

Prevention **UNFPA** Regional Strategy
Stratégie Régionale
العنف
Gender-Based Regional Strategy
المنطقة العربية
Response
Gender-Based Violence
Arab States
La Région Arabe
العنف المبني على النوع الاجتماعي
Violence

UNFPA Regional Strategy on
Prevention and Response to
Gender-Based Violence in the
Arab States Region

UNFPA Regional Strategy on
Prevention and Response to
Gender-Based Violence in the Arab States
Region

2014-2017

November 2013

Table of Contents

TABLE OF CONTENTS-----	2
LIST OF ACRONYMS-----	3
1. Introduction: Gender Based Violence in the Arab Region-----	4
2. UNFPA'S Commitments to Combat Gender Based Violence-----	14
3. Comprehensive Response to Gender Based Violence Strategic Framework-----	17
4. Four Pillars of ASRO's Gender Based Violence Strategic Framework-----	18
5. Partnerships-----	27
ANNEXE -----	29
Strategic Framework and Related Partnerships for GBV	
P revention and Response in the Arab States Region-----	30

List of acronyms

ASRO	Arab States Regional Office
CAWTAR	Center for Arab Women Training and Research
CEDAW	Convention for the Elimination of Discrimination Against Women
COs	Country Offices
CSW	Commission on Status of Women (UN)
ESCWA	Economic and Social Commission for Western Asia
FGM/C	Female Genital Mutilation/ Female Genital Cutting
GBV	Gender-Based Violence
GCC	Gulf Cooperation Council of the Arab States
HIC	High Income Countries
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
ICPD/PoA	International Conference on Population and Development / Plan of Action
ILO	International Labor Office
LAS	League of Arab States
MENA	Middle East and North Africa
MD/MDG	Millennium Declaration/Millennium Development Goals
M&E	Monitoring and Evaluation
RapA	Rapid Assessment
RBM	Results-Based Management
RO	Regional Office
RP	Regional Program
SitAn	Situation Analysis
STDs	Sexually Transmitted Diseases
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees

UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNFPA ASRO	United Nations Population Fund Arab States Regional Office
UNFPA CO	United Nations Population Fund Country Office
UNICEF	United Nations Children Fund
UN GAR	United Nations General Assembly Resolution
UN SCR	United Nations Security Council Resolution
UN SG	United Nations Secretary General
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNSCR	United Nations Security Council Resolution
VAW	Violence Against Women

1 Introduction

Gender Based Violence in the Arab Region

Gender-based violence (GBV) is not unique to the Arab region; it is a global phenomenon that cuts across cultures, age groups, and economic and social status. Evidence published by WHO in 2013 shows that one in three women in the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner.¹ The corresponding statistic for the region that includes almost all Arab countries is 37 percent, which makes it the region with the second highest prevalence in the world following closely after Southeast Asia (37.7 percent).²

GBV is an umbrella term that includes many types of violence; see below the box no. 1. The forms of GBV most frequently reported in the Arab region are domestic violence, child marriage, female genital mutilation/cutting (FGM/C), trafficking, rape, sexual slavery, forced prostitution and so-called “honour crimes” including mutilation, acid throwing and killing. GBV and the threat of such violence exercised by individuals, families, communities and institutions in both formal and informal ways in the Arab region negatively affects health outcomes, violates human rights, constrains choices, decisions and actions, and negatively impacts the ability of individuals and families to contribute to and benefit from development.

BOX No.1 *What is GBV?*

Gender-based violence is defined in the UN Multilingual Terminology Database as follows: “Acts of physical, mental or social abuse (including sexual violence) that is attempted or threatened with some type of force (such as violence, threats, coercion, manipulation, deception, cultural expectations, weapons or economic circumstances) and is directed against a person because of his or her gender roles and expectations in a society or culture. A person facing gender-based violence has no choice to refuse or pursue other options without severe social, physical or psychological consequences. Forms of GBV include sexual violence, sexual abuse, sexual harassment, sexual exploitation, early marriage or forced marriage, gender discrimination, denial (such as education, food, freedom) and female genital mutilation.” GBV is usually based on unequal power relationships among men, women, boys and girls. Women and girls are the most frequent but not the only targets due to social norms and beliefs that perpetuate their second-class social status. GBV occurs in peacetime, during and after armed conflicts, and in the context of natural disasters. This strategy addresses GBV, however its interventions target women and girls, as victims and survivors of violence.

¹ http://www.who.int/reproductive_health/publications/violence/en/index.html

² Note that the countries in WHO’s Regional Committee for the Eastern Mediterranean (EMRO) correspond roughly to those in the Arab region mentioned in this paper. All ASRO countries except Algeria and Libya are included in EMRO; however, EMRO’s territory also includes Afghanistan, Bahrain, Iran, Kuwait, Pakistan, Qatar, Saudi Arabia, South Sudan and United Arab Emirates.

A- Listed below are a few of the root causes and contributing factors of persistent GBV in the Arab states region. a- The major root causes are

Persistent gender inequality

Indicators from the Arab region show some of the highest rates of female illiteracy and the lowest rate of female labor force participation in the world.³ Women in the region continue to encounter serious problems of access to health care and information, education and income, resulting in widespread levels of poverty and exposure to violence. In addition, women in the region have limited legal rights and access to justice, albeit with variations among countries and between rural and urban women. These conditions are exacerbated by social exclusion, restrictions on fundamental freedoms and a lack of democracy. The World Bank argues that there is a “gender paradox” emerging in the Middle East and North Africa: Many countries have made progress in closing gender disparities between men and women in education and health outcomes, yet these human development indicators have not led to increased female participation in the economic or political spheres.⁴

Cultural and social norms

While most Arab states indicate a willingness to combat GBV, the status of women and girls in the region continues to be challenged by traditional discriminatory attitudes and harmful practices. According to research by the World Bank, social norms influence expectations, values and behaviours. As such, they can prevent laws, better services and higher incomes from enhancing the status and authority of women. In such cases, policy makers need to consider whether the norms themselves can be shifted to improve gender outcomes.⁵ The Arab region, though diverse, is characterized by patriarchal social systems and family structures that give prominence to the role of men in both public and private spheres.⁶ As described in the 2004 World Bank report, Gender and Development in the Middle East and North Africa, the centrality of the family plays a large role in determining gender roles and power relationships and works to the disadvantage of women and girls. In cases of GBV, perpetrators or family members – in fact, most perpetrators are family members, friends or partners – often control the woman or girl to such an extent that she is physically, psychologically or economically dependent and incapable of seeking help.

Over 35 population based studies from Asia, Africa, Latin America and the Middle East have demonstrated that attitudes condoning partner violence on the part of both women and men are highly predictive of rates of perpetration.⁷

Traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations. Every social grouping in the world has specific traditional cultural practices and beliefs; some are beneficial to all members while others are harmful to a specific group such as women. In the Arab region some of the harmful traditional practices that affect women and girls include female genital mutilation and cutting (FGM/C); child marriage; taboos and practices that prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; a preference for sons; female infanticide; early pregnancy; and dowry price. Despite their harmful nature and violation of international human rights laws, such practices persist because they are not questioned and thus assume an aura of morality in the eyes of those practicing them.⁸

BOX No.2

“In the Arab region, one in seven girls marries before her 18th birthday. Families who marry off their daughters at such a young age may believe that it is in the girls’ best interest, not realizing that they are violating their daughters’ human rights. Early marriage often means an end to the girls’ schooling, forced sexual relations and early childbearing. Moreover, girls who marry at a younger age are generally more vulnerable to spousal violence than girls who wait longer to marry. Child marriage often perpetuates a cycle of poverty, low education, high fertility and poor health, which hinders societies’ economic and social development.”

3 Arab Human Development Report, 2006

4 Opening Doors: Gender Equality and Development in the Middle East and North Africa, World Bank, 2013

5 World Development Report, 2012, World Bank, page 168

6 Analysis and comment: Reproductive health of Arab young people, British Medical Journal, October 2006. <http://dx.doi.org/10.1136/bmj.38993.460197.68>

7 Lori L. Heise, What Works to Prevent Intimate Partner Violence: An Evidence Review, 2011. Page 13 Sheet No. 23, Harmful Traditional Practices Affecting the Health of Women and Children.

8 Fact

B- The major contributing factors to persistent GBV in the Arab states region are

Political transitions across the region

From the onset of political transitions in the region in 2011, commonly referred to as the Arab Spring, the hopes of millions were raised for a better and more equitable future. Unfortunately, women and girls have not yet benefited proportionally from the social and political upheaval and in fact, many consider that women's rights are under threat, as are their security and stability, due to the emergence of conservative movements and extremist groups.⁹ More and more, the human rights of women and girls are subject to political manipulation, and violations of these rights are being used as a weapon of war. Indeed, political violence is being used to create a climate of terror to force women and girls to change the way they dress, stop them from moving freely in society, and keep them from speaking out on behalf of their interests. In some situations of civil and political unrest or instability, including during the pre- and post-electoral violence in Tunisia, Egypt and Syria, sexual violence has reportedly been committed against political opponents, both male and female. In countries where extremist movements are emerging, the main obstacle to securing unambiguous human rights for women remains the resistance of ruling conservative parties.¹⁰

Lack of political commitment

UNFPA's rapid assessment which was conducted to inform this strategy has determined that most countries in the Arab states region have taken steps to address gender inequality and GBV.

All governments in the region except for Sudan and Somalia have formally endorsed, albeit with reservations, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).¹¹

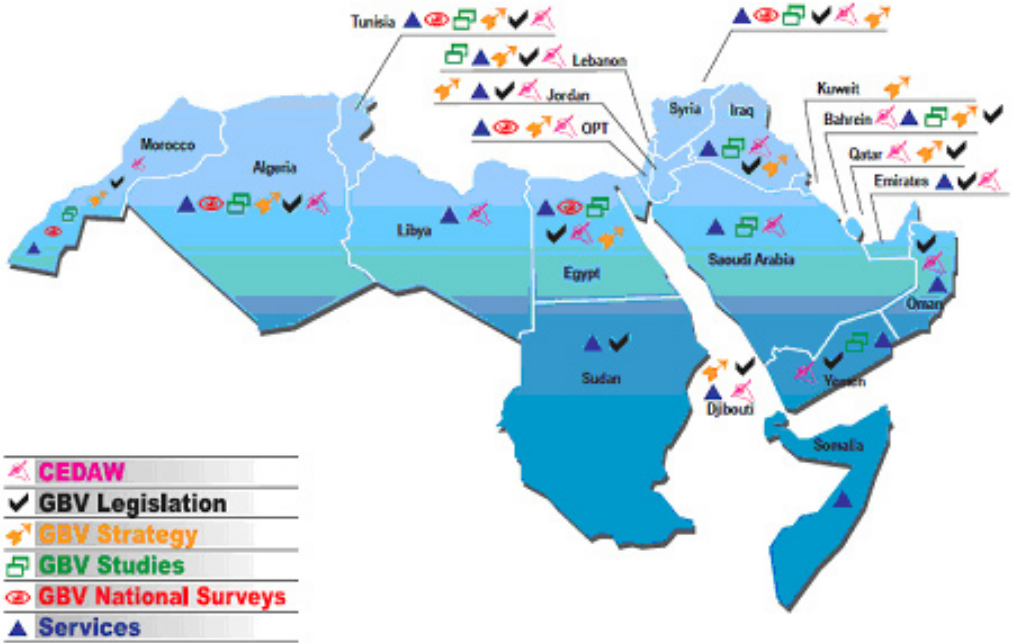
9 For instance, an experts group meeting of UN Women, UNICEF, WHO, UNDP, UNFPA and ESCAP, which took place in September 2012 in Bangkok, noted several negative trends in Libya, where men won 119 of 120 directly elected seats in Parliament in the last election, and 32 of 80 seats reserved for political parties went to women. Yemen continues to set the bar low for women's political rights in the region in the aftermath of the revolution. With only three women serving in the interim government, and only six out of 30 members of a technical committee preparing for a national dialogue leading to a new constitution, the country is still not enabling women to enjoy equal political rights with men. In Egypt, women won less than 2 percent of the seats in the 2011 parliamentary elections.

10 Though conservative groups are pressing to issue constitutional articles, laws and policies to decriminalize GBV in the Arab world, advocacy groups are working hard to stop them. Note recent developments in the Egyptian Constitutional Court on FGM/C.

Various forms of national women's machineries exist in these countries; separate ministries for women's affairs were established in Palestine, Algeria and Iraq, while other countries formed women's councils or committees (Bahrain, Egypt and Lebanon) and Jordan set up a mixed model of a women's council and ministry.¹² However, only five countries have worked on the design and implementation of strategies to combat GBV (Iraq, Morocco, Algeria, Tunisia, Palestine) and a few initiated GBV legal reform to address sexual harassment, FGM/C and so-called honour killings (Algeria, Morocco, Tunisia, Egypt, Jordan, Lebanon, Djibouti, Sudan). Many countries have prioritized the provision of services for GBV survivors (Morocco, Algeria, Iraq, Jordan and Tunisia). In addition to qualitative research, many countries have conducted household surveys on GBV (Algeria, Morocco, Tunisia, Syria and Egypt) or intend to establish a GBV observatory (Morocco, Algeria and Tunisia). The map of the region below provides an overview of efforts to strengthen women's and girls' human rights including GBV prevention and response. But despite these efforts, the lack of will on the part of some decision makers, especially in countries where the power of extremist and fundamentalist movements is growing, reduces the room for maneuvering by political leaders and civil society activists who wish to introduce legislative reforms aimed at gender equality. For instance, only two countries in the region, Morocco and Tunisia, have strategic frameworks in place. Although many governmental and nongovernmental entities have done various degrees of work, in some countries they have limited influence due to their weak mandate as well as limited resources. In addition, many are closely associated with the states that have established them to comply with international agreements such as CEDAW and the MDGs. As a result, their programs and initiatives are mainly supported by international organizations.

¹¹ Except for Sudan and Somalia, all concerned countries ratified CEDAW and some are working to remove the reservations (Morocco, Tunisia, Algeria); two have ratified the CEDAW Optional Protocol (Libya and Tunisia). Though CEDAW does not refer specifically to VAW or GBV, it is the international legal framework that addressed gender equality and women's empowerment. CEDAW is also the only human rights treaty which affirms the reproductive rights of women and targets culture as well as traditions as influential forces shaping gender roles and family relations. The CEDAW committee through its general recommendations has addressed the concept of VAW by urging all state parties to condemn all forms of discrimination against women. Even if other terminology for GBV is used, such as family violence or domestic violence, those countries that have GBV national strategies or are working on draft laws have clearly made a commitment to eradicate discrimination against women as set forth in CEDAW and its optional protocol of 1993 on the elimination of VAW.

¹² Report on the Status of Arab Women 2005: Background and Future of Women's Movements in the Arab World, ESCWA, Beirut, 2006; UNIFEM Progress of Arab Women report.



BOX No.3 Global Commitments to Address GBV

In recent decades, the international community has put GBV forward as a public health concern and a human rights issue. The link between GBV and human development has been identified by many international human rights principles that guide UNFPA policy and programming.

- 1979** UN General Assembly adopted the **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**, which established gender discrimination as the root cause of violence against women (VAW).
- 1993** At the **World Conference on Human Rights**, women's rights were recognized as human rights, and VAW was identified as an abuse and violation of those rights.
- 1993** The UN adopted the **Declaration on the Elimination of Violence against Women**, which asserts that all states should condemn VAW and not invoke any custom, tradition or religious consideration to justify its continued existence.
- 1994** **International Conference on Population and Development (ICPD)** urged countries to eliminate all forms of exploitation, violence, abuse and harassment of women, adolescents and children through preventive actions and the rehabilitation of victims and survivors. It urged countries to empower women and take the necessary steps to eliminate gender inequality.

- 1995** During the **Fourth World Conference on Women** in Beijing, the 189 assembled nations adopted the Platform for Action, which defined VAW as a violation of women's human rights and an impediment to their full enjoyment of all human rights.
- 2000** UN Security Council adopted **Resolution 1325** on women, peace and security, ensuring increased representation of women at all decision-making levels in institutions and programs devoted to the prevention, management and resolution of conflict. UNSCR 1820 (2008), 1888 and 1889 (2009), 1960 (2010) and 2106 (2013) built upon 1325 and brought a sharper focus to eliminating conflict-related sexual violence.
- 2008** Launch of the 2008-2015 campaign, **UNiTE to End Violence against Women**.
- 2013** **57th Commission on the Status of Women (CSW)** recommitted itself to the elimination and prevention of all forms of violence against women and children following the precursor 1993 Declaration on the Elimination of Violence against Women.

A weak protective legal framework

As in many other regions, there is no specific legal instrument for combating GBV in the Arab states, and national legislation and law enforcement mechanisms for eliminating GBV are scarce. Furthermore, such legislation can be a double-edged sword. While some provisions protect women from public and private forms of violence, others allow for mitigating circumstances, in effect legitimizing, if not encouraging, discrimination and violence against women. In many cases, legal solutions prioritize male interests.¹³ In those cases in which legal reforms are carried out, the limited impact for women on the ground highlights the importance of ensuring that structural adjustments and socio-economic programs accompany and support legal reforms. Legal reform must take place hand-in-hand with broader initiatives for change if it is to be effective in tackling gender inequality. The problems that need to be addressed include lax enforcement of existing laws, poor multi-sectorial coordination, poor data collection and monitoring mechanisms, limited involvement of boys and men, and budget constraints.

¹³ NGOs report that in many cases female survivors of GBV are put in jail to “protect” them from honour killings. In other instances, women who finish a prison sentence must be picked up by a man or legal guardian; otherwise, they will remain incarcerated for the rest of their lives without being charged or convicted of a new crime.

Scarce data

The region has witnessed an improved flow of data on GBV types, prevalence and trends as a result of research studies conducted by universities, NGOs and individual researchers as well as national household surveys conducted in a number of countries including Algeria, Egypt, Syria, Morocco, Tunisia and Palestine. While these surveys add to existing knowledge about GBV in the region, a lack of data is the rule in most countries in the region. In fact, the lack of data even in countries with national strategies is often identified as a major challenge, and improvements in data collection and reliability are recommended. Where data exists, it is not utilized for planning, evidence-based policy dialogue or advocacy. The lack of GBV data or evidence is used as an excuse not to prioritize interventions for addressing GBV.

The challenges related to collecting data and documenting programming is particularly relevant in humanitarian and fragile settings (see BOX 4: Review of GBV Prevention and Response in Humanitarian Settings in the Arab States Region). Sexual violence is underreported even in well-resourced settings, and it is even more difficult, if not impossible, to obtain an accurate measure of the problem in an emergency. In fact, humanitarian guidelines explicitly state that even in the absence of evidence, all humanitarian actors must assume that GBV is taking place and is a serious and life-threatening protection issue, regardless of the presence or absence of concrete reliable evidence.¹⁴

Heightened vulnerability of marginalized women

Research has shown that across all contexts – development, humanitarian, fragile, conflict and post-conflict – marginalized women and girls (street children, women and girls engaged in sex work/transitional sex,¹⁵ refugees and migrants¹⁶) face a heightened risk of GBV. These existing vulnerabilities are further exacerbated during crisis.

The Arab states are currently a highly unstable region with decades-long conflicts in Palestine, Somalia, Sudan and Yemen; a humanitarian crisis in Palestine linked to occupation and a displaced population; and violent unrest in Syria that has spilled across its borders, produced a major refugee crisis and thrust that nation to the center of world debate. Most countries in the region are experiencing conflict, have areas or populations with humanitarian concerns and needs, or are classified as fragile.

¹⁴ Guidelines on Gender-Based Violence Interventions in Humanitarian Settings, IASC, 2005

¹⁵ Standing Up, Speaking Out, UNAIDS, 2012: intersection of violence, sex work, drug use and HIV: page 22

¹⁶ HIV Vulnerabilities of Migrant Women: from Asia to the Arab States, UNDP, 2008.

In some countries, these transitions have undermined progress in gender equality and have further endangered the rights of girls and women. There are a growing number of reports that some Syrian refugees arriving in Jordan, Lebanon, Yemen, Iraq and Turkey are opting to marry off their very young daughters, believing that such marriages offer a form of protection and insurance.¹⁷ The same phenomenon is also reported to occur in Libya, due in large part to the existence of offices where such marriages between Libyan men and young women refugees from Syria,¹⁸ have been arranged. In Palestine and in particular in Gaza, as a way to cope with overcrowding in houses caused by demolitions, closures and blockades, families more frequently consent to marriages for their young daughters, increasing the prevalence of early marriage.¹⁹ To summarize, political instability has contributed to environments where the risk factors for GBV are heightened. In other countries, the impact is more direct; for example, it has been reported that armed conflict has led to the use of rape and other forms of sexual violence as tactics of warfare, although cases of conflict-related sexual violence still remain largely unreported. Some of the countries in conflict and post-conflict situations, including Iraq, Lebanon, Libya, Palestine, Somalia, Sudan²⁰ and Syria,²¹ have denounced conflict-related GBV in its various forms; however, the vulnerability of women and girls in humanitarian and fragile settings has increased due to the breakdown of traditional protective structures, which has fostered the likelihood of immunity for perpetrators. Last but not least, conflict weakens the capacity of services to respond to the needs of GBV victims and survivors.

17 So far 10 official marriages have been documented at Camp Zaatari between Syria and Jordan, according to a survey conducted by a Syrian researcher. (See <http://al-akhbar.com>.) Rights workers tracking the issue in Syria and Turkey have started to hear second and thirdhand reports of rape from the thousands of refugees who have fled besieged Idlib and Aleppo for border camps. (See <http://www.awid.org/Library/Rights-groups-detail-rape-in-Syria-s-civil-war>.) Women Under Siege, a Women's Media Center initiative on sexualized violence in conflict, has reported more than 80 sexual assaults on Syrian refugees from Idlib and Aleppo.

18 According to a Sky News documentary about child marriage in Syrian refugee camps in Jordan, these offices are arranging marriage papers for men from Libya, Kuwait, Saudi Arabia and Jordan.

19 Norwegian Refugee Council, Overview of the housing situation in the Gaza strip, March 2013, pp.21-24.

20 According to UN statistics from 2000, about 1.8 million Sudanese women in the south were forced by prolonged strife to desert their villages and townships and flock to refugee areas in the north.

21 Gender-Based Violence Rapid Assessment, Syrian Refugee Populations, Lebanon, ABAAD Resource Center, August 2012.

2 UNFPA's Commitments to Combat GBV Globally

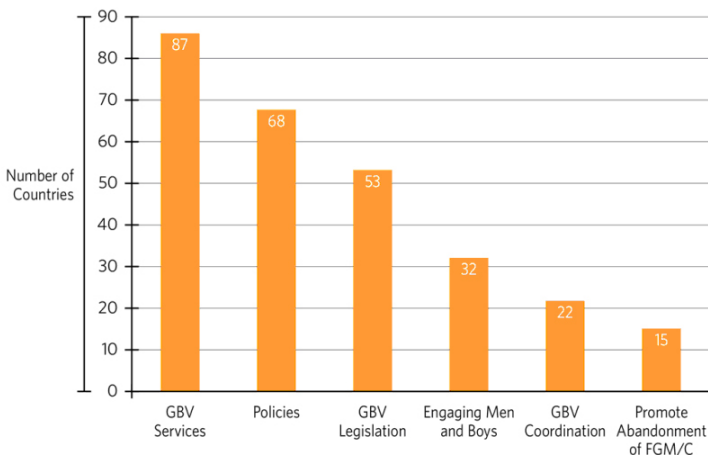
In line with UNFPA'S mission as well as commitments made by the UN and international community, addressing GBV is a priority for the Population Fund. The current Strategic Plan (SP) for 2008-2011 (extended to 2013) and the SP for 2014-2017 sharpened the organization's focus on its primary goals: to achieve universal access to sexual and reproductive health, secure reproductive rights and reduce maternal mortality. The Fund believes that the advancement of gender equality and women's empowerment are worthy goals by themselves and are also central to achieving success in the area of sexual and reproductive health rights (SRHR), particularly the fight against gender-based violence (GBV) including violence against women (VAW) and other harmful practices widely regarded as violations of human rights. It is the belief of UNFPA that GBV is a global health concern of epidemic proportions with serious implications for the SRHR of all.

UNFPA's global commitments to the elimination of GBV were reflected in UNFPA's Global Strategy for Addressing GBV (2008), and the majority of country offices have developed programmes addressing GBV, as shown below.



Delivering Globally

93% of UNFPA Country Programmes include GBV

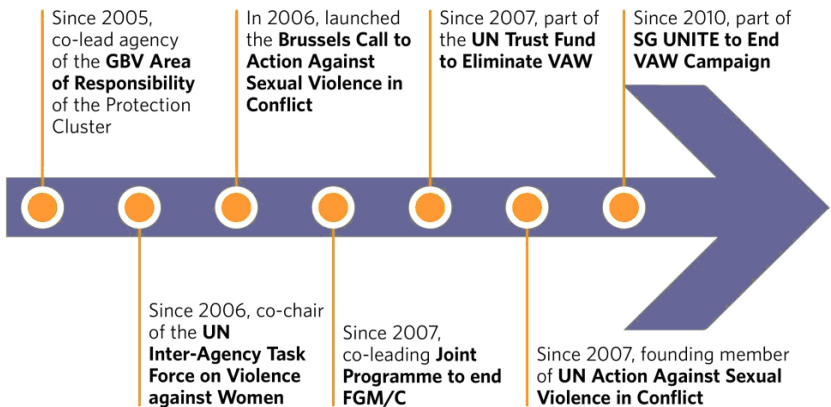


In 2013, the Fund reaffirmed its commitment to the eradication of GBV and identified the following areas of attention that will be reflected in the 2014-2017 Strategic Plan: (1) addressing data gaps; (2) strengthening capacities; (3) providing comprehensive services; (4) promoting best practices; (5) focusing on adolescents; (6) dealing with harmful practices; (7) addressing youth and security; and (8) engaging men and boys.

UNFPA's GBV programming in humanitarian settings generally builds on pre-crisis leadership and engagement on GBV issues with ministries of health and social affairs sectors. UNFPA plays a key role in developing inter-agency capacities to prevent and respond to GBV in humanitarian settings. UNFPA co-leads the GBV Area of Responsibility (AoR), an inter-agency coordination mechanism, to support GBV response in humanitarian settings under the Global Protection Cluster. In many ways, the strategies, tools and resources available to support GBV programming in humanitarian settings are further developed than those for development settings. For example, from 2005 UNFPA has led the development and rollout of IASC guidelines that set forth steps to be taken to effectively mainstream lifesaving GBV interventions across humanitarian actions. Since 2008, UNFPA has coordinated a global, inter-agency initiative for the management of data on GBV in humanitarian settings (GBVIMS), which has been introduced in Jordan, Lebanon, Somalia, Sudan and Yemen. UNFPA COs and their inter-agency partners are encouraged to take advantage of such resources and mechanisms to support GBV capacity in humanitarian settings, including the GBV Rapid Response Team and GBVIMS Surge Team.



UNFPA's Key Leadership Role



With other UN actors, implementing **UNSCRs 1325, 1820, 1888, 1889, 1960, and 2106**

UNFPA’s Commitments in the Arab Region

The Arab States Regional Office of the United Nations Population Fund (UNFPA-ASRO) has developed a GBV Prevention and Response Strategy to reinforce the efforts of UNFPA country offices and their partners to address a number of GBV priorities and challenges, including in humanitarian settings and fragile contexts. It is a road map that will guide UNFPA GBV policy and programming throughout the region. The strategy will be implemented in the following Arab countries where UNFPA currently has country offices: Algeria, Djibouti, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, the GCC office in Oman, Somalia, Sudan, Syria, Tunisia and Yemen.

To prepare the strategy, UNFPA-ASRO conducted a rapid assessment of GBV prevention and response programs in 13 country offices of UNFPA in the Arab region. The process included distribution of a questionnaire to UNFPA staff and a desk review of GBV stakeholder reports, legal frameworks, and program and service reports. UNFPA staff provided both an overview and a baseline for the assessment of GBV in the Arab states. The results showed that UNFPA COs have been engaged primarily in the following activities:²²

Table No. I

Key Areas of UNFPA CO GBV Programmes in the Arab Region

Programme Intervention Area	UNFPA Country Offices
Policy and program advocacy, development and implementation	Morocco, Algeria, Djibouti, Lebanon, Iraq, Egypt, Palestine, Syria, Jordan, Yemen and Tunisia
Communication/advocacy	Lebanon, Djibouti, Egypt, Somalia, Palestine, Iraq, Jordan, Tunisia and Sudan
Provision of services	Yemen, Iraq, Morocco, Jordan, Sudan, Lebanon, Syria, Palestine and Egypt
Operations in natural disaster, conflict and post-conflict situations to address the needs of nationals and refugees	Palestine, Iraq, Lebanon, Yemen, Sudan, Tunisia, Jordan and Syria

In addition to the Situation Analysis and Rapid Assessment, in early 2013 UNFPA ASRO commissioned a review of GBV programmes implemented in humanitarian contexts in the region to strengthen the limited evidence base. Box 4 highlights the review’s major findings.

²² “Rapid assessment of GBV prevention and response programs” report, UNFPA, 20/10/2012

BOX No. 4 *Review of GBV Prevention and Response in Humanitarian Settings in the Arab States Region*

One hundred and twelve (112) projects from 11 countries in the region were included in a review of programming from 2008-2012 to prevent and respond to GBV in the Arab region during humanitarian crises. The review found that overall, there is limited availability of GBV data and evidence in the region. The lack of information endemic in humanitarian actions appears to be even more of a problem in GBV programmes in humanitarian settings. While GBV has been integrated into the majority of emergency appeals in the region related to humanitarian projects, funds are scarce and scattered across projects. GBV projects are often characterised by a strong transformational intent, last longer (two to four years versus six to 12 months in humanitarian projects) and focus primarily on capacity development of targeted participants. Five key areas of effectiveness/good practices for GBV projects with relatively longer-term engagement and funding in conflict-affected countries were identified: (1) community mobilization; (2) engagement of men and boys; (3) communication strategies and use of technology; (4) focus on age as risk factor as well as determinant for social change; and (5) institution building.

Bizarri, Mariangela. Prevention and Response to GBV in Humanitarian Settings in the Arab Region, March 2013.

3 Development of a Comprehensive Response to GBV Strategic Framework

This GBV strategy grew out of priorities identified in the Situation Analysis and Rapid Assessment exercises. Out of this regional strategy document ASRO will develop a detailed rollout plan. To ensure accountability ASRO will build a monitoring and evaluation framework to assign responsibilities at headquarters and the regional and country offices. This strategy identifies four main areas of interventions that will contribute to reducing incidents of GBV against women and girls in the Arab region. The desired goal of the regional strategy is that women and girls in the Arab region, including in humanitarian and fragile contexts, can enjoy and exercise their sexual and reproductive health and rights in an environment free of GBV. There are four suggested outcomes. UNFPA's humanitarian programming will be aligned with the proposed outcomes, which are applicable to humanitarian settings and fragile contexts although implementation and results may vary depending on context. These are reflected in more detail below.

4 The four pillars of ASRO's GBV strategic framework



PILLAR 1: Reinforce positive social norms, attitudes and behaviours at community level

Ensure that women and girls know their rights and are empowered to claim them as individuals and collectively. Make sure men and boys are enlisted in the fight to end GBV. Cultivate values, attitudes, behaviors and practices among individuals, communities and institutions to recognize GBV as unacceptable and a crime. Strengthen the capacity of the community and religious leaders, both males and females, as well as networks and groups of men and boys to advocate against GBV. Mobilize media professionals and youth-led organizations and networks to combat GBV.

OUTCOME 1 Women, girls and local communities are empowered to address GBV.

Output 1.1. Women and girls are aware of their rights and empowered to claim them.

Output 1.2. Capacities of the community (individual and groups) and religious leaders (males and females) are enhanced to advocate against GBV.

Output 1.3. Networks/groups of men and boys are formed/strengthened to address GBV.

Output 1.4. Media professionals and networks are mobilized to address GBV.

Output 1.5. Youth-led organizations and networks are mobilized to address GBV.

To eliminate GBV, a multi-sectorial and multi-stakeholder approach must be taken. The long-term solution is to change social and cultural norms so that gender equality is upheld, the status of women and girls is elevated, and violence is rendered socially unacceptable. Only then the cycle of violence will be broken. Given that in many societies, large numbers of men and women believe that it is acceptable for men to use violence against their partners, the goal of social norm change is challenging. Its achievement requires profound attitudinal change on the part of women, men and children, and it requires institutions including political, business and cultural leaders, the judiciary and the media, to promote and model those changes. At the same time, empowering women to act as agents of change and be actively involved in community campaigns against GBV is essential as is the provision of GBV prevention and protection services.

Given the centrality of community mobilization, UNFPA will engage the following groups as agents of change to support its work across pillars: (1) civil society including community-based groups; (2) men and boys; (3) media; and (4) adolescents and youth. Engagement of these groups both as targets and as change agents will be innovative and could include community dialogues, theatre, radio, social media campaigns, and sensitization and awareness raising workshops for participants ranging from male parliamentarians to soldiers, other uniformed personnel and fathers.

BOX No.5

UNFPA will build on its current efforts to engage men and boys to address GBV, such as UNFPA's partnership with the European Union and Oxfam/GB to implement a multi-year campaign in Palestine, the Iraq/Kurdistan region, Jordan and Lebanon. As a result of this sub-regional programme, men's forums were established to combat GBV and VAW and have successfully enlisted police and other security officials as well as male religious and community leaders. UNFPA country offices in Morocco, Egypt, Jordan, Sudan and Palestine have also had varying degrees of success in engaging men and boys in the fight against GBV/VAW, offering a range of different experiences from which lessons can be drawn.

Working with media is essential in any community mobilization to reach the widest possible population. Innovative and culturally relevant mass media and social media campaigns will be developed, and the media will be enlisted in efforts to bring about changes in the public's attitudes and behaviours. UNFPA would also like to change the way that media outlets in the region report on GBV issues to ensure that they are more sensitive and that their reports reinforce positive attitudes and behaviours instead of perpetuating negative ones. Specifically, UNFPA will work to help media representatives understand the intricacies of GBV, including the links between GBV and human rights, gender equality, and social norms and development. Working with adolescents and youth to reinforce positive social norms is also critical because this is the time of life when expectations and values are shaped.²³ This strategy is consistent with UNFPA's Strategic Framework for Young People in the Arab Region.

BOX No.6

YOUNG PEOPLE IN ARAB STATES: CHANGING THE WORLD FOR THE BETTER

Strategic Action Framework for Programming on Young People

UNFPA ASRO puts the holistic and multifaceted needs of young people in the Arab states at the forefront of its programmes in the region. This approach is embodied in the Strategic Action Framework for Programming on Young People. The proposed strategy represents an evolution and regional adaptation of the UNFPA Strategy for Adolescents and Youth; it is responsive to new regional realities and institutional priorities.

The strategy outlines three key objectives:

- Facilitate equitable access to decent employment and livelihoods by strengthening young people's capacities and life skills.
- Improve young people's SRH by ensuring access to high-quality sexual and reproductive health information, education and services for all young people in the region.
- Create an environment conducive to the civic engagement of young people in order to accelerate social and economic development. Promote a culture of dialogue, tolerance, communication, leadership and life skills in the context of youth-adult partnerships.

These priorities are each addressed on four strategic levels: policy advice and advocacy; data and research; information and education; and services. Gender equality and GBV/VAW are incorporated as cross-cutting issues and strongly represented in all pillars.

In humanitarian and fragile settings, UNFPA's efforts will focus on identification of community-based, faith-based, and women's and youth groups along with key male figures to engage in comprehensive community mobilization programs.

²³ World Development Report 2012, pages 32-33.

At the onset of an emergency, however, the communications strategy may emphasize more basic messages such as the availability of services and how to minimize risk. Engaging humanitarian partners to support GBV prevention and response will also be important for advocacy efforts.

PILLAR 2: Strengthen national capacity to provide comprehensive services

Build national capacities to establish a national multi-sectorial system for quality treatment of GBV victims and survivors, including a referral system that encompasses health services, police, judges and social services. Develop the national capacity of health providers, law enforcement agents, judges and social workers to incorporate a rights-based approach and an integrated quality response to GBV including in humanitarian and fragile contexts.

OUTCOME 2 A national multi-sectorial system for quality treatment of GBV victims/survivors, including a referral system (health, police, judges, social services) in place and institutionalized.

Output 2.1 Capacities of health providers, law enforcement agents, judges and social workers strengthened in a rights-based approach and integrated response to GBV.

Output 2.2 National sector-specific protocols developed and/or implemented.

Output 2.3 National multi-sectorial coordination mechanisms in response to GBV established and functional.

Despite some advances, female survivors and victims of GBV are prevented from easily accessing special or multi-sectorial services in most of the concerned countries. When they succeed in doing so, they often face more obstacles related to the inability of service providers to properly respond to their complex needs and assure them of a compassionate and confidential response. The reasons are many and include insufficient resolve and lack of funding, targeted interventions, qualified personnel, and technical and institutional capacity of service providers. Although prevention measures have been intensified, the implementation hasn't been effective because states typically do not adopt an integrated and comprehensive approach that embraces all stakeholders and addresses the essential needs of victims and survivors of violence.

Many countries have worked on various aspects and dimensions of programs and services; for instance, Algeria, Morocco and Palestine

are trying to develop and/or consolidate referral systems. In another example, the GBV Support Network in Morocco is a unique mechanism coordinated by the Ministry of Justice and Liberty (MJL) for access to justice and legal empowerment. The network involves the Ministry of Health (MoH) for health services, the Police Department for protection services, and associations and civil society organizations for counselling and escorting victims to other institutions in the network. It also involves the Ministry of Social Development. In Palestine the referral system has just been endorsed by the cabinet. In other countries sectorial plans have been developed encompassing the ministries of health, interior, justice and social affairs to ensure an integrated approach (Iraq and Tunisia). Therefore, UNFPA is well-positioned to scale up its efforts to support multi-sectorial and referral systems that are built on the Fund's interventions in the above mentioned countries.

Unfortunately, service providers often ignore or are not aware of protocols to deal with survivors, who, as a consequence, are reluctant to access treatment or do not benefit optimally from treatment. In addition, due to the scarcity of space for private consultations and the storage of confidential medical records, service providers are not well equipped to respond to GBV survivors and victims. Indeed, the inability to guarantee privacy and confidentiality has the potential to put GBV victims and survivors at risk of further harm and abuse. Therefore, national systems need to be supported to put in place standard operating procedures to care for GBV survivors and create coordination and referral systems to ensure a comprehensive chain of service providers.

To implement effective programs and services, clear indicators and monitoring systems still need to be put in place along with clearly delineated lines of accountability. In addition, the establishment of interventions and services cannot rely solely on international donors. These policies have to be included in national agendas in order to be realized through multi-sectorial programs and financed by public spending. In partnerships with UN agencies, particularly UN Women, UNFPA will use evidence-based advocacy and policy dialogue to advocate for more investments (financial, technical and human resources) by national governments to address GBV.

In humanitarian and fragile contexts, survivor access to quality services with a focus on medical and psychosocial support and security will be prioritized; these services will adhere to the core objectives of the Minimum Initial Service Package (MISP). GBV response will be integrated with lifesaving RH services through both the provision of services and the procurement of essential supplies, equipment and drugs to trained health workers. A special focus will be given to addressing sexual violence in conflicts and fragile contexts. As the situation allows, survivors will have access to legal and livelihood

support. All partners and service providers will be committed to the guiding principles of working with GBV survivors and ensuring confidential service provision.

PILLAR 3: Strengthen national capacity to strategically address GBV

Build national capacity to strengthen/develop Monitoring and Evaluation Frameworks, including GBV multi-sectorial action plans. Produce and disseminate evidence-based data and research related to GBV. Document and disseminate examples of good practices in addressing GBV, including in humanitarian and fragile contexts.

OUTCOME 3 GBV in the Arab region is strategically addressed through evidence-based programs and policies.

Output 3.1 GBV evidence-based knowledge products and good practices are produced, documented and disseminated.

Output 3.2 GBV evidence-based knowledge products and good practices are produced, documented and disseminated.

As stated above, numerous actions have already been taken at all levels to prevent and address GBV, but the lack of coherent policies, strategies and programs shows that much work has yet to be done to resolve the numerous problems that survivors face. As previously mentioned, few countries have developed national strategies and plans dedicated to GBV. Only some countries have invested in the effort to translate such policies into legislation, programmes and services, and they are not in the majority (Iraq, Morocco and Yemen). Such weaknesses stem from the absence of appropriate sectorial reforms (health, justice, social affairs and interior). Moreover, in countries where such plans exist, their efficacy has been undermined by weaknesses in implementation due to lack of capacities, weak political commitment and prevailing popular culture, which doesn't endorse gender equality and women's empowerment.

UNFPA will invest more in policy dialogue within the UNCTs as well as with national policy makers to make sure that GBV prevention and response has been prioritized as a human rights issue and public health concern. In partnership with agencies such as UN Women, policy makers, parliamentarians, women's groups and civil society organizations will be engaged to make sure a national strategic framework is adopted to respond to GBV against women and girls. UNFPA will build on its good record of social mobilization in the region to raise the capacity of social groups to advocate for laws that address GBV.

Advocacy for more solid data and evidence to be gathered by regional, national and international GBV stakeholders is strongly needed. UNFPA already has a track record of policy dialogue and development and implementation of programs and strategies in countries such as Morocco, Algeria, Djibouti, Lebanon, Iraq, Egypt, Palestine, Syria, Jordan, Yemen and Tunisia. Moreover, the organization has invested in communications and advocacy in countries such as Lebanon, Djibouti, Egypt, Somalia, Palestine, Iraq, Jordan, Tunisia and Sudan. Building on these efforts, UNFPA is positioned to lead evidence-based advocacy and policy dialogue at all levels to encourage governments to develop and adopt national GBV action plans.

UNFPA will support the generation of evidence and data on GBV prevalence, types and trends, and the Fund will undertake studies and research on people's knowledge, attitudes and practices.

UNFPA also will carry out sociological research on social norms and gender relations, and the impact of GBV on the individual, family and society at large. In addition, the Fund will conduct routine assessments on the effectiveness of the GBV prevention and response interventions. Finally, UNFPA will advocate for and ensure that ethical and security considerations are upheld in all research and data collection.²⁴ Efforts will be made to collect data and to strengthen or develop data collection systems and tools, qualitative research, population-based surveys, and programme and impact evaluations. UNFPA will explore how to establish or strengthen a regional mechanism or forum to facilitate improved data sharing and analysis. In humanitarian and fragile contexts where national systems may be weak, non-existent or not addressing the needs of the affected populations, UNFPA COs will strengthen leadership on GBV coordination; they will advocate for the adoption of standard operating procedures, mainstream GBV across sectors of humanitarian response, and where applicable, support the introduction of GBVIMS to strengthen safe and ethical data collection systems. UNFPA country offices will harness the support available through the UN's GBV Area of Responsibility by hosting deployments from the GBV rapid response team for inter-agency GBV coordination and focused support from GBVIMS.

PILLAR 4: Build political will and legal capacity to prevent and respond to GBV

Enhance national capacities to develop/reform legal frameworks, laws and policies to comply with international agreements, declarations and treaties that criminalize GBV.

²⁴ For eight key recommendations, see WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies, WHO Department of Gender, Women and Health, 2007.

OUTCOME 4 Reformed legal frameworks, laws and policies in accordance with international agreements, declarations and treaties that address GBV.

Output 4.1 Capacities of duty bearers are supported to develop/update rights-based anti-GBV laws and policies.

Output 4.2 Capacities of rights holders are supported to advocate and promote anti-GBV rights-based laws and policies.

With regard to GBV legislation, UNFPA COs mentioned numerous shortcomings in existing legislation, and they stressed the need for more specific GBV legislation addressing punishment and reparations. However, they also recognized that strengthening the legislative framework to combat GBV is just one important step that needs to be complemented with other measures described in Pillar 2 to ensure access to justice, health, including reproductive health and psychological services, and a clear referral system.²⁵

Institutional forms of GBV, which exist even in countries considered advanced, include numerous violations of human rights, such as the right to education, health and reproductive rights, the right to work, and the right to freedom of movement, participation and choice. For instance, some penal codes allow mitigating circumstances for those accused of killing women and girls and claiming to do so in the name of honour (Jordan, Syria and Palestine). In other instances, girls are forced to marry their rapists (Algeria, Morocco and Tunisia). This is a legalization of crimes against women and girls and an obvious violation of their human rights. Discriminatory cultural beliefs and practices make it difficult for women to take advantage of the few laws that guarantee their rights. Most of the time, cultural norms are used as an excuse.²⁶ Legal services are limited and not always accessible to women and girls.

Although legal protection against rape, FGM/C and sexual harassment exist in the majority of countries under review, there are no specific comprehensive laws covering all forms of domestic violence and abuse. The concept of family violence, including wife beating and marital rape, is becoming more diluted while the notion of intimate partner violence is culturally rejected. Moreover, practical barriers keep women from seeking protection orders, such as a lack of specialized courts and personnel, including interpreters, and limited hours when family courts are open. When women do report family violence to police, they risk being turned away.

²⁵ Refer for more details to Annex 1 of this strategy.

²⁶ For more information, see UN Women for Arab States & The Committee on Elimination of Discrimination Against Women (CEDAW Committee) Regional Consultation for the Proposed General Recommendation on Women Human Rights in Situations of Conflict and Post Conflict contexts," Amman, January 2013.

Law enforcement officers often prioritize preserving family unity and push battered women to reconcile with abusers rather than pursuing criminal investigations or assisting women in getting protection orders. Laws must enforce equal legal standing for men and women, combat and punish discrimination and violence, and safeguard the security of GBV survivors and victims. However, weaknesses in the justice system, including in the courts, hamper the effective enforcement of existing laws.²⁷

BOX No.7

In Tunisia, UNFPA supports the Ministry of Women and Family Affairs (MOWFA) in its efforts to review as well as advocate for the full implementation of the national strategy on VAW. To achieve that goal, a working group was established in 2012 whose members include gender and/or GBV focal points from various ministries. In addition, a sub-group was put in place in 2013 to draft a comprehensive GBV law. This group is expected to work on a GBV referral system and standard operating procedures at the national level.

UNFPA will scale up this kind of intervention, strengthening national capacities to draft comprehensive laws and enable national justice systems to implement whatever legal frameworks exist. UNFPA will diversify capacity-building methodologies to encourage south-south cooperation; the establishment of regional knowledge and training centers; and improved follow-up and engagement of trainees.

Some of the key actors to be targeted with capacity-building efforts include: UNFPA and partner UN agency staff; national government counterparts from key ministries (health, justice, social affairs, statistics, population) and parliamentarians; service providers (health workers, social workers, police, security forces); community and religious leaders; women and youth groups; CBO and NGO partners; the media; and academic institutions.

Specific areas for capacity building and specific target groups will be determined at the country level; however, UNFPA ASRO will support the country offices by conducting an assessment of UNFPA staff and partner capacities to address GBV prevention and response. Furthermore, the regional office will assess the capacities of leading academic and training institutions to determine their suitability to support and lead regional capacity-building efforts. UNFPA will support regional and national networks and civil society organizations in evidence-based advocacy in order to develop specific and comprehensive laws. To do that, UNFPA will support the generation of data on GBV

²⁷ Benhadid F., CEDAW +30 and Beijing +15 reporting

prevalence and trends; public knowledge, attitudes and practices; sociological research on social norms and gender relations; the impact of GBV at individual, family, national and regional levels; and the effectiveness of prevention and response interventions. UNFPA will advocate for and ensure that ethical and security considerations are upheld in all research and data collection.²⁸

In humanitarian and fragile contexts, UNFPA will ensure that protocols are in place to allow for provision of multi-sectorial services (including clinical management of rape) and that survivors are able to access legal aid and justice according to their preferences. Moreover, UNFPA will strengthen the capacity of national stakeholders to reinforce protection systems in order to address the issue of sexual violence in conflicts and fragile contexts.

²⁸ See WHO's ethical and safety recommendations on sexual violence in emergencies, referred to above.

5 Partnerships

UNFPA envisions a regional strategy that will expand beyond its traditional partners to encompass regional parliamentary forums, faith-based and inter-governmental organizations, civil society and academic institutions, Arab women and youth coalitions, and national and regional media professionals and networks. The strategy will be implemented in close partnership with donors, including those in the private sector, and perhaps engage donors from GCC to mobilize funds to combat GBV across the region.

At the community level, UNFPA will partner with faith-based regional organizations that people turn to for guidance such as Al-Azhar and its national affiliates. At the national level, UNFPA will forge strong alliances with ministries of health, justice and social affairs as well as national women's networks, women's national machineries, population councils, offices of statistics and academic institutes. To address policy makers, UNFPA will strengthen its partnership with regional bodies such the League of Arab States and the African Union as well as other regional networks and associates such as the Arab Women Organization.

UNFPA will continue to strengthen its partnerships with UN agencies. Examples of such collaboration includes working with UN Women on building national capacity to reform legal frameworks; with WHO to promote and establish national health sector protocols and build the national capacity of health service professionals to provide services to GBV survivors; with UNAIDS to address the linkages between GBV and HIV; and with UNHCR and OCHA on GBV prevention in humanitarian settings.

Table No. 3
UNFPA Partnership Framework: Pillars of GBV Strategy

Pillars	UN partners in capacity building	UN partners in advocacy	UN partners in emergencies
PILLAR 1: Reinforce positive social norms, attitudes and behaviours at community level	UNAIDS, UNICEF, UNESCO, UN WOMEN, UNDP	UNAIDS, UNICEF, UNESCO, UN WOMEN, UNDP	UNHCR, UNICEF, OCHA
PILLAR 2: Strengthen national capacity to provide comprehensive services	WHO, UNICEF, UNAIDS	WHO, UN WOMEN, UNDP, UNICEF, IOM, UNAIDS	UNHCR, OCHA, UNICEF
PILLAR 3: Strengthen national capacity to strategically address GBV	WHO, UN WOMEN, UNICEF	UNAIDS, OHCHR, UN WOMEN, IOM	UNHCR, OCHA, UNICEF
PILLAR 4: Build political will and legal capacity to prevent and respond to GBV	UN WOMEN, UNDP	UNDP, UN WOMEN	OCHA, UNHCR, UNICEF

UNFPA’s engagement at the global level with two key networks – UN Action Against Sexual Violence and the GBV Area of Responsibility (AoR) – provides the Fund with access to a range of humanitarian, security and political actors as well as donors with whom UNFPA can interface to address sensitive issues and achieve intervention on a large scale.

The attached results matrix identifies major national, regional and international partners and target audiences. It was developed through a results-based management perspective emphasizing strategic interventions to ensure accountability, inclusiveness, participation and ownership.

ANNEX The Results Matrix

Strategic Framework and Related Partnerships for GBV Prevention and Response in the Arab States Region

Impact	Women and girls in the Arab region, including in humanitarian and fragile contexts, can enjoy and exercise their sexual and reproductive health and rights in an environment free of GBV.	
Outcomes	<p>Output 1.1. Women and girls are aware of their rights and empowered to claim them.</p> <p>Output 1.2. Capacities of the community (individual and groups) and religious leaders (males and females) enhanced to advocate against GBV.</p> <p>Output 1.3. Networks/groups of men and boys formed/strengthened to address GBV.</p> <p>Output 1.4. Media professionals and networks mobilized to address GBV.</p> <p>Output 1.5. Youth-led organizations and networks mobilized to address GBV.</p> <p>Output 2.1: Capacities of health providers, law enforcement agents, judges and social workers strengthened in a rights-based and integrated response to GBV.</p> <p>Output 2.2.: National sector-specific protocols developed and/or implemented.</p> <p>Output 2.3: National multi-sectorial coordination mechanisms to respond to GBV established and functional.</p>	Partners
Outcome: 2 A national multi-sectorial system for quality treatment of GBV victims/survivors, including a referral system (health, police, judges, social services) in place and institutionalized.		<p>At regional level UNIC, UNAIDS, UN Women, UNDP, UNICEF, UNESCO, media networks and professionals, and regional entities such as Al-Azhar, CAWTAR, KARAMA and Gender and Reproductive Health and Rights Resource Center (GRACE).</p> <p>At national level: civil society including NGOs, community and religious leaders, youth-led organizations and networks, men and boys groups to combat GBV.</p> <p>WHO, UNHCR, OCHA, UN Women, UNDP, UNICEF, IOM, UNAIDS, national entities including governments and civil society.</p>

<p>Outcome 3: GBV in the Arab region is strategically addressed through evidence-based programmes and policies.</p>	<p>Output 3.1. GBV national M&E frameworks, including multi-sectorial action plans, developed.</p> <p>Output 3.2. GBV evidence-based knowledge products and good practices produced, documented and disseminated.</p>	<p>At global and regional levels: WHO, UN Women, UNICEF, UNIC, UNAIDS, OHCR, donors. Regional organizations such as LAS, ESCWA, ECA and AU. Global and regional research institutions and academia. Global and regional GBV experts. Regional research institutions such as American University of Beirut, American University of Cairo, Ahfad University, Sudan, Birzeit University, Palestine, individual experts, regional media and donors.</p>
<p>Outcome 4: Reformed legal frameworks, laws and policies in accordance with international agreements, declarations and treaties that address GBV.</p>	<p>Output 4.1. Capacities of duty bearers are supported to develop/update rights-based anti-GBV laws and policies.</p> <p>Output 4.2. Capacities of rights holders are supported to advocate and promote anti-GBV rights-based laws and policies.</p>	<p>At regional level: UN Women, UNDP, ESCWA, Arab Parliamentarians Network, LAS, CAWTAR, KARAMA, Arab Women's Coalition, Arab Youth Coalition, Y-PEER and donors.</p> <p>At national level: all national partners including national governments and civil society.</p>

