') into DTM here

Analysis

Keep in mind that the sample size and strategy will influence how the data can be used. A non-random sampling strategy and non-representative sample size is oftentimes used when doing key informant interviews. This should be reflected in the analysis and write up

[1]The DTM is chosen as one example of a key informant survey. It is chosen here as it is multi-sectoral and non-cluster specific. However, the same principles hold for integrating GBV risk mitigation into other key informant surveys, whether they are cluster-specific or not.

of your report. In other words: your findings cannot be considered as representative of the surveyed population, but are indicative only.

Mostly, large-scale key informant interviews are quantified (i.e. structured surveys) that will facilitate analysis. For open interviews (i.e. without set answer options), look for recurrent themes in the answers of participants.

When integrating into KII multi-sectoral needs assessments such as the DTM, do consider that most key informants will be *male*. In addition, there is often one voice speaking for an entire community. While this does not render data unusable nor irrelevant, it does ask for additional data collection particularly when it comes to GBV risks, as female voices and perspectives need to be included to properly assess and analyze them.

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[2]:

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).

[2] 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.