Tackling violence against women and girls in Gaza

Catherine Müller and Jean-Pierre Tranchant

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About the authors

Catherine Müller is a research fellow at the Institute of Development Studies (IDS) in the UK. As a trained economist and applied researcher, she has gained an in-depth knowledge of quantitative and qualitative research design and data analysis methodologies in different country contexts across Europe, Africa, the MENA region, South Asia and Latin America. Her main areas of work are related to interpersonal violence, violence against women and girls, and women's empowerment – both within and outside conflict and humanitarian settings.
Email: c.mueller@ids.ac.uk

Jean-Pierre Tranchant is a research fellow at the Institute of Development Studies (IDS). He is an applied economist, specialised in the quantitative analysis of household surveys and cross-national data using experimental and quasi-experimental methods. His research areas include impact evaluations of development projects, the relationships between decentralisation and ethnic conflict, the impact of violent conflict on household welfare and malnutrition, domestic violence and violence against women and girls.
Email: JP.Tranchant@ids.ac.uk

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International Institute for Environment and Development
80-86 Gray's Inn Road, London WC1X 8NH, UK
Tel: +44 (0)20 3463 7399
Fax: +44 (0)20 3514 9055
www.iied.org

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This working paper presents the findings of a research project on the protection of women against violence in the context of urban humanitarian crises. Gaza, a highly urban and densely populated area, is a site of ongoing complex emergency, with bouts of acute violence. As such, it is challenging for humanitarian work. Analyses of original and secondary quantitative and qualitative data underscore that violence against women varies along their lifecycles, and is aggravated by humanitarian crises and exposure to political violence. The findings recommend that service providers work with local actors and embed currently scattered emergency gender-based violence (GBV) systems into a unified and shared development framework.

Contents

Acronyms

CMHP	Community Mental Health Programme
CSO	Civil Society Organisation
DV	Domestic violence
FG	Focus group
FGD	Focus group discussion
GBV	Gender-based violence
GBV IMS	Gender-based Violence Information Management System
GBV-WG	Gender-based Violence Working Group
IDP	Internally displaced person
IPV	Intimate partner violence
MoE	Ministry of Education
MoH	Ministry of Health
MoI	Ministry of Interior
MoSD	Ministry of Social Development
MoWA	Ministry of Women's Affairs
MS	Minimum Standards
NGO	Non-governmental Organisation
NRC	Norwegian Refugee Council
oPt	Occupied Palestinian territories
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics
SOPs TWG	Standard Operating Procedures Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UN HABITAT	United Nations Human Settlements Programme
UNHRC	United Nations Human Rights Council
UNICEF	United Nations Children's Fund
UNITAR	United Nations Institute for Training and Research
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNRWA	United Nations Relief and Works Agency
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VAW	Violence against women
VAWG	Violence against women and girls
WAC	Women's Affairs Centre
WaSH	Water, Sanitation and Hygiene
WHO	World Health Organization

Executive summary

This paper presents the findings of a research project aimed at furthering understanding of protection of women against violence in the context of urban humanitarian crises. This was carried out in the context of Gaza, which is the site of an ongoing complex emergency, with occasional bouts of acute violence. The ongoing conflict with Israel and military operations, the blockade and restrictions on mobility and freedom of movement, high rates of poverty and unemployment, and intra-Palestinian feuds have had – and continue to exert – tremendously negative effects on the population. In addition, Gaza is a highly urbanised and densely populated area, with almost 75 per cent of its population living in urban spaces, adding to the many challenges to humanitarian work.

We conducted empirical analyses of original and secondary quantitative datasets on domestic and intimate-partner violence against women in the Gaza Strip and West Bank to understand the impact of the conflict on domestic violence (DV) and its channels. Findings from original qualitative research and participatory workshops with key stakeholders involved in the provision of services aimed at supporting and preventing violence against women and girls in Gaza inform our discussion on service provision in humanitarian crises.

Our findings underscore that experiences of violence vary along the life stages of women. Married women face smaller risks of intimate partner violence (IPV) when their involvement in household decision making increases, something that is not true for unmarried women. However, unlike married women, unmarried women are particularly vulnerable to DV in large households. All women are protected from violence through social support networks; this effect is slightly more pronounced for unmarried women.

We also show that violence against women (VAW) through IPV is aggravated by humanitarian crises and exposure to political violence. During the military operation in the summer of 2014, the risk of experiencing DV increased substantially for married women. After the cessation of the military conflict, that risk decreased to pre-conflict level; however the risk of experiencing multiple types of DV increased for unmarried women. These effects are channelled through the impact of political violence on heightened stress within households and increased marital control.

Preventing VAW in the occupied Palestinian territories (oPts) – and Gaza in particular – is made more difficult because of the continuous stress exerted on the Palestinian people by the political violence exercised by Israel and the intra-Palestinian political divide, which also hamper the establishment of institutional response mechanisms across the oPts; patriarchal gender norms and traditions that contribute to the proliferation and acceptance of violence against women and girls; and the limited capacity of non-governmental organisations which provide most services.

Through the discussion of the needs of vulnerable groups and service providers, and the way in which consideration of the Minimum Standards for the Prevention and Response to Gender-Based Violence in Emergencies could improve the provision and accessibility of services in the Gaza Strip, we identified three main areas of action.

First, to better protect women and girls, service providers must build an information system that allow them to know what types of violence primarily affect different population groups and which avenues of support are used and why. Second, local actors (including survivors, at-risk populations, organisations and communities) must be included in identifying needs, barriers, and challenges to service provision, understanding the local distribution of power, and identifying potential 'ways in'. Working closer with communities should also be considered with respect to identifying support in emergencies in order to reach remote and hard-to-reach groups. Third, the currently scattered emergency efforts against gender-based violence (GBV) should be embedded into a unified development framework that is shared across all actors. A common database based on agreed definitions, standards, indicators and information, that allows information exchange across organisations, would lay the basis for replacing the current 'ad hoc cooperation system' – based on personal relationships and bilateral agreements – with a much-needed functioning unified referral system.

List of figures and tables

1 Motivation

In this project, we study the relationships between political violence[1] and violence against women and girls (VAWG) in the Gaza Strip and the West Bank, which, including east Jerusalem, form the occupied Palestinian Territories (oPts). Gaza is a context of interest to the academic and humanitarian communities worldwide, especially so with respect to protection in urban crises.[2] The situation in the Gaza Strip is characterised by a prolonged humanitarian crisis with ongoing restrictions on access and movements on land, air and sea, and repeated outbreaks of extreme hostilities, such as the Israeli military operation 'Protective Edge' in 2014, which resulted from the ongoing Hamas-Israel conflict. Both violent outbreaks and the continuing socioeconomic pressures on families and individuals have profoundly negative impacts on well-being and social relations. Gaza's unemployment rate reached 43 per cent towards the end of 2014 – "probably the highest in the world" (World Bank, 2015: 5) – with youth unemployment at about 60 per cent. Together with political stalemates, restrictions on freedom of movement, the constant expansion of settlements in the West Bank, and three large military operations since 2008, which led to severe destructions of lives and assets across the Gaza Strip, the oPt have seen internal family and factional feuds and – as some actors and observers have described – the resulting "collapse of social cohesion", that contributes to the violence in Palestinian lives, including violence against women (Kuttab *et al.*, 2011: 22).

Prolonged exposure to violence increases the accumulation of daily stressors, which risks triggering or aggravating gender-based violence (GBV) in general, and intimate partner violence against women, in particular (Wirtz *et al.*, 2013; Llosa *et al.*, 2012; HSR, 2012; Annan and Brier, 2010; Horn, 2010). When violence is pervasive and sustained, family relations suffer from the conflict-related changes in gender roles and activities (Al-Krenawi *et al.*, 2007); and violence tends to become a 'normal' conflict-resolution tool (Jewkes, 2002). Forced displacement of populations, separation of families, disruption of community and institutional protection structures, and challenged access to justice for survivors due to conflict, put refugees and internally displaced persons at particular risk of GBV (UNHCR, 2003).

A small number of studies have suggested a link between the political violence of the Israeli occupation and changes in gender roles that have led to frustration and tension in households (such as Johnson (2011), cited in of UN Women, 2013; World Bank, 2010); and perceptions about the link between the second Intifada[3] and increased psychological and emotional violence against women; sexual harassment; and physical and sexual violence against women (of Women's Studies, 2013). Some studies, such as Müller and Barhoum (2015); Al-Krenawi *et al.* (2007); Clark *et al.* (2010) and (Haj-Yahia and Clark, 2013) also suggest the presence of a link between the political violence and acts of

[1] 'Political violence' is taken to mean the chronic ongoing violence (such as restrictions on movement or the impact of the blockade in Gaza) associated with the occupation of Palestinian territories and sporadic Israeli military operations in Gaza.
[2] In this report, we follow the UN's Global Protection Cluster definition of 'protection' as "all activities aimed at obtaining full respect for the right of all individuals, without discrimination, in accordance with the relevant bodies of law", ie protecting people – vulnerable due to conflict or disaster – from harm by others.
[3] This term (also 'Al-Aqsa intifada') is used to refer to the second main Palestinian uprising against the Israeli occupation, which broke out in 2000 and ended in 2005 with the declaration of a truce between Mahmoud Abbas and Ariel Sharon.

violence against women. However, these studies could only show correlations so far; and two recent reports explicitly called for more research on the links between occupation violence and domestic violence in the oPt (UN Women, 2013; UNFPA, 2014).

Protecting women and girls from gender-based violence in the oPt is made challenging due to several factors, including gender norms and traditions, the inter-Palestinian political division and violence, and the political violence as a result of the Israeli occupation, which will be discussed further in Chapter 5. National and international organisations have for many years fought hard to bring more attention to the issue of violence against women and girls, and to design and implement strategies and programmes aimed at supporting survivors and preventing (further) violence for the current and next generations.

Understanding the challenges of protection and service provision in the oPt humanitarian setting can help in the design of and thinking around humanitarian service delivery in other urban settings. In fact, there is very little evidence on 'what works' in terms of interventions to prevent or respond to VAWG in conflict or humanitarian settings (Murphy *et al.*, 2016). Furthermore, the few evaluations that have been carried out are usually focused on rural populations or camps (*ibid.*) Yet, about 60 per cent of refugees worldwide live in urban environments, mostly in conflict-affected or low-income countries (IRC, 2016). Little understanding exists on how populations in humanitarian settings – particularly the displaced – negotiate spaces and livelihoods in urban environments. Also, the interplay of development and humanitarian actors in urban environments and understanding how the most vulnerable could be best supported and protected need unpacking (Haysom and el Sarraj, 2012). Understanding how service provision in fluid and rapidly changing contexts (eg where acute emergencies quickly unfold) is especially relevant as it relates to the ongoing debates around the humanitarian-development nexus and on how crisis responses can contribute to longer term resilience.

2

Study questions and approach

The project addressed two main research goals:

1. To show the link between political violence and violence against women and girls, with a focus on domestic violence as the most frequently observed type of VAWG, and to inform on (potential) channels.
2. To understand how current protection efforts by humanitarian actors can help alleviate the risk of women and girls suffering from domestic violence, and how these efforts could be improved in a context of dense settlements where complex and acute emergencies chronically unfold.

The project was carried out in partnership with the United Nations Population Fund (UNFPA) in Palestine, a key actor on women and girls' health in the oPt with its work in GBV, maternal health, and sexual and reproductive health. It is currently leading a number of interventions aimed at eliminating GBV in humanitarian contexts such as: i) improving the availability of compassionate and confidential health and psychosocial services for GBV survivors; ii) strengthening GBV prevention and protection; iii) improving safe and ethical aggregate and standardised data collection and evidence to facilitate broader trend analyses for advocacy and policy; and iv) leading a well-functioning GBV working group (GBV-WG) supported in the West Bank and Gaza. Since 2015, the GBV-WG has operated as one of the humanitarian working groups of the Protection Cluster, and is responsible for the communication of humanitarian GBV services (Wadi, 2016).[4]

UNFPA was involved in the preparation of the research to ensure that the research questions were strongly policy relevant, to provide data, documentation and access to programme staff, to link up with the wider humanitarian community and government, and to take a key role in the dissemination and policy engagement activities. The study was also supported by the Women's Affairs Center (WAC) in Gaza, an independent and non-profit Palestinian NGO with the purpose of advocating women's rights and gender equality through capacity development, information, and innovative research and advocacy programmes.

Given the two distinct research aims, we pursued parallel strategies. First, we reviewed the existing literature, both academic and 'grey' on the link between political and violence against women and girls, and on the protection of women and girls in Gaza. We drew in information provided by the GBV-WG network, led by UNFPA.

Second, to empirically test the link between occupation violence and domestic violence, we used the PCBS (2011) dataset, as well as a unique household survey collected in the Gaza Strip in 2015 (see Müller and Barhoum, 2015), in combination with information on infrastructure destruction during the Israeli military operation provided by UNOCHA (2014). Insights from qualitative discussion groups informed and enriched our approach and findings.

[4] A list of member organisations is given in Annex 1.

Finally, and within the context of other activities in Gaza, such as the third round of service mapping of GBV services and the first ever international seminar on GBV in the Gaza Strip, we conducted two participatory workshops with organisations and key stakeholders in GBV service provision. The first workshop took place in October 2016 and focused on:

a) Identifying relevant services, activities and responsibilities

b) Exploring agencies' and organisations' knowledge and cooperation

c) Identifying gaps in services and activities, particularly in times of emergency

d) Exploring priorities for the improvement of existing or the provision of new services, again particularly in light of the risk of changing states from ongoing to acute emergency, and

e) Identifying organisations and individuals to involve in planning and coordination.

The second workshop in early December 2016 was devoted to a discussion on the findings of the October workshop, to validate and add to its conclusions.

The following chapters present and discuss the findings from these research activities. Chapter 3 gives an introduction to the context of the Gaza Strip and West Bank as an ongoing – sometimes acute – humanitarian emergency and the state of violence against women therein. Chapter 4 describes the empirical part of the study and its findings; and Chapter 5 gives more details and insights into the workshops. We conclude the paper with Chapter 6, which discusses the main recommendations for GBV service provision in the Gaza Strip in particular, and in other urban humanitarian contexts in general.

3 Context

With almost three quarters of its population living in urban spaces, the Gaza Strip is highly urbanised and also very densely populated. The population density of Gaza has been estimated at 14,500 inhabitants per sq km in Demographia (2016), which ranks it at 104th in the world (out of 1,022 built-up urban areas worldwide).[5] Jabalya Camp and Ash Shati Camp are both estimated to accommodate more than 50,000 inhabitants per sq km (UN Habitat, 2014), which puts their population density at the first place in the world, ahead of that of Dhaka (44,100). Frequent destruction and replacement of infrastructures and dwellings, as well as the population growth being confined within a geographically restricted area, has led to acute overcrowding and a complex housing crisis (UN Habitat, 2014). Haysom and el Sarraj (2012) note that about 9 per cent of the housing shortage in 2012 was due to the Israeli military operation 'Cast Lead' in 2008/9. Furthermore, Gaza still experiences a rapid urbanisation rate of 3.1 per cent/annum (UN Habitat, 2014).

A large majority (70 per cent) of Gaza's population is composed of refugees from the Arab-Israeli conflict in 1948, and their descendants. The 1967 war between Israel, Syria, Jordan and Egypt marked the beginning of the Israeli occupation of the West Bank (including East Jerusalem) and the Gaza Strip, which entails both physical and administrative restrictions. Between 1970 and 2005, Israel established 21 settlements in the Gaza Strip, further reinforcing restriction of movements and adding to the destruction of homes and land to make space for Israeli settlements and outposts. Between 2000 and 2004 alone, around 2,500 houses were demolished (Haysom and el Sarraj, 2012). With Israel's disengagement from the Gaza Strip in 2005, movements within the Gaza Strip became easier; however, controls on the movement of people and goods in and out of Gaza by Israel (along with neighbouring Egypt), as well as ongoing Israeli military operations exert violence against the population of Gaza on a continuous basis. According to the UN, "the chronic nature of the protection crisis that drives the humanitarian need challenges any notion of the short-term nature of emergency response" (UN, 2016:106).

The first and second Intifada had large impacts on poverty levels and caused much destruction in Gaza. For example, the number of families depending on food assistance from UNWRA increased from just under 9,500 in 1990 to 120,000 just a year later; and during the second Intifada, about 15 per cent of agricultural land in the Gaza Strip was destroyed, together with irrigation networks, wells, greenhouses and water pumps (Alexander, 2007). The damages incurred during military operations in August and November 2006 ('Summer Rains' at US$46 million and 'Autumn Clouds' at US$23.3 million) further hit the agricultural sector (about half of the damages) and destroyed homes, roads, electricity and other infrastructure (*Ibid.*). Since 2008, Gaza has seen a further three large military operations.[6] Together with the ongoing blockade that led to and continues to contribute to deteriorating

[5] The report contains population, land area and population density for all 1,022 identified built-up urban areas (urban agglomerations or urbanised areas) with populations of 500,000 or larger.
[6] 1) Operation 'Cast Lead' (the 'Gaza War') in 2008–09, where an estimated 1,167 Palestinians died (http://pchrgaza.org/en/?p=1846); (2) Operation 'Pillar of Defence' November 2012, which killed 171 Palestinians, of which 102 were civilians (http://pchrgaza.org/en/?p=5538); (3) Operation 'Protective Edge' in Summer 2014, in which 2,251 Palestinians, including 1,462 civilians (551 children and 299 women) were killed (UNHRC, 2015).

economic conditions, political stalemate, restrictions on mobility and freedom of movement, and high rates of unemployment and poverty, all these factors and developments have resulted in the above-mentioned "collapse of social cohesion" (Kuttab *et al.*, 2011: 22). This has also been aided by the fierce military conflict between Fatah and Hamas in 2007, which had a massive impact on social relations, families, and gender roles in Gaza (Ebeid and Al-Belbeisi, 2009).

As Kuttab *et al.* (2011) repeatedly stress in their work, the political and occupational violence are inherently intertwined with violence against women:

> *"Palestinians in the oPt are not subjected to a classical war, but to continuous aggression and consistent violations of human and women's rights under protracted belligerent occupation. The aggressor in this case is an Occupier, which not only violates different international conventions, mainly the Fourth Geneva Convention, but also applies legal, administrative, political and economic procedures which, although not violent in nature, are inherently more dangerous, as they create a condition of deprivation that initiates violence at different scales. The deprivation of the right to national self-determination and the denial of social, political and economic autonomy in a gendered society all constitute violent acts of the occupation. Similarly, restrictions on the mobility of people and commodities, including the policy of siege on the Gaza Strip as well as the fragmentation and cantonization of communities through checkpoints and the Barrier in the West Bank, are all violent acts that impact women within families and within Palestinian society at large. The daily deprivation of social and economic security at the household level; the threat and insecurity of living in continuous crisis; the loss of private spaces such as homes and lands through confiscation or demolition; and the inability to secure a job, shakes the social fabric of the Palestinian household and heightens the loss of self-identity and social space of women, which in turn, leaves them more vulnerable. The inter-relatedness of the forms of violence from the Israeli occupation coupled with the different forms of violence resulting from traditional patriarchal family structures have been exposed through the women's stories gathered in the research for this report."* (Kuttab *et al.*, 2011: 19)

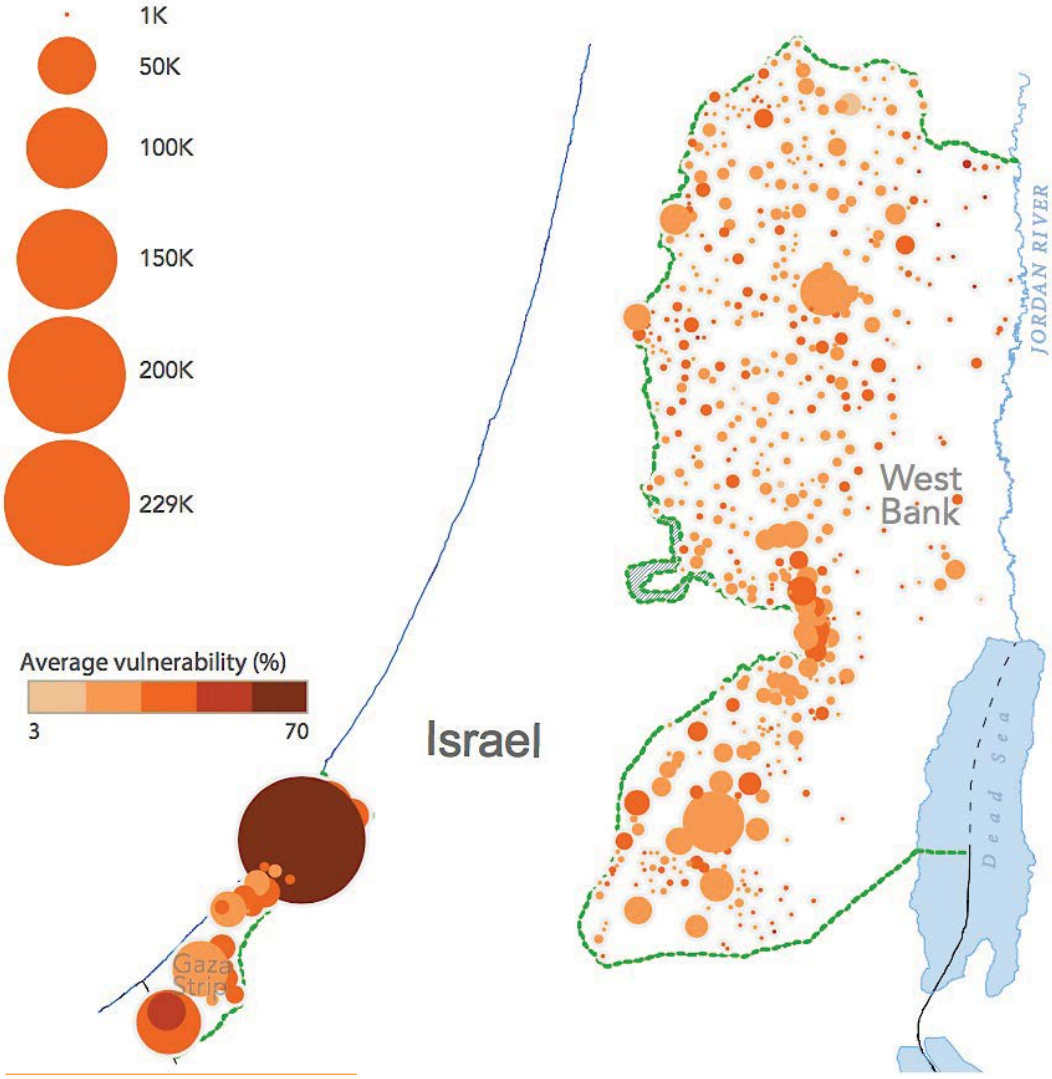
The last military operation of July-August 2014 led to the highest number of civilian deaths since 1967. A total of 2,251 Palestinians were killed, including 551 children and 299 women; and more than 1,500 Palestinian children were orphaned. Aerial bombardments, naval shelling and artillery fire also led to the destruction and damage of 18 health facilities, 31 educational facilities, 1,855 ha of agricultural land, and 1,263 greenhouses (UNITAR, 2014). More than 25,000 housing units were either completely destroyed or incurred severe or major damage, and 143,680 homes were partially damaged or had minor damages (UNOCHA, 2015). Given the high population density, around 28 per cent of the population was internally displaced at the height of the hostilities.

NRC (2015) provides an insightful report on the continued impact of the 2014 conflict, as well as the blockade and ongoing humanitarian crisis, on women and their families. For many of the women, the most pressing concern after the military operation in 2014 was the damage to or destruction of their homes. More than 40 per cent of the interviewees had not yet been able to return, and many still did not know when they would receive help with rebuilding or repairing their homes. A survey of IDPs showed that 74 per cent of IDP households depended on trucked water sources; and 60 per cent said that the domestic water quantity was insufficient (UNOCHA, 2016a). Another priority for the women is support for their children. Almost all of the women spoke of the children having nightmares, exhibiting behavioural problems, and showing difficulties studying at school – all related to what they experienced during the war. The NRC report also explores the psychological impact on the women and their relationships with their husbands and family, and women's concerns and fears for their children's futures given the economic situation and outlook. These concerns and fears that play on women's minds are direct consequences of the occupation violence aimed at the whole population. And for most women, concerns about their loved ones hurts as much as violence targeted at them directly. It 'rounds' the picture of women being affected directly and indirectly on several different levels, the political, the interrelational, and the personal.

The year 2015 saw somewhat of a relaxation of restrictions by Israeli authorities and an increase in the volume of people and goods that moved in and out of Gaza (UNOCHA, 2015); in fact, truckloads during 2015 were five times what they were in 2014. However, this was still only a tenth of the volume witnessed in the first five months of 2007, before the imposition of the blockade. Furthermore, the Rafah passenger crossing has been almost continuously closed by Egypt since October 2014, leaving thousands of people stuck. These and the devastated infrastructure, the remaining 95,000 people still displaced, poverty levels at 39 per cent, unemployment rates at 43 per cent (exceeding 60 per cent among youth), and a food insecurity level at 47 per cent (World Bank, 2015; UNOCHA, 2015), make it clear that the underlying challenges remain unchanged.

Figure 1 below links to these issues and gives an overview on the location of the most vulnerable clusters across the oPts in 2015. This multi-cluster vulnerability assessment was conducted under UNOCHA's

Figure 1: Severity map



Source: UNOCHA (2015)

coordination and in partnership with the Palestinian Central Bureau of Statistics, and took into account a large range of humanitarian indicators ('Vulnerability Profile Project VPP+'). These indicators relate to issues of physical protection, access to land and livelihoods, water and sanitation, education and health. The figure gives an idea about the dispersion and level of vulnerability by aggregating communities based on their level of vulnerability (high, medium and low). Even though the map is not suitable for the quantification of people in need, it does show clearly that vulnerability levels are very high and widespread across the Gaza Strip. According to UNOCHA (2015), 70 per cent of the Gaza population is in need across most sectors.

The underlying challenges mentioned above are the need for protection "for at least 1.8 million Palestinians experiencing or at risk of (by way of illustration) conflict and violence, displacement, denial of access to livelihoods, administrative detention, psycho-social distress or exposure to explosive remnants of war"; the need to ensure essential services; and the need to support vulnerable households to cope with the prolonged humanitarian crisis they live in and the recurrent shocks they face (UNOCHA, 2015: 5).

These challenges are interconnected, and they are all interlinked with the violence against women and girls that has been documented. Overcoming these challenges will not eradicate this type of gender-based violence on its own, but it would help remove some of the stressors that exacerbate it. The urban environment causes a particular challenge in that overcrowding is a known risk factor of violence, and the lack of anonymity makes reporting violence or seeking services more sensitive. However, high population density and the clustering of people could also facilitate the delivery of key services (including protection).

4

Domestic violence against women and political violence in the oPt

4.1 Key issues and findings of previous studies

Work on VAW in the oPt has been carried out since the early 1990s. However, interest increased amongst a wider range of actors and organisations, spurred by the publication of the results of the national PCBS Domestic Violence Survey in 2005 – at that time "one-of-a kind study in the Arab world" (PCBS, 2006: 5). This survey aimed at providing comprehensive statistics on domestic violence (DV) in general and to place this phenomenon within the larger situation of violence against women, men, children, and the elderly in Palestinian society. As Kuttab *et al.* (2011: 22) put it, this study "granted the issue a form of legitimacy at the national level, despite it being socially taboo".

Table 1 gives an overview on some of the most recent studies on violence against women over the last five years. Their findings are briefly outlined below, to paint the picture of where we currently stand.

The combination of unequal gender roles in Palestinian society, restriction of movement and political violence, linked with the Israeli occupation, the intra-Palestinian divide, and limited legal authority and protection of women, generates different vulnerabilities for women and men, and for boys and girls. Men are more vulnerable to military or settler violence, while women are more vulnerable to DV, particularly in times of crises. Women and girls in particular have also been shown to suffer from restriction of movement, demolition of their house and place of livelihood, and displacement, as these increase the risk of violence, and women and girls bear the brunt of the consequences of overcrowding and disrupted access to basic services and livelihoods.

Table 1: Overview of recent studies on VAW

STUDY	METHOD	NOTES
Association between exposure to political violence and intimate-partner violence in the oPt, 2000	• Quantitative data (PCBS, 2006) • Logistic regression analysis	• Direct and indirect exposure to political violence • All forms of IPV are positively associated with exposure to political violence
Violence Survey in the Palestinian Society, Palestinian Central Bureau of Statistics, 2011	• Quantitative data collection • Survey is representative of the Palestinian population in both Gaza and the West Bank	• Aimed at gathering and providing detailed and representative statistics about violence in the Palestinian territories • For men the focus was on experiences of political, occupational violence • For women the investigator team additionally collected information on domestic violence
Gender-Based Violence in the Occupied Palestinian Territory, Bisan Center for Research and Development, 2011	• Comprehensive qualitative work • Literature review and content analysis • FGDs and interviews with women and girls in shelters, directors and staff of women's organisations, government representatives, lawyers, and police officials	• A particular effort was made to include women in border areas (buffer zone in Gaza, close to the Wall in West Bank) in order to understand the impact of political violence on women's daily lives, eg after the Israeli military attacks on Gaza in December 2008 and January 2009
Intimate Partner Violence in the oPt: Prevalence and Risk Factors, 2013	• Quantitative data (PCBS, 2006) • Logistic regression analysis	• Also accounts for family stressors • Family stressors are positively associated with all forms of IPV • Exposure to political violence is positively associated with some forms of IPV
Protection in the Windward, UNFPA and The Culture and Free Thought Association (CFTA), 2014	• Qualitative study implemented immediately after the operation 'Protective Edge' • Focus group discussions (FGDs) with more than 200 women and men in shelters and host family homes; 18 key informant interviews with representatives of local and international organisations; a service mapping with 22 local, international and UN organisations; and a safety and protection assessment tool in 13 shelters targeted by the study	• Aim to understand and highlight the conditions of women and girls in shelters and with host families during the latest war on Gaza • To evaluate the services and protection mechanisms available to and aimed at women and girls during the operation
Gaza: The Impact of Conflict on Women, Norwegian Refugee Council, 2015	• Qualitative FGDs with 117 women in early March 2015	• Focuses on women's experiences during the military operation in the summer of 2014, as well as the continued impact of the ongoing occupation, conflict and Israeli imposed blockade
Violence against women in the Gaza Strip after the Israeli military operation 'Protective Edge', Müller and Barhoum for ActionAid and Alianza por la Solidaridad, 2015	• Quantitative and qualitative research components between April and July 2015 • Quantitative survey representative of women aged 17 and above across the Gaza Strip. • Three rounds of qualitative focus groups and interviews with more than 300 women and 130 men, 7 key informant interviews with religious and community leaders and roundtables with 28 members of CSOs	• Aim to complement studies such as CFTA (2014) and get an idea about the types, prevalence and frequency of violence experienced by the whole population of women and girls in the Gaza Strip, not restricted to any sub-groups

Table 2: Types of VAW in public and private spaces

PREVALENCE RATE	TYPES AND ACTS	MAIN PLACE AND PERPETRATORS OF VIOLENCE
28.2%	Verbal humiliation, cursing and abuse	Mostly at home by husbands and partners
15.9%	Verbal harassment	Outside the home in streets and shopping places; mainly by male strangers
10.9%	Physical abuse	At home; mainly by husbands and other family members
3.4%	Serious physical abuse	
3.9%	Sexual harassment or attempted abuse	Mostly at home by husbands and partners
3.9%	Threat of having children taken away	Mostly at home by husbands and other family members

Source: Müller and Barhoum (2015) based on a representative sample of 440 women aged 17+ across the Gaza Strip.

Care responsibilities – which are often already extremely time-intensive and physically demanding in non-emergency situations – are made even more burdensome by the restricted access to services, restricted mobility and lack of resources. For example, 23 WaSH items are included in the 'dual use' list and thus restricted to import by Israel (UNOCHA, 2015).[7] Vulnerabilities of women and girls also stem from the discriminatory legal rights of women, eg regarding housing and land rights, practices such as early marriage and, as mentioned before, restricted mobility of women and girls.

Political violence affects women directly, for example through killings, injuries, arrests of family members; and indirectly through the effects of movement restriction, militarisation of society and intra-Palestinian political violence. The closing of borders and the ongoing blockade on Gaza additionally leads to poverty, unemployment and psychological pressures on families, often affecting women particularly badly (Kuttab *et al.,* 2011; Müller and Barhoum, 2015).

Since 2008, six per cent of all deaths from political violence and one per cent of Palestinian prisoners in Israeli jails have been women (Kuttab *et al.*, 2011). The most recent episode of large-scale violence in Gaza took place from July to August 2014; the 51-day-long bombardment killed 2,251 Palestinians, including 1,462 civilians, of whom 299 were women and 551 were children. It also injured 11,231 Palestinians, including 3,540 women and 3,436 children (UNHRC, 2015). At the height of this military operation, nearly 500,000 people – 28 per cent of the population – were displaced (UNOCHA, 2016a); and more than 90,000 people were still displaced in early 2016. We have not found estimates of how many of the displaced are women and girls; however, it is well established that the impact of displacement is highly gendered, eg in terms of security, mobility and economic engagement, and in terms of women's roles as caregivers to their families and communities, both directly and indirectly (we return to the impact of displacement on women and girls later in the report).

Checkpoints and restrictions on movement in the oPt affect the whole population, but is a source of particular concern to pregnant women. Giacaman *et al.,* 2007 (cited in Kuttab *et al.*, 2011) show that 20.5 per cent of women did not give birth in their preferred location because of the barriers to free movement. Mobility restrictions are also affecting women's ability to secure their working rights by preventing them from participating in trade union activities. According to PCBS (2011), 3.3 per cent of ever-married women[8] were exposed to psychological violence at checkpoints by soldiers, 0.6 per cent were exposed to physical violence, and 0.2 per cent were exposed to sexual harassment.

Looking at **non-political forms of violence against women (VAW)**, between August 2014 and July 2015, 37.3 per cent of women reported having experienced at least one incident of any of the types of violence – domestic or non-domestic (Müller and Barhoum, 2015). Of these 164 women, more than 40 per cent experienced more than two different types.

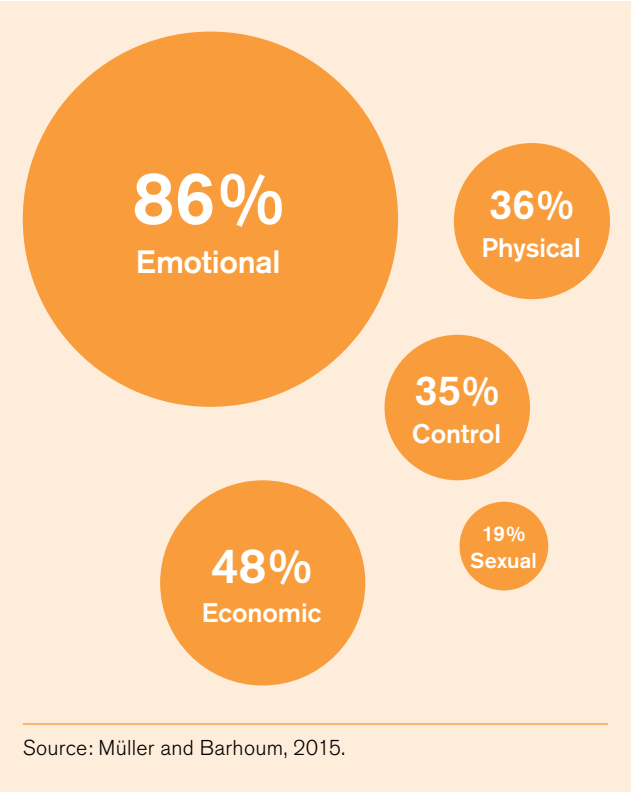
[7] Dual use items are goods, software, technology, documents and diagrams that could be used for civilian as well as military purposes. Israel manages its own dual use lists for the oPts, one specifically for Gaza, which are more restrictive than international lists. The list contains basic construction materials such as cement, gravel and steel bars, as well as other equipment critical for the provision of basic services.
[8] This term refers to women who were currently or previously married at the time of the survey.

As shown in the last two columns in Table 1, violence is mostly perpetrated at home by husbands. This is not surprising as intimate partner violence (IPV) has been recognised as the most common form of VAWG worldwide (WHO *et al.*, 2013). The second largest group of perpetrators comes from the immediate family environment. Strangers are mainly responsible for verbal harassment in public places, such as shopping areas and streets, and for sexual harassment or attempted sexual abuse.

The PCBS 2011 study showed some more insights into the non-IPV types of violence in the oPt. In 2010, 10.2 per cent of female youth aged 18–29 experienced psychological violence in the street, 0.6 per cent experienced physical violence, and 3 per cent experienced sexual harassment. Focusing on ever-married women, this affected 5 per cent in terms of psychological violence, 0.6 per cent in terms of physical violence, and 1.3 per cent in terms of sexual harassment. One of the common places where violence happens is schools: 28.6 per cent of boys and 16.7 per cent of girls aged 12–17 were exposed to physical or psychological violence from other students or teachers over the 12 months preceding the survey (PCBS, 2011). Prevalence of IPV is substantially higher than of non-IPV in oPt, with 37 per cent of married women having experienced at least one form of IPV. There is a marked difference between IPV prevalence in West Bank (30 per cent) and the Gaza Strip (51 per cent).[9]

Recent figures for the prevalence rates of **domestic violence** across the Gaza Strip come from Müller and Barhoum (2015). During the 11 months since the summer of 2014, 39.6 per cent of women (174 in total) reported experiencing at least one of the types of DV. Again, the most common form of violence was of a psychological nature, mostly in the form of cursing, insults, yelling and screaming. The second most prevalent form of abuse since the military operation was economic abuse. Women reported being refused sufficient funds for daily expenses, the threat of withdrawal of financial support and control of their expenses, ie checking in detail what a woman had spent her money on (see Figure 2 for percentage breakdown of the types of violence). Some of these rates are similar and some vary from those of PCBS (2011) partly because of differences in the measurement of violence.[10] Furthermore, of the women who experienced DV, more than 60 per cent experienced at least two different types of violence, and 6.3 per cent experienced all five types. In particular, economic and physical violence often occurred together with psychological abuse.

Figure 2: Types of violence experienced by women who are affected by domestic violence



Source: Müller and Barhoum, 2015.

4.2 Relationship between VAW and political violence

Although we have described both separately above, there is a strong presumption that political violence is associated with higher rates of violence against women and girls. In the case of the oPt, three studies have previously investigated this link. Clark *et al.* (2010) used the PCBS (2006) to estimate how the incidences of women suffering from intimate partner violence relate to the direct and indirect exposure of households (husbands) to political violence. They found that women whose husbands had been directly exposed to political violence were 47 per cent more likely to report experiencing psychological IPV, 89 per cent more likely to report experiencing physical IPV, and 2.2 times more likely to report experiencing sexual IPV. All these effects were strongly statistically significant, even after accounting for other risk factors and characteristics of the households. Corresponding effects for indirect exposure (including economic effects) were slightly lower in magnitude but still significant statistically. The second study is by Haj-Yahia and Clark (2013).

[9] Based on data from over 80 countries, WHO *et al.* (2013) found that almost 30 per cent of women worldwide who have ever been in a relationship have experienced physical and/or sexual violence by their intimate partner. Lifetime prevalence rates across the oPt are thus close to the global average, whereas they are significantly above average in the Gaza Strip itself. Furthermore, current prevalence rates, ie exposure during the 12 months preceding the survey are usually lower than lifetime experience, again showing the above average experience by women in the Gaza Strip.
[10] See Müller and Barhoum (2015) for details on the questionnaire.

Using the same 2006 PCBS dataset, the authors set out to identify the main risk factors of male-to-female IPV, emphasising the role of political violence and family stressors. They found that exposure to political violence increases the occurrences of women suffering from severe psychological IPV and moderate physical IPV, but was unrelated to sexual IPV. Family stressors, on the other hand, were significantly related to all three forms of IPV (both moderate and severe).

The third study is by Müller and Barhoum (2015), who have investigated this relationship in the context of Gaza by comparing the prevalence rates of violence against women before, during, and after the military operation of the summer 2014 (through a survey of 440 women). They found an increase in women's self-reported rates of victimisation (from domestic and non-domestic violence) after the military operation; with a particularly large increase in reported rates of physical abuse and, to a lesser extent, verbal abuse.

Generalising the findings of that survey, Müller and Barhoum (2015) calculate that more than 4,300 out of 100,000 women across Gaza aged 17 and above have experienced violence directly as a result of the military operation of the summer of 2014 (*ibid*: 52). The authors found that displacement was significantly correlated with experiences of emotional domestic violence, controlling behaviour, and non-domestic violence during the military operation, and some focus group participants suggested that many women and girls were vulnerable to gender-based violence, including rapes, in shelters.

Looking specifically into the issue of protection and shelters, the investigation of displaced women and girls by UNFPA and CFTA (2014) brought some very important insights in terms of responsiveness and shortcomings of humanitarian support and how to account for girls and women's needs in the design and implementation of protection programmes. The report stressed the need to ensure the physical and psychological safety of women and girls, as well as their integrity and human dignity. The study showed that women's and girls' living conditions in the emergency shelters were very different from those in their homes, exposing them to psychological pressures, anxiety and fear. Over 30 per cent of female IDPs interviewed for UNOCHA (2016) indicated that their shelter lacked safety, dignity and privacy. Women and girls experienced many types of violence during the 2014 escalation of violence, both in emergency shelters or host families' homes; and as too often, they responded to these types of violence with silence, or passed violence onto their children, especially onto girls. This silence was also observed in PCBS (2011) and Müller and Barhoum (2015). There is great social pressure and expectations to not talk about abusive relationships with anyone outside the family; and only some of the most severe cases get reported to authorities. UNFPA and CFTA (2014) also found that girls and women were subject to discrimination in receiving aid and services in emergency shelters; that some displaced women were dismissed due to overcrowding, and some women were even maltreated by the shelters' administrations and workers.

To summarise, women experience many different kinds of violence in the Gaza Strip. The aim of the next section – the empirical analysis – is to investigate the link between political violence and domestic violence in the oPts. In this section of the report we attempt to analyse statistically the links between political violence and domestic violence against women and girls in the oPt. We do this separately for Gaza and the West Bank, using different data sources.

4.3 Domestic VAWG and the military operation of 2014 in Gaza

To analyse the link between political violence and domestic violence against women in Gaza, we made use of qualitative group discussions and interviews, and unique quantitative data on domestic and intimate partner violence before, during, and after the Israeli military operation 'Protective Edge' in the summer of 2014 from a representative sample of women aged 17 and above (Müller and Barhoum, 2015). It is important to emphasise that because of the longevity of the political violence exerted on the Gaza Strip and its implications for social and economic factors that could themselves be related to risks of violence perpetration and victimisation, we measure in this analysis the impact of the intensification of the conflict, not the impact of the ongoing political violence itself.

The data was collected for a study on "Violence against women in the Gaza Strip after the Israeli military operation 'Protective Edge' 2014" (Müller and Barhoum, 2015), and was funded by ActionAid and Alianza por la Solidaridad in 2015 (*Ibid.*, 2015). The aim of the study was to complement existing work on subsets of the population and provide an insight into the wider situation of women across the Gaza Strip for advocacy and programming purposes. Qualitative focus groups and interviews were carried out with more than 300 women and 130 men, 28 members of local organisations, and 7 key informants. The quantitative survey was completed by 440 women.

For our empirical analysis, we focused on a questionnaire module on domestic violence. This type of violence captures intimate partner violence by husbands for married women; and in the case of never-married women, it captures violence by parents, siblings, or

other family members living in the same household as the women interviewed. Respondents were asked a number of behavioural questions on specific acts of violence, informed by the 'Violence in the Palestinian Society' survey (PCBS, 2011) and a first round of qualitative work that preceded the survey.[11]

Using this information, we followed two 'strands' of enquiry, with the ecological model forming the basis of our analysis (see Heise, 1998; 2011; Jewkes, 2002). This model posits that VAW is related to several factors on individual, relationship, community and societal levels. Factors relating to risks of violence include personal histories, attitudes towards gender roles and norms, access to and control of resources, power relations between individuals where violence can occur and within families, dynamics with and between other people in the community, colleagues, peers within institutions, amongst others. All these are shaped by cultural and social norms about gender, as well as the use of violence as a means of solving conflict in general, political, economic, and legal frameworks.

4.3.1 Domestic violence against women in Gaza

Our analysis of the qualitative data revealed that many of the discussions reflected several aspects of the ecological model. For example, stated reasons for VAW by men and women in focus groups could be grouped into: (a) personal characteristics, such as young age, lack of maturity, psychological pressure, lack of responsibility; (b) interpersonal relationship dynamics, such as a lack of mutual understanding or trust, controlling behaviour, intergenerational transmissions of violence, bad friends, bad communication, jealousy, and rushed marriages; and (c) structural reasons, eg lack of job opportunities, unemployment, 'bad' traditions, lack of respect towards women, stigma, the Israeli occupation and blockade, the government, illiteracy and a lack of education, and gender roles and norms.

What stood out in the discussion of reasons for violence or ways to avoid it was the perceived 'centrality' of the role of women in violence against them. The discussions always evolved around what women could do to avoid or what they must have done wrong to receive violence. For example, violence against younger girls or young married women was often portrayed as corrective or protective, whereas married women old enough to 'know better' were perceived as being punished for wrong behaviour. Also, women were advised to behave and obey, to be patient and tolerant, not to provoke, and to "be satisfied with what they have and keep their mouth shut" (Müller and Barhoum, 2015: 48). The discussions about outside help were also centred around expectations as to how victims should behave. In several focus group discussions, participants agreed that it was okay for women to seek outside help – but only if the family did nothing. The survey data shows that almost 80 per cent of women agreed with the statement that "family problems should not be discussed outside the home". *Mukhtars*[12] were mentioned as acceptable mediators; however, most of them are male and confined to their own traditional values and that of their clientele. Local organisations find working with them on GBV issues rather difficult.

In the first 'strand of enquiry', we used the quantitative data to look at the **correlates of domestic violence before the military operation in 2014**, taking into account several potential explanatory factors at different levels of the ecological model mentioned above. We found that DV does not seem to be disproportionately experienced by any particular groups of women. Individual and household characteristics, such as age, education level, marital status or the working status of the household head, are not significantly correlated with incidences or levels of domestic violence against women (see Table A1 in Annex 3). This very much resonated with discussions in focus groups, which revealed perceptions by women and men that the risk of violence against women did not really change with age – or there were conflicting arguments why one might be lower/higher than the other – just the perpetrators and the 'reasons' would differ (as discussed above).

Nevertheless, we did find that women in larger households are more likely to report having experienced domestic violence; an increase in household size by one member is associated with an increased risk of likelihood to experience DV by 11 per cent and an increased risk of experiencing several types of DV by 7 per cent. This could be related to two factors: increasing numbers of household members create more stress, and conflicts arise which could result in increased risks of violence (Straus *et al*., 1980; Flake, 2005); or larger numbers of family members could be indicative of higher dependency ratios and economic pressure and stress because of insufficient resources (Carlson, 1984). We investigated this issue further by studying the relationship between the age dependency ratio and the ratio of working household members versus overall household size. According to these

[11] See more details on the survey and qualitative methodology in Müller and Barhoum (2015).
[12] *Mukhtars* and *mukhtaras* are responsible for restoring justice and solving disputes between members of communities. Most families have a *mukhtar* – someone who helps solve problems between family members without resorting to formal judicial systems – of their own. Although most of these 'mediators' are male, female *mukhtaras* are particularly useful for women who need assistance in solving conflicts or need advice related to divorce, inheritance and sexual violence.

investigations, the composition of the household does not matter; so it is likely that it is the overcrowding of households *per se* that contributes to increased risks of domestic violence against women. Haj-Yahia and Clark (2013) have found in the Palestinian context that larger household size is associated with increased risk of IPV. As described above, urban areas in Gaza are more likely to be characterised by lack of space.

Our empirical analysis also gave evidence to women's participation in decision making in the household and the number of friends – an indicator of (potential) social support – having cushioning effects on both the prevalence and the number of different types of violence experienced. A one unit increase of women's participation in decision making results in a decrease of DV reporting by 12 per cent, and a decrease in risk of several types of DV experienced by 9 per cent. These effects are statistically significant, but only weakly, at the 10 per cent level. However, the effect of social support on the likelihood and number of DV experience is stronger in terms of significance level. Having one additional good friend in the neighbourhood reduces the risk of violence by 13 per cent, and the risk of increasing numbers of types of violence by 3 per cent.

The relationship between household size and risk of domestic violence completely disappears when restricting the sample to married women (Table A2 in Annex 3), and is much larger and highly significant when focusing on non-married women only. One more household member increases the risk of non-married women experiencing domestic violence by 34 per cent and the risk of experiencing multiple forms of violence by 18 per cent. The cushioning 'effect' of friends is particularly strong for non-married women, as it is related to both a reduced likelihood of experiencing domestic violence and the number of different types of domestic violence at the same time. This was not anything that was discussed or came out in the qualitative part of the research; however, other work, such as that by Yount (2011) in Egypt found that women often advise each other and share 'best strategies' on how to avoid spousal violence, something that results in 'strategic conformity'. As our qualitative work showed, much of the hypothetical advice offered to women included being patient and tolerant and not provoking men; thus, it is possible that this strategic conformity is at play here too, and more likely when several friends convey these messages. For unmarried women, we can only speculate. For example, it could be that non-married women – as mentioned mainly younger and never married – benefit from more freedom of movement and escape crowded homes more often (for which the number of friends could be an indicator). Future research might want to uncover these channels in more detail.

4.3.2 Analysis of the relationship between domestic VAWG and the military operation

The relationship between the political violence and violence against women was discussed in the FGDs. With respect to the 2014 war, all FG participants spoke about the stress of the destruction, overcrowding, lack of services, loss of livelihoods and incomes, and constant fear. Many fights over resources were witnessed, as well as verbal abuse and divorces, particularly amongst displaced couples. Women spoke a lot about the anger of brothers and husbands during and after the military operation, but also about families sticking together. In our survey sample, 71.8 per cent of respondent reported some damage to their housing, and 42 per cent of the respondents had been temporarily displaced; 75 per cent of them stayed with family or friends and 17.8 per cent in schools. Furthermore, 13.6 per cent of all participants reported at least one incident of damage to productive assets.

Nevertheless, many focus group discussants felt that the underlying causes of violence against women exist independently of the 2014 war; and that the war, occupation, and internal political conflict are 'merely' aggravating factors. Looking at the statistics, we found that most women who responded to the survey and identified as survivors of domestic violence since the end of the military operation had experienced domestic violence before.

The second strand of enquiry estimates **the effect of the military operation in the summer of 2014** by exploiting information on the levels of self-reported domestic violence before, during, and after the operation. We also generated information on the respondents' exposure to the effects of the military operation by documenting whether they were displaced by the conflict and the level of destruction in their neighbourhoods. The former information was gathered from the survey, and for the latter, we matched the respondents' place of residence before the military operation with information on destructions from the 'Gaza Strip Atlas' (UNOCHA, 2014). This Atlas provides detailed information on the number of moderately damaged, severely damaged, and destroyed infrastructure in affected neighbourhoods across Gaza. Figure A1 in Annex 2 gives an overview of the geographical spread and severity of the damage to and destruction of buildings in 2014.

However, finding a relationship between the extent of exposure to military violence and domestic violence would not necessarily imply that there is a causal link between the two. It is possible that displacement is not only dependent on the scale of damage to one's own

house or that of other people in the neighbourhood, but also on the ability to cope with the damage. But this in itself could be related to socioeconomic characteristics of the household or household members, which are also related to the likelihood of women experiencing domestic violence.

To estimate the **causal impact** of the war on domestic violence, we use an instrumental variable approach. An instrument is a variable that is strongly correlated with the explanatory variable of interest (displacement due to the war), but that is not systematically related to any other potential factors that drive domestic violence. We use the extent of infrastructure destruction in the respondents' neighbourhoods as an instrument. Specifically, we would expect that the higher the density of settlements, the higher the number of people who will be affected by bombing and other destructive violence. On the one hand, the scale of destruction in the neighbourhood is likely to be strongly correlated with fact that households have to leave their house. On the other hand, the scale of destruction in itself is not likely to be related to the experience of domestic violence against women (apart from its effect through induced displacement). The first stage of this instrumental variable estimation confirmed that neighbourhood destruction of infrastructure is strongly correlated with displacement.[13]

Estimation results

We found that experiences of domestic violence before 2014 – both in terms of whether or not a woman had experienced domestic violence, or the number of types of violence encountered – are highly correlated with the experiences of domestic violence during and after the military operation (see Table A1 in Annex 3). Women who report having been exposed to DV before the Israeli operation were around 150 per cent more likely to experience violence between the end of the war in August 2014 and July 2015 than women who were not previously exposed to domestic violence. The same is true when we look at the number of types of violence experienced by women: a one unit increase in the number of types of domestic violence experienced by women before the war is associated with a 140 per cent higher chance of reporting higher numbers of types of domestic violence afterwards.

The estimations also establish that displaced women have an increased likelihood of experiencing multiple types of domestic violence than non-displaced women. Displacement affects the overall likelihood of experiencing any one type of domestic violence during, but not after, the military operation. However, the observed increase in the risk of experiencing multiple forms of domestic violence during the conflict escalation also continues (and is even more statistically significant) after the military operation.

Comparing married and non-married women (see Tables A2 and A3), we find that the impact of the 2014 war in Gaza on domestic violence incidences is higher among non-married women. The war is found to increase the number of types of domestic violence experienced by married women by 22 per cent during the war, and increases the risk of multiple types of violence after the war by 30 per cent for non-married women. These results show that differences exist relating to changing risks of violence for women across various stages of their life cycle, and relating to the stage of conflict.

4.4 Political violence and domestic violence against women in the West Bank

The goals of this investigation have been to add to the studies by Clark *et al.* (2010) and Haj-Yahia and Clark (2013) by using the 2011 PCBS survey and to complement Müller and Barhoum (2015) and Chapter 4.3 above by looking explicitly at the **mechanisms** linking political violence and IPV.[14] By better understanding the pathway leading from the former to the latter, practitioners will be better placed to design and implement the most effective policies.

Broadly speaking, and following the discussion in Clark *et al.* (2010), two main classes of explanations have been advanced for the existence of a link between political violence and IPV. First, violence may reinforce a feeling of humiliation among men who find themselves unable to protect and provide for their families. In a context of strong gender role differentiation, continuous failure for men to conform to their ascribed role due to political violence may thus lead to humiliation and frustration. In turn, this frustration has been hypothesised to directly increase risks of violent behaviour (eg Dobash and Dobash, 1979; Haj-Yahia, 2000), or has led men to reassert power within their household (Goode, 1971).

[13] See Wooldridge (2010) for a general discussion on instrumental variable.
[14] Due to the data in PCBS (2011), this part of the study only focuses on married women and intimate partner violence. Section 4.3 also included domestic violence by non-intimate partners, such as siblings, parents and other household members.

Second, political violence may impose a strong and continuous strain on families. Inability to go to work and to secure a livelihood due to movement restrictions pushes households into poverty. The exposure to daily humiliations and hurdles linked to the occupation are also likely to make basic tasks very frustrating and hard to complete; increasing stress and inter-personal conflict (including IPV).

In this analysis, we will attempt to measure the role of various sources of political violence-related stress – economic, family- and health-related – on marital IPV. To disentangle the effect of political violence, we first estimate whether risks of IPV are indeed higher among women exposed to political violence. We do that through multivariate logistic regressions that control for the most known risk factors of IPV in addition to political violence. In a second stage, we introduce variables describing each source of stress in the regressions. If the effect of political violence happens to unfold through one of these mediators, the coefficient associated with political violence will reduce in magnitude and the coefficient associated with the relevant mediator will be statistically different from zero. If the mediator accounts for all of the effects of political violence, the coefficient of political violence should become indistinguishable from zero.

4.4.1 Data and methods

The variable of interest the analysis tries to explain is IPV. In PCBS (2011), IPV is captured by three sub-scales of the revised conflict tactics scale.[15] This allows us to create variables of IPV –psychological, physical and sexual – as in Haj-Yahia and Clark (2013). Each of these variables indicates whether or not the respondent reported at least one act for each of the relevant sub-scales. In addition to that, we also created an index of marital control based on the answers to nine questions aimed at capturing the extent of the husband's control over their wives. We aggregated the responses to these questions and standardised the index for ease of interpretation.

Our main variable of interest as an explanatory variable is exposure to political violence. It is calculated as in Haj-Yahia and Clark (2013) and is simply a count of the number of acts of political violence listed in the exposure to political violence inventory (EPVI) that was experienced by the household over the last 12 months. The mean exposure to political violence was lower in 2011 (0.4) than it was in 2006 (1). The difference is largely explained by the withdrawal of the Israeli forces from the Gaza Strip in 2005. The acts of violence listed in the EPVI may occur if there is a continuous interaction between the Israel Defence Forces (IDF) and settlers on the one hand, and the Palestinians on the other hand, and/or in the case of a military intervention. As both conditions were not met in Gaza in the year leading up to the 2011 survey, political violence through direct contact with army forces or settlers is almost entirely absent from the Gaza strata of the sample. This is why we focused on the West Bank for the analysis. The mean value of political violence in the West Bank is 0.55 (which is still lower than the figure for the West Bank and Gaza in 2006). For ease of interpretation, we discretise the variable of political violence so that it takes the value 1 if at least one act of violence is reported, and 0 otherwise.

Mediating variables. To measure economic stress, we use expenditures per capita and a measure of subjective material well-being (which takes the value 1 if the respondent reports that income is enough to cover household needs). To measure family-related stress, we use a variable describing whether the woman feels that she has not had enough time to interact with her husband and children over the last 12 months (which could lead to reproaches from husbands), whether taking care of the family required an increase amount of time over the last 12 months, whether one of her children was involved in illegal activities over the last 12 months, and whether troubles with her husband increased over the last 12 months. Finally, health-related stress is measured through a binary variable that takes the value 1 if the woman was sick and had to be hospitalised in the last 12 months.

Control variables. We controlled for a range of variables, which have been considered as risk factors in the literature. Consistent with the ecological framework mentioned in Chapter 4.3, the variables describe the characteristics of the individual (ie the women), the households, and the wider context.[16] Included women's characteristics are: age, the number of years of education, education status (currently enrolled; was enrolled and did not graduate; was enrolled and graduated; never enrolled), and employment status (working or non-working). We also created an index of decision-making power within the household. This was based on the responses by the wives on 'who has the final say' in making decisions on 15 domains. The index is the number of domains for which the wife has at least equal power as the husband. Household characteristics that are included relate to: refugee status (registered refugee; unregistered refugee; non-refugee), locality type (urban; rural; camp), whether the household lives in a house, and an assets index (number of assets owned by the household).

[15] The revised conflict tactics scale is a widely used measure of domestic violence developed by Straus *et al.* (1996).
[16] Adding relational variables pertaining to the husband causes the sample size to drop and adds very little explanatory power. We omit these from the regressions, but the results are available upon request.

4.4.2 Descriptive statistics

Table 3 shows the value of all key variables described above. Eleven per cent of women were exposed to political violence in the West Bank in 2011. Almost half of women were exposed to psychological IPV (49 per cent), 18 per cent were affected by physical IPV, and 12 per cent by sexual IPV. In terms of stressors in the last 12 months, more than half of the women (52 per cent) reported facing increased demands from family members, 27 per cent had been sick and hospitalised, with 24 per cent reporting lacking time to interact with their husband and children, 19 per cent reporting heightened troubles with their husbands, and less than 3 per cent reporting that one of their children were involved in illegal activities.

Correlation between stress and political violence

Before estimating the mediating role of stressors, we first looked at the correlation between these and political violence. Table 4 shows that exposure to political violence is associated with a notably higher prevalence of stressors. Women exposed to political violence reported facing increased demands from family members compared to non-exposed women (the proportion was 61 per cent versus 50 per cent for non-exposed women, an increase of 22 per cent). They were also more likely to report lacking time to interact with husband and children (26 per cent versus 18 per cent, an increase of 39 per cent) and more frequent troubles with their husbands over the last 12 months (by 44 per cent). Additionally, exposed women were 33 per cent more likely to have been sick and hospitalised than non-exposed women; and their children were more than three times more likely to have got involved in illegal activities. There is no association between monthly expenditure and political violence, but women from exposed households are less likely to report that the income is enough to cover household needs (29 per cent versus 34 per cent, a decrease of 17 per cent). Overall, then, there is a strong association between political violence and stressors. The following analysis assesses whether political violence is associated with IPV, and how much of this association stems from these stressors.

Table 3: Correlates of IPV among married women of the West Bank: political violence and stressors (2011)

	MEAN	SD	N
Political violence	0.11	0.31	2936
Psychological IPV	0.49	0.50	2936
Physical IPV	0.18	0.38	2936
Sexual IPV	0.12	0.33	2936
Marital control	0.0	1.0	2936
Increased demands from family members over the last 12 months	0.52	0.5	2907
Lack of time to interact with husband/children over the last 12 months	0.24	0.42	2886
Increased troubles with husband over the last 12 months	0.19	0.39	2914
Children involved in illegal activities over the last 12 months	0.03	0.16	2403
Respondent has been sick and hospitalised in last 12 months	0.27	0.44	2915

Note: Authors' calculations based on PCBS (2011).

Table 4: Association between political violence and stressors

	NOT EXPOSED TO POLITICAL VIOLENCE	EXPOSED TO POLITICAL VIOLENCE	P-VALUE OF DIFFERENCE
Increasing demands from family members	50.1%	60.8%	0.001***
Not enough time to interact with husband and children	22.5%	32%	0.000***
Troubles with husband increased in last 12 months	18.4%	26%	0.001***
Children involved in illegal activities	2%	7.2%	0.000***
Sick and hospitalised in last 12 months	25.9%	35%	0.001***
Monthly expenditures per capita (shekel)	527.4	535.5	0.78
Income is enough to cover household needs	34.1%	28.5%	0.05**

Note: Authors' calculations based on PCBS (2011). * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

4.4.3 Estimation results

Table A4 in Annex 4 presents the multivariate regressions of marital IPV. We see that political violence is consistently associated with higher occurrences of IPV. Exposed women are 70 per cent more likely to report psychological IPV than non-exposed women, and the difference is highly significant statistically (at 1 per cent). Corresponding figures are 56 per cent and 84 per cent for physical and sexual IPV, respectively.

Looking at the controls, we can see patterns emerging. Younger women are much more vulnerable to IPV than older women. Each additional year of age reduces the occurrence of IPV by 2 to 4 per cent, depending on the type of violence. Unregistered refugees are more likely to report sexual IPV (by 74 per cent, but in only one specification), but otherwise the status of the household is not related to IPV. Education is not associated with psychological IPV, and while every year of completed education reduces the occurrence of physical and sexual IPV by 4 per cent, these effects are no longer statistically significant once we introduce the potential stressors in the regressions. Women with higher decision-making power are considerably less affected by IPV: each additional domain for which the woman has at least the same power of decision making as her husband decreases the incidences of victimisation by 12 per cent to 14 per cent for all types of IPV. On the other hand, working women are about twice as likely to report IPV (all three types) than women working in the household or who are not working, and the effect is highly significant statistically.

The results highlight a complex relationship between population density and IPV. Women in rural areas – where density is lowest – are consistently less exposed to psychological IPV, but not to the other types as are urban women. Women living in camps – where density is highest – are also less likely to be affected by psychological IPV than urban women, but conversely they are much more likely to report physical IPV than urban women (by a factor ranging from 2.2. to 2.9). Finally, women living in houses seem more vulnerable to psychological and physical IPV than women living in flats, but the effect disappears once the stressors are introduced.

Mediating role of stressors

Whereas columns 1, 3 and 5 of Table A4 in Annex 4 estimate the association between IPV, political violence and controls, columns 2, 4 and 6 add the stressors to the regressions. The results confirm the hypothesis that part of the effect of political violence on IPV is channelled through a heightened presence of stressors. This is true for all three types of IPV. However, the magnitude of these mediations is lower than expected. In particular, women exposed to political violence remain 42 per cent more likely to suffer from psychological violence than non-exposed women, even when the effect of all stressors has been accounted for (versus 70 per cent when these are not accounted for). Likewise, women exposed to political violence remain 39 per cent more likely to experience physical IPV and 50 per cent more likely to experience sexual IPV than non-exposed women when the effect of stressors is accounted for, versus 56 per cent and 84 per cent respectively when stressors are not included.

Looking in detail at the role of individual stressors, we see that economic and health-related stressors are not a significant predictor of IPV. Likewise, there is no association between children's involvement in illegal activities and IPV. On the contrary, women who report increased demands from family are 20 per cent more likely to report psychological IPV (an effect significant at 10 per cent) and women who report lacking the time to interact with husband and children are 45 per cent more likely to report suffering from sexual IPV (an effect significant at 1 per cent). Unsurprisingly, the largest role of stressors is that of increased trouble with husbands. Women who report this are 3.8 times more likely to report psychological IPV, 5 times more likely to report physical IPV and 2.4 times more likely to report sexual IPV. Overall, these results confirm that political violence increases IPV through the strain it puts on households (as seen from increased demands from family and lack of time for interaction). Increased trouble with husbands may be a sign of stress as well as a sign that humiliated and frustrated husbands 'take it out' on their wives.

To shed more light as to whether the 'humiliation' or 'stress' explanation is most relevant in the West Bank, we replicate the analysis of Table A4, but we added another channel through which political violence may influence IPV, namely **marital control**. If husbands feel the need to reassert their power within their households due to ongoing frustration/humiliation, this will be captured by our index of marital control. If, in contrast, political violence increases inter-personal conflicts through stress and strain, marital control should not be significantly impacted. The standardised index of marital control in the West Bank is 0.17 standard deviation higher for women exposed to political violence than for non-exposed women (-0.05 versus -0.22).[17] This suggests that political violence may well increase IPV through the channel of humiliation.

Table A5 in Annex 4 shows the results of multivariate regressions of IPV when political violence, martial control and stressors are simultaneously introduced in the regression (as well as controls, which are not reported in the table). The table shows that marital control is strongly associated with IPV: a one standard deviation of the index increases the odds of psychological IPV by 70 per cent, doubles the odds of physical IPV, and increases the odds of sexual IPV by 2.3 times. Furthermore, once marital control is introduced in the regressions, the effect of political violence becomes smaller and is less precisely estimated. In detail, the effect of political violence on psychological IPV is slightly reduced (to 1.36 versus 1.42 in Table A5) but the effect is now only significant at 10 per cent. The effect of political violence on physical violence goes from 1.39 to 1.28 and is no longer statistically significant. The effect of political violence on sexual violence goes from 1.5 to 1.36 and is also no longer statistically significant. At the same time, the effect of all stressors becomes indistinguishable from 0, except for that of increased troubles with husbands, which remains strongly significant (albeit slightly lower in magnitude).

4.4.4 Summary

Our results for the West Bank in 2011 confirm those from Clarke *et al.* (2010) and Haj-Yahia (2013) on all of the oPt for 2006. There exists a strong and statistically significant association between exposure to political violence and risks of male-to-female IPV. This is true even when one controls for a wide array of potential risk factors.

Looking at the mechanisms behind this relationship, we have shown that the effect of political violence mostly unfolds through increased marital control and increased trouble between wives and husbands. These are consistent with two views of the effects of political violence: one that emphasises its role through the humiliation and frustration of men (and which generates heightened marital control in return), and one that emphasises its impacts through the daily strain and stresses it inflicts on households (and which manifests itself by increased inter-personal conflicts). However, we do not find support for an effect of political violence going through heightened economic stress, family problems (beyond those with the husband), or health-related channels. At this point, it is worth stressing that the Israeli-Palestinian conflict is not the sole cause of domestic or intimate-partner violence in Gaza or the West Bank. Traditional patriarchal family structures and social norms are deep-rooted factors of violence against women and girls. Thus, even putting an end to the political violence would not eradicate this type of gender-based violence. However, stronger protection systems would contribute to reducing the prevalence of violence against women by better managing the effects of stressors associated with conflict.

Although we believe this analysis is useful in charting out the pathways connecting political violence and IPV, we must remain aware of its limitations. First, we do not know if increased troubles between wives and husbands are the result of heightened stress (which is the interpretation we prefer so far), or the result of increased marital control (in that case, all of the effects of political violence we found would stem from men's humiliation). Second, the regressions only show statistical associations and do not lend themselves to causal interpretation (unlike the analysis on Gaza for which we use an instrumental variable approach). Third, there exist other stressors and channels in the literature that could not be measured through the PCBS dataset.

[17] The higher the figure, the more marital control.

5

Service provision for women and girls in Gaza

5.1 Existing services

As mentioned in Chapter 1, preventing VAW in the oPts is made more difficult by a variety of factors, such as: the political violence exercised by Israel which continuously exerts stress on the Palestinian people and contributes to normalising violence; the intra-Palestinian political divide which continues to hamper the establishment of institutional response mechanisms across the oPts; and patriarchal gender norms and traditions that limit women's rights and contribute to the proliferation and acceptance of violence against women and girls. As Kuttab *et al.* (2011: 61) note, "traditional social networks, like the extended family (*hamula*) or the clan, as well as government ministries, like the Ministry of Social Affairs, and the police, are all uncomfortable dealing with abused women".

In the context of state-building in the oPts since the Oslo Accords, donors, civil society organisations, women's movements and research centres have been central to bringing the issue of VAW to the fore, resulting in more awareness of the issue within and outside the oPts, an increase in academic attention, and the establishment of services aiming to support survivors and prevent violence against women and girls (Kuttab *et al.*, 2011). The Palestinian Authority (PA) has developed a 'National Strategy for Combating Violence against Women' (2011–2019), which has started the process of promoting expertise within different ministries and police departments; and shelters have been introduced in order to protect women in the West Bank. However, due to the internal political divide in Palestine, institutionalised response mechanisms that have been put in place by relevant PA ministries in the West Bank[18] have unfortunately not yet been replicated in Gaza. However, the PA endorsed the national referral system in 2013, and during the time period of this project, draft Standard Operating Procedures (SOP) were under review.

As UNFPA (2013: 5) noted, "in Gaza due to the [sensitivity] of the GBV issue with the de facto authority and the no contact policy[19] for many international organizations few actors aim at work with the ministries and programs look more at the civil society", ie the available response in Gaza is mainly provided through humanitarian and development interventions that support local organisations. For example, the United Nations Relief and Works Agency for Palestine

[18] For an overview on the nature of women's exposure to violence and access to security and justice in the West Bank see Roseveare *et al.* (2015).
[19] Term used to describe the isolation policy of Hamas, whereby many governments do not work with the local authorities in Gaza due to its status as a registered terrorist organisation in those countries. This in turn makes it difficult for some INGOs to engage.

Refugees in the Near East (UNRWA) has been operating a referral and case management system through its community centres and clinics. Since 2011, 21 one-stop centres offering psychosocial services and legal counselling besides primary healthcare have been established in Gaza in UNRWA health centres. However, critical gaps remain despite forensic facilities and adequate temporary protective shelters being provided in coordination with other organisations. Community mental health programmes (CMHP) in Gaza[20] have played a particularly central role functioning as primary identifiers and responders to GBV (see UNWRA, 2015).

A GBV-WG was established in 2012 under the umbrella of the UN Gender Task Force. It is chaired by UNFPA and works to "boost co-ordination between UN agencies, with governmental and non-governmental organisations and to strengthen and support multi-sectorial approaches for prevention of and response to GBV" (UNFPA, 2013). Since its inception, the GBV-WG has initiated three rounds of service mapping: the first in 2013; the second in 2014/2015; and the third in 2016.

In both 2013 and 2015, service delivery was found to focus mainly on the prevention of violence. The main areas of interventions were training, capacity building, and awareness raising. The most frequently provided service in both the West Bank and Gaza was psychosocial support; with healthcare being the least provided (UNFPA, 2013; 2015a).

These findings are reflected in a study on the availability and relevance of services related to GBV before and immediately after the Israeli military operation in the summer of 2014 by UNFPA (2014). Key informant interviews, with representatives working in social and health service provision for women, and a service survey with 22 organisations across the governorates, 49 per cent of which provided services through paid employees, 27 per cent through volunteers, and 24 per cent through national partners of international and UN organisations, were carried out for the purpose of the study. The survey showed that only five of the 22 organisations had medical staff to provide services for GBV survivors, and only three of those had teams with specialised training in clinical care for GBV survivors (UNFPA, 2014). This ratio of trained (and untrained) personnel vis-a-vis the number of girls and women who experience violence is highly inadequate. Given that healthcare is an excellent entry point to improve the effectiveness of GBV detection, prevention and response (GBV-WG, 2015), much progress could be made if this was addressed.

5.2 Main challenges for service provision

Several studies have identified a range of challenges for local and international organisations responding to violence against women in particular. These challenges relate to the recognition of the issue by society; the legal situation, with discriminatory laws that perpetuate violence against women; the political situation within Gaza and in relation to Israel; and the capacities of non-governmental organisations which try to step in where the government fails to provide.

Challenges related to the lack of social awareness toward issues of violence against girls and women are increased by the widespread belief that women should accept the status quo in order to preserve family peace, and therefore not speak up outside their home if faced with violence. This leads to a stigmatisation of female survivors of violence, and a situation where outside help is only sought in the severest cases; women often do not even ask their families or friends for help (Müller and Barhoum, 2015; PCBS, 2011).

Societal recognition of the seriousness of VAW prevails in many parts of the population, but it is not considered a "priority issue or a real risk to Palestinian social cohesion" (Kuttab *et al.*, 2011: 9). Also, the inter-political fights between Fatah and Hamas make the implementation of the national strategy on VAW very difficult. This, as well as the inherent patriarchal culture of society, results in a lack of political push for policy reforms that would punish perpetrators of VAW instead of accepting arrangements made through customary laws. This lack of recognition also leads to a shortage of funding and provision of the necessary infrastructure for tackling VAW from the government. This happens in a context where all institutions already struggle with lack of finances and infrastructure due to the ongoing blockade. This is a particularly strong challenge in more marginalised areas.

Furthermore, the change of daily realities, priorities and resources when moving from ongoing to acute emergencies, such as in the summer of 2014, adds to postponements and the halting of efforts towards developing strategies and implementing services for survivors of gender-based violence. For example, as Kuttab *et al.* recount from an interview with former Ministry of Women's Affairs (MoWA) staff, "due to the political conditions in Gaza, including the devastation caused by the December 2008/ January 2009 aggression on the Gaza Strip, work by the ministries previously related to the PA has either

[20] Also in the West Bank.

been stopped or slowed down. For example, MoWA in Gaza had established a complaints mechanism in the police station to document and follow up on VAW cases, but this has now stopped functioning" (2011: 53). The political volatility in the Gaza Strip and its impact on sustainability was also mentioned by implementing organisations in the study by Müller and Barhoum (2015).

These emergency situations also disrupt the work of non-governmental organisations. For example, the massive scale of displacement during the last military operation exceeded organisations' capacities in terms of funding, as well as staff capacities. In addition, many reported that movements between the five governorates were difficult as a result of the "continuous and arbitrary shelling" (UNFPA, 2014: 23). A major positive impact to the service provision for GBV survivors could be made if contingency plans were designed and fed into preparedness, and more coordination between organisations took place (UNFPA, 2014; Kuttab *et al.*, 2011; Müller and Barhoum, 2015).

5.3 Participatory workshop

In light of the situation and challenges described above, this project organised a participatory workshop, which brought members of the GBV-WG together (which included local organisations, international donors and agencies) and which aimed to:

(1) Identify which relevant services and activities were available, and who was responsible for them

(2) Explore agencies' and organisations' knowledge and views of the different services and activities

(3) Discuss who accesses services and activities and who does not;

(4) Identify gaps in services and activities

(5) Explore priorities for new services or activities, particularly in light of the risk of changing states from acute to ongoing emergency, and

(6) Identify organisations (and people) to involve in project planning and co-ordination.

The workshop took place on 11 October 2016, and was structured in a way that allowed maximum time for discussion and exchange of ideas. Recent developments and concurrent activities in Gaza were taken into account in the planning of the workshop, such as the third service mapping initiated by the GBV Working Group which was carried out from August 2016 onwards (see Chapter 5.1). The project members had given feedback on the 2016 UNFPA service mapping questionnaire in order to get more detailed information on where services were available.

An important development was that the first international seminar on 'Gender-based violence (GBV) in the humanitarian context of the Gaza Strip' took place in Gaza City on 21-22 September 2016. It was attended by more than 200 representatives of local organisations, policy makers, agencies, donors, NGOs and researchers. Organised by UN Women, the seminar aimed to discuss violence against women and girls in Gaza and the way forward for service delivery and prevention in the Gaza Strip. The main discussion points coming out of the seminar were:

- Many different types of violence affect women and girls in the Gaza Strip. These include types that are prevalent everywhere, eg physical, sexual, economic, psychological and social abuse, as well as some that are specific or 'new' to the local context, such as the violation or lack of property and inheritance rights, addiction to tramadol[21] specifically as a result of the wars (this has also been documented in UNICEF, 2011), and sexual exploitation at border crossings.
- In the context of service provision, much emphasis was put on the need to create quality services that are sustainable, and the need to target specific groups such as women with disabilities, female-headed households, women with older children, and women in conflict with the law.
- A unified data collection template, which has been implemented in the West Bank, should also be implemented in the Gaza Strip in order to better plan, coordinate and monitor progress.
- Although much is being done with respect to mental health and psychological support (also as shown by the mapping), most of this work is targeted at children, and GBV survivors are not yet included enough in these services.

One of the main learning points was the urgent need to intensify communication and collaboration between organisations. Efforts to strengthen inter-organisational ties and cooperation have been ongoing for a while, exemplified by the creation of the GBV sub-working group in 2013. Most recently, these efforts resulted in a final draft of the 'Interagency Standard Operating Procedures for Prevention of and Response to Gender-Based Violence and Child Protection in Gaza – Palestine'. These were developed by a SOPs

[21] UNICEF (2011) noted that 98 per cent of interviewed youth reported to have problems with aggression and difficulties sleeping, resulting in 40 per cent of them using tramadol in the hope of improving their sleeping and reducing anxieties.

Technical Working Group (SOPs TWG) under the umbrella of the child protection and GBV sub-working groups. The SOPs TWG was led by the Norwegian Refugee Council (NRC) and was composed of the Ministry of Social Affairs, UNICEF, UNFPA, the Tamer Institute, Ma'an, SoS, and Alianza por la Solidaridad. The final draft is the result of extensive consultations with national and international stakeholders involving over 49 ministries, institutions and organisations. Part of these SOPs are the 'Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies' (UNFPA, 2015), laying out how to respond to GBV in emergencies in Gaza.

Following on the learning from the international seminar and in close discussions with UNFPA, we decided to use the participatory workshop to discuss how the UNFPA Minimum Standards in Emergencies could be taken forward for service provision in Gaza, and what practical implications this would have for local partners as well as agencies and international organisations. Given that the global launch of the Minimum Standards (MS) is, at the time of publishing, still very recent (March 2016), this discussion with implementing partners was the first of its kind. It also provided learning for UNFPA on how to conduct similar workshops in other countries and contexts.

The participants received a short introduction to the project and an overview on where this workshop fits in relation to the project and the situation in Gaza. UNFPA then gave a short recapitulation of the Minimum Standards that had been introduced to the organisations earlier in the year, with an emphasis on the main objectives and a short re-introduction of each standard. The participants were then divided into five groups of three people each. Each group discussed three of the Minimum Standards,[22] taking into account predefined questions on: 1) applicability of the standard in general and to date; 2) key actions that need to be taken to achieve the standard; 3) the main actors necessary to achieve the standard and how these actors could be engaged; and 4) how to measure progress. The participants were asked to first discuss their thoughts and ideas in the groups, make notes reflecting their discussions and then present and discuss their ideas with all participants. The discussions were facilitated by Amira Mohana, from UNFPA Palestine (UNFPA-PS).[23]

5.3.1 Minimum Standards for prevention and response to gender-based violence in emergencies

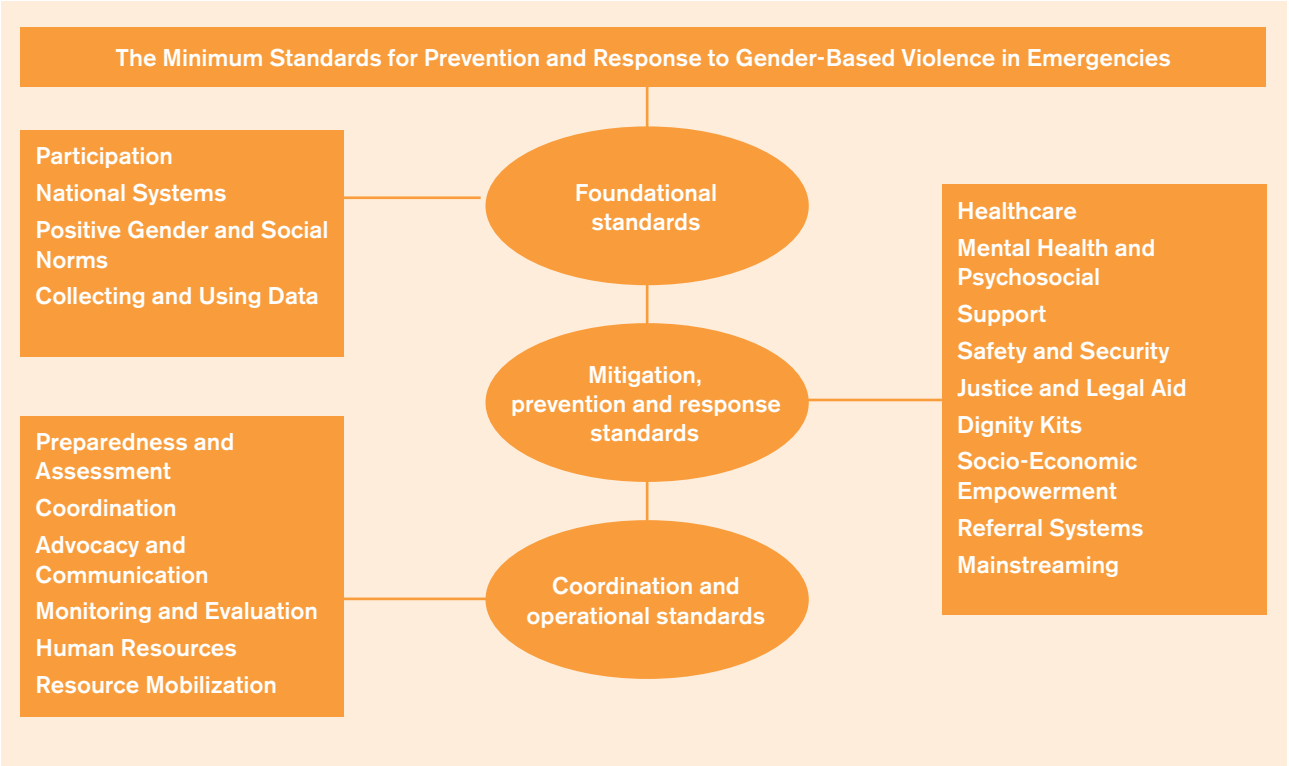
Before setting out the main action points to be taken forward from the workshop, we provide a short overview of the minimum standards. They are a set of 18 interconnected standards based on international best practices; and integrate existing standards, such as the Sphere Standards, the Minimum Standards for Child Protection in Emergencies, and the Guidelines for Integrating GBV interventions in Humanitarian Action. They were developed by UNFPA as the coordinator of GBV prevention and response in emergencies, to be used as a reference by UNFPA, its partners, national authorities, other UN agencies, international, local and community organisations and implementing partners. The aim of the standards is to provide a clear understanding of effective and appropriate GBV prevention and response mechanisms in emergencies. Offering concrete actions that are applicable in various emergency contexts, the MS entail "tools to address the bottlenecks that prevent the prioritisation of GBV prevention and response in emergencies, and guidance on working in partnership with survivors and members of the crisis-affected population to build individual and community resilience" (UNFPA, 2015: vi).

Figure 3 shows the grouping of the standards into three parts: 1) foundational standards, which speak towards the engagement of communities, the support of national systems, promotion of positive gender and social norms, and the collection and utilisation of data; 2) the standards focused on mitigation, prevention and response, in particular psychosocial support, safety and security, justice and legal aid and socio-economic support for GBV survivors, as well as clinical, reproductive and sexual health; and 3) coordination and operational standards, with a focus on coordination, M&E, preparedness, communication and the securing of human and financial resources in emergencies.

The standards apply equally in urban and rural context. However, where for example in urban areas populations or groups are scattered, the standards recognise that initial contact and mapping of informal places and networks might be facilitated by the use of "multifunctional teams, including local partners" (UNFPA, 2015: 65).

[22] Given the overall number of participants, Standards 15, 17 and 18 were not discussed.
[23] The whole workshop was carried out in Arabic and a translator organised by WAC.

Figure 3: Overview of the Minimum Standards for prevention and response to GBV in emergencies



The following describes the main discussion points for each of the Minimum Standards discussed in this process; and are followed by summary recommendations for agencies, donors and implementing partners in the Gaza Strip. These recommendations therefore represent the local understanding and ideas of how to prevent gender-based violence in emergencies and facilitate access to multi-sector response services for survivors in the Gaza Strip.

5.3.2 Key learning regarding the Minimum Standards

Foundational standards

The foundational standards focus on the engagement of communities, the support of national systems, the promotion of positive gender and social norms, and the collection and utilisation of data (see Figure 4). The participation of crisis-affected populations builds on existing knowledge, capacities and resources, and ensures that assistance is relevant, reaches vulnerable groups, and is delivered in a context-appropriate

Figure 4: Foundational standards

STANDARD 1	Communities, including women and girls, must be engaged as active partners to end GBV and to promote survivors' access to services.
STANDARD 2	Actions to prevent, mitigate and respond to GBV in emergencies strengthen national systems and build local capacities.
STANDARD 3	Preparedness, prevention and response programming promotes positive social and gender norms to address GBV
STANDARD 4	Quality, disaggregated, gender sensitive data on the nature and scope of GBV and on the availability and accessibility of services informs programming decisions, policy dialogue and advocacy.

manner. Furthermore, the participation and capacity building of local communities and local and national systems build and strengthen preparedness and resilience and contribute to the sustainability of services and structures. Particular attention needs to be paid to include the most vulnerable populations in order to better understand their needs and ways of approaching and including them in preparedness, prevention and response programmes. From the workshop discussions, it seemed that the foundational standards were in particular need of attention in the current situation in the Gaza Strip.

For instance, the need for a common database that would help identify individuals in need of support or at risk and show how women and girls make their way through the system of support was discussed at length (Standard 4). This would help traceability, follow-up and ensure that individuals are helped to the best extent possible. Under the current system, some organisations treat each woman as one single case no matter how many types of support she receives. Other organisations however, treat each type of support as one entry in their database, no matter whether it is for the same woman or not. This also means that a woman is registered three times if she receives support from three different organisations. A common definition and database would help organisations to systematically and comparably identify to what capacity they are working, carry out needs assessments, identify duplication of work, and gaps in service provision, etc. These data could also be cross-referenced with other databases, eg on IDPs, which would in turn enable 'holistic packages of support' to be offered where needed, as well as lay the foundation for a better understanding of the connection between different types of risk and vulnerability. Communication and information exchange amongst organisations through this common database would also allow cases to be identified where individuals or families receive erroneous support, something some of the organisations were worried about.

The discussions at the workshop revealed that everyone understood the advantages of a shared database and a common understanding of standards, indicators, and information collected. It was agreed that the introduction of such a database would yield an excellent opportunity to achieve this common understanding, and ensure that all services working in any capacity with GBV survivors would be staffed by a GBV expert or staff sensitised to GBV. Together with UNOCHA, UNFPA has developed a gender-based violence information management system (GBV IMS) for the GBV-WG partners to report on the types and prevalence rates of GBV on a quarterly basis. Furthermore, UNFPA is supporting Al Muntada (an NGO coalition to combat VAW) in the West Bank to develop a comprehensive IMS system following international standards for five service providers to report and use for planning, advocacy and programming.

There were also very interesting discussions about how to better engage women and girls, men and boys, and communities as a whole in prevention and support activities (Standard 1). The workshop participants recognised that there was room for improving the engagement of women in the planning of programmes and implementation of services, and for engaging men and boys. One concrete idea was to hold workshops where women survivors would learn about the concepts of GBV, and the causes, consequences and ways to address it, which in turn would put them in a position to participate in the planning of programmes, proposal writing, and project implementation. It was also discussed how women survivors could be more actively consulted and could participate when planning services and when service staff are trained. In order to better engage men and boys, participants suggested working not just with individuals, but also with whole families, including husbands and children. However, it was also clear that in order to achieve this aim, more staff and better logistical infrastructure was necessary.

With respect to strengthening national systems and building local capacity (Standard 2), some clear limitations and challenging factors were identified. Although some rules exist on how to handle cases of GBV, non-government institutions provide most of the programmes and services; and the political situation – the blockade and military operations as well as the political divide – are risk factors that challenge the strengthening of national systems. For example, Jordanian rule is dominant in the West Bank, and Egyptian rule dominates in Gaza. Workshop participants suggested the continuation of advocacy campaigns for new rules to protect GBV survivors and for the unification of laws across the occupied Palestinian territories. Key government actors with respect to GBV are the Ministry of Women's Affairs (MoWa), the Ministry of Social Development (MoSD), the Ministry of the Interior (MoI) and the Ministry of Health (MoH), all of which are members of the sub-working group. One outcome of ongoing efforts is the referral system. The need for the capacity building of staff in order for the system to be effectively implemented is a challenge, but was also identified as a great opportunity for change and subsequently agreed upon during a conference organised by the MoWA with the key ministries, held on 4 December 2016 in Gaza, which aimed to make progress towards the activation of the national referral system.

Finally, looking at the promotion of positive social and gender norms to address GBV (Standard 3), revealed quite some outstanding challenges but also success stories that showed that change is possible. Traditional leaders such as the *mukhtars* have not worked on

GBV in the past; however since the last war in 2014, the attention to GBV has increased and thus opened a window of opportunity to take this work forward. Service providers at the workshop recounted how ten years ago no woman would ever go to court or seek legal advice, but nowadays, they come to share their stories and accept support. In order to ensure that preparedness, prevention, and response programming promote positive gender and social norms even better, participants suggested engaging people with decision-making power, such as businessmen and *mukhtars*.

Mitigation, prevention and response standards

The mitigation, prevention and response standards focus on the specific strands of services provided to women, girls, men and boys in the areas of healthcare, including sexual and reproductive health and the distribution of dignity kits, mental and psychosocial support, safety and security, justice, and legal aid. They also focus on the way affected and vulnerable populations are referred within a multi-sector GBV response and prevention system, on support to mitigate risks through the socioeconomic empowerment of women and girls, and the general inclusion of thinking and acting on the reality and risk of GBV throughout all humanitarian sectors at all stages of their programme cycles. Workshop discussions around these issues were very lively and the participants had many insights to offer from their work and experiences.

During the last emergency in July/August 2014, the capacities of the healthcare services (Standard 5) were seriously challenged in general and in relation to GBV in particular. Several factors played into this: the scale of the devastation and needs of the population were much larger than anyone had prepared for. Hospital and health centre facilities were used by IDPs while some were used by fighting factions. Facilities that were not damaged or destroyed focused on emergency treatments to save lives and delayed all other cases, including GBV cases. However, it was also acknowledged that GBV is generally not a priority issue for all members at the MoH, and that there is a lack of strategy and focal points. Furthermore, some representatives oppose putting GBV – and some acts of GBV in particular – higher up on the agenda because it is not supposed to be something that exists

Figure 5: Mitigation, prevention and response standards

STANDARD 5	GBV survivors, including women, men, girls and boys, access quality, life-saving healthcare services, specifically clinical management of rape (CMR).
STANDARD 6	GBV survivors have safe access to quality mental health and psychosocial support focused on healing, empowerment and recovery.
STANDARD 7	Safety and security measures are in place to prevent and mitigate gender based violence and protect survivors.
STANDARD 8	The legal and justice sectors protect survivors' rights and support their access to justice consistent with international standards.
STANDARD 9	Culturally relevant dignity kits distributed to affected populations to reduce vulnerability and connect women and girls to information and support services.
STANDARD 10	Women and adolescent girls access livelihood support to mitigate the risk of GBV, and survivors access socio-economic support as part of a multi-sector response.
STANDARD 11	Referral systems are established to connect women, girls and other at-risk groups to appropriate multi-sector GBV prevention and response services in a timely and safe manner.
STANDARD 12	GBV risk mitigation and survivor support are integrated across humanitarian sectors at every stage of the programme cycle and throughout the emergency response.

in the society. More engagement with potential agents of change[24] will be needed to substantially alter these attitudes across the ministries. One specific strategy suggested in the discussions was to acquire project or programme funding directly and then take it to the ministry for cooperation and support, as some of the funds held by the ministry and earmarked for GBV projects are restricted or spent on other priority issues. Further suggestions were to run GBV centres in each hospital or clinic in order to slowly embed GBV into the general strategy of the MoH, and to engage with GBV in reproductive health.

Other areas for improvement which would have a big positive impact are in increasing the capacity of health service providers in relation to dealing with GBV survivors and referrals, and enabling all doctors to log cases of rape centrally.[25] Furthermore, a culture of privacy and confidentiality has to be built and fostered that extends to women and girls. Traditionally, women in the Gaza Strip, especially in the marginalised areas, prefer to be accompanied by their mother, another family member, or their husband when they seek health services, particularly when these are provided by male health providers. Another point to consider is the fact that health insurance does not cover fees for GBV cases. All residents within Gaza can access services in government hospitals; however, all GBV cases coming through emergency or health services that request a medical certificate from the hospital have to pay 180 New Israeli Shekels (NIS).[26]

With respect to mental health and psychosocial support to GBV survivors (Standard 6), many organisations worked with women and children before the war in 2014 and many such programmes have been offered since. This reflects the findings of UNFPA (2013; 2015a) that the service most provided in the Gaza Strip is psychosocial support. However, workshop participants discussed the challenges posed by the extent of mental health disorders after the last war, which would require psychiatric help that is not widely available. After the summer of 2014, organisations carried out field visits in order to get an estimate of the extent of help needed. One of the main opportunities currently is to build emergency teams of medical and counselling experts, which were lacking in 2014. Early training of emergency teams in all geographical areas and potential places of service provision and the gathering of statistical data on population needs would increase the potential for safe access to good quality services for GBV survivors in emergencies and in general. One challenging factor is the lack of experts, which also relates to the fact that organisations can only offer group, but not individual support, which would be particularly crucial for severe and sensitive cases, such as rape and other forms of GBV.

Workshop participants were very critical of the provision of safety and security in order to prevent and mitigate GBV (Standard 7), and acknowledged it as a real challenge so far. During the state of emergency, public security services were not operational, and organisations were completely dependent on local community members, who are mostly non-trained experts, and on *mukhtars* who not always share their point of view. Participants acknowledged the need for substantive policies to protect women, staff with a good understanding of GBV to provide professional services, well-prepared and resourced shelters to meet all gendered needs and a functioning referral system. The need for better coordination between local and international organisations, a formal organisation to provide security, and improved collaboration between UNWRA and other organisations to provide safety and security was also expressed.

The main providers of support for women accessing the legal and justice system (Standard 8) are human rights organisations, *mukhtars*, national and international organisations, research organisations and universities, and the legislative authority. However, during emergencies, all courts shut down and are not able to support women asking for help from this sector. It is then up to the non-governmental organisations to provide consultations, awareness training, documentation and referral services to women and girls that have been subject to GBV. In order to better prepare for emergencies, but also for their work in general, participants felt that better documentation was needed, as well as better communication and coordination amongst organisations. Lack of funding, the political situation and duplication of services, such as counselling in the legal sector, were perceived as the main challenges. Participants discussed the role of social media to create awareness and spread knowledge, and mobile legal clinics to better reach women and girls across the Gaza Strip by making services more easily accessible.

[24] Participants observed that it is often personal contacts and individuals that carry change forward.
[25] At the moment, only three doctors in Gaza are certified to provide medical forensic reports, all male. Even though three female doctors have also been trained to carry out forensic checks, these female doctors still need to refer their results to the authorised male doctors in order to issue reports.
[26] This is also the case in the West Bank.

Participating organisations had many ideas on how to improve the distribution of dignity kits across women and girls and the connection to relevant information and services (Standard 9). These suggestions included joint needs assessments with women and girls to better understand their needs, and the distribution of vouchers or coupons for women to get items they needed from shops. The latter would avoid distributing nappies to women without babies, young infants or dependent adults, and thus help save resources. Four key actions necessary to meet this standard were identified: (i) to ensure fairness of distribution; (ii) to ensure that the most marginalised and vulnerable groups were covered; (iii) to prepare teams of volunteers to work during the emergencies; and (iv) to better coordinate across organisations in order to avoid duplication of distribution in some and lack of support in other shelters and areas. Work on this issue was seen as a good opportunity to work with and foster relationships with local social committees, who could also help with the distribution and ensure that all women and households were included, including those most remote and hard to reach. For example, groups of community volunteers supported MoSA to run and manage the governmental shelter, which hosted IDPs during and after the military operation in 2014, and they helped distribute items, organise people, and facilitate activities, etc. The workshop participants saw corruption as the main obstacle to distribution and support to families.

The inclusion of women and girls in livelihood support activities in order to mitigate risk or as part of a multi-sector response (Standard 10) was felt to be quite a challenge within the context of Gaza with its masculine culture and gender norms that impede women from contributing freely in economic activities. The other factor contributing to a lack of opportunities for involvement is the political situation and ongoing blockade of Gaza, resulting in an unemployment rate of around 43 per cent in 2015 (World Bank, 2015). Workshop participants were aware of the fact that there were very few organisations offering livelihood projects and programmes for women – partially because donors are reluctant to support activities in which such small numbers of women participate. Identifying, contacting and working with organisations active in this field were key actions identified to strengthen this component.

The establishment of working referral systems (Standard 11) is one of the major challenges that organisations, agencies and the government have been working on over the last years. It was perceived as a great opportunity for organisations to create strong networks across which women in need will be able to reach timely, relevant, and high quality services. Some partnership agreements for referral are already in place within organisations. Staff members dealing with women and girls assess whether the organisation has the skills to work with women and girls, or whether they would have to refer them to other organisations. However, for the Palestinian Center for Human Rights (PCHR) and other organisations, referrals to other organisations currently depend on personal knowledge and relationships; and a systematic system with cross-organisational agreements and specific procedures is yet to be finalised and implemented. Once these procedures are in place, staff will have to be trained to ensure that everyone within all organisations is aware of who provides which services.

The integration of GBV across humanitarian sectors is crucial at every stage of the programme cycle and throughout the emergency response (Standard 12). Workshop participants noted how survivors are at the forefront of all discussions, and how service providers are sometimes only thought of at a later stage. However, without careful and thorough awareness and understanding of gender issues, service providers will not be able to provide meaningful and adequate services. Serious sensitisation and skills training that increase the quality of services and turn providers into 'agents of change' were some of the needs and action points identified by the participants. Furthermore, the organisations felt that GBV should be included in all organisational mandates, as voluntary GBV work would end after programmes terminate. GBV information should be collected throughout the planning, monitoring and evaluation stages in the health sector, educational organisations and shelters.

Coordination and operational standards

The final six standards focus on assessment, coordination, advocacy and communication around GBV and on the securing of adequate human and financial resources for rapid qualified, competent and skilled service provision. Another aspect of these types of standards is the emphasis on being prepared in terms of knowing who the vulnerable populations are, what their needs could and will be, and having systems in place that will be fit for purpose. Given the time constraints and number of participants at the workshop, we decided to focus on Standards 13, 14 and 16.

Good quality gender assessments and risk management measures (Standard 13) are fundamental for identifying and serving vulnerable groups at risk of GBV. Organisations noted that in light of the political situation, risks were permanent to many parts of the society. Populations who are especially vulnerable during emergencies are women and girls, children in general, women in buffer zones and marginalised areas and women and girls aged 18 and above. Legal and psychological awareness raising and capacity building for women, as well as advocacy against GBV with communities as a whole, were identified as

Figure 6: Coordination and operational standards

STANDARD 13	Potential GBV risks and vulnerable groups are identified through quality gender sensitive assessments and risk mitigation measures are put in place before the onset of an emergency.
STANDARD 14	Coordination results in effective action to protect women and girls, boys and men, mitigate and prevent gender-based violence, and promote survivor's access to multi-sector services.
STANDARD 15	Coordinated advocacy and communication leads to increased funding and changes in policies and practice that mitigate the risk of GBV, promote resilience of women and girls, and encourage a protective environment for all.
STANDARD 16	Objective information collected ethically and safely, is used to improve the quality and accountability of GBV programs.
STANDARD 17	Qualified, competent, skilled staff are rapidly recruited and deployed to design, coordinate and/or implement programmes to prevent and respond to GBV in emergencies.
STANDARD 18	Dedicated financial resources are mobilized in a timely manner to prevent, mitigate and respond to GBV in emergencies.

preventive action to mitigate risks of GBV against these populations before emergencies occurred. In addition, workshop participants suggested already engaging service providers and (potential) beneficiaries of the services before the emergency, in order to create relationships and trust, which would then facilitate cooperation and service provision during emergencies. This would also help to overcome the lack of knowledge about available services and challenges underlying customs and gender norms. During emergencies, responses to interventions with those population groups could be a way to learn what worked and to what extent needs had changed.

Coordination (Standard 14) is seen as key to activate a referral system that allows effective services provision and protection of survivors of GBV and those at risk. In Gaza, the GBV-WG conducts service mappings at regular intervals in order to update existing information and help connect and integrate existing and new services. As mentioned above in reference to the referral system, organisations feel that there is room for improving cooperation and coordination amongst different service providers, in particular for developing a clear system that organisations know about and can work with.

Finally, and in relation to Standard 4 – the collection of good quality, gender-sensitive disaggregated GBV data – participants emphasised that the collection of objective data would be useful in order to increase the availability and accessibility of much-needed services (Standard 16). The service mapping, population surveys and the planned, shared database on GBV survivors were good examples of that. However, here as well as in Standard 4, there was discussion about what information could be shared and what might be too sensitive. While some participants clearly focused on the advantage of sharing data across service providers in order to improve the system, others felt there was a trade-off to be made with confidentiality. The need to achieve both transparency and compliance with privacy issues was emphasised. In order to control and ensure quality, the idea of working with a complaint system was raised.

5.3.3 Key actionable points for GBV services

Figure 7 presents a word cloud created from the notes on actionable points from the workshop discussion. It gives an indication on the themes most prominently shared among participants. The capacity of staff, in terms of numbers but also knowledge, sensitisation and skills; the provision and exchange of information; and better work across organisations in order to ensure and improve services were repeatedly mentioned in discussions on the Minimum Standards. The main actionable points that came out of the discussions at the workshop can be broadly categorised into four areas: 1) actions focusing on GBV survivors, populations at risk, decision makers and communities in general; 2) actions that focus on service providers; 3) actions that work across organisations; and 4) actions related to the collection, provision, and use of data.

Figure 7: Word cloud of top 20 terms when discussing action points

These themes and ideas were presented and discussed with a small group of leading representatives from local organisations in a preliminary results workshop.[27] This took place on 15 December 2016 at UNFPA in Gaza. Due to logistical difficulties – the border crossing was supposed to be closed during the initially planned time of travel – the research team participated via Skype. In coordination with UNFPA, we presented the preliminary findings, and UNFPA then led a group discussion on agreements, additions and suggested changes, which were then fed back to the research team in a bilateral discussion immediately afterwards. The final ideas and suggestions on how to operate the Minimum Standards are presented below.

Working with women and girls:

- Actively consult and seek the participation of survivors of GBV when planning services. Organisations noted that donors rarely fund **planning** activities; thus advocating for this type of funding would be a step to be taken beforehand.
- Actively consult GBV survivors to identify topics and mandates that staff are trained on.
- Enable and actively engage GBV survivors in implementation and impact assessment of service delivery. For example, workshops with GBV survivors could be conducted to gather knowledge on concepts of GBV, GBV prevention and GBV protection. This knowledge would enable them to participate in the planning of programmes and implementation of projects.
- Conduct joint needs assessments with women and girls in relation to the distribution of dignity kits.[28]
- Plan to distribute legal, health, and psychosocial mobile clinics to enable access and quality provision of services for women and girls.

Working with decision makers:

- Foster and expand relationships and engagement with people in decision-making power positions to drive change in relation to gender norms and attitudes, eg businessmen and the informal justice system.
- Engage more with potential agents of change in ministries to push for awareness, attitude change and a subsequent change of priorities and the implementation of GBV-sensitive programmes and policies.
- Advocate for and mainstream a gender and GBV concept and referral system for technical staff inside ministries.
- Reactivate a national strategy plan for VAW 2011–19 through advocacy and lobbying.

[27] See list of participants in Annex 5.
[28] Workshop participants voiced a strong preference for abstaining from documentation in the form of photographs and videos during the distribution of food and dignity kits in order to preserve the dignity of women and girls.

- Create a national coding system for GBV survivors so all organisations can deal with survivors anonymously through a shared database.

Working with the wider community:

- Create and engage social and community committees in setting up intervention plans and providing services.
- Engage with and use social media in awareness-raising activities.
- Unify the referral systems under which organisations and institutions work and advertise in order to make GBV survivors aware of better, cross-sectoral services that could make a real change.
- Engage service providers and at-risk populations before emergencies to create relationship and trust (this could be done at community level).

Actions for service providers and agencies:

- Maintain trained staff working with GBV survivors (after funding runs out).
- Build capacity of staff to provide services to GBV survivors based on Minimum Standards and main principles for dealing with GBV survivors.
- Create, prepare, and train emergency teams to cover all geographical areas and potential places of service provision. In order to cover both physical and mental wellbeing, this team could, for example, include a group of one doctor, a psychologist and a coach.
- Build staff knowledge and understanding of the referral system.
- Build an emergency referral system as part of the general referral framework.[29]
- Increase livelihood and economic empowerment programmes across Gaza Strip for GBV survivors.
- Identify focal points in each centre, health centre and school who specifically deal with GBV survivors. These are then responsible for detection, dealing with, and referring GBV survivors.
- Build capacity for these focal points on GBV concepts, dealing with GBV survivors, and the functioning of the referral system.
- Distribute vouchers and coupons for quicker and more targeted access to much needed items from shops.
- Run mobile legal clinics to make services more accessible across the Gaza Strip, including the more remote areas.

Actions across organisations:

- Ensure better coordination between local and international organisations.
- Engage in building trust and confidence between UN agencies and local organisations that could provide different services, safety and security.
- Agree on common definitions, standards, indicators and information to be collected and shared across implementing, coordinating and supporting organisations and agencies. This includes an agreement on levels of transparency and privacy.
- Establish a common database or the cross-referencing of databases that allows access and gives information to other, non-GBV-related service providers.
- Identify a GBV focal point in each hospital or clinic.
- Mainstream GBV into all services, which will be provided during emergencies.
- Include GBV in all organisational mandates.
- Continue advocating for clear policies for the protection of GBV survivors and the unification of laws across the oPts.

Data:

- Collect data before emergencies, categorised by needs (economic, social, healthcare, etc.)
- Collect GBV-related information at all stages – during planning, monitoring and evaluation across the health sector, educational organisations and shelters.
- Collect and analyse responses to interventions during emergencies by way of monitoring and evaluating, to inform on changes where needed.
- Continue regular service mapping.

[29] Not all organisations provide services during emergencies, which needs to be taken into account when setting up referral systems.

6

Conclusions and recommendations

Many of the research findings, particularly those from the qualitative strand working with local and international organisations in the Gaza Strip, resonated with findings in the literature on other conflict or humanitarian settings. Based on our two research strands and the desk-based research conducted for this project, below are three main recommendations to support protection from violence against women and girls in humanitarian emergencies.

(i) Addressing knowledge gaps

1. VAWG is a problem in humanitarian settings, not only with respect to non-IPV violence. Both the prevalence and severity of IPV increase with exposure to political violence.
2. The experiences of VAWG vary amongst different population groups. Women of different age groups have different protecting and aggravating factors that affect their risk of becoming victims of violence.
3. Likely channels through which political violence relates to heightened risk of intimate partner violence are increased attempts by husbands to reassert marital control and increased trouble between wives and husbands.
4. Little evidence exists on what works for the prevention of VAWG and service provision to VAWG survivors.

Recommendations:

- Data on VAWG should be collected whenever possible before emergencies occur. These data should aim at not only collecting information on prevalence rates across space, but also at gathering information that helps understand underlying causes, consequences and dynamics across different stages of the life cycle. Of particular importance here are also insights into the supply and demand dynamics of services – what protective and supportive services are available; how are they delivered; who accesses them, who does not, and why?
- Using service-based data can be an acceptable alternative if no VAWG data exists (Murphy *et al.*, 2016; Stark and Ager, 2011). However, these data are likely to provide biased insights. Nevertheless, incorporating questions to GBV survivors on their experiences of GBV services could prove useful for M&E purposes.
- More research should be conducted on the effectiveness of interventions against VAWG in conflict and humanitarian settings. Furthermore, more evidence in urban and non-camp based settings is needed, as most of the world's displaced population are now living in these environments.

(ii) Enabling and working with local actors

1. Local actors have intimate knowledge of the dynamics and power relationships between population groups, formal and informal institutions. This knowledge can be particularly important in urban contexts where target groups and populations might be scattered. Furthermore, they have often worked for years trying to overcome and tackle challenges, and have much experience on what works and could work.
2. Local actors sometimes seem unaware of information that exists on topics at the heart of their work. It is not always clear whether that is because some reports are only available in English, or because the information might not be easily accessible or promoted for people to know about them, or because it is not always possible to find the time to read documentation on top of fulfilling the workload. It might well be a combination of all three factors; more interactive modes of communication might be needed to counter this.
3. As important as the work with local organisations is the work with (potential) beneficiaries. Survivors of violence that have/are receiving services are best placed to shed light on questions such as what services should be provided, what barriers exist for accessing these and how these should be overcome.
4. Community members can become agents of change and support efforts aimed at changing community perceptions that influence and shape gender roles and expectations.

Recommendations:

- Local knowledge on circumstance and dynamics should be taken into account when thinking about and designing programmes and interventions. This would help to prevent replicating or installing parallel systems, or diverting scarce resources into building structures that are not used. Furthermore, building systems that get buy-in from local organisations and populations would make offered solutions more sustainable.
- An active exchange of knowledge with local actors, including the preparation of evidence from external research in a local language with which local staff are comfortable, should be part of these efforts. Much evidence is generated with the input of local actors, but tools have to be found to ensure that conclusions and action points are drawn together, and that gathered evidence is available to all staff and researchers on the ground, also those who only or mainly speak local languages.
- Active engagement with survivors of violence and vulnerable populations could make a real difference in understanding which services could be best delivered and how, and what might work in order to change daily realities for women and girls in their homes and communities.
- Communities should be involved in programming efforts aimed to create awareness and understanding of VAWG in order to foster environments that allow a change in perceptions about gender roles.

(iii) Building emergency systems within a 'normal' cooperation framework

1. Not all services that are available in 'normal' circumstances are operational during emergencies.
2. Many organisations have their own internal referral systems and cooperate with other service providers based on personal relationships and bilateral agreements. However, to offer comprehensive services to survivors of violence without delays, information exchange and working referral systems across all service providers would be needed.

Recommendations:

- It is important to pay attention to dynamics within and amongst communities; and to the provision of services in and outside of acute emergencies. This is especially important in complex contexts, which are characterised by overcrowding and repeated displacement of populations. Some services are not provided during emergencies, and the design of continuous systems has to take into account (potential) service provider disruptions and population flows.
- Agreeing on common definitions, standards, indicators, and information to be collected and shared across implementing, coordinating, and supporting organisations and agencies is of utmost importance.
- Establishing a common database or the cross-referencing of databases that allows access and gives information to other services, including non-GBV related service providers, is needed in order to establish a functioning unified referral system.
- Communities can also be engaged during emergencies in order to reach more vulnerable and hard-to-reach populations and areas. They should therefore be involved in preparedness activities and the planning of emergency services in order to be able to support or replace services that become inoperable during emergencies.

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Annexes

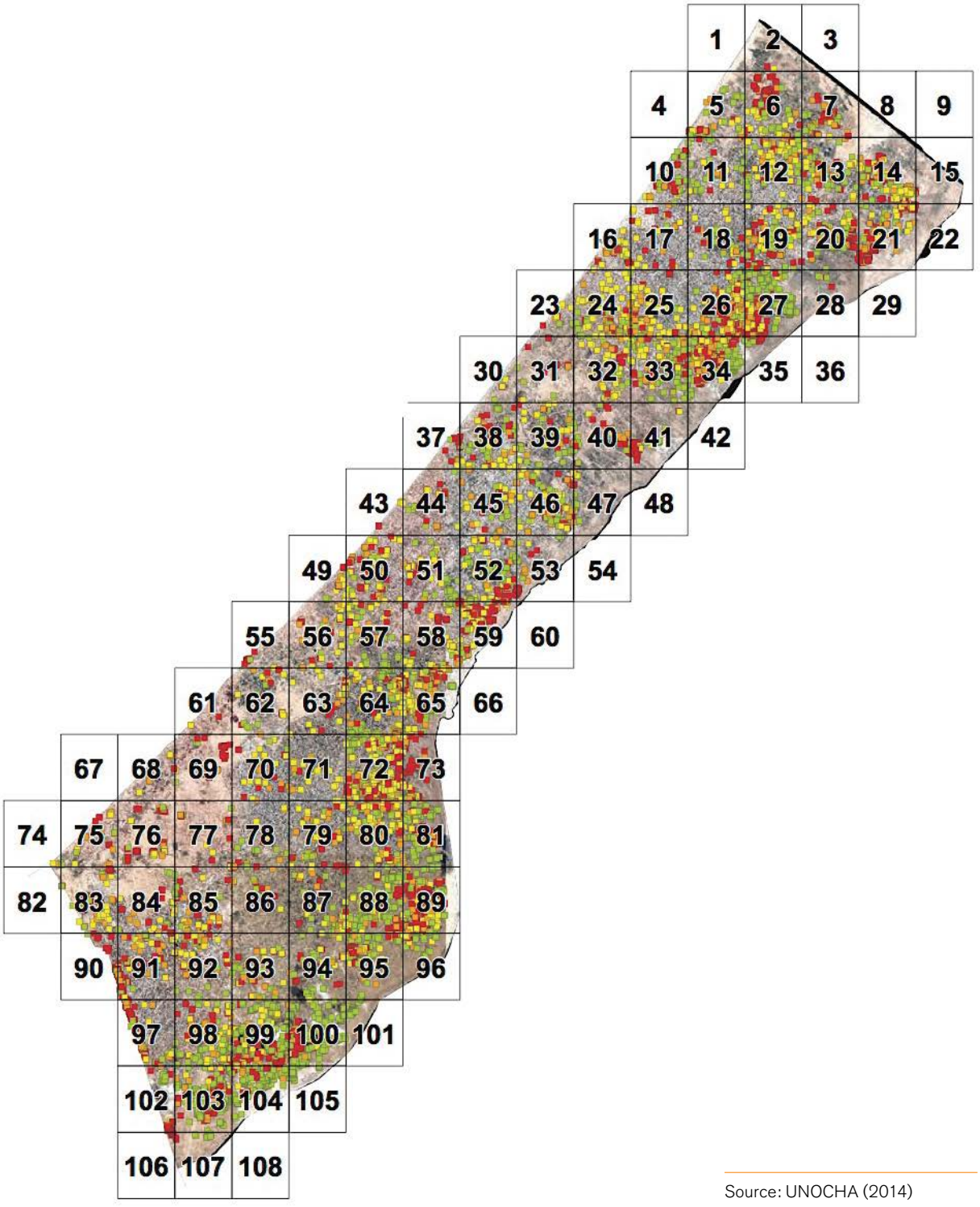
Annex 1: Member organisations of the GBV-Working Group in Palestine

ACTIONAID	
AISHA	Association for Women and Child Protection
Alianza (Former APS)	Alianza por la Solidaridad
CFTA-WHC Buraij	Culture and Free Thought Association - Women's Health Center Buraij
CFTA-WISAL Network	Culture and Free Thought Association -
CWLRC	Center for Women's Legal Research and Counselling
IR	Islamic Relief
MAPUK	Medical Aid for Palestinians UK
MDM France	Médecins du Monde France
MoH	Ministry of Health
MoSA	Ministry of Social Affairs
MoWA	Ministry of Women's Affairs
OCHA	Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the United Nations High Commissioner for Human Rights
Oxfam	Oxford Committee for Famine Relief
PCDCR	Palestinian Center For Democracy and Conflict Resolution
PCHR	Palestinian Center for Human Rights
PFPPA	Palestinian Family Planning & Protection Association
RCS-WHC Jabalia	Red Crescent Society for Gaza Strip – Women's Health Center Jabalia
UHWC	Union of Health Work Committees
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNDP	United Nations Development Programme
UNESCO	United Nations Organization for Education, Science and Culture
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
UNRWA Gaza	United Nations Relief and Works Agency Gaza
WAC	Women's Affairs Center
WATC	Women's Affairs Technical Committee
WFP	World Food Programme
WHO	World Health Organization

Note: Members list as of September 2016.

Annex 2: Map of infrastructure damage during 2014 across the Gaza Strip

Figure A1: Map of infrastructure damage during 2014 across the Gaza Strip



Source: UNOCHA (2014)

Annex 3: Regression results for Chapter 4.3 (Gaza)

Table A1: Correlates of domestic violence before, during and after the 2014 war in Gaza

	(1) DV BEFORE	(2) NUMBER OF TYPES BEFORE	(3) DV DURING	(4) NUMBER OF TYPES DURING	(5) DV SINCE	(6) NUMBER OF TYPES SINCE
DV before			2.09*** (0.074)		2.48*** (0.053)	
Number of types before				2.02*** (0.065)		2.40*** (0.060)
Displaced			1.15** (0.064)	1.26* (0.18)	1.06 (0.042)	1.21** (0.093)
Age	0.99 (0.009)	1.00 (0.006)	1.00 (0.0013)	1.00 (0.0025)	1.00 (0.00094)	1.00 (0.0017)
Education	0.94 (0.082)	0.98 (0.069)	1.02* (0.010)	1.04* (0.022)	1.01 (0.0088)	1.00 (0.028)
Household head working	1.43 (0.37)	1.21 (0.19)	1.01 (0.039)	0.99 (0.060)	1.02 (0.023)	1.07 (0.062)
Married	0.82 (0.18)	0.88 (0.13)	1.03 (0.034)	0.96 (0.055)	1.04 (0.030)	0.99 (0.072)
Household size	1.12* (0.064)	1.08* (0.048)	1.01* (0.0058)	1.02* (0.0095)	1.01 (0.0054)	1.02 (0.011)
Decision-making	0.88* (0.064)	0.91* (0.048)	1.00 (0.0089)	0.97 (0.020)	1.01* (0.0054)	1.00 (0.013)
Number of friends	0.87** (0.054)	0.97** (0.014)	1.00 (0.0028)	1.00 (0.0076)	1.00 (0.0024)	1.00 (0.0053)
Social events	1.00 (0.054)	1.00 (0.025)	1.01 (0.0060)	1.00 (0.018)	1.00 (0.0046)	0.99 (0.012)
Gender roles	1.01 (0.017)	1.01 (0.012)	1.00 (0.0026)	1.00 (0.0044)	1.00 (0.0017)	1.00 (0.0053)
N	440	440	439	439	439	439
R^2	0.06	0.05	0.62	0.75	0.83	0.85

Exponentiated coefficients; Standard errors in parentheses
* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Table A2: Correlates of domestic violence against married women before and after the 2014 war in Gaza

	(1) DV BEFORE	(2) NUMBER OF TYPES BEFORE	(3) DV DURING	(4) NUMBER OF TYPES DURING	(5) DV SINCE	(6) NUMBER OF TYPES SINCE
DV before			2.09*** (0.083)		2.51*** (0.065)	
Number of types before				1.92*** (0.083)		2.40*** (0.071)
Displaced			1.22*** (0.070)	1.34 (0.25)	1.07 (0.069)	1.24 (0.18)
Age	1.01 (0.013)	1.01 (0.0083)	1.00 (0.0013)	1.00 (0.0031)	1.00 (0.0013)	0.99* (0.0027)
Education	0.96 (0.11)	0.95 (0.076)	1.01 (0.011)	1.01 (0.022)	1.01 (0.0094)	0.99 (0.021)
Household head working	1.63 (0.53)	1.41* (0.27)	1.03 (0.045)	1.04 (0.078)	1.01 (0.029)	0.99 (0.06)
Household size	1.05 (0.064)	1.03 (0.037)	1.00 (0.0065)	1.00 (0.012)	1.01 (0.0069)	1.02** (0.012)
Decision making	0.86* (0.074)	0.88* (0.056)	1.00 (0.0087)	0.97 (0.023)	1.01 (0.0066)	0.99 (0.017)
Number of friends	0.87** (0.056)	0.97 (0.033)	1.00 (0.0053)	0.98 (0.013)	1.00 (0.0043)	0.99 (0.0078)
Social events Household size	1.00 (0.058)	1.01 (0.03)	1.01 (0.0076)	1.01 (0.022)	1.01 (0.0065)	1.01 (0.013)
Gender roles	1.03 (0.023)	1.01 (0.012)	1.00 (0.0027)	1.00 (0.0047)	1.00 (0.0018)	1.00 (0.0038)
N	321	321	320	320	320	320
R^2	0.05	0.05	0.61	0.73	0.84	0.89

Exponentiated coefficients; Standard errors in parentheses
* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Table A3: Correlates of domestic violence against non-married women before and after the 2014 war in Gaza

	(1) DV BEFORE	(2) NUMBER OF TYPES BEFORE	(3) DV DURING	(4) NUMBER OF TYPES DURING	(5) DV SINCE	(6) NUMBER OF TYPES SINCE
DV before			2.08*** (0.15)		2.46*** (0.09)	
Number of types before				2.26*** (0.13)		2.42*** (0.14)
Displaced			1.00 (0.10)	1.12 (0.22)	1.06 (0.052)	1.30* (0.2)
Age	0.97 (0.019)	0.99 (0.0094)	1.00 (0.0029)	1.00 (0.0044)	1.00 (0.0012)	1.00 (0.003)
Education	0.88 (0.14)	1.01 (0.091)	1.01 (0.011)	1.06* (0.036)	1.00 (0.019)	1.03 (0.087)
Household head working	1.10 (0.52)	0.88 (0.27)	0.99 (0.056)	0.97 (0.091)	1.07* (0.038)	1.32** (0.18)
Household size	1.34*** (0.13)	1.18*** (0.067)	1.02 (0.014)	1.03 (0.027)	1.00 (0.0058)	0.99 (0.022)
Decision making	1.00 (0.15)	1.00 (0.096)	1.01 (0.020)	0.96 (0.034)	1.01 (0.011)	1.00 (0.031)
Number of friends	0.82** (0.081)	0.97** (0.013)	1.00 (0.0036)	1.00 (0.0083)	1.00 (0.0019)	1.01 (0.0065)
Social events	0.94 (0.13)	0.96 (0.062)	1.01 (0.014)	1.00 (0.031)	1.00 (0.0083)	0.93* (0.037)
Gender roles	0.96 (0.035)	0.99 (0.024)	1.00 (0.0050)	1.01 (0.010)	1.01 (0.0037)	1.00 (0.013)
N	119	119	119	119	119	119
R^2	0.18	0.14	0.65	0.82	0.84	0.78

Exponentiated coefficients; standard errors in parentheses
* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Annex 4: Regression results for Chapter 4.4 (West Bank)

Table A4: Correlates of marital IPV among married women of the West Bank: political violence and stressors (2011)

	(1) PSYCHOL. IPV	(2) PSYCHOL. IPV	(3) PHYSICAL IPV	(4) PHYSICAL IPV	(5) SEXUAL IPV	(6) SEXUAL IPV
Political Violence	1.70*** (0.20)	1.42*** (0.18)	1.56*** (0.22)	1.39* (0.25)	1.84*** (0.29)	1.50** (0.30)
Stressors						
Increased demands from family members		1.19* (0.11)		1.06 (0.18)		1.32 (0.24)
Lack of time to interact with husband/children		1.23 (0.16)		1.04 (0.17)		1.45** (0.26)
Increased troubles with husband in the last 12 months		3.81*** (0.53)		5.11*** (0.64)		2.37*** (0.37)
Children involved in illegal activities		0.99 (0.39)		0.90 (0.36)		1.55 (0.57)
Sick and hospitalised in last 12 months		1.09 (0.1)		0.92 (0.13)		1.10 (0.15)
Monthly expenditure per capita		1.00 (0.000075)		1.00 (0.0002)		1.00 (0.00019)
Income is not enough		1.12 (0.15)		1.14 (0.24)		0.96 (0.15)
Controls						
Age	0.98*** (0.0032)	0.98*** (0.0052)	0.97*** (0.0033)	0.96*** (0.0050)	0.99 (0.0049)	0.98** (0.0088)
Refugee status (r: registered refugee)						
Unregistered refugee	0.66 (0.20)	0.55 (0.21)	1.46 (0.49)	1.07 (0.39)	1.74*** (0.37)	1.23 (0.36)
Non-refugee	0.82 (0.10)	0.82 (0.12)	0.95 (0.13)	1.10 (0.15)	0.78 (0.12)	0.87 (0.16)
Education status (r: currently enrolled)						
Enrolled but did not graduate	0.98 (0.16)	1.00 (0.27)	1.25 (0.49)	1.21 (0.50)	0.94 (0.41)	0.90 (0.38)
Graduated	0.88 (0.16)	0.93 (0.26)	1.12 (0.51)	1.02 (0.50)	0.81 (0.35)	0.74 (0.31)
Did not enrol	1.09 (0.29)	1.08 (0.29)	1.21 (0.53)	1.47 (0.91)	1.33 (0.67)	1.19 (0.75)
No. of years of education	1.01 (0.014)	1.00 (0.016)	0.96** (0.017)	0.97 (0.019)	0.96* (0.019)	0.96 (0.024)

	(1) PSYCHOL. IPV	(2) PSYCHOL. IPV	(3) PHYSICAL IPV	(4) PHYSICAL IPV	(5) SEXUAL IPV	(6) SEXUAL IPV
Working	2.11*** (0.28)	1.92*** (0.29)	2.54*** (0.54)	2.31*** (0.60)	1.85*** (0.32)	1.11 (0.40)
Decision Power Index	0.86*** (0.015)	0.88*** (0.015)	0.83*** (0.023)	0.84*** (0.019)	0.83*** (0.020)	0.86*** (0.018)
Type of locality (r: urban)						
Rural	0.84*** (0.044)	0.87** (0.054)	0.75*** (0.065)	0.90 (0.11)	0.85 (0.21)	0.99 (0.31)
Camp	1.83** (0.47)	1.78* (0.54)	2.30*** (0.33)	2.91*** (0.59)	1.39 (0.33)	1.34 (0.36)
Lives in house	1.25* (0.15)	1.19 (0.17)	1.22*** (0.096)	1.12 (0.15)	0.94 (0.097)	0.89 (0.13)
Household size	1.01 (0.019)	0.99 (0.021)	1.01 (0.019)	1.00 (0.035)	1.00 (0.035)	1.02 (0.049)
Assets index	1.00 (0.029)	1.00 (0.026)	1.02 (0.028)	1.02 (0.024)	1.05 (0.033)	1.05 (0.040)
Observations	2934	2324	2934	2324	2934	2324

Note: authors' calculations based on the PCBS (2011).
Exponentiated coefficients; Standard errors in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Table A5: Correlates of marital IPV among married women of the West Bank: political violence, stressors and marital control (2011)

	(1) PSYCHOLOGICAL IPV	(2) PHYSICAL IPV	(3) SEXUAL IPV
Political Violence	1.36** (0.18)	1.28 (0.24)	1.36 (0.26)
Index of marital control	1.72*** (0.11)	1.99*** (0.27)	2.17*** (0.17)
Stressors			
Increased demands from family members	1.18 (0.12)	1.04 (0.22)	1.32 (0.28)
Lack of time to interact with husband/children	1.22 (0.19)	0.99 (0.18)	1.39 (0.28)
Increased troubles with husband in the last 12 months	3.54*** (0.47)	4.52*** (0.56)	1.87*** (0.34)
Children involved in illegal activities	0.97 (0.40)	0.88 (0.33)	1.60 (0.52)
Sick and hospitalised in last 12 months	1.12 (0.091)	0.92 (0.14)	1.09 (0.16)
Income is not enough	1.16 (0.16)	1.22 (0.28)	1.05 (0.20)
Monthly expenditures per capita (shekel)	1.00 (0.000082)	1.00 (0.00019)	1.00 (0.00020)
Observations	2324	2324	2324

Note: authors' calculations based on the PCBS (2011). Exponentiated coefficients; standard errors in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. The regressions include the same set of controls as in Table A 1.

Annex 5: Lists of workshop participants

Participatory workshop, 11 October 2016

1	Union of Health Work Committee	Mona Mosa
2	Union of Health Work Committee	Sami Abe Naser Attallah
3	Center for Women's Legal Research and Consulting (CWLRC)	Linda Hamde Abu Marsa
4	Aisha Association	Reem Franah
5	Aisha Association	Marwa Elwan
6	Palestinian Center for Democracy and Conflict Resolution (PCDCR)	Abeer Al Kfarna
7	Ministry of Health (MoH)	Mounir Al Oqalie
8	Palestinian Center for Human Rights (PCHR)	Hanan Matter
9	Palestinian Center for Human Rights (PCHR)	Majda Sheata
10	Bait Al Amman Shelter for Women	Soha Samir Qanetta
11	Bait Al Amman Shelter for Women	Hanady Skaik
12	Women Affairs Center	Reem Al Nairab
13	Women Affairs Center	Hana Al Zant
14	Wefaq Association	Samaher Abu Zyaid
15	Red Crescent Society WHCJ	Amal Al Haj
16	Palestinian Worker Women Society for Development (PWWSD)	Sawsan Alyan
17	United Nations Population Fund (UNFPA)	Amira Mohana

Preliminary results workshop, 15 December 2016

1	Palestinian Center for Democracy and Conflict Resolution (PCDCR)	Abed Al Monem Tahrawi
2	Red Crescent Society WHCJ	Mariam Shaqura
3	Ministry of Health (MoH)	Sawsan Hamad
4	Union of Health Work Committee	Mona Musa
5	Aisha Association	Reem Franah
6	UN Women	Areej Al Ashabbb
7	United Nations Population Fund (UNFPA)	Amira Mohana

This working paper presents the findings of a research project on the protection of women against violence in the context of urban humanitarian crises. Gaza, a highly urban and densely populated area, is a site of ongoing complex emergency, with bouts of acute violence. As such, it is challenging for humanitarian work. Analyses of original and secondary quantitative and qualitative data underscore that violence against women varies along their lifecycles, and is aggravated by humanitarian crises and exposure to political violence. The findings recommend that service providers work with local actors and embed currently scattered emergency gender-based violence (GBV) systems into a unified and shared development framework.

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International Institute for Environment and Development
80-86 Gray's Inn Road, London WC1X 8NH, UK
Tel: +44 (0)20 3463 7399
Fax: +44 (0)20 3514 9055
www.iied.org

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