UNFPA

Protection Cluster
Gender Based Violence Sub-Cluster
occupied Palestinian territory

MAPPING INTERVENTIONS
PREVENTING AND RESPONDING TO

GENDER BASED VIOLENCE

IN THE OCCUPIED PALESTINIAN TERRITORY
(WEST BANK, EAST JERUSALEM AND GAZA STRIP)

November 2016

Mapping interventions preventing and responding to Gender Based Violence (GBV) in the occupied Palestinian territory – 2016 (West Bank, East Jerusalem and Gaza Strip)

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ACRONYMS

WB:	West Bank
GBV:	Gender Based Violence
GBV-WG:	Gender Based Violence - Working Group
VAW:	Violence Against Women
HRP:	Humanitarian Response Plan
HNO:	Humanitarian Needs overview
IASC:	International-Agency Standing Committee
CEDAW:	Convention on the Elimination of All Forms of Discrimination Against Women
CRC:	Convention on the Rights of the Child
IHL:	International Humanitarian Law
IHRL:	International Human Rights Law
SOP:	Standard Operation Procedures
IMS:	Information Management System
IDP:	Internally Displaced Persons
PNA:	Palestinian National Authority
PCP:	Palestinian Civil Police
FJPU:	Family and Juvenile Protection Units
PSS:	Psychosocial Support
MOSD:	Ministry of Social Development
MOWA:	Ministry of Women Affairs

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INTRODUCTION

The Gender Based Violence Working Group (GBV-WG), chaired by UNFPA, has undertaken two mapping activities of GBV interventions in Palestine in the years 2013 and 2014. Both mapping reports informed the UNCT Gender Task Force and provided data on the overall GBV work without distinction between development and humanitarian interventions. In 2015, the GBV working group evolved to operate as one of the humanitarian working groups of the Protection Cluster and assumed the responsibility to report on humanitarian GBV services with clear distinction from development interventions.

The current mapping report will compile an updated data on both types of GBV interventions with clear distinction between them and will provide observations on results, identifying gaps and challenges and offer recommendations to the GBV-WG and GBV service providers for future action.

Objectives of the mapping

The overall objective of this mapping is to provide a general overview of existing types of GBV projects and protection services that combat GBV in the occupied Palestinian territory. The mapping will address both development and humanitarian aspects and will focus on ongoing projects and programmes implemented by UN, international and national NGOs and governmental stakeholders. In addition, the results of the mapping will inform the Humanitarian Response Plan (HRP) and relevant indicators as well as planned GBV- WG strategy and annual action plan.

The results will provide basis for coordination of existing efforts, avoid duplication and strengthen collaboration for a multi-sectorial prevention, mitigation and response to GBV. The identification of gaps will allow for improved and strategic interventions in preventing and responding to gender based violence in both regular and humanitarian programming.

The mapping has been undertaken with support from UNFPA and the GBV-WG and in collaboration with OCHA using the 4Ws' approach:

- **Who**: identifying types of organizations/institutions working in GBV in the occupied Palestinian territory including East Jerusalem and Area C.
- **What**: identifying interventions/projects/services provided to women children and families with a GBV marker for each to learn if GBV is a primary/secondary or only a component of the reported interventions
- **Where**: marking geographical areas of interventions at national (All Palestine), regional (West Bank, East Jerusalem and Gaza Strip) and district levels including Area C.
- **When**: examining timeframes of ongoing and planned GBV projects/interventions within the time frame of the National Strategy on Violence Against Women (VAW) ending 2019.

Mapping – concepts and definitions

a. **Gender-Based Violence** refers to the 2015 IASC definition of the Guidelines on GBV in Humanitarian settings which stipulates that GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private".[1]

1 According to the IASC Guidelines on Gender-Based Violence in Humanitarian settings (2015), (p.5)

This definition includes both adults and children and exclusively refers to six core types of GBV:

- Rape
- Sexual assault including harmful traditional practices
- Physical assault
- Forced marriage
- Denial of Resources, Opportunities or Services
- Psychological / Emotional Abuse

Please refer to Annex 1 for further clarification / definitions on the GBV forms included under each type

The report uses GBV/VAW based on the definition of VAW in the declaration CEDAW, while GBV is inclusive to all persons including children, VAW sustains positive bias towards women as most vulnerable group to GBV. CEDAW defines VAW as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'.

a. **Development GBV programmes; projects; interventions** refers to all programmes/projects/interventions that primarily address society born GBV and inherent factors within the Palestinian society that aggravates GBV. These projects are not included in the Humanitarian Response Plan (HRP) and most likely respond to one or more of the national sector strategies and relevant UN Development Assistance Framework (UNDAF) and is part of the regular sector programming.

b. **Humanitarian GBV programmes projects and interventions** refers to all programmes/projects/interventions that primarily address GBV inflicted on vulnerable groups, particularly internally displaced women and children in situations of crisis and are mainly focused on provision of services. Crisis could be ad-hoc man-made like war/conflict situations (e.g. Latest Israeli hostilities on Gaza Strip) or protracted emergency like the continued occupation measures in the West Bank including area C and East Jerusalem and Gaza Strip or due to forces of nature like floods, drought and earthquakes. Usually, these projects are included in the HRP.

Components of the mapping

The mapping will describe GBV interventions/programmes/projects through six key elements that reflect the situation of GBV work in Palestine in a structured and standardised approach. Some of these elements fluctuate in their significance and relevance between development and humanitarian settings. These elements emulate the key components of a protection from GBV system that GBV workers aspire to establish in the occupied Palestinian Territory. Hence, mapping interventions addressing these components will somehow indicate the trend in the GBV system development.

The elements are:

1. **Coordination among GBV stakeholders**: identifying existing coordination interventions (or lack thereof) and indicating their effect on implementation mechanisms to the extent possible; exploring linkages between development and humanitarian GBV work. In addition, this element will examine interventions' harmonization with Strategic Objectives (SO) of the VAW national strategy and HRP.
2. **Policy development and policy dialogue**: mapping interventions addressing GBV related policies, plans of action, strategies and SOPs including for emergency and scale up mechanisms. Additionally, those related to reporting to treaty bodies on CEDAW and CRC and on GBV violations of International Humanitarian Law (IHL).

3. **Capacities**: drawing a general picture of development and humanitarian interventions that address technical and financial capacities as well as infrastructure rehabilitation among GBV stakeholders.
4. **Prevention and response services**: detecting types of existing GBV services in both humanitarian and development contexts including health care, psychosocial support, legal aid, security and protection, family support and economic enablement.
5. **Process of detection, response and referral mechanisms**: identifying interventions that develop and improve multisectoral GBV case management approaches, protocols and referral pathways and their guiding operating procedures.
6. **Accountability**: learning about interventions addressing GBV Information Management Systems (IMS) and complaint mechanisms as well as about GBV research and rapid appraisals during emergency.

METHODOLOGY

The GBV-WG chaired by UNFPA, contributed to the development of the methodology of the mapping through two workshops held in the West Bank and Gaza in which data collection tools were examined. Verification and endorsement of the collected information will be undertaken by the GBV-WG before finalisation of the mapping report.

Data collection process was undertaken through:

- **Review of existing literature:** a desk review of the earlier two mapping reports, available assessments and reports and relevant evaluations was carried out.
- **Development of a questionnaire:** a questionnaire was developed in accordance with the UNFPA requirements in line with the 4Ws approach. The questionnaire addressed the six elements of GBV work in development and humanitarian contexts. Two similar but separate sections were developed for GBV development and humanitarian programmes / interventions. In addition, a version of the questionnaire was designed compatible with the OCHA 4Ws on-line data base for future use. (Please see the questionnaire in Annex 2)
- **Few Interviews with key informants** including UNICEF Jerusalem and Gaza Office, MOH and Civil Police- FJPU were undertaken to get insights on lacking information on case management protocols and referral pathways.

Constraints in data collection process

- Face to face consultation workshops with GBV partners in Gaza was cancelled due to lengthy procedure of permit issuance for the Mapping consultant. The consultation workshop and interviews were conducted using video link / conference calls.
- The GBV questionnaire was not filled by many from the Gender Units in respondent ministries mostly due to lack of information or authorization to share related ministry data.
- The data collection process could have been much faster if the questionnaire were filled by field workers rather than sending it by e-mail to be filled by partners. In addition, some of the GBV stakeholders found the questionnaire not easy to fill, particularly those who were not present in the workshop in which partners were walked through the questionnaire.
- The questionnaire was available only in English language. As majority of the GBV service providers are national institutions, it was recommended to translate the questionnaire into Arabic for future use.

Gender Based Violence Context

GBV is a key protection concern in the occupied Palestinian territory. According to Palestinian Central Bureau of Statistics (PCBS) 2011 Violence Survey, an average of 37% of women are victims of GBV in Palestine; in the Gaza Strip, this percentage increases to 51%. The protracted humanitarian crises has impacted gender and family dynamics and exacerbated GBV in all its forms, including sexual violence, intimate partner violence, and child marriage. In addition, preliminary findings from an IDP survey in Gaza indicated that 73% of households perceive an increase in the incidence of GBV against women adolescent girls and children during crisis.[2]

2 Humanitarian Needs Overview, 2016, p. 6

Distance, mobility restrictions, fragmentation of areas and services, and reluctance to report GBV due to fear of stigma, social exclusion, honour killings or reprisal, all limit survivors' access to and utilisation of critical services. In addition, survivors and communities have minimal information on existing services and how to access them.

In the absence of a coherent systematic approach to combating GBV, available services and capacity of service providers remain limited. According to PCBS, in 2011 only 0.7% of GBV survivors seek help due to the lack of confidential and compassionate services, and fear of stigma and reprisal[3]. The continuum, process and quality of services are key elements of systems of protection from GBV that support and promote confidentiality and increase access of survivors to services.

3 Humanitarian Needs Overview, 2016, p. 16

MAPPING RESULTS

The following analysis is based on data collected from 33 organizations (Ministries (8), UN/INGOs (11) and NGOs/CBOs (14)) which reported 121 development (or often referred to as regular) interventions and 28 humanitarian. In addition, it is informed by literature review and the few interviews with GBV partners.

The report is divided into six sections. The first part describes what is standard or best for the element of that section. The middle part provides data collected in the mapping which is compared between development and humanitarian interventions at different levels. The end part provides observations that are not exclusive to the data collected under the section.

1 - GBV Coordination Interventions

Coordination interventions indicate that efforts were put to develop a functional, harmonised national system for protection from GBV that links both the humanitarian and development dimensions.

In the past few years, concrete efforts were exerted to reinforce coordination mechanisms among GBV partners at national, regional and district levels including governmental and community based organizations, international NGOs and UN. For instance, the GBV Working Group chaired by UNFPA evolved to become a working group that coordinates both development and humanitarian GBV prevention and response programmes under the UN Cluster and UNDAF systems. While the National Committee to Combat VAW, chaired by MOWA, continued to oversee the implementation of the National Strategy to combat VAW and coordinate GBV development programmes; currently developing Al-Marsad and the National Observatory on violence against women. The NGO Forum to combat VAW (Almuntada Coalition) is also serving as a coordination body for 13 NGOs and CBOs in the WB. Other NGO/CBO coalitions also exist at district and regional levels to combat GBV like MIFTAH and Amal coalitions in the WB and Gaza.

In addition, other coordination mechanisms that serve GBV work at multiple levels exist among ministries and NGOs including MOSD led Child Protection and GBV Networks in Gaza and Chid protection Networks' Steering Committee in the WB, UNICEF co-led Child Protection Working Group and UNRWA Family Protection Committees in the refugee camps. Nonetheless, these mechanisms vary in the linkages among them, the standards they follow and target groups they serve. Therefore, coordination is constrained among partners at different levels and can be described as unsystematic, inconsistent and often limited[4]. This will become clearer in the following sections of the report.

In this mapping, coordination interventions were detected at all levels in 87% of GBV development projects, primarily led by governmental and non-governmental organizations, mainly in the WB and at national level, and to a lesser extent in Gaza.

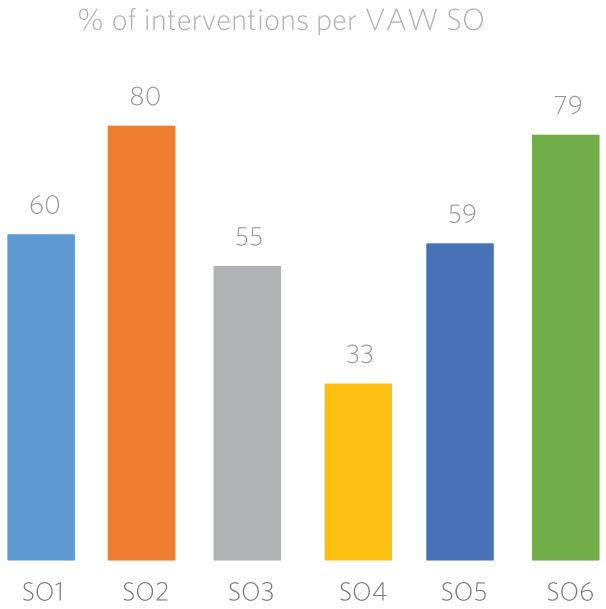
In comparison, coordination interventions were reported in 25% of humanitarian GBV projects largely led by UN / international entities at national level and in Gaza at 29%. Humanitarian coordination interventions led by governmental institutions were not reported, hence none of respondent ministries was identified in a coordination role on humanitarian GBV interventions during crisis.

Nevertheless, it was apparent that both development and humanitarian coordination structures contributed to convening partners on a unified conceptual framework to address VAW/GBV. For instance, in the development context, the highest at 80% and 79% of regular interventions were in line with Strategic Objectives SO2 and SO6 of the National Strategy to Combat VAW, mainly focusing on enhancing legal

4 - National Strategy to Combat VAW 2011-2019/ UNFPA – Protection in the Windward, Conditions and rights of IDP girls and women during the latest Israeli Military operation on the Gaza Strip / and UNICEF report - Review of the Child Protection system in Palestine

frameworks and institutional mechanisms besides prevention of violence. Whereas, the least addressed strategic objective at 33% was SO4 on improving response to VAW in health services. Remaining SOs were addressed at different rates as seen in figure 1.

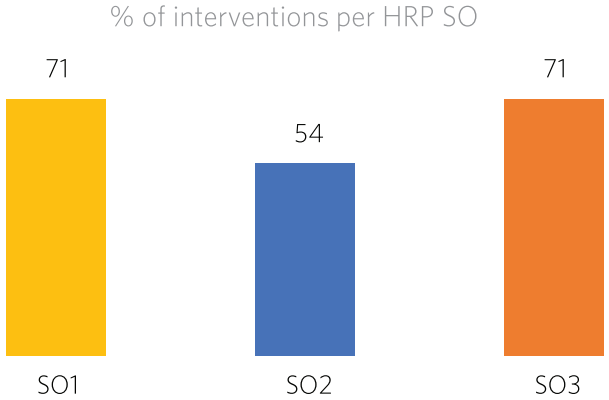
Figure 1: percentage of **development** interventions addressing Strategic Objectives (SOs) of National Strategy to Combat VAW



VAW Strategic Objectives	
SO1	Promote protection and empowerment mechanism for women subjected to violence resulting from the Israeli occupation;
SO2	Promote a legal framework and institutional mechanisms to protect women from violence;
SO3	Improve social protection and social support offered to women victims of violence;
SO4	Improve health services in dealing with cases of VAW;
SO5	Improve the protection, jurisdiction, sharia and defense systems to protect women from violence based on a women's rights based approach;
SO6	Promote the principle of violence prevention as part of the strategic direction of institutions working on the protection of women's rights.

Similarly, most of humanitarian interventions at 71% were in line with SO1 and SO3 of the 2016 HRP, whereas, the lowest at 54% of the interventions were responsive to SO2, which addresses access to essential health services particularly in Gaza. (Please see figure 2).

Figure 2: percentage of **humanitarian** interventions addressing Strategic objectives of the Humanitarian Response Plan (HRP) 2015



HRP Strategic Objectives	
SO1	Protect the rights of Palestinians under occupation in accordance with International Humanitarian Law (IHL) and International Human Rights Law (IHRL).
SO2	Ensure acutely-vulnerable Palestinians under occupation in the Gaza Strip and the West Bank have access to essential services
SO3	Strengthen the ability of acutely-vulnerable Palestinian households to cope with protracted threats and shocks

Observations:

- The above indicates fragile linkages between the development and humanitarian coordination mechanisms, which often seem parallel and show a very limited role of governmental institutions in leading coordinated response during crisis. This could be attributed to inadequate contingency planning in the regular national planning process; limited human resources and financial and technical capacity of ministries to respond during emergency. Besides, there is a perception among government actors

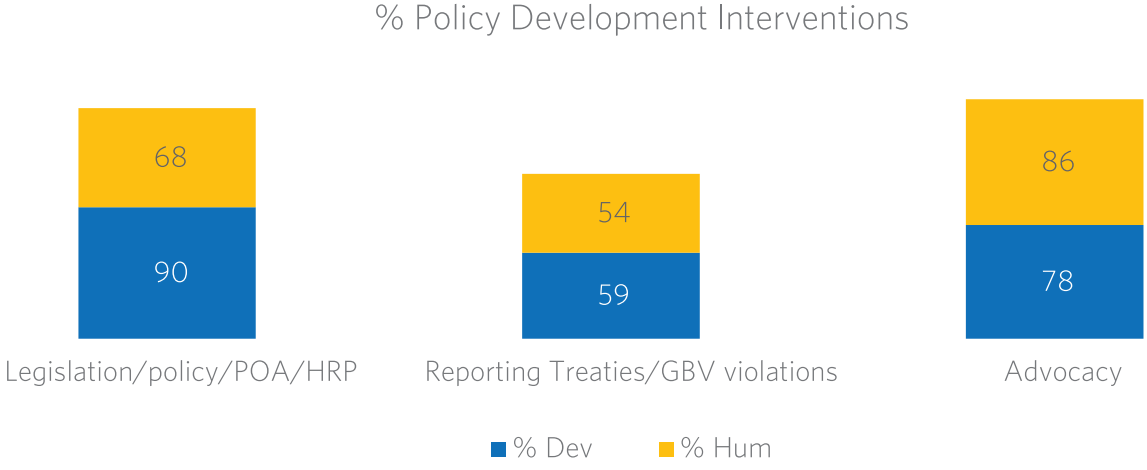
that humanitarian work is more the responsibility of the UN and international community rather than partner ministries.

- Coordination structures contributed to convening partners on a unified conceptual framework (VAW National Strategy and HRP) to address VAW/GBV. While improvement at service provision level was only identified in the development of regulatory tools including GBV and Child Protection SOP in Gaza Strip and the National Referral Protocol in the WB. Harmonised implementation remains an issue to be addressed as will be seen under other sections later in the report.
- The gap in responding to VAW SO4 and HRP SO2 - related to interventions perusing response and access to GBV health services - appears in both development and humanitarian settings and will infiltrate to the remaining five elements as will be seen later in the report.

2 - Policy Development / Policy Dialogue

- In order to ensure inclusion, standardization and sustainability of GBV work in the national development agenda, it is inevitable to support the advancement of relevant legislative and policy frameworks in line with international standards including for emergency.
- Improvement of policies addressing violence against women, girls and children in Palestine is a process that may have gained additional momentum among GBV stakeholders after PNA recent ratification and commitment to mandatory reporting of international human rights' treaties e.g. CEDAW and CRC. This is particularly true for the development or enactment of a set of policies and legislations including - but not exclusive to - the Family Protection Law, Child Law, Juvenile Protection Law, Police Family and Juvenile Protection Units' GBV strategy and Standard Operating Procedures, the GBV and Child Protection SOP and Referral Protocols, PSS Minimum Acceptable Standards and Referral Protocol of UNRWA Family Protection Committees.
- Data collected under this section shows that 90% of regular (development) GBV interventions address policy development and legislation, managed largely by NGOs at 72% at country level. While, 78% of interventions focus on advocacy and 59% on action and follow up related to international treaties with approximately equal involvement of government and UN/INGOs.
- In comparison, in humanitarian setting, mostly in Gaza Strip, the focus of interventions is largely on advocacy for GBV centred policies at 86%, followed by 68% of interventions involved in policy for emergency preparedness, scale up mechanisms and GBV SOP. Interventions on reporting GBV violations was noticed at 54% where national and international NGOs and UN are the key actors in both WB and Gaza Strip, while government institutions were not reported taking part in these efforts. Please see figure3.

- Figure 3 -



Observations:

- The above reflects attention given to GBV related policy development and policy dialogue and advocacy. However, it is equally important to ensure endorsement and implementation of these policies and legislations at service provision level and in an equal pace among primary service providers of social welfare, health, education and justice.
- Government in the WB and Gaza was not reported leading humanitarian policy work (e.g. developing national emergency preparedness plans and mechanisms for coordinating response and scale up efforts) it is rather supporting NGOs, UN and INGOs efforts.
- Regular GBV policy development interventions are more focused on legislation and to a lesser extent on advocacy, while the opposite is true in humanitarian interventions. NGOs are predominantly taking lead in humanitarian setting and have the lion's share of interventions in the development context.

3 - Building Capacity on GBV

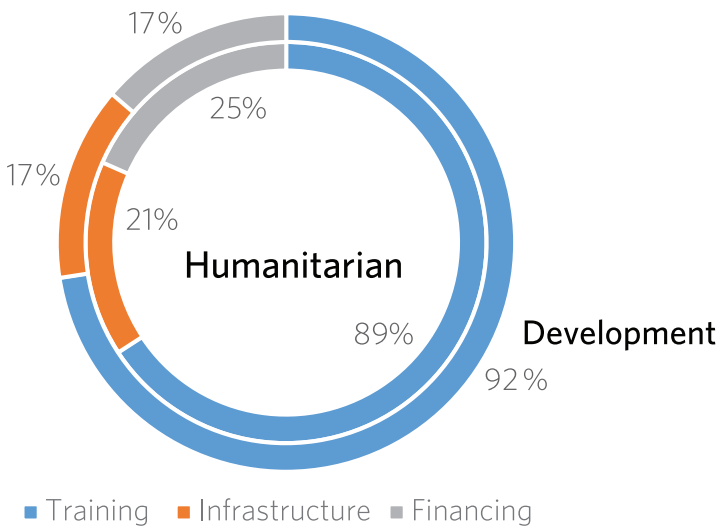
- The capacity of GBV stakeholders is vital for quality and sustainability of interventions in regular work and a detrimental factor in the ability of these interventions to prevent and respond to GBV in emergency or crisis situations. In addition, it increases access of women and children to services and reinforces potential of rehabilitation and reintegration of survivors. Currently, the financial, technical and human capital capacity of stakeholders, particularly governmental, is limited and fall short in front the GBV prevention and response needs.
- Mapping of capacity building interventions, training was reported the highest implemented at 92% of regular GBV work, while equally lowest percentages were reported at 17% for each infrastructure and financing. 24% of training interventions take place in the WB (40% in Area C) and only 2% in East Jerusalem, and 21% in Gaza. These interventions were reported mainly by national NGOs at 63% while governmental institutions reported 17% and UN/INGO 12%. Infrastructure development and financing are implemented mainly by government with bulk in the WB, 1% and 3% in Gaza and none in East Jerusalem. More than half of the training interventions are ongoing and 6% are planned.
- Regular training interventions addressed GBV prevention more than specific response aspects. Majority aimed at building the capacity of male partners, youth, religious leaders, media personnel, policy makers, women survivors and professionals in protection from GBV and maintaining and reporting human rights. Training for economic enablement and specialised training on referral and case management was less reported.

  Similar to the development GBV work, training was reported the highest capacity building intervention in humanitarian context at 89% while the lowest were for interventions of infrastructure rehabilitation at 21% and financing at 25%. The training interventions are implemented mainly in Gaza at 57% by national NGOs and UN/INGOs in comparison to 25% in Area C and 4% in East Jerusalem. Capacity building interventions by government in humanitarian setting was not detected. 54% of training interventions are ongoing.

  Humanitarian training activities focused mainly on managing stress and life skills, sensitization towards IHL and IHRL and GBV in humanitarian context. Few addressed GBV case management and referral pathways and economic enablement.

- Figure 4 -

Capacity Building - Development and Humanitarian



Observations

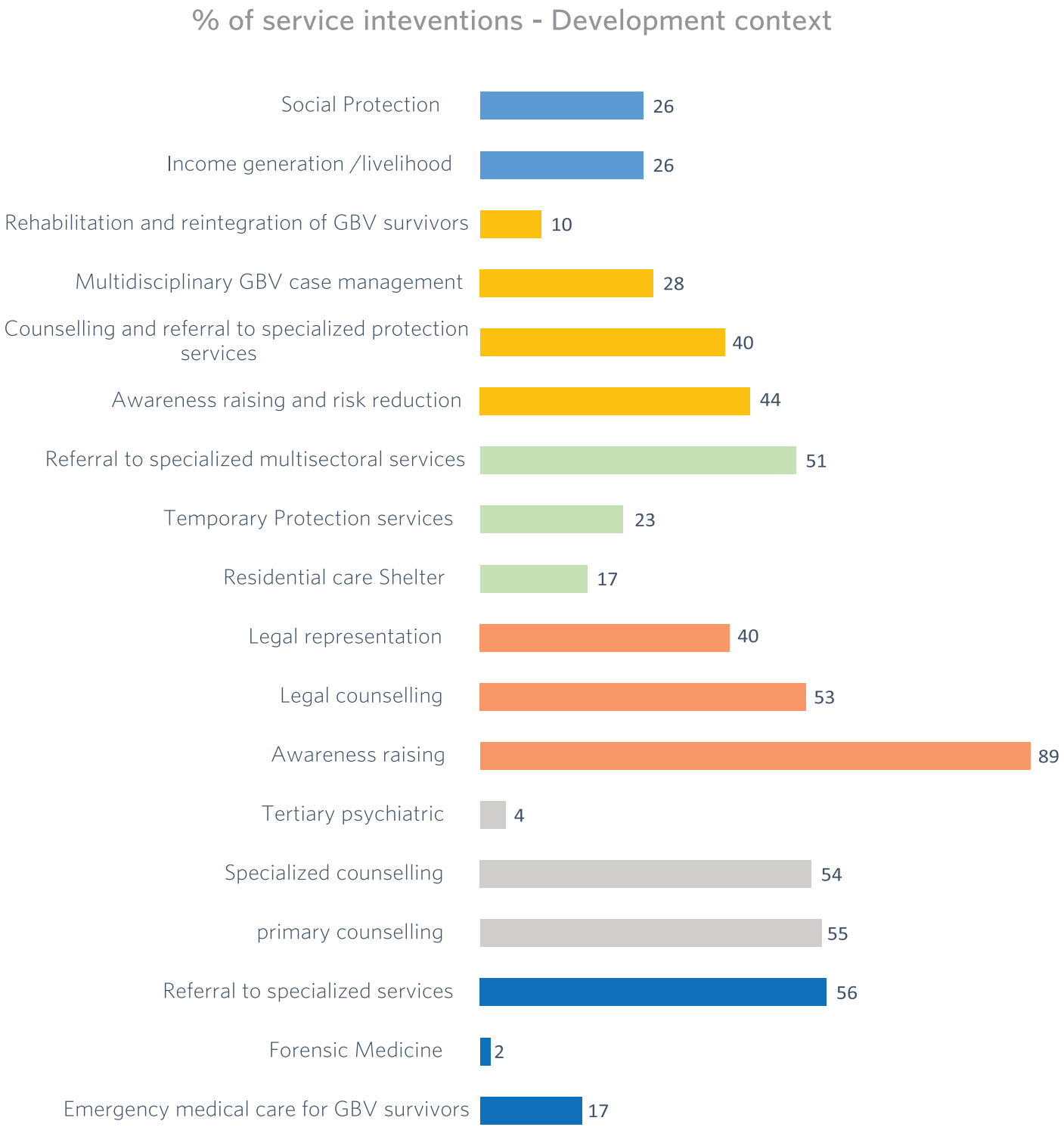
- No doubt, investing in building the human capacity is key to quality standardized GBV services. Nevertheless, it is inadequate without infrastructure rehabilitation to meet minimum acceptable standards for confidentiality, safety and security of GBV survivors and service providers alike. This is vital to address the gap in seeking services by GBV survivors.
- Financial resources are impartial for response to and reintegration of GBV survivors, particularly for economic enablement of impacted women.
- GBV training in both development and humanitarian contexts is focused more on prevention and less on specific response processes, which emphasizes the disconnect between the development of standards and their implementation at service level.

4 - Prevention and Response Services

In order to provide vulnerable women, children and families access to quality GBV protection services, prevention, care and reintegration, it is essential to reinforce community practices and mechanisms that protect women and children from GBV, and ensure standardized operating procedures in existing protection sub-systems across sectors. In addition, it is fundamental that GBV services in these sub-systems are operational at primary, secondary and tertiary levels; and responsive to needs and rights of GBV survivors in both developmental and humanitarian contexts.

In developmental context, 18 areas of GBV service interventions were reported under health care, psychosocial support, legal aid, security and protection, family support and economic enablement services. The highest percentage was for legal aid - awareness raising at 89% mainly run by NGOs in the WB, while the lowest at 2% was for forensic medicine in health care interventions mainly in Gaza Strip. Please see Figure 5.

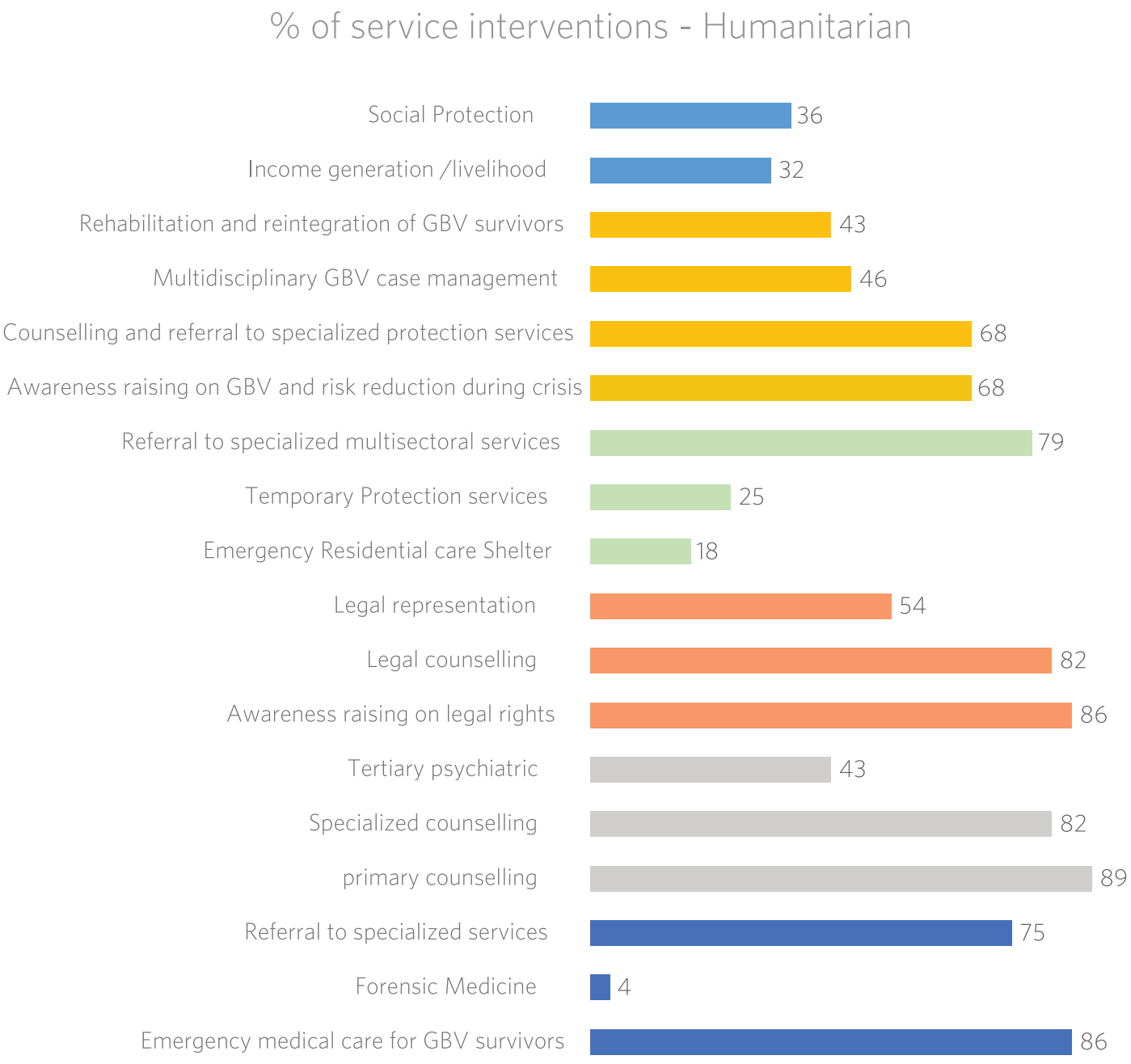
- Figure 5 -


% of service inteventions - Development context
Social Protection
26
Income generation /livelihood
26
Rehabilitation and reintegration of GBV survivors
10
Multidisciplinary GBV case management
28
Counselling and referral to specialized protection services
40
Awareness raising and risk reduction
44
Referral to specialized multisectoral services
51
Temporary Protection services
23
Residential care Shelter
17
Legal representation
40
Legal counselling
53
Awareness raising
89
Tertiary psychiatric
4
Specialized counselling
54
primary counselling
55
Referral to specialized services
56
Forensic Medicine
2
Emergency medical care for GBV survivors
17

- **Legal aid remaining interventions** scored 53% for legal counselling, mainly in Gaza and least at 40% for legal representation. They are almost equally distributed between WB and Gaza with insignificant percentage in East Jerusalem.
- **Health care interventions** are concentrated on referral to multisectoral specialized services at 56% mainly in Gaza Strip, largely run by NGOs and some UN / INGOs and only 1% by governmental institutions. Equally in the WB and Gaza, 17% of interventions support emergency medical care. The lowest percentage was reported at 2% for forensic medicine in the WB (UNODC and Mehwar Shelter related interventions). MOH forensic medicine services cover both humanitarian and development for all Palestine.
- Majority of the **PSS interventions** are primary and specialized counselling at approximately 55%, implemented mainly in Gaza and Area C in the WB including 3% in East Jerusalem. The interventions are the principle response services to GBV. However, concern was raised by GBV stakeholders regarding quality of services, short term nature of interventions and lack of sustainability.
- More than half of **security/protection interventions** are for referral to specialized services and 23% for temporary protection services. While residential care/shelter registered the lowest percentage at 17%, majority of the interventions take place in the WB except for referral to specialized services, which is implemented also in Gaza. The gap in temporary protection services and residential care pose a challenge for complete recovery and reintegration of GBV survivors.
- **Child protection and family support prevention interventions** were detected at the highest percentage in comparison to service provision, rehabilitation and reintegration. For instance, awareness raising and risk reduction interventions were detected at 44% descending to 28% for GBV case management and lowest at 10% for rehabilitation and reintegration of survivors. The latter indicates a considerable gap in services needed to enable survivors reach full recovery. In addition, NGOs has the lion's share in these interventions with less shares for government, UN and INGOs. This could be attributed to national scale type of interventions which relevant ministries and UNRWA undertake, yet coverage and reach to most vulnerable groups of women and children remains an issue.
- **Economic enablement** remains among the lowest implemented GBV interventions with equal focus at 26% on income generation and social protection. Interventions are implemented in Gaza more than the WB, by NGOs at 19% and 6% by government and 2% UN/INGOs. Economic empowerment of GBV survivors is vital for reducing risk of re-victimization and supporting complete reintegration.

In Humanitarian service interventions, the highest percentage was for PSS – primary counselling at 89% mainly in Gaza, run by national and international NGOs and UN, while the lowest at 4% for forensic medicine in health care interventions. Government engagement in the interventions was not reported. Please see figure 6.

- Figure 6 -



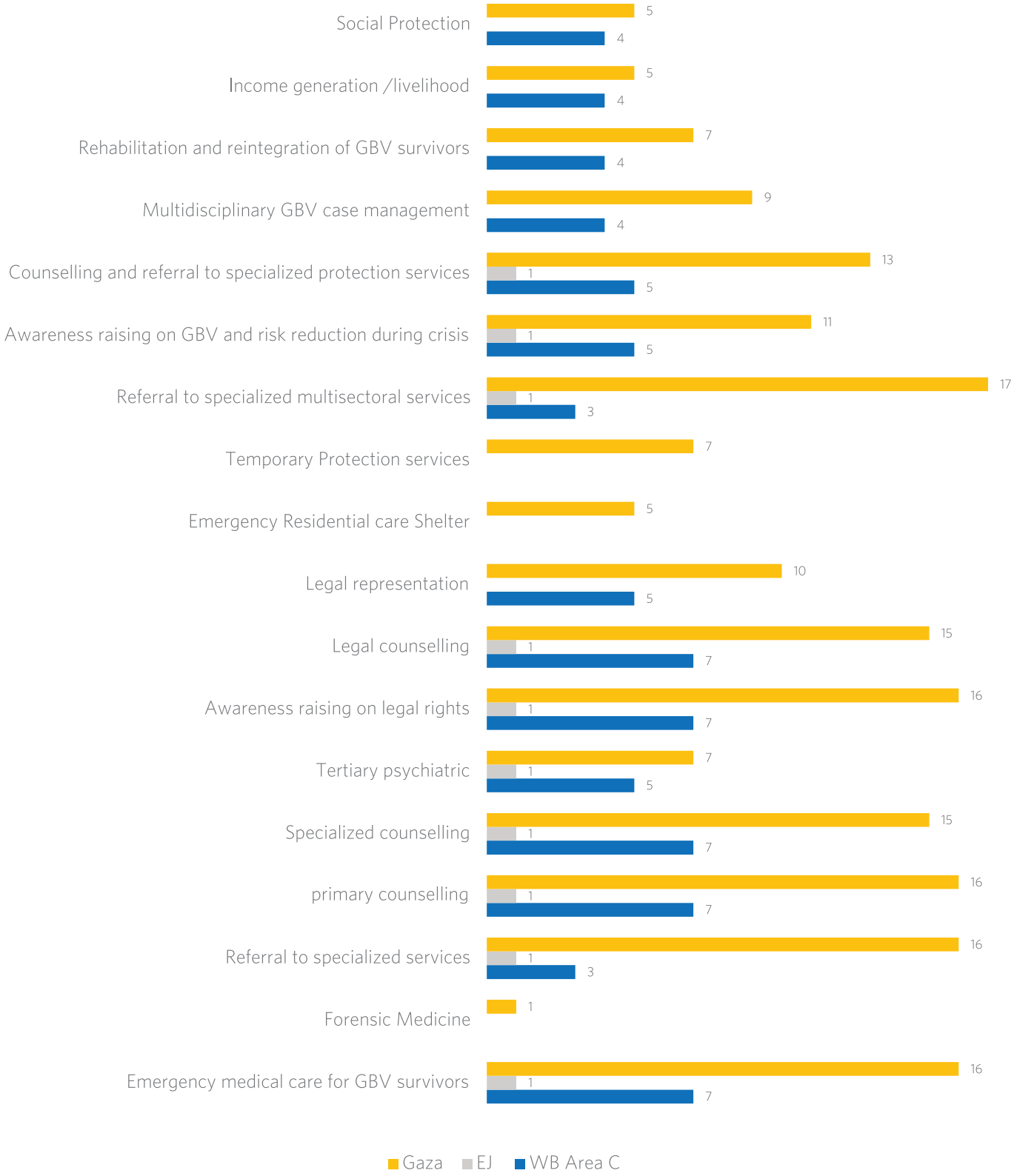
- **Psychosocial primary and specialized counselling interventions**, as in the development context, continued to register the highest percentages at approximately 89% and 82%. They are implemented mainly in Gaza and Area C in the WB including 4% in East Jerusalem. The interventions are the key response services to GBV, however, PSS sustainability and impact on survivors are subject to integration with other service interventions.
- **Majority of health care interventions** are focused principally on emergency medical care then referral to multisectoral specialized services, mainly in Gaza, and run by NGOs and relevant UN organizations.

Only 4% were reported in East Jerusalem. One humanitarian forensic medicine intervention at 4% was reported in Gaza in comparison to 2% in the development interventions. MOH forensic medicine services cover both humanitarian and development for all Palestine. The challenges impacting regular GBV health care persists in humanitarian context. Very limited governmental interventions in regular GBV work were reported but none in humanitarian context.

- **Legal aid interventions** - awareness raising and counselling were among the highest implemented in humanitarian interventions at 86% and 82% respectively, while legal representation was the least provided at 54%. The interventions are undertaken largely by NGOs with support from UN / INGOs, mainly in Gaza and Area C in the WB and only at 4% in East Jerusalem. The trend in legal aid service provision is similar in regular and humanitarian settings except the number of interventions is considerably higher in the latter. Focus on interventions remains on prevention.
- 79% of **security/protection interventions** is for referral to specialized services and 25% for temporary protection services, implemented mainly by NGOs, INGOs and UN. Residential care/shelter registered the lowest percentage at 18%. Majority of the interventions take place in Gaza except for referral to specialized services, which is implemented also in the WB at 7% (11% in Area C and 4% in East Jerusalem). As it is the case in the development context, the gap in temporary protection and residential care services pose a challenge for complete recovery and reintegration of GBV survivors.
- **Child protection family support** - awareness raising risk reduction, counselling and referral to specialised services are equally ranking interventions at 68%, while case management, rehabilitation and reintegration of survivors were much lower at approximately 43%. Majority of interventions are taking place in Gaza mainly by NGOs. Governmental interventions were not reported. Clearly, the gaps in regular GBV interventions continued to impact relevant humanitarian services. Therefore, it is essential to enhance specialised service provision, case management, rehabilitation and reintegration to ensure a full continuum of emergency response services ending with reintegration of GBV survivors.
- **Economic enablement**- income generation and social protection interventions scored lower percentages than majority of humanitarian interventions at 32% and 36% respectively. However, these percentages are higher than those in the development context. They are implemented almost equally in the WB and Gaza, by NGOs at approximately 29% and 4% UN/INGOs. Economic empowerment interventions for GBV survivors is vital for reducing risk of re-victimization and complete reintegration. Please see figure 7 for geographical distribution of humanitarian service interventions.

- Figure 7 -

Geographical distribution of service interventions - humanitarian



Observations:

- GBV referral services in the governmental health care sector are considerably constrained and very limited forensic medicine services is a concern to be addressed.
- PSS interventions are the principle response services to GBV in areas of need, however, concerns were raised by GBV stakeholders regarding quality of services and lack of sustainability.
- It is evident that majority of the legal aid interventions are prevention oriented rather than response and actual representation of GBV survivors.
- The gap in interventions addressing temporary protection services and residential care pose a challenge for complete recovery and reintegration of GBV survivors. Interventions that reinforce community protection mechanisms could be part of the future actions to address this issue.
- GBV case management, rehabilitation and reintegration of survivors are the least addressed in child protection and family support interventions, which indicates a considerable gap in services that enable survivors reach full recovery. Coverage and reach to most vulnerable groups of women and children appears to be an issue.
- Low percentages of income generation and social protection related interventions could reflect lack of cohesion between GBV interventions with support systems. Economic empowerment interventions for GBV survivors is vital for reducing risk of re-victimization and complete reintegration.
- East Jerusalem is least served by GBV interventions.

5 - Process of Early Detection, Response and Referral Pathways

Systems of social services that give due consideration to GBV are capable of detection and protection of at risk groups of women and children. In these systems, the process of early detection and response interventions is usually regulated by GBV standard operating procedures, referral and implementation of multisectoral case management approach in which rehabilitation and reintegration services are provided ultimately to GBV survivors.

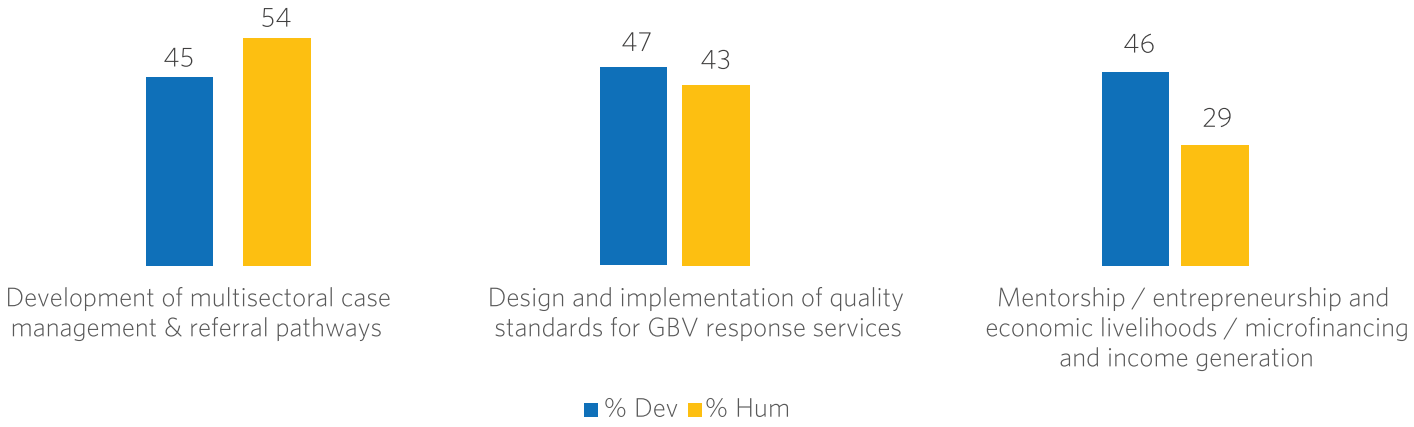
Pertinent to the processes of GBV detection, response and referral pathways, it was evident that 47% of development GBV interventions concentrated on design and implementation of standards for GBV response services. Whereas, 45% concentrated on development of multisectoral case management and referral pathways. Majority of these interventions take place in the WB, whereas interventions addressing mentorship/entrepreneurship take place in Gaza at 46%. The bulk of the interventions is undertaken primarily by NGOs and to a lesser extent by governmental institutions.

In humanitarian interventions, the highest percentage at 54% was reported for development of multisectoral case management and referral pathways and lowest at 29% for mentorship/entrepreneurship and income generation. Whereas, 43% of interventions were for design and implementation of quality standards for GBV response services. Vast majority of interventions are implemented by NGOs, UN and INGOs, mostly in Gaza. Please see figure 8 for both development and humanitarian interventions addressing response and referral pathways.

None of the developmetal or humanitarian interventions for development of referral systems and case management were reported in East Jerusalem.

- Figure 8 -

% of interventions focusing on Process of response and referral pathways



Observations:

- In spite of the fact that approximately half of the development and humanitarian interventions focus on design and implementation of GBV SOP, case management and referral, it is evident that GBV referral sub-systems are incoherent and vary tremendously between regions (WB and Gaza Strip) and across social sectors among GBV service providers.
- Taking into consideration findings in earlier sections, it is noticed that MOSD, UNRWA, MOEHE, PCP and NGOs, all run GBV protection sub-systems that follow different SOPs and provide contrasting services to different target groups, with minimal linkages among them. Additionally, MOH as a major health service provider has basic guidelines for protection from GBV services that yet need to be developed and linked with the above mentioned sub-systems.
- Interventions addressing community GBV protection processes were not visible
- Mentorship / entrepreneurship and income generation is the weakest link in the process as reflected in the service interventions for economic enablement. It needs to be addressed to enhance the opportunity for survivors to lead a decent life.

6 - Accountability

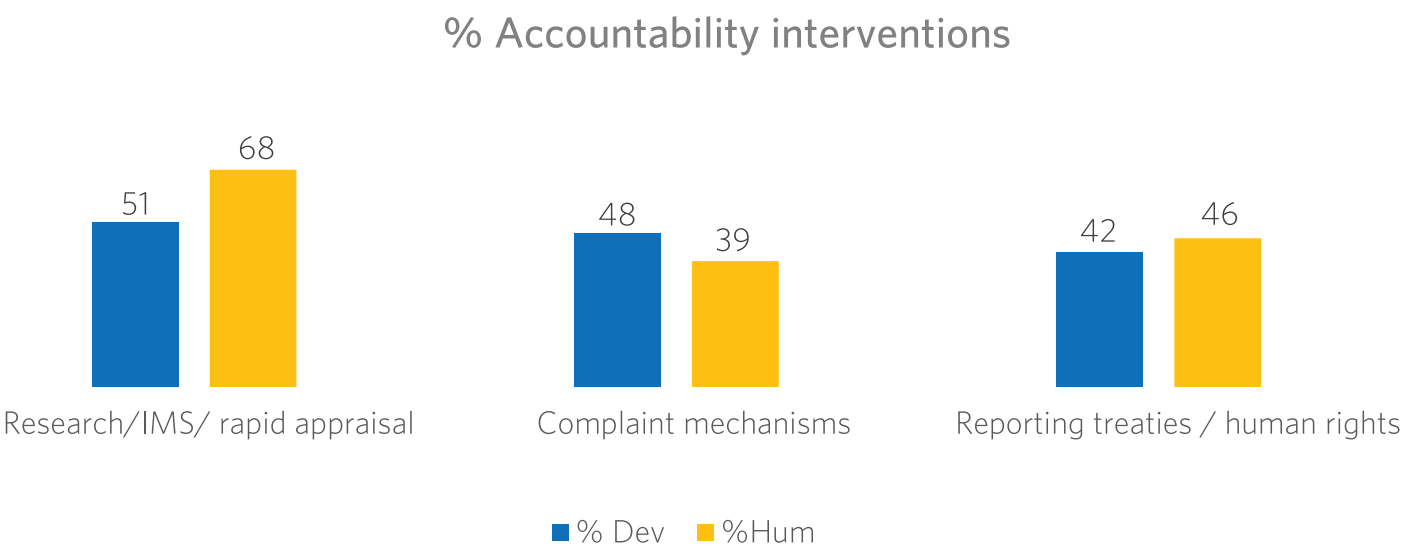
It is crucial for GBV stakeholders to be aware of their roles and responsibilities in GBV protection sub-systems to ensure that women, children and families are protected through a friendly complaints mechanism. In addition, having a GBV Information Management System (IMS) as part of the overall protection from violence, data enables frontline workers and professionals to track GBV survivors' cases and identify trends. This is only possible when GBV sub-systems are interlinked and partners assume their roles in the protection process, and when knowledge generated from research or routine data is used to inform future actions in combating GBV.

Regular accountability interventions included 51% for research and development of information management systems, 48% for complaint mechanisms mainly in Gaza and 42 % for reporting treaties primarily at Palestine level with focus on the WB. Interventions were mainly implemented by NGOs, followed by governmental institutions and UN/INGOs. Percentage of accountability interventions in East Jerusalem was insignificant.

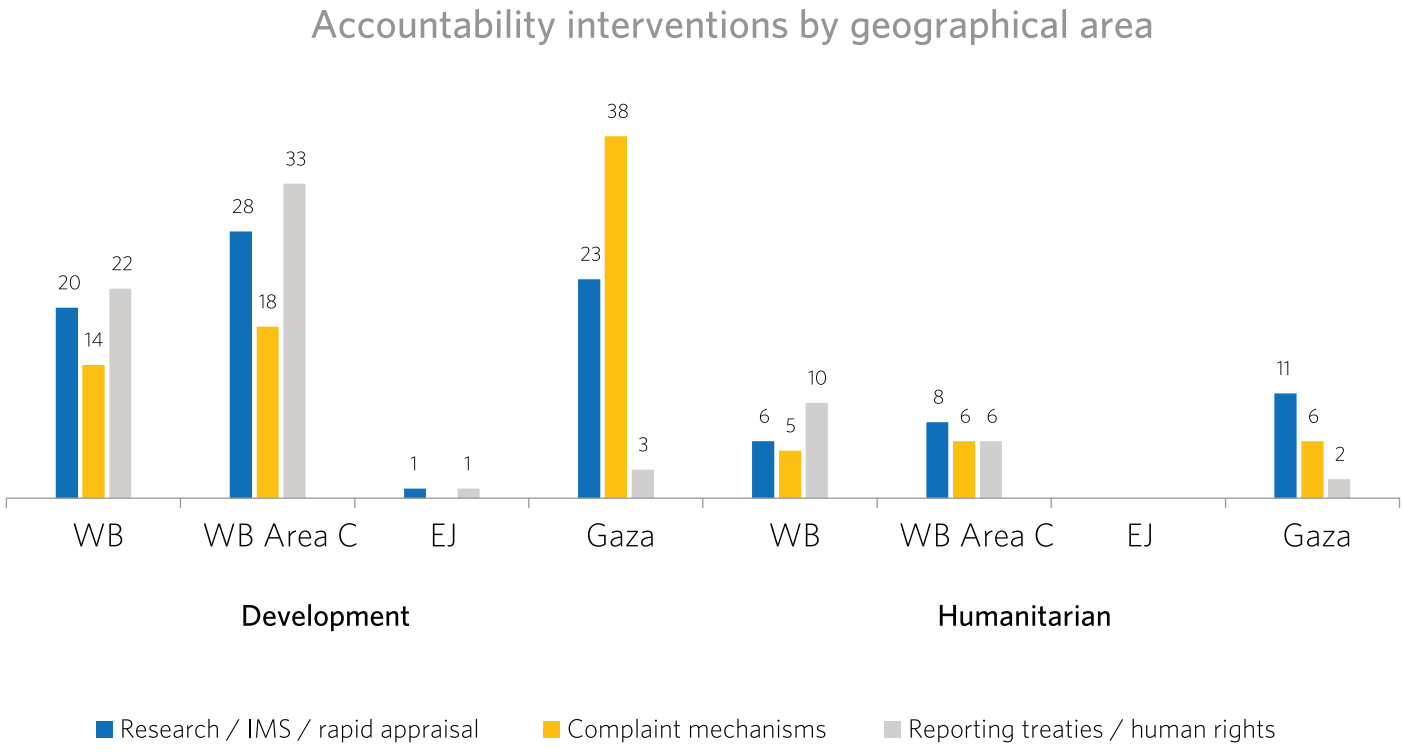
In humanitarian interventions, the highest percentage 68% was for research rapid appraisal and IMS, mainly in Gaza and WB – Area C, while the lowest at 39% for complaint mechanisms. Interventions reporting human

rights violations reached 46%, taking place mainly in the WB. Humanitarian accountability interventions were implemented mostly by NGOs and UN/INGOs. Government involvement in these interventions was not detected. No interventions were reported in East Jerusalem. Please see figures 9 and 10 for visual reflection of the above.

- Figure 9 -



- Figure 10 -



Observations:

- The highest percentage of accountability interventions in development and humanitarian settings is related to research and IMS, however taking into consideration findings of earlier sections, it is most likely that existing IMS reflect the state of fragmentation and incoherence in data collection and tracking trends. Hence, available data is less likely to be comparable at regional or national levels.
- East Jerusalem has the least development accountability interventions and none in humanitarian, which is a continuation of a trend that has been developing throughout the sections of this report for the other components of GBV work. Least targeting of EJ by GBV interventions as a whole is a gap, which needs to be addressed.

CONCLUSIONS - TRENDS

The outcomes of the mapping under this section are derived from:

Development GBV interventions

Considering the findings under the six components above, it is evident that regular GBV interventions scored the highest for training, policy development and legislation, and legal aid awareness raising, while lowest for forensic medicine, tertiary psychiatric services and rehabilitation and reintegration of GBV survivors. The second lowest rate of interventions, which also requires attention of GBV actors include emergency medical care for GBV survivors , residential care /shelter, rehabilitation of infrastructure and financing GBV programmes. (Please see figure 13 at the end of this section).

Majority of the interventions are undertaken in the WB including Area C, mainly in the northern governorates, whereas the least served are Salfit, East Jerusalem, Jericho and Bethlehem. In Gaza, the least served is Beit Lahia in North Gaza followed by Rafah in the south. Most served locations are rural at 73% followed by urban and refugee camps with small difference between them, Nomad areas are the least served at 38%. GBV is the primary objective of 74% of the interventions. Please see figure 11.

Humanitarian GBV interventions

It is apparent that humanitarian GBV interventions show highest percentages for training, PSS primary counselling followed by advocacy, emergency medical care and legal aid awareness raising. Whereas, interventions for forensic medicine scored the lowest, followed by emergency residential care and shelter for GBV survivors and rehabilitation of infrastructure for GBV services. (Please see figure 14 at the end of this section).

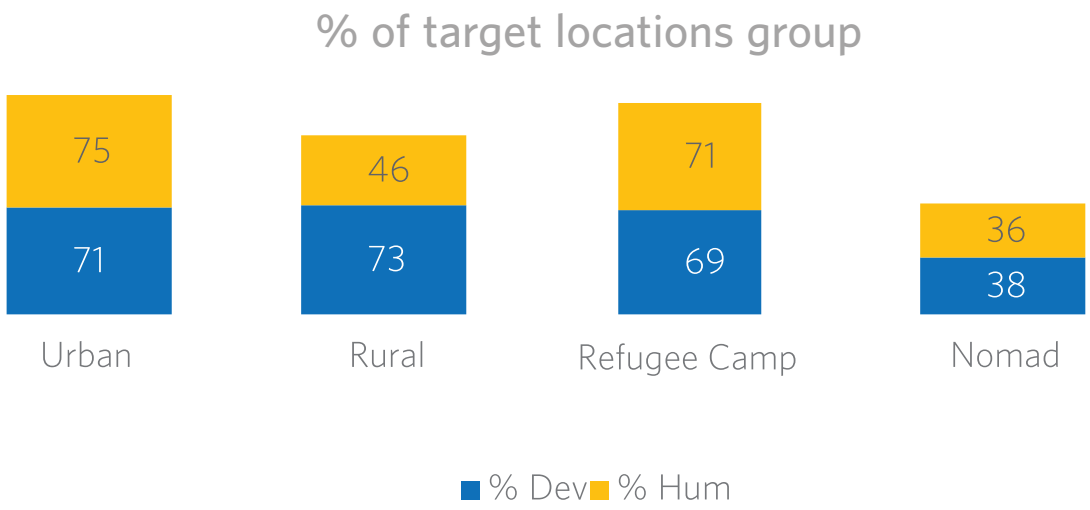
Half of the reported interventions are undertaken in all Gaza and approximately one third in Area C in the WB. Interventions are taking place mainly in Gaza and Rafah governorates, whereas in the WB, the least served by interventions are Ramallah, East Jerusalem, Bethlehem, Hebron and Jericho. This could be attributed either to limited interventions in these locations or underreporting. Most served locations reported are urban at 75% followed by refugee camps at 71%, while 46% of interventions serve rural areas and least at 36% in Nomad areas. GBV is the primary objective of 82% of the interventions. Please see Figure 12 below.

Development and Humanitarian – target age groups

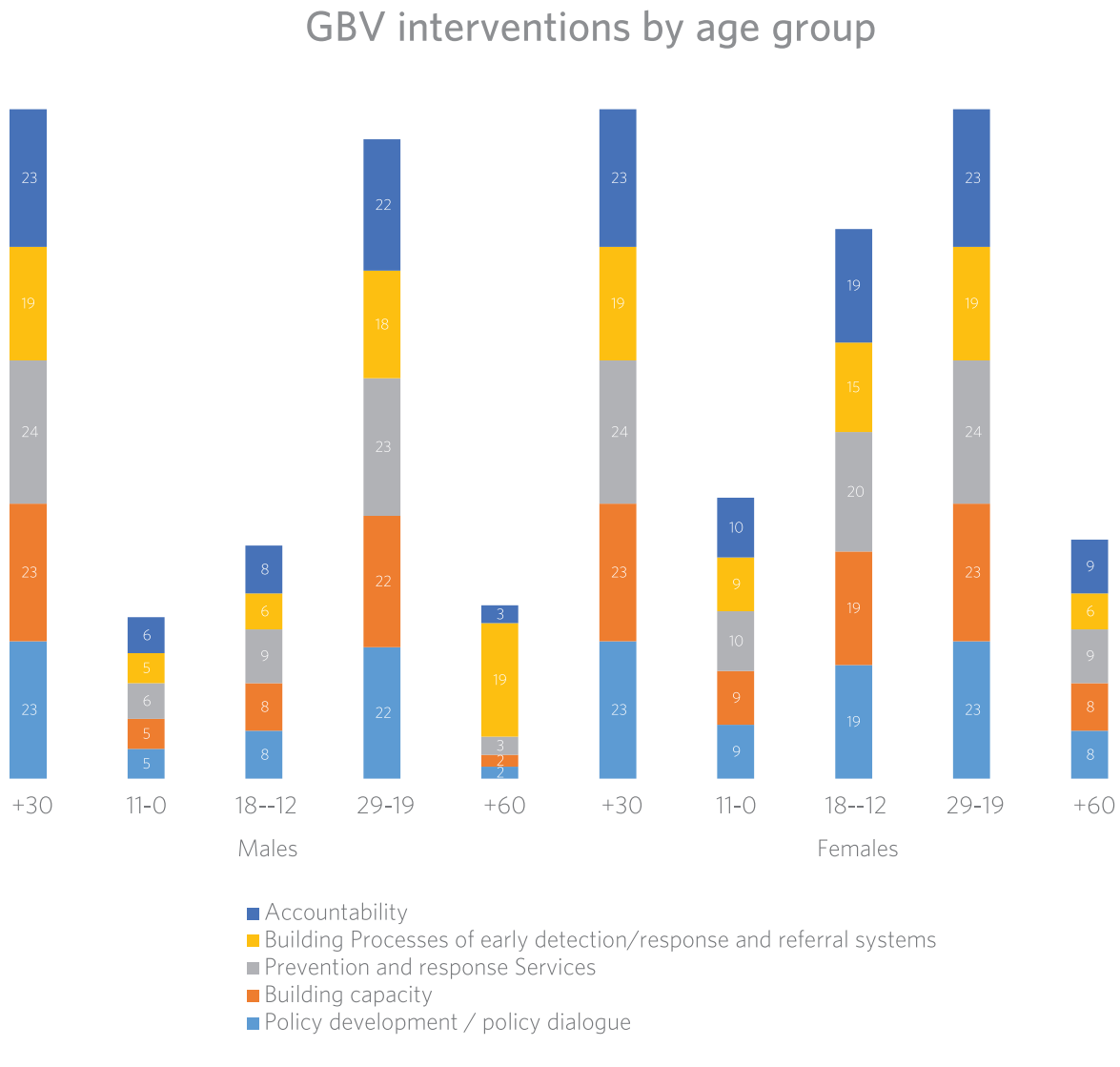
The most targeted age group for GBV interventions, equally for both sexes, is over 30 years of age, followed by age group 19 - 29 years with small differences between males and females. Continuing in a descending manner, GBV interventions target female age groups 12-18 and 0 -11 twice more than males in the same age groups. The least targeted are the elderly age group (60+ years) for both sexes with increased targeting for females. In addition, 71% of humanitarian and 53% of development interventions have persons with disability in their primary target groups. (Please see Figure 12 below)

Potential to Scale up during emergency: Half of the development interventions and 32% of the humanitarian expressed ability to scale up their activities during emergency.

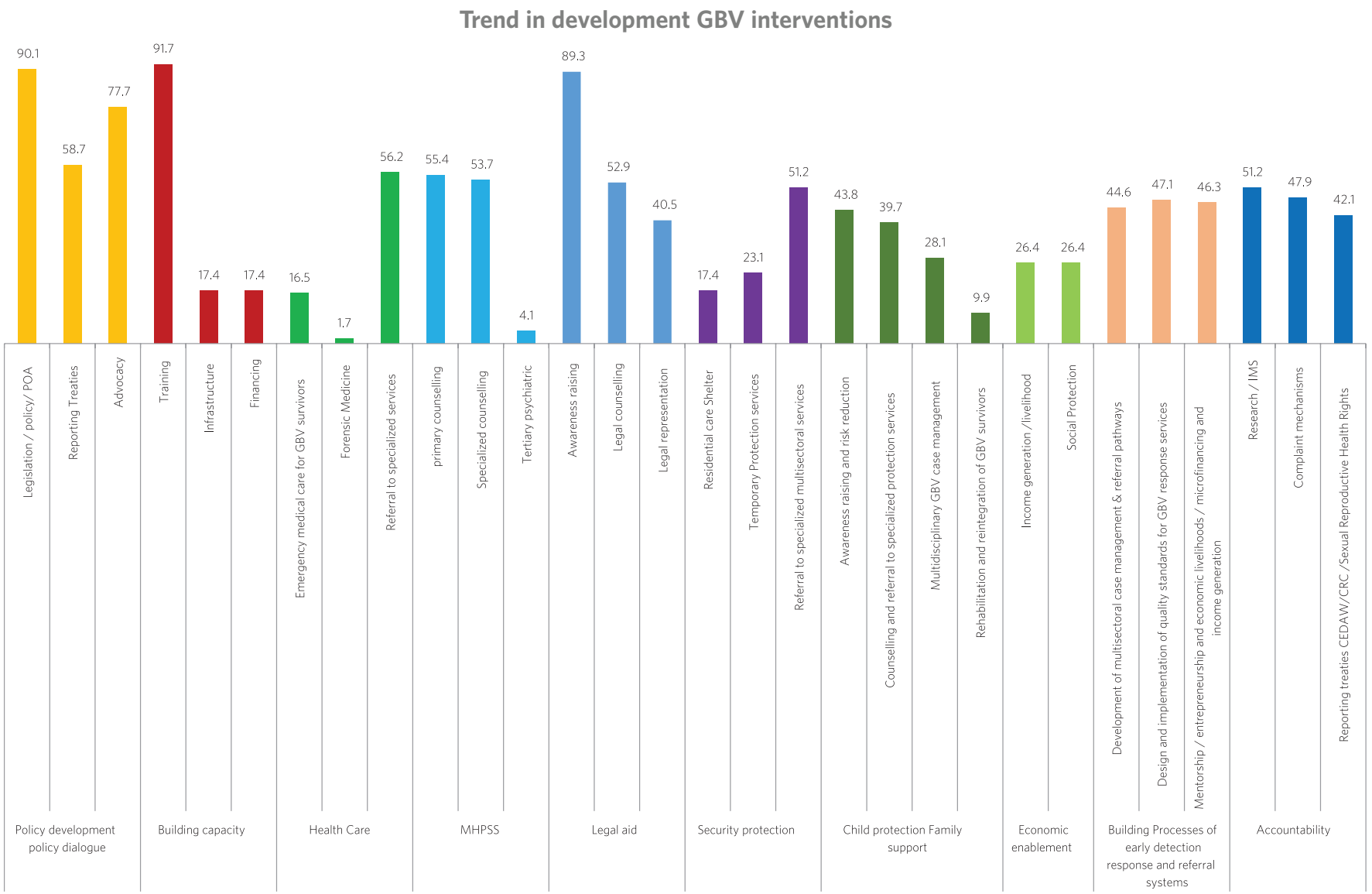
- Figure 11 -



- Figure 12 -

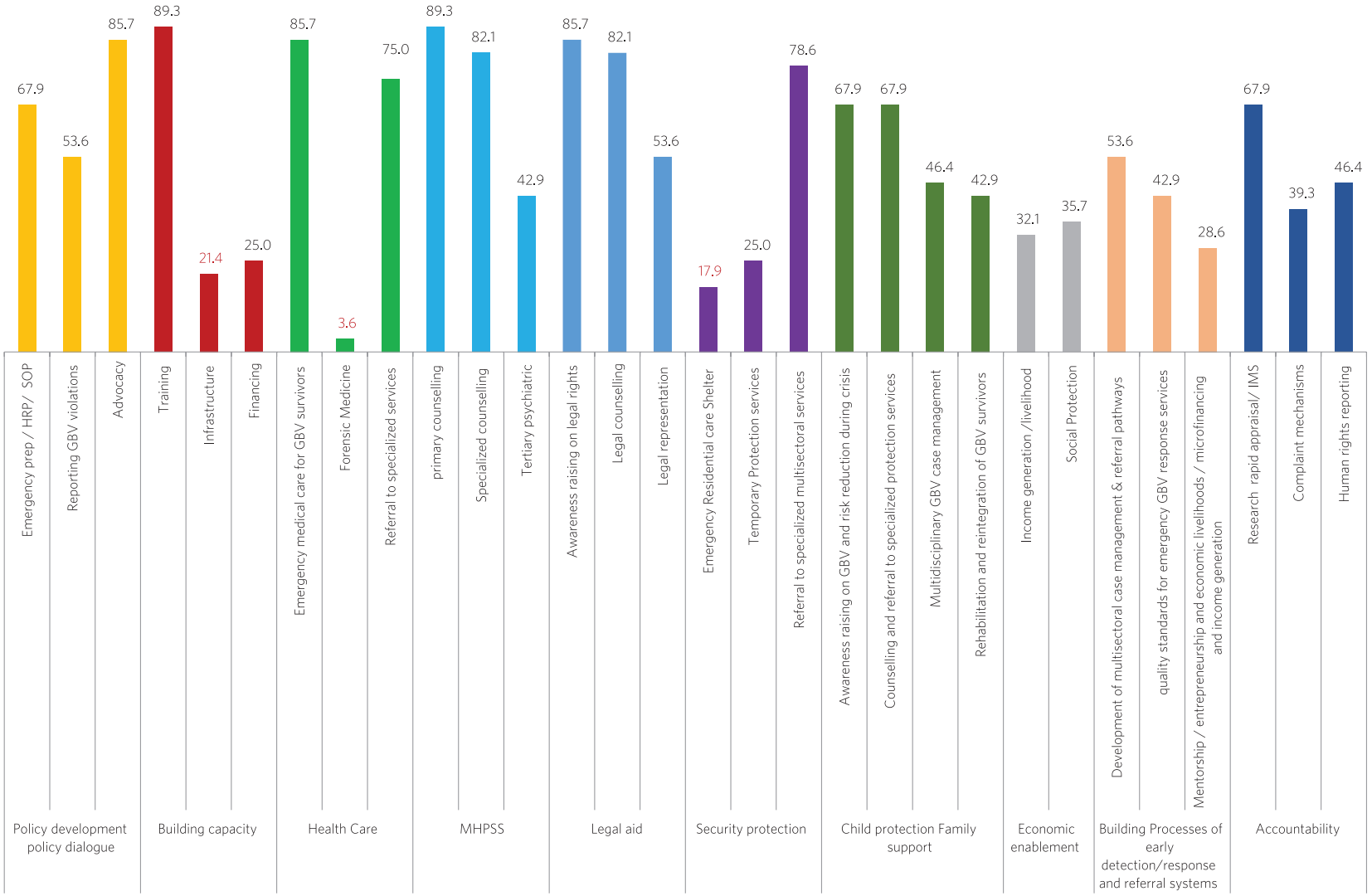


- Figure 13 -


Trend in development GBV interventions
90.1
58.7
77.7
91.7
17.4
17.4
16.5
1.7
56.2
55.4
53.7
4.1
89.3
52.9
40.5
17.4
23.1
51.2
43.8
39.7
28.1
9.9
26.4
26.4
44.6
47.1
46.3
51.2
47.9
42.1
Legislation / policy/ POA
Reporting Treaties
Advocacy
Training
Infrastructure
Financing
Emergency medical care for GBV survivors
Forensic Medicine
Referral to specialized services
primary counselling
Specialized counselling
Tertiary psychiatric
Awareness raising
Legal counselling
Legal representation
Residential care Shelter
Temporary Protection services
Referral to specialized multisectoral services
Awareness raising and risk reduction
Counselling and referral to specialized protection services
Multidisciplinary GBV case management
Rehabilitation and reintegration of GBV survivors
Income generation /livelihood
Social Protection
Development of multisectoral case management & referral pathways
Design and implementation of quality standards for GBV response services
Mentorship / entrepreneurship and economic livelihoods / microfinancing and income generation
Research / IMS
Complaint mechanisms
Reporting treaties CEDAW/CRC /Sexual Reproductive Health Rights
Policy development policy dialogue
Building capacity
Health Care
MHPSS
Legal aid
Security protection
Child protection Family support
Economic enablement
Building Processes of early detection response and referral systems
Accountability

- Figure 14 -

Trend in humanitarian GBV interventions



CONSTRAINTS IMPACTING GBV INTERVENTIONS

Similar to most interventions in Palestine, combating GBV face multiple challenges that impact its design and implementation. Below listed some of these constraints including those collected from respondents:

1 - Context

Social:

- Violence is seen as a normal part of women and girls' daily life, which increases their vulnerability during crisis. Increased incidence of GBV inflicted on women and girls during and post crisis due to heightened distress was noticed
- Stigma feelings towards GBV services in general and Mental Health and Psychosocial Support in particular limited women from seeking specialized services when needed
- Socio-economic hardship in Gaza increased women's need and demand on GBV services against limited services available for them.
- Views of authorities in Gaza and the West Bank about GBV and lack of open discussion on the issue limited GBV streamlining and programming.

Political:

a. **Occupation:**

- The political divide of the occupied Palestinian Territory as per Oslo Accord (Areas A, B and C) and the Israeli annexation of East Jerusalem, has partially and / or totally diminished the PNA jurisdiction in these areas. This situation posed great challenges for PNA to develop a cohesive national system and provide essential GBV services
- The lack of right to movement makes it difficult for GBV survivors to seek services especially in rural areas (Area C).
- The unstable political situation and frequent aggression on Gaza, particularly, the latest 2014 Israeli offensive, has deeply aggravated families and womens' needs to protection from GBV, while it delayed implementation of response activities for months. The protracted emergency in the West Bank has a similar hampering effect on GBV interventions.
- The nine year blockade and restrictions on movement and goods between Gaza and the West Bank limited movement of GBV professionals and frontline workers, which hindered face to face external meetings/training etc. In addition, there were difficulties in supplying spare parts for maintaining the hardware of information systems.
- Frequent electricity cut off (more than 50% of time), frequent shortage and increased prices of fuel for standby generators increased operational and maintenance cost.
- The shortage of fuel in Gaza disrupted public and private transportation, which caused delays in the attendance of participants to training and awareness sessions and other GBV related events.
- The Israeli detention of PLC members had resulted in suspension of the Palestinian Legislative Council, which interrupted the legislative process and forced GBV partners to seek alternative lengthy legislation mechanisms.

b. **Internal Conflict:**

- Internal political division created discrepancy in GBV work between Gaza and the WB; programmes are not aligned.
- Government of National Consensus formulated June 2014, proved to be ineffective in intra-Palestinian reconciliation during the hostilities. Lacking the ability to rule on the ground in Gaza Strip, which is still the case to date, created discrepancy in the rate of implementation of humanitarian interventions
- No contact policy of donors, UN and INGOs with relevant governmental entities in Gaza, restricts implementation and coverage of GBV interventions.

2 - Coordination / Policy development and capacity building

- Very limited role of the government in coordinating and providing humanitarian services and the budget for gender related programmes is not available.
- Inadequate linkages between WB and Gaza GBV coordination mechanisms, which are stronger at the planning level and less evident in implementation
- Weak public policies that prevent GBV and protect women and girls at risk of being harmed including during crisis
- Hampered legislative reform processes, particularly on VAW / GBV related policies and laws. Extensive delays occurred not only due to the sensitivity of the issue but also to the suspension of the PLC.
- Lack of a GBV strategy endorsed by the defacto Government in Gaza
- Limited technical, human and financial capacity of governmental partners in general and for GBV in particular. Inability to systematically respond to increased needs due to chronic crisis.
- Lack of institutional capacity on the side of humanitarian actors (particularly sectors and clusters) in mainstreaming gender in their response.
- Lack of fund amongst Gaza SCOs limited their capacity to provide comprehensive referral services.

3 - Process and range of services

- Lack of national functional referral system and awareness on available GBV services
- Lack of GBV systematic response in Gaza strip
- Administrative procedures of Ministries and lengthy processes between planning and implementation
- Relief services overrides GBV humanitarian interventions in early response phase in Gaza, which delays implementation as planned
- Multiple hostilities in Gaza within a short period of time has accumulated continuous unmet GBV humanitarian needs and exceeded the capacity of any one institution to respond effectively
- A huge gap exists between women's fundamental needs and GBV response services. PSS alone falls short of meeting these needs
- Short term intervention undermines sustainability of GBV service provision especially PSS and legal aid
- Lack of humanitarian GBV intervention in shelters

4 - Accountability

- Lack of reliable systematic and coherent statistics on GBV including information about basic needs of women in need of urgent intervention.
- Limited documentation and evaluation of effectiveness of complex multi-sectoral programmes and coordination functions.

Impact of constraints on GBV interventions:

Impact	Number of interventions		% Dev	% Hum
Delayed	46	7	38	25
suspended	9	2	7	7
Changed direction	25	1	21	4
Downsized	11	1	9	4
Cancelled	9	0	7	0
Other	2	7	2	25

RECOMMENDATIONS

The following are key recommendations for the GBV-WG, MOWA (as the lead Ministry on VAW) and other pertinent ministries, UN and I/NGOs to facilitate and or implement interventions that are 1) informed by a strategic direction towards establishing a cohesive protection from GBV system 2) guided by a clear plan of action and 3) responsive to the rights of the most vulnerable to GBV and accountable:

Strengthened coordination – development outcomes should be able to respond to humanitarian needs

- The GBV Working Group is best positioned to take lead in developing a strategic framework for GBV subsector including for emergency and crisis intervention endorsed by all GBV actors to be reflected in relevant national development plans.
- The GBV Working Group is to facilitate the process of development and implementation of a costed GBV POA that equally reflect development and humanitarian programming with clear role of each partner in implementation. A fundraising/financing strategy should be attached to the POA.

Standardised prevention and response services – case management and referral

- Analysis of existing sub-systems for protection from GBV across social sectors to identify amalgamation elements
- Harmonisation of existing SOPs and referral pathways in one national referral mechanism for women, girls, men and boys building on available good practices (e.g. MOSD led GBV and CP Networks, UNRWA referral pathways) and ensure strengthening and linking informal community mechanisms with that of the formal system.
- Ensuring implementation of GBV related policies and legislation at service provision level (i.e. development of regulatory tools and GBV centred policies) among primary service providers, particularly in the governmental health referrals
- Assessment of the capacity of the health system to identify and respond to violence against women, children and families and support development of health case management and referral sub-system
- Supporting Civil Police and relevant actors to develop forensic medicine services for GBV in the WB and Gaza Strip.
- Providing PSS services as part of a comprehensive package of essential services for GBV impacted women, children and families, during crisis and in regular situation.
- Enhancing child protection and family support case management, rehabilitation and reintegration of GBV survivors to ensure a full continuum of response services. Outsourcing certain GBV service delivery to NGOs and CBOs could be an option for primary ministerial actors.
- Improving support for temporary protection services and residential care to meet needs of women and children impacted by GBV including infrastructure rehabilitation. Support GBV interventions that strengthen community protection mechanisms in combating GBV.

Reinforced capacity – prevention and response processes – accountability

It is recommended for the GBV – WG to start action on the following:

- Development of a capacity building plan for GBV stakeholders in accordance with their roles and needs.
- Primary focus should be on specialised training for implementation of GBV detection, case management and referral system
- Increased support for infrastructure rehabilitation is needed to ensure confidentiality, safety and security of GBV survivors and frontline workers alike.

- Improved support to economic enablement interventions for women (Income generation) is likely to reduce re-victimization of survivors
- Standardization of and integration of GBV data collection tools in existing IMS of protection systems across social sectors.
- Undertaking a GBV services scoping mission in East Jerusalem to inform programming and support design and implementation of GBV interventions.

ANNEXES

ANNEX 1

Gender Based Violence (GBV) exclusively refers to any of the following six core types of GBV created for data collection and statistical analysis of this mapping and any other GBV research: They should be used only in reference to GBV even though some may be applicable to other forms of violence which are not gender-based.

1. Rape: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.
2. Sexual Assault: any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. FGM/C is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. This incident type does not include rape, i.e., where penetration has occurred.
3. Physical Assault: an act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. This incident type does not include Female Genital Mutilation/Cutting.
4. Forced Marriage: the marriage of an individual against her or his will.
5. Denial of Resources, Opportunities or Services: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.
6. Psychological / Emotional Abuse: infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc

ANNEX 2

Mapping interventions preventing and responding to Gender Based Violence (GBV) in Palestine Questionnaire - 2016

The objective of this mapping is to provide a general overview of existing types of GBV projects and protection services that combat GBV in Palestine (including East Jerusalem and Area C). The mapping will address both development and humanitarian aspects[5] and will focus on ongoing projects and programmes implemented by international and national NGOs and governmental stakeholders. The results will provide basis for coordination of existing efforts and avoid duplication, and strengthen collaboration for a multi-sectorial response to GBV. The identification of gaps will allow for improved and strategic interventions in preventing and responding to gender based violence in both regular and humanitarian programming.

When the mapping document is finalized it will be shared with the GBV Working Group members and national partners for verification. Upon endorsement of the report, UNFPA will share widely with all stakeholders.

In order to ensure a uniform understanding among all the participants in the mapping, the following explains the definition and types of Gender-Based Violence.

Gender-Based Violence is defined as an umbrella term for:

"Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private."[6]

This definition includes both adults and children and exclusively refers to six core types of GBV:

- Rape
- Sexual assault including harmful traditional practices
- Physical assault
- Forced marriage
- Denial of Resources, Opportunities or Services
- Psychological / Emotional Abuse

Please see Annex 1 clarifying the GBV forms included under each type for easy reference.

IMPORTANT: How to use the check box and drop down menu to answer the questionnaire:

This is an active box which you can check or uncheck by clicking on it

Choose an item. : This is a drop down menu. Click on it to make it active, then click on the right hand arrow to show the list from which you can select.

Thank you for taking the time to respond to this questionnaire.

If you have any questions or need clarification, please contact one of the Following GBV Mapping team members:

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UNFPA Programme Analyst, Nishan Prasana Krishnapalan, krishnapalan@unfpa.org

Full GBV Mapping Questionnaire - 2016 (Separate PDF Document)

5 Please see definitions of Development and Humanitarian aspect of GBV in Annex 1 attached to the questionnaire
6 According to the IASC Guidelines on Gender-Based Violence in Humanitarian settings (2015), (p.5)

ANNEX 3:

4Ws Matrix for Development GBV Interventions (Separate excel document)

ANNEX 4:

4Ws Matrix for Humanitarian GBV Interventions (Separate excel document)

Delivering a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled.

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