Photo: UN Women/ Halla al-Safadi

Photo: UNRWA

Photo: Red Crescent Society for Gaza Strip/2021

Clinical Management of Rape in the State of Palestine in the Context of COVID-19

UN WOMEN

CLINICAL MANAGEMENT OF RAPE IN THE STATE OF PALESTINE IN THE CONTEXT OF COVID-19

March 2021

Acknowledgments and Disclaimer:

This policy brief was produced thanks to funding from the Government of Japan and the Strategic Partnership Framework (SPFII). The views and opinions expressed in this document do not necessarily represent the views of the donors, UN Women, the United Nations or any of its affiliated organizations.

Researchers: Marta Agosti, PhD / Atria Mier

Design: UN Women/Yasmina Kassem

Publication by UN Women Palestine Country Office.

INTRODUCTION

"Violence against women is a problem of epidemic proportions. It causes devastating, life-long damage to women. It also hurts the economic and social health of their families, communities, and countries" (WHO 2018b).

In 2020 as we prepared for the 25th Anniversary Beijing Platform for action, the world woke up to the announcement of a global pandemic that shook the grounds of social norms that govern our ordinary life. COVID-19 broke through as an inevitable reality with tragic consequences for many. It sank economic opportunities, isolated people from their loved ones, and was –and still is- a serious health concern for our elders, chronic patients and many others with less resources to confront uncertainty and poor and overrun public health systems. COVID-19 heightened the differences brought up by the intersections among gender, age, education, class, ethnicity, or nationality with fatal consequences. In the same span of time, leadership on various levels of the health systems were tested with the task of maintaining life itself.

In this scenario, the protracted crisis in Palestine did not halt. At the same time that communities wondered how to keep a social distance in crowded domestic and public spaces (notably in Gaza Strip, the most populated area in the world) and to adhere to restrictions on mobility; demolitions and evictions persisted. According to OCHA (2019), by May 2019, demolitions in Area C had already surpassed the total number of 2018, reaching a new record number of forced evictions and demolitions and this trend has continued in 2020. In December 2020 OCHA announced a "record number of demolitions and seizures since OCHA started documenting this practice in 2009" resuming the demolition of inhabited homes in East Jerusalem and 75 per cent of a Jordan Valley herding community demolished; infrastructure dismantlement and disruptions in the water supply to 700 people (see ***West Bank demolitions and displacement | United Nations Office for the Coordination of Humanitarian Affairs - occupied Palestinian territory).***

Violence stemming from the Israeli occupation continued to permeate all spheres of Palestinian society; "[d]emolitions of Palestinian property and forced evictions increased, and settler violence continued at the high levels of the previous reporting period, including during the COVID-19 pandemic, and largely with impunity" (UNSG 2020). COVID-19 served to aggravate the pre-existing conditions of vulnerability among the Palestinian community.

COVID-19 has also exacerbated pre-existing inequalities at the societal and family levels. Women, who were already overwhelmed by domestic tasks, were forced to take on board home-schooling. Mobility restrictions, while part of patriarchal norms in Palestinian society now became even more rigid; economic opportunities, already scarce, were narrowed down even more for women – who were more frequently employed in the informal sector and lack good working conditions.

COVID-19 has tested the resilience of families across the world and this situation has in particular intensified pre-existing factors that trigger sexual, and gender-based violence (SGBV) in Palestine.

Lessons learnt from outbreaks in humanitarian settings and gendered impacts

Lessons from the Ebola or the Zika outbreak provide important knowledge that could help to bring forward the gendered dimensions of the humanitarian and COVID-19 crises that are often overlooked. Past epidemic outbreaks have produced lessons learnt around gender considerations in health crises that have yet to be applied to COVID-19. During the 2014–16 West African outbreak of the Ebola virus disease, gendered norms meant that women were more likely to be infected by the virus, given their predominant roles as caretakers within families and front-line health-care workers (Davies and Bennett 2016). Sexual and reproductive health rights resources were diverted to the Ebola crisis management itself, resulting in a rise in maternal mortality (Sochas, Channon, and Nam 2017). Retrospective analysis of the COVID-19 pandemic may point to similar trends in Palestine, leading to a rise in mortality among people affected by non-COVID-19 related conditions, like non-communicable diseases.

Gendered Impacts of COVID-19: The Shadow Pandemic

As early as 9 April 2020, United Nations issued a policy brief, entitled **"The impact of COVID-19 on women"**, asserting that "across every sphere, from health to the economy, security to social protection, the impacts of COVID-19 are exacerbated for women and girls simply by virtue of their sex" (UN 2020). Recent studies (see ***UNFPA / Juzoor 2020; NIAF 2020***) point to similar trends in Palestine, with a considerable increase in the demand of Mental Health and Psychosocial Support Services (MHPSS) from women, girls and boys in connection to an intensification of violence.

In the midst of the COVID-19 pandemic the "shadow pandemic" (UN Women 2020a) SGBV kept growing, impacting and devastating the lives of women worldwide, while related SGBV services were shot down, many women found themselves trapped in total lock down with their perpetrators.

In this context, SGBV services are not only lifesaving but also fundamental to social cohesion. Emergency contraception, first psychosocial aid and post-exposure prophylactics for sexually transmitted infections (STI's), including HIV, are the first milestone of a system of care that nurtures life and prevents women, children and men, communities and societies from falling apart, fragmented by violence, stigma and cultural taboos.

The pandemic has come to accentuate the factors that foster SGBV in Palestine. For instance, according to UN Women, approximately 15 per cent of married women in Gaza have experienced incidents of sexual abuse by their husbands over the previous year.
More than half of these experienced it repeatedly (3+ times), while East Jerusalem was not covered by this report, West Bank show similar trends (UN Women 2017). Institutional collapse, the disruption

in the rule of law, disintegration of social networks, rampant impunity, generalized use of violence and, as in many conflicts, the use of sexual violence itself as a weapon of oppression and the targeting of civilians are common features that underpin the high prevalence of SGBV in humanitarian settings. In the context of Palestine, the Report of the Special Rapporteur on Violence against Women (Human Rights Council 2017) highlighted the poor structural conditions and normalized societal behaviours that foster SGBV and protect perpetrators.

"The outcome of this situation is that the perpetrators of crimes and human rights violations, both Israeli and Palestinian, against Palestinian women are able to act with impunity" (Rought-Brooks, Duaibis, and Hussein 2010 p126).

Communities and survivors themselves often resort to silent and harmful coping strategies, hand-in-hand with a lack of identification of certain norms,

acts and behaviours as sexual abuse, all of which results in a culture of normalization of sexual violence.

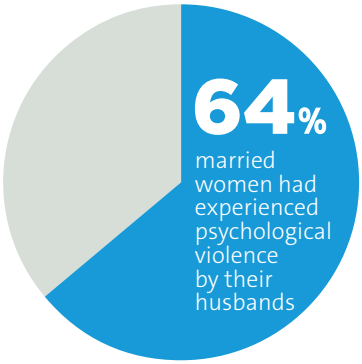
The close link between gender- based violence and gender social norms in the context of the Israeli occupation explains how and why different constituencies are exposed to SGBV. The occupation renders Palestinians vulnerable and disenfranchised and normalizes the violence that is entirely rooted in the occupation. Refugees, victims of demolitions, Bedouin communities and the population living in Gaza; and children, adolescent girls and boys; divorcees, women head of households, pregnant and lactating women and sex workers – all these constituencies experience a higher prevalence of sexual violence precisely because they inhabit situations of vulnerability.

The Israeli occupation and the political violence, which includes restrictions on movement, house demolitions, separation of family members - among many other acts of violence and oppression,- have exacerbated and increased cases of violence against women in the occupied Palestinian territories (Baldi 2018), as has the COVID-19 pandemic.
A rapid needs assessment has identified new modalities to deliver SGBV services, including remote access to counselling and tools adapted to protect data of survivors and the enhancement referrals through IT tools (see ***WAC 2020***), although management of sexual violence itself shall always be done in person. Despite these efforts, SGBV is known to be substantially underreported and incidents that entail important safety risks such as cases of sexual exploitation and abuse, remain largely invisible to the reporting channels. Underreporting signals that survivors do not trust we can guarantee their safety and assistance and that the provision of SGBV services, particularly clinical management of rape (CMR), is not survivor-centred (see ***UNFPA/PMRA 2021).***

In recent years, there has been a substantive effort to document femicides in Palestine, shedding light on the most pervasive form of sexual violence; WCLAC (2018; 2019) documented 36 and 24 cases respectively. In the lack of appropriate reporting and safe channels, femicides highlights a reality where silence operates as the most common response to sexual violence (see ***Shalhoub-Kevorkian 2002***). But silence itself is the most harmful yet most prevalent mechanism to cope with sexual violence (see ***Hasisi and Bernstein 2019; 2019; Suzanne Ruggi 1998***).

Consequences of sexual violence

Hand-in-hand with clear evidence of underreporting, there is often a narrow understating contained in the definitions of sexual violence. Two common features that are also applicable to the Palestinian context are the focus on domestic violence and on ever-married women; and a definition of rape that excludes acts frequently committed under crimes of sexual abuse and exploitation. The former directly excludes vulnerable groups that perpetrators prey on, precisely because they are vulnerable. The latter directly renders invisible the many behaviours, acts and forms that sexual abuse and exploitation involves. Nonetheless, the Palestinian Central Bureau of Statistics (PCBS) issued a report in 2019, on the findings of a survey on violence that conveys a proxy analysis of the prevalence of it in Palestine. The PCBS report (which did not gather data in East Jerusalem) signals that for example 64 per cent of ever-married women in Gaza had experienced psychological violence at the hands of their husbands;



61 per cent of women who experienced violence chose to remain silent; and that 50 per cent of married women with disabilities had experienced violence at the hands of their husbands (PCBS 2019).

61% of married women who experienced violence chose to remain silent

50% of married women with disabilities had experienced violence by their husbands

While the report does not convey accurate data on sexual violence, it helps to understand that there are niches –non-married women, exploited women for sexual purposes, women in conflict with the law, people with disabilities, adolescents, inter alia, where SGBV prevalence could be noticeably or substantially higher than the national average statistics presented in the report.

There are multiple harmful consequences of sexual violence. While we could divide them into health,

social and economic consequences for society; there are immediate health consequences of sexual violence that transcend overtime to weaken communities at large.

The short term, most common, severe effects of sexual violence are as follows:

- Physical Injuries: including but not restricted to vaginal and/or anal tears, bleeding and infection, vaginitis, contusions, vaginismus, trauma injuries, chronic pelvic pain, dyspareunia, fistula (especially in gang rapes and when objects are used for penetration), urinary tract infections, including pyelonephritis
- Unwanted and early and high-risk pregnancies • Sexual Transmitted Infections (STIs), including HIV/Aids and syphilis.
- Airborne transmitted diseases, like COVID-19
- Mental health: Post-traumatic stress disorder (PTSD), anxiety, depression, self-harmful behaviours and risky behaviours, addictions, panic attacks, sleep deprivation, suicidal thoughts and suicide attempts
- Death: either through the physical consequences of the assault itself, through a successful suicidal attempt or through so called 'honour killing'

Survivor-centred and human rights approach: the role of the health sector

The shutdown of essential lifesaving services in the framework of total lockdowns, including referrals and emergency sheltering, is a cruel reality for survivors that often contribute to situations of confinement with abusers.

When survivors continue to receive services, the fear of being infected and often unpleasant past experiences with service providers have driven them away thereby deterring them from using scarce available resources. In that regard, UNFPA (2020) has issued an updated report on the experiences of survivors seeking protection which concludes that "despite a growing tendency of survivors to access services, especially women with disabilities, the number of reported cases of SGBV remains low, and is mostly affected by: restrictions on accessing such services; social stigmatization of accessing these services; fear of being exposed; and distrust of the existing service provision system" (Ibid p.3.)
While there is no one solution fits all, a survivor-centred approach is the first milestone of a system of care that encourages service providers to truly engage with intimate forms of suffering and then healing of survivors and the communities they belong to. This approach would rely on the following principles: dignity and respect; the right to a life free of violence, to self-determination and to the highest attainable standard of health; non-discrimination, privacy and confidentiality; and the right to information (WHO 2020).

Systems attuned to the survivors ensure that every person that disclose is listened to in a non-judgmental way. There are women and girls in jail in different countries, who after being raped, are charged with "infidelity" or even injured or killed, due to so called 'honour crimes'. One can ascertain that within global patriarchy with its local adaptations, a widespread "culture of rape" and "violence against women" exists and feeds upon victim-blaming, shaming and wholesale impunity.

Well-trained professionals, namely (but not restricted to) health workers, social workers, the police and the judiciary are fundamental to maintain core service and support survivors of sexual violence in their journey: identification, management and referral and ensuring compassionate and empathetic services are essential. Active listening and empathy are crucial. Duplicate inquiries, follow-up questions and requisite for justifications have often driven away survivors, re-victimizing them and breaking the chain of trust needed to establish confidentiality. Survivors should always be believed and listened to in a non-judgmental way. Active listening means advice will not be provided as the survivor will make her own decisions once all the relevant information is presented. A survivor must be reassured that it is normal to feel a range of feelings, from anger, to anxiety, shock or even guilt, and that several services are in place to attend to her needs.

An important angle of combatting sexual violence is based on the understanding that medical practices and the care of survivors is embedded in a system full of societal mechanisms that enable the rearticulation of discriminatory practices. Doubting the survivors is one of them. For this reason, first-time receivers of sexual violence disclosures must be well equipped to listen and to refer the survivor to appropriate services and reporting mechanisms in a timely and confidential manner.

An appropriate response to sexual violence must secure the activation of the protection mechanism and first aid assistance within the 24h/72h period following the first account disclosure. Guidelines like WHO (2020; 2017); and IASC (2010; 2015; 2018); local studies like the report of the Palestinian Medical Relief Association (UNFPA/PMRA 2021); and some regional examples, like Interagency GBV case management guidelines in Jordan (UN/ INGOs 2017) and the medical protocol developed in Egypt (UNFPA Egypt 2015), offer some valuable resources to tailor effective responses. Of primary importance here is the crucial understanding that in the first hours of the response is where the bond with the survivor is created and where the system can address intervention to stop long health and societal consequences such as pregnancies out of rape and STIs including HIV.

All the procedures, the way they will be performed, and their consequences, including physical and legal ones, need to shall be explained thoroughly and they should not take place if the survivor has doubts or does not understand them fully. For example, a forensic examination of rape survivors might take from three to seven hours and not all survivors are ready to undergo such a process. Obtaining consent at every step of the assistance is a fundamental right of survivors and to address consent, survivors must be properly guided and informed, which requires appropriate training of services providers.

The health-care sector needs to acknowledge that the vast majority of times, it is the entry point for survivors; thus, the way SGBV is managed will very much determine the survivor's health- seeking behaviour and the chances that she will continue in the system. Similarly, it must be understood that harmful social practices closely interact with societal pressure and together they continue to perpetuate discrimination.

For instance, a source of serious breach of the right of survivors is often found in virginity testing, embedded in the practice of forensic medicine, which also triggers the compulsory reporting – thus involvement of local authorities that will reproduce discriminatory and harmful practices, such as mediation to marry the perpetrator in cases of rape. The medical examination and compulsory reporting require the presence of a forensic doctor which is currently being done without the informed consent of the survivor. Compulsory reporting places survivors under the national referral system, which often implies the involvement of mediation bodies that reach a "deal" among families, the community and the law, for example, to marry victims to their rapists; moreover, compulsory reporting may put survivors at risk of so-called "honour crimes". The role of forensics in issuing the reports on cases of sexual violence is thus essential to avoid these practices.

These practices represent a violation of the survivor's human rights and are detrimental to her physical, psychological and social well-being. Its elimination require a comprehensive societal response supported by the public health community and health professionals (see ***WHO 2018 on the joint statement for the elimination of virginity testing).*** Weak or lack of treatment and documentation of SGBV cases at their first contact with the health system is a clear obstacle to assist and redress incidents of rape and SGBV (see ***UNFPA/PMRA, 2021***).

A survivor-centred approach enables the survivor to make her own decisions at all stages. In that regard, service providers must always enable the survivor to make informed choices.

Physical space of health care facilities and integrated services

A UNFPA (2020) study also highlighted that the "lack of privacy and confidentiality was highlighted as a pressing and common fault across all service provision channels, along with social stigma and victim-blaming practiced by service providers, which further deter survivors from seeking protection" (Ibid. p.4). The physical space that the survivor walks into for assistance does matter and should be organized in a very specific manner:

- Keeping the time between the needed services as short as possible. Make the space welcoming (for example appoint one person to accompany the survivor throughout the whole process), and provide important information in local dialects, in braille and in illustrated drawings for illiterate survivors to understand.
- Ensure female staff are present at all stages, as survivors commonly do not feel comfortable with male practitioners. This means nurses, midwifes, doctors, forensics, psychologists, right defenders and lawyers, staff attending emergency shelters, cleaning staff, clerks, administrative staff, basically anyone working directly with survivors, in what must be a "safe space" for them.
- Tailor response services in a manner that a survivor discloses her situation to the minimum possible number of people, and make sure that she is not forced to produce a narrative of the assault -- if not absolutely necessary and for reasons explained ahead and with her/his consent. This is particularly important when liaising with investigations. The common principle is that the fewer the number of people involved the better for the healing process.
- Organize the collection of evidence in private, safe and confidential spaces, and in such a way that the incident is recorded once and that information is made available for all the professionals who might need it, such as forensics.
- A good practice is to integrate comprehensive services in the same space, for example a health-care facility or a community-based organization space. This means typically to include health, legal and psychosocial support services with referrals to emergency shelters and hospitals.

For some essential life-saving services this might prove challenging, for example if clinical management of rape, including surgery, is needed, a qualified team of doctors and forensics will be essential and an Emergency Room and a variety of medical supplies will be needed. The best-case scenario would be a hospital with a space for integrated services for SGBV survivors, but this might not be possible as a homogenized practice in Palestine, where the population faces severe constraints in accessing public services due to the occupation. Moreover, such restrictions are currently further accentuated by COVID-19 mobility restrictions. In addition, in area C a large proportion of the population lives in remote or hard-to-reach areas. Many health and protection cluster partners operate throughout the area with mobile clinics to deliver essential health care and psychosocial support services. Working with these services to integrate SGBV is therefore an important opportunity. The report of the Palestinian Medical Relief Association delved into the complexities of appropriate provision of CMR in Palestine, yet it is an important baseline to set the path for improvement (see ***UNFPA/PMRA 2021***).

Given the context, there should be always an SGBV specialist among mobile clinic staff, and all the required medication for the clinical management of rape should be delivered to survivors within the framework protocol of 72 hours. This medication should include, at a minimum, the emergency contraception pill, antiretroviral medication for post-exposure prophylaxis, prevention of tetanus, prevention of hepatitis B, painkillers and antibiotics for STIs. Referral mechanisms must be in place, especially for urgent cases where surgery is needed, as well as preparations to conduct such surgery within the mobile clinics if circumstances do not allow for survivor transportation. (For an exhaustive checklist of requirements for providing quality clinical care, see ***WHO 2020, Annex I)***.

The eight basic steps in the clinical management of rape, described by WHO (2020), are:

1. 
First-line support: listening, inquiring about needs and concerns, and validating the survivor

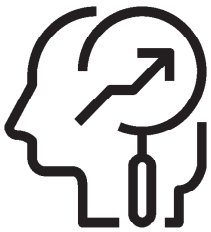
2. 
Obtaining informed consent and preparing the survivor

3. 
Taking the history

4. 
Performing the physical and genital examinations

5. 
Providing treatment

6. 
Enhancing safety and referrals for additional support

7. 
Assessing mental health and providing psychosocial support

8. 
Providing follow-up care

If adequately equipped, mobile clinics may perform clinical management of rape, even though it is preferable to refer urgent cases to hospitals, if and when possible. It is also important to allocate specific time-slots for SGBV services integrating them within sexual and reproductive health services) as typically mobile clinics are overburdened with patients, especially with the COVID-19 pandemic framework.

Referrals

Stakeholders engaged in SGBV case management should coordinate at all levels of intersectoral and multisectoral linkages at the GBV subcluster level, and they should be aware of the psychosocial mental health support services, legal aid, livelihoods support, emergency sheltering and health-care services available in each area, including a follow-up case management system. Otherwise there is a high risk of survivors getting lost between services. Tools like the Gender-Based Violence Information Management System (GBVIMS+) and Primero might be helpful for that purpose.

Maintaining a survivor-centred approach implies that survivors' rights are protected in every instance when assistance is provided. Information on all referral pathways, investigative processes and legal consequences must be available and health workers must acknowledge them. Similarly, the assistance systems should be aware of potential barriers to access services, e.g. transportation.

Practical recommendations

Palestine is a fragmented socio-political entity, which implies that responses must be context-related and services must be adapted to the different legal, socioeconomic and political realities of Gaza, the West Bank and East Jerusalem. In addition, Palestine is a very volatile region, always in danger from the occupation, so the health sector needs to have emergency responses plans and protocols and procedures that can adapt to an escalation of conflict and to sudden emergencies (aside from the

Photo: Red Crescent Society for Gaza Strip/2021

COVID-19 pandemic). Intersectoral and multisectoral responses will be crucial to provide comprehensive, quality and adapted responses for SGBV survivors through all the occupied Palestinian territories

Life-saving services must be available from Day 1 of a crisis, through all phases of an emergency, and their availability must be 24/7, even in total lockdown situations. Agreements with the respective Ministries of Health in Gaza and Ramallah must be sought in order to guarantee SGBV and SHR services under all scenarios. The humanitarian community at last must agree on intersectoral and multisectoral approaches to support the Ministry of Health in providing and guaranteeing those services.

Survivors need health care, including sexual and reproductive health services, clinical management of rape, mental health and psychosocial support, legal assistance, livelihood support and access to justice. This holistic approach is needed to address the process of healing. Thus the need for clear, agreed and good quality referral pathways for survivors, including case management follow-up systems.

One should always have a SGBV specialist among the staff of mobile clinics and staff providing door-to door services. In that sense it is also advisable to train non-health-care staff, like social workers and nutritionists in early detection and referral.

Mobile clinics must be equipped with the basic post-rape management kit to be administered in the first 72 hours. A standard operative procedure on clinical management of rape in mobile clinics is highly advisable given the volatile situation in the West Bank and the need to rely on mobile services. It is advisable to provide free transportation for the most vulnerable population, if needed.

Women's socially prescribed care roles typically place them in a prime position to identify trends at the local level that might signal the start of an outbreak and thus improve global health security (Wenham, Smith, and Morgan 2020). They are also in a better position to identify SGBV cases and to provide community-based case management. Relying on womeńs and community-based organizations, namely youth, human rights, LGTBIQ+ civil society organizations, and engaging them in the cluster system and the humanitarian response should be a priority.

In addition to the direct health consequences mentioned, stigma and social perceptions of raped and abused survivors are factors that negatively impact their health-seeking behaviour, thereby endangering their right to heal. Considerable work on womeńs rights and social perceptions needs to be done at the community level.

The survivor centred approach conflicts with virginity tests and other "traditional mechanisms" that should be tackled in a sensitive but firm manner, as a survivoŕs rights must prevail. Engagement with womeńs organizations and civil society organizations should help to address the matter in a sensitive and culturally appropriate way by adopting a DO NO HARM approach.

CMR (see ***UNFPA/PMRA 2021***) and forensic practices need to be reviewed through the lenses of a survivor-centred approach (for more on modern forensics in Palestine (Daher-Nashif 2017). The humanitarian community must advocate for the adoption of such a methodology and promote the qualification of female forensic doctors.

For SGBV case management of children one must refer to the book, published in 2017, WHO clinical guidelines, Responding to children and adolescents who have been sexually abused.

Bibliography

Ahrens, Courtney E, Rebecca Campbell, N Karen Ternier-Thames, Sharon M Wasco, and Tracy Sefl. 2007. "Deciding Whom to Tell: Expectations and Outcomes of Rape Survivors' First Disclosures." Psychology of Women Quarterly Vol. 31 Issue 1, p38-49. 12p. 4 Charts.: 12.

Al-Ali, Nadje, and Nicola Christine Pratt. 2009. "Introduction" in Women and War in the Middle East: Transnational Perspectives. London ; New York: Zed Books.

Baldi, Giorgia. 2018. "'Between Patriarchy and Occupation: Violence against Women in the Occupied Palestinian Territories' in Reconsidering Gender - Based Violence and Other Forms of Violence against Women." In Reconsidering Gender - Based Violence and Other Forms of Violence against Women. Libellula Edizioni.

Baron, Beth. 2006. "Women, Honour, and the State: Evidence from Egypt." Middle Eastern Studies 42 (i): 1–20.

Daher-Nashif, Suhad, 1975-. 2017. "Historical and Present-Day Practices of Forensic Medicine in Palestine : Body, Society, and Science." Jerusalem Quarterly (Institute of Jerusalem Studies) 70 (January): 75–95.

Davies, Sara E., and Belinda Bennett. 2016. "A Gendered Human Rights Analysis of Ebola and Zika: Locating Gender in Global Health Emergencies." International Affairs 92 (5): 1041–60.

DCAF. 2012. "Palestinian Women and Security: A Legla Analysis." Research Cnter. The Geneva Center for the Democratic Control of Armed Forces (DCAF).

García-Moreno, Claudia, Kelsey Hegarty, Ana Flavia Lucas d'Oliveira, Jane Koziol-McLain, Manuela Colombini, and Gene Feder. 2015. "The Health-Systems Response to Violence against Women." The Lancet 385 (9977): 1567–79.

Hasisi, Badi, and Deborah Bernstein. 2016. "Multiple Voices and the Force of Custom on Punishment: Trial of Family Honor Killings in Mandate Palestine." Law and History Review 34 (1): 115–54.

———. 2019. "Echoes of Domestic Silence: Mechanisms of Concealment in Cases of 'Family Honour Killings' in Mandate Palestine." MIDDLE EASTERN STUDIES 55 (1): 60–73.

Hatem, Mervat. 2000. "The Pitfalls of Nationalism Discourse" in Gender and Citizenship in the Middle East. Edited by Suad Joseph. Contemporary Issues in the Middle East. Syracuse, N.Y: Syracuse University Press.

Hawari, Yara. 2020a. "Patriarchy in Palestine | Women's Rights." AlJazeera, April 12, 2020.

———. 2020b. "COVID-19 in the West Bank and Gaza: A Second Wave under Military Occupation and Siege." Middle East Institute (blog). July 29, 2020.

Hlavka, Heather R. 2014. "Normalizing Sexual Violence: Young Women Account for Harassment and Abuse." Gender and Society 28 (3): 337–58.

HRW. 2018. "Palestine: 'Marry-Your-Rapist' Law Repealed." Human Rights Watch (blog). May 10, 2018.

———. 2019. "The Deadly Toll for Palestinian Women." Human Rights Watch (blog). September 19, 2019.

Human Rights Council. 2017. "Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, on Her Mission to the Occupied Palestinian Territory/State of Palestine." UN A/HRC/35/30/Add.2. NY.

IASC. 2010. "Global Review of Protection Form Sexual Exploitation and Abuse by UN, NGO, IOM and IFRC Personnel." IASC.

———. 2015. "IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action." OCHA.

———. 2018. "IASC Plan for Accelerating Protection from Sexual Exploitation and Abuse in Humanitarian Response at Country-Level."

NIAF. 2020. "COVID-19 Protection Needs Identification and Analysisin the State of Palestine." UN - Ocha. Palestine: UNICEF.

OCHA. 2019. "Record Number of Demolitions, Including Self-Demolitions, in East Jerusalem in April 2019." United Nations Office for the Coordination of Humanitarian Affairs - Occupied Palestinian Territory. May 2019.

OHCHR. 2014. "Murder of Women in Palestine under the Pretext of Honour." Women's Human Rights and Justice. Palestine.

PCBS. 2019. "Preliminary Results of the Violence Survey in the Palestinian Society." Goverment. Palestine: PCBS.

PSEA Network. 2020. "Development of Prevention of Sexual Exploitation and Abuse (PSEA) Protocol for Victims' Assistance in the State of Palestine." UN. Palestine: UN.

Rought- Brooks, Hannah, Salwa Duaibis, and Soraida Hussein. 2010. "Palestinian Women: Caught in the Cross Fire Between Occupation and Patriarchy." Feminist Formations Vol. 22, No. 3, Women in the Middle East (Fall 2010), pp. 124-145 (22 pages).

Ruggi, Suzanne. 1998. "Commodifying Honor in Female Sexuality: Honor Killings in Palestine." Middle East Report, no. 206 (April): 12–15.

Shalhoub-Kevorkian, Nadera. 2002. "Femicide and the Palestinian Criminal Justice System: Seeds of Change in the context of State Building?" Law & Society Review, Vol. 36, Issue 3 (2002), pp. 577-606

Sochas, Laura, Andrew Amos Channon, and Sara Nam. 2017. "Counting Indirect Crisis-Related Deaths in the Context of a Low-Resilience Health System: The Case of Maternal and Neonatal Health during the Ebola Epidemic in Sierra Leone." Health Policy and Planning 32 (suppl_3): iii32–39.

UN. 2020. "Policy Brief: The Impact of COVID-19 on Women." NY.

UN/ INGOS. 2017. "Interagency GBV Case Management Guidelines – in Humanitarian Settings Jordan." Technical Manual. UN/ INGOS. Interagency GBV case management guidelines – in Humanitarian settings.

UNFPA. 2020. "Seeking Protection- Survivors of Sexual Violence and Their Access to Services in Palestine." Palestine: UNFPA. WHO.

UNFPA / Juzoor. 2020. "Impact of the COVID19 Outbreak and Lockdown on Family Dynamics and Domestic Violence in Palestine." Research Paper. Palestine: UN/ INGOS.

UNFPA Egypt. 2015. Medical Protocol Guidelines/ For Management of Victims of Gender Based Violence (Including Sexual Violence). Cairo: UNFPA - MoH.
UNFPA/ Palestinian Medial Relief Association. Assessment of Clinical Management of Rape in Occupied Palestinian Territories. UNFPA/ PMRA Palestine. 2018 Draft.
UNSG. 2020. "Israeli Settlements in the Occupied Palestinian Territory, Including East Jerusalem, and the Occupied Syrian Golan." UN A/75/376. NY: UN..
UNWOMEN. 2017. "Navigating through Shattered Paths: NGO Service Providers and Women Survivors of Gender-Based Violence: An Assessment of GBV Services in Gaza." Palestine.
———. 2020a. "The Shadow Pandemic: Violence against Women during COVID-19 | UN Women – Headquarters." 2020.
UNWOMEN, Christopher. 2020b. "Government and Partners Discuss Women's Rights in Palestine." Question of Palestine (blog). October 2020.
WAC. 2020. "Rapid Needs Assessment of GBV Survivors during the COVID-19 Pandemic." Palestine.
WCLAC. 2018. "WCLAC Annual Report 2018." NGO. Palestine.
———. 2019. "WCLAC Annual Report 2019." NGO. Palestine.
Wenham, Clare, Julia Smith, and Rosemary Morgan. 2020. "COVID-19: The Gendered Impacts of the Outbreak." The Lancet 395 (10227): 846–48.
WHO. 2017. Responding to Children and Adolescents Who Have Been Sexually Abuse - WHO Clinical Guidelines. WHO.
———. 2018a. "Eliminating Virginity Testing: An Interagency Statement." Human Rights WHO/RHR/18.15. WHO.
———. 2018b. "WHO: Addressing Violence Againts Women. Key Achievements and Priorities." WHO. WHO/RHR/18.18.
———. 2020. Clinical Management of Rape and Intimate Partner Violence Survivors Developing Protocols for Use in Humanitarian Settings. WHO.

About the authors:

Marta Agosti, PhD is a Research Associate at SOAS-University of London and the International PSEA-Network Coordinator for oPt. She has worked and researched with women survivors of sexual violence in the MENA region since 2007.

Atria Mier is a gender specialist with fifteen years of experience in development and humanitarian action. She is seconded by UN Women to the Health Cluster to mainstream gender in its humanitarian response to COVID-19 in Palestine.