Girls and women speak out from Afghan moral prisons: Tackling extremism and violence against women in a conflict environment

Mahendru, R.

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Name(s)

Dr. Ritu Mahendru

Institutional affiliation(s) of the author(s)

Canterbury Christ Church University

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Author(s) contact details

- Dr. Ritu Mahendru: Research Associate; Canterbury Christ Church University mahendru.ritu@gmail.com

Girls and women speak out from Afghan moral prisons: tackling extremism and violence against women in a conflict environment

Dr. Ritu Mahendru

Abstract

This empirical research documented voices of women and girls in female shelters and prisons in Samangan, Laghman and Wardak provinces who experienced systematic sexual and gender based violence before and after they escaped forced marriages, forced virginity tests, physical and sexual violence. Women who challenged the status quo, fundamentalism and extremism faced imprisonment for up to five years. The research interviewed primary, secondary and territory health care professionals, who carried out or witnessed invasive virginity tests. The evidence suggests that women are being deprived of basic human rights of exercising autonomy and freedom. It shows difficulties some health professionals' encounter in documenting, reporting and treating cases of violence against women and girls. The research concludes that a survivor-centered approach, and secular framework is required against tyranny, misogyny and oppression. Instead of imposing moral arguments and harmful laws that undermine women's rights, brave leadership at many levels is required to tackle health inequities, dismantle patriarchy, counter fundamentalism and other entrenched systems of inequality. A new kind of feminist citizenship is needed not based on identity but political values.

Key Words: Public Health, Conflict, Gender Based Violence, Women's rights, and Survivor-Centred Approach

Setting the Scene

Countless girls and women in Afghanistan face many forms of sexual and gender-based violence (SGBV). It remains a huge challenge in a country marred by conflict and instability. However, this is not a new phenomenon, the 'oppression of Afghan women did not start with the Taliban nor has it ended with their defeat' (Brodsky, 2003). Historical evidence suggests that several Afghan kings and politicians lost their lives and positions by struggles relating to women's rights (Ahmed-Ghosh, 2003). Rostami-Povey (2007:297) asserts that Islamic culture and religion in Muslim majority societies are the key determinants of female and male identities and are often used to justify war and several other cultural and social practices. In Afghanistan, the interaction of Islamic culture and religion with secularism, national, ethnicity and other important historical, social and economic mechanisms structure the lives of most women and men.

Historically, the gender practices in Afghanistan have been politically, socially, economically, geographically and historically motivated generating serious consequences for women to access equal citizenship and democratic rights. Under mujahedeen and Taliban rule, discrimination against women and girls was widespread. Women were banned from accessing basic health, education and employment services. Access to public places without the *Mahram* (male guardian) and healthcare delivered by men were prohibited. Women were forbidden from exposing their skin in public and engaging in politics. Healthcare during this era was virtually non-existent for women who were also banned from working. Taliban enforced their version of Islamic Sharia law legalising brutality. Public stoning to death and flogging were among the brutal punishments used against women who made any attempts to infringe upon these decrees. The punishment of women was a public demonstration of Islamic fervor to strengthen repressive and patriarchal structures by assigning them a socio-cultural value before the entire community (Azarbaijani-Moghaddam, 2009). The institutional legitimization of GBV favouring a culture of rape and impunity and controlling female bodies in public and private spaces became a norm. The community members became guardians of repressive Islamic laws under the notion that protecting the honour of a woman in a household and/or a village is fundamental to collective identity. Women became vulnerable to violence from their families and groups of men if they appeared unruly, disloyal or 'dishonour' the communal acquiescence.

Taliban's overthrow in 2001 elevated the confidence of Afghan women hoping the new era would improve their status. Yet several fundamentalist groups in Afghanistan still "perpetuate and strengthen already existing male-dominated patriarchal structures and practices, and they do not hesitate to use violence to exact compliance and spread fear" (Alvi, 2012). Violent public assaults on women are still omnipresent under customary laws and in some areas with Taliban's strong hold. In 2019, four women were brutally flogged for leaving homes without their husbands and not being fully veiled in Sancharak district in Sar-i-pul (Janjua, 2019). However, this is not an isolated case. Several reports from 2018 and 2019 stated that Taliban flogged women for singing and dancing, and for visiting the doctor in the absence of a *Mahram* and for using their mobile phones (RAWA, 2019a) . Any disobedience to the legacy left by Taliban can result in serious consequences for women. These cases also highlight the ineffectiveness of Afghan justice system that failed to prosecute perpetrators of violence.

Conflict and International Aid

While the war ended and the international aid poured into Afghanistan, 18 years of aid has meant little for Afghan women's rights. Misogynist ideologies, views, and attitudes continue to embolden Taliban rhetoric in the post-war context. The fundamentalist mentality that existed during Taliban era still exists in many parts of the country. Evidence confirms that the US-led coalition established a new government in Afghanistan based on their alliances with *Mujahideen* (Islamic parties who fought against the Soviet Union in 1979 also formed of traditional warlords)[i]. The *Mujahideen* gained key positions in government with the subjugation of the overwhelming majority in Parliament with all prevailing prejudices against women completely in place. These felonies, particularly the VAWG these groups waged during the civil war, were simply overlooked by NATO's occupation forces. This provided an advantage for Afghan warlords to institutionalise a culture of impunity and deepened the roots of Islamic fundamentalism at a structural level (Ahmad and Avoine, 2016).

Another ominous trend in the recent history that has undermined Afghan women's rights are the ways in which international aid is managed and distributed. While views on women may have become moderate in some parts of Afghanistan, especially in Kabul, owing to frontline women activists and organisations, their positions remain highly marginal. The 'orientalist approach' (Said, 1979) and capacity to account for the complexities of women's lived experiences was simply absent. Systematic misuse of funds in the Afghan government and ways of contracting/subcontracting companies overseas by international donors has been a continuous problem and also meant that much of the funds would go to foreign contractors rather than Afghan women. International gender programme designs have often been poor and failed to meaningfully engage Afghan women in the process leading to miscarriage of justice and mismanagement of funds. The Afghan government and international donor community have neglected women's rights and failed to tackle the widespread discrimination faced by them.

The World Bank (2017a and 2017b) provides a dismal picture of crucial education and health indicators affecting women's status. Afghanistan has one of the lowest literacy rates in the world with literacy prevalence of only 29.8% as compared to 55.4% men ages over 15. Forms of public violence including deliberate attacks on female students and women teachers continue today and remain unpunished. The country has one of the highest maternal mortality rates of 638 per 100,000 live births, compared to 320 regionally and 280 globally. According to this study, 60% of women have no access to skilled birth attendants. While the country has made concentrated efforts to re-establish its health infrastructures, the provision and uptake of health services has been an on-going challenge in part owing to accessibility, remoteness, poverty and restrictions on women's mobility (Thommesen et al, 2020). Reports suggest that administrations of both Afghan President Hamid Karzai and Ashraf Ghani have frequently sacrificed women's rights for political gains (Barr, 2020).

Customary laws and access to justice

The on-going conflict and political instability exacerbate gender inequalities embedded in Afghan local power structures marred by ethnic, religious, and tribal traditions (Metheny and Stephenson, 2019; Swaine et al., 2019). Customary laws in Afghanistan exist in the form of community and district councils often led by men. The village

councils (*jirgas* and *shuras*) comprised of religious and tribal leaders where local decrees are formed and implemented. The existence of multiple legal mechanisms and state structures, due to instability, particularly in rural areas, has meant that *shuras* continue to administer justice (Afghan Women's Network, 2016). However, such judgements violate and discriminate against women and girls' rights (Taucher et al., 2014). These tribal laws and social codes are frequently associated to Pashtunwali, and are widely practiced as a component of customary law, especially in rural Pashtun majority areas, who make up the largest ethnic group in Afghanistan (Kakar, 2002). This is where serious issues such as domestic violence, marital rape, child and forced marriages and other forms of abuse are debated, negotiated and justified (Ahmed-Ghosh, 2006). Women who break the social codes of conduct under these laws face severe consequences ranging from incarceration to risk of further violence and in some cases death (Human Rights Watch, 2009).

In 2015, the brutal murder of a 27-year-old Afghan woman, Farkhunda Malikzada, in broad daylight in the Kabul city generated an outcry across the world (Fluri and Lehr, 2019**).** Farkhunda was falsely accused of burning a Quran. The murder reflected the level of fundamentalist and extremist mentality prevalent across the Afghan society. The very foundation of this fundamentalist ideology is to control the minds and bodies of women by making links between national and religious fervour. If women resist the control, they face further violence or threat of violence aimed at creating an environment of terror and impunity. Farkhunda's lawyer has stated that the government handled Farkhunda's case in a "corrupt manner" (Telegraph, 2015). This widespread attitude is prevalent in the state institutions and remains unchallenged by the US-led coalition in Afghanistan (Ahmad and Avoine, 2016).

Studies suggest that more than half of the women and girls in detention are being held for "moral crimes," such as adultery or running away from home, despite the fact that running away from home is not a crime in Afghan law. The United States Institute of Peace (USIP) reports that many legal provisions for women fail to be applied in practice, stating that: 'female victims of sexual violence […] are frequently persecuted and incarcerated for moral crimes, and their predators are only infrequently indicted or incarcerated' (USIP, 2014). The *jirga* members perpetuate impunity by using traditional mediation processes conducted entirely by senior men (Ahmad and Avoine, 2016:95). With rampant SGBV inherited from years of war, these processes have become highly problematic for women. The local councils routinely turn female victims of violence away and coerce them into accepting the mediation creating a culture of impunity, even when girls and women have suffered heinous crimes such as rape, forced marriages and forced sex work.

In addition, consistent evidence reports that the Afghan government have failed to bring killers of prominent women in public life to justice, creating an environment of impunity for those who target women (Human Rights Watch, 2009). The increased level of injustices and corruption prevents women from seeking legal protection. The culture of impunity reinforced the subordination and lower status of girls and women, normalising and perpetuating the cycle of violence in all spheres of society. Whether it is a high-profile woman under threat, a young woman who wants to escape a child marriage, or a survivor of rape who wants to see the perpetrator punished, the response from the police or courts is often hostile (Human Rights Watch, 2009). The message often women receive is there is no help available.

It also important to note the role of military counter-insurgency strategies as well as USIP 'peacebuilding' efforts to devote funds and energy to informal justice systems. Evidence provided by Wimpelmann (2013) clearly demonstrates that the importance of informal justice was not simply because people wanted it, but also because different forces were heavily promoting it as part of counter-terrorism and stabilisation, sometimes against the wishes of local activists including women's rights activists.

Harmful practices and healthcare

Women in Afghanistan face serious morbidity and mortality as a result of different forms of GBV, mainly physical and sexual violence, and remain disadvantaged in accessing appropriate and timely health care (WHO, 2014). A study carried out by Nijhowne and Oates (2008) reported that an overwhelming 87.2% of Afghan women reported experiencing at least one form of domestic violence (physical, sexual, psychological or forced marriage) and 62% experienced multiple forms of violence. According to UNICEF (2018), Afghanistan has the 18th highest absolute number (572,000) of child brides in the world. The study reported that 35% of Afghan girls are married before the age of 18 and 9% are married before their 15th birthday and nearly a tenth of Afghan adolescent females give birth every year as a consequence of early marriage and lack of access to reproductive health information and services (UNFPA, no date). Afghan women have a fertility rate of 7.5 births per mother, and with a skilled birth attendant present at only 14% of births (UNDP, 2008)[ii].

Some of the other adverse harmful practices identified by Afghanistan's Ministry of Public Health (MoPH) includes forced, child and exchange marriage (*Baadal*), giving away girls to settle disputes (*Baad*)[iii], honour killings, restriction on women's freedom of movement and denying them right to education, work and access to health services. Patriarchal societal practices such as early marriage, rights surrounding sexual practices, and the need to obtain husband's permission to receive health care, all have a large impact on women's health in Afghanistan. *Baadal* and *Baad* are practiced to maintain family honour and status, with their role to control female bodies. Another problematic aspect of *Baadal* and *Baad* is the exclusion of women from the process and lack of concern for their rights or well-being in the outcomes these forums produce, particularly health outcomes (Smith, 2009). Two studies revealed that 83% and 75% of Afghan women respectively, expressed the view that it was a wife's duty/obligation to have sex with her husband even when she did not want to. In the same study, 93% of women said that they needed authorisation from their husband or a male relative to seek professional health care. Accessibility, lack of healthcare professionals, and variability in the utilisation of health care services have been cited as major problems for Afghan women (Najafizada et al., 2017). There is a shortage of healthcare professionals in Afghanistan due to insecurity, and the situation does not seem to be changing. An assessment of resources allocated to Afghanistan's Basic Package of Health Services (BPHS), the government's national health programme delivered by NGOs, do not provide a promising picture either. The annual operational cost of delivering the BPHS has remained low. While the yearly allocation increased by the end of 2010 from USD 4.55 to close to USD 5 per capita, the currency depreciation has translated into decline in the actual allocation. This very low delivery cost has pushed competing NGOs to often underbid to the point that their programme proposals no longer match their own written budgets: a number of NGOs have been found operating with budgets of roughly USD 3.5 (Michael et al, 2013).

These indicators are underscored by social, cultural, economic factors and family perceptions that contribute towards these indicators in the country. Sociocultural and geographical factors related to the treatment of women and perceptions about medical interventions often deprive women of essential health services. The quality of care from public and private providers during pregnancy and childbirth are cited as a recurring concern exacerbated by health system constraints and factors linked to insecurity (Christou et al, 2020). Harmful traditional practices and strict gender roles legitimise and perpetuate various forms of VAWG, including early marriage, cultural taboos and practices preventing women from making informed decisions about their own fertility, early pregnancy and bride price, among others, which are associated with poor health outcomes and inequities. As a result, women often fail to achieve their full potential as productive members of society because these discriminatory views and harmful practices result in unequal access to education, healthcare, economic opportunities and leadership positions.

Many women end up resorting to some extreme measures in the absence of appropriate legal, economic and social support. Forced marriages and domestic violence are also driving women to self-immolate (Kumar, 2017). Despite efforts to end domestic and interpersonal violence, it is viewed as an acceptable act of disciplining girls and women. Several women-led organisations have established female shelters to provide refuge to girls and women who flee from abusive households. However, shelters remain underfunded and operate in a covert manner to protect women from their families. Similarly, women organisations that manage shelters are under constant danger from the family members of the women being sheltered (Fluri and Lehr, 2019). However, RAWA (Revolutionary Afghan Women Association) (2019b) argues that several womens' rights organisations work under the government wing and within an Islamic framework that has done nothing but disservice to women. They also view this kind of feminism as an adjunct to imperialism and fundamentalism. RAWA unmistakably remains the most radical and polyethnic advocate of Afghan women's rights challenging patriarchy and systems of oppression against the forces of fascism. The women of RAWA have long been lone voices in trying to bridge the gap between feminism and secular democracy, forging a new form of feminist citizenship to create a radically free and egalitarian society based on political values rather than identity. Their unique political experiment of secular resistance against structural oppression in the midst of war is notable that has also cost them several lives, including the killing of RAWA's founder, Meena, in 1987. RAWA works underground in most parts of Afghanistan but face enormous difficulties hindering their work. Yet they have demonstrated leadership in defence of key principles of secularism, democracy and equality tied to state accountability for gender justice. While RAWA remains a personal inspiration for me, they should not be seen as the only relevant actors (women's organisation) to respond to SGBV in Afghanistan.

UN mechanisms seldom endorse secularism. The work of the Special Rapporteur, Karima Bennoune, on 'rights in the field of culture' has advocated a universal and secular approach citing fundamentalism a critical threat to human rights. In her report on universality, the Special Rapporteur called for separation of religion and state: "Reaffirm the importance of secularism and the separation of religion and State, and of secular spaces, for the full implementation of freedom of religion or belief and all other human rights" (UNODC, 2018:22)

An unstructured research in a humanitarian setting

A mixed-method research study was carried out in 2014 in BPHS and EPHS clinics, offices of the government ministries: MoPH, Ministry of Women Affairs (MoWA), Ministry of Haj, and its provincial departments, NGOs, female prisons and shelters, health *shuras*, and female and male Community development Councils (CDCs) Samangan, Wardak and Laghman provinces. Hence, a purposive sampling was employed. However, for the purpose of the paper only relevant data will be reported. Data from 106 participants (F=53, M=53) was gathered with 16 focus group discussions (FGDs) and 36 unstructured interviews that aimed to capture views and experiences of health professionals documenting and treating SGBV cases, and the impact of harmful traditional practices on girls' and women's health and social rights. Each interview and FGD lasted from 1-2 hours. The conversations were voice recorded in a digital device with written and verbal consent obtained from all participants. However, for the purpose of this study, the priority is to present girls' and womens' voices and experience of injustices. Similarly, the study was carried out in specific settings across the three provinces therefore is not a representation of country as a whole.

Mixed methods included a generic questionnaire, interviews and FGDs to capture data from different groups as well as to minimise pre-existing assumptions, manage power relations, and to get sense of what was going on the field (Mahendru, 2010). It is to be noted that mixed methods approaches were used since this is what the setting required and not merely to complement methods (Mahendru and Tasker, 2020). Besides the Belmont report principles (1979), which were locally contextualised, the study followed strict ethical procedures of informed consent, anonymity and confidentiality and took a survivor-centred approach (UNFPA, 2012). The names of the interviewees and all relevant information about them were kept in a password-protected computer and all the voice recordings were further destroyed. The study understands the power imbalance between the researcher and the participants. Using feminist research principles (Mahendru, 2010), I consciously facilitated power by managing the power imbalance and relationship to those whose voices are systematically stifled due to their social positioning as victims or survivors of SGBV as well as female health professionals who work at the grassroots level in insecure settings and are also victims of SGBV. Similarly, identities of the GBV survivors and frontline health workers are protected in this paper by carefully citing their quotes only indicating their profession and/or location wherever appropriate. While boys and men in Afghanistan benefit from gender power relationships, the research recognises that they can also find themselves in disadvantaged positions depending on the spaces they occupy. The research interviewed two male victims of honour crimes. However, the data is not big enough to report and requires another paper. The focus of this article is to represent Afghan women and their lived realities who remain disproportionally disadvantaged and face extensive systematic inequalities and exclusion in private and public spaces due to their social positioning.

Questionnaire

The generic questionnaire helped with initiating discussions with health professionals from BPHS and EPHS clinics in a sensitive manner, to break the ice and understand their knowledge and attitudes towards SGBV. The quantitative questions were designed to understand at what levels the participants agreed with SGBV against women and

men and explored the types of GBV that exist in the country with responses ranging from 'yes', 'no', 'never' to 'I don't know'. The questionnaire was designed loosely with specific sections focused towards understanding health and other professionals' capacity, attitudes and approaches to treat and respond to emergency SGBV cases.

An un-structured feminist approach

In addition to the generic questionnaire, survivors of SGBV were simply asked to share their stories in their own ways i.e. no identifiable structure was followed to control the interviews. I did not pre-design any themes or a structured questionnaire rather used a grounded approach (Glaser and Strauss, 1967) guided the interviews and FGDs. While I had some themes in my mind, the information was not used rationally. Probing was used rationally as a key method to gather further information whenever appropriate. This explored themes around different forms of violence that girls and women face in Afghanistan, how child and forced marriages are negotiated; and causes and consequences of GBV. This approach allowed themes to emerge from the data that informed the research questions and enquiry clearly displaying the relation between emotion and knowledge (Holland, 2007). The emphasis was to understand the many issues, emotions and experiences that affect the health and well-being of Afghan women by giving power to the most vulnerable so that they can tell stories in their own ways. The grounded theory allowed me to move with the data and review the research approach based on the context and situation.

Providing health services in a conflict environment

Health practitioners were asked if they have heard of the term 'Gender Based Violence'. A number of participants, especially the frontline workers such as the midwives and emergency nurses in BPHS and EPHS clinics, either have never heard of the term or confused it with the term Gender Equality. While the participants could not define the term 'Gender Based Violence', after hearing the term 'violence' in *Dari* i.e. *Khushonat*, they understood it as an umbrella term for any harm that is targeted towards women. This exemplifies some of the difficulties between international intervention and local understanding and expectations. There remains a significant lack of trust between many Afghan communities, international intervention and the Afghan government.

The participants discussed the social expectations and positioning of women. There was a consensus that women's husbands, in-laws and their own families cause VAWG. However, it was not clear who the first point of help for GBV survivors was and how the cases were reported and referred to the legal institutions. Therefore, customary or informal systems of justice are seen by many as a more just and quicker system for arbitrating disputes. There were no formal mechanisms in place to prevent and respond to GBV cases. Frontline health workers and lawyers reported challenges in dealing with and registering GBV cases. They lacked appropriate training and capacity to manage the difficult situations, they also feared for their lives:

'We don't know how to resolve these issues. These are criminal cases. Not our headache. We are not providing them counselling; we won't give them any suggestions because something may happen to us. The woman's family or rapist could harm us. We hide the cases too. We feel unsafe.' BPHS, the two Midwives.

"We are scared. We can't provide any support. We are scared. If we ask someone [identify GBV] the case will not be confidential. The case will become public. We are scared of our lives. We are afraid from their community and family." Midwife, EPHS

A legal professional reported similar experience: *'Sometimes, I receive threats from husbands if I fight for a woman's right to divorce. They can kill me', Female Defence Lawyer, Mazar-e-Sharif*

In the absence of an effective legal system, the health and legal workers faced difficulties and challenges in providing appropriate advice to the victims of GBV. They also felt that the cases would not remain confidential due to strong community connections, but also because their own lives will be at risk in providing referrals or advise. Health professionals face constant harassment and threats from clients' husbands and communities. If a health professional intervenes and provide advice on GBV and family planning issues, they can be at a risk of serious harm.

In the absence of weak institutional systems, the customary laws exacerbate VAWG with "complex ideological and political system that contributes to unbalancing power relations and at times generates high levels of violence in almost all cultures" (Ahmad and Avoine, 2018:89). The female health workers underscored that men have the power and authority to bring about change. The male community leaders must be engaged in preventing and responding to GBV. This should include promoting gender transformative approaches to promote a women's rights agenda (Al-Tuwaihri and Saadat, 2018). Women rights organisations often negotiate the mediation process, works within a religious and morality framework, and prevent the majority of the cases from being reported. There was also a gap in the knowledge of frontline health workers and senior/male health professionals (e.g. Provincial Hospital Directors (PHDs), doctors and male emergency health nurses). PHDs suggested that the number of GBV cases reported in their settings was significantly low when compared to the figure provided by female frontline health professionals who were in direct contact with the patients on an everyday basis. Although, it was not a requirement for health workers to report or record GBV cases, female health workers had a fair idea about the number GBV cases they identify every month.

Gender and social norms: a culture of impunity

Low social status and social stigma deter women from going against their families to pursue justice, particularly in cases of domestic abuse. For a woman even to approach the health professionals, police or courts requires her to overcome public contempt, which is still attached to women leaving their houses without a *Mahram*. This potentially results in under-reporting of SGBV cases. Those who do try seeking help could end up facing further challenges, such as encountering lack of concern, and hostility. This was reflected in the statements provided by men in decision-making positions, who held negative attitudes towards women and opposed their movement in public places, drawing connections between the attitudes presented with the sharia law:

"Women shouldn't go out without Mahram. Women should respect their husbands […] if women don't listen they can beat their women", Male Doctor, BPHS

"Most of us have two wives. Our honour, dignity, religion does not allow women to go out on her own. Women shouldn't go alone because women aren't aware of the area. Women should not go out without their husband permission." Health Shura, Samangan

"Families are very conservative. If we work, we are not allowed to come late." Midwife, Samangan

The quotes above are clear examples of how deeply entrenched harmful traditional practices are in Afghanistan where the application of violence is justified, legitimised and perpetuated in all corners of the country, denying women the rights and the opportunity to achieve their full potential as productive members of society. When women seek support the justice system hand down guilty convictions, whereas the sentences are far less for men who commit the violence and crime. They are released with impunity without the 'honour' dimension (UNAMA, 2018). The lack of justice compounds women's vulnerability. The women and men in the position of power such as the senior officials from the Ministries of Women, Haj and Justice unanimously justified VAWG clearly stating, *"Girls shouldn't run away, because it is against Islam. If they do they will face prison".*

Harmful traditional practices: Causes of GBV

Adverse traditions such as *Baadal* and *Baad* make girls and women more susceptible to violence. Numerous participants highlighted that they have been either victims of *Baadal* or *Baad* or they know of one or more people in their families who have been part of an exchange. The participants included female health practitioners who also suffered from *Baadal* and *Baad.*

"My father forced me to marry someone. I was exchanged [Baadal]. He married a woman and gave away two of his daughters to the sons of the woman he wanted to marry." Female Health Counsellor, BPHS, Samangan

The male health workers in contrast defended and justified such practices, as the quote from a male PHD Director suggests below:

"Both are bad traditions. This is not in Islam. I don't know why people do that. There have been cases in my family where my brother had a Baadal. Our Baadal is different. We are sitting together. We know each other and we can read each other's minds." PHD Director, EPHS, Wardak

GBV is normalised especially in cases where women start to break gender and social structures imposed my local councils and families. Female experiences in this study reflected some degree of agentic autonomy (Takhar, 2016) in their everyday negotiation of spaces trying to carve their own path. However, they do so with a degree of risk even if it means risking their lives. For example, both female and male participants highlighted that one of the causes of conflict between women and men are that *"women are trying to seek more independence".* They stated that girls and women are protesting more, less passive and intolerant of mistreatment due to the rise in education and employment opportunities for them. However, it is the men's sense of masculinity, which is under attack, who use verbal and physical abuse to maintain their power as the dominant gender within the household and in the society overall.

"Men can't be blamed. Women should stay in a frame. If they cross this, it causes problem. Men want their women to wear hijabs. Women don't want to wear hijabs. It causes conflict. Women shouldn't be outside all the time. They have domestic duties like looking after children." Male PHD Director, EPHS, Wardak

BPHS and EPHS health professionals, especially men, held discriminatory values and perceptions that perpetuate harmful traditional practices. The above quotes reflect the misogynist views originate from entrenched discriminatory views and beliefs about the role and position of women and girls in society affecting their sexual and reproductive health rights. Despite the existence of CEDAW[3] and EVAW[iv] laws (read Hakimi, 2020 for progress on EVAW law), the health professionals neither seem to be aware or conscious of the legal obligations, they also see themselves as gatekeepers of their culture, tradition and religion to control female bodies and sexuality, which takes priority over their duty as a health professional or doctor.

Walwar, Qalin and Mahr: the bride price

Cultural practices such as paying for the bride in forms of *walwar* or *qalin* were reported as causes of violence that secure a man's right to rape any woman and beat his wife, because he is "*frustrated*", "*tired*", "*hungry*" and "*doesn't have the money to repay the loan he took to pay for the bride*". *Walwar* and other harmful practices such as *Baadal* are often associated to the Pashtun tribe. However, in this study these practices were found to be prevalent across the three provinces regardless of participants' ethnic identity. Other factors reported that cause violence are preference for sons and if a woman leaves the house without the permission of the husband and/or his family, if she fails to perform domestic duties, and/or if a girl/woman flee household violence.

"Men work hard when they come back home if wife says anything, men can beat her. There is no law for this but this is allowed." Male Health Shuras, Samangan

"Whatever he [the husband] says should be accepted. Because boy's family paid Walwar they think she is Ghulam [slave]. When woman's family don't accept Walwar, they think the girl is not good enough." Midwife

A lot of boys aren't able to marry because they can't afford to pay Walwar, they are sexually frustrated so they rape." Male Emergency Nurse, EPHS, Wardak

The majority of the participants justified VAWG as a result of the socio-cultural practices that put economic pressure on men to pay the debts off taken to pay for the bride. Other reasons included: "*men are short-tempered with less emotional control".* It was also suggested that men are the breadwinners therefore the economic pressures fall back on them despite the fact that many GBV survivors reported their husbands were unemployed. The evidence suggests that poor households end up marrying off daughters to "settle debts incurred in their son's marriages. Bride price also precipitates forced marriages because this money often forms an important source of income for impoverished households" (Solotaroff and Pande, 2014:48).

Early and forced marriages

The National Risk and Vulnerability Assessment (NRVA, 2012) study of Afghanistan reported consistent pattern of gender inequalities in all major social indicators. It showed visible gender differentiation in marriages whereby women get married and

widowed earlier (due to the age gap between spouses) and in significantly larger shares. The NRVA study showed that girls and women remain disadvantaged as compared to boys and men in accessing both primary and higher level of education. The figures suggest that Afghanistan is failing to meet its Sustainable Development Goals on gender equality and education (SDG, 2017).

Similarly, 23 female participants in this study reported getting married under the age of 16, 9 reported being under the age of 13 and the rest of them were married before their 18th birthday. There was a widely held belief that girls should get married at the age of 13 (after their first period) or in some cases 16. Health *Shuras*, CDC members, health workers and government authorities witnessed girls getting married as young as 7 and 9 who are normally married to older men.

"In 24 hours, if we have 20 cases [of pregnancy] at least two are in the ages between 14 and 15." EPHS Midwife, Samangan

"They marry a girl when she is 7 or 9 and marry her to 18 years old and they have sex right after marriage. Four years ago a 9 years old girl was married to a 50 years old man. He was a mullah in Rui-Do-Ab. Last 3-4 years, we tried preventing some of these cases from happening." Department of Woman Affairs (DOWA), Samangan

"Yes, even 10 year old girls are given away, there are still such cases. For instance there was a 7 year old girl exchanged. I went to their house and talked with the girl's brother that this is not right, she is very young you should not do that. No one referred to Shura, I did it through my personal connection." CDC Members, Samangan

"In my village, girls get married at the age of 13, 14, 18. When they have their menarche (first period), they get married. Sometimes they get married to boys their own age but sometimes they are given to very old men. It's violence because they are not mature enough to make their own decisions. Girls and boys don't know how to deal with it. When a boy grows older and become an adult, he finds another wife because marriage was done without his knowledge. They have sex at that age as well." Female, BPHS, Wardak

"It varies. Most common age is 15-16 but in some cases we also see 9 years old getting married but when they turn 14 or 15, they go to their husbands family." Health Shuras, Wardak

While health and legal professionals and some CDC members intervened directly to prevent child and forced marriages, in general, they are in a minority. Girls still get married very early and have children early (NRVA, 2012). Female sexuality and bodies are a site of contestation for community leaders and families due to honour and shame rooted in cultural and traditional practices. Endorsements of harmful traditional practices by state institutions and structures have helped normalise VAWG either by dismantling/ignoring legal protections or by hollowing out support systems. While CDCs contain some of the seeds of incipient 'survivor centred approaches', in many cases, it remains a patriarchal structure with little female voice and participation in decision making processes.

Escaping forced and child marriages

One of the common themes that emerged across all interviews was a growing concern about girls as young as 13 and older fleeing home to escape forced and early marriages, *Baadal*, *Baad*, and physical violence.

"It was a forced marriage. They engaged me with a cousin of mine. I was engaged with him for eight months. I ran away and married my boyfriend who is in Kabul" GBV survivor, 17 years old, Female Shelter

"I ran away from home with a guy when I was 19. I have been here for the past 1.5 years. My boyfriend asked my father for my hand but my father didn't agree. My father wanted to do a Baadal for himself". GBV survivor, 21 years old, Female Shelter

"Women run away because of violence in families for example someone must be beating her or someone threatened the girl to kill. Some cases are because they are forcing the girl to marry.", says a DOWA representative holding her *chaderi* in Samangan

When girls and women run away there is little social support and social protection available for them. Women often run away with the hope to obtain freedom. However, this is a double-edged sword. While women are trying to escape violence, they face further violence from families and at the hand of legal authorities who perpetuate discriminatory and degrading practices. MoWA is leading the Afghan Social Protection Sector to achieve gender equality targets, and the senior female officials in the study were found to justify harmful practices under the Islamic banner. Females pursuing agency is seen as a product of radical feminism. Under this argument VAWG is legitimised, justified and perpetuated without any critical feminist analysis.

Sexual violence and marital rape

The lower status of women, and its acceptance within Afghan society and cultures, is one of the manifestations of gender inequalities and gender power imbalance. There were several instances where women in prisons and shelters as well as female health workers themselves narrated their lives in ways that positioned them as having lower status. Here violence becomes an accepted way of life whether it is physical, sexual or emotional. Some women including midwives and health counsellors described experiences with their husbands as *"repulsive"*. They found it difficult to negotiate sex and safe sex. The desirability of a woman's body in Afghan culture is associated within the discourses of family and community honour and reputation. In this context, a female body often appears to be a body for others. Women, however, negotiated this control but conceded to their male partner's sexual demands; because of the significance of their culture, religion, family and/or community to them, and legal structures that were corrupt and favoured men.

"He does it [have sex] even by force, I am his wife. Men will have sex no matter whether the women want it or not, whether she is busy or not. If I tell him my child is crying or I have something urgent to do, he will not accept it. Sharia has given him the right to do that. If I don't obey he will get angry with me, he thinks because I am educated and he is illiterate I am undermining him, or will say you don't like me. However, men should know they should not force their wives to have sex with them." Survivor and BPHS Midwife

The term rape was mentioned in almost every interview as a form of violence mainly against girls and women in the three provinces. Health professionals reported that girls as young as 12 were getting raped in their own homes and in public places. However, the families of the girls discover incidents when the girls were visibly pregnant and after they had sought assistance from a health worker after 6-7 months in pregnancy. Girls are unable to abort pregnancy at that stage and midwives in the BPHS and Health Sub Centres stated that rape victims who become pregnant are ostracised by their families, and there is also a danger to their lives. As a result of pregnancy, girls normally disappear without a trace and are killed by fathers and brothers. Some of the female prisoners I interviewed were imprisoned as a result of rape.

An 18-year-old survivor recounts her experience in the moral prison, holding her toddler while weeping inconsolably:

"My family had gone to my uncle's house when this happened. I was alone when my uncle came to my room and threatened me with a knife and raped me. I was scared and froze and didn't know what was going on. This happened three times and I got pregnant. I never told my family because of the fear of getting killed. When they found out at the seventh month, I told them what had happened. My uncle accused me of seducing him and lying. He never faced trial and I was brought here for zina (adultery and/or sex outside marriage)".

Zina, running away and informal justice systems are key to understanding why GBV is both recognised by front-line health workers but undermined by law and senior officials and by 'experts' from the international community. *Zina* is seen as an act of adultery and 'sex outside marriage, which also includes two unmarried partners, and erases the distinction between consensual and coercive sex', so that women reporting rape or fleeing marital violence and rape may be charged either with *zina* or running away. The existence of '*zina'* laws and laws against blasphemy and apostasy are warning signs of fundamentalism – whether they are enforced by the state or by the community, as the example of the killing of Farkhunda shows.

Instances above are the exemplars of patriarchal practices. Whether women contest this patriarchal system remains deeply embedded under their feminised subjected positions; their defence remains obstructed in the field of misrepresentations that construct and reproduce particular, often imaginary, notions of their cultures. Their own ability to decipher their own experiences and vocalise is a reflection of female agentic experience too wherein women are found to be expressing their voice and their sexual rights that the legal and social system fails to guarantee in terms of their safety and protection. As Fluri and Lehr (2019:154) stated "the weak and poor experience marginalization in both informal and formal systems of justice because they lack influence within the informal system and cannot pay the requisite bribes in the formal system".

Access to reproductive health services

One of the recurrent themes of the study was that girls and women are denied access to reproductive health services. They were prevented by their husbands and in-laws to access antenatal clinics. Midwives from all provinces highlighted the concern that girls and women are missing the antenatal appointments, which is an indication of GBV. Despite the fact that maternal mortality and child mortality in Afghanistan is at a

decline, access remains a huge challenge for health professionals (Mumtaz et al., 2019). Health decisions for women are often made by their husbands and women have a very little or no say in it. The research evidently showed that violence during pregnancy often increases (also see Gonzalez, 2018). Similarly, health professionals interviewed in this study received numerous cases of miscarriages and identified pre-natal and post-natal depression as a result of GBV. The other signs of GBV during pregnancy highlighted by health professionals were *"non-attendance at antenatal appointments", "attendance always with a partner and/or a family member who refuses to leave the room, is dominant or aggressive"*, and identification of multiple injuries at different stages of pregnancy i.e. before, during and after the child birth. The health workers also suggested that women get blamed for miscarriages or termination of pregnancy that causes further violence.

"I have identified GBV cases during delivery. When we ask clients during the presence of their mother or sister-in-laws, the client is unable to share. They put their hands on their own mouths due to the fear of further violence. We directly don't ask anything but we indirectly discuss with women, ask them and try to explore the cases. We tell them not to fight with your husbands, we ask them to be patient with their husbands, there is violence by mother and sister in laws who encourage the husband to beat." Midwife, EPHS

"I had a case two days ago. A 25 years old lady was two months pregnant and had a labour pain. It wasn't a stage for labour pain or delivery. I saw a lot of bruises on her body. I asked her. She said she fell off the stairs. I enquired further she said the same things but when I asked in private, she told me that her husband had beaten her. Her mother- and sister-in-law had provoked the husband. He used his feet on her face. He had kicked her face several times. Her tooth had been broken and her face was swollen. She lost the child as an outcome of violence" Midwife, BPHS

"There was a 23 years old lady who was married only for 7 months. During the 6 months in her pregnancy, her husband had beaten her. Her husband had forced her to drink something. Her family brought her to the hospital and we had to clean her stomach. I cried with her mother. The child didn't die. We don't know what happened to the case about how CID handled the case but the girl came again to the hospital for delivery with her mother." Midwife, EPHS

Resisting control: the cost of freedom

Women who try escaping violence are usually accused of and charged with *zina*; they are forced into virginity tests to prove their purity and in many cases without the survivor's consent. Even if the tests prove that they have previously not been engaged in sexual intercourse, they are incarcerated for attempted adultery.

"We are told to perform the virginity tests. Girls are normally accompanied by the police. There was a 13-year-old girl who did not want to go through the tests. Her mother and 2 others nurses held (pinned) her down while I carried out the test. If she is virgin she shouldn't be afraid", Female health worker, Wardak

"I don't know why girls run away, they shouldn't do that. That's a bad practice. I don't approve of it. If you don't want to get married talk to your parents. This is not the way.

If they run away, they should be in the prison. It's against the law, it's against Sharia, they bring shame to the family." *Senior Government Official, Ministry of Haj, Kabul*

"Yes, girls who run away from home should be imprisoned and carrying out virginity tests are important. It's against our religion and Islam to run away." DOWA, Samangan

Health workers who carried out virginity tests or witnessed them believed they were doing the right thing. None of the health and legal workers realised that such 'testing' was in itself a violation. This illustrates perfectly the way in which health workers are drawn into coercive practices, which are in themselves a form of SGBV. In several cases, religious justifications were provided for such practices that violate international standards of human rights. However, women themselves find these practices abhorrent and unjust:

"I had run away to escape forced-marriage. My family found out where I was. Then the police came and took me to the hospital for virginity test. I kept crying and saying no but no one heard me. Even my family didn't do anything. I was announced a virgin but still imprisoned for adultery." Female prisoner, Laghman

Though 'running away' is not a crime, it has been criminalised not only by the local authorities but also the highest court. This bolsters the points made by interviewees accepting coercion and violence in the name of sharia, and the religious attitudes undermining women's rights.

In 2018, a group of United Nations agencies has issued a joint statement calling for a ban on tests meant to assess the virginity of a girl or a woman, which is a common practice in at least 20 countries, including Afghanistan (WHO, 2018).

Emotional and physical violence was also reported within moral prisons and female shelters. A member of staff constantly monitored our interactions with women in a female shelter near Laghman managed by DoWA. The women described their situation in shelters as being in a semi-prison. They were not allowed to make contact with their families to prevent further retaliation. Their freedom of movement is restricted yet the government insists that they stay in shelters. Women and their children (some of them who were born in prisons) lacked access to basic services such as regular meals, clean water and basic hygiene and sanitation facilities.

Some of the children were as young as 6 months and eldest child was 5 years old. The authorities refused to provide food to the children of female prisoners as their *"children are not registered in the prisons and their food is not included in the budget"*. Women felt *"suicidal"* living in such conditions. Women accepted these conditions since they *"have nowhere to go"*.

VAWG was not limited to home, girls and women in female shelters and moral prisons reported physical violence by the officials in charge of these places. This included "*beating ruthlessly*", resulting in serious injuries and harm. They blamed the government for keeping them in shelters and prisons.

"The behaviour of the staff is really bad. Sometimes they beat us with iron rod. We were badly injured and were in a lot of pain. They are still here and no healthcare was provided. The head was also amongst those who had hit us. The court was informed about this but it was presented and prepared in such a way that we eventually got blamed for everything. I have no trust in the justice system. They don't want to work. They take bribes. If you know someone in the system, if you have the money, you can buy the law. It's easier for men. Men will sympathise with men." Female Prisoner and Former Midwife

When everything fails Afghan girls and women use suicide as the last resort to end violence in their lives. The health practitioners repeatedly informed us that they receive several cases where girls as young as 13 are attempting suicide, as *"they do not have anywhere to go"*

"Some young girls take poison to escape violence. They come here. The age groups are 25-26." EPHS Midwife

"We mainly get suicide cases under the age of 15. Most of them are married." Male Emergency Nurse, EPHS

"Two months ago a 17 years old girl had taken pills. We washed her stomach and referred her to Kabul clinic. It was a forced marriage case. They wanted her to marry her cousin." *BPHS Midwives*

The Afghan government is failing to provide appropriate psychosocial support to women who have experienced traumatic events. Amongst other inequalities, women are facing a huge mental health crisis. Safi (2018) reported that 1800 Afghans attempted suicide in 2017 of which 1400 were women. This figure is almost twice as high as the year before. Since mental health care and suicide are extremely stigmatised in Afghanistan, many suicide attempts and severe mental health crises go unreported.

Conclusion

SGBV is arguably a widespread human rights violation, a pervasive and systemic public health issue for girls and women in Afghanistan. It is clearly a complex and multidimensional issue embedded within the broader socio-economic, political, tribal and cultural context. The study shows that multiple causes of SGBV present extremely distressing situations for girls and women. One and the foremost problem for women is deep-rooted gender inequalities facilitated by harmful traditional practices and lack of effective survivor-centred support. The interplay of social power relations at individual, family, community, government and social level exacerbates women's vulnerabilities. In order to dismantle systematic patriarchy, changes need to be made in all corners of the government institutions who perpetuate violence and harmful traditional practices against girls and women. Girls and women who attempted escaping forced and child marriages, *Baad, Baadal,* and reported rape were subjected to invasive virginity tests some of them were as young as 12. They ended up in prisons and female shelters where they lacked basic services and faced further violence. Most healthcare providers, justice department and in some cases DoWA did not offer any concessions to these women who sought justice and support. Health workers and justice department held girls and women responsible for running away from home and justified the

punishment under the *Sharia Law*. The ones who did want to help, often midwives and frontline workers, feared for their own lives and lacked skills to deal with SGBV cases.

Survivor-Centred Approach

A survivor-centred approach to address violence against women in Afghanistan is required that seeks to empower the survivor by prioritising her rights, needs and wishes. It means ensuring that survivors have access to appropriate, accessible and good quality services, which includes healthcare, psychological and social support, security and legal services. It is essential that competent service delivery actors have the appropriate attitudes, knowledge and skills to prioritise the survivor's own experiences and input. By using this approach, professionals can create a supportive environment in which a survivor's rights are respected and in which she is treated with dignity and respect. A survivor-centred approach helps to promote a survivor's recovery and to reinforce her capacity to make decisions about possible interventions (UNFPA, 2012).

MoPH and WHO launched a Treatment Protocol for Primary Health Care in Afghanistan in 2014 to strengthen the overall capacity for the delivery of a multi-sectorial response to GBV in Afghanistan, particularly with regard to the prevention, response and management of GBV cases, which also includes appropriate reporting of cases to legal authorities. The protocol also aims to provide survivor-centred care. However, United States Institute of Peace reports that many legal provisions for women fail to be applied in practice, stating that: 'female victims of sexual violence […] are frequently persecuted and incarcerated for moral crimes, and their predators are only infrequently indicted or incarcerated' (USIP, 2014).

Engaging women-led organisations

The research concludes that government institutions have much to learn from feminists on the front lines of social change in Afghanistan who could become better allies through increased engagement with local women-led secular organisations. Some community-based activism and best practices have been found to be effective to uphold women's rights to live free from violence in the Afghan context[v]. However, there are debates amongst different feminist groups on appropriate politics of solidarity and sisterhood with diverse strategies who often struggle to find a common ground (Kandiyoti, 2007). There is indeed extensive diversity of thought and ideology among women activists on the best approaches to improving the lives of women and stopping gender-based violence. Women's activism in Afghanistan is not one group or monolith of ideological similarities. These range from liberal-feminist to leftist-feminist and Islamic-feminists. While focusing on the diverse approaches of Afghan women activists is essential, we would need to dismantle systems and structures that seek to protect fundamentalist thinking. Despite the current peace talks, women's position in the Afghan society remains marginal and if we are to assess the situation of women in Afghanistan, "attempts must be based upon as informed and unromantic an assessment as possible" (Riphenburg, 2004: 404). Afghan women were still fighting for a seat at the table during the recent peace talks. Religious fundamentalism is at the heart of the issue where power is offered to religious and tribal leaders who have created an atmosphere in which Afghans end up following religious, rather than civil law.

As Revolutionary Association of the Women of Afghanistan (RAWA), a women led secular organisation who have a long history of fighting SGBV in Afghanistan, including during Taliban control, states: "no political gains and no security for women

will be obtained unless fundamentalism is tackled and secular democracy is instituted. Only then, state-misogyny can start to be addressed".

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