

RESEARCH PAPER

NAVIGATING THROUGH SHATTERED PATHS: NGO SERVICE PROVIDERS AND WOMEN SURVIVORS OF GENDER-BASED VIOLENCE

AN ASSESSMENT OF GBV SERVICES IN GAZA



SEPTEMBER 2017
UN WOMEN

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Gaza, September 2017



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FOREWORD

To have a closer look at the reality of GBV services, UN Women has commissioned the development of this study as an attempt to assess the achievements, continuing obstacles and gaps among the community of service providers in Gaza.

Utilizing a multi-staged methodology encompassing both qualitative and quantitative sources and research tools, the study examines the nature and/or limitations of NGO GBV interventions within the wider social and institutional context of Gaza; how the latter impacts the strategies and effectiveness of NGO providers as well as the possible solutions for GBV victims.

The study also tries to find answers to the gaps and needs of existing services from the point of view of GBV survivors through tracing their specific case histories and attempts to find paths out of abuse. For that, the study looked into the experiences of 14 women at various stages of dealing with domestic abuse. The aim was to first trace their pathways into abusive relationships to better understand the settings and relationships that shaped them, as well as the dynamics and circumstances that often precluded women from exiting them. The ultimate aim was to uncover the paths through which women at-

tempted to find solutions to the abusive situation. And finally, the analysis sought to identify the actual roles formal service providers played in supporting these women in their struggles to find pathways out of abuse.

We hope that this study will inform the work of humanitarian, human rights and development actors and that it presents an opportunity to strengthen the available GBV services; addressing gaps in professional capacity and services quality, accessibility, and sustainability. We also hope that actors will place greater focus on income generation support programming for GBV victims. In line with victims' priorities, it should be addressed as a primary component of GBV treatment and response, rather than remaining secondary to current programming. Similarly, is the need to address victims' housing rights through provision of independent housing where they and their children can live lives free of abuse.

Finally, we would like to thank all the courageous women in Gaza who shared their stories and genuinely expressed their hope for a better future that is violence free. Their voices made this study possible.

UN Women Palestine Country Office

INTRODUCTION

1.

Background to Initiatives to Combatting Violence Against Women and Gender-based Violence in Gaza

After the outbreak of the second intifada¹ in 2000, the international donor community began to put a priority on addressing the problem of violence against women in the West Bank and Gaza. This was in response to a number of factors including:

- a. The outcome of the first national survey in 2005 on violence against women in the West Bank and Gaza Strip by the Palestinian Central Bureau of Statistics (PCBS) showed high levels of domestic violence in Palestinian society.
- b. Local service providers engaged in combatting violence against women had long lobbied the Palestinian Authority and international donors to make its prevention and treatment a priority.
- c. Donors began to respond to their responsibilities in the context of two UN Resolutions (1325 on Women, Peace and Security and 1820, on the prevention of sexual violence in war). These underlined global findings relevant to the situation of Palestinians under Israeli occupation that armed conflict and insecurity increased the vulnerability of women and girls to various forms of gender-based violence (GBV).

In 2010 the PCBS undertook a second survey of violence against women in Palestine. The data showed that in comparison to 2005, levels of domestic violence in the West Bank had declined while in Gaza in the context of five years of unending siege, sanctions, livelihood collapse and a devastating Israeli military offensive, domestic violence levels had increased. These findings confirmed donors' already high commitment to combatting violence against women and GBV in Gaza and worked to establish it as the most

visible programmatic response to the gender-based needs of Gazans under the comprehensive humanitarian crisis they continue to face until now.

Due to international sanctions on the de facto Hamas government authorities in Gaza (called the "no-contact policy"), the international community's support for interventions to combat violence against women and GBV in Gaza have been overwhelmingly focused on local non-governmental organizations (NGOs). This includes both frontline NGO providers and human and women's rights organizations undertaking prevention-focused activities.

Fifteen local NGOs (including two completely focused on GBV services) and 40 community-based organizations (CBO's) undertaking prevention and referral in coordination with NGO providers make up the community of non-governmental GBV service providers in Gaza (See Box 1). These are loosely organized through two platforms; **al Amal** coalition of NGOs and **al Wessal** network of CBO's. The initiative to combat violence against women by the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) was not included in this study (See Box 3).

This report is a first attempt to assess the achievements, continuing obstacles and gaps among the community of NGO providers in Gaza. This overall infrastructure to combat violence against women and GBV has evolved haphazardly and has been based primarily on the initiative and priorities of individual donors compounded by the instabilities created by the ongoing emergency situation in Gaza. As such the architecture of interventions that has developed across the series of local providers

¹ The second Palestinian uprising against the Israeli occupation which began in September 2000.

tends to be fragmented, reflecting both the political and programmatic priorities of a loosely organized international donor community responding ad hoc to local needs in the absence of a master strategy. This outcome has been fed by the split in Palestinian governance between the West Bank and Gaza, as well as by the lack of strategic coordination internally among NGOs in Gaza. Since the creation of the Palestinian National Committee to Combat Violence against Women in 2008, followed by the 2011 adop-

tion of the National Strategy to Combat Violence by the Palestinian Authority's Ministerial Committee, donor initiatives to combat violence against women in the West Bank have had to align themselves with Palestinian national priorities. In contrast in Gaza where under the de facto government the National Strategy has been made inoperable, donor responses to violence against women and GBV appear to be primarily undertaken according to their own perceived priorities.

2. The Gaza Context

The effectiveness of existing GBV interventions, as well as their problems and gaps cannot be addressed without understanding the Gaza context. Living under first direct and then indirect Israeli occupation for five decades, Gazans are also living under a de facto government, lacking international legitimacy and operating under international sanctions. Devastating Israeli policies of siege (in which even a life-saving exit from Gaza is often denied); blockade (in which the minimum of basic goods cannot enter or exit Gaza) are compounded by massive and repeated military offensives that have caused major infrastructural devastation, loss of life and destroyed already compromised livelihoods². Any one of these policies on its own would have major destructive effects on any population. Taken together they have had catastrophic effects on the social, physical and psychological wellbeing of Gazans.

Rather than repeat the well-documented socio-economic effects of this comprehensive and unending destructive environment, the findings of epidemiological surveys on Gazans' sense of their own security and wellbeing might better capture the human costs of these policies. Following the 2009 major Israeli military offensive, 88% of the Gaza population asserted that "suffering" was part of their lives; 85%

expressed fears of threats; 45% had high levels of human insecurity and almost 50% were experiencing high levels of distress³. In 2011, when asked about their emotional wellbeing over a two-week period, more than 90% said they had experienced feelings of being 'broken or destroyed'; 77% said they had experienced various levels of depression; and almost 70% said they had experienced stress related to trauma.⁴ Following that in 2016, 73% of Gazans said they were experiencing some level of depression, 50% stated they had no hope for the future and 5% had contemplated suicide.⁵ In that same survey more than 60% of men had acute levels of fear for their own and their family's safety, as well as their family's future; and more than 40% had acute levels of worry about being able to provide for their family in the present.⁶

In all of these surveys, Israel's actions (be it occupation, siege and/or military offensives) come out as the overwhelming causes cited by Gazans for their suffering, deprivation, distress, absence of mental and physical wellbeing and lack of human security.

Throughout this study, the various effects of Israel's policies and violent actions against the Gaza population repeatedly surfaced across different issues and contexts. In the case of a woman suffering abuse

2 Comprehensive Israeli military assaults on Gaza include those of 2008-09, 2012, and 2014.

3 Ziadneh et. al, 'Sources of Human Insecurity in Post-War Situations: The Case of Gaza', *Journal of Human Security*, 2011, vol. 7, no. 3, p. 29; Abu Rmeileh et al., 'Humanitarian crisis and social suffering in Gaza Strip: an initial analysis of aftermath of latest Israeli war', *The Lancet on-line*, 2010.

4 Barber et.al., 'Mental Suffering in Protracted Political Conflict: Feeling Broken or Destroyed', *PLOS ONE Journal*, May 2016, pp. 8,9.

5 UNWomen/IMAGES, *Masculinity and Gender Equality Survey: Palestine Report* (forthcoming 2017)

6 Ibid.

from a husband, whom she remembered enjoying a happy marriage with until he lost employment in Israel. Or in a comment by the head of Gaza's only shelter for GBV victims who stated that victims' re-integration into Gazan society was critical, otherwise they would end up locked in "a prison within a prison". Israeli policies could also be identified as a major obstacle when NGO providers talked about the gaps and limitations in GBV services. The siege has put major constraints on developing professional human capacity in many areas of GBV service provision. Gaza's needs are now dependent on an

ever-narrowing small pool of professionally trained providers, whose chances of getting further training or the ability to build a new generation of professionals is precluded by ever more elusive Israeli permits. And perhaps most telling was the fact that most GBV providers and survivors interviewed for this research had lived under the impact of Israel's siege for so long their analysis of problems and proposals for solutions often showed they could no longer see beyond the very narrow parameters Israel's policies had imposed on their lives.

3. The Study

The research for this study was undertaken over an eight-month period in 2016 and 2017. Its main aim is to understand the continuing gaps and needs of

GBV prevention and service activities as they have evolved in Gaza among the community of local NGO's who compose its main infrastructure.

3.1. Methodology

The methodology used for this study was multi-staged and used multiple methods encompassing both qualitative and quantitative sources and research tools. The individual sections of the report explain the more specific details of the research tools used for data collection and analysis of the study's various components. They also describe the ethical and safety standards adhered to in the research process.

This section will provide an overall picture of the research strategy, including its overall rationale and how its various components worked together. A main goal in the design of the methodology was to enable ongoing cross-confirmation of findings (sometimes called triangulation) across different types of data and categories of respondents.

STAGE 1: LITERATURE REVIEW AND DESK REVIEW:

These included reviewing the following:

Source	Methodological outcome for design of the Study
Contextual studies relevant to understanding GBV/VAW in Gaza such as on the formal and informal legal system, psycho-social health/ services and emerging social issues	The need to study the nature and/or limitations of NGO GBV interventions within the wider social and institutional context of Gaza; how the latter impact the strategies and effectiveness of NGO providers as well as the possible solutions for GBV victims. The need to include cases of GBV victims who had not used NGO services to understand the nature of access limitations.
GBV/VAW focused studies on Gaza, including prevalence survey data	The need to go beyond prevalence data and understand the relationship between specific demographic and socio-economic characteristics and degrees of vulnerability to different types and levels of violence. To assess whether there is a profile of women in Gaza society more vulnerable to VAW

Mapping exercise data on GBV service providers and donor funding for GBV interventions	Identified the range of NGO service providers that needed to be included in the sample; the main sectors of GBV activities to be covered and identified imbalances in sectoral activities that needed to be assessed.
International literature on best practices in GBV service provision	Provided global criteria against which service provision in Gaza could be compared; the need to identify and understand gaps between global norms and local interventions. The need to assess service provision as an interlinked comprehensive system providing clear paths of support to victims.
Tools used internationally for GBV service provision assessment	The need to include assessments by GBV service providers and service users. The need to build Gaza-specific assessment tools since international ones were designed for GBV One-stop centers with a focus on sexual violence services.

STAGE 2: QUANTITATIVE DATA BUILDING AND ANALYSIS:

The second stage of research focused on quantitative data analysis and gathering using two main data sets: the Palestine Bureau of statistics 2010 Violence Survey and case file records of 3 NGO GBV

service providers. The aim was to develop a base of macro-level information that could be subsequently compared with qualitative data findings.

Source and Description of Data	Purpose	Cross-Cutting Dimensions
In-depth social and demographic analysis of Palestine Bureau of Statistics 2010 Violence Survey data set	<ul style="list-style-type: none"> To develop a statistical profile of women in Gaza who are more vulnerable to various types and degrees of VAW Identify who might be more likely to seek what types of GBV interventions 	<ul style="list-style-type: none"> Together provided a comparison between profile of victims in the wider society and profile of victims using GBV services Case file data provided indications of issues to be followed up in qualitative interviews such as: problems with referrals and tracking cases; imbalances in types of interventions used
Analysis of case files of 150 individual service users at 3 NGO GBV service providers. Individual case data was disaggregated and entered as variables into a pre-designed quantitative template to enable analysis	<ul style="list-style-type: none"> Build a profile of who are the dominant users of NGO GBV services Build a profile of dominant treatment strategies used by providers Assess service providers record keeping and tracking systems of cases 	

STAGE 3: QUALITATIVE DATA STAGE

A. First Round Data Collection: Interviews with NGO Service Providers and women GBV victims/service users

Building on the findings of the first two stages qualitative interviews were undertaken with NGO GBV

service providers and with GBV survivors, including those who had not been beneficiaries of NGO services.

Source and Description	Purpose	Cross-Cutting Dimensions
<p>NGO Service providers</p> <p>In-depth interviews with specialists in 9 NGO GBV service providers, 2 focused re-interviews.</p> <p>Total: 11 interviews</p>	<ul style="list-style-type: none"> To identify the issues and gaps in GBV prevention and treatment services and activities in Gaza from the point of view of NGO providers. To assess strengths and weaknesses in current programming and priorities for developing services. To assess knowledge and use of global norms and practices in current GBV service provision. 	<ul style="list-style-type: none"> Comparison of gaps in chain of services and support identified by NGO providers with those experienced by GBV victims Comparison between assessments of specific services by providers and user/ beneficiaries of services Comparing priorities for specific services between providers and victims Correlating findings on victim profiles with quantitative data Comparison of how providers and victim experiences shed light on wider social and political constraints in addressing GBV in Gaza
<p>GBV Victims/Service users</p> <p>In-depth life history/ case history interviews with individual women victims of VAW</p> <ul style="list-style-type: none"> 9 women who received NGO services 5 women who had not received NGO services <p>Total: 14 interviews</p>	<ul style="list-style-type: none"> To understand women's pathways into and out of abuse To understand obstacles women face in accessing NGO services To assess roles that NGO providers and other formal and informal agents played in providing support and pathways out of abuse To assess the experience and impact of specific NGO service interventions To identify gaps in the inter-linked chain of service needs of victims Women's assessments of the services they had received 	

B. Second Round Data Collection: Focused Interviews with relevant governmental actors/ Focus Groups with expanded range of NGO providers

The final phase of qualitative research aimed to deepen, widen and confirm findings of the previous stages. This was undertaken through focused interviews with relevant government actors and through two focus groups held with an expanded range of NGO providers.

Source and Description	Purpose	Cross-Cutting Dimensions
<p>Governmental Actors</p> <p>Specialist interviews with actors in the governmental sector located in critical roles needed to address needs of GBV victims</p> <p>A total of 4 focused interviews were held: two with the police/ justice sector; one in the health sector and one in protection/shelter</p> <p>Total: 4 interviews</p>	<ul style="list-style-type: none"> To understand current policies and provisions in governmental services for GBV victims in Gaza To understand how government policies, procedures and services for GBV victims interact or relate to those provided by the NGO sector To identify sources of support and obstacles to support from within the government sector towards current NGO GBV services and GBV victims 	<ul style="list-style-type: none"> Correlated issues and gaps between chains of service provision as identified by both NGO providers and GBV victims Correlated issues of weak capacity/ poor government services as identified by NGO providers and GBV victims Confirmed some positive assessments by NGO providers and GBV victims of specific actors within the governmental sector

<p>NGO Service Providers</p> <ul style="list-style-type: none"> • Two focus groups interview sessions • Total of 10 individual participants representing 10 NGO GBV service providers <p>Total: 10 interviewees</p>	<ul style="list-style-type: none"> • To share the preliminary findings on service assessment, obstacles, gaps, victim profiles, priorities for services with service providers across GBV sectors and institutions in order to confirm, contradict or deepen all aspects of the research 	<p>The two final focus group sessions were completely devoted to confirming or contradicting the whole range of research findings.</p>
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3.2. The Chapters

Chapter I: Analyses the existing statistical base on the prevalence of violence against women and GBV in Gaza with an emphasis on understanding its causes, patterns as well as demographic and socio-economic profiles of victims.

Chapter II: Attempts to understand who are the users of GBV services in Gaza, through analysing case file records of main NGO providers. This also enabled a simultaneous review of service providers' tracking and record keeping systems which displayed the similarities and differences between the profiles of victims in the larger society and the more specific profiles of service users.

Chapter III: Focuses on NGO service providers own analysis and assessments of the positives and negatives of current GBV prevention activities and treat-

ment services. What are the gaps and needs they identify as crucial to developing more effective responses to GBV in Gaza?

Chapter IV: Attempts to identify the actors and causes for gaps and limitations in current GBV programming in Gaza as first step in finding strategies to respond to them.

Chapter V: Addresses the gaps and needs of existing services from the point of view of GBV survivors through tracing their specific case histories and attempts to find paths out of abuse.

Chapter VI: Provides the individual case histories of the women survivors whose experiences with GBV services were analysed in the previous chapter.

The final part of the report offers conclusions and recommendations

3.3. Terminology and Gender Focus

VAW or GBV? Women or Gender?

This report primarily employs the term "gender-based violence" (GBV) but like many international agency publications often uses it interchangeably with "violence against women" (VAW). The meaning and use of these two concepts continues to be debated among international institutions that still have not agreed on a unified terminology. However, there is agreement that violence against women (VAW) is the most common form that gender-based violence (GBV) takes; in any context it is men and masculine norms that overwhelmingly perpetrate violence against women.

However the two terms also differ in the emphases they put on the causes and meanings of violence. Violence against women was originally defined by the UN 1993 Declaration on the Elimination of Violence Against Women (DEVAW) as:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychologi-

cal harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.

The definition of VAW goes on to describe forms of violence that can be perpetrated against women by the family, community or state.

The definition of gender based violence, evolved from DEVAW's use of the term in defining violence against women. However, GBV has become an umbrella term for any harm that is perpetrated against a person's will that results from power inequalities based in gender roles. It also emphasizes that GBV is violence used to assert and enforce unequal gender roles and norms. While both terms assert the relationship between violence and unequal gender roles and norms, the GBV definition tends to emphasize the role of gender power relations in both explanations and programmatic recommendations to end violence. In doing so, GBV theoretically widens the scope of what can be considered violence thus widening the possible range of interventions to treat it.

In Gaza (as elsewhere) the overwhelming majority of GBV victims, as well as users of GBV services are women. Most NGO service providers or those undertaking prevention activities integrate the possibility that men and boys may be victims in their programming. They also consciously operate under the broader definition of GBV rather than VAW. NGO providers do target men and boys in awareness sessions, but annually receive very few cases of male victims of violence seeking their treatment services. As such this study focuses on women victims of GBV and the services they receive from NGO providers. In addition, it focuses primarily on the experiences of currently or previously married women victims – who also make up the majority of GBV service users. Social surveys have shown that unmarried women and girls also suffer from high levels of violence in Gaza and Palestine more generally. However, the circumstances, nature of violence and treatment

interventions specific to the needs of unmarried women and girls differ from those of ever-married women. Thus integrating the specific range of GBV issues associated with this female demographic was beyond the time and space limits of this research but urgently warrants its own dedicated study.

Finally, this report also uses the terms “victims” and “survivors” interchangeably. The Feminist anti-violence movement prefers to use the term “survivor” for women who are or have suffered from violence as a way to emphasize women’s courage and will to survive and recover from abuse. Social science language, in line with criminology uses the word, “victim” to emphasize that women who experience violence have experienced a criminal act to their dignity and wellbeing. In general, the report reflects these by using “victim” when dealing with women in the abstract and “survivor” when dealing with the concrete experience of specific women.

BOX 1. NONGOVERNMENTAL GBV PREVENTION AND SERVICE PROVIDERS IN GAZA

Nongovernmental GBV Prevention and Service Providers			
	Fully specialized on GBV	Member of al Amal Coalition	Location
1. Culture and Free Thought Association		Yes	Khan Yunis
2. Women’s Affairs Technical Committee		Yes	Gaza City
3. Aisheh Association for Women and Child Protection	Yes	Yes	Gaza City
4. Center for Women’s Legal Research and Consulting	Yes	Yes	Gaza City
5. Palestinian Center for Human Rights		Yes	Gaza City
6. Creative Women’s Association		Yes	Gaza City
7. Palestinian Center for Democracy and Conflict Resolution		Yes	Gaza City
8. Wefaq Association for Women and Child Welfare		Yes	Rafah
9. Women’s Affairs Center		Yes	Gaza City
10. Jabaliya Women’s Health Center		Yes	Jabaliya
11. Union of Health Work Committees		Yes	Gaza City
12. At’aa Association		Yes	Beit Hanun
13. Bureij Women’s Health Center		No	Bureij

14. Gaza Community Mental Health Program		No	Gaza City
15. Center for Community Media		No	Gaza City
Other Nongovernmental Actors involved in GBV Prevention and Service Provision			
Community Based Organizations	40 CBO's organized in Wessal Coalition. In coordination with NGO providers undertake advocacy/ awareness, detection and referral		
UNRWA One Stop Referral system	21 one stop referral centers in UNRWA Health clinics plus awareness and advocacy		

BOX 2. GOVERNMENTAL SERVICE PROVIDERS

Governmental Service Providers in Gaza	
Government Ministries	<p>Ministry of Social Affairs runs the only shelter for GBV victims which provides social welfare support to victims</p> <p>Ministry of health provides forensic exams of GBV victims in 3 government hospitals (only Shifa does specialized in sexual violence cases)</p> <p>Ministries of Interior and Justice responds to GBV cases through police and courts</p>
'Beit al Aman'	The only comprehensive Shelter for GBV victims in Gaza run by Ministry of Social Affairs ⁷
Informal Justice Providers	Reconciliation Committees, Male and Female Mukhtars

⁷ Although The Center for Women's Legal Research and Consulting provides a 'day shelter' for victims, they do not provide round-the clock ongoing shelter of victims.

CHAPTER I.

DETERMINANTS OF WOMEN'S GREATER VULNERABILITY TO FORMS OF DOMESTIC ABUSE IN GAZA: WHAT DO THE STATISTICS SAY?

1.

2005 versus 2010 PCBS Surveys: Evidence of the Effects of Military Violence and Comprehensive Blockade on Intimate Partner Violence⁸ in Gaza

The prevalence findings of the two Palestinian Central Bureau of Statistics (PCBS) Violence Surveys are the evidence base for much of the concern and investment in services and interventions around violence against women and GBV in Gaza. The second survey in 2010 found that 76.4% of married women in Gaza had experienced any incident of psycholog-

ical violence, 34.8% had experienced any incident of physical violence and 14.9% had any experience of sexual violence. Importantly these represented an increase in the high levels of domestic violence in Gaza found in the previous 2005 survey, while over the same period levels of domestic violence had actually decreased in the West Bank.

TABLE 1

Year	Types of Domestic Violence					
	Physical		Psychological		Sexual	
	Gaza	West Bank	Gaza	West Bank	Gaza	West Bank
2005	31.7%	35.1%	53.4%	73.5%	13.1%	16.8%
2010	34.8%	17.4%	76.4%	48.8%	14.9%	10.2%

Source: PCBS Violence Survey 2006, 2011

Between 2005 and 2010, married women in Gaza reported a 3% rise in physical violence, a 23% rise in psychological violence and 2% rise in sexual violence. In comparison, over the same period in the West Bank married women reported that levels of physical violence dropped almost by half; levels of psychological violence dropped by almost a quarter and levels of sexual violence dropped by more than one third. In sum, by 2010 there was a total reversal of the situation in 2005, with Gazan women suffering higher levels of all types of domestic violence compared to their West Bank counterparts.

These overall trends are clearly related to the drastically different socio-economic and security environment that West Bankers versus Gazans experienced between these two periods. While Israel had a unilateral withdrawal from Gaza in 2005, Gaza contin-

ued to be under the weight of Israel's constant military re-invasions and aerial bombardment. Added to this was the 18-month period of internecine political violence following the contested elections of 2006; the imposition of a comprehensive blockade in 2007; and a 23-day long devastating Israeli military invasion ("Operation Cast lead") in late 2008 and early 2009. By 2008 Gaza had the highest unemployment levels in the world (at 40%) and 52% of households had been plunged into poverty⁹.

In contrast, over the same period the situation in the West Bank was relatively more stable and secure than it had been five years earlier. By 2010 there was a relative but significant drop in checkpoints¹⁰; unemployment was down to 15% (from 27% in 2005); and the Palestinian Authority was experiencing an extremely high level of international legitimacy and

8 Both the 2005 and 2010 PCBS Violence Surveys measured experiences of violence within the home, workplace and public sphere as well as from a variety of perpetrators. However, both surveys found that the vast majority of incidents of violence reported by women took place in the home and that among married women, spouses were the overwhelming perpetrators. This is why the analysis here focuses on PCBS's findings on married women's experiences of IPV. Importantly, as shall be seen in subsequent chapters of this report physical, mental or sexual IPV almost always occurs in conjunction with a range of other abuses to women's rights and dignity.

9 See UN Women, Who Answers to Gazan Women? An economic security and rights research, 2011.

10 See OCHA Special Focus June 2010. Movement and Access Restrictions in the West Bank

material support under the Fayyad Government. As an International Crisis Group report noted in 2010, “the Palestinian Authority (PA) largely has restored order and a sense of personal safety in the West Bank, something unthinkable during the second intifada.”¹¹

Clearly, there is an impact of the overall human security and economic environment with levels domestic violence, but claims about a direct link be-

tween rising levels of domestic violence in contexts of occupation, conflict and heightened insecurity need to be made very carefully. This is because the global standard survey frameworks for measuring domestic violence (or violence against women more generally) cannot capture direct links between an overall crisis environment and individual experiences of domestic violence – and indeed is not designed to do so.

1.1. Issues and Constraints of the PCBS 2010 Violence Survey Methodology

When measuring the three main types of domestic violence (psychological, physical, sexual), the PCBS used the global standard for measuring violence against women in the developing world.¹² It uses a specific framework for measuring levels of domestic violence called the Conflict-Tactics Scale II (CTSII). It is important to understand what exactly that framework measures in order to understand what the data outcomes on domestic violence in Gaza might actually represent.

The CTSII does not use the terms “violence or abuse” when asking married women about their experiences of domestic violence. In accordance with what is suggested by the WHO, it uses neutral language and asks women about experiences of dealing with arguments and conflicts with spouses over the past year as well as in previous years. As such women may think they are simply being asked about routine arguments rather than abuse. The framework then provides women with a list of potential acts that spouses may have used with her over the past year. The acts include verbal ones (e.g. shouting and cursing); physical ones (e.g. beating and pushing) and sexual ones (e.g. refusing to use contraception). If a woman says she experienced even one act, she will be counted as a victim of either psychological, physical or sexual violence.

There have been many critiques of the CTS (including of the CTSII) by clinicians who work with victims of intimate partner violence (IPV), as well as by sociologists of the family specialized in IPV.¹³ One is that it does not include respondents’ subjective understandings of the incident (whether they saw it as an instance of abuse or simply an argument). But clinicians working with abused women have been most critical of the fact that the framework conflates single situational acts with repetitive acts of violence that are indicators of patterned behaviour by perpetrators whose aim is to control their partners and destroy their sense of self. Only the latter do they consider a situation of abuse. Instead, the data outcomes of these measures result in collapsing one or two acts of a husband pushing his wife in momentary anger, with cases in which a husband has systematically and continuously perpetrated many acts of violence against her, including more severe acts.

Academic specialists on IPV/domestic violence argue that in doing this the CTSII conflates two very different types of inter-personal violence: expressive or “situational couple violence” that is a product of specific circumstances and instrumental violence that is patterned, goal-oriented, abusive behaviour

11 International Crisis Group. ‘Squaring the Circle: Palestinian Security Reform Under Occupation’ September 2010.

12 As prescribed by the WHO and used by the Demographic and Health Surveys (DHS) that are the basis of the United Nation’s tracking system on health and demography globally. See: Putting Women First; Ethical and Safety Recommendations for Research on domestic violence against women. Geneva. World Health Organization. 2002. <http://www.who.int/gender/violence/womenfirstseng.pdf>

13 For these debates see: Russell P. Dobash and R. Emerson Dobash, ‘Women’s Violence to Men in Intimate Relationships: Working on a Puzzle’, *British Journal of Criminology* 44, no. 3, 2004, pp. 324-49; Michael P. Johnson, ‘Patriarchal Terrorism and Common Couple Violence: Two Forms of Violence Against Women’, *Journal of Marriage and the Family* 57, no. 2, 1995, pp. 283-94; P. Johnson, Michael & M. Leone, Janel, ‘The Differential Effects of Intimate Terrorism and Situational Couple Violence: Findings From the National Violence Against Women Survey’, *Journal of Family Issues - J FAM ISS.* 26. 2005, pp. 322-349; Kimmel, Michael S., ‘Gender Symmetry in Domestic Violence’, *Violence Against Women*, Vol 8, Issue 11, June 2016, pp. 1332 – 1363; Walby and Myhill, ‘New Survey Methodologies in Researching Violence Against Women’, *British Journal of Criminology*, Vol 41 No 3, pp. 502-22.

that has been called “coercive control”. They argue situational couple violence is momentary spousal conflict that is qualitatively different than ‘coercive control’. The latter, a violent power relationship of domination and abuse that profoundly injures the victim’s sense of self, produces deep emotional scars and can result in grave bodily harm is what they consider abuse.

The relevance of these critiques to the Gaza context, is that there is a high probability that much of the domestic violence captured by the PCBS 2005 and 2010 surveys is situational couple violence – i.e. the outcome of specific periods and moments of stress due to impacts of the ongoing blockade, economic collapse and military destruction. Because of the extremely harsh situation that couples face over a prolonged period of time, it is likely that coping strategies break down and acts of physical and verbal violence ensue. However, these should not be conflated with cases that most of the front-line service providers in Gaza deal with in which women are suffering from more instrumental and system-

atic forms of abuse that have deep and long-term effects on the women’s psychological and physical wellbeing.

Based on these insights, the following analysis of the PCBS 2010 data on domestic violence will systematically differentiate between married women who have experienced 1 or 2 instances of violence the previous year with those who have experienced 3 or more instances (in this study called repetitive incidents of violence). The empirical line between what might be situational couple violence versus systematic abuse (or coercive control) is hard to draw in survey data. However, conflating one or two instances of less severe acts with multiple and more severe acts does a disservice in attempting to uncover and understand the needs and circumstances of women in critical situations of abuse.

The statistical analysis of the PCBS 2010 Violence Survey data set in this chapter will only focus on the experience of currently or previously married women.¹⁴

Married Women: What Factors Make Them More Vulnerable to Physical Domestic Violence?

In 2010, 35% of married women in Gaza had experienced at least one instance of physical violence the previous year, but almost half of these (16% of married women) experienced it repetitively and one third of them had experienced a more severe form of it.

Approximately 35% of married women had experienced any incident of physical violence from spouses in the year preceding the 2010 survey. In two-thirds of these cases (or 23% of all married women) they experienced less severe acts of physical violence with the main acts of physical abuse experienced being:

- a slap in the face (19%)
- being pushed strongly (18%)
- hair-pulling/arm twisting (16%)
- throwing an object at them that could have hurt them (14%).

Of one-third of married women who experienced any physical violence (or 12% of all married women), more severe acts included:

- attempt to strangle (3.6%)
- attacking with a knife (2.3%)
- beating resulting in a coma (2.3%)

In terms of the repetitive nature of physical abuse, for half the women who experienced any act of violence from their spouse over the previous year (or 16.4% of married women in Gaza) it was one or two incidents only; while for the other half (again 16.4% of married women in Gaza) it was experienced repeatedly (3 or more times).

14. This is due to space constraints and because issues and programming covered in this report are more immediately relevant to “ever married” women. Single women’s particular experiences of GBV and programmatic needs warrant their own future specialized study.

Household poverty dramatically raises women's vulnerability to repeated physical violence

Harsh economic circumstances of the household clearly have an impact on married women's vulnerability to physical violence. Married women in well-off households may have experienced slightly more instances of physical violence (18%) than women in less-well off households (16%). But the stronger correlation is that women in the poorest households

were more vulnerable to repetitive experiences of physical violence; they were three times more likely to experience repetitive physical violence than well-off women (29% versus 9%) and twice as likely to experience repetitive physical violence than married women whose households' economic situation was average (29% versus 14%).

Number of Experiences Physical Violence in the Previous Year	Economic Situation of Household			
	Very Good/Good	Average	Poor/ Very Poor	All Women
None	72.1%	70.7%	54.4%	67.5%
1-2 times	18.3%	15.0%	16.8%	16.4%
3 or more times	9.6%	14.3%	28.7%	16.1%
Total	100.0%	100.0%	100.0%	100.0%

Source: PCBS Violence Survey Data 2010

This pattern is confirmed by another measures of poverty in the 2010 PCBS survey; 23% of women who said their household income in the previous year was much lower than their needs experienced more than three instances of physical violence compared to 14% who said their income was lower than their needs and 12% who said it was somewhat lower than their needs.

The link between poverty and women's heightened

vulnerability to repetitive domestic violence is supported by findings from the qualitative research in this report. Poverty in itself creates stressors, but the use of violence is not inevitable as can be seen by the fact that in more than 50% of poor households' wives did not report any physical violence. Instead, one needs to look towards how various coping mechanisms for dealing with poverty might produce greater domestic violence or not.

Married women in larger households of 8-10 members are more vulnerable to repeated physical violence than even larger or smaller households

Larger numbers of family members living in one household is usually an indicator of poverty but it also correlates with women's greater vulnerability

to spousal violence. Forty per cent of Gazans live in households comprised of eight or more family members.

Number of experiences of physical violence in the previous year	Number of Family members in the household			
	1-4	5-7	8-10	11+
None	67.3%	65.7%	62.5%	65.0%
1-2 times	21.0%	18.6%	14.6%	17.6%
More than 3 times	11.7%	15.6%	23.0%	17.3%
Total	100.0%	100.0%	100.0%	100.0%

Source: PCBS 2010 Violence Survey Data

The data in the above table shows that 20% of married women living in households with eight people or more – experienced systematic physical violence (more than 3 times) compared to only 14% of them living in households with less than 8 members.

This finding not only relates to poverty, but to the

impact of household crowding and its related stressors for increasing vulnerability to violence. Further research needs to be made on why women in households of 8 to 10 members are more likely to experience repetitive physical violence than those in even larger (11+ member) households.

Due to how the question was framed, it is not possible to draw a direct correlation between wife's vulnerability to physical violence and husband's unemployment or underemployment

The survey only asked whether husbands had a variety of problems at work in the year previous to the survey. Given the entrenched structural unemployment and underemployment faced by male breadwinners that had persisted for nearly a decade in 2010 – the one-year time frame of the question could not capture the reality of male unemployment

in Gaza. As such, there is little correlation with experiences of physical violence by the minority of women who said their husbands experienced 'problems at work' in 2009. The high correlation between physical IPV and poverty is a more relevant indicator of the nature of male unemployment in Gaza and wives' greater vulnerability to abuse.

Loss of a close family member does correlate with women's greater vulnerability to physical violence, raising the probability of repeated acts of abuse by 10%

Type of Violence	Number of Experiences of Violence in the Previous Year	A close family member of wife or husband died previous year		
		Yes	No	Total (All Women)
Physical	None	59.0%	68.8%	65.1%
	1-2	18.4%	17.8%	18.0%
	3+	22.6%	13.4%	16.9%

Source: PCBS Violence Survey Data 2010

In households who had lost a close family member over the previous year 10% more married women experienced repetitive physical violence compared to those who did not. Rather than grief being a mo-

tivator of violence, the more likely explanation is the growth of family conflicts around inheritance or child custody when a male family member dies or is killed.

Regionally women in Gaza and Deir al Balah governorates had a higher vulnerability to repeated physical violence while women in Rafah had the lowest vulnerability to any, including repeated acts

By region, married women living in Gaza City and its environs had the greatest vulnerability to physical violence at home with 45% having experienced any

incident over the previous year, followed by women in Northern Gaza (at 37%) and women in the middle region (at 35%).

Number Of Experiences Physical Violence in the Previous Year	Governorate				Rafah
	Gaza North	Gaza City	Deir al Balah/	Khan Yunis	
None	63.0	55.4	65.4	73.7	84.0
1-2 times	19.5	25.2	15.2	11.8	6.7
3 or more times	17.5	19.4	19.4	14.5	9.3
Total	100.0	100.0	100.0	100.0	100.0

Source: PCBS 2010 Violence Survey Data

Rafah comes out as the region where married women had relatively the lowest vulnerability to physical violence at home. In terms of repetitive or systematic physical violence (three or more incidents) women in Gaza City and the Deir al Balah/ Middle Area were most vulnerable with 19% of married women in these two regions having experienced violence at this level over the previous year.

Though no direct correlation can be made, the three governorates where women were relatively more susceptible to physical domestic violence in 2009 (i.e. the reference year in the 2010 survey) were also the three most affected by Israeli's major military offensive, "Operation Cast Lead" over that time period.

2.

Married Women: What Factors Make Them Less Vulnerable to Domestic Physical Violence?

Vulnerability to physical violence in marriage diminishes with age. Younger married women are more vulnerable to any instance of violence, but it is women 20-29 years of age that are more vulnerable to repetitive physical violence

Married women in the youngest ages (15-19 years) have the highest vulnerability to physical violence from spouses with 42% having any experience of physical abuse in the previous year. However, married women in the youngest age category predominantly suffered from 1-2 incidents of physical abuse

(at 28%). But it is married women between 20 and 29 years of age that are more vulnerable to repetitive or systematic physical violence from their spouses. 22% of them experienced 3 or more incidents of physical violence in the previous year compared to only 14% of wives aged 15 to 19.

Number Experiences of Physical Violence in the Previous Year	Age					Total (All women)
	15-19	20-29	30-39	40-49	50+	
0	58.4%	63.8%	63.2%	69.5%	76.1%	65.2%
1-2	27.7%	14.0%	20.2%	13.0%	15.7%	18.0%
3+	13.9%	22.2%	16.5%	17.4%	8.2%	16.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: PCBS 2010 Violence Survey Data

Overall the findings confirm that vulnerability to any spousal physical violence is linked to life cycle; youngest age categories do have the most overall

experience of any incident while the oldest age categories have the lowest relative overall experiences of any incident of physical violence.

Higher educational achievement strongly diminishes women's vulnerability to physical violence

Number Of Experiences Physical Violence in the Previous Year	Married Women Educational Achievement Level				Total (All Women)
	Elementary or less [0-4 years]	Preparatory [5-7 years]	Secondary [8-12 years]	More than Secondary [12+ years]	
0	64.5%	59.7%	65.5%	77.9%	65.2%
1-2	16.2%	22.8%	17.2%	10.3%	18.0%
3+	19.3%	17.5%	17.3%	11.8%	16.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: PCBS 2010 Violence Survey Data

College or University Education levels strongly correlate with lower incidence of physical violence at home; only 22% of married women with this educational level experienced any incident of physical violence in the previous year compared to be-

tween 35% to 41% of women with lower levels of education. Moreover, the experience of repetitive physical abuse was two-thirds less among highly educated women compared to those with lower educational levels.

Fully or partially employed married women are significantly less vulnerable to physical domestic violence than those who are unemployed or outside the labour-force (predominantly housewives). But unemployed women show the highest vulnerability to repeated physical domestic violence

Globally, women's employment has been positively correlated with less vulnerability to domestic violence and the Gaza data overall confirms this pattern. In 2010 married women inside the labour-force reported 13% less domestic violence than women

outside the labour force. Married women who were fully or partially employed also reported the lowest levels of repetitive physical violence at approximately 11% of them compared to 17% of women outside the labour-force.

Number Of Experiences Physical Violence in the Previous Year	Married Women's Labour force Status			
	Inside the Labour Force			Outside the Labour Force
	Full Employed	Part-time Employed	Unemployed	
None	77.1%	77.9%	77.2%	63.8%
1-2	13.0%	10.2%	3.0%	18.8%
3+	9.9%	11.9%	19.8%	17.4%
Total	100.0%	100.0%	100.0%	100.0%

Source: PCBS 2010 Violence Survey Data

3.

What Factors Increase Married Women's Vulnerability to Sexual Domestic Violence?

Approximately 15% of married women experienced any incident of sexual abuse by husbands over the previous year; more than half of these (8% of the total) experienced it repetitively (three or more incidents). Approximately 40% of these women (or 6% of married women in Gaza) experienced more severe incidents of husbands using threat or physical force to compel sexual relations

The main type of act reported by wives, was husband's refusing to use contraceptives during intercourse (at 8.5% wives in Gaza being subjected),

followed by the use of force to compel the wife into intercourse (at 6% of married women in Gaza).

Household poverty correlates with married women's greater vulnerability to repetitive incidents of sexual abuse

Married women in the poorest households have an approximate 10% higher level of any incident of spousal sexual violence than women in households with higher standards of living. They are much more vulnerable to repetitive incidents of spousal sexual

violence: women in these households experienced 3 times the level of repetitive sexual abuse as did women in the wealthiest households and twice the level of women in households with average income.

Experiences of Sexual Violence in the previous year	Economic Situation of the Household			
	Good/Excellent	Average	Poor/ Very Poor	Total/ All Women
None	88.5%	86.6%	77.8%	85.3%
1-2	5.9%	6.1%	7.7%	6.4%
3+	5.6%	7.3%	14.4%	8.3%
Total	100.0%	100.0%	100.0%	100.0%

Source: PCBS 2010 Violence Survey Data

The same age categories (20 to 29) of married women who have greater vulnerability to repetitive physical violence also have greater vulnerability to repetitive sexual violence

Twenty-one percent of married women aged 20-29 said they had any experience of sexual violence by husbands in the previous year (compared to

15% among all married women). Almost half these women experienced sexual violence from spouses repetitively.

Experienced Sexual Violence in the previous year	Age				
	15-19	20-29	30-39	40-49	50+
Any incident	10%	21%	14%	12%	15%
3+ incidents	5%	10%	8%	7%	9%

Source: PCBS 2010 Violence Survey Data

Women's higher education achievement strongly correlates with lower vulnerability to spousal sexual violence; incidents of marital sexual violence drops by half among women with college or university education

The highest levels of incidents of spousal sexual abuse were among women with a secondary education at 19% of them experiencing any incident and 13% of them experiencing repetitive incidents.

In contrast, women with higher education had the lowest incident level at 7% (less than half the level among all married women in Gaza).

Experienced Sexual Violence in the Previous Year	Women's Education Achievement				
	Elementary or Less	Preparatory	Secondary	College or University	Total
None	84.8%	84.9%	80.8%	92.5%	85.1%
1-2	5.3%	7.5%	6.7%	5.5%	6.6%
3+	9.9%	7.6%	12.5%	2.0%	8.3%

Source: PCBS 2010 Violence Survey Data

As well, only 2% of married women with higher education experienced repetitive instances of sexual violence from their spouse the previous year com-

pared to an average of 10% of women with lower levels of education.

Women's employment significantly lessens their vulnerability to spousal sexual abuse

Women's employment does lessen vulnerability to intimate partner sexual violence: 9% of employed women experienced any incident; as did 6% of partially employed women; and less than 3% of women searching for work. In contrast, 16% of married wom-

en outside the labour force experienced any incident of spousal sexual abuse. On average, 3% of women inside the labour force had repetitive experiences of sexual abuse compared to 9% (or triple the number) of married women who were outside the labour force.

4.

What factors Increase Married Women's Vulnerability to Psychological/ Verbal Violence?

More than three-fourths (77%) of married women experienced incidents of verbal abuse from their spouse in 2009; 85% of those experienced verbal abuse repetitively

The main types of psychological/verbal violence experienced included:

- Yelling/shouting (73% of married women who experienced any incident)
- Cursing/insulting (45% who experienced any incident)
- Making hurtful or provoking statements (42% who experienced any incident)

Main correlates with repetitive verbal abuse include: larger household size and being in the age category of 30 to 49 years old

The data shows no correlation between women's employment status or household poverty and women's vulnerability to systematic verbal abuse. Among women with higher education there is between an 8 to 14% drop in experiences of repetitive verbal abuse compared to married women with lower education levels. But there is again a strong correlation with household size: 73% of married women living with 8 to 10 family members, experienced repetitive verbal abuse compared to 50% of women in smaller households and 63% of women in households of more than 11 persons. In terms of age, 73% of married women aged 30 to 49 experienced

repetitive verbal abuse compared to 57% of women in the youngest age categories and only half (52%) of women aged 50 years and above. One explanation is that relatively more mature wives of these age categories are more likely to assert their opinions and priorities – which in turn may trigger greater levels of verbal abuse in reaction. In the 2010 survey, 44% of married women in Gaza claimed they themselves had verbally abused their husbands in the previous year (equalling slightly more than half the percent of married women who were verbally abused by husbands during the same period).

5.

Married Women Victims of Abuse and Help-Seeking Behaviour

Married women who experienced repeated incidents of physical, psychological or sexual abuse were more likely to seek any form of help, including reaching out beyond the family than did women who experienced one or two incidents

Married women's help-seeking behaviour regardless of the level or types of violence they experienced usually involved multiple actions; the same woman might talk to her husband as well as tell her family and seek support from a community figure. In oth-

er cases, experiencing the first incident the woman may do nothing, but facing another incident, she might talk to her husband, then her family and ultimately if the abuse continued seek help from a wider range of potential service providers or interveners.

Women who were subject to repetitive physical abuse were more likely to seek help from family, friends and formal service providers than those who experienced one or two incidents. In both situa-

tions talking to husbands and involving her family were the main preferred strategies (at two-thirds to three-fourths of women experiencing any level of violence exhibiting these responses).

Number of incidents of physical violence in the previous year	Help seeking behaviours of women who experienced physical violence from spouse					
	Talked with husband	Told Friends/colleagues	Told Family	Informal Community Figure	Legal figure or police	Women NGO/medical centre
1-2 incidents	51%	8%	61%	2%	0.5%	4%
3 or more incidents	64%	30%	73%	11%	5%	13%

Source: PCBS 2010 Violence Survey Data

But women who experienced repetitive physical violence were approximately 12% more likely to talk to husbands and family about it than women who experienced 1-2 incidents. Women who experienced repetitive physical violence were four times more likely to seek help from friends or colleagues (at 30% versus 8% of women who experienced lower incident levels); they were more than five times more likely to seek help from a community figure (at 11% compared to only 2% of women who experienced lower incidents of physical violence); 10 times more likely to seek help from the police or legal authority (at 5% versus 0.5%); and 3 times more likely to seek help from a women's

NGO or medical centre (at 13% versus 4%).

The general pattern is similar for women who experienced various levels of verbal/psychological abuse; women who experienced repetitive incidents were more likely to seek help from within the family and beyond it compared to those who experienced 1 or 2 incidents only. However on every help-seeking action women who experienced verbal or mental abuse were much less likely to seek help than women who experienced physical abuse.

Similarly, there is an increase in women's help seeking behaviour when sexual abuse is experienced repetitively.

Number of incidents of sexual violence in the previous year	Help seeking behaviours of women who experienced sexual violence from spouse					
	Talked with husband	Told friends/colleagues	Told family	Informal community figure	Legal figure or police	Women NGO/medical centre
1-2 incidents	39%	14%	66%	4%	2%	4%
3 or more incidents	62%	24%	70%	11%	5%	15%

Source: PCBS 2010 Violence Survey Data

Twenty-three per cent more women who experienced repetitive sexual abuse tried talking to their husbands than did women who experienced one or two incidents (at 62% compared to 39%); 10% more women who experienced repetitive sexual violence from their spouse told friends/colleagues about it than those who experienced lesser incident levels; 4% more sought help from their family; three times

as many sought help from a community figure than did women who experienced lesser incidence levels of sexual abuse; 2.5 times as many sought help from police or legal figures and almost four times as many sought help from Women NGOs or a medical centre than did women who experienced one or two incidents of sexual violence.

BOX 3. UNRWA'S ONE STOP REFERRAL CENTRES IN GAZA*

Though not included in this study, UNRWA's One Stop Referral Centres are an important part of the overall non-governmental infrastructure addressing GBV in Gaza.

Since 2009, the Agency has developed a multi-pronged approach to GBV focusing on three main areas:

- * Training UNRWA staff to identify, refer and provide support to GBV survivors
- * Developing referral pathways through building partnerships with external service providers
- * Raising awareness and involving the Refugee community in protection, response and prevention of GBV.

The cornerstone of these interventions is a one-stop referral system based in UNRWA health centres. Since 2011 GBV staff have been trained in 21

health centres to identify, counsel and support GBV survivors by providing psychosocial services and legal aid along with regular health services. Psychosocial counsellors act as case managers, assessing needs and recommending intervention plans. These case managers within the Health Centres coordinate services for victims from within the Agency as well as beyond it. Legal cases are referred to the Network of Legal Aid providers in Gaza with whom the Agency has a standing agreement, while more difficult psychological cases are referred to the Gaza Community Mental Health Program. Staff in other front-line service roles within UNRWA including Relief and Social Services and Women Program Centres also identify and refer cases to the One-Stop Centres.

*For an example of how UNRWA's referral system supported one survivor, see Pathways Case Study B7, 'Amina'.

CHAPTER II.

PROFILE OF SERVICE USERS: WHO USES NON-GOVERNMENTAL GENDER-BASED VIOLENCE SERVICES IN GAZA AND WHY?

To understand more systematically who uses the range of GBV services provided by the NGO sector the study undertook an analysis of more than 150 case files in 3 main front-line GBV service providers. By selecting all case files that were opened in a specific month (November 2015), enabled comparisons to be made while reaching some overall conclusions about the backgrounds and experiences of clients, as well as the services they received. The review of case files also allowed an assessment of record keeping

within the organizations – and to what extent these systems enabled service providers to track specific cases.

It is extremely important to keep in mind that the following data does not represent the experiences of all women in Gaza. Instead it represents a self-selected sector of women who sought GBV services – those who are likely to be facing more extreme circumstances.

1. Number of cases and period of treatment

On average each service provider had 50 new cases a month. The dominant duration of support given to clients was five to six months

The three organizations received approximately 50 new cases each per/month. The total number of case files covered was 158. The overall stage of the

cases when reviewed 13 months later (December 2016) was as follows:

Stage of Cases Initiated in November 2015 (as of December 2016)					
Still in process	Completed	Cut-off	Referred to other	No Data	Total
11%	68%	7%	6%	8%	100%

Source: Gaza NGO GBV service providers case file records

The overall range of time in which the service user was receiving support/ treatment from the organization was a minimum of less than a month to 13 months. The modal period of time a case was treat-

ed was between five and eight months, which represents 40% of the cases reviewed. Another 27% of cases lasted less than two months.

Length of Support/Treatment from Service Providers						
0-2 months	3-4 months	5-6 months	7-8 months	9-10 months	11-12 months	13+ months
27%	10%	13%	30%	2%	4%	7%

Source: Gaza NGO GBV service providers case file records

2. The Quality of Case File Records

Only one out of the three service providers had detailed computerized case file data; most had hand-written case files

All three organizations collected detailed written records on cases that came to them in the initial meeting with the service user. Only one had a systematic computerized database that most of the data was available on; the other two had handwritten case files where the data had to be analysed and collected by hand. As well, record keeping was not always careful; for instance 13% of case files had no data on the service users age and 35% had no data on the clients' number of children. In one organization there were multiple case file numbers across differ-

ent programs for the same client (meaning that an individual couldn't be tracked across programs provided by the same organization). At the same time, individual specialists within the organizations (psychosocial or legal counsellors) were usually able to fill in data gaps on cases with information they had acquired through the experience of treating them. While all case files kept records on whether the client was referred and to whom, there were very few instances in which the outcome of the referral was documented.

3. Demographic Profile of Clients

The demographic profile of clients is similar to the findings on female violence against women victims in the PCBS 2010 Survey although there were greater numbers of women with higher education seeking support from providers.

In terms of age, 62% of all new clients clustered in the age range of 20 to 39 – ages that represent the stresses of family formation, as well as those associated with more mature marriages and teenage chil-

dren. The high number of women seeking services in the 20-29 age group dovetails with the findings on violence against women in the general population.

Age	Percent of Cases	Number of Cases
No data	13.3	21
12-19	7.6	12
20-29	32.3	51
30-39	29.7	47
40-49	13.3	21
50 and above	3.8	6
Total	100.0	158

Source: Gaza NGO GBV service providers case file records

In terms of educational profiles, there was a higher illiteracy rate among clients at 10% than among women in the general Gaza population – but this is due to the overall higher age profile of clients and the near absence of youth age categories. As well there were more highly educated women seeking

services for violence against women than found in the general population as reflected in the PCBS 2010 Survey. Potentially, women with higher levels of education are more aware about the existence of service providers, or more open to seek help from them than are women with the lower levels of education.

Education	Percent of Cases	Number of Cases
No data	3.2	5
Illiterate	10.1	16
Less than secondary	29.7	47
Some/all secondary	36.7	58
Partial university	6.3	10
Graduated university	12.7	20
Missing system	1.3	2
Total	100.0	158

Source: Gaza NGO GBV service providers case file records

Less than 10% of the clients were single, 63% were married at the time of registering for GBV services and approximately 25% were in various situations of marital dissolution; only 1% were widowed. The high numbers of divorced, widowed or “hanging

divorcees” attests to the fact that these women are usually the most poverty stricken and are the most vulnerable to various forms of coercion and violence by ex-spouses and former in-laws in Gazan society.

Marital Status	Percent of Cases	Number of Cases
Married	63.3	100
Single	9.5	15
Divorced	16.5	26
Widowed	1.3	2
Hanging Divorce ¹⁵	7.0	11
Missing system	2.5	4
Total	100.0	158

Source: Gaza NGO GBV service providers case file records

Approximately 60% of currently or previously married clients had children at the time of their first meeting (76% of currently married women; 58% of divorcees; 100% of widows and 70% of women who

were “hanging”). As mentioned earlier, a third of the case files had no data on whether clients’ had children or not.

¹⁵ ‘Hanging’ Divorce’ is the term for the legal status of women who are trapped in an unresolved divorce. For further explanation, see Box 4

Number of Children	Percent of Cases	Number of Cases
No data	35.4	56
No children	2.5	4
1 child	11.4	18
2-3 children	22.2	35
4-6 children	16.5	26
7+ children	12.0	19
Total	100.0	158

Source: Source: Gaza NGO GBV service providers case file records

By region the clients were almost equally distributed between Gaza City (44%) and the Middle Camps Area (40%) with a lesser 14% from North Gaza and only 1% from South Gaza. Since this is a targeted

sample – the absence of cases from the south is due to the study not including a main GBV service provider from that region.

4. Socio-economic Situation

More than similar demographic characteristics it is dire economic circumstances that typifies the majority of clients

Two thirds of the clients described their economic situation as destitute or poor. Among the “desti-

tute” category were clients who had lost their home in the last Gaza War.

Economic Situation	Percent of Cases	Number of Cases
Destitute	30.4	48
Poor	38.0	60
Medium	26.6	42
Well-off	4.4	7
Total	100.0	158

Source: Source: Gaza NGO GBV service providers case file records

Only 10% of the clients were employed, the overwhelming majority (70%) listed their employment status as ‘housewives’.

Employment Status	Percent of Cases	Number of Cases
Housewife	77.2	122
Employee	3.8	6

Unemployed	6.3	10
Self-Employed	3.2	5
Worker	2.5	4
Student	7.0	11
Total	100.0	158

Source: Source: Gaza NGO GBV service providers case file records

5. Initial Entry into Service Provider

A quarter of women had been referred to the service provider by another formal institution

The overwhelming 93% of clients came to the service provider without anyone accompanying them on their initial visit. In terms of referral, 44% of the clients had been referred – but the majority of those referrals (66%) took place within the same organization (i.e. being referred from one program to another).

In terms of the other portion of referred cases: 17% were referred by other NGOs, 13% by a governmental institution; 1% by a ‘third party’. As such, only 26% of all clients had been referred to the service provider by a different institution.

6. Summary of Main Issues Facing Clients

In summarizing the multiplicity of problems that clients faced – the two categories that emerged as dominant were economic deprivation/abuse followed by long-term systematic abuse. A high but lesser number of clients faced current threats of violence at the time they first visited the service provider

Staff in the three organizations were asked to analyse the case files and summarize the overall nature of the problems clients faced in terms of two main categories of issues provided below. Given that all

of the women who went to service providers faced a range of problems simultaneously, all of the cases were listed as having two main sets of issues – although in many cases they would have had more.

Main Issues Facing Clients	Percent of Cases	Number of Cases
Economic deprivation/ economic injustice or abuse	58%	92 cases
Long-term systematic abuse	49%	77 cases
Current threats of violence	40%	65 cases
Social Isolation/ isolation from family	19%	30 cases

Jealousy/controlling behaviour	11%	18 cases
Effects of drug abuse	9%	14 cases
Physical violation of child/children	2%	3 cases
Other	6%	10 cases

Note: The women who answered were asked to select two main issues that they have faced. 2.5% (or 4 cases) were missing from the total.

Source: Gaza NGO GBV service providers case file records

The three most dominant issues that clients had were economic deprivation or injustice (58%) followed by long-term systematic abuse (49%) and current threats of violence (40%). This was followed by social isolation/ isolation from the family (19%), jealousy/ controlling behaviour (11%) and effects of

drug abuse (9%). Physical violation of children was low at 2% while another 6% of clients suffered from other main issues.

Looking at the distribution of types of cases across the three organizations there are some clear differences.

Main Issues Facing Client	Service Provider/ Organization			Number of Cases
	A	B	C	
Long-term systematic abuse	43%	40%	17%	77 cases
Current threats of violence	23%	46%	31%	65 cases
Economic deprivation/ economic injustice	30%	56%	13%	92 cases
Physical violation of child/children	100%	0%	0%	3 cases
Social Isolation/ isolation from family	13%	50%	37%	30 cases
Effects of drug abuse	14%	64%	21%	14 cases
Jealousy/controlling behaviour	28%	17%	56%	18 cases
Other	30%	0%	70%	10 cases

Note: The women who answered were asked to select two main issues that they have faced.

Source: Gaza NGO GBV service providers case file records

Organization A had all of the abuse of children cases and more than 40% of the long-term abuse cases. Organization B had 2/3 of the cases that were the effects of drug addiction; more than 50% of the cases of economic deprivation/injustice; 50% of the cases that suffered from social and or family isolation; and the highest number (46%) of the cases facing current threats of violence. Finally, organization C had

the highest number of the jealousy/controlling behaviour cases at 56% as well as having 70% of “other” cases – which were primarily legal problems.

The distribution of types of cases across the organizations may be due to how caseworkers in each analysed and coded the problems facing clients. Or it may be a product of the organization’s reputation in providing specific services or assistance.

There are strong links between the cases that suffered from economic deprivation/ injustice and long-term abuse, as well as immediate threats of violence

In terms of types of problems faced by many or most cases – three main links can be made. First of all between long term abuse and economic deprivation; 50% of all the cases (77 cases) were cited as suffering from long-term systematic abuse, and almost 2/3 of these also suffered from economic deprivation/ in-

justice. Secondly of the 41% of cases facing “current threats” of violence, 50% of those also suffered from economic deprivation/injustice. Clearly there is a strong relationship between economic deprivation/ injustice and long-term as well as immediate term threats of abuse.

All of the women dealing with cases of drug addiction were cited as experiencing long-term abuse

Of the types of problems clients cited, some were more likely to link with long-term systematic forms of abuse. For instance all (100%) of the drug abuse related cases also cited long-term abuse as a main

issue they were facing; as did 68% of those who had cases of child abuse and 40% of those who suffered from social or familial isolation. Once again, jealousy/controlling behaviour did not correlate.

7. Specific Forms of Violence Faced by Clients

Given that women had sought help for various forms of violence/ abuse, much higher numbers of them were suffering from multiple forms of violence than is found in general surveys of violence against women in Gaza.

In the record keeping on cases, individuals are asked whether they have suffered from a variety of forms of violence. It is important to keep in mind however, that there is no time period specified – i.e. clients

may have experienced any of the following specific types of violence at any period in their lives, or they may have experienced them immediately preceding their first visit to the service provider.

Psychological		Physical		Sexual		Social		Economic		Legal	
%	No.	%	No.	%	No.	%	No.	%	No.	%	No.
92%	145	69%	109	27%	43	87%	137	80%	126	43%	68

Source: Gaza NGO GBV service providers case file records

In ascending order; 27% of cases were victims of sexual abuse; almost 70% were victims of physical abuse; 80% faced economic abuse; close to 90% social abuse and more than 90% psychological abuse. Given that the case files represent a self-selected sample of individuals who sought GBV related services the high rates of various forms of violence they

faced is not surprising. And given that the number of cases cited as suffering from the various types of violence is almost 4 times the number of overall case files – the majority of women who sought help from service providers were suffering from multiple and compounded abuse.

While physical abuse was high among married women, it was even higher among women in various situations of marital dissolution

The vast majority of victims of physical violence were currently married women (67%). However other marital statuses had a higher likelihood of facing physical violence; all (or 100%) of widows and those

unable to complete a divorce ('hanging') had experienced physical abuse; while 77% of divorcees had experienced physical violence.

Women who faced a main problem of social and familial isolation were more vulnerable to physical abuse, followed by women who faced economic deprivation/injustice as well as long-term systematic abuse

Although all women who were dealing with problems of child abuse said they had experienced physical abuse, in terms of number of cases this was very low (at three cases total). However, the highest

correlation after this was among women who faced social/familial isolation as a main issue, at 87% of them having experienced physical abuse.

While 69% of women clients had experienced any physical violence, higher numbers of them experienced more severe forms than was found in social surveys on violence against women generally in Gaza

While slightly more than 2/3 of clients (69%) had experienced any physical violence, 60% of these had experienced more than one type of physical violence. Nearly half the women clients had been beaten (49%). This was followed by less severe forms

(slap or push) the former experienced by 37% of clients and 41% having experienced the latter (keeping in mind these may be the same women who experienced both).

Type of Physical Violence	Percent of all cases	Number of Cases
1. Slap	37%	58
2. Shaken or pushed violently	41%	65
3. Beaten	49%	78
4. Beaten in front of others	28.5%	45
5. Burnt or attempt to burn	2%	3
Broke bones	3.7%	10
Attempt to kill – attack with knife, gun or strangulation	8%	13
Subtotal	169%	109

Source: Gaza NGO GBV service providers case file records

More than a quarter of women clients had been beaten in front of others; 8% had experienced an attempt to kill them (with strangulation, a knife or a gun); almost 4% had bones broken; and 2% had experienced attempts to set them on fire. All of the levels of severe violence among women clients are

much higher than was found in the general population of women in the PCBS 2010 Violence Survey. It is likely that women who suffered more severe forms of physical violence are more likely to seek help from providers.

More than a quarter (27%) of women clients had experienced sexual violence at home. Cases of rape and incest were extremely low suggesting the degree to which women facing these circumstances continue to fear scandal and social retribution if they seek help in the public realm

Coerced sexual relations were experienced by 11% of women cases. Divorced women (including “hanging” divorcees) reported suffering from coerced sex at a higher rate than currently married women (60% of the former versus 44% of the latter). In 8% of the cases it was either being forced into unwanted sex-

ual practices and another 8% of cases citing spouses using sex-enhancing drugs during intimate relations. In general surveys, coercing pregnancy is the main form of sexual violence cited by women, while among women clients it is cited by only 5% of cases.

Type of Sexual Violence	Percent of All cases	Number of Cases
Coerced Sex	11%	17
Use of drugs in Sex	8%	13
Unwanted sexual practices	8%	13
Enforced pregnancy	5.1%	8
Sexual Dysfunction	5%	8
Sexual disloyalty	2.5%	4
Attempted rape	2.5%	4
Rape	0.6%	1
Attempted Incest	1.3%	2
Incest	0.6%	1
No data	4%	6
Other	3%	3

Source: Gaza NGO GBV service providers case file records

Cases of actual or attempted rape and incest, both come out very low – suggesting the degree to which taboos about these extreme forms of sexual vi-

olence (as well as the real dangers of taking them public) continues to prevent women from seeking the help of service providers.

A very high number of cases (87%) said they faced forms of social violence, with mistreatment by husbands' family being the main abuse

After maltreatment from husband's family; being forbidden to see one's own family was experienced by 38% of the cases; a situation that was higher among women in states of marital dissolution, than among married women. One fifth of women suffered from enforced social isolation an abuse higher among unmarried and "hanging" women

than among married women. Given the lack of time frame, this may be severe social control exercised by parents over a divorced daughter or it may have been control exercised by an ex-spouse and his family during the marriage. Ten per cent of cases were women being denied visitation to their children – all of them in various states of marital dissolution.

Type of Social Violence	Percent of All Cases	Number of Cases
Predominantly Faced by married and divorced		
Bad treatment by husbands family	62.7%	99
Forbidden to see family	38%	60
Family Conflicts	31%	49
Enforced social isolation	22%	35
Denied visitation of children	10%	16
Predominantly Faced by Young Unmarried		
Deprived Education	18.4%	29
Deprived right to marry	3.8%	6
Forced marriage	3.2%	5
Other	22%	14
No data	12.7%	20

Source: Gaza NGO GBV service providers case file records

For younger women, denial of rights to complete education was the main form of social abuse at (18%) followed by lack of rights to marry whom they

wished (4%) or being forced to marry against their will (3%).

Eighty per cent of the cases said they suffered forms of economic violence, with "poverty" being cited by 60% of the cases as the main economic abuse they face

Given that 2/3 of all women clients described their economic situation as poor or destitute it is not surprising that such a large number of cases said the nature of the economic violence they faced was simply – poverty. However, for a large number of cases economic deprivation was also a product of

husbands denying them income for the needs of the household (42% of cases) or denying needs of the children (34% of cases). More than 70% of women whose divorces were "hanging" and 57% of married women cited the latter two conflicts.

Type of Economic Violence	Percent of All Cases	Number of Cases
Poverty	58.9%	93
Denied daily economic needs by husband	41.8%	66
Children denied their basic needs	34%	54
Denied right to work	10%	16
Denied inheritance	2%	3
Other	3.8%	6
Not specified	19.6%	31

Source: Gaza NGO GBV service providers case file records

Ten per cent of the cases said they had been forbidden to work, the majority of them married women. While inheritance issues came out very low, this is

most likely due to the fact that the data represents a small sample size within a short time period.

More than a quarter of clients sought legal support for maintenance payments

After issues of maintenance, the second most common legal issue women cited facing was divorce, a situation facing almost 20% of all cases. Child cus-

tody/ visitation problems were faced by 10% of all cases.

Type of Legal Violence	Percent of All Cases	Number of Cases
Maintenance case	26.6%	42
Divorce case (any type)	19.6%	31
Child custody/visitation Case	10%	16
Income cases (access to pension or social compensations)	5.7%	9
Assets case (gold, property etc....)	3.2%	5
Ruling not implemented	1.9%	3
Inheritance case	1.3%	2
Other	3.8%	6
Not specified	0.6%	1

Source: Gaza NGO GBV service providers case file records

8.

Impact of Abuse on Victims

More than a quarter of clients had contemplated or attempted or suicide

The majority of clients suffered from multiple impacts on their mental and social health due to the situation they were facing. Sixty-three per cent said they were nervous and couldn't sleep; 60% 'lived in fear'; almost 50% felt socially isolated; 40% had a poor relationship with their spouse and 27% said they had contemplated or attempted suicide. The

strongest variable that thoughts/ attempts of suicide correlated with was victimization by sexual violence, with 47% of sufferers from these acts having tried or contemplated suicide. By age, women in the 40-49 age group showed the highest rate of suicidal thought or attempts at 40%.

9.

Perpetrators of Abuse

The vast majority of perpetrators of abuse were current or ex-husbands

Clients overwhelmingly cited husbands as the main perpetrators of the various forms of abuse at 82% covered in the case files, with 9% of these being divorcees or women not being granted a divorce from recalcitrant husbands. In-laws come out second (at 21%) as perpetrators and given that a number of women cite multiple perpetrators (the total per cent of responses is 167%) many of the women suffer-

ing from in-laws are also suffering from husbands. Abuse from in-laws correlates by age with those at the early stages of marriage (20-29) with 47% of cases in this age group suffering abuse from in-laws.

Female relative comes out third at 15% of perpetrators and given the categories it is likely that they are siblings, sisters-in-laws or aunts.

In more than a quarter of cases, women said the main perpetrator suffered from mental health issues. In almost one-fifth of cases perpetrators were addicted to drugs

Forty-four per cent of clients stated that the perpetrator also exercises violence against children in the family; 42% said the perpetrator had used violence in the past; and 35% said that the perpetrator was currently threatening to use violence against them (a significantly lower per cent than the 75% who cited 'current threats of violence' as their main form of abuse – thus here what may be meant is physical violence). Twenty-seven per cent of clients say the per-

petrator suffers from mental health problems and another 18% say they are addicted to drugs. Only 1% stated the perpetrator has a gun at home and 13% say they have other negative behavioural issues. The significant level of women citing a husband's drug abuse and/or mental health issues is confirmed by the findings from the in-depth pathways analysis of women victims in the following chapters.

10.

Recommended Interventions

Social welfare or assistance came out as the predominant recommended intervention, followed by psychological counseling as the second most prominent intervention

In 62% of the cases the provider recommended that the client could be treated solely within the organization while another 38% recommended they be treated internally as well as with another service provider or actor.

Given that economic deprivation/destitution was experienced by two-thirds of the clients, it is logical that in the case of 58% of clients social welfare support/assistance is a recommended intervention.

Recommended Interventions	By Organization/Service Provider			TOTAL CASES	
	A	B	C	%	#
	%	%	%		
Social Welfare/ Assistance	70.8%	65%	38%	58%	92
Legal Aid Only	2.1%	5%	5%	7.6%	12
Psychological Counselling Only	56.3%	23.3%	32%	36%	57
Both Legal and Psychological	18.8%	26.7%	28%	24.7%	39
Mediation	6.3%	3.3%	42%	16.5%	26
Other	18.8%	3.3%	3.3%	7.6%	12

Source: Gaza NGO GBV service providers case file records

The next highest course of recommendation is solely psychological counselling – recommended in 36% of the case. A mixture of psychological counselling and legal aid is recommended in almost one-quarter of the cases (at 24.7%). Solely legal aid comes out at a

low 7.6% of the recommended treatment for cases. Finally, in 17% of the cases mediation is recommended – but this is recommended overwhelmingly by only one service-provider.

Service providers also highly recommended the inclusion of other informal and formal interveners to treat the case, with the highest level of recommendation that a family figure be included in the overall intervention

Along with recommended treatment within the organization, in 77% of all cases, it was recommended

that other non-NGO interveners should also be included in treating the case.

Other interveners suggested to participate in case treatment or resolution		
Type of Intervener	Percent of all cases	Number of Cases
Family Figure	38.6%	61
Shari'a Court	34%	53
Reconciliation Committee	20.3%	32
Mukhtar or Mukhtara	17.7%	28
Medical Doctor	12%	19
Medical Psychologist	5.7%	9
Social Figure	3.2%	5
Civil Court	0.6%	1
Police	0.6%	1
Other	3.5%	6
Not specified	23.4%	37

Source: Gaza NGO GBV service providers case file records

In almost 40% of the cases, the service provider recommended that a family figure be included in attempts to treat the case. Most likely this is a senior informal authority within the women's wider family. Next in a third of the cases, the Shari'a court authorities are to be included (at 34% of the cases -- slightly less than women who are facing a legal issue). Informal actors in reconciliation and media-

tion (reconciliation committees and makhatir) are recommended to be involved in more than a 1/3 of cases (38%). In only 12% of the cases is there a recommendation for medical intervention and an even less, 6% for medical psychiatric intervention. Finally, inclusion of the police or civil courts both come out extremely low -- recommended in only 1 case out of the entire 158 case files covered.

BOX 4. CRITICAL ISSUE IN PREVAILING ISLAMIC FAMILY LAW RELEVANT TO WOMEN'S VULNERABILITY TO DOMESTIC VIOLENCE IN GAZA

Prevailing Islamic family law puts women at a sharp gender disadvantage in most arenas of social and economic life. But specifically in relation to their vulnerability to domestic abuse and inability to exit from an abusive marriage, the following aspects of prevailing family law in Gaza kept arising in the research as the most critical:

Guardianship and women's right to choose a marriage partner:

Women need the consent of a male guardian in order to get married for the first time, regardless of their age. If a male guardian is unavailable, the judge is permitted to act in his place. Though Hanafai law (the main school of Shari'a in Gaza) allows that a previously married woman (specifically, no longer a virgin) has the right to her own guardianship and thus the right to select a groom without male guardians' consent – Shari'a judges rarely recognize this right if it is undertaken in defiance of her family's wishes. [See the case of Ilham]. Women's lack of right in either situation to marry as they choose gives a large power over families to impose on them unwanted marriage partners and marriage. Although in principle, the courts will not marry a woman against her will, young women find it near impossible to publicly defy their families' wishes in court.

Domestic Abuse:

The prevailing criminal code is completely absent on the issue of domestic violence. Family Law deals with it only in divorce and under the concept of "discord and strife" which is one of 6 bases for women to petition/initiate a judicial divorce tafriiq [see below].

Divorce:

Women's right to divorce are severely circumscribed. Generally, there are three main types of divorce possible under prevailing Family Law in Gaza.

Talaq: Unilateral Divorce: a male prerogative

Men have a unilateral right to a no-fault divorce known as Talaq. There are very few limitations on

the husband's right to Talaq. Rather than facing outright obstacles, husbands' legally ordained economic obligations in divorce acts as a check on men easily undertaking one. This includes paying wives any outstanding part of their initial dowry, as well as paying their full-deferred dowry as written in the marriage contract. In addition are court adjudicated regular maintenance payments to the ex-wife and children still legally under her custody. A wife can be divorced without her presence or knowledge – though legally she should be informed within a week. A husband's extra-judicial invocation of divorce is legal as long as it is ultimately registered in the courts.

Khul' and Tafriiq -- 2 paths for women to initiate divorce:

A Khul' divorce involves a wife forfeiting all or most of her economic rights in marriage (including: returning her preliminary dowry, her assets gained through marriage, her deferred dowry and any maintenance payments). On this basis the husband consents to the dissolution of the marriage. The courts do not decree a Khul' divorce, it only records a decree as the outcome of a consensus decision by the two parties. As such, a Khul' divorce besides leaving women economically bereft also depends on the husband's agreement.

Tafriiq in principle is the only means for a woman to petition for as well as get a divorce without a husband's consent. There are 6 legal bases on which a wife can initiate Tafriiq proceedings but she carries the burden of proof and faces an extremely daunting process in rallying the required evidence. These are:

- Husband's absence for more than one year;
- His imprisonment for more than three years;
- Inability to provide adequate maintenance (Nafaqa)
- Impotence or inability to consummate the marriage
- Insanity or other serious physical or mental disease

‘Discord and Strife’

Women have to rally a large array of evidence in order to prove just cause of the specific harm, including medical and bureaucratic reports as well as witnesses. In the case of impotence or mental health, recalcitrant husbands can simply refuse to undertake the required medical tests. Proving that maintenance responsibilities have not been met are also extremely difficult. If a husband has even only had phone contact with his wife or children during a year, his absence is no longer grounds for her divorce.

‘Discord and Strife’, which specifically includes husbands use of verbal and physical abuse leading the marriage to become untenable as grounds for a wife to petition for divorce is exceedingly difficult to prove. Unless the husband accepts the grounds of her claim (which they usually reject), the wife must provide evidence from the criminal justice system (a police report and forensic medical examination) as well as two eyewitnesses to the abuse – often a near impossibility in domestic violence cases. If her case is rejected she may after six months re-submit it with further evidence, but she has recourse to this legal path only twice.

“Hanging” Divorcees; A legal loophole used to punish wives seeking divorce

Women who initiate a Tafriiq case against their husbands, until it is finally resolved are in an unresolved marital status, known colloquially as a “hanging” divorcees. Any woman pursuing this path is likely to become “hanging” for a few years given that front-line legal service providers say it takes approximately 3 years defending these cases in court. Moreover, given that the courts still try and solve these cases through arbitration – preferring to rule based on husband’s accepting of the charges; women in effect become trapped in an unwanted marriage because in practice the judges have left the power in recalcitrant husbands hands. The legal fees for these cases are extremely high given that a lawyer is almost always necessary over a few years (approximately \$5,000 in total). At the same time husbands rarely pay maintenance to wives who have petitioned for Tafriiq while women in this unresolved status are not eligible for social assistance from the Ministry of Social Affairs. In sum, they are likely to become destitute at their family’s home and at the end get an arbitrated Khul’ divorce where

they give up all of their outstanding marital economic rights. [See the case of Ilham in chapter V and VI]

Maternal Custody:

Until 2009, a divorced or widowed mother had the right to hold custody of daughters until age 9 (with a possible extension by a judge until age 11) and of sons until age 7 (with a possible extension until age 9). Then the husband or his family had the right to take custody of the children. Even these minimum custodial rights are rescinded if she remarries. Following the comprehensive Israeli Military Aggression “Cast Lead” in 2009, the Sharia judiciary in response to the numbers of war widows made an extraordinary change to the law and decreed that widows could keep open-ended custody of their children as long as they did not remarry. However, the child custody laws for divorcees remained unchanged. As can be seen throughout this research, losing custody of young children to their abusive spouses and their families are the dominant reason women continue to stay in an abusive marriage. In response to this an informal coalition of front-line service providers and human rights organizations in Gaza have mobilized to make the open-ended custody rights of widows equally applicable in the case of divorced mothers. At the time of the research, the amended law was waiting to be approved by the Supreme Shari’a Council in Gaza, with one lawyer involved in the lobbying expressing optimism that it will pass.

The least effective [interventions] are around awareness – it’s a crowded field so many organizations do it and the same people are targeted over and over again. [‘Fadwa’]

... a woman victim comes and X-trainer tells her details about the types of violence etc... And then she returns [for sessions] and trainer-Y then trainer-Z tell her the same – they don’t increase her understanding but just repeat the same stuff. [‘Bassima’]

GBV deals with the personal/intimate life of women so you put an 18-year-old [trainer] to convince a woman victim of sexual violence or violated by her husband, what does she know... what can she tell them? [Ahmad]

CHAPTER III.

PROBLEMS AND GAPS WITHIN CURRENT VIOLENCE AGAINST WOMEN PROGRAMMING: THE PERSPECTIVES OF GAZA NON-GOVERNMENTAL FRONT-LINE AND SECOND LINE SPECIALISTS

Given the prolonged, cumulative and comprehensive nature of the context of the Gaza Strip local organizations face a host of formidable challenges in providing consistent and good quality GBV interventions and services.

This section will focus on the main limitations and challenges of current GBV interventions in Gaza as identified by local organizations that are specialists in the field.

1. Methodology

The issues identified in current service provision were based on various phases of interviewing; an initial stage of in-depth interviews undertaken with a total of nine local GBV service providers provided the preliminary findings. These were then cross-compared with material from interviews with individual women/victim survivors (including those who had and had not received NGO services). Finally, the overall analysis of issues from these two phases were then shared with two focus groups (each composed of five service providers) in order to confirm, generalize or deepen the basic findings. Between the two stages of interviewing service providers a total

of 19 individuals from 10 provider institutions were covered, all of them involved in providing front-line services to GBV victims as well as undertaking advocacy and awareness actions.¹⁶

As agreed upon with the service provider individual interviewees and focus group participants, to enable the greatest freedom to express constructive criticism of the current state of GBV programming, only pseudonyms are used in the study. The actual names of research participants are listed in the final appendix both for the sake of transparency and to recognize their contribution to this study.

2. Prevention-focused Interventions: Awareness and Advocacy

2.1. Awareness-Raising

According to the mapping exercise undertaken by UNFPA in 2015, 12% of donor supported GBV interventions in Gaza were “awareness raising” activities,

making it the second largest sector of donor supported GBV activities among a possible 14 activity areas.

2.1.a Limitations and Problems Identified

The least effective [interventions] are around awareness – it’s a crowded field so many organizations do it and the same people are targeted over and over again. [‘Fadwa’]

... a woman victim comes and X-trainer tells her details about the types of violence etc... And then she returns [for sessions] and trainer-Y then trainer-Z

tell her the same – they don’t increase her understanding but just repeat the same stuff. [‘Bassima’]

GBV deals with the personal/intimate life of women so you put an 18-year-old [trainer] to convince a woman victim of sexual violence or violated by her husband, what does she know... what can she tell them? [Ahmad]

¹⁶ The individual in-depth interviews included: three senior staff/ directors in local NGOs whose main focus was front-line service provision to GBV victims; two of these were interviewed twice. Another three were senior staff/ directors in Gaza women or human rights NGOs that integrated GBV prevention or treatment in their programming. Two other interviewees were specialized staff (a legal rights and a psychological counsellor). The final interview was with the director of a local community-based organization who undertook GBV programming.

There is a general consensus among local NGO specialists that awareness raising workshops about violence against women/GBV are the predominant form of intervention being undertaken in Gaza. The target group of awareness raising interventions

tends overwhelmingly to be women at the community level. Workshops are predominantly delivered to these target groups through the mediation of community-based organizations (CBO's).

Low Capacity of Many Trainers

A number of NGO GBV specialists suggested that GBV “awareness” raising sessions is the intervention that predominates because organizations find it much easier than providing specialized services which demand professionally trained staff and sophisticated systems, as well as involves many challenges and conflicts with various sectors of the community and government authorities. Given that a lot

of donor funds have been targeted at awareness activities with little quality control over the standards, as well as low investment requirements for staff and infrastructure, many organizations have entered the sector. Indeed, a CBO staff member interviewed said that their organization had hosted more than 150 GBV awareness training sessions last year.

Competition, Overlap and Lack of Cumulative Learning Outcomes

A number of specialists assert that a lot of “awareness” has become about quantity not quality (focused mainly on being able to report to donors that large numbers of participants were reached). Some stated that donors focus too much on awareness training at the expense of other interventions. There was consensus among specialists that many of these interventions are characterized by low professionalism of trainers; negative competition between providers; lack of coordination in targeting which results in ineffective replication of activities (sometimes redundant ones); and ultimately little ability to achieve cumulative impacts. In addition, training content was predominantly the same basic material, which added to the problem of replication of target groups meant that it was often being repetitively delivered to the same audiences. Some specialists said this meant it had had limited impact

beyond creating very rudimentary awareness; others suggested it might lead to boredom and alienation among target groups; while others claimed that repetition was necessary for ‘the message to sink in’.

A potential contributing factor to the low expertise level of “awareness” trainers is that in some cases the sector seems to be used for dual “humanitarian” purposes – for GBV prevention, as well as a job creating activity for unemployed female university graduates. More experienced trainers expressed concern about what is at stake when weak trainers, with limited relevant life experience are given the responsibility of dealing with the sensitive and complex issues of GBV. In addition, donors were criticized for a lack of professional criteria when sometimes selecting local partners to deliver awareness workshops.

2.1.b. Positives of Awareness Raising Interventions and Attempts to Redress Limitations

Positive dimensions of awareness raising interventions that were raised or arose from other parts of the research:

- A number of specialists claimed that violence against women is now an issue that can be dis-

cussed publicly in Gaza. Clearly, awareness raising interventions (along with public advocacy campaigns) have contributed to making violence against women a legitimate issue of public concern in Gaza.

- The Pathways research on individual women victims/survivors showed that for a number of them awareness raising sessions run at local CBO's had been their entry point to both knowledge about NGO service provision and access to it. It was clear that what motivated women to go to these sessions was the possibility of getting humanitarian aid but by participating in the sessions they had found support for dealing with their experience of GBV. As such, despite criticisms of the level of training content being offered by some NGO actors, awareness sessions at CBOs can be an important link to women in local communities who have limited knowledge of GBV service providers and how to reach them.
- A number of advanced trainers said NGOs and CBOs are becoming more aware of the need to have highly skilled trainers. But the limited number of experienced professionals remains an issue.
- A number of specialists mentioned that they now focused on new target groups (such as youth or university students) in order to prevent the issue of replication.
- Others mentioned trying to find and develop new content for training materials, specifically about GBV in the context of an armed conflict.

2.2 Advocacy

2.2.a. Limitations and Problems Identified

According to the 2015 UNFPA mapping exercise, 11% of donor supported GBV interventions in Gaza were under the rubric of advocacy.

All the advocacy is squeezed into the period of the 16 days campaign against violence but then the rest of the year advocacy activities are scattered – and there's no accumulation, it's no good. [Fadwa]

Not only around GBV but on other issues the efforts of advocacy around changing laws and legislation has really dried up, advocacy is still done but it is all awareness and consciousness raising. [Nariman]

All of the efforts [around violence against women/ GBV] have been important but if there's no formal political will all this work is just a drop in the ocean because at the end of the day I need government political will in order to protect women. The state should be my priority in seeking dignity for women, if the state lifts its hand from the problem and doesn't take responsibility for every sector in need of rehabilitation ...and not just women then its all a drop in the ocean. [Nariman]

Three main problems were identified by GBV specialists in the area of advocacy:

- Weak capacity among local organizations;
- Non-continuity in advocacy efforts thus not leading to cumulative outcomes; and indirectly,
- Obstacles created by the division of the government and the donors' no-contact policy with the de facto authorities.

Weak Capacity

As a number of specialists mentioned above because advocacy requires more skills, knowledge and longer timelines it has become subordinate to awareness activities. Furthermore, advocacy has the potential

to lead to conflict between GBV NGOs, local communities and governing authorities. Hence the already weak capacity in advocacy is aggravated by the challenging political context of Gaza.

Non-continuity

A number of specialists asserted that donors played an important role in promoting advocacy activities. However, timelines for advocacy seemed to be donor driven and limited to intense periods (such as the global *16 Days of Activism Against Gender-Based Violence* Campaign) with little support for more systematic and ongoing advocacy throughout the year. Thus advocacy activities squeezed into such a short time scale result in some of the replication problems of target groups that we have seen in awareness raising.

ence Campaign) with little support for more systematic and ongoing advocacy throughout the year. Thus advocacy activities squeezed into such a short time scale result in some of the replication problems of target groups that we have seen in awareness raising.

Lack of Targeted Advocacy/Ignoring the Governing Authorities

Since the political division in Palestinian governance between the West Bank and Gaza, NGOs have had to comply with no-contact rules imposed by donors in relation to the de facto authorities in Gaza. Therefore, advocacy activities – which go beyond public awareness campaigns and require targeted interaction and lobbying with local governing authorities, have become largely null and void in Gaza. There are two consequences: firstly, what might be understood as public awareness campaigns in other contexts, have come to be known as “advocacy activities” in Gaza. Hence efforts like the 16 days campaign rather than advocacy is more akin to public awareness. Secondly, those NGOs that engage in individual advocacy with the de facto governing authority (primarily in terms of legal interventions) have to turn down donor support that is conditioned by the no-contact policy. In many cases this directly

contradicts the very set of principles that are needed to address GBV/violence against women. The quote above by Nariman underlines the limited outcomes when there are no advocacy efforts targeted at changing government institutions and policies.

However, it was apparent that most front-line service providers were (or have to be) engaged in informal, individual advocacy efforts with various sectors of the governing authorities in order to address critical needs of their clients. A number of front-line specialists highlighted important advocacy efforts they had made with the Ministry of Social Affairs; judges in the Shari’a courts as well as on the Shari’a Higher Council; the Ministry of Health and the Ministry of Interior. These were not “organized” advocacy efforts but were informal lobbying efforts made in order to change a particular policy on behalf of a specific victim.

2.2.b. Positives of Advocacy Interventions and Attempts to Address Limitations

None of the specialists consulted for this report highlighted a positive outcome from the main advocacy activity (the 16 days campaign) but as we can see above, none were critical of its content but rather of the absence of more ongoing, coordinated and better targeted activities.

In the final focus groups however a number of participants mentioned collective advocacy efforts they

had undertaken with the government authorities, without donor support or contrary to donor policies. These included: post the 2009 Israeli aggression lobbying for a change to child custody laws for widows; opposing a government requirement that female lawyers should wear hijab in court and currently work to have child custody laws changed for divorcees (see Table 2).

3. Treatment Focused Interventions

3.1. Psychosocial Interventions

According to the mapping undertaken by UNFPA in 2015, 10% of donor supported GBV initiatives in Gaza

are psychosocial – making this type of activity the largest sector of treatment-focused interventions.

Treating mental health related issues and effects of GBV/VAW should be divided into two different levels and types of services:

- Professional mental health services that deal with chronic, more serious and usually more persistent psychological and behavioural problems;
- Psychosocial services that treat more situational, temporary mental health problems such as war trauma and that require shorter-term interventions.

In Gaza, the vast majority of mental health interventions in general (not just for GBV) are psychosocial rather than professional mental health services.

Since the 2009 Israeli military confrontation on Gaza a number of specialist reports have assessed the volume, efficacy and level of psychosocial interventions that have been provided to the Gaza population¹⁷. They found that there has been a major donor commitment to psychosocial interventions -- especially targeted at women and children in order to address the range of destructive impacts on mental health and wellbeing due to the effects of the three major Israeli military confrontations as well as ongoing blockade and sanctions on Gaza. However, the reports note that the high tides of psychosocial interventions in Gaza are linked to donors respond-

ing to immediate periods of humanitarian emergency (such as the aftermaths of the Israeli 2009, 2012 and 2014 military aggressions).

Following the 2009, military confrontation the studies found that many local organizations developed psychosocial programming that the authors describe as, “mostly reactive and subject to the availability of outside funding”¹⁸. Post-2014, they found that many psychosocial projects again were set up due to the availability of donor funding, some recruiting staff with no relevant experience and implementing as many as 17 projects within a very short one-to-three month period¹⁹. Moreover they found that only a third of organizations that undertook psychosocial programming had any experience in providing such services.²⁰ As such, the majority of interventions were structured group activities, psychosocial first aid, awareness raising, debriefings and open fun days; few organizations provided professional individualized care, case management or individual counselling. The report concludes: “There are significant concerns about the quality of psychosocial services as well as their long-term sustainability”²¹. NGO GBV service providers confirmed this general picture.

3.1.a. Limitations and Problems Identified

Look, everyone does psychosocial, but it's not in-depth – they give the woman a set number of three sessions of counselling, then discharge her. That's it. A project may dictate three sessions for every woman as if it's the Bible – and then they're abandoned. Our specialist followed some cases over 8-10 sessions, followed them in depth to the very end. Unless we can work like that we won't take cases. [Bassima]

Yes, our interventions are affected [by donor timelines]. To be successful in the psychosocial support of

say, sexual violence cases, we need two years for the woman to achieve a return to normal balance. There is no [donor] project that understands this concept and allows these projects to last for this period of time. Our last project lasted for eight months each so we can't deliver the comprehensive treatment that's needed. This paralyzes our work. [Firdaus]

I've had cases that I've sent somewhere for psychosocial counselling and they come back and say they were told to do two rounds of prayer and God will help you endure... I get really upset. [Rana]

17 Hart, Jason, “Protecting Palestinian Children from Political Violence: The Role of the International Community”, Forced Migration Policy Briefing #5, 2010; Abu Hamad et. al., Mental Health and Psychosocial Service Provision for Adolescent Girls In Post-Conflict Settings: The Case of the Gaza Strip, Rebuild Consortium Country Report, 2015.

18 Abu Hamad et. al. p.34

19 Abu Hamad et.al. p. 36

20 Abu Hamad et. al. p.40

21 Abu Hamad et. al. p.40

The problems identified in interviews with violence against women/GBV specialists in Gaza paralleled the general findings outlined above. Moreover, their comments also tended to suggest that the boundaries between general psychosocial interventions and more professional individual mental health services for women GBV sufferers have become blurred. The

general problem of low professional capacity and understanding of psychosocial interventions was clearly identified. They linked this to the absence of professional training, as well as to the fact that donors often invested more in emergency psychosocial interventions rather than professional mental health specialties.

Insufficient donor timelines

Donor timelines impact on the quality of psychological interventions for GBV survivors. Specialists continued to highlight that the majority of aid for GBV mental health related services is for psychosocial programming within the framework of emergency response – that is usually on very short project cycles. As such, when women and other victims need longer-term professional mental health

support, these short project cycles do not allow for their treatment to continue. Besides the negative results for the victims involved, given that mental health services continue to be viewed negatively within the Gaza social environment, instability in delivering these services has a possibility of delegitimizing them in the eyes not only of victims but the larger society.

Weak or unprofessional interventions

A number of specialists employed the “do two rounds of prayer” phrase when referring to the weakness of some of the psychosocial (if not professional mental health) interventions available to women in Gaza. Religious belief plays a positive role as part of a holistic therapeutic mental health inter-

vention when based on patient’s belief system. But there was a concern from specialists that therapeutic recommendations that were using religion may either be ideologically motivated by the therapists’ own beliefs or was covering up for their lack of professional knowledge and skills.

Lack of access to medication

A final problem identified by one service provider was the lack of access to essential prescribed psychotropic medicines for women they were treating for serious mental disorders, or for victims’ spouses – whose mental health problems were linked to

their abusive behaviours towards their partners. While the cost of some of these drugs was sometimes the main obstacle, in the case of some specialized medicines the problem was Israel’s restrictions on importing certain medicines into Gaza.

3.1.b. Positives of Psychosocial Interventions and Attempts to Address Limitations

The mental health services offered by Gaza Community Mental Health Centre were cited very positively by a number of service providers who regularly referred their clients to them for professional services. Also as mentioned in some of the statements above

some organizations do have the professional infrastructure of services that have been able to follow through with the long-term and intensive therapy necessary for some GBV survivors and are grateful for the flexibility of some donors to adapt project

timelines so as to ensure needed treatment of victims is not suddenly cut off.

Despite criticisms of the post-2014 flood of “psycho-social activities” that seemed to be more about externalizing feelings, sharing traumatic experiences or taking part in enjoyable or entertaining activities a number of specialists mentioned their importance and benefits. First was the real need for women to share their painful experience and have some relief from the traumas of the war, thus these activities often had therapeutic effects for women suffering from “normal levels” of short term trauma. For women with deeper mental health problems these activities often helped organizations to identify them and try and connect them with more professional services.

4. Legal Interventions

According to UNFPA in 2015, 7% of all donor supported GBV/violence against women interventions in Gaza were in the area of legal services.

In non-conflict settings, best practice legal treatment of GBV/violence against women involves

In another case, one program that deals with violence against women in partner conflicts by working with both wives and husbands as well as their children, said their activities of organizing “family days” to promote emotional wellbeing by providing outings for families under pressure was a crucially important activity given the constant stress and hardship of life in Gaza that was often the source of family problems including violence.

A number of specialists said that out of moral duty and commitment they continued to provide psychological services to women clients in the process of treatment even when donor funding had stopped. What they could not do however was to take on new clients in the absence of funding.

three areas of legal intervention: legal awareness and education; reforming national legislation; and providing direct legal services and support to victims. The main focus of legal interventions around GBV in Gaza has been limited to two of these; legal awareness and direct legal support to victims.

4.1. Limitations and Problems Identified

Most needed are better interventions around legal aid. We have a lot of legal aid but they're all traditional efforts -- we haven't changed a thing...We have to go back to reforming the laws, even if the PLC isn't working... maybe we can't change laws and decisions just now at the level of the executive or legislative or Shari'a courts but we need to be working on them. [Nariman]

We do awareness-raising about human rights and make recommendations at meetings, we target law students and judges, but what's the result of these recommendations? The problem is the division and siege. [Nafiseh]

Organizations have a legal clinic but they wont

take a tafriiq case (wife initiated divorce) because it takes three years in court so you need a lawyer to follow her all that time and then the program is cut, that's it the project is over -- so the woman is told go and come back when there's a project [Rana]

Back in 2008, I told [donor X] I cant wait until the division is over if a woman comes to me and needs help with her rights that only the government can give -- its a reality we have to deal with. We dealt with the occupying government in the past and we'll deal with this government -- if we've been able to change the behaviour of the Hamas authorities by 10% then I served the people 10%. [Ahmad]

Lack of Legal Reform Advocacy/ Split in Governance

As highlighted above, a consequence of the “no-contact” policy with de facto government and the reluctance from some local NGOs to legitimize the Hamas authorities has meant that campaigns for legal reform that dominated the Palestinian women’s movement agendas of the 1990s have completely disappeared. In this context one specialist argued that legal awareness training, be it to members of the judiciary or women themselves had limited impact in the absence of a clear strategy and activism around legal reform.

Some Gaza GBV specialists argued that despite the political context ways forward needed to be found to work on legal reform for GBV victims, rather than simply continuing to provide women support to get their rights from a legal system that is inherently unsupportive of their needs. A way to overcome legal obstacles resultant from the political divide is to focus on changing the procedural dimensions of the law rather than its actual reform. This has been the strategy pursued by a number of women’s legal rights activists in the West Bank that have pushed

for administrative changes to a number of procedures that they see as creating strategic changes for women within various aspects of existing family law.²² For example, a specialist suggested to promote the creation of special units in Shari’a courts to expedite the legal processes for GBV victims which she and others said were slow and onerous, often forcing women to seek a solution outside the formal legal system.

A number of specialists also highlighted practical obstacles they faced in dealing with GBV related legal cases due to the political divide and thus the parallel and competing legal systems. For instance, a service provider described a recent case they had of a woman trying to divorce her fiancé in the West Bank and how competing legislation between the two regions made finding a legal solution almost impossible. As well, attempts to find solutions were further undermined by Israel’s blockade which limited their approach to try and reach relevant West Bank authorities by phone only.

Donor Timelines

Donor timelines for support and funding also impact the representation of women in legal cases because they can be lengthy processes not achievable within the limits of a project cycle. Some organizations often declined women seeking a divorce because they could not ensure they would be able to follow

through on these cases. Similar to the problems mentioned regarding psychosocial programming and the closing of a project, a number of specialists had faced problems of women’s legal cases left “hanging” when a project came to an end.

Informal Justice and Mediation

On the whole, especially female specialists were negative about the role of informal legal mediation.

At the same time, they acknowledged that it is often women GBV sufferers’ preferred path since it is

22 Hammami, Rema and Penny Johnson. 2014. Change and Conservation: Family Law Reform in Court Practice and Public Perceptions in the Occupied Palestinian Territory; Summary Report of 2013 Family Law Survey Findings. Institute of Women’s Studies, Birzeit University

quicker, cheaper and more socially acceptable than going through the formal legal system. A 2012 study by the NRC on customary dispute resolution mechanisms in Gaza²³ notes that these informal systems tend to be very patriarchal in their structure as well as approach.

Only one specialist was from an organization actively focused on informal justice providers and various forms of mediation in dealing with women's legal issues as they relate to violence against women/GBV. Their approach to mediation goes beyond a simple reliance on traditional informal justice actors and mechanisms and uses three different paths:

- Treating cases in full coordination with the local Shari'a courts with the aim of facilitating a legal process that would take longer if left solely in the hands of the court. In these cases, either the judge or the family counselling units in the Shari'a courts refer cases to the Center that they think could be solved through mediation, and the final outcome is written as a legal decree by the court authorities.
- Undertaking the mediation at the Center on the basis of formal rather than customary law. The

final agreement is registered in the court and is recognized by them as a formal legal decree. If the agreement subsequently breaks down the decree is taken into account as part of the legal record of the case

- Undertaking the mediation at the Center on the basis of formal rather than customary law, but without a final legal decree.

In all three paths informal justice providers such as representatives from reconciliation committees and male or female mukhtars are usually members of the mediation committee. But the provider actively trains individuals in the informal justice sector and focuses on developing their awareness about GBV and women's rights – rather than simply involving them without awareness or training.

The analysis from the Pathways research on individual survivor/victims (see chapters V and VI) shows that at some stage in their case history many passed through interventions with various informal justice providers from their local communities. But for the majority, the involvement of male informal justice actors was at best, ineffective when directly concerning GBV.

4.2. Positive of legal Interventions/ Attempts to Address Limitations

There were no specific positive dimensions of legal initiatives raised in the interviews. Instead there was a shared assumption that legal support to women victims was such a critical need and that despite short donor timelines or the lack of a transformative approach to gendered law in Gaza, current initiatives were in and of themselves very positive in enabling women to access rights. This was especially so when compared to a previous or "normal" situation in which women victims had no access to material or institutional support when facing the legal system in Gaza.

All specialists had at some point made personal in-

terventions with legal authorities on behalf of individual victims – often relying on good relations with individual judges in divorce and guardianship cases. As well a number of human rights and law specialists undertook training with sectors of the legal authorities under the Hamas government and had found that opening professional channels of communication had been a positive investment, though mainly towards treating individual cases.

A few had dealt with the problem of donor timelines by referring new or in-process cases to other providers whose legal clinic project cycles were still ongoing.

23 Adamczyk, Sarah and Barbara Col. 2012. Customary Dispute Resolution Mechanisms in the Gaza Strip. Norwegian Refugee Council.

5.

Health Initiatives

As cited by the UNFPA, at only 4% of all GBV/violence against women donor supported initiatives in Gaza in 2014 health comes out as one the most limited area of treatment-centred activities. The low emphasis on health issues related to GBV/violence against women victims' specific needs was confirmed in the problems identified by GBV specialists. Only two local NGOs specializing in GBV had a health-based program, largely because their start-up in the 1990s was focused on women's health issues.

At a minimum in any context, health services for GBV victims need to individually or collectively play three main roles:

Detection: regular or specialized women's health services can be an entry point for GBV victims seeking help; or when medical staff are trained to detect the signs of violence systems are in place to either treat all aspects of the abuse (as in one-stop cen-

tres) or to refer victims to needed services outside the health centre. Two women's health NGOs (in Bureij and Jabaliya) to some extent fit the one-stop services model while the UNRWA's referral fits the second, referral model.

Medical treatment specific to GBV: In cases of physical and sexual violence, GBV sensitive treatment of injuries, or in the case of the latter protocols to deal with unwanted pregnancy and sexually transmitted diseases. In this study, only the two women's health NGOs (mentioned above) provide most of these specialized medical services to victims.

Legal medical examinations and the collection of forensic evidence for criminal legal proceedings as well as social services. Currently in Gaza only evidence collected by two female staff at Shifa government hospital can be used as forensic evidence of GBV in legal proceedings.²⁴

5.1. Limitations and Problems Identified

You start with the clerk at the governmental hospital who takes her information

and the process of blaming starts: "Forgive your husband etc..." And then you even get the nurse telling her that if she didn't do anything wrong then her husband wouldn't have hit her... Then the medical report is useless in the court... as if they think that if you want a usable report to raise a case in court you have to be totally destroyed,

beaten not once but 20 times, otherwise there's no case...[Firdaus]

When we refer to governmental institutions, they ask for a medical report as proof that the woman was subjected to violence but most times the medical report is unfair to the woman. ...The medical reports many times are useless because they don't reflect the degree of harm/injury the woman suffered and this is a great problem... [Rana]

Limited NGO Providers of GBV Health Services

Overall, there was a consensus that there are very few organizations offering specialized medical services to GBV victims. The majority of specialists have to refer medical cases to the few specialized NGO

providers with health services. As such, outside of the UNRWA framework and a very limited number of NGO providers, there were few opportunities to use these services for basic detection.

²⁴ Although one provider said they had been able to get forensic exams done through Gaza's Red Crescent hospital as well – an option other providers were not aware of.

Government Hospital's Medical Role/Forensic Services

The main critical focus of NGO specialists when talking about GBV health services was focused on the government sector and the problematic way it carries out its mandate in dealing with GBV cases. Specialists mentioned the lack of awareness and insensitivity of government health workers in dealing with victims, a problem with particularly grave consequences in cases where women needed a forensic medical exam. These examinations are required in Gaza not only in cases where women want to follow

through on legal criminal proceedings, but also in order to get the minimal government social support offered to GBV victims (from the Ministry of Social Affairs). The lack of professional and sensitive training results in a lack of professional protocols for examining GBV victims, with the result, according to a number of NGO GBV specialists who had actually had specific cases where the government forensic exams and the reports based on them were unusable in court.²⁵

5.2. Positives of Existing Medical Interventions/Attempts to Address Limitations

For those NGO service providers that offer women's health care generally, as in other global contexts they have found providing general health services is an extremely effective vehicle to detect then treat potential victims of abuse. This study only dealt in-depth with one NGO provider of such services, they regularly detected victims through their interactions with women coming for their regular women's health services and then were able to provide them

with or link them to specific services for whatever dimension of GBV they were suffering from. This was confirmed by the case of, two of the women in the Pathways research on individual survivor/ victims (chapters V and VI), who by telling abusive husbands they were simply going for a regular medical check at NGO providers with health services, were able to seek and reach a service provider for help and treatment with their abuse.

6. Protection/Shelter

According to UNFPA, only 4% of donor funds for GBV in Gaza in 2015 went towards protection and shelter for GBV survivors.

The provision of safe accommodation/shelter to survivors and support services to their accompanying children is cited as a fundamental principle in providing basic essential services to victims of GBV.

UN Women and other International Agencies in their literature on GBV services, recommend the provision of one shelter that provides safe emergency accommodation, qualified counselling and other assistance for every 10,000 inhabitants. In Gaza there is only one comprehensive shelter for a population of more than 1.8 million people. Moreover, given that the sole shelter (Beit al Aman) was founded and

run by the standing government authorities it has been caught in the destructive political dynamic of the split in governance/no-contact policy.

Shelter's where GBV survivors can find immediate protection from threats to their life; or get long-term treatment in a safe and protective environment should, however, be only one element in a whole chain of protection providers and their allied infrastructures. This starts with the existence of an overarching legal framework that ensures recognition of and rights of victims to protection from perpetrators; that is then translated into policies, laws and protocols across the justice sector (the criminal courts and police); as well as into relevant government services (particularly in health, social welfare and housing).

²⁵ According to the head of the Women's Health Department in the Ministry of Health, only starting in 2016, did they begin to take on GBV as a specific health issue and began participating in training on the issue. As such, in the government health sector individual norms and biases in treating GBV victims have predominated in the absence of professional training and awareness.

This infrastructure should operate in the both the immediate emergency situation, but also over the longer term to support victims in their recovery and ability to live dignified, secure lives.

In Gaza the absence of this wider infrastructure of protection, severely compromises the possible effective role of a shelter in providing both short and long-term safety and security to victims.

6.1. Limitations and Problems Identified

The least investment has been put into protecting women -- women suffering from violence have little formal protection because of the political situation. [Ahmad]

The hardest thing is providing protection and security to women... How many times did we have cases in Gaza where a woman was urgently in need of protection and she ended up being killed on the basis of 'honour'. A problem remains the general cultural situation in the context of what's legally possible, in terms of what the level of awareness is... the legal procedures that result in protecting the killer – the issue of culture and protection are

the biggest dilemmas. [Nahda]

...the police dealt with her [a 15-year-old victim of incest] like she was the criminal...'Confess it wasn't your father, we know it was someone else' the whole time using masculine culture against her. Then her male relatives kicked her mother and the children out of the house because they don't want to be associated with the case. And as the girl goes to follow up on the pregnancy at the X Clinic, the whole time there's a policewoman with her and everyone's dealing with her as if she's the guilty one instead of treating her like the victim. [Fairuz]

When NGO specialists were asked what was the hardest part of working on GBV in Gaza, for many it was the near impossibility of providing shelter and protection to female victims. Numerous examples of cases showed that in the absence of working towards gender sensitive legal frameworks, the existing government procedures reflect and exacerbate dominant masculine cultural values that perceive victims as the perpetrator of a moral crime rather than as a victim, thus making their protection near impossible. This is all the more so given that often the cases that are in most urgent need of protection are those involving sexual violence – particularly incest and rape, where male perpetrators and the masculinist culture surrounding them aim to protect the family's reputation at any cost – including the life of the victim:

- In terms of Beit al Aman, the sole shelter facility in Gaza (established by the de facto authorities), specialists had mixed assessments about quality of care as well as their general approach [See Box 5]. Specialists who had worked with the shelter (with many of them having referred cases to them) were more positive. Specialists who had no

experience with the shelter continued to perceive it in light of its initial negative reputation when a very conservative director ran it with little sensitivity or awareness about GBV.

- One specialist condemned the shelter's solution for a rape case in which the victim was married to her rapist. However, as highlighted by the Pathways research on individual women victim/survivors the difficulty of finding solutions for victims of sexual violence is compounded by the Gaza context. Thus, the strategies that staff in the shelter use for extremely difficult cases, in the absence of a wider framework for the protection of women victims and their ability to simply live free from fear of familial retribution while locked in the open air prison of Gaza needs to be put in context, rather than being judged by a set of norms or standards that have little traction in Gaza's contemporary reality. For both service providers and victims, protection is often more about finding the least bad solution among a series of very poor choices.

- The overall consensus towards the Beit al Aman shelter was that specialists should take advantage of its current openness to learn from the NGO sector so as to help build its capacity. At the same time, previous attempts to open an NGO shelter

should be stepped up. This would help cover the critical dearth of shelter for GBV sufferers as well as give greater choice to survivors seeking protection services.

Housing

A protection issue that arose forcefully in the individual case studies of victims (in the final two chapters of the report) is the critical role that independent housing can play in enabling a survivor to exit abuse, or live in an environment where she can better cope or contain it. Housing figured very strongly as both an obstacle and a potential solution when many women victims discussed their needs. For some women, exiting the abuse was almost impossible due to their family being unwilling or unable to take in the women's children. While the legal constraints of female custody of children was a main obstacle, for many this could have been overcome if there was a provision of independent housing for them and their children. In three other case studies, women said they could better contain abusive husbands (who in two cases were mental health patients) if

they had a home separate from his extended family. Addressing the priority many survivors put on housing is in line with the core ethical principles of global GBV service provision that constantly underline the importance of putting the needs and priorities as articulated by the victim/survivors first.

Specialists confirmed that independent housing, especially for GBV victims with children was a critical priority but one that they had found very difficult to address due to donor priorities. One suggested that more could be done to integrate these needs in the on-going shelter reconstruction process. Others suggested that more focus should be put on legal mechanisms to evict the abuser from the home while giving women victims and their children rights and protection to stay in it.

Protection Needs of Service Providers

Though only one NGO specialist raised the issue, it is clear in some cases that service providers themselves can come under threat by perpetrators and their families. An NGO specialist from a centre in southern Gaza said when they initially opened they

faced constant threats from ex-husbands and other relatives of GBV victims. They asked for help from the regional governor who until now posts a police officer at the Centre's entrance.

6.2. Positives of Protection Interventions/Attempts to Address Limitations

More than any other area of service provision, specialists' overwhelming focus was on the absence of

such services and the inability to overcome this critical gap.

7.

Livelihoods/Social Support

According to UNFPA, only 4% of all donor supported GBV interventions were directed towards livelihood support in 2015.

7.1. Limitations and Problems Identified

The typical woman [GBV victim we see] has her house destroyed, lives in extreme poverty, gets beaten every day, and is incapable of defending herself or children from her husband. It's compound abuse. It is very unusual to come across a woman who has good living conditions and is subject to sexual or physical abuse... Only a few organizations work on economic empowerment: very few because of donor policies. [Bassima]

We are more and more convinced that economic

empowerment is crucial in the struggle against violence – it needs to go alongside with protecting women from violence... We had a project of empowering women sufferers through small loans and income generation training. It was so much work to convince donors. It was really successful but they wouldn't continue with the project... Now we have 300 women on the waiting list for our economic empowerment program – waiting because of the funding. We could take even more if there was funding. [Rana]

An overwhelming majority of front-line service providers cited poverty as a critical feature of GBV in Gaza, based on the basic fact that the majority of women who seek their services are poor, often desperately so. This is confirmed by the data on victim/clients from the organizations' case files; the findings in the analysis of the PCBS Violence survey as well as the in-depth Pathways research with individual survivor/ victims. As such, the majority of NGO service providers saw livelihood support and economic empowerment projects as a centrally important component of treatment focused interventions. At the same time, they expressed frustration that support for GBV survivors livelihood support strategies held a low priority among donors, as attested to by UNFPA mapping of donor support.

The leading front-line providers emphasized how centrally they have come to see the issue of poverty

and livelihoods as drivers of violence against women, as well as in enabling women to exit from it. But those organizations that integrate economic empowerment into their services had all faced major constraints that were an outcome of donor policies.

In terms of the quality of existing economic empowerment programs there was the view that specialized GBV service providers were doing more strategic projects than CBOs. At the same time, they recognized that income generating projects for GBV victims could not operate solely according to market principles and strict repayment schedules that is the norm in regular microfinance programs. Instead, they cite the need for more modest and flexible forms of financial support that would be more appropriate to the needs of women trying to emerge from the compounded trauma of long term abuse.

Social Welfare Support/The Ministry of Social Affairs

The actual and potential role of the Ministry of Social Affairs was raised by a number of specialists when talking more specifically about their experiences with getting social support for specific women victims. Overall, any provider who raised the issue noted the obstacle of getting aid for women victims

due to the current policies of the Ministry. In specific, women whose divorce was "hanging" who could be stuck for long periods of time without any maintenance from recalcitrant husbands, did not meet the Ministry's criteria for social support.

7.2. Positives of Economic Empowerment Interventions

All of the specialists viewed economic empowerment programs as a critical need and one that is and should be a crucial component of treating and supporting women victims.

Findings from the individual interviews with survivors underlined that taking part in skills and income generation training had been extremely therapeutic for those who had received these from service providers. Even the process of learning a new skill had had immensely positive affects on the women's self-esteem and outlook on their future. Two women

survivors noted that because of income generation training their husband's had either allowed them to keep visiting the service provider (when they had been initially violently opposed to it) once they saw that she was getting practical skills that might lead to her earning income. Sadly, in all the cases where women had taken part and were very enthusiastic about these specific programs, they had all been promised a future small "project" or loan but funding for these had not been found by any of the providers by the time the field research ended.

8.

Cross-Cutting Issues

8.1. Referral

Referral protocols and systems are a fundamental dimension of providing and ensuring that victims have safe and systematic access to the range of timely services they need and in a way that is the most relevant to their particular case. Without a clear framework of referral, there is a strong chance that victims will suffer further as they attempt to make their way through an unclear and disconnected network of specialized providers. Coherent, institutionalized referral systems also ensure that when a case goes to court or faces government bureaucracy, various providers operate in tandem and can be brought together effectively to defend and

support them. In situations where there are one-stop centers that provide comprehensive services to victims, a referral system continues to be important as the means to establish a link between treatment services for victims and the criminal justice system.

In Gaza, there are no comprehensive GBV one-stop centers.²⁶ Moreover, given that the GBV providers in Gaza are overwhelmingly from the NGO sector and are specialized in different services, linking between them as well as between them and the criminal justice system and other critical components of the governmental sector becomes even more crucial.

8.2. Limitations and Problems Identified

Many of the institutions we refer cases to don't follow up [with us] and treat it as if its only their case, they don't have a written system for registering referrals, or you find someone referring a case and then they forget it and then fight over whose case it is... There are many problems in referral processes -- everyone wants to have more cases as if the number of cases is more important than the quality of services... [Fadwa]

All the cooperation is subjective and based on personal initiative and connections. There's a real weakness because there's no formal system. Until now it's all personal initiatives and also personal knowledge – even the shelter or the ministry it's

based on knowing particular people. Or for instance a case we sent to Shifa [hospital], there was a counsellor working there who had been at one of our training workshops and that's why she followed up so well with our case. [Rana]

A large number of women are just looking for assistance not really services these are the cases that move and are referred a lot – they want to go to a lot of organizations to see whether they can get economic support and it creates a big mess in referrals... Or you get situations a woman keeps coming back because they came to you first and they feel good and comfortable with you [Ahmad]

26

Even UNRWA's 'one-stop centres' operate primarily as referral centres.

A “System” Based on Informal Networks

Practically all of the NGO providers in Gaza regularly and constantly have cases referred to them as well as refer cases to other providers. However overwhelmingly, referral arrangements are “informal” and primarily based on networks between individuals across organizations and institutions rather than formalized institution-to-institution protocols. At most, providers have a written agreement with only one or two other providers even when they regularly refer clients.

One specialist said that their organization in the absence of a systematic referral system used the networks and a memorandum of understanding they had developed by being part of al Amal Coalition. However, she was the only member of the

coalition interviewed who mentioned it as the vehicle for referral.

All of the specialized providers were aware of the effort to build a national referral system in the West Bank since 2013 and that it had not succeeded in taking off. A number of them had participated in one or both recent donor initiatives to build a referral system in Gaza but were pessimistic about its translation into a practical system on the ground. One service provider who had participated in these initiatives in Gaza expressed frustration that they had been done on project time-scales by two different donors – which was deemed the reason for their lack of final implementation.

Inability to Follow Up with Referred Cases

Most NGO specialists felt the absence of an overall referral system was a critical problem, but primarily so because it undermined their ability to consistently follow-up and track cases they had referred. Only in sexual violence cases (see below) did specialists stress that the absence of a system caused greater suffering to victims because there were no standard procedures and protocols to bring service providers together to treat these cases safely and coherently. Instead, the main issue raised was that the lack of a referral system precluded the initial provider from

finding out what had happened to the victim once they referred them and could not ensure the quality of services they had received. Some suggested that organizations do not provide information to the original provider about clients the former have referred to them due to competition between organizations. This is similar to the problem in awareness interventions, when some providers prioritize reporting large numbers of beneficiaries to donors, over the quality of actual service provision.

Problems Created by Service Users

In terms of tracking cases, problems are also created by service users. Poor and destitute women often make multiple rounds to the same NGO in search of humanitarian aid, appearing with referral slips again and again from providers that have passed them on. In other cases, referred women keep returning either because they feel more comfortable with the

original provider rather than the one they have been referred to, or simply cannot find the services they need at the referred institution (such as treatment for addiction). All of these cases create chaos in the record keeping and case file management systems of service providers.

Inability to Ensure Quality Services

Others raised referral as a problem not in terms of the lack of a system, but the lack of ability to ensure good quality services were being delivered. Some noted that the service provider they referred a client

to had used approaches they fundamentally disagreed with (such as suggesting prayer as psycho-social treatment or “tribal justice” for a legal case).

Need to Prioritize Needs of Sexual Violence Victims

If there was a strong consensus, it was on the urgent need to develop a sound and systematic referral system for victims of sexual violence, although there was even greater consensus that these cases are so sensitive that ultimately it would be better to create a comprehensive service centre to treat them.

As one specialist noted, referring such cases often simply exacerbates their suffering and trauma. It also creates a much higher likelihood that victims’ confidentiality will be compromised – with potentially life threatening consequences for these cases in Gaza.

9. Collective Strategy and Coordination

9.1. Limitations and Problems Identified

When we did the al Amal coalition, we had three different programs that complemented each other and were based on a shared vision and principles. Working together we came up with a shared vision and mechanism we all agreed on. Now everyone works on their own and according to whatever leaning they have.... [Nairuz]

It is nonsense how different organizations work separately despite the presence of networks and coalitions. There is failure in coordination of our

services for GBV victims. We need a clear methodology and strategic plan to support each other and minimize duplication of services. [Bassima]

There are many good GBV programs and services in Gaza and organizations are offering the best they can do, but the problem is that there’s no shared vision or strategy... Programs are often very good but if there’s no coordination between them we can only go so deep in providing services [Ahmad]

The two coalitions that were founded to serve as platforms for NGO GBV providers (al Amal Coalition) and CBO’s (Wessal Coalition) to develop a united strategy and vision, as well as to coordinate GBV activities do not seem to be actively operating as the vehicles to achieve these. The study found that in recent years both coalitions appear only to be active

during short periods when there is a major Public Advocacy/Awareness initiative underway.²⁷

All of the specialists interviewed emphasized the critical absence of a shared strategy and vision among NGO providers. The outcome of this is two-fold: specialists said there was no shared institution-

27 Predominantly the global 16 days campaign.

al strategy that could translate the fragmented efforts of individual organizations into more effective strategic outcomes. Moreover, because of a lack of coordination organizations were often structurally competing with each other resulting in gaps in

service provision going unmet while in other areas there was overlap and unnecessary replication of activities and services – both in terms of the type of services and their geographical reach.

9.2. Positives of Coordination/Attempts to Address Limitations

For providers who had been part of al Amal Coalition in the past when it was active they mentioned it as a highly positive experience. Most specifically they cited having a shared philosophy and vision towards GBV, which meant they worked more effectively and towards a shared goal, while also having trust in the quality of services of network member when referring clients between them.

For many members the network continued to play an informal role both in lieu of a formal referral system, as well as when seeking services for a client during a funding gap. Also as can be seen in the case of advocacy around legal change that providers have undertaken without donor support, network members continue to informally work together on specific issues.

BOX 5. BEIT AL AMAN, THE ONLY COMPREHENSIVE SHELTER FOR WOMEN IN GAZA*

Founded in 2011, by the Ministry of Social Affairs under the Hamas de facto authorities, Beit al Aman (Safe House) remains the only comprehensive shelter for women and children victims of GBV in Gaza.

Located in an attractive large building in Gaza city, the shelter can house 50 women and their children in well-equipped bedrooms or suites. The premises include a shared kitchen, bathrooms and living room. The lower floor houses a library, theatre/TV room, leisure area, meeting room and a visitors' hall. Outside there is a large courtyard that includes a volleyball pitch, and an open area surrounded with flowerbeds. The shelter has a bright, clean and positive atmosphere. Two policemen are stationed at the entrance around the clock.

Since 2012, a female director with a BA in social work and diploma in public administration has run the shelter. Her professionalism and commitment to sensitively meeting the needs of GBV survivors has enabled the Safe House to earn the respect of NGO front-line service providers who have worked with her. The shelter has 22 employees. Professional staff includes: nine female counsellor/social workers; 2 psychiatrists; a nurse; 2 occupational trainers; and a policewoman. It also uses external staff for training services (such as ICT) as well as more specialized legal aid (lawyers from the Palestinian Center for Human

Rights, PCHR – an organization that has a long-standing formal agreement to provide services to the shelter).

According to the Director, the shelter receives women who come themselves, as well as those referred by government departments, including ministries, the judiciary, members of the legislative council and the police, as well as those referred by NGO service providers. Some women come seeking only consultation and advice while others are sent or arrive seeking protection/accommodation.

The shelter has standard procedures for dealing with new cases. An initial consultation takes place with a social worker who also records the main details of the case. The social worker then discusses next steps with the director and if accommodation is required an intake form is filled. Women taken into the shelter are provided with whatever personal items they may need such as clothing and personal care. The nurse is on hand in case there is an urgent need to treat wounds or take forensic evidence. At this point the victim is told to simply rest for three days before making any decisions about her future. Once these procedures are completed, the Director informs the woman's husband or family that she has been admitted into the shelter, as she says in order to, "... avoid escalation of the problem".

After three days in the shelter, the victim starts social and psychological counselling. Only then is a possible strategy to treat the case discussed. The victim's preferred solution along with the case history and circumstances are presented in detail to a "case conference" whose participants depend on the particular needs and priorities of the specific victim. According to the Director, the "case conference" usually includes a delegate from the following: the Police and the Ministry of Interior's Public Relations Departments; a specialist from the Reconciliation Committee of the Legal Scholars Association (RCLSA); a lawyer and social worker from the Palestinian Center for Human Rights (PCHR); a social worker from the Shelter, as well the Director herself.

Depending on the victim's preferred solution, the case is then taken forward by one of these parties. For instance, when women prefer reconciliation through the informal justice system the RCLSA takes the case forward; if she prefers to raise a formal legal case, the PCHR takes the lead. In cases where women prefer to scare or punish the perpetrator, the Police and the Ministry of Interior assume the main role. The Director states that few of their cases have opted for informal justice/reconciliation because as she explained: "Women do not trust the tribal solution which usually causes more injustice being inflicted on the oppressed".

The case conference is held once a week always with the presence of the two representatives from PCHR. Since 2011, their lawyers have represented 43 cases from the shelter in Gaza's courts, as well as provided legal consultation to another 240 women at the shelter. The PCHR social worker also visits the shelter on a semi-daily basis and has over the past two years provided systematic training to the staff.

Women coming for day consultations are offered professional social, psychological and legal counselling. Women under protection at the shelter also have access to psychotherapy, medical treatment or referral for treatment, coordination with social welfare assistance, as well as training courses (in ICT, embroidery and tailoring).

The shelter runs on a loose daily schedule for women under protection, although they are free to use their time as they choose. Breakfast is followed by women participating in whatever training course they prefer. Individual counselling sessions are then followed by the period for family

visits. Throughout the day, women can choose to simply rest or read. A cook prepares all meals but women are asked to provide input into the weekly menus and if they prefer, they can cook for themselves. After dinner they are free to watch television in the living room (with no restrictions on channels). There are also religious learning sessions for those who wish to attend between the sunset and late evening prayers. After 10pm television is switched off. The shelter tries to take women under its protection on outings – mostly to the beach and under the protection of the policewoman in the evenings.

The number of women in the shelter varies from day to day. The Director said that the largest number they ever had at one time was 35 women, although there are usually less than 15. According to the shelter's statistics, the numbers of women using the services almost doubled between 2015 and 2016. In 2014, 90 women were accommodated in the shelter (along with 36 accompanying children), while another 36 women went for day consultations. In 2015, this increased to 118 women under protection (along with 38 accompanying children) while 105 women used their day services. In 2016, the shelter accommodated 221 women along with 86 accompanying children, while providing day services to another 101 women. The Director believes this growth is not due to growing rates of GBV, but to greater public knowledge about the shelter and its growing positive reputation with both within the governmental and NGO sectors. .

Due to the positive changes made by its second, current director, the shelter has overcome many of the initial criticisms lodged against it by NGO service providers. However, some continue to underline its limitations. These include: the shelter's lack of a rights-based approach to GBV; limited professional competencies of some of its staff; the absence of empowerment programming and finally a policy of rejecting cases where a woman's "morality" is an issue. However, shelters in the West Bank also face the latter dilemma, usually rejecting cases where women have been sexually trafficked for fear that their presence will undermine the already weak social legitimacy of their institution as well as the reputation of the women it is sheltering.

* For more in-depth understanding of how the shelter works see Pathway case studies: A2 Manal; and AE1 Ilham

CHAPTER IV.

THE GAPS: IDENTIFYING THE ACTORS AND CAUSES

Identifying the gaps and problems of current programming is quite straightforward; more complex is to identify the individual sources or determinants of them. Given that the crisis in Gaza is so comprehen-

sive and compounded by so many negative policies and events, the source of particular gaps and problems has become more systemic.

1.

Recurrent Problems Identified Across Programming

	Low Capacity/ Human Resources	Poor Quality Control	Faulty Priorities/ Resource Targeting	Inappropriate time-lines	Anti-Victim Policies	Lack of Strategy/ coordination
Awareness	✓	✓	✓	✓		✓
Advocacy	✓	✓	✓	✓		✓
Psychosocial	✓	✓	✓	✓		
Health	✓				✓	
Legal			✓	✓	✓	✓
Protection	✓		✓		✓	✓
Referral		✓				✓
Livelihoods			✓			

The main causal actors and agents in these processes include Israel as the occupying power, the Donor Community and International Agencies, the de facto government authorities in Gaza and the NGO sector

itself. In all cases explaining the specific gaps, obstacles and potential remedies, dual or multiple actors are involved.

1.1. Low Capacity and Weak Human Resources

Raised in Relation to Awareness, Advocacy, Psychosocial and Health Interventions

1.1.a. The Role of Israel's blockade

Israel's occupation and the blockade of Gaza have a critical though often unnoticed impact on GBV/ violence against women provisioning. In terms of professional capacity building no or limited mobility to education and professional training schemes beyond Gaza's borders creates a closed circle of skills and knowledge within Gaza. The existing handful

of highly trained professionals are also locked under the blockade and are unable to infuse this closed local circle of professional capacity with alternative knowledge, approaches and experiences coming from outside the Gaza Strip. Moreover, the blockade has led to a growing brain drain of specialized professionals from Gaza.²⁸

²⁸ Even during this study two very specialised professionals became unavailable due to their decision to emigrate.

In terms of GBV services, these specific impacts on capacity can be seen in the gaps and weaknesses in awareness raising and advocacy, where highly qualified trainers are very limited.

This overall situation is now exacerbated by the fact that the Israeli permit administration also makes access to Gaza almost impossible for GBV specialists with Arabic language skills (a real necessity for effective training-of-trainers in the Gaza context). In addition, over the last two years Israel has increasingly denied permits to specialists to take part in activities outside the Gaza Strip; and when they do the time limits on permits makes participation in any in-depth training a near impossibility.

Furthermore, access and mobility restrictions due to

the blockade also have similar major impacts on the capacity of **psychiatric and psychological services**, and for providers of GBV specialized health services limiting the ability for specialists to get professional training, including clinical experience in especially the mental health field, including in various specializations.

Indeed, when talking about the effects of Israel's blockade on human capacity, it may be more appropriate to talk about **enforced de-professionalization**. This is all the more frustrating given that the same policies that have led to mass trauma in Gaza and growing mental health issues are simultaneously the ones preventing the development of those needed to treat them.

1.1.b. The Role of Donors

In the resource depleted conditions of Gaza, donors have a large but often unacknowledged amount of power vis-a-vis NGOs and the wider community. Donor control of financial provisioning means they can set the agendas and priorities as well as pick and choose among local providers willing to deliver them. At the same time, it is clear that donors are also overwhelmed with addressing so many needs in Gaza.

In terms of capacity building in relation to **awareness and advocacy**, some questions donors need to reflect on include:

- To what extent have donor policies prioritized creating mass awareness and advocacy at the expense of investing in high-level local capacity to deliver these beyond primary knowledge levels that seem to dominate in awareness workshops?
- Given that community awareness-raising has been a main activity over a few years, is it time to think of investing in more focused awareness raising, targeting specific actors and sectors as well as investing in human capacity that can take GBV awareness and advocacy to a level beyond the basics?
- To what extent has the “no-contact” policy with the de facto authorities led to under-investment in human resources to undertake strategic and targeted advocacy for change to the procedures and policies for prevention and treatment of GBV.

In terms of **Psychological and Psychosocial interventions**:

- Donors need to try and re-balance interventions around mental health in Gaza – away from the overwhelming investment in short-term mostly first aid psychosocial activities and put more emphasis on professional mental health services capacity building. The very limited professionally trained psychiatric staff and infrastructure that exists in Gaza are already overwhelmed. This creates a series of negative knock-on effects where victims (as well as is often the case – perpetrators of GBV) are unable to access stable and good quality treatment. As recent reports outline there are a number of critically missing mental health specialties in Gaza including child and adolescent psychiatry. One could add to this the dearth of psychologists trained to deal with other GBV related needs, such as victims of sexual violence and drug addiction.

And in terms of **Health-Focused Interventions**:

- Donors need to reflect on the impact of the no-contact policy. Little or no investment in capacity building in the government health sector to deal with GBV victims has led to a situation in which victims are subjected to insensitive and humiliating treatment by government health staff charged with treating victims of violence. This also results in compromising the legal evidence for women wanting to exit an abusive situation when staff do not have the requisite capacity to properly undertake forensic examinations.

1.1.c. The Role of the Standing Government and the Palestinian Authority

Both Palestinian governments have various responsibilities to play in treating areas of low professional capacity in various areas of government service provision. The standing government in Gaza has shown low awareness and desire to treat violence against women/GBV as a serious area of government concern (except when incidents are perceived as endangering social stability). Thus they have undertaken little or no investment in capacity building across the entire government sector in Gaza necessary to deal with GBV. While the Palestinian

Authority has signed several initiatives and taken policy decisions, they have been slow in translating these into concrete changes on the ground. In both cases, both the Palestinian Authority in the West Bank and the de facto authorities in Gaza continue to put an extremely low priority within the health sector in investing in mental health services, including in addiction programs which are the two health services that emerged as very relevant to treating a significant number of perpetrators of GBV during the research.

1.1.d. The Role of Local Providers/NGOs

While identifying low capacity in **awareness raising and advocacy** interventions, the local community of service providers also need to address their own roles in addressing these gaps. Some questions they might reflect on include:

- How can local organizations collectively and individually ensure the professional development of their own trainers?
- How might they work together to lobby for greater priority to be invested in capacity building to develop awareness and advocacy interventions?
- To what extent does continuing to take easily available funding for primary level awareness, advocacy and psychosocial activities simply contribute to the lack of donor investments in better professional capacity building being prioritized in these interventions?

1.2. Weak Quality Control

Raised in relation to Awareness, Advocacy, Psychosocial interventions and Referral

The issue of poor quality interventions cannot be separated from the problem of low investment in and obstacles to capacity building discussed above. However, the issue of quality control also relates to both a lack of licensing/accreditation systems (including of ethical standards) to ensure that interventions and services meet a minimum of professional standards.

It is clear across the GBV NGO sector in Gaza that there are no formal procedures in place to ensure

that trainers and practitioners have a necessary level of competence to undertake their roles in a professional and ethical manner. While individual organizations may have their own guidelines and procedures in relation to staff undertaking these activities, the lack of an external licensing body or procedure seems to have contributed to the general “open to all” approach that marks these areas of intervention accounting for the patchy level of professional quality of delivery noted by NGO specialists.

1.2.a. The Role of Donors

Donors have made immense investments in the development of Standard Operating Procedures (SOPs) for the NGO/GBV sector (that have yet to be implemented). However, investing in procedures to assure minimum standards of competence for staff under-

taking aspects of especially **awareness training and psychosocial interventions** has not been a priority.

In terms of quality control surrounding the issue of **referrals** between providers, donors have also invested heavily in two attempts to build a sound

system of referrals that might have played a role in treating the absence of procedures for assuring minimum professional standards among specialized staff providing GBV services. In any future initiative to develop protocols of a referral system, this dimension needs to be taken integrated.

1.2.b. The Role of Local Providers/NGOs

Given the absence of an external system that ensures minimum professional competence of their staff and ethical standards in their delivery of services means that local providers have been left to deal with this according to their own ethical norms and commitment to professionalism. Some questions local providers might need to reflect on include:

- To what extent is there a need to develop a shared

Finally, donors might want to reflect on whether the standard reporting and assessment procedures they currently use to monitor interventions they wish to or have supported, include mechanisms to ensure the minimal professional competence of the human resources involved in their implementation.

or peer group-based system to ensure professional and ethical competence of staff involved in various aspects of GBV prevention and treatment? What are the specific areas of GBV prevention or service delivery where this is most urgent?

- What basic mechanisms might service providers develop that can ensure that individual providers are meeting minimal professional and ethical standards?

1.3. Skewed Priorities/Ineffective Targeting of Resources

Raised in relation to: Awareness, Advocacy, Psychosocial, Legal, Protection and Livelihood Interventions

1.3.a. The Role of the Occupying Power

The problem of skewed priorities and ineffective targeting of resources was raised in relation to the distribution of resources across the sectors of GBV intervention, as well as within specific intervention areas. While donors and the de facto government are the practical main agents in the problem of faulty targeting of resources, Israel's blockade creates the overall environment in Gaza, where the population's most basic needs are in a near constant state of emergency and the taken-for-granted infrastructures that enable human wellbeing are

endlessly stretched to their limits while enduring multiple cycles of direct military destruction. In this context, that extremely stretched resources for the almost infinite basic human needs of Gazans have been invested in GBV services might be seen as a major achievement. Nevertheless, how those resources have been targeted across GBV prevention and treatment activities and services have not always been in the best interests of meeting the needs of GBV survivors.

1.3.b. The Role of Donors

In terms of **awareness and advocacy** Interventions, while UNFPA mapping in 2015 found that there was a near equal balance in investments in both (at 12% in awareness and 11% in advocacy), NGO service providers actually saw this translated on the ground into much more awareness raising than advocacy. Clearly service providers want more resources, as well as more sustained investments in advocacy

rather than simply awareness-raising.

While no service provider felt there was an over-investment in psychosocial or legal services, they consistently criticized the very low investments in **economic and livelihood interventions for GBV survivors**. This was a very stark case of a service deemed a very high priority by front line providers and vic-

tims that continued to be treated as very low priority by donors.

In terms of **psychological and psychosocial interventions**, as stated earlier, rebalancing needs to be made from investments that have overwhelmingly gone to primary “first aid” level psychosocial activities towards those that build professional and specialized therapeutic and psychiatric personnel and services.

Priorities in the area of legal interventions need to integrate more than legal awareness and support, but also advocacy for changes to the legal system or

at least to procedural changes that could be strategically important to support the needs of GBV victims.

Because of the no contact policy, no investments have been made to the whole chain of agents necessary for victim’s **safety and protection** in the government sector. This includes Gaza’s only shelter; government health personnel tasked with forensic medical examinations; as well as the police and criminal justice system. All these actors, that are totally excluded from donor support are all fundamental chains in the network needed to protect the most severe categories of GBV victims in Gaza, as well as to ultimately provide them with justice and dignity.

1.3.c. The Role of Local Providers

Donors may have power to set agendas and priorities, but they ultimately can only achieve this when local organizations allow them to do so. If local organizations do not work together to set priorities

collectively and make sure that these are adhered to by individual organizations, donors will continue to have the upper hand in a free market of individual organizations competing against each other.

1.3.d. The Role of the de facto Government Authorities

While the de facto Government authorities in Gaza may have been excluded from donor-supported GBV initiatives, as one provider noted, they “collect our taxes” and carry fundamental responsibilities to provide for the protection and wellbeing of their citizenry – especially the most vulnerable.

On the whole, the authorities have offered little or no resourcing or policy change initiatives to meet

the needs of Gazans suffering from GBV/violence against women. Indeed, they are accused of enabling the dominant “blame the victim” approach (particularly when the victims are women). Ultimately they have shown a preference for preserving male hierarchies of power rather than confronting the realities of and the significant harm that gender violence causes it victims.

1.4. Inappropriate or Destructive Timelines

Raised in relation to Advocacy, Psychosocial, Legal and Livelihood Interventions

1.4.a. The Role of Donors

That Gaza is in a state of humanitarian crisis is without question. But this “crisis” is enduring and open-ended. This raises the fundamental question of whether humanitarian modalities including their timelines are actually appropriate to treat the needs of this specific context.

While the three major military confrontations on Gaza have created periods of intense emergency, the ongoing and open-ended collapse of livelihoods and

wellbeing in Gaza is the product of Israel’s comprehensive blockade. None of these destructive policies seems to have an end point in sight. In responding to the needs for GBV interventions in Gaza, almost all international agencies and INGOs cite the 2015 Inter-Agency Standing Committee (IASC) *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings* as their reference. That guide states that the acute emergency period usually lasts from a

period of two weeks to several months, after which the interventions proposed in the guidebook, should be “scaled up”. The guidebook contains no other information on timelines but its focus is on setting up systems within the initial stages of a humanitarian emergency.

An important dimension of defining Gaza as a humanitarian emergency is that it has enabled donors to access humanitarian funding channels to Gaza. Especially over the high tides of Israeli military violence, this aid has been crucial. But its longer-term effects in the context of building a stable and comprehensive system of activities and services to prevent and treat GBV in Gaza has been less positive. A main outcome has been that support for GBV programming has been project based and specifically in the case of humanitarian aid it has been based on extremely short project cycles completely inappropriate to meeting the ethical and safety standards promoted by the IASC and other UN Agencies guidelines for treating GBV victims.

- Donors need to be more responsible in their use of humanitarian project cycle and even development project cycles when dealing with GBV services. The effects of service instability may not be harmful in the case of an interrupted awareness raising program, or the sudden end of a project for recreational “fun days”. But service instability has

the potential to cause grave harm to abused and vulnerable women when support for their psychological or legal aid is suddenly cut-off.

- Project cycles create other difficulties for service providers, who constantly have to search for other providers to take on cases when their funding is about to end. Long term planning by providers is made virtually impossible. And finally, cutting of services negatively affects the trust and legitimacy of service providers in the eyes of the women and the communities they serve.
- Many aspects of a sensitive and effective GBV prevention and treatment system need much more stable forms of funding than the present project based funding allows. The West Bank leader in the field of GBV prevention and treatment, WCLAC has from the time of its founder Maha Abu Dayyeh, refused funding that is not program-based – because as she said, the sensitive care, treatment and protection of survivors of abuse cannot be planned and implemented within the timeline of a project.
- And finally, basing GBV services on project cycles ultimately makes the development of a **referral system** inoperable. If SOPs are put in place but the service providers in the referral network do not have stable funding in which to provide stable service that the protocols depend on, the referral system will ultimately be unworkable.

1.4.b. The Role of Local Providers

As with agenda and priority setting, donors will continue to operate according to their own timelines unless local organizations work together to demand more appropriate policies. As long as one organi-

zation is willing to accept an inappropriate project timeline for delivering GBV services, it is likely that these policies will continue.

1.5. Anti-Women/Anti-Victim Policies and Procedures

Raised in relation to Legal, Health and Protection/Security

1.5.a. The Role of Israel’s Occupation

The occupation and blockade narrow the range of possible solutions for GBV victims to small geographic prison of Gaza, critically in relation to the **security and protection** needs of women whose lives

are under threat. This results in the only option being securing them by placing them “in a prison within a prison” in the words of the director of the only shelter in Gaza rather than being able to find new

and secure lives in the West Bank as happened prior to Israel's blockade. In this sense, Israel's policies

towards Gaza can be considered as anti-victim and anti-women.

1.5.b. The Role of the de facto Government Authorities

As attested to throughout this and other reports all GBV service providers in Gaza are working in a context in which both formal and informal law, government policy, procedures and rhetoric as well as dominant social norms are stacked against them and the victims they serve. In their efforts at prevention and treatment service, providers are all working against a comprehensive environment of obstacles that are the outcome of masculinist hierarchies and the range of formal and informal mechanisms that work to keep them in place.

This creates a setting in which victims are constantly blamed for their abuse (or treated as if they were the perpetrators of a social or moral crime) by society and most actors across the government spectrum. Victims' efforts to seek help or redress are treated as scandalous behaviour. And rather than supporting

their access to justice, dignity and wellbeing the majority of actors across the government sector insist victims' priority should be on preserving their marriage and family at any cost.

Local providers are extremely skilled at trying to manoeuvre through this environment and negotiate the best set of circumstances and options for their clients based on what is possible within the extreme limits of options available to women and the low horizons that have been imposed on Gaza as a whole. They also identified specific areas where these dominant masculinist norms are at their most acute in preventing the access of women to critical means to survive or exit from abuse: **the legal system**, in specific family and criminal law; **health services** in the government hospitals and the weak or near absence of **protection/security for victims**.

1.5.c. The Role of the Palestinian Political Division:

This report has consistently uncovered how the division between governing authorities in Gaza and the West Bank impacts the entire universe of provision, policy, **legislation**, legal protection, justice, **protection**, **shelter**, professionalism and support in terms of GBV/violence against women.

The de facto government is primarily responsible for the negligent ways in which they treat victims in extreme life threatening situations within Gaza un-

der the Israeli blockade. But the split in governance also blocks the possibility for constructive change in the Palestinian security and policing sectors in ways that would be necessary to meet the needs of GBV victims. As well, the non-cooperation between the two Palestinian authorities precludes even entertaining their coordinating life-saving exits of victims from Gaza to the West Bank – a procedure that prior to the split (and blockade) had saved the lives of a number of victims in Gaza.

1.5.d. The Role of Donors

Donors have continued to rely on general awareness-raising about GBV among the Gaza population at large and service provision to victims through the NGO sector. As highlighted throughout the report, by ignoring the entire government sector in these efforts donors have hindered the very goals of wider

social change around GBV/violence against women that they support. As importantly, the no-contact policy has severely compromised the ability of service providers to fully address the critical needs of victims, particularly in relation to **justice**, **protection**, **shelter and healthcare**.

1.6. Lack of Coordination and Shared Strategy

Raised in relation to Awareness, Advocacy, Legal, Protection/ Safety Interventions and Referral

Specialists identified the following practical causes for the competition, lack of shared strategic vision and formal on-going coordination between NGO service providers in Gaza:

- When working in coalitions, individual institutions still do and have to focus on their own agendas and priorities. Thus there is often a structural contradiction between individual institutions and the collective they are part of.
- There was no independent coordinator assigned to run past coalitions, only a hosting NGO thus time and energy for shared work could not always be prioritized by members of the host institution.
- The division in governance has meant that the National Committee to Combat Violence Against Women in the West Bank could not be activated

in Gaza. Although individual providers, when able to get permits to exit Gaza to the West Bank, have actively participated in its meetings, none of their outcomes could be translated practically into Gaza.

- The lack of coordination between donors in Gaza means they treat GBV providers as a free market and pick and choose partners and prioritize agendas as they please. In so doing, they actually encourage competition rather than coordination between local GBV service providers.

As discussed earlier, until local providers organize themselves collectively and put forward a shared strategy, it will be extremely difficult to address many of the gaps and problems they have identified in current programming.

BOX 6. THE FATE OF TWO NATIONAL INITIATIVES IN GAZA TO MEET NEEDS OF DIVORCED WOMEN, INCLUDING GBV SURVIVORS: “FAMILY FORUMS” AND “THE PALESTINE MAINTENANCE FUND”

In the late 1990s, a strategy to enable divorced women to see their children when ex-husbands refused them access was developed by the Palestinian women’s movement activist with the support of the Palestinian Authority. Recalcitrant ex-husbands were put under court order to bring children in their custody to so-called Family Forums, held regularly at government premises under police watch, so that mothers could exercise their visitation rights. Many front-line GBV specialists consider the forums a poor stopgap measure, noting the presence of police creates a negative environment for children. But in the absence of alternative solutions, a number of NGO GBV service providers in Gaza continue to organize them with the support and protection of the judiciary and police. Currently, service providers hold regular family forums at their premises in Rafah, Khan Yunis, Gaza City and Nusseirat Camp.

The Palestine Maintenance Fund (PMF) was brought into being by presidential decree in 2005

and began operating in the West Bank and Gaza Strip in 2007. The fund was an answer to the critical problem of enforcing court-ordered maintenance payments by husbands, ex-husbands and fathers. By 2013, the fund had supported a quarter of a million individuals. The money for the fund is based on a share of court fees for marriage and other contracts, as well as maintenance payments collected through enforcement by the courts and police. Although the level of monthly maintenance women and their children receive from the fund is very low, it plays a critical role in their livelihood support – often allowing GBV sufferers to exit from an abusive marriage and economically maintain their children. According to GBV specialists, in Gaza, since the takeover by the Hamas authorities, while money for the fund continues to be collected, it has only been disbursed twice to its intended beneficiaries. For all intents and purposes the PMF has ceased to operate in Gaza.

CHAPTER V.

PATHWAYS INTO AND OUT OF ABUSE: UNDERSTANDING WOMEN SURVIVOR'S LIFE AND CASE HISTORIES

The study conducted in-depth life history interviews with 14 women at various stages of dealing with domestic abuse. The aim was to first trace their pathways into abusive relationships to better understand the settings and relationships that shaped them, as well as the dynamics and circumstances that often precluded women from exiting them. The ultimate aim was to uncover the paths through which women attempted to find solutions to the abusive situation. And finally, the analysis sought to identify the actual roles formal service providers played in supporting these women in their struggles to find pathways out of abuse.

The next chapter (VI) provides the in-depth individual case histories of the 14 women survivors this

analysis is based on. This chapter takes the cases as a whole and attempts to uncover the shared and recurring patterns in these women's life and case histories in order to identify processes relevant for service providers in preventing entry into abuse or in delivering interventions better able to overcome the constraints women face in attempting to exit from them. The small number of cases (as well as their variation) cannot be considered a representative sample of the diverse situations and experiences of VAW that women face in Gaza. Instead, the focus here is on obtaining a deep contextual understanding of life circumstances, possible strategies and constraints from the point of view of women survivors of violence.

1. Methodology

Originally the study sought to include cases based on two main categories defined by the extremity of their overall circumstances: women in grave life-threatening situations versus women in abusive circumstances that might be acute but not life-threatening. The first group was sought through interviews with survivors whose history of abuse had led them to the extreme endpoints of the Gaza women's prison or Beit al Aman Shelter. The second group were primarily (but not completely) found through NGO service providers.

As the interviews proceeded, it became clear that many of the women originally identified as experiencing harsh circumstances actually belonged in the category of 'extreme/life-threatening' cases, either due to the degree of violence they had suffered or because the women themselves had at some point in their pathway attempted suicide. In addition, the histories of the three women's experiences and struggles to exit violence were so singular it became necessary to create a third category of "exceptional/extreme" cases.

1.1. Criteria

Based on this, the 14 cases have been re-organized in the following analysis into three main categories:

Category A: Extreme Cases. (4) This included women who had experienced life-threatening violence including attempting suicide.

Category AE: Exceptional Extreme Cases. (3) This included women whose experiences though extreme, were also atypical, in both their particular pathway of abuse and its eventual resolution. It includes: a young woman rape victim condemned to death for the murder of her husband; a young woman raped

by a potential suitor and now engaged to him; and a divorcee who defied family threats to her life and through religious and political support was able to claim the life partner she preferred.

Category B: Harsh Cases. (7) This included women who were still in or had faced harsh abusive circumstances but had not reached a point where their lives had been threatened or they had attempted suicide.

Twelve of the cases were currently or previously married at the time of the research – of the remaining two, one was single and the other engaged.

1.2. Ethical Considerations

The interviews were always held in complete privacy and with the survivors' full knowledge and

agreement after the aims of the study were carefully explained to them. They were told that their

full anonymity would be respected in the study and that their safety was of the utmost importance. As well, they were free to stop the interview at any time. Researchers undertook the interviews with the highest level of sensitivity necessary when dealing with abuse survivors. At the same time, the inter-

views were often extremely difficult. Women who had passed through long-term systematic abuse or who had just passed through a grave incident often found it hard to focus or narrate their experiences in a coherent way. For the researchers, hearing their stories was often an extremely painful experience.

2.

Shared Characteristics and Patterns

2.1. Married Women's Pathways into Abusive Circumstances: Coerced Marriage

Of the 12 married cases, 10 of them had been married against their will to a husband they considered undesirable and inappropriate

In the majority of cases (10), the women had been forced into their marriages by their family and married to a groom they themselves perceived as inappropriate or incompatible. The motivation of the women's families to impose a bad marriage on daughters fall into three patterns: pressure from more powerful relatives (A3 Samera, B2 Yara); an attempt to discipline an assertive daughter (AE1 Ilham) or to cover up a "problem" with her as in the case of Nahla (AE2) who had been raped before marriage; or simply due to poverty and a way to dispose of another mouth to feed (B3 Aida, B7 Amina).

In three of the cases (A2, A4, AE2), the forced marriage resulted in the women ending university education they had begun and wanted to complete.

In three other cases, the forced marriage ended the women's hopes of attending university in the future. In these six cases, the women had aspirations to a better future of higher education followed by employment, however their aspirations were thwarted by an unwanted marriage. As well, for the three women whose higher education was halted, there was a large disparity between their and their husband's education – most notable in the case of Nahla (AE2) whose groom could barely read and write.

While a small minority of the cases were married under 18 years of age, early marriage was not a major characteristic of the cases – instead, coerced marriage to an unwanted groom was the dominant path into an abusive relationship.

2.1.a. Inappropriate grooms/problem husbands

In two cases (A3 Samera, B7 Amina), the family knew the groom had mental health and/or addiction problems prior to contracting the marriage. However, in the first case, the family was forced to marry their daughter to him from fear of more powerful relatives. In the latter case, the family wanted to dispose of her due to poverty. In five cases, (for example A1 Maysa, AE1 Ilham, B4 Inas, A4 Sana) the women and their families had been deceived and the groom's family had hidden information either about a mental or physical health condition or the groom's employment or other circumstances. Ilham's family (AE1) had not been told the groom was unemployed and a decade older than claimed during the engagement; Maysa's family (A1) did not know the groom

was certifiably mentally ill; and Sana's (A4) that he had a physical disability.

Two of the women were married to men with certified mental health problems (A1 Maysa, A3 Samera). Inas' (B4) husband was not diagnosed but she believes he has a mental health condition. In four cases the spouse was or became addicted to the opioid, Tramadol over the course of the marriage (A2 Manal, A3 Samera, B4 Inas, B7 Amina). A3 Samera is a case where the husband was both mentally ill and a Tramadol abuser – and she herself became an addict. In the case of A6 Amal, the perpetrator was her Tramadol-addicted father. In total, in 5 of 14 cases, the perpetrator was abusing Tramadol.

For four of the women, the initial abuse took place before marriage, for most of the others it began early in their married life

Two of the 14 cases were raped before marriage, both by stranger non-relatives (AE2 Nahla and AE3 Fadwa). Nahla's mental abuse (control and coercion) by her family led her to flee the home but without exit, support or safe haven she had been made vulnerable to rape by a stranger. Fadwa was raped by a suitor (known to her and her family) who exploited the chaotic circumstances of the 2014 war to sexually violate her.

In Nahla's case, the onset of abuse began with her family which then set her on a path of repetitive and compounded abuse. Ultimately the only exit she could find from the chain of abuse (starting with her family, then the rape by a stranger and then the forced marriage to an abusive husband through which her family tried to cover the rape) was to murder her final abuser (her husband). The likelihood that Nahla was suffering deep psychic trauma at the time she murdered her husband was never taken into account by the court that condemned her to death. Within weeks of the traumatic experience of being raped by a stranger, Nahla found herself forced to have coerced sex with another stranger – this time an abusive and unwanted husband. It is extremely likely that Nahla, murdered her husband, in an attempt to end a situation she experienced as repeated rape.

In other two cases, the abuse also began in the home of their natal family, in the case of B6 Amal (who was physically and mentally abused by her Trama-

dol –addicted father as well as by her brother), but also in the case of Manal (A2) whose family beat her to force her into her unwanted marriage. When she fled back to them, she was beaten in order to force her back to her husband. However, in the case of all of the women who were forced by their family into an unwanted marriage this would have been experienced as psychological violence, perhaps most acutely in cases where their family were uncaring and unsympathetic to them (A2 Manal, AE1 Ilham, B7 Amina).

For the majority (10) of the women, the onset of physical or sexual along with psychological abuse by their spouses happened almost immediately after the wedding night within the first days or the first few weeks of marriage. Almost all of them were severely physically attacked by spouses and in the case of Samera (A3), she was raped by her spouse on her wedding night. In the case of Nahla (AE2) she was beaten for refusing to sleep with her husband. Only one case (B2 Yara) experienced intense psychological abuse but no physical or sexual abuse in the early days of her marriage. In one case (B1 Huda) the marriage started off well but became physically abusive later when the husband lost his work in Israel with the onset of the blockade. Out of all of the cases, only Huda connected her husband's abusive behaviour to the trauma and hardship of having had a good job that he lost and could never recuperate from. It is noteworthy that Huda's marriage was not forced but consensual.

2.2. The Economic Context of Abuse: From Poor Families to Structurally Unemployed Husbands

The majority of women came from families who were poor or very poor and in the majority of cases were married into families in similar or sometimes worse economic circumstances.

None of the spouses of the 12 married women had stable or good quality employment when the abuse started. In eight of the cases, the husband was long term structurally unemployed. Three of the cases (the spouses of A3 Samera, B1 Huda, and B4 Inas) had

a past experience of relatively good employment in Israel before the blockade, while it is likely that B3 Aida's husband had worked in Israel before becoming long-term structurally unemployed in Gaza. In three other cases, husbands had very poor levels of

self-employment in Gaza; AE2 Nahla's spouse was a donkey cart driver while A2 Manal's spouse was a motorbike taxi driver. In six of the cases, the spouses were receiving some form of aid (either from the Ministry of Social Affairs due to a mental or physical disability) or from a charity, while the majority of husbands or their families were also highly dependent on UNRWA or other agencies' rations.

Given that most of the women started marriage with a spouse who was structurally unemployed or extremely poorly employed with no hope that their

situation was going to change, the impact of unemployment and hopelessness on their perpetrators is impossible to assess. The closure to work in Israel has been ongoing for more than 15 years, and over that time alternative employment opportunities for men in Gaza have constantly narrowed, worsened or been lost. Compounded by repetitive and major military devastations, it is likely that many of husband perpetrators were already suffering from depression, anger and drug abuse connected to unemployment and hopelessness at the time of their marriage.

2.2.a. Abusive Marital Households

The majority of women not only married an abuser, but their abuse was compounded through living with his extended family

For the majority of married cases, the abuse by husbands was compounded either by direct abuse from his family members or the abusive environment of his family's household. Only three women lived in independent homes with their spouses upon marriage (A2 Manal, B1 Huda and B7 Amina). The other nine moved in with their husband's extended family upon marriage; some suffering direct physical abuse from multiple perpetrators (B3 Aida, B5 Rula); others sexually threatened by the husband's family members (A3 Samera, B2 Yara); while in the majority of

the cases they were ill-treated (criticized or treated like a servant by husband's family members) simultaneous to the husband physically abusing them. In three of these cases, mothers-in-law actively encouraged or supported their sons in abusing the wife (A4 Sana, AE1 Ilham, B3 Aida). In only one case did a victim have sympathy and support from a mother-in-law and husband's brothers, while in one case (A1 Manal) other family members simply ignored the husband abusing her.

3. Pathways out of Abuse

3.1. First Path of Response: Family

The reaction of all of the 12 married women after experiencing the initial instances of abuse by a husband was to seek help from their own family within the first few weeks of the marriage. Almost all the women returned (hardaneh – or in a “state of anger”²⁹) to their own family to seek their intervention and support. However here the paths split according to what type of support and intervention women

sought versus what support and intervention their family was willing to provide.

Group 1: The majority of still childless women sought an immediate exit through divorce but they did not have family support to pursue one

Seven women returned to their families and sought their support to exit the marriage through divorce in

29 This is the customary and socially accepted practice for women facing conflicts with their husband. A wife returns to her family (usually without children) for unspecified lengths of time with the aim of pressuring the husband to resolve the particular conflict in order for her to return to him.

the initial stage of the marriage (Manal A2, Samera A3, Sana A4, Nahla AE2, Aida B3, Rula B5, Amina B7). The determining issue was that they were not yet pregnant and therefore the potential of losing children did not represent an obstacle in their desire for divorce. In fact, two of the seven, Amina and Ilham consciously avoided getting pregnant in order to facilitate exiting the marriage. However, in all of the seven cases their family refused to support them in seeking a divorce. The only woman from this group who was able to go forward with a divorce at this stage was Ilham (AE1), on the basis of her husband being sexually dysfunctional rather than him being abusive.

Group 2: Women with children or pregnant women feared losing children so did not seek family support for a divorce

Three women Maysa A1, Huda B1, Inas B4 were encouraged or at least supported by their family to get a divorce but were already either pregnant or had children. In two of the cases their family conditioned the divorce on their immediately giving children over to their father. In the case of Huda, she did not seek a divorce because when her husband's abuse began, her children were already at an age that (under prevailing family law) would have resulted in

leaving them in the custody of their abusive father.

Group 3: Only one case sought family mediation and reconciliation rather than divorce, despite being still childless

B2 Yara, a victim of psychological violence mainly from her husband's siblings (and controlling but "loving" behaviour from her young husband) sought to be reconciled with her husband on condition of living with him in an independent home far from his family.

First stage outcomes: Only 2 out of 12 married women got an immediate exit from the abusive marriage

Only two women were able to get an immediate exit from the abusive marriage; Yara B2 and EA1 Ilham. In the first case this was not desired but imposed on Yara by her husband's family and in the second case, Ilham then became stuck for four years as "hanging divorcee".

The other six women (in group 1 above) who could have exited if a divorce had been supported by their families then became trapped due to getting pregnant; resulting in a total 10 of the cases now unable to leave because it would involve giving up children immediately or in the future.

3.2. Second Stage of Attempts to Cope with Abuse

Women now entrapped in an abusive marriage became locked in a closed circle of running to their family then returning to the abuser – sometimes for years. A few sought interventions from informal justice/reconciliation agents

"Nine years and I was running back and forth between my husband's and my family – but no one did anything for me." [Manal]

For all of the ten women who became trapped in an abusive marriage once they had children the only path was to seek periodic respite from the abuse at their family's home. While not an exit from the situation being hardaneh sometimes for long periods of time provided a breathing space from the abuse. In Manal's case (A2) however despite constantly returning to her family they also physically abused her to get her to return to her husband. In Sana's case (A4) where family support was completely absent and there was no possibility to take periodic breaks at their home this may have resulted in her attempt-

ing suicide at a much earlier stage than other women in the group who did.

At the early stages of this entrapment, three women sought the intervention of informal reconciliation and justice providers. Sana A4 got the local reconciliation committee through her local mosque to intervene (but in fact against her abusive mother-in-law in order not to be evicted); similarly Samera AE3 got the local reconciliation committee to intervene to stop her husband from divorcing her so she could stay and protect her children; and B7 Amina's family got the local mukhtar and later the local reconciliation committee to intervene – by making her abusive husband sign a pledge not to abuse her – that had no effect on his behaviour nor to which he was held to account. For the first two women, it seems the scandal of getting informal justice providers involved was only justifiable in case of losing housing or avoiding divorce, rather than to stop the abuse.

Second Stage Outcomes: Only 1 out of the 10 women was able to exit from the early stage of entrapment in an abusive marriage, but her “exit” was to the women’s prison and a death sentence

The only woman to exit from this early stage of entrapment was Nahla (AE2) who did so through murdering her husband. She is now in Gaza’s women prison awaiting execution by hanging and has not been able to see her little son for almost two years.

Except for Sana, all of these “trapped women” talked about returning to their parents hardaneh countless times over the years that for some of them would

reach into decades. And as they and especially their female children got older, the entrapment was compounded by fears particularly for their daughter’s physical safety and in a two cases (B4 Inas, Samera A3) their daughters’ possible vulnerability to sexual violence from their abusive father.

At this stage nine women continued to be trapped in abusive marriages.

3.3. Third Stage Attempts: Formal Intervention

Most women’s paths led to formal interveners only after years of entrapment in the abuse. Five women’s first experience of formal intervention was the police or religious authorities/courts. Four women finally reached NGO service providers.

Two of the remaining nine entrapped women’s initial path to formal interveners was to the police. Manal A2 and Aida B3 all finally sought protection from the police in a moment of extreme or life threatening abuse. Manal repeatedly sought aid from her local police station but she always refused to make a formal complaint, the official requirement the police demands from victims in order to undertake any response. In Aida’s case, it was the husband who got the police involved when he falsely charged her and their children with theft. In Manal’s case police demands she make a formal criminal complaint was a condition that blocked her getting basic protection and support. Especially given her already brutalized state, she feared even worse retribution (not only from the abuser but from his and her own family) if she made a formal complaint.

Three other women’s first path to formal interveners was with either a religious authority or the Shari’a court. Ilham (AE1) had already dealt with the Shari’a court in getting her early exit from her abusive and unwanted marriage but had subsequently ended up “hanging” for 4 years – neither married nor divorced in the eyes of the law. She subsequently sought the advice of a Shari’a authority in order to get the right to her own guardianship so she could remarry as she chose and got his full support to pursue a very dangerous path in defiance of her family, as well as received his protection (via the government shelter). Amina (B7) sought the advice of a religious judge

to understand whether her husband’s constant announcement of unilateral divorce had any legal status – which it didn’t. Rula (B5) repeatedly thrown out of her home by her abusive husband at some point with the support of her family filed for maintenance in the court (though not stated in the interview, this likely was a means to pressure him to take her back given the evolution of her pathway afterward).

Four women (Maysa A1, Sana A4, Samera (A3) and Inas (B4)) sought or were linked up with NGO service providers only after years of abuse. Sana who initially had a failed intervention of a reconciliation committee (see above) subsequently gave up searching for help for a few years. Then she heard about a women’s health NGO provider that she specifically went to for its GBV services, approximately 5 years into her abusive marriage. Maysa spent 14 years in the trapped circle of running between her parents and her abusive husband with her main priority focused on finding a way to get a home independent of her husband’s family for herself, him and their children. Her first entry to any formal intervention was through seeking humanitarian aid at a local CBO post-2014 Israeli military aggression where by coincidence a trainer from an NGO GBV service provider turned out to be running a psychosocial support session who detected Maysa’s symptoms and systematically linked her with provider X, from whom she is still getting support and treatment. Inas (B4) after years of solely seeking help from her parents made contact with NGO provider N in her community after the crisis of her husband selling the house they received as compensation for a home destroyed by Israel in the 2014 war. In Samera’s case, her brother made contact with NGO service provid-

er X on her behalf when she was hospitalized following a suicide attempt. The hospital did not ask whether she had been abused but brought her out of a drug-induced coma and then kept her in order to treat her Tramadol addiction.

Third Stage outcomes: Three of the four women who had linked up with NGO service providers while not exiting from the abuse, through ongoing support found the solutions they believed were in their best interest.

The four women who finally linked with NGO service providers did not choose to pursue a divorce. In the case of Maysa, Sana and Inas, once helped by providers, they no longer sought other interventions because they were getting support they perceived as appropriate to their specific needs and circumstances. These three women have chosen to stay in their marriage and with the support of providers felt empowered to cope with their husband's behaviour

and keep their marriage intact.

In the case of the fourth woman, Samera, the support given by the NGO provider, though critical, was unable to offer the protection she needed from her abusive, mentally ill husband. The NGO service provider besides treating her addiction, tried to support her with the intervention that she saw as most critical – getting a home independent of her mentally ill, Tramadol-addicted husband's family. NGO provider X provided 6 months rent for Samera and her children to rent a small home far from her husband and his family. However, although this gave Samera a protected space from her husband's family, it did not provide her and daughters protection from the main perpetrator – her husband (see below) and her path to an exit from the abuse continued.

At this stage, six women's pathways continued because a solution to their abuse eluded them.

3.4. Fourth Stage Attempts: Between the Police and the Courts, Between the Shelter and Service Providers

Of the 6 married women whose path out of abuse continued to elude them the path of the two whose first formal interveners was the police (Manal A2 and Aida B3) at this stage diverged.

Following an extreme incident in which her husband slashed her face with a broken bottle, Manal ended up in hospital and then decided to seek once again the help of the police because the husband threatened that once she left the hospital he would, 'finish the job'. This time she was willing to file a formal criminal complaint against him, which meant she could not return to her family and had nowhere to go. A sympathetic policeman took her home to his family and after a few days, on learning about the government women's shelter, sent Manal there. With the support of staff at the shelter, Manal decided to initiate divorce proceedings. Whether she will continue to pursue this path remains unknown given that she was still at the shelter at the time of this research.

Aida's husband unilaterally divorced her (and remarried). She is currently pursuing all of her legal economic rights from him in the Shari'a court and has hired a lawyer to do so. Aida's case is exceptional in that she has economic resources of her own having worked in income generation for many years,

and bought an apartment in her own name where she currently lives with her children. She has never sought services from an NGO service provider.

The three women whose initial formal intervention was through religious figures or the Shari'a court: Ilham AE1, Rula B5 and Amina B7, also had divergent paths at the stage. Ilham pursued the original path of getting a religious leaders intervention again – but this time she went to the top – the high judge of the Shari'a courts in Gaza (Qadi al Quda) -- who supported her raising a formal case in the court for the right to be her own guardian and again provided her protection from family retribution by coordinating her refuge at the government's women shelter. Ilham's path is exceptional among the cases because it was completely based on interventions from the institutional religious sphere and figures and institutions of the standing government authority. It was also a path that was completely driven by Ilham, rather than as in many other cases where formal interveners (government or not) were at times imposed on the women or brought to them by supporters or perpetrators. Ilham's strategy and path paid off – and with the backing and lobbying of the current head of the government shelter (along with the support of the Shari'a High Court judge) was able to find an

exit from the threat of possibly grave violence, while winning the right to decide and make her future with the man of her choice. A critical resource Ilham has is she is the only woman among all the cases with a full university education and after having worked as a legal secretary had good connections with the network of religious/legal authorities who came to her aid and support.

Rula's path through formal interveners that started with the Sharia courts subsequently went through myriad other formal interveners including: the police, the Shari'a courts, the informal justice system (a female mukhtar) and an NGO service provider that however missed an opportunity to help her. Crucially however, except for the police all of these interventions were instigated by her husband in order to keep her in the marriage. A near fatal attack by her husband in 2015 led her to file a formal complaint at the police with the support of her family. The husband signed an oath with the police and Rula returned to him for the sake of her daughters. A year later she again returned to make a formal complaint at the police this time against his sister who had publically attacked her in the street. Again, the police had her husband's family sign an oath not to attack her. In the meantime, while Rula was hardaneh at her parents, her husband filed a case in the Shari'a court to force her to return his daughters and made a revocable divorce in order pressure her to return home. He also involved a female mukhtara (in order to "calm" the situation). The female mukhtara's intervention on Rula's behalf was to demand that the husband provide an independent home as a condition for Rula's return. Despite his refusal/ inability to meet this condition Rula returned to him for the sake of her 3 daughters. The mukhtara also put Rula in touch with NGO service provider "H", whose staff however, failed to communicate with Rula the possible ways they might support her, as well as failed to follow up with her after her initial visit. Rula is still with her abusive husband and his family. With limited education, absolutely no financial resources and having lived for 13 years in a situation of compound abuse by her husband and his family, she sees no other options but remaining there because she does not want to lose her daughters. The focus of her struggle with her husband is not so much over the physical and mental abuse but over core rights that she has under Shari'a law – that he return her dowry money that he spent and that he provide her

with an independent family home (both rights are backed in prevailing family law in Gaza). However, he has consistently held the upper hand against her attempts to get these by using his leverage of their daughters' custody. The effects of long-term and relentless abuse have clearly impacted her spirit and mental wellbeing. When asked what she might do if her husband again threw her out of the house, she replied: "I don't know I am all over the place, my brain is shattered".

Amina who also started with an intervention by a religious leader next found her way inadvertently to an NGO service provider. While getting a medical check at an UNRWA clinic, a counselor recognized her symptoms and put her in touch with service provider Y and gave her a referral to them. But unlike other cases who finally found support from NGO service providers, her path continued through to the police and another NGO service provider. On telling the first NGO service provider Y that she wanted to pursue a divorce, their legal counselor advised that in order to do so she would need the support of her family. They and her husband however punished Amina for going to the provider and badly beat her. Then with the support of Center Y she went to make a formal police complaint about the beating but then rescinded it under advice from the police who told her she might be putting her life at risk from her family if she did so. Service provider Y then referred her to Service Provider X, where besides getting psychological counseling Amina has been taking income generation training courses. The center follows up with her and her drug addicted husband who came to accept her visits to Center X because he is hopeful that her training will lead to her bringing income into the household. For the moment, the support she gets from the service provider seems to have enabled Amina to cope with her situation rather than seek a divorce.

Finally, there is Samera whose first path to a formal intervener was NGO provider X contacted by her brother who gave her support for independent housing. However, the NGO was not able to provide her and her children with protection and her husband a few months later arrived at the dwelling and violently attacked her and their daughters. Samera rushed for help to the police, who refused to intervene unless she made a formal complaint – which she refused in order to not precipitate retribution

including a divorce where she might lose her daughters. Subsequently, Provider X was unable to keep supplying rent to Samera and her children – thus she returned to her family while the provider was able to get her daughters taken in by SOS village in Gaza so they would not have to return to the home of their drug addicted mentally unstable father. Samera (like Maysa A1, Rula B5 and previously, Yara B2) sees getting a home independent of her abusive spouse's family as her main solution rather than divorcing her husband. With the help of Center X and her brother, she was able to buy a piece of land that might make this a possibility in the future. In the meantime, she received psychiatric support for herself and the children from provider X, as well as medical support to overcome her addiction to Tramadol.

Fourth Stage Outcomes: Of the final six women, two were able to permanently exit from the abuse while another two with the help of NGO service providers chose to stay and cope with their abusive spouse. At the time of the research the fate of the final two women was unclear. One was still contemplating

her options while at the government shelter, but the other remains unable to see any possible solution or exit for herself or her daughters.

Two of the six women were able to exit completely from the abusive situation at this stage. Ilham was able to move onto a new life with her chosen partner while Aida's exit from abuse was through being divorced by her husband – a conclusion she had hoped for. Manal, at the government shelter when the research was underway stated she wanted to pursue a divorce, but it is unclear whether she has. Two of the women, Amina and Samera, similar to the three women in stage 3 who linked up with NGO service providers have chosen to stay and cope with the marriage with the ongoing support and treatment offered by the providers. Rula, however remains stuck in the abuse without any formal support or vision of a possible exit from it. The researchers for this study put her in contact with a local service provider – but it is unclear whether Rula will pursue their services.

4.

The Role of Service Providers and Other Formal Interveners

In assessing the actual and potential role of various service providers and formal interveners once wom-

en went beyond depending only on family support one can find the following:

4.1. Informal Justice/Reconciliation Committees, Informal Mediators and Mukhtars

These were often a first line of interveners beyond the family. Sometimes brought in by the woman's family, other times sought out by women themselves. In the 5 cases that used these interveners 2 used them to deal with conflicts related to the abuse (threats of being divorce or evicted from the home) rather than to deal directly with abuse itself. When dealing with the former informal interveners seemed to be effective, when dealing with the lat-

ter (making men sign oaths not to abuse their wife again, or in the case of the intervention of a female mukhtar (who did have training from a local NGO provider) their interventions did not have any effect on the abusive situation – given that they had no leverage to change perpetrators behaviour. It is also significant that none of the informal justice actors provided victims with information on NGO providers or encouraged them to seek their services.

4.2. The Police

A number of women mentioned that despite having experienced extreme moments of abuse they would never seek help from the police because it would cause shame and scandal. However, 7 out of the 14 women went to their local police station at some stage in their path. For 2 this was their first contact with a formal intervener and for 3 they went to the

police multiple times over the lifecycle of the abuse. In almost all these cases, women sought the police's protection in a moment of extreme violence. And overwhelmingly the police refused to undertake any intervention unless the women made a formal criminal complaint, which the women refused to do given it would precipitate either violent retribution

from the spouse or her own family or would make a divorce inevitable. In some cases when women were ready to go forward or did file a formal complaint, it was the police who talked them out of it. On the whole the role of the local police was to leave women without any protection and send them back to

their family and the abuse. In only one case did the police put a woman in touch with a service provider – the government shelter and that was on personal initiative. Again, there was no case in which the police put women in touch with an NGO provider.

4.3. The Shari'a Courts/Religious Authority Figures

A number of women with the support of their family used the Shari'a courts over the life-cycle of their abuse, primarily for material conflicts related to the abusive marriage (such as maintenance payments). In most cases women or the perpetrator used the courts as a means of pressure in these conflicts over material issues related to the marriage and in all of these cases, abusive husbands had the upper hand. Only one woman petitioned the court for a divorce in order to exit from the abusive marriage. The outcome was that she became a "hanging divorcee" for four years and was only able to get a final divorce after waiving all her economic rights in order to get a decree based on her husband's consent. The same

woman used her knowledge and connections with figures in the Shari'a authorities to intervene on her behalf and against her family's legal control over her. These same figures also involved the government shelter in her protection. The particular case is exceptional (she is the only pathways case with higher education who had been employed). Instead, for the majority, the Shari'a courts did not play a direct role in protecting or supporting women in abusive marriages – but were primarily a means through which material related conflicts were played out. However compared to the informal justice sector and police, in a number of cases staff in the Courts did relay information to women about NGO legal services.

4.4. Beit al Aman, the Only Comprehensive Shelter in Gaza

Three women mentioned they knew of the shelter but even when facing extreme moments of abuse, would not seek its protection because it would ruin their and their daughters' reputations to go there. Despite this general perception, two of the women at some point ended up there. Manal was taken there on the personal initiative of a sympathetic policeman when she was in an extreme situation. Ilham was twice sent there for her protection by religious authorities who were defending her legal right to her own guardianship in defiance of her

male relatives. Both women were extremely positive about the shelter's atmosphere, staff and professional and emotional support they offered. In addition the current head of the shelter played a critical role in finding a resolution for Ilham that resulted in the outcome she had been working toward for many years. The shelter was the only actor in governmental sector where there was active and on-going co-ordination and communication with NGO service providers on behalf of victims.

4.5. Government Hospital and Mental Health Clinics

Three women over the life cycle of their abuse ended up in government hospitals with critical wounds from their spouse's violence or following a suicide attempt. In all of three cases, government medical staff did not even ask whether they were victims of abuse (although two of the women said they would have denied it if they had been asked). However, in all three cases hospital staff did not even provide women with information about potential GBV service providers. On the other hand, the only one among these three who did undertake a forensic

medical exam at a government hospital in order to raise a criminal case against her husband said that the staff were kind and professional. However, even after completing the forensic exam, the police ended up mediating with her husband rather than following through on the criminal case.

Two women were married to abusers who were suffering from diagnosed mental health problems and were under regular treatment from governmental mental health services. In neither case did mental health staff ever talk to the women or their fami-

ly about the possibility that the men's conditions might include physical or mental violence towards their wives and children.

Given that for 4 other women (see below) their path to help and support from service providers was

through non-governmental medical services, in contrast similar opportunities for detection and referral have been missed in the government health sector because of their total lack of GBV training, awareness and protocols.

4.6. NGO GBV Service Providers and their Services

Five of the twelve married women never interacted with an NGO service provider during the history of their abuse. In three of these cases they found an exit from abuse outside NGO paths (through the Shari'a courts and/or legal authorities). Two of these cases did eventually link up with NGO providers but only **after** they had exited from the abuse (both to get legal support in pursuing maintenance claims). Another case, Manal, now that she is in the government shelter will probably be linked with an NGO provider depending on decisions she makes there (to return to the abuser or pursue a divorce). And finally in the case of Nahla the rape victim who is in the women's prison awaiting execution, one wonders how her path may have been different if she had ever linked up with an NGO service provider.

For four of the seven married women whose paths did link with an NGO service provider over their history of abuse, seeking health services from an NGO provider was the entry into ongoing GBV service provision (with one of these referred to an NGO provider by an UNRWA clinic). For another woman her entry was through searching for humanitarian aid at a local CBO that referred her to a service provider; for another it was on the recommendation of a female mukhtar; and finally in the case of Samera, her brother brought in a provider when she was hospitalized following a suicide attempt.

In only one of these seven cases (Rula) the initial connection with an NGO service provider, was a one-time visit that did not translate into her seeking further support. In the other six cases once connected, women entered into long-term and on-going support relationships from the NGO service provider. A range of services were received, primarily psychological support and counselling, some livelihood support and training and in a few instances

legal support. In all these cases it was very clear that providers had used a victim-centred approach and provided the women with information and guidance that helped them make their own decision in terms of what direction to go. Overwhelmingly the women chose to stay with an abusive husband and cope with the support and on-going intervention of the provider. In some of these cases, women claimed they loved their husband, but in the majority of them it was because they did not want to lose their children by petitioning for a divorce.

While the women assessed the providers support extremely positively in helping them to cope, it is clear that providers were limited in the help they could offer in three critical areas; protection, housing and livelihoods. In two cases, even after a provider was involved, the women ended up seeking police intervention when violent husbands had attacked them. In these cases, under care of the NGO provider the women had gone home – but the provider could offer them no protection. In a number of cases, the women prioritized having a home independent of spouse's abusive family setting as a main avenue to deal with their abuse. NGO providers tried to support them but were under serious constraints in doing so due to lacking funds that could be used to this end. And while a number of women said they felt empowered by the income generating training they had received from NGO providers (with some of them seeing producing income as a strategic solution to their abuse) service providers were also constrained by funding in following through on these critical needs.

The only two women who sought systematic legal aid from service providers were both already divorcees, who had not sought NGO service providers prior to their divorce.

CHAPTER VI.

INDIVIDUAL CASE HISTORIES OF WOMEN SURVIVORS' PATHWAYS

CATEGORY A. EXTREME CASES [MAYSA, MANAL, SAMERA, SANA]

Case A1. Maysa	
Demographic:	<ul style="list-style-type: none"> • Age 37, married for 17 years. • Education: Preparatory • 8 children (oldest 15 / youngest 2 years old) • Has never worked outside the home
Current economic circumstances	Poor/ destitute: Household receives 500 NIS monthly government support for husband's mental disability as well as tri-monthly food rations. Husband is long term unemployed due to disability. Maysa received some support to build a small independent home in a vulnerable zone close to the northern border. She is heavily in debt to the contractor who built it (see below)
Marriage Age and Circumstances	At age 20, to a non-relative (whom she preferred to marry rather than a traditional cousin marriage). Only upon marriage did she discover the husband was certified mentally ill and under treatment from government mental health clinic. They lived with his large extended family with only their own room.
Nature of Abuse and Duration	Within a week of being married, the husband attacked her with a screwdriver. His brothers physically intervened but didn't help or explain his violent behaviour. While episodes of extremely violent abuse (one resulting in a miscarriage) continued throughout their marriage, the immediate issue for Maysa became the mentally abusive context of living with her husband's family who treated her like a maid and constantly criticized her without offering any but the most basic protection from her violent husband. Maysa believed she could better handle the problems of her husband (and its effects on her and the children if she was in an independent home with him. During the 2014 Israeli war, after brother-in-law violently beat one of her children she moved her family out of her in-laws. With the meagre social welfare payments all she could afford was to move all 10 of them (including her husband) into the storeroom of a shop rented from her husband's relative. They lived there for the next year.
Family support/ Initial help seeking	On discovering that her husband was mentally ill and under medication a few weeks into her marriage, Maysa sought help from her family. Her father was ready to support her in divorcing her husband, but since she was already pregnant, he conditioned the divorce on her giving up the child to his father's family. Maysa refused, unable to leave her child with an unstable and abusive father and his family who also exhibited uncaring and abusive behaviour.
Support mentioned but not pursued	None
Entry point to formal interveners or services	Maysa's point of entry to formal GBV assistance was an outcome of seeking humanitarian aid at a local charity. Once the family lived on their own she sought humanitarian aid from local community organizations and mosques in her village. Following the 2014 Israeli aggression, she and her sister went to a psychosocial activity held in a CBO in their community. The counsellor identified that Maysa was suffering from abuse and connected her with X organization who contacted her a few days later. They encouraged her to come to their centre in Gaza City and said they would pay for her transport if she did. They said they would explain everything to her at the Centre.
Constraints from exiting	Maysa faced a black or white choice; to stay in the abusive marriage or lose her children. In terms of getting help, poverty and lack of knowledge prevented her from reaching service providers until she stumbled on organization X through searching for humanitarian aid. Instead of a full exit through divorce Maysa therefore sought an exit for her from the environment of her in-laws home to an independent home where she could control her husband's outbursts and protect her children. Poverty, lack of assets and lack of income was the main constraint to this.

GBV services received and assessment	Maysa describes her support and treatment from Association X as literally saving her life, given that she had contemplated suicide on a number of occasions. She describes the interaction by staff at X as “caring” and making her feel “secure”. When asked about what particular help she received, Maysa emphasizes the livelihood support she received. This included: training in crafts production and small business skills; a connection made to an organization that provides reconstruction money who (after her lobbying) gave her a small stipend towards building a family home; transport costs from her home to the association; financial help on occasion towards her husband’s medication). Maysa also emphasized the positive impact of the psychosocial support she received, including: group counselling, home visits, individual counselling, as well as the general therapeutic effects of undertaking the work in crafts. She strongly remarks on how her overall support and ongoing connection to the association gave her a sense of meaning in her life, self-respect and hope
Outstanding issues/ priority needs	Husband is not “cured” but Maysa has been given support to better cope with him. She is heavily in debt – her family gave her a small piece of land but she got into debt to build their family dwelling on it. This has weighed heavily on her existing burdens and mental state. Her husband’s physical abuse continues intermittently and there are no new treatment interventions for him – he simply continues to be on the same medication he has taken his whole life.

Case A2. Manal	
Demographic:	<ul style="list-style-type: none"> • Age 28, married for 8 years. • Education: first year of university • 4 children (3 girls / 1 boy -- all under 8 years old) • Has never worked outside the home • Manal is currently in Beit al Aman, the government shelter for GBV victims.
Current economic circumstances	Poor: Husband is self-employed as a motorcycle transport driver. From a marginal squatter community the household also received some support from charities. Husband is long term Tramadol addict.
Marriage Age and Circumstances	At age 20, a forced marriage to a relative that ended her university studies. They lived in a separate home next to his parents in the same squatter community as her family.
Nature of Abuse and Duration	Husband was extremely physically abusive from the start of the marriage. He has beaten her in the street and also in front of her children. Twice over the course of the marriage she attempted suicide. After 6 years of marriage he took a second wife – but they divorced after a year. The husband is psychologically manipulative – whenever confronted by family members he would threaten to self-harm.
Family support/ Initial help seeking	Manal had no support from her family though constantly sought their help. She says they blamed her for her marital problems and themselves beat her in order to get her to return to her husband. She spent much of her married life returning to her family who would then force her back into the abusive situation She says between them and her abusive husband – she had nowhere to go “but the street”.
Support mentioned but not pursued	None
Entry point to formal interveners or services	Police: She went many times to the local police station over the course of her abuse, but was told that it was a family problem and there was nothing they could do. In 2016 the turning point was when her husband slashed her face with a broken bottle where she ended up in hospital. Because of the extremity of the abuse, her family took her to the police station to make a complaint. The same police sent her to another station where she began the current criminal process in place for dealing with domestic violence cases. She went and got a medical report from Shifa hospital, made a complaint at the Zeitun police station that was passed on to the deputy prosecutor. At the police station she told the investigator that she had nowhere to go – he took pity on her and took her home to his family. After three days, again on personal initiative the police officer helped her move into the Government women’s shelter (it seems he did not know about it initially). Manal also did not know about the shelter “if I knew there was place like this I would have come here a long time ago”

Constraints from exiting	Lack of family support was a main constraint – only when her family helped her in the police station was she able to get on a path where she might exit from the situation. Lack of police response to her previous individual pleas for help was another constraint. Lack of information was another – she had never contacted any formal provider besides the police. Unlike other cases, Manal hoped to divorce and did not raise the issue of losing her children.
GBV services received and assessment	In regards to her attempts to get police intervention in the past, Manal says “they did nothing for me”. She thanks the personal initiative of the police officer for finally getting her to the shelter. She is extremely positive about the women’s shelter and mentions the feeling of security and safety: “It’s the first time I’ve had a good night sleep in years”. She has sat with a psychologist and has already met a lawyer who has taken the details of her case. They told her to simply rest for a few days and will discuss with her options and choices of action. “When I sat with them they made me feel very comfortable”, they’ve made me feel at home”. “My family came and tried to take me home – I want to stay here where I feel secure”. “They make me feel like I can finally find a solution after nine years”.
Outstanding issues/ priority needs	Manal clearly suffers psychological effects from many years of being abused. At the time of being interviewed at the shelter she was not always coherent and did not seem to fully comprehend the implications of the exit path she had chosen (in terms of the hardships and losses that divorce and breaking with her family would incur). Instead she was focused on the possibility of starting a new life by returning to university.

Case A3. Samera	
Demographic:	<ul style="list-style-type: none"> • Age 34, married for 14 years. • Education: finished 9th grade (engaged in 8th grade) • 5 children (oldest 13/ youngest 3 years old) • Has never worked outside the home
Current economic circumstances	Husband’s family average income: Husband had worked in Israel before becoming long-term unemployed. He is a certified mental health patient who gets treatment from a government mental health clinic. He is also a Tramadol addict as well as an abuser of recreational drugs. With the help of organization X Samera was able to rent an independent home in 2015 but it was financially unsustainable so she went to live with her family while her daughters were at SOS village and her sons were with their father at his family’s home. With the help of organization X, she was able to buy land to build an independent home registered in her name with money from a work injury case of her husband in 2016.
Marriage Age and Circumstances	At age 20, a forced marriage to her 27-year-old paternal cousin who was known to be mentally ill – but the marriage was forced on her family by more powerful relatives. His violent behaviour during the engagement led to a divorce (with the support of her father), but powerful relatives intervened to force the marriage through. Throughout the marriage they lived with his extended family who were also a major source of her abuse.
Nature of Abuse and Duration	Samera was violently victimized by her husband, as well as sexually victimized by his male family members. On her wedding night she was raped by her husband and subsequently faced sexual harassment by her father-in-law (her Uncle) as well as one of her brothers-in-law who she says raped another sister-in-law living in the household. According to Samera two of her brothers-in-law are drug dealers and it was in this context that she herself became a Tramadol addict. Her husband had been under medication for many years by a government mental health clinic – she claims the treatment simply makes him sleep for a few days and then he returns to being violent with her and the children. She has attempted suicide numerous times over the course of the marriage. The impacts of her addiction to Tramadol compounded her vulnerability to domestic violence and sexual exploitation from her husband and his brothers.

Family support/ Initial help seeking	<p>Samera's family, especially her brother, has been supportive of her from the start but were weak in the face of her husband's relatives. Over 14 years she repeatedly went back to her parents' house for months at a time but under pressure from her brother-in-law would return to her husband's family. She was also motivated to return by fear for her children (especially her two oldest daughters) – not wanting to leave them vulnerable to physical and sexual abuse from her husband's family members. Her numerous suicide attempts might also be considered a call for help (though one cannot assume that her intention was not to end her life). Her brother has intervened on her behalf in various ways over the years (see below) and was pivotal in linking her up with a GBV service provider.</p> <p>The only time she sought help beyond her family – was in an attempt to prevent being divorced from her husband. After leaving to her parental home so many times, her husband sought to divorce her (under pressure from his oldest brother). Samera had the local reconciliation committee intervene in order to allow her to return to her husband (once again, for the sake of her children).</p>
Support mentioned but not pursued	<p>In a critical moment (see below) Samera sought police intervention when her husband violently attacked her and the children when they were living alone. However, the police though coming to the scene – refused her pleas to take him to the government mental health clinic and said they could do nothing unless she filed a formal complaint against him. Samera refused to go pursue this path fearing that such a move would result in her divorce and losing her children.</p>
Entry point to formal interveners or services	<p>In late 2014, Samera once again attempted suicide. Rushed to Shifa Hospital she stayed in a coma induced by the drug overdose of her attempted suicide. When she became conscious, staff at Shifa transferred her to the mental health ward in order to treat her for addiction to Tramadol. At this point her brother made contact with X organization on behalf of his sister who came and visited her in hospital and got her specialized medication (not available at the government clinic) that would help get over her drug addiction. Samera's brother explained to the specialists from X organization that his sister's problem was not limited to drug addiction – but that she had lived in a long-term comprehensively abusive situation.</p> <p>X organization's initial strategy was to get Samera and her children out of the abusive environment of the husband's family; they provided 6 months of rent for them to live in an independent home far from the husband and his family. The husband however came to the home and violently attacked Samera (who was pregnant) and the oldest daughter. She got the police to informally intervene based on their shock at her physical injuries (see above) but they would not provide fundamental help unless she made a formal complaint which she refused to do fearing it would end in divorce and loss of her children.</p> <p>After being unable to cover the rent, Samera had to return to her family, but got X organization to intervene on behalf of her daughters and find them protective housing at SOS village while her sons went to stay with their father and his family.</p>
Constraints from exiting	<p>Although Samera was fortunate to have a supportive family their ability to impact on the behaviour of their more powerful (and potentially dangerous) relatives was minimal.</p> <p>Another constraint is the mental health impact of the totality of abuse she experienced over so many years compounded by the effects of her own drug addiction; she stayed trapped in a repetitive cycle of the same attempts to deal with her abuse over many years.</p> <p>Fear of the consequences of seeking help was a major obstacle. Samera's fear of making her abuse public and the possible repercussions of it was a major constraint in seeking more public forms of 'help'. As with most of the other cases – fear of losing her children compounded by fear of leaving them vulnerable to abuse in the home of her husband and his brothers was the fundamental obstacle in her seeking a divorce. This also impacted on her refusing formal intervention by police authorities (i.e. making a formal complaint against her husband) given that retribution would be her husband divorcing her.</p>

GBV services received and assessment	X organization provided a comprehensive range of services and support to Samera and her children. This included: medical help (drug treatment therapy for her addiction to Tramadol); on-going psychological counselling for her and her children; attempts to deal with her and her children's need for protection and safe shelter (through rent provision for an independent home and when that failed securing the daughters a place at SOS village). They have also provided legal counselling and support, as well as offered Samera training courses in income generation (that she says she is too "mentally tired" to take at the moment). At the time of the interview X organization's lawyer helped her and her brother secure a piece of land in her name in order to build an independent house. (see below)
Outstanding issues/priority needs	Samera does not want to divorce her husband, because she is certain his family will claim custody of the children. Instead, she seeks an independent home in her name where she believes she can cope with her husband (with her brother's help) as well as protect her children. She says, "if I have a house in my name, I can kick him (her husband) out and can call the police – it's my house and he can no longer attack us". In early 2017, a longstanding work injury compensation claim of her husband's was won, the lawyer from X organization helped her use the money to secure a piece of land in her name on which to build. At the time of the interview she had been free from Tramadol for two weeks.

Case A4. Sana	
Demographic:	<ul style="list-style-type: none"> • Age: 31; married for 9 years (in 2008) • Education: 3 years of university • Has 5 young children (oldest 7, youngest 3 months) • Has never worked outside the home; she studied social work at university but was not allowed to complete final year upon marriage although promised
Current economic circumstances	Very poor: Husband was unemployed from start of the marriage. They depend on government social welfare received due to husband's physical disabilities (back disc; retinal disease and leg problems that she did not know about at the time of marriage).
Marriage Age and Circumstances	Marriage at age 22 to her maternal cousin. She moved in with him on a separate floor but kitchen and bathroom were shared with his mother. The engagement was beset by conflicts between their families over her dowry –that was finally set very low (at 1,000 versus the norm of 3,000 to 6,000 Jordanian dinars). Husband and mother-in-law demanded Sana give them back her dowry gold immediately after the wedding.
Nature of Abuse and Duration	She was beaten on first day after the wedding. She says, 'After that, it became the usual routine'. Husband used constant physical abuse that sometimes escalated to trying set her on fire and attempting to push her out the window. Over time she attempted suicide a number of times. Husband's widowed mother encouraged the abuse and did not allow her family to visit. Abused for 9 years
Family support/Initial help seeking	Abandoned by her parents who live in another city, newly pregnant, she sought support from an uncle who lived nearby. The uncle told Sana that leaving her husband would only create more problems for her family. In anger at her help seeking, her husband beat her and broke her arm then threatened to blow up the house with the gas canister. His mother called the police and he was imprisoned for 3 days on charges of attacking his mother. From then on, his mother tried to have him terminate the marriage – but he refused. A few months later Sana, heard about the local reconciliation committee at the mosque and contacted them. They intervened but only to stop Sana and her husband being evicted by her mother-in-law; they did not see fit to raise the issue of Sana's abuse.
Other support mentioned but not pursued	After her disappointing experience with seeking help from her uncle and then the reconciliation committee, Sana abandoned searching for help for the next two years.

Entry point to formal interveners or services	In her second pregnancy, at a prenatal check up she heard about Centre “T” from other women at the clinic. Lying to her controlling husband, she said she was going to the centre only for a check of her diabetes and hypertension.
Constraints from exiting	Lack of family support as well as isolation from family. Not wanting to abandon her children.
GBV services received and assessment	<ul style="list-style-type: none"> • Mainly psychological counselling and support for herself and her children. Also practical skills to deal with husband when he is in a state that can lead to her being abused. • She has also received health treatment for conditions that are and aren’t related to the abuse. • Counsellors have intervened with school administrators when the husband created problems for the children’s schooling • She took a business course and hopes to receive social assistance when and if the centre has funds for it <p>Sana feels safe and supported by the centre and its staff -- it has been literally her and her children’s lifeline for 5 years. Even her husband has come to see her connection with the centre positively</p>
Outstanding issues/ priority needs	At the time of the interview, Sana’s husband had been “stable” for 30 concurrent days. She would still prefer to leave him but says “I tell him to give me the children and I don’t want anything else. Absolutely nothing. Just give me the children. He refused every time -- he knows their my soft spot.”

Case AE1. Ilham

Finding solutions from support systems of Islamic Jurisprudence and the standing government

Ilham 31, has been in a long running conflict with her Hamas affiliated family over the right to marry the man she chooses. She ultimately chose the path of seeking support within the Shari'a justice system and the Hamas authorities.

She was forcibly married by her family at 24 soon after she completed a university degree as a Shari'a legal assistant. Her husband, a 39-year-old non-relative, was unemployed. Ilham was hurriedly married off to this inappropriate groom because she had made it known to her family that she wanted to marry a man they did not approve of.

Within a few weeks of her marriage, the husband beat her head against the wall so violently that she had to be rushed to hospital. On being told that the battered woman was a new bride, the sympathetic doctor told her family that her symptoms showed a lack of will to live that could only mean she had no desire to return to her marriage. He gave her a forensic medical report that she however did not take to the police (a necessary step if she were to file for a divorce) because her father and brother threatened that if she did – they would kill both her and the man she still wanted to marry. Ultimately, however, Ilham was able to convince her family soon after to allow her to seek a divorce from the husband based on the fact that he suffered from sexual dysfunction.

The husband refused to give her a final divorce with the result that Ilham spent the next four years at her family's house as a "hanging divorcee". She says, "He wanted to empty me...four years of my life were completely wasted". The husband finally gave her a final divorce only after she liquidated all her assets and borrowed money to pay him 3,000 Jordanian dinars along with waiving all of her marital economic rights (deferred dowry).

While the husband's abuse was over, her father and brother kept her imprisoned and isolated at home, continuing to refuse to let her marry the man she wanted. Ilham says they were trying to appease one of her male relatives, a powerful figure in Hamas's military wing who had taken a personal stand against Ilham marrying according to her will.

After the divorce, she worked as a legal secretary for the Shari'a court in her community. Well-versed in her Shari'a legal rights, she sought help from a sheikh she worked for who was a member of Gaza's League of Islamic Jurists. He agreed to intervene by writing to her father a legal opinion: that given Ilham was no longer a "maiden", the father's legal authority in decisions over whom she could or could not marry depended on her consent (i.e. that he was exercising unjust authority over her right to remarry). The sheikh told Ilham that while he intervened she should go into protection at the government shelter (Beit il Aman) where he could ensure that her father and brother would not be able to harm her and made arrangements for her with the shelter director.

The sheikh had the government shelter receive Ilham while he sent the communication to her father. The shelter treated her well but its then-director ultimately let her down. After a few days there a cousin came to the shelter telling the then director that they agreed to let her marry, but he needed to take her back to her family immediately. Ilham and the sheikh knew it was a trick but given that the shelter director did not want to keep hosting her, she agreed and returned to her family where she was badly beaten and threatened and once again kept isolated at home.

The man she wanted to marry undertook the next series of interventions. A former PA employee (deemed inappropriate by her family because of his political background and because he was a divorcee with children) organized numerous delegations from various political and social factions to visit the father to convince him to let them marry – but to no avail.

Ilham's next strategy was to go to the highest Islamic legal authority in Gaza in matters of family law, the Qadi al Quda or high judge of the Shari'a Court system. She told him that she wanted her legal right in Shari'a to marry and did not want to marry against her father's will (or as she said, "I told him I'm no longer a maiden, I want to marry, I have a proposal and I want a permissible (halal) path to marry". The judge warned her that this meant going to war with her family and said only if she was prepared to do that she needed to raise a legal case against her father's and brother's right of guardianship over her. He promised that such a case could be cleared in the courts in two weeks after she expressed fears concerning her four-year experience of getting a divorce. Similar to the first sheik, the judge counselled that for her protection she should go to the government shelter as soon as she raised the case in court. He also encouraged her with the news that the shelter had a new director who this time would be caring and supportive of her case. Moreover the judge contacted the head of the Hamas women's movement to coordinate Ilham's protection at the shelter and gain her support for Ilham.

At her local Shari'a court where she went to raise the case to have the rights to her own legal guardianship (and thus remove the power of her father and brother to decide who she could or could not marry), the new sitting judge implored her not to go forward, saying that if it went ahead with the case and lost, her life could be in danger from her father and male relatives. However, after calling the new head of the shelter who promised to support her and with the backing of the high judge, Ilham went ahead.

At the shelter, awaiting its outcome, Ilham had the full support of the shelter director, as well as comprehensive support including meetings with a psychological counsellor and legal counsel – including visits from the lawyer from legal rights provider “M” who had dealt with her divorce. She was also offered training courses but said, “I’m not interested in embroidery”. Of the shelter and its staff she says, “I feel protected and comfortable here, they are all standing with me, and the director is committed to find a solution to my case – she is using her own ways to help me”. However, Ilham lost the first case and ended up staying at the shelter for three months. Over that period, the director strategically used her network of relationships across the government (including police, ministries and high level government contacts) as well as lobbied the league of Islamic jurists to find a solution for Ilham to marry.

The outcome in February 2017 was that Ilham won an appeal and was married a few days later to her chosen groom in a wedding ceremony held at the shelter. All of those who had worked supporting her brave and tireless fight to marry whom she chose attended, as did the other women seeking protection at the shelter. Besides using her connections to make that outcome possible, the director had also used her networks to ensure that Ilham would not be harmed by her powerful relative. As of April, Ilham is happily married and living with her husband and she has been reconciled with her father.

Case AE2. Nahla Abu Youssef* **Sentenced to death by hanging for the murder of her husband**

Nahla is the first woman to be sentenced to death in the occupied territories since 1994 when a Palestinian justice system first came into being. Her case highlights general concerns over the continued use of the death penalty in Gaza by the de facto government authorities. It also highlights the way the criminal justice system does not treat the effects of being a GBV victim as mitigating circumstances in a homicide.

Fatima Ashour a lawyer was given permission to visit and interview Nahla on her agreement at the Gaza women’s prison where she’s been held since late January 2016. Nahla was convicted and sentenced by the Khan Yunis Court of First Instance on October 6, 2016. At the time of the interview she was awaiting the outcome of the appeal against her death sentence to be held on December 16th. The appeal was refused and Nahla’s sentence stands.

Nahla from Abassan al Kabira village is 27-years-old and the mother of a two-year old son that her husband’s family has refused to let her see since she was taken into custody.

In narrating the path that led to her current situation, her problems began with her older, very authoritarian and controlling brother. She says he controlled her every movement, not allowing her to have a phone and rarely leave the house because he was scared that she would get into communication with young men. “When they see me at the balcony they assume I am talking to someone... they don’t want us to touch the door, go out on the roof, they want to keep us locked up all the time”. She spoke about an adolescent crush she had, that lasted for seven years and started when she was in 7th grade. “It was just looks of admiration from a distance, I talked with him only once”. When her brother found out she’d been in communication with him, he beat her, an occurrence that according to Nahla was the norm at home.

In her late teens, Nahla’s reaction to these beatings was to run away from home – but with nowhere to go to in the large prison that is Gaza, she would just aimlessly wander the streets and return home the same day. On one occasion after she ran away, her brother beat her so seriously she had a black eye and broken arm and she ended up in hospital (where her mother told her to say she fell down the stairs).

When she was 19 she says she twice tried to commit suicide with poison. The first time she told hospital staff it was just a case of food poisoning, the second time she says she told them the truth – that she’d tried to kill herself because her brother abused her. “I wanted the hospital to get them (her family) to sign a pledge not to do it again but nothing happened”. After that incident, Nahla had her only experience with a formal service provider; the ministry of social affairs contacted her to attend a workshop that she did attend. When asked what it was about she replies: “Violence against women, and then we played for a bit”. She says she “enjoyed it” and wanted to return but her family wouldn’t let her.

When asked whether she ever tried to resolve the problems with her brother, she answers, “His hands speak louder than his mouth”.

After her first year at university her brother found out that she secretly had a mobile phone. Besides beating her and locking her in her room, he told her she could never return to university. “To my family, love is forbidden, they beat me every time they see me reach for the door, especially my brother Mohammed.”

On the first day of university classes that she'd been denied to attend, Nahla rebelled and left the house. Not having any money or knowing where she was going, she ended up walking to Gaza City. Over two days she wandered the city, one night sleeping in the rubble of a bombed house and the next on the stairs of a high-rise building. The next day wandering in the square of the Unknown Soldier she was offered help by a stranger who said she could rest at his family home. Once there, he raped her. She left and walked to the beach where the police found her and delivered her to her uncle's family. At first she told no one of the incident (including the police) but finally told her mother who took her to a private doctor who she says, said, "it was only a scratch".

Nahla's family's solution to her being raped was to quickly force her into a marriage with a relative -- the husband that she eventually murdered. The husband, a donkey cart driver ten years older, suffered from some degree of mental illness or disability and could barely read and write. He had been previously married but divorced after three months. Nahla says of his mental health problems, "He used to rip his clothes off and threaten me with a knife."

Her mother showed her how to cover up that she wasn't a virgin for her wedding night. But she mostly refused to sleep with her husband; "I couldn't bear him to get near me". Her husband and in-laws physically beat her for "disobedience" -- for refusing to sleep with her husband. Like most women in abusive situations, she constantly returned to her family, "too many countless times". She sought help from her paternal uncle (given that her father was deceased) but his reply was, "if you leave your house again I will break your legs. No women of our family acts this way".

For two years and nine months, Nahla was locked in the cycle of fleeing to her family home only to be returned to the abusive environment at her husband's family. At that point Nahla says, "I got tired of going back and forth, and then what happened, happened."

Nahla got her husband to walk with her to an uninhabited area where she stabbed him multiple times in the neck with an ordinary knife. She says, "I wasn't myself when I killed him" and when asked if she intended to kill him she replies, "No, I wanted him to divorce me, but I couldn't control myself, I kept stabbing." She also says, "He used to beat me, his family [beat me] too and if I ran away they would say, she ran off with some guy".

She returned to her family's house and two days later, the police found the body. Nahla didn't confess at first, although the police claim they had evidence. A police officer that had found her at the beach three years earlier (immediately after the rape) got her to confess by saying, "I know you were forced to marry against your will and you didn't want him, tell me what happened and don't worry". In the process Nahla also told the police about the rape -- she remembered the perpetrator's name. It seems the police questioned him but no one knows for what purpose and what was the outcome.

Over three hearings Nahla had no legal representation because she says her family did not have money to hire a lawyer. The court subsequently appointed her a lawyer, but she says, "he left me when the court sentenced me to death". The court appointed her another lawyer for her appeal. Throughout her detention and the legal proceedings, a mental health specialist never examined Nahla.

A number of public appeals have been launched on her behalf including from al Muntada Coalition and the Palestinian Independent Commission for Human Rights. But the response of the criminal justice system in Gaza to arguments that Nahla needs to be recognized as a victim, rather than simply a perpetrator can be seen in the words of Nafez al-Madhoun, chairman of the Higher Judicial Institute in the Ministry of Justice (in Gaza):

"We, as a Palestinian society, do not distinguish between a man and a woman in terms of sanctions, which apply to everyone. It does not make sense for human rights and women's organizations to demand equality between men and women and then demand a reduced sentence for [Nahla].... Palestinian society is a tribal community, where people still commit acts of vengeance. "If local authorities do not achieve justice and properly punish murderers, the security situation would be undermined."

Similarly, Gaza's attorney general Ismail Jabr said in an interview to AFP: "Palestinian law does not make a distinction between criminals according to their sex".

When asked what she would advise other women who had been in her situation Nahla responded, "Go to human rights associations, they will help you. I would have if I knew there were any".

* Given that Nahla's name is in the public sphere, she is the only victim whose true name is used in this report

Case AE3. Fadwa Raped under cover of the 2014 Israeli military aggression

The interview was conducted with Fadwa's mother, Nisreen who is 47, the mother of nine children, seven of them who were still living at home during the 2014 war. Nisreen's husband works outside the country in order to support his family and was not in Gaza when the war took place.

The daughter Fadwa was at the time of the war 17 years old and about to finish her tawjihi. Nisreen and her husband are clearly loving and caring parents. They had wanted all of their daughters to complete their higher education but couldn't afford to, as well they both strongly believe in their daughters' rights to have the final say in marriage proposals.

About a year before the war, when Fadwa was in 11th grade, her mother found out that she was in a flirtation with a young man who began conversing with her while she was walking to school. A relative told Nisreen she had seen a young man on a bike trying to talk to her daughter while the girl kept walking ahead of him.

Nisreen's reaction was to give Fadwa a beating and informed her husband what happened. His reaction according to her was different:

"Her father took the girl for a meeting alone, he did not beat her, just talked to her. I asked him to fill me in what happened in the meeting. He said that there is no story, I am going to end it all now. I will go to the boy's family and ask them to stop their son from following my daughter. Their son is the one at fault by following our girl and flirting with her. I will tell the boy's father that if I catch his son following our girl again, then they are going to find him at the hospital..."

But a few days later she found Fadwa using her phone and talking to the young man. Grabbing the phone, she screamed at the boy to leave her daughter alone. But later that day he called back and explained himself to Nisreen saying that his intentions were honourable, he was in love with her daughter and wanted to marry her. When Nisreen retorted that he should then ask for her hand correctly, he replied that he was still in school and had two brothers in line to get married before him. Nisreen told him for the sake of her daughter's safety and reputation he should stay away from her until he could afford to marry her and, if he did she would allow them to do so. The young man agreed and to her surprise abided by their agreement, and made no contact with Fadwa until the 2014 war.

With her husband out of the country, and their community under aerial bombing Nisreen fled with her seven children still at home and a few clothes to seek shelter at an UNRWA school where they spent the duration of the war. At the shelter, Nisreen received phone calls from the young man wanting to check on their safety and wellbeing. Then during a ceasefire he said he wanted to come and make sure they were all right. Nisreen agreed saying, "It was a big place with millions of people around". He and his friends came bringing food, water and mattresses; he apologized for his previous behaviour and reassured her that it was because he'd been young and immature but that his intentions were honourable. He was happy to say that his older brother was about to get married and his second oldest one had broken an engagement, thus opening a faster path for him and Fadwa to become engaged. He invited the family to come to his friend's house to get clean water and bathe. As Nisreen said, "That is what many people did, they opened their houses for the displaced people who ran for their lives without taking anything with them before they leave... [H]is friend's wife kindly received us, she let us take water and use her bathroom to wash and so on. We trusted her".

In the next ceasefire, Nisreen took a daughter and went to their home to pick up some clean clothes. In the meantime, Fadwa decided to fetch clean water from the same woman who had received them previously. At the house, the woman told Fadwa she could bathe if she wanted. While Fadwa was bathing, the young man showed up and raped her, or what her mother calls, "did the unthinkable". Nisreen doesn't know if the woman conspired to let the rape happen, but says the house was so small and Fadwa kept screaming but the woman never appeared. Nisreen says, "I can't believe it – there were people dying, others burning and my daughter ... I swear every time I remember the issue I get so sick but it's all my fault".

Fadwa only told her older sister what happened and swore her to secrecy. But a few weeks after the war the original story with the young man erupted into a full-scale scandal that almost had Fadwa killed by her cousins. The young man was seen in the neighbourhood, and neighbours spread rumours that he must have been there to have an evening liaison with Fadwa. The rumours spread to the point that members of the Qassam Brigade took him to the police where he was badly tortured in order to get a confession. Nisreen's husband was still out of the country, so she was left to face his male relatives who then showed up at their house and dragged Fadwa into the street to publicly beat and possibly kill her. Only Nisreen's strength of character was able to get them to stop. Since then she has broken all relations with them and her neighbours.

Soon after, her older daughter told Nisreen what happened to Fadwa during the war. Nisreen says: I lost it, I started hitting myself, wondering what am I going to do now? What kind of shame she brought to me and her sisters, I could not think and directed all my anger at her. I beat her and felt I don't want to see her anymore. I knew what happened was against her will as she told her sister and I, but she brought it on herself.

Nisreen called the young man who had raped her daughter and met him in a park. She told him that he had to bring his family to ask for Fadwa's hand and that if they didn't, she would get the police involved regardless of the consequences. Not hearing from the family she told the details of the crisis to director of service provider "K" located in her community. The director first went and contacted the young man's family and set up a meeting between Nisreen and the young man's mother (who tried to blame Fadwa and her mother for what happened and then suggested that instead of marrying them, Fadwa should have hymen reconstruction surgery). Nisreen replied, "I told her listen what happened is your son's fault and it was during the war not in my place so let's focus on solving the issue before it is out of control..." She insisted on the marriage so as not "to gamble with my daughter's life". When still nothing happened with the family, the director of "K" organization used her contacts in the police and explained to them in detail the sensitivity of the case and the need to keep utmost secrecy. The police took the perpetrator into custody and would not release him until his family would sign a marriage contract. The family, however, told Nisreen in all honesty they did not have any money to cover the dowry. She said she would borrow the money that they would put in her hands in public – thus giving everyone the impression that a formal dowry had been given. Once the marriage contract was signed, the young man/ perpetrator was released from prison.

Fadwa is still with her family as her fiancé's family tries to amass the finances for the wedding costs.

About the police Nisreen says, "They were nice to me. At the beginning, they investigated me about the incident and believed me because it all happened during the war and at other people's home... The police told me to go back to them if they did not keep their word of giving you dowry and do what people do in general for marriage."

Fadwa's rapist fiancé visits her weekly at her parent's house. Nisreen says he is extremely sorry for his actions and truly loves Fadwa. His family have as much as possible tried to make amends for the son's actions.

Nisreen got to know about Service Provider "K" during the war when they came to the UNRWA shelter to deliver humanitarian relief as well as providing information about the services they provided. After the war Nisreen visited and took courses and listened to lectures at the centre. She said she knew the director could help her because she'd sat through a legal rights lecture and the director had told them that they would help any women who had a problem.

CATEGORY B. HARSH CASES [HUDA, YARA, AIDA, INAS, RULA, AMAL, AMINA]

Case B1. Huda	
Demographic	Age 37, married for 20 years. Education: Less than high school 7 children (oldest 19 / youngest 2 years old) Has never worked outside the home
Current economic circumstances	Poor: Household receives some government social support; husband has only intermittent employment.
Marriage Age and Circumstances	At age 17, to a non-relative. At the time husband was employed in Israel. Initially it was a good cooperative marriage where she managed the household income
Nature of Abuse and Duration	Four years into marriage, husband lost employment and began at times to physically abuse her. She blames his cigarette addiction; "When he can't afford to smoke, he takes it out on me and beats me in front of the children and this has affected my psyche". Abuse for 16 years and continuing although under better control
Family support/ Initial help seeking	She would regularly return to her family (hardaneh). Had good family support. Husband would agree to stop the abuse but, she would return to him and the cycle would begin again.
Support mentioned but not pursued	She did not seek help from community figures or police because it would be "a disgrace"

Entry point to formal interveners or services	About a decade ago, she went for a prenatal check-up to women's centre 'T' that has GBV services. There she told one of the staff about the abuse from her husband who then linked her with their other services.
Constraints from exiting	Exit from the marriage not desired. Because the partnership had been positive in the past, she sought to get treatment for herself and husband and fix the marriage.
GBV services received and assessment	Long term support over many years from Center 'T' including: <ul style="list-style-type: none"> • Psychological counselling for herself, husband and children • Collective outings for her and children • Practical strategies to deal with husbands temper • For a period an income generating project that she and husband worked in together • Very important: regular home visits from staff • Says the support from centre "T" has positively changed her life
Outstanding issues/ priority needs	Husband is not "cured" but with help has been able to recognize and better control his behaviour. Huda believes his problems are an outcome of unemployment – thus steady employment might play an important mitigating factor.

Case B2. Yara	
Demographic	Age 22, divorced at 21 Education: Less than Tawjihi 1 child, a baby son currently in her custody at her parents She has never worked outside the home
Current economic circumstances	With no source of income while living at her parents with she hopes to find income generating work (see below)
Marriage Age and Circumstances	Married against her will to cousin at age 19. She had wanted to finish university. Suffered great psychological stress and pressure in her husbands' extended family. Though young she suffered a heart attack in her first year of marriage while pregnant.
Nature of Abuse and Duration	19-year-old husband was extremely controlling; as was her sister in law who treated her as a maid. She was then sexually harassed by two different brothers-in-law; one of them attempted to rape her. Two years of abuse
Family support/ Initial help seeking	Strong support from her father who interceded multiple times and encouraged her to get a divorce early on. She returned to her parent's home pregnant, recovering from a stroke. Father's intervention led to an agreement that the husband would repay her dowry (he destroyed it when she left) and set her up in independent home once the child was born. Though husband followed through with agreement, Yara was subsequently sexually harassed/ assaulted by her brothers-in-law. Her own father interceded again on her behalf but in the meantime her father-in-law blamed her for the incidents (and family scandal) and forced his son to divorce her.
Support mentioned but not pursued	Yara had strong support from her family/ father thus never pursued any other line of intervention – particularly since her husband was a relative and the larger family were already involved.
Entry point to formal interveners or services	Only post-divorce did she seek external assistance from Association 'W', which she'd heard would help her with income generation – her main priority upon divorce.
Constraints from exiting	With strong family support she had no constraints exiting the marriage. However, this was is not her priority (see below)

GBV services received and assessment	<ul style="list-style-type: none"> • Psychological counselling; “I go there every week, empty everything out and feel better”. She says the counsellor is very important because she has no friends except for her. • Some legal support – the centre will pay her lawyer’s fees, once she has paid 80 shekels for the court costs – a sum Yara is trying to collect in order to pursue her deferred dowry. • Income generation: the Centre has no funds, but have promised her that she will be included in projects when they do.
Outstanding issues/priority needs	She prefers to return to her husband. As a divorcee her future is very bleak and constrained, and she will eventually lose custody of her son. Although her family are kind and supportive she sees no happy future possible as a young divorcee

Case B3. Aida	
Demographic	<p>Age: 49; married for approximately 33 years. Divorced in 2016</p> <p>Education: preparatory school</p> <p>Has 6 children (oldest 27/ youngest 7 years old)</p> <p>Worked with a local CBO for more than a decade as well as does animal husbandry (and was main family income earner); is also a female preacher and Quran teacher</p>
Current economic circumstances	Poor: Husband is a carpenter, but barely supported his family. Through years of work she saved money to buy an apartment in her name from her husband’s brother and is the main breadwinner taking care of her children.
Marriage Age and Circumstances	Forced marriage at age 14 to a cousin who was 20. She lived with him and his mother – both abusive and controlling; he abused her systematically physically, she systematically mentally. Aida made sure not to get pregnant for the first six years of marriage in hopes that she could leave the marriage.
Nature of Abuse and Duration	From the start of the marriage, husband beat her if she “disobeyed” his demands and this continued over three decades of marriage; but he also systematically withheld economic support that led Aida to seek income on her own in order to take care of her children.
Family support/Initial help seeking	Within the first year of marriage, her father supported her in seeking a divorce, but he passed away soon after, and since then she had little or only negative support from family members. Over the years, family clan leaders intervened numerous times, promises were made but the husband simply returned to abusing her. She says family leaders just wanted to keep her in the marriage at any cost.
Other support mentioned but not pursued	None
Entry point to formal interveners or services	Initial formal intervener was the local police brought in by her husband. In 2016 her husband, unilaterally divorced her; locked her and the children out of the apartment that was in her name (where they’d been living); and then filed a case against her and his oldest son with the police claiming they’d stolen money from him and locked him out of his home. The police and prosecutor dropped the charges after realizing they had all been fabricated. But the husband had enough connections to have his son imprisoned on charges of theft. Aida with her own income hired a lawyer to get the son released. The husband subsequently married again and Aida is pursuing her legal rights with him through the courts.
Constraints from exiting	Lack of family support to pursue a divorce. Clan/family pressure to keep the marriage intact.
GBV services received and assessment	Aida feels the police ultimately treated her fairly but that they had to respect her ex-husband’s complaint because he was a man: “They knew he was lying and that he was unjust to me and the children but they still dealt with his claims because he was a father.” She has just been assigned a lawyer by a local GBV provider in her area and at the time of the study this was the only service she received.

Outstanding issues/ priority needs	She is currently pursuing her legal rights from her ex-husband in court and is in a relatively better position than other women GBV victims – she experienced her divorce as the liberation she always wanted from her abusive marriage; she is living in a home in her own name. On the negative side, although her children are with her and her husband is disinterested in them, the younger ones (who are of an age where the father can demand custody) are a vulnerable point he can use in negotiating with her to waive her maintenance rights and deferred dower in lieu of keeping custody.
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Case B4. Inas	
Demographic	Age: in her 50's; married for approximately 20 years. Education: preparatory school Has 3 children (2 teenage daughters and a younger son) She has never worked outside the home
Current economic circumstances	Destitute: Inas's husband has been unemployed for many years, a Tramadol addict who over the years sold their household possessions to support his habit; their home was destroyed by Israeli bombing during the 2014 Israeli aggression; they received a replacement home that her husband sold pocketing the money. They now live in an extremely impoverished rented home and are destitute -- depending on donations of food and other basic items from friend and neighbours and rare intermittent income when her husband finds work.
Marriage Age and Circumstances	Married late at 31, her husband was a non-relative neighbour who worked in Israel and then became only intermittently employed in Gaza when the border was closed. The marriage was bad from the start: he exhibited controlling behaviour, at first slapping her and then one month into the marriage beating her badly. She believes he has mental health problems but he only went for diagnosis a few weeks before the research interview.
Nature of Abuse and Duration	Controlling behaviour, psychological and physical abuse – including beatings in the street. He was constantly kicking her out of the house and often threw her family out when they visited. He also beat the children and psychologically manipulated them. After the war, he bought a gun into the home but never directly used it to threaten her or the children. She has been abused for two decades – but her primary worry is her teenage daughters.
Family support/ Initial help seeking	She would regularly return to family or stay with them when she was kicked out. Her family including her brother consistently encouraged her to divorce him but she always refused; initially for fear of losing her children and then when they were older – fear of leaving her teenage daughters with him. When her husband sold the replacement house, her brother demanded that she divorce her husband; when she refused her family broke off all communication with her.
Support mentioned but not pursued	She heard about the government shelter from Centre X (see below) as a place to protect her daughters from their father but decided that “the stigma” attached to women going there was too high a cost.
Entry point to formal interveners or services	When her husband sold the house in 2015, she went to X centre in her community and asked advice. They provided her with choices such as speaking to the police (about her abuse) or pursuing a divorce. She refused to do either because of fear of losing her children and leaving them alone with their abusive father.
Constraints from exiting	Like many victims, Inas was trapped in the abusive marriage in order to keep and protect her children from the abuser.
GBV services received and assessment	From Center X, she received legal advice as mentioned above – but decided not to pursue it. Instead, she and her daughters are receiving psychological counselling. Recently, the Center helped her encourage her husband to see a male psychologist under the pretext that he might be able to be certified in order to get social support from the MoSA.
Outstanding issues/ priority needs	Inas says her husband has not sexually abused his daughters, but it is clear that she has fears that he might be capable of it when drugged if she was not there to protect them.

Case B5. Rula	
Demographic	Age: 35; married for 13 years (in 2004) Education: primary school only Has 3 daughters (oldest 11, youngest 2)
Current economic circumstances	Very poor: Husband unemployed from start of marriage due to effects of a head injury. They depend on government social welfare on the basis of her husband's disability that she did not know about at the time of marriage. Rula herself applied for the social support and with the agreement of the ministry had it put in her name so she could control it and make sure it was spent on her and her girls rather than consumed by husband. Overtime she spent all of her dowry gold in order to meet the family's basic needs.
Marriage Age and Circumstances	Marriage at age 22 to a distant relative. She moved in with him into a room at his family's house with many brother and sister's in-law. Her husband started abusing her early in the marriage; she was treated like a maid by his siblings, overtime her husbands brothers and unmarried sister also used physical as well as mental violence against her.
Nature of Abuse and Duration	Regularly physically and mentally abused by husband, who sometimes attacked her with dangerous objects such as a screw-driver. He and his siblings also constantly threw her out of the house. His family members would insult and abuse her. 13 years of abuse and on-going
Family support/ Initial help seeking	Rula has constantly returned to her family for weeks at a time and has their emotional support. Overtime her poor and aged father encouraged Rula to seek a divorce but on condition that she leave behind even the daughters she still had custody rights over – something Rula refused to do
Other support mentioned by not pursued	None
Entry point to formal interveners or services	<ul style="list-style-type: none"> With the support of her family twice (when she was kicked out of the home) she filed cases in the Shari'a court first for maintenance then when revocably divorced (see below) she filed for her deferred dowry and furniture. Two years ago beaten badly by her husband and kicked out of the home, with the support of her family she finally went to the local police. After a medical exam and report made at the government hospital (where she says she was treated well) she filed a complaint against her husband, who however refused to show up at the station. Once the police located the husband they made him sign a statement that Rula requested: that if he threw her out again he would have to pay back the 1,000 dinars of dowry gold that she had spent maintaining their household. She returned to him for the sake of her daughters. In 2016 after her sister-in-law attacked her in the street (including throwing stones at her and pulling off her hijab in public), Rula (again with her family's support) went to file a complaint at the police station, this time against her sister-in-law. The police had her husband's oldest brother sign an agreement that his sister would not attack Rula again. In the meantime, her husband made a 'revocable' divorce (talaq raj'ee); raised a case in the Shari'a court to have his daughters brought home (since Rula had taken them with her to her parents house) as well as sought the intervention of M, a mukhtara who Rula says he involved to 'stop the situation from escalating'. The mukhtara contacted Rula and negotiated her conditions of return to her husband (that he provide her with a home independent from his family). The husband said he was unable to provide an independent dwelling, despite this Rula returned to him not wanting to abandon her daughters in the near or future term if he completed divorcing her. The mukhtara told her about NGO Centre 'H' that Rula visited only once and where she says they asked her a list of questions about whether she had experienced violence and then two weeks later they called her to come in for legal advice. After that she never returned because she says they never called her again.
Constraints from exiting	Not wanting to abandon her children.

GBV or other services received and assessment	The police undertook the minimum responsibilities required by law when faced with GBV cases. In the first police intervention rather than arresting the husband on the basis of the forensic evidence a police officer ‘mediated’, saying according to Rula, “... you have children between you and we don’t want the problems to get bigger” – thus only getting him to sign a pledge. In the second case, they also got her brother-in-law to sign a pledge rather than undertake any criminal proceedings. The staff who undertook the forensic examination at the government hospital according to Rula, treated her with humanity. The mukhtara was unable to provide any solution for her – not having any form of legal or other leverage over the husband. NGO provider “H” does not seem to have communicated sensitively or clearly with the victim who saw no point in revisiting them. In terms of legal advice, she says, “They gave me a brief understanding of what are and aren’t the rights for women”.
Outstanding issues/priority needs	Rula continues to be in the abusive situation with her husband and his family. She concludes, “If anyone wants to help me and I hope God helps me too, I want to be able to rent a house and get out of the situation I’m living in and to be provided with a job”.

Case B6. Amal	
Demographic	Age: 27 (divorced in 2014 before consummation of marriage) Education: Tawjihi Intermittently works secretly as a house cleaner to earn money
Current economic circumstances	Poor: Currently lives with her widowed mother, 2 brothers and 2 sisters. Youngest brother has a mental disability and receives sponsorship from an Islamic charity). After death of father, family depends on economic support from mother’s family. Amal has urinary incontinence for which she has received no treatment.
Marriage Age and Circumstances	Forced engagement at age 23 to an acquaintance of her aunt – the administrative marriage took place but the actual marriage was never consummated. Amal did not want to marry due to embarrassment about her condition but was forced into the engagement/marriage by her abusive father and brother. On finding out that the groom’s family had a history of criminal activity, her uncle and grandfather helped her “divorce” soon after the 2014 Israeli offensive. From fear of the groom’s family, Amal and her family waived all of her economic rights and returned her preliminary dowry.
Nature of Abuse and Duration	Amal grew up in a household terrorized by a drug-addicted father (Tramadol) who also encouraged his eldest son to use violence in order to control his sisters. She self-harms (cutting) and it is likely that her adult incontinence is also a psychological outcome of her abusive childhood. The father died in 2015 of a heart attack.
Family support/Initial help seeking	<ul style="list-style-type: none"> Amal’s only solace growing up was her younger sister who also suffered from the father’s and brother’s abuse. Her mother, also victimized was unable to support or protect them In her late teens she went to the police to inform on her father’s drug use – a solution she imagined would end his abuse of the women in the household. He was subsequently arrested (without the knowledge that she had informed on him), but was released without charges due to having connections.
Other support mentioned by not pursued	She mentioned “H” Centre in her immediate community that provides GBV services but says she was scared to go there in fear of being recognized by someone who would inform her family and create a scandal.
Entry point to formal interveners or services	Later, as a divorcee and upon the death of her father Amal started to look for aid in order to support her mother and siblings. Through begging for taxi rides and asking women strangers she followed leads to various NGOs in Gaza City (far from where she lives). Centre “F” with GBV services has tried to help her by providing psychological counselling and offering her training but Amal only shows up sporadically and her focus is on getting immediate financial help.
Constraints from exiting	As a child growing up in a household dominated by an abusive father, only her mother could have herself exited through divorce, but this would have left Amal and her sister alone at the hands of their abusive father. In terms of her current situation, although the source of the abuse is gone (her father) its impacts continue (see below)

GBV or other services received and assessment	Although GBV service providers have attempted to help Amal move forward with her life, the long-term mental health effects of her childhood abuse make helping her exceedingly difficult since she sees her problems only in terms of immediate financial needs.
Outstanding issues/ priority needs	Amal's case needs systematic psychological treatment, but given that she is socially functional and rejects what counsellors have recommended she will likely continue in the same pattern of behaviour.

Case B7. Amina	
Demographic	Age 26, married for 10 years. Education: Some Secondary school 4 children (oldest 9 / youngest 2 years old) Has never worked outside the home
Current economic circumstances	Poor: As a refugee household they receive food aid from UNRWA. Since 2016 husband receives government social welfare because of a work disability. Husband a long-term Tramadol addict who denies income to his wife, spent her dowry gold and has incurred many debts in the community presumably to support his drug addiction.
Marriage Age and Circumstances	At age 16, to a relative who was 19. Growing up with a widowed mother who had 1 son and 7 daughters, Amina who'd hoped to go to university, was forced into marriage at an early age by her grandfather to relieve the financial burdens on her widowed mother. The husband was sexually dysfunctional on the wedding night so beat her. They had a separate apartment in the family building. Amina was lucky to have the sympathy of her mother-in-law and brothers-in-law in the same building who understood the husband was abusive.
Nature of Abuse and Duration	The husband has constantly abused her physically, at times beating her with a stick as well as in public. He also systematically withholds income from her and the children. He has kicked her out of the house on numerous occasions and has verbally "divorced" her many times. Amina also accuses him of attempting to prostitute her to his friends in order to get money.
Family support/ Initial help seeking	Amina immediately informed her mother of the beating she received on her wedding night. The mother (in a weak position herself) talked to the husband and the family brought him a faith healer. She would constantly return to her family, but they gave limited if any support and refused that she get a divorce. Amina tried to prevent pregnancy early in the marriage so she might be able to exit. She had more sympathy from her mother-in-law and her brothers-in-law who at one point beat her husband in order to get him to change.
Support mentioned but not pursued	Centres Y and X both suggested to Amina that she could go to the government shelter with her children when her husband abused her badly, but she said she refused because she'd heard from other women (at one of the centres) as well as the police that the shelter housed women with a bad reputation. Amina's case encompasses multiple sectors of interveners-- governmental, informal and finally NGO/ GBV service providers
Entry point to formal interveners or services	<ul style="list-style-type: none"> • 2 months into the marriage her grandfather brought a mukhtar to intervene who got the husband to sign a pledge to stop the abuse – to no effect. This was followed by an intervention by the local reconciliation committee (also arranged by her grandfather) also with no effect. • Amina visited a local sheikh to understand whether her husband's verbal divorces had legal standing (they did not). • Finally, a year ago at an UNRWA clinic where she was being treated for cramps, the counsellor recognized her symptoms and got her to share her story. The counsellor gave her a referral to Center "Y", a GBV service provider in Gaza City. After a few months receiving services at Centre Y (see below), they referred her to Centre X that had services more relevant to her needs.

Constraints from exiting	The main constraint was her mother and grandfather's refusal that she divorce. In this case, the victim was ready to leave the abusive situation without her children, perhaps because she could trust them to the care of her husband's family.
GBV services received and assessment	<p>In Center Y, she received psychological counselling every 2 weeks as well as met a legal counsellor; upon informing the legal advisor that she wanted a divorce – she was told to get the agreement of her family. Her mother eluded calls from the Centre legal staff who tried to reach her by phone. Centre Y also met with Amina's husband who promised to treat her well. However, he complained to Amina's mother and uncles about her scandalizing him at Centre Y, in retaliation they beat her, threatening that the centre would not be able to protect her from them or her husband. In reaction, Amina tried to file a complaint with the police – who warned her that if she followed through with the complaint, her brother and uncles might kill her so it was better she return to her husband and rethink her actions before proceeding – which is what she did.</p> <p>Centre Y also took her and her children on an outing to the beach. Amina says, "they treated me nicely but didn't find a solution to my case". After a few months, Centre Y referred her to Centre X so she could receive training in income generation. Amina's husband has visited Centre X and was so impressed with his wife learning income generation skills he wanted his sister to join the training. About her experience at Centre X, Amina says, "now I take sewing training, I am so proud of myself because I didn't imagine that I can do anything, now I can sew a baby's dress, and so on, I feel myself as a new person. I come here every day". Other services from Centre X include: a referral for health treatment; paying her transportation to the centre without which Amina would not be able to go. Also psychotherapy sessions, "whenever I feel sad or angry and I need to talk I go to my psychotherapist". The director of Center X has also called Amina at home when the husband is likely to be abusive, "they call me if I don't come (to the centre), they care about us". When her husband was acting erratically due to taking drugs the director followed up with her by phone and sent a lawyer with Amina to the police station. Amina wanted again to make a complaint to force the police to take her husband to a sanatorium to receive treatment for addiction. Once again the police said she needed to sign the complaint but counselled that if she did her life would probably be threatened by her family. She did not make the complaint.</p>
Outstanding issues/priority needs	Amina though still with her abusive husband feels very optimistic about the income generating skills she is receiving from Centre X. Her husband and family allow her to keep visiting the centre because she and they are convinced that in the future she will be able to start a project that will bring in income to the household. Centre X promises her that when they have funding for projects they will support Amina in starting one.

CONCLUSIONS

1.

State of Knowledge about abusers, victims and drivers of violence against women/GBV in Gaza

Various dimensions of the study found some consistent patterns in terms of perpetrators, victims and drivers of violence against women in Gaza specifically against women in the context of marriage.

Both the case file data of GBV service providers, as well as individual pathway research with GBV victims commonly found the following: Perpetrators tend to be husbands, with no or very poor and unstable employment with many dependent on charitable or humanitarian aid. A significant number were found to be abusers of the highly addictive opioid Tramadol, while a minority suffered from mental health issues. On the whole, the perpetrators covered in the study also tended to have low education—often lower than that of their victims.

In-depth analysis of PCBS data sets, provider case files and individual pathway research on Victim/Survivors all showed the following in terms of ever-married women GBV victims who were the focus of the research: These women have less than university education and rarely have any experience of the labour market. They tend to have come from poor families and were married into poor households. Rather than only early marriage, forced marriage to an unwanted/inappropriate spouse is a main characteristic. Women victims of repetitive and compounded abuse were the most likely to seek help beyond the family, and were the predominant users of NGO GBV services.

Case file data of service providers, individual pathway research and analysis of PCBS data all contributed to understanding possible Contexts/Drivers of GBV: Impoverishment and the absence of better economic horizons for breadwinners and their households appear as central drivers of violence against women in the study. Poverty also links with another issue that emerged as strongly linked to violence against women; crowded households with

women victims often citing living in extended-family households of their spouses as compounding their abuse. Factors that enable situations of abuse to continue included: perpetrators rarely (if ever) face legal, criminal or social penalty for their behaviour; violence against women in the context of marriage is not considered a crime in civil law and salient Islamic family law in Gaza and dominant social norms continue to prioritize preserving a marriage regardless of its costs to victims. Given these circumstances, it is not surprising that almost all victims covered in the report had suffered from long term and compounded forms of abuse.

Recommendations: Rather than continue repeating general prevalence surveys of violence against women in Gaza, more focused and disaggregated research needs to be undertaken. The study found that when PCBS domestic violence data was disaggregated by women who had experienced only one or two instances of any type or level of violence from those who had experienced repetitive (including grave levels) that a more specific pattern could be identified of characteristics and circumstances that make women more vulnerable to domestic violence. This type of targeted analysis is much more useful in developing targeted prevention strategies, as well as in identifying possible victims. Future studies should also be undertaken that focus on the drivers, impacts and experiences of GBV among the young and unmarried. GBV research (including this study) has overwhelmingly focused on female married victims to the detriment of both attention, understanding and treatment of GBV among other groups, particularly male and female adolescents. In addition, there is absolutely no research that has been undertaken specifically focused on GBV perpetrators in Gaza – an absolute necessity to make both prevention and treatment programming more inclusive and effective.

2.

The state of GBV Service Provision in Gaza

When looking at the state of NGO GBV service provision in Gaza, the study found a number of positive achievements:

- **Making VAW/GBV a legitimate issue of social concern among wide sectors of the Gaza population.** This has been accomplished not only through myriad social awareness activities, but also through the daily interventions providers have made on behalf of victims with sectors and levels of government actors, local community leaders, formal and informal legal actors, as well as across the NGO sector generally. That more women are seeking more services from a range of providers compared to a few years ago is probably due to greater social recognition of violence against women as a real problem along with greater public knowledge about the existence of services. It is notable that this has been achieved despite the existence of conservative government authorities in a context where so many other fundamental human priorities need addressing.
- **Building a solid base of expertise to address the psychological, social and legal needs of violence against women/GBV survivors across a range of organizations.** Despite concerns over quality of some interventions and gaps of professional capacity in some areas, overall providers have developed core staff with good competency in a range of critical GBV services. Given the limited access to external training primarily due to Israeli policies – much of this has been an outcome of self-learning, experience and positive exchange of knowledge between specialist providers.
- **Sustaining practical and strategic informal networks between providers, as well as with critical governmental actors necessary to address GBV cases at the community and regional level.** Formal network mechanisms among providers were not very active at the time of the research, but informal links, networks and cooperation among providers was often very strong. These compensated for the absence of a formal referral system, helped provide solutions for victims when an individual organization faced funding gaps, as well as enabled providers to individually and collectively find practical and sometimes strategic solutions

for victims despite the often-insurmountable obstacles posed by the Gaza context. All providers had developed positive informal lines of communication with sympathetic actors across various sectors and levels of the government authority. The study found that these informal links were often crucial in addressing the fundamental needs of victims.

However, a number of **vital gaps in NGO programming** were identified that included:

- **Capacity Gaps:** There is a limited pool of highly trained professionals to deliver more advanced training in awareness and advocacy and the need for more professional development in the delivery of psychosocial and mental health interventions. In terms of the latter, there is a critical gap of professionals in a number of mental health specializations necessary to treat GBV victims and GBV perpetrators.

Recommendations: Greater investment needs to be made in more professional level, including specialized capacity building across all of these sectors. This is essential in terms of the mental health sector of GBV service provision, where donors have prioritized the outreach capability of psychosocial first aid at the expense of specialized mental health services for GBV victims including children and victims of sexual abuse. As well, in their international advocacy, donors might want to highlight how Israel's blockade has undermined the quality of some services for GBV victims by impeding access to professional training.

- **Referral and Coordination Gaps:** In the absence of an active and formal coordination structure between providers, informal referral systems could not ensure quality of treatment received by referred victims; could not track the results of treatment; and most critically, could not ensure victims anonymity was respected by other (often non-NGO) providers, thus potentially compromising their safety. Providers emphasized that given the difficulty of securing and treating sexual violence victims in Gaza, a dedicated comprehensive service centre might better meet their specific needs than would a referral system.

Recommendations: Given that donors have already invested in two attempts at a referral system among NGOs in Gaza, with no practical outcome to date, an immediate priority should be put on creating a basic system for the safe and secure referral of victims of sexual violence. However, this cannot be accomplished without some inclusion of sectors of the de facto government authorities. If this is not feasible, then it might be preferable to follow through on the recommendation made by providers of establishing a dedicated one-stop treatment centre for these particularly urgent, sensitive cases.

- **Gaps in Quality of Services:** Related to the gaps identified above, is the lack of systems and protocols to ensure ethical and professional standards of care and delivery of activities across the NGO GBV sector as a whole. The study found that most advanced providers independently complied with global ethical and professional standards and principles in the treatment of GBV victims. But in the absence of an overarching set of protocols, not all GBV activities and services delivered in the NGO sector have met these criteria.

A possible recommendation is the creation of a peer review system of professional and ethical standards among service providers, with oversight offered by independent legal, mental health and other professionals.

- **Gaps in Stability of Services:** The study found that the majority of programming in the NGO sector was built on the fixed time scales and vulnerabilities that attend to donor projects, rather than having long-term program-based support. In the worst cases, highly sensitive GBV services were being delivered to GBV victims based on the extremely short life span of humanitarian project cycles.

Recommendation: Donors need to make much greater efforts to secure program-based support for GBV service provision in Gaza. The ability to deliver stable, ongoing services to victims is a fundamental ethical principle in GBV treatment as underlined in global best practice literature.

- **Gaps in ability to deliver some priority services:** The cases of GBV survivors involved in the study and service providers, themselves, both put a priority on two services they identified as essential but NGOs were unable to address: income gener-

ation support schemes and independent housing. Income generation support was highly prioritized by victims and had extremely positive impacts on their ability to recover from violence while helping gain perpetrators' acceptance of involvement with GBV service providers. Housing independent of an abusive spouse, or of the abusive environment of his family household was a main priority for a number of victims who identified it as the essential path out of abuse. In both cases, service providers could not meet these essential needs because of a lack of donor priority. A third critically missing service NGOs were unable to provide was safety and protection to victims, especially those facing life-threatening situations (see below).

Recommendations: Much greater priority needs to be put on income generation support programming for GBV victims. In line with victims' priorities, it should be addressed as a primary component of GBV treatment and response, rather than remaining tertiary to current programming. Similarly, is the need to address victims housing rights through provision of independent housing where they and their children can live lives free of abuse. Overall, donors need to review the balance of support for GBV across sectors and within them: currently awareness and advocacy garner almost the same amount of resources as all GBV service provision interventions taken together.

- **Gaps in vision/absence of collective strategy:** Although the community of NGO providers in Gaza has built an infrastructure of services to prevent and treat GBV, they have done so largely without a shared vision or common agenda underpinning their work. Gaps and obstacles are dealt with ad hoc; sector priorities tend to be set by donor resources (as do service and activity timelines); thus rarely have practical achievements been translated into wider strategic gains on behalf of GBV sufferers in Gaza. At the same time, except for the annual 16 days advocacy campaign, donors themselves and INGOs show little collective vision or strategy; uneven coordination between themselves; and even less coordination with Gaza GBV service providers. The picture that emerges from the study is that many donors follow their own or national governments agendas and simply fund activities with partners based primarily on their own priorities.

Service providers, though overwhelmed with responding to the needs of their beneficiaries and donor expectations while themselves suffering from Gaza's comprehensive crisis, still need to look beyond short-term priorities of their institutions. Collective strategy and coordination are fundamentally about shared political will and commitment; this may benefit from donor support, but cannot be built on it. Donors also need to address whether their own existing coordination mechanisms actually function to deliver a strategic, responsive and inclusive answer to address the problem of GBV in Gaza.

More importantly, **crucial gaps** were identified in the **overall architecture of GBV Services in Gaza**, primarily due to donors "No-Contact Policy" with the de facto authorities. These gaps included:

- The total absence of formal training in GBV sensitization, professional capacity building, or development of protocols and systems of care, protection and justice for survivors throughout the government sector. The health sector, judiciary, policing and justice, social services sector as well as the entire government education system have been excluded from the concerted efforts made

by the international donor community to address GBV in Gaza.

- The study has shown how non-engagement with these government sectors (deemed essential actors in prevention and treatment of GBV in global best practice standards) has undermined or put serious limits on what can be achieved for victims by NGO providers alone. And most urgently, the study found that this policy had made it impossible for NGO providers to ensure the safety and protection needs of GBV victims, including those in life-threatening circumstances.

Recommendations: The findings of the study underlined the need to strengthen the cooperation with governmental institutions. As the study has shown, GBV service providers have constantly identified sympathetic sectors and individuals within government institutions and built channels of communication and cooperation on behalf of victims. Building on these relationships in the present is of utmost importance to secure the protection needs of GBV victims. Investing in them with an eye to the future is also vital in ensuring the institutionalization of GBV prevention and treatment services in a post-conflict Gaza.

APPENDIX I.

Research Interviewees

NGO Sector / Interviewees and Focus Group Participants

Reem Fraina - Director - AISHA Association for Woman & Child Protection
Firyal Thabet – Director – Women’s Health Center – Bureij Refugee Camp
Mohamed Ayeshe – Psychologist - Women’s Health Center –Bureij Refugee Camp
Amal Syam - Director of Women’s Affairs Center
Suhair Ababa - Lawyer – Women’s Affairs Center
Nadia Abu Nahla Director - Women’s Affairs Technical Committees- Gaza Office
Abdel Moneim Tahrawi - Projects Manager Palestine Center for Democracy and Conflict Resolution (PCDCR)
Zainab Al Ghonaimi – Director – Center for Women’s Legal Research and Consulting
Yunes Tahrawi – Lawyer – PCDCR
Samar Hamad – Advocacy and Lobbying Consultant- PCDCR
Najah Ayash – Director – Women’s Activity Center – Rafah
Tahreed Jom’a – Executive Director – Union of Palestinian Women Committees
Buthaina Sobeh – Director – Wefaq Society for Woman and Child Care
Mariam Shaqura – Director of Women’s Health Center – Jabalia
Tahani Qasem – Communication and Outreach coordinator – Center for Women’s Legal Research and Consulting
Sherin Rabi’ – Training Program Coordinator – Women’s Affairs Center
Nezarya Yaseen – Lawyer and Legal Consultant – PCDCR

Government Sector Interviewees

Hanadi Skaik - Director – Beit Al Aman Center for Women and Family Protection
Nareman Odwan- General Director of Women’s Police
Mohamed Abu Tabikh – First lieutenant – Police
Dr. Sawsan Hammad – Director of Women Health and development department – Ministry of Health

UN Agencies

Amira Mohana - Gender Program Associate/ Gaza / UNFPA

NOTE

NOTE

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