

THE SORROW REMAINS INSIDE



APPLYING A MIXED METHODS APPROACH TO UNDERSTAND
THE RELATIONSHIP BETWEEN GENDER- BASED VIOLENCE AND
MENTAL HEALTH, COPING AND SERVICE SEEKING AMONG
LEBANESE AND SYRIAN REFUGEE WOMEN IN LEBANON.

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Applying A Mixed Methods Approach
to Understand the Relationship between
Gender-Based Violence and Mental
Health, Coping and Service Seeking
among Lebanese and Syrian Refugee
Women in Lebanon.

Acknowledgments

ABOUT THE GLOBAL WOMEN'S INSTITUTE (GWI):

The Global Women's Institute (GWI) is a research institute based at The George Washington University in Washington, DC. GWI conducts applied research and advocacy to better prevent and respond to violence against women and girls in humanitarian and development contexts. Our focus is supporting NGO and civil society actors to better meet their knowledge and learning needs through technical accompaniment processes to safely and ethically engage in GBV research, monitoring and evaluation in crisis contexts. For more information, visit globalwomensinstitute.gwu.edu.

ABOUT ABAAD:

ABAAD, founded in 2011, is a Lebanon-based non-profit, and non-religious civil association that aims to promote sustainable social and economic development in the MENA region. ABBAD seeks to promote equality and partnership between women and men and activate women's participation through policy development, legal reform, integrating the concept of gender, enhancing male participation in this process, eliminating discrimination, empowering women and enhancing their capabilities to participate effectively in their societies. ABAAD also seeks to cooperate with civil society organizations involved in gender equality programs and advocacy campaigns. ABAAD adopts the principle of equal opportunity and is committed to protection from sexual exploitation and abuse.

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LIST OF ABBREVIATIONS

AOR	Adjusted odds ratio
COR	Crude odds ratio
CRM	Complaint response mechanism
FGD	Focus group discussion
GBV	Gender-based violence
GWI	Global Women's Institute
HESPER	Humanitarian Emergency Settings Perceived Needs Scale
IGAs	Income generating activities
IMC	International Medical Corps
IPV	Intimate partner violence
ITs	Informal Tented Settlements
MdM	Médecins du Monde
MH	Mental health
MHGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MoPH	Ministry of Public Health
NMHP	National Mental Health Programme
NPSV	Non-partner sexual violence
NPV	Non-partner violence
PSEA	Protection from sexual exploitation and abuse
PSS	Psychosocial support
PTSD	Post-traumatic stress disorder
SGBV	Sexual and gender-based violence
UNHCR	United Nations High Commissioner for Refugees
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WGSS	Women and Girls Safe Spaces
WHO	World Health Organization

LIST OF DEFINITIONS

Child: a person under the age of 18, notwithstanding the legal age of consent in a given country

Child marriage: a marriage of a girl or boy before the age of 18 and refers to both formal marriages and informal unions in which children under the age of 18 live with a partner as if married.

Early pregnancy: also known as teenage pregnancy or adolescent pregnancy, is pregnancy in a female under the age of 20.

Gender-based Violence (GBV): violence directed against a person because of that person's gender or violence that affects persons of a particular gender disproportionately. It causes severe harm to families and communities, and is likely to result in physical, sexual, psychological or economic harm, as well as suffering to those subjected to it.

Intergenerational transmission of violence: refers to the notion that experiencing abuse or witnessing violence as a child leads to adult perpetration of violence toward spouses and partners and one's own children

Parent-to-child abuse and child maltreatment: physical, sexual, and/or psychological maltreatment or neglect of a child, especially by a parent or a caregiver. Child abuse may include any act or failure to act by a parent or a caregiver that results in actual or potential harm to a child, and can occur in a child's home, or in the organizations, schools or communities the child interacts with. The term 'child maltreatment' is used as an umbrella term to cover neglect, exploitation, and trafficking.

Sexual assault: sexual contact or behavior that occurs without the explicit consent of the victim, inclusive of attempted rape, fondling or unwanted sexual touching, and forcing a victim to perform unwanted sexual acts.

Rape: The penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.

BACKGROUND

Nine years into the Syrian crisis and almost a year into Lebanon's economic crisis [1], the outlook for those residing in Lebanon is becoming increasingly precarious. Protracted displacement and increasing vulnerabilities related to the legal status, economic insecurity, and severe living conditions in crowded settlements lead to a host of hardships and risks, including gender-based violence (GBV). GBV, including domestic violence, sexual harassment, and exploitation, as well as forced/early marriage, remains the main protection concerns for women and adolescent girls [2]. Failure to adequately respond to acts of GBV and their repercussions limit the scope of social recovery from humanitarian crises as well as the well-being of survivors [3].

In addition to political and economic instability, the COVID-19 pandemic has exacerbated the susceptibility for GBV, mental health and psychosocial problems. As of July 14th, 2020, the virus had spread to over 13 million people in 213 countries and killed over 575,000. Despite the relatively limited scope of the pandemic in Lebanon (2,419 cases and 36 deaths as of July 14th, 2020), COVID-19 is a "crisis within a crisis" and further limits access to resources, employment, and healthcare [4]. And while the data collection for this report was conducted in April/May of 2019, the results are still pertinent today, since COVID-19 as well as the economic and political crises have aggravated both GBV and mental ill-health amongst those residing in Lebanon. The new barriers to accessing services with most service providers discontinuing group and non-urgent in-person services are of equal importance as well. Most humanitarian GBV and mental health and psychosocial support (MHPSS) service providers in Lebanon have either shifted to remote modalities or limited the number of beneficiaries accessing group activities. This presents new challenges to access the said services as a result of Lebanon's power outages and beneficiaries' limited access to Wi-Fi or personal smartphones/computers [5].

GBV impacts the physical, mental and social health of survivors, their families and communities. Studies link GBV exposure and the development of psychological distress or mental health disorders, such as depression, PTSD, anxiety, and including suicidality [6]. A 2013 World Health Organization (WHO) assessment study showed a correlation between women with severe mental health difficulties and the likelihood of experiencing violent victimization. The report's systematic review of scientific data on intimate partner violence (IPV) and non-partner sexual violence (NPSV) found that women who experience IPV are twice as likely to experience depression [7].

In addition, studies by Liebling and Kiziri-Mayengo [8] and Jewkes et al. [9] showed a correlation between physical or sexual IPV and depression and post-traumatic stress disorder (PTSD). In their 2017 study, Jewkes et al. [9] determined that 84.8% and 71.8% of women in post-conflict Papua New Guinea who experienced more than one episode of physical or sexual IPV showed high levels of PTSD and depressive symptoms, respectively. There were lower, yet significant, percentages of women in Papua New Guinea who experienced increased symptoms of depression and PTSD following exposure to non-partner rape. The psychosocial impacts of GBV have implications for the families and communities of the

survivor, and the survivor may face social repercussions, such as divorce, abuse, or ostracism [10]. Failures to respond to GBV incidents limit the scope of social recovery from humanitarian crises as well as the well-being of survivors [3]. Added to the prevalence of significant emotional and psychotic disorders among Syrian refugees [11] and the lack of sufficient resources in Lebanon, this raises the question of the mental health status of GBV survivors in Lebanon, especially given the refugees' additional displacement-related vulnerabilities. There is a significant lack of research on the direct correlation between exposure to all forms (i.e. emotional, psychological, economic, physical, and sexual) of GBV and mental and psychological wellbeing in the Lebanese context. Not only should such a research assess risk factors, but it should also assess the protective factors and effective response within the framework of mental health and GBV in Lebanon in order to fill the gap of positive research on mental wellbeing and GBV. Hence, this study was conducted in view of gaining a better understanding of this relationship, of these factors, and of the ways in which mental health may hinder or promote an effective response to GBV.





EXISTING WORK ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES IN LEBANON

There are several systems in Lebanon that work on MHPSS, including a National Mental Health Programme (in line with WHO's Mental Health Gap Action Programme or mhGAP), a National Mental Health Strategy (in line with the WHO's mental health action plan 2013-2020), an MHPSS Task Force [12], a United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) referral system for Palestinians who need MHPSS services, NGO MHPSS services, five mental health (MH) hospitals, and eight hospital psychiatric wards ("Re-forming mental Health in Lebanon", 2016) [13]. The Lebanese Ministry of Public Health's Mental Health and Substance Use Strategy for Lebanon 2015-2020 details the difficulties faced in MHPSS provision, including under-funding, insufficient or ineffective coordination between MHPSS actors and service providers, and a general gap in knowledge about MHPSS among health providers [14]. This strategy outlines that, among the populations vulnerable to mental health disorders, are survivors of GBV [14]. According to Kik and Chammay, the strategy aims to address mental health by building a sustainable national system for care [15].

There are relatively few strong regional actors providing specialized care [15], many of which are NGOs. For example, Médecins du Monde (MdM) has worked with the MoPH since 2015 to reform service provision and develop a community-based approach to mental health care [16]. A growing body of mental health-focused research among Syrian refugees, including those living in Lebanon, demonstrates the necessity for NGOs and academics to collaborate on producing high quality research to further identify and contextualize the needs of communities at risk and adapt programs and systems to better serve them. [17,18,19]. Furthermore, there is a strong demand for consistent and culturally appropriate mental health care that engages the local community while incorporating psychosocial care [20,21].

STUDY JUSTIFICATION AND OBJECTIVE, AND RESEARCH QUESTIONS

Conducted in partnership with Lebanese GBV service providers and academics, this study aims to meet the need for a safe, ethical, and action-oriented research on the intersection of mental health and GBV in Lebanon. The study objective is to provide a better understanding of mental health among adult women survivors of GBV in Lebanon, in order to increase awareness among the affected population and health/service providers about how these issues are related, and support better referral pathways as well as access to and quality of services and policies. It responds to calls for a better integration of GBV considerations into MHPSS services programming and vice-versa (two separate 'sub-sectors' within humanitarian coordination systems).

The specific research question is: What mental health needs do adult women GBV survivors

have, and how do the latter affect their ability to access GBV and MHPSS services in North Lebanon and the Bekaa? The study assesses the risk for and protective factors of experiencing GBV among Syrian and Lebanese women living in Lebanon, exploring their intersections as well as the enablers and barriers to accessing quality services. Besides the findings shared herein, a set of actionable recommendations to better meet the needs of those who suffer this double burden, while also capturing what women are already doing to support themselves and each other, are provided.

The research plan was shared with the sexual and gender-based violence (SGBV) and MHPSS Task Forces prior to field implementation in view of collecting feedback from members of both groups and adapting tools and protocols accordingly. Moreover, it aimed to mitigate potential unintended negative consequences and increase relevance for and uptake of findings by relevant actors. Both task forces are comprised of specialized actors in the fields of GBV and mental health, respectively, from UN agencies and international and national NGOs, and aim to coordinate and improve humanitarian and civil society interventions in the fields of GBV and MHPSS, respectively. The SGBV Task Force, which holds meetings on a monthly basis, is coordinated by the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Population Fund (UNFPA) through the Inter-Agency Standing Committee (a forum aimed to strengthen humanitarian response). The MHPSS Task Force is run through the Ministry of Public Health's National Mental Health Programme with the support of the WHO, the United Nations Children's Fund (UNICEF), and the International Medical Corps (IMC), and also meets monthly.

METHODS

This is a mixed-methods study consisting of a randomized cross-sectional survey with adult women, as well as focus groups with women community members, service providers, and community members.

Quantitative design

Sampling Frame

The quantitative study targeted adult women between the ages of 18-65 years who have accessed ABAAD's non-case management services at least once. Case management clients were excluded at the direction of the service provider in order to respect their privacy. Therefore, the used sampling frame, comprised the list of all ABAAD's psychosocial clients, exclusive of case management clients. This is important to remember throughout the analysis as it is not a random sample drawn from the general population, and findings cannot be generalized as such. However, by respecting the privacy of case management data and engaging women who have some interaction and trust in ABAAD's services, the survey warranted the safe engagement of almost all of the contacted women and provided a better understanding of their needs on two sensitive topics, i.e. on GBV and mental health.

Participants were selected through random sampling from ABAAD's population of beneficiaries accessing psychosocial activities, inclusive of Lebanese as well as Syrian and Palestinian refugees living in Lebanon, with at least 50% from Syrian refugee communities. These names were chosen randomly from the databases of psychosocial support (PSS) beneficiaries in the North and the Bekaa, using the randomization function in Microsoft Excel.

The sampling frame consisted of women who accessed ABAAD's psychosocial support services in 2017 and 2018. A total of 976 participants were enrolled from two governorates, North Lebanon and the Bekaa, with the aim of interviewing at least 824 women to provide statistical power to estimates resulting from the survey. This was calculated based on a 99% confidence interval level for 4,000 beneficiaries in the North and Bekaa in 2017 and 2018, with a 4% margin of error. The final number of surveys decreases the margin of error to 3.6%. Based on the aforesaid sampling strategy, 981 women were contacted and 974 agreed to participate in the study (573 in the Bekaa and 400 in the North). Of the sampled women, 973 successfully completed the survey. Several factors account for the 30% response rate. First, the focal persons and data collectors noted that many Syrian refugees may have either returned to Syria or changed their phone number, and thus inaccessible. Additionally, not all beneficiaries have mobile phones (or want to share their personal phone numbers), so they will put down a neighbor's or friend's phone number in ABAAD's databases when receiving services. These beneficiaries were also difficult to reach and enroll.

Social workers operating in two of ABAAD's Women and Girls Safe Spaces (WGSS) structures in the North and Bekaa contacted selected respondents by telephone to explain the objective and details related to the study and to ask them if they would like to be involved. If the respondent consented, an agreed interview time was set. Women who were incapacitated or otherwise ineligible (for example, cannot be reached) were registered as a non-response (NR).

Table 1: Response Rate

HOUSEHOLD RESPONSE RATE	
Number of women randomly selected for contact	2,500
Number of women contacted	981
Number of women unable to be contacted, incapacitated, or ineligible	971
INDIVIDUAL RESPONSE RATE	
Number of selected women who completed the interview at an ABAAD center	585
Number of selected women who completed the interview at an alternate location ¹	389
Number of selected women who did not complete the survey	2 ²
Number of selected women who declined participation	5
Individual response rate	30%

Data Collection Tools and Measures

The data collection team consisted of nine female enumerators (3 in the North, 6 in the Bekaa) from the areas in which they were conducting surveys, with training and piloting inclusive of an additional (10th) enumerator to allow for the possibility of an alternate in the event a team member was sick or did not perform well. Training was provided by the Global Women's Institute (GWI) and ABAAD's team members on GBV and mental health concepts, trauma-informed interviewing, quantitative research principles, data collection methods, and staff care and supervision; it was followed by two weeks of piloting.

Interviews were conducted in-person at ABAAD's Women and Girls Safe Spaces (WGSS) in order to ensure confidentiality and safety of participants and enumerators in a setting familiar to the participants. In cases where participants were unable to travel to the ABAAD's Center nearest them, interviews were held at a mutually agreed and confidential space. Transport stipend was provided as well as snacks during the interview.

The quantitative research tools employed in this study were adapted from scales used in humanitarian contexts, as well as those used by ABAAD in their ongoing research about GBV. Each tool is described briefly in Table 2, along with its validity within the Lebanese context.



¹ Alternate locations included over the phone, their home, and another NGO location

² Reasons for non-completion were discomfort with the nature of the questions.



Table 2: Scales used to develop quantitative tool

TOOL	DESCRIPTION	VALIDITY IN LEBANESE CONTEXT
Humanitarian Emergency Settings Perceived Needs (HESPER) Scale [22]	The HESPER scale was developed to rapidly assess perceived population needs in humanitarian settings in low- and middle-income countries. It “enables the perceived problems of people living in humanitarian situations to be assessed quickly and reliably, directly on the basis of their own views.” [23]	HESPER has been field-tested in various humanitarian settings (including Jordan). Pilot participants found items comprehensive and relevant, suggesting criterion and content validity. “The scale has been found to be applicable and useful in several diverse humanitarian settings, and is available in English, French, Spanish, Arabic, Nepali, and Haitian Creole. So far, the HESPER Scale has been tested only in adult populations.” [23] We chose to include 5 questions related to “serious problems” with environmental factors such as food, separation from family, safety, etc., that were most relevant to our study population.
COPE Inventory [24]	A list or ‘inventory’ of various coping mechanisms such as “trusting in God” or using emotional support and friends’ advice as means of coping.	Has not been validated in Lebanon or humanitarian settings.
Kessler Psychological Distress Scale (K-6)	The K6 is an abbreviated version of the K10, widely used measure for either screening or severity. Due to the K6’s brevity and consistency across sub-samples, it is preferred when screening for mood or anxiety disorders. [25] Responses to six items are scored on a five-point Likert scale with the range “all the time” (1) to “none of the time” (5), and higher scores indicative of less symptoms, with overall scores ranging from 6 to 30. [26] Serious mental illness has a positive score in the higher range, between 19 and 30.	The K6 Arabic version screening tool for serious mental illness (not inclusive of psychotic symptoms) has been validated for use in Lebanon. [27] A 2018 study by Segal et al. [28] has employed screening tools such as the K-6, the Primary Care Posttraumatic Stress Disorder (PTSD), and the Modified Mini International Neuropsychiatric Interview, to measure mental illness prevalence among Palestinian and Syrian refugees in Lebanon, finding that over half of refugees experience serious mental illness, PTSD, or both.
WHO “Situation of Women and Girls’ Health and Life Experience in Conflict Settings” survey questionnaire [29]	Adapted from the WHO Multi-Country Study on Women’s Health and Life Experiences to capture information on intimate partner violence and non-partner sexual violence in conflict-affected settings.	Adapted and piloted in humanitarian contexts by GWI, IRC and CARE in South Sudan. [30]

The final selection and adaptation of scale(s) was done in concert with GWI and representatives from the MHPSS Task Force in Lebanon to develop the survey instrument. The instrument was designed to categorize in the first place the types of violence experienced (without probing for further details to avoid re-traumatization), to assess symptoms of mental health and well-being (through 1 or 2 of the scales listed above, adapted with input from MHPSS specialists in Lebanon), and to gather information relating to access to services, focusing on any barriers or enablers to accessing GBV services (both initially and when continuing to use those services).

The final questionnaire was divided into two main components. The first is the administrative form, where data collectors track the interview (interviewer code, date, location, and supervisor), completion of the questionnaire/reason for non-completion, and whether informed consent was obtained. Once individual consent was confirmed, the second part was administered to the respondent and consists of the following sections (in order):

1. Demographic information related to the respondent and (if applicable) her partner;
2. Household socioeconomic status;
3. Environmental vulnerabilities, using questions from the HESPER scale;
4. Psychological distress, using all questions from the interviewer-administered K-6 questionnaire;
5. IPV (ever-partnered women only) and NPV (all women) – using questions from the WHO “Situation of Women and Girls’ Health and Life Experience in Conflict Settings” questionnaire;
6. Coping and help seeking strategies – using questions from the COPE Inventory;
7. Access to services - using questions designed by the study team based on their experience on similar studies; and
8. A general question to invite any other comments or questions the respondent thought the survey did not address and providing referral information.

The full questionnaire is included in Annex I. Questions were asked to all respondents, with the exception of IPV questions being asked only to ever-partnered women (established in the demographic portion of the questionnaire). Survey questions and skip logic were programmed using the KoBo Toolbox suite developed for use in humanitarian and crisis environments in English, then translated into Arabic by ABAAD’s staff for field use. Enumerators were provided with Android tablets with the KoBo Collect app, designed to protect against survey data loss in areas without over-the-air (OTA) data services available. Data collection began in mid-March 2019 and was completed by early May 2019 to avoid conducting interviews during the Holy Month of Ramadan when the subject matter could be considered inappropriate.

Qualitative design

Following the quantitative survey, 15 focus group discussions (FGDs) were conducted to further explore findings within the quantitative portion of the study, for example probing additional information related to barriers/enablers to accessing services raised there. A total of fifteen FGDs (7 in each governorate, and 1 on a national level) were conducted with community leaders, service providers, and women community members in each of the governorate:

- Three FGDs with GBV and MH frontline service providers from civil society, international NGOs, UN and international organizations, or private organizations, 1 in each governorate plus 1 at the national level. (3 in total)
- Two FGDs with community leaders consisting of community leaders, faith leaders, representatives from women's organizations, and other key community members who can enrich the data in relation to overall GBV and MH service delivery and demand in respective locations. These groups will be separated by gender. (4 in total)
- Four FGDs in each governorate with women community members, to enrich the information on GBV from a community perspective. (8 in total)

Two FGD guidelines were developed, one targeting service providers and community leaders, and another for community members. The latter comprised open-ended questions as well as participatory exercises addressing both MHPSS and GBV-related topics, and are included in Annexes II and III.

Participants of the FGDs were chosen by sending an email to all members of the SGBV and MHPSS task force members, and asking that they send one relevant staff member, who either specializes in GBV, MH, or both. This included members of national NGOs, international NGOs, and UN agencies.

A note taker was present, and upon receiving informed consent, audio recordings were made in all but one FGD in the North during which one participant expressed discomfort with recording devices. FGDs were conducted in Arabic and directly transcribed in English. The research team used a thematic approach analysis in order to analyze the qualitative data, developing codes through the review of the first two transcripts, then continuing to add and revise codes in an iterative process using grounded theory to guide the analysis. Dedoose qualitative software, a computer assisted qualitative data analysis software, was used to support the qualitative analysis. The analysis focused on participants' conceptualization and understanding of GBV and mental health, as well as on factors that support or hinder GBV survivors with mental health needs to access services. Data analysis focused on determining best practice principles for supporting this sub-population of GBV survivors to safely access services.

Table 3: Number and Type of FGD Participants

	NUMBER OF PEOPLE	NUMBER OF GROUPS
Service Providers	19	3
Community Leaders	32	4
Women Community Members	63	8
Total	114	15



ETHICAL CONSIDERATIONS

The study followed established ethical guidelines for research on GBV [31,32]. These guidelines included warranting that an informed consent is sought on a voluntary basis, the ability to withdraw from participation at any time, and ensuring confidentiality of those enrolled. Moreover, in order to uphold the confidentiality of the collected data, digital safeguards, such as password protected files and coded data that cannot be linked back to the individual, were used. Due to the sensitivity of the issue, a psychologist/mental health specialist was part of the research team to give expert advice and consultation, follow-up on specific cases, and ensure ethical implementation. ABAAD's social workers and involved enumerators were trained to provide safe and appropriate referrals to specialized services of GBV and MH as needed. Further details of potential risks and mitigation measures taken are detailed in Table 4. The study received ethical approval from the Institutional Review Board (IRB) of Notre Dame University in Lebanon.

Table 4: Potential Risks and Mitigation Measures

POTENTIAL RISKS OF CONDUCTING A STUDY OF SUCH A SENSITIVE NATURE IN A HUMANITARIAN SETTING	MEASURES TAKEN TO MITIGATE THESE RISKS
Re-traumatization of survivors	Staff and data collectors trained on both GBV and MH conducted the research activities by, and the ethical data collection in order to prevent re-traumatization of survivors or preclude any data leakage. Privacy was upheld by conducting interviews in private rooms within ABAAD's WGSS.
Lack of social support systems and formal/specialized support services	Trained staff members was thoroughly informed about safe identification and appropriate referral pathways in Lebanon, as well as about local referral pathways in the regions. All survey respondents have been served by ABAAD, and GBV services continued to be available in all research locations under this project at ABAAD's GBV structures, i.e. at the WGSS at the Social Development Centers of the Lebanese Ministry of Social Affairs. For other specialized services not provided by the organization, referral to ABAAD's local team via hotline numbers was followed by referral to relevant service delivery points as per need and geographical location.
Greater risk for breach of confidentiality	Follow-up with a portion of participants to assess for unintended (positive or negative) consequences from their participation, as an ongoing safety measure while the research was still underway. Confidentiality and verbal consent for all participants and collected data in order to prevent data leakage and any leakage-related repercussions (e.g. abusive family members causing further harm to the survivor).

Greater community tensions due to research topic	Specialized services (GBV, case management and MHPSS) provided pro bono at ABAAD's structures. In addition, ABAAD has a referral system with Médecins Sans Frontières, MDM, and IMC for psychology and psychiatry services as needed. All these services were offered pro bono as well.
Diversion of resources from direct life-saving humanitarian efforts	Participation in this study doesn't affect participants' access to life-saving humanitarian services. Their data will remain confidential and will not compromise their access to other services, and all data collectors and focal persons are sensitized on referrals when requested or needed by participants.

ABAAD has established safety and do-no-harm policies in order to ensure that participants are reached safely and have easy access to services when needed. These policies include protection from sexual exploitation and abuse (PSEA), staff code of conduct within the workplace and in the field, a complaint response mechanism (CRM) in case of concerns or complaints for any right-holders, and a data safety policy that ensures the confidentiality and safety of data belonging to right-holders or study participants. These are available upon request.



The benefits of this study include

1. Creating evidence-based recommendations for GBV actors on employing mental wellbeing considerations in their work, and mainstreaming mental wellbeing into programs that directly engage GBV survivors.
2. Providing insight into the relationship between exposure to GBV and mental wellbeing, and formative research to be eventually able to deliver evidence of the impacts of GBV on mental wellbeing.
3. Gauging local service providers as well as both learning from and informing them about specific, contextual needs related to GBV and mental wellbeing.
4. Providing data to inform further research, programming and inter-agency coordination on issues of MHPSS. Actors who will benefit from this are the Ministry of Public Health (programming and inter-agency coordination within the National Mental Health Programme and MHPSS Task Force), as well as primary healthcare providers (diagnosis and referral systems for both MH and GBV), NGO and UN agencies working in the MHPSS field (programming and MHPSS service provision for survivors of GBV, as well as GBV detection in people with MH needs).

Results of the Mixed Methods Analysis



DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS OF STUDY PARTICIPANTS

Lebanese women comprised about one-third of the study population, with the remainder identifying as Syrian or Palestinian³, all of whom were aged 18 to 65 years. Median age among the respondents was 38, with Lebanese women older than Syrian women (median age 42 vs. 36). Overall, participants in this service-based population sample tended to be older than the national average [33], with the median age ranging from 36 to 42. More than half of respondents had less than primary education and there were significant differences in education beyond secondary by nationality, with 17% of Lebanese women indicating education beyond secondary compared to 6% of Syrian women.

The vast majority of women (91%) have ever been partnered (93% of Syrian women vs. 89% of Lebanese women), and the same proportion reported having ever been married. Marriage in this population occurs early in a woman's life; the median age for marriage is 18 and the majority of women are married before the age of 20 (50% Lebanese and 68% Syrian). Thirty percent of Lebanese and 44% of Syrian women were married before the age of 18. Fifteen percent of women said they were not asked if they wanted to marry the men who ultimately became their husbands. Though Lebanese and Syrian women reported nonconsensual marriages at similar rates over their lifetime, twice as many Syrian women (11%) reported nonconsensual marriage before their 18th birthday as Lebanese women (5%). The majority (86%) of women have been pregnant at least once and early child bearing is also prevalent among the study

Table 5: Demographic characteristics of survey participants

	ALL N= 969 (%)	LEBANESE N= 352 (%)	SYRIAN N= 617 (%)
Age (Median)	38	42	36
Education			
Less than primary	58	53	62
Completed primary	27	26	28
Completed secondary	5	5	5
Higher	10	17	6
Ever partnered	91	88	92
Age at first union			
Under 15	11	7	12
15 to 19	52	43	56
20 to 24	26	33	22
25 or older	12	16	10
Married before age 18	35	30	44
Nonconsensual married	14	14	16
Forced child marriage	8	5	11

population, with 12 % of Lebanese and 20% of Syrian women reporting their first pregnancy occurring before the age of 18.

Employment was low among participants. Only 15% of women reported working for money, and Lebanese women were more likely to earn money than Syrian women were. The source of household income was significantly different between nationalities with half of the Syrian women reporting humanitarian aid as the primary income for their household compared to the same proportion of Lebanese women who said their husband provided the bulk of the income.

Table 6: Economic characteristics of survey participants

	ALL N= 969 (%)	LEBANESE N= 352 (%)	SYRIAN N= 617 (%)
Works for money	15	19	13
Main source of income			
None	5	5	6
Money from own work	8	10	6
Husband	29	60	17
Parents	10	16	6
Other relatives	4	5	3
Social services	5	2	6
Humanitarian aid	34	6	50
Others	6	7	6

It should be emphasized that survey respondents represent the population whence the sample was derived, i.e. ABAAD's service beneficiaries. Common features of the beneficiaries are marginalization due to refugee status and/or low socio-economic resources, early marriage that is often entered without their consent, and early pregnancy that can further stress capacity and resiliency of households and communities.

ENVIRONMENTAL VULNERABILITIES

Ninety percent of the survey participants reported having a serious problem due to unmet needs. Food insecurity – too little, poor quality, or inability to prepare available food – was the most reported vulnerability (71%). More than half of the women reported having serious problems due to physical health (62%) or being separated from family members (56%), and half listed safety and security where they live (50%) as a serious problem.

³ A total of 9 women identified as Palestinian in the survey, 7 (78%) of whom indicated that they had migrated to Lebanon because of the Syrian conflict. The researchers acknowledge that the status of and resources available to Palestinian women differ from those of Syrian women; however, due to their small number and migration status, the experiences of Palestinian women in this study are included with those of Syrian women for analysis.

Table 7: Environmental vulnerabilities among survey respondents

	ALL N= 969 (%)	LEBANESE N= 352 (%)	SYRIAN N= 617 (%)
Serious problem with food (not enough, good enough, unable to cook)	70	62	74
Serious problem with no easy and safe access to a clean toilet	29	17	37
Serious problem with physical health (due to illness, injury, disability)	62	56	66
Serious problem with safety and security where she lives	50	38	57
Serious problem because she is separated from family members	56	23	74
Number of environmental vulnerabilities			
None	9	20	4
1	11	18	7
2	22	26	19
3	27	21	30
4	22	11	28
5	9	4	12

Host and refugee participants in the North and Bekaa regions echoed food insecurity as a widespread problem, but observed the lack of access to financial resources as their main source of vulnerability and as a foundational contributor to the tense atmosphere and increased demands on families. As one women community member in the North summarized, “no matter how you twist it, we go back to the main issue: the economy,” whereas another participant argued that “financial relief leads to psychological relief.” In the North, both host and refugee community members noted that the tense atmosphere, increased demands (e.g. demands for husbands to make money and support their families and for women to carry all household responsibilities), and difficult financial situations increase distress, anger, irritability, isolation and mental fatigue. Refugee FGD participants also discussed safety and security vulnerability in terms of lack of safe or spacious shelter and separation from family members, fear of kidnapping and arbitrary detention, and fear of family members being harmed by security and army forces.

With regard to vulnerability due to physical health, women community members also discussed the circular interaction between mental and physical health, one woman asking, “How am I to provide [for] myself? I am mentally drained...my back hurts, my legs hurt.”

Lack of safe access to a clean toilet was reported by more than one quarter (29%) of survey respondents and varied by location and nationality. More than twice as many (37% versus 17%) Syrian women reported this being a serious problem, which corresponds to the disproportionate number of Syrian women living in informal tented settlements (ITSs). It should be noted, however, that the problem of safe toilet access is not confined to specific living environments, as both regions have participants living in ITSs and more formal and structured housing. When examined by region, 21% of women in the North and 35% of women in the Bekaa Valley reported serious problems with toilet access. Toilet access did not emerge in the free-listing of environmental factors that most affect mental health in any FGD, however.

Community leaders in the North and Bekaa reported ignorance and low levels of education and religious knowledge as a main source of depression, and noted the impact of harmful traditions and values on the mental health of women. One of these traditions is child or forced marriage, “which includes a large age difference and is for financial relief”. For example, “the [community] leader may choose a partner for the woman, without her approval, or even without the approval of the parents sometimes. If the eldest of the family gave an order, it has to be followed. There's no way not to abide by it. Most traditional marriages happen this way.” Another community member described norms and traditions that are patriarchal in nature, and that, for example, allow “a boy to go out, but a girl can't.”

KEY FINDINGS

Gender-Based Violence

GBV reported in this study spans every level of public and private life, including dimensions of violence such as economic and emotional violence by partners, physical and sexual violence by partners and non-partners, and familial and structural violence such as forced child marriage, harmful social norms, and discrimination. High rates of violence reported by survey participants are reflective of a sample derived from ABAAD's psychosocial support service beneficiaries (with the exception of case management beneficiaries), and not of the general population. While the survey participants reported violence based on the WHO violence scale, FGD participants used free listing, and thus yielded less structured results.

Intimate Partner Violence

Overall, more than three-quarters of surveyed women in the study population have experienced at least one act in any dimension of IPV during their lifetimes, and half have experienced this violence in the past 12 months. Figure 1 shows that the most prevalent type of vi-

olence amongst Lebanese women is emotional (54%) followed by economic (44%), physical (37%) and sexual (28%) whereas, among Syrian women, the highest prevalence comprises economic violence (55%) followed by emotional (48%), physical (40%) and sexual (39%). The current prevalence of IPV follows a similar trend (Figure 2). It is important to highlight in this context that 1 out of 2 participants have suffered physical and/or sexual IPV. This figure is higher than the global figures of women having underwent this type of lifetime violence where the prevalence is around 1 out of 3 women having underwent [7].

Figure 1: Lifetime prevalence of IPV, overall and by nationality

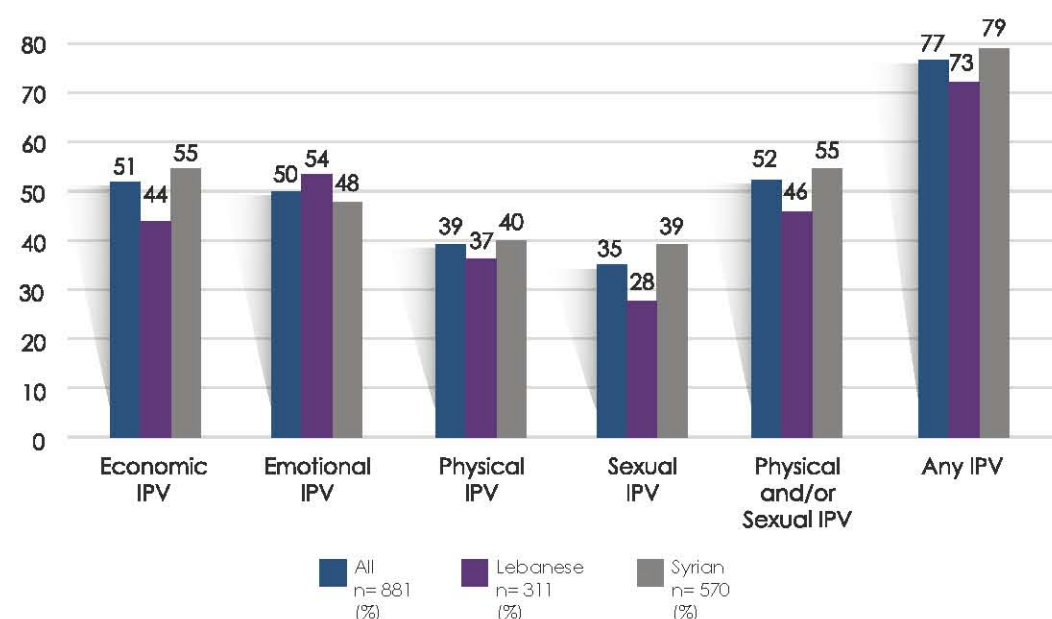
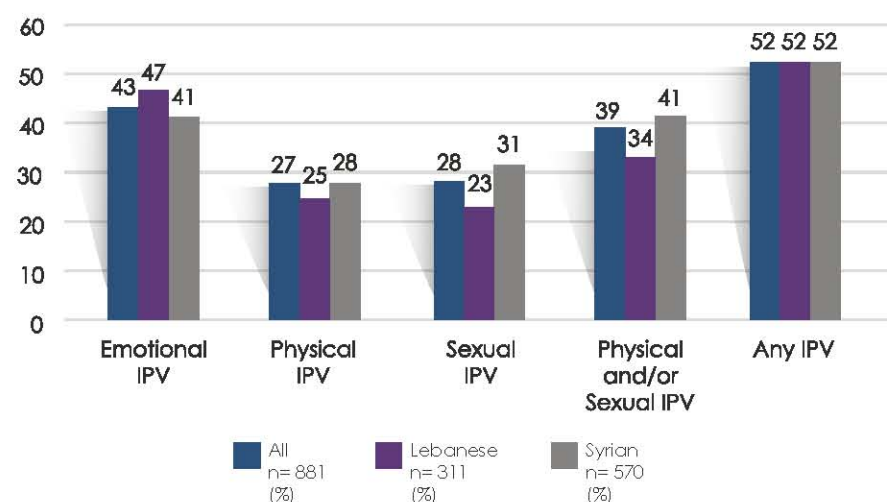


Figure 2: Current prevalence of IPV, overall and by nationality



Non-Partner Physical and/or Sexual Violence

All types of NPSV, with the exception of rape, occur at similar rates among Lebanese and Syrian participants, suggesting that the refugee status is not a primary risk factor among women seeking non-case management psychosocial services from an NGO.

Reported by 19% of women, unwanted sexual touching constituted the most common type of NPSV. Nearly one in ten (9%) women said they have been offered money or other favors in exchange for sex in their lifetime. Two percent reported that they had ever been forced to undress or forcibly stripped of their clothing by a non-partner. Four percent have experienced a rape attack which is not completed (an attempted rape). Twice as many Syrian women reported being raped by a non-partner (2% vs. 1%) compared to Lebanese women.

Stigma, fear, and a miscellany of other factors lead to under-reporting of GBV and hinder the measurement of accurate prevalence levels. Since this survey's sample is drawn from ABAAD's service population, exclusive of those actively engaged in a case management program, it is noteworthy to mention that the surveyed rates of IPV, as well as non-partner physical and sexual violence, are under-estimates [34].

Other GBV

Additional themes surrounding GBV that were not captured by the survey emerged from the FGDs. Among these were structural violence in the form of political and economic volatility, lack of protective policies and laws, lack of judicial and social accountability, gender inequality, and religious courts and officials, compounded with widely accepted social mandates that "allow for sexual and physical violence" against women [Bekaa mixed-gender service provider].

One participant stated that women are not protected from violence, even on a structural level, describing the government as "a facilitator of violence due to lack of laws and regulations (e.g. rape, sexual assault, etc.) and the laws of the Shari'a courts, or the lack of enforcing [laws] or being held accountable to them." This refers to laws that dictate civil rights, such as marriage, divorce, custody, and others, as well as laws that are made to protect against sexual abuse, but which are not comprehensive. A service provider noted that "there was a law that used to force men to marry their rape victims, rather than putting them in jail. You'd imagine that he would rape her every night." In addition to allowing child marriage, the courts "do not favor women when it comes to divorce, custody, and asset division".

FGD participants also raised the issues of "moral failure" and additional aspects of participants' and partners' direct social environment such as prior experience of violence, harmful social norms, lack of awareness, and behavioral factors (e.g. cheating, use of substances such as "hash," and lack of respect or religiosity). Participants described customs "in which a woman cannot go from one place to another without having her father or mother with her. Some people still follow this custom. Even if you trust others, society would lead you to



lose your trust in others... There is moral failure in this area and in the country as a whole." Community leaders in the North noted that a "violent childhood can serve as a warning" for future perpetration of violence, arguing that those who experience childhood violence are more likely to perpetrate violence themselves as they grow older. Figure 3 illustrates other environmental factors related to violence, segregated as per the ecological model.

RISK FACTORS FOR GBV

Risk Factors for Intimate Partner Violence

What influences the risk of experiencing IPV? The analysis was conducted to identify key factors at play in the lives of women and girls that increase the likelihood of experiencing IPV during the lifetime and in the past 12 months. For this report, the analysis focused only on the association of different factors with physical and/or sexual IPV. Physical and/or sexual IPV was used as the primary outcome because it represents the main indicator from the Sustainable Development Goals in which countries monitor their progress in the elimination of IPV. However, this use is not meant to reduce the importance of other types of violence in the lives of women, such as emotional and economic violence.

Physical and/or sexual IPV were analyzed in accordance with thematic factors: women's sociodemographic characteristics, partners' characteristics, and marriage and family circumstances for significant differences in the proportion of women experiencing IPV under different conditions (Annex 2). Bivariate and multivariate analyses of significant factors were conducted to determine the crude odds ratios (COR) and adjusted odds ratios (AOR). These thematic factors were included in the questionnaire to capture some of the associated factors related to IPV that are in the Ecological Framework adapted by [35]. Key factors from the analysis are discussed in this section.

Educational attainment. Women's educational attainment is significantly associated with experiencing physical and/or sexual IPV. Overall, women who have attained secondary or higher education status reported experiencing physical and/or sexual IPV less frequently (42%) than women who have completed only primary (46%) or less than primary (57%) education. The multivariate analysis showed that women whose partners have less than primary education were 60% more likely to experience IPV compared to those with secondary or higher education. FDG participants also noted lack of educational opportunity as one of the exacerbating factors for IPV, one participant noting that a woman needs to have a "strong personality, and that's the first thing that springs from getting an education."

“

[Poverty] weighs heavily on the shoulders of a man...and triggers the cycle of violence.

Mixed-gender service provider FDG, Bekaa

Work and income. Working for money or engaging in income generating activities (IGAs) is significantly associated with IPV. Overall, women who engage in IGAs were 1.7 times more likely to experience IPV than women who do not, while women whose husbands were not gainfully employed at the time of the survey were 30% more likely to have experienced IPV in the past 12 months. Lack of significant differences in lifetime IPV based on husband's current work status may simply reflect an ongoing cycle of male employment/unemployment influenced by longstanding institutional factors such as economic instability and national labor policy, where financial and status stressors come and go. Being the primary household income source was also significantly associated with a woman being at increased risk of IPV. Women who said the primary household income source was their own earnings or from humanitarian aid reported similar elevated rates of physical and/or sexual IPV (60% and 59% respectively), and are twice as likely to have experienced IPV in their lifetimes compared to women who said their husband provided the main income source.

This was supported in FGDs, where the most commonly reported exacerbating factor was the lack of access to financial or basic resources, or economic instability and lack of access to job opportunities. Moreover, many participants linked poverty and harmful masculine norms as an IPV catalyst. One male participant noted that "the economic situation, the lack of jobs, and the lack of ability to secure the house's needs" act as major stressors for men in the community. Another said that men are constantly "thinking about how [they] will pay electricity bills, how [they] will get water, food for [their] kids... [Then] when [their wives] come and tell [them they] want something and [they're] helpless so [they] hit [them]. This is the reason behind physical violence.

Forced child marriage. Three quarters of women who were forced to marry prior to the age of 18 reported physical and/or sexual violence in their relationship compared to half of women who married older with consent. The multivariate analysis indicates that these women are twice as likely to experience IPV during their lifetimes and in the past 12 months compared to women who married by choice at an older age.



“

...they [young married couples] are not going to understand each other or know how to deal with each other at this young age... Battery and other problems exist between them for sure, to the extent of seeking a divorce.

Women community members FDG, Bekaa

Participants of the women community member's FDG described how forced child marriage is related to IPV due to a lack of “understanding” leading to tensions and arguing among the couple. Multiple focus groups also listed prevention of early marriage as a protective measure against IPV.

Environmental vulnerabilities. Though they are commonly thought of in the context of non-partner violence risk, environmental vulnerabilities are a source of stress for women and for their households as they may trigger IPV. In the study population, a number of different environmental stressors represented significant factors in physical and/or sexual IPV. For instance, women who reported serious problems due to physical illness, injury, or disability were 40% more likely to have experienced IPV during their lifetimes and twice as likely to have experienced IPV in the past 12 months compared to women who said they did not have any serious problems due to physical health. Similarly, women who report lack of safe access to a clean toilet or separation from family members were also more likely (40% and 50%, respectively) to have experienced IPV during their lifetime. Furthermore, the women who reported problems due to lack of safety and security where they live were 40% more likely to have experienced IPV in the past 12 months. It is remarkable that no FGDs raised these as part of a pathway to violence inside the home.

In sum, women who have low educational attainment, work outside the home, have a primary source of income other than the one their husband earns, were forced to marry before the age of 18, and have environmental risk factors are at a higher risk for having ever suffered physical and/or sexual IPV pursuant to this study's findings. Women who specifically have serious problems due to lack of security where they live or due to physical challenges, or whose partners are not currently employed, are more likely to have experienced physical

and/or sexual IPV in the past 12 months. Other vulnerabilities emerging from the FGDs can be found in Figure 3.

WOMEN'S INDIVIDUAL CHARACTERISTICS

Nationality

The proportion of women experiencing physical and/or sexual IPV varies significantly by nationality, ranging from 46% of Lebanese women to 55% of Syrian women. The bivariate analysis reveals that Syrian women are 1.4 times more likely of ever experiencing this type of violence. The occurrence of physical and/or sexual violence also continues at high rates among this group over the lifetime; 34% of Lebanese and 42% of Syrian women (overall 39%) said they have experienced one or both of these types of violence in the past 12 months.

Age at First Pregnancy

Early child bearing is also significantly associated with an increased risk of IPV. Among women who had their first pregnancy before the age of 18, 62% have ever experienced IPV. Women who had their first pregnancy at 18 or older reported significantly less IPV in their marriages (49%, COR 1.7).

PARTNER CHARACTERISTICS

Education

Men's educational attainment is a significant factor associated with physical and/or sexual IPV. The bivariate analysis demonstrated that women whose husbands have less than primary education were 1.7 times more likely than those whose husbands have completed secondary education or beyond to have experienced physical and/or IPV. In real proportions, 56% percent of women whose husbands have the lowest educational attainment reported ever experiencing IPV compared to 43% of women whose husbands had the highest. Education was not a significant factor, however, in physical and/or sexual violence experienced in the last 12 months.

Work Status

As with women, men's work status is a significant factor associated with physical and/or sexual violence. Circa half (47%) of women whose husbands were currently unemployed reported experiencing IPV during the past 12 months, compared to 38% of those who reported their husbands were employed at the time of the survey. Partner unemployment, however, was not a significant factor in lifetime IPV.



Risk Factors for Non-Partner Violence

Nearly one third (31%) of women in the study group have experienced one or more incidents of non-partner physical and/or sexual violence in their lifetime. Non-partner violence experienced by the sample group includes physical violence (15%) such as being beaten or threatened with a weapon, sexual assault (20%), including rape (completed or attempted), and unwanted sexual touching as well as sexual exploitation, such as offers of money or other advantages in exchange for sex ("transactional sex", 9%).

The key findings in this section stem from the analysis of women's characteristics and of the environmental vulnerabilities and, specifically, their correlation with non-partner sexual violence. NPSV is clearly gender-based and constitutes a violation of a woman's body, a violation which transcends pain or injury due to physical violence.

Similar to IPV, NPSV was analyzed in the context of individual, relational, and community factors. All types of NPSV were used in the analysis rather than a representative variable.

Location. More than one in four women (26%) in the North reported having experienced non-partner sexual assault and more than one in ten (12%) have been propositioned for sex in exchange for favors, while 17% of women in the Bekaa have experienced sexual assault and 6% have been propositioned for sex in exchange for favors. The multivariate analysis indicated that women in the North are nearly twice as likely as women in the Bekaa to experience sexual assault (OR 1.9) or transactional sex (OR 1.8) over the course of their lifetimes. This may be due, in part, to higher female employment in the North among other reasons. There was no significant difference in descriptions of NPV between regions in the FGDs, however. Both groups described fear of sexual assault occurring in public spaces, with one participant pointing out that "there might be sexual abuse from the driver" in a cab or a school bus.

Age. The age of women is a significant factor in NPSV. Younger women reported significantly higher rates of non-partner sexual assault than older survey participants. The youngest women in the study sample, aged 18-24, are over four times more likely to have ever experienced sexual assault than women in the oldest group, aged 55-65.

Women community members described situations where younger women and girls are at risk, including while traveling to school with a hired driver or being at home in crowded conditions with male relatives' visitors. One service provider described a right-holder's fear of sending his daughters to school: "I always tell the father that he should send the girls to school because his kids are so good at school. He would say what if they were cat-called? What if they caused me issues? But I would tell him that it's not their fault. There are ways you can take care of them." A participant in Qobbeh described the risk of sexual harassment or assault while traveling to school, noting that "a lot of girls stopped their school and university education due to these issues. Unless their own men drive them there and bring them back." This is an example of the double burden faced by girls: difficulty with finding safe transportation to school limits their access to education, and may force them to spend time in unsafe

spaces at home. There was also discussion by adult women about lack of safety in traveling without a father, husband, or son for accompaniment.

Work outside the home. Working for money or engaging in income generating activities (IGAs) is significantly associated with NPSV. Women who engage in IGAs were more than twice as likely to have experienced non-partner sexual assault as women who do not work for money and more than three times as likely to have been propositioned for sex in exchange for favors. Work outside the home exposes women to being in spaces that are not socially sanctioned as women's spaces, and to traveling between home and work locations without the benefit of accompaniment. Female focus group participants discussed the challenges faced by women under the authority of unscrupulous employers, as well as those created when male family members were unable to accompany them to and from their place of employment. One participant in the Bekaa described that there are "girls who go work at farms, tending cows, picking olives and fruit. They work in agricultural areas, picking cherries, fruit. There is also a lot of exploitation here because there's a time for each [shift], so the manager adds extra time over their original time and most of the time there isn't someone else to delegate the work to, and they promise to pay them extra, but they don't."

The quantitative analysis, supported by focus group participants' insights, indicates that the key factors increasing risk of NPSV against women are young age, region, and engaging in income generating activities outside the home.



ENVIRONMENTAL VULNERABILITIES

Among the study population, women who reported having a serious problem with the HESPER categories broadly related to their ability to access resources reported higher rates of non-partner sexual assault and transactional sex than those who had fewer problems. For instance, 22% of women who reported having a serious problem with food (defined as having enough food, "good enough food", or not being able to cook food) have experienced sexual assault, and 10% have experienced being propositioned for sex in exchange for money or other favors (transactional sex) while 16% of women who have no serious problem have experienced sexual assault and 5% have been propositioned. Similarly, nearly a quarter (24%) of women who said they have a serious problem due to physical health or disability reported being sexually assaulted, and 10% reported transactional sex. Physically healthier women, in contrast, had much lower rates of sexual violence (14% and 6%, respectively).

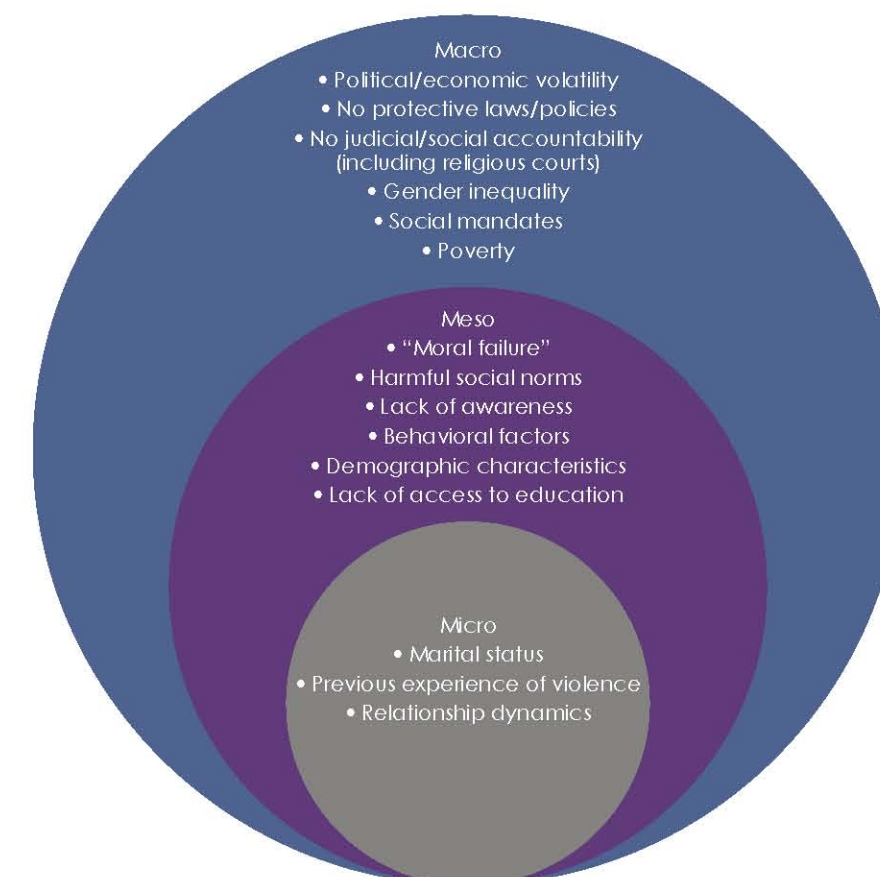
Women who reported having serious problems due to lack of easy and safe toilet access, lack of safety and protection where they live, or being separated from family members reported significantly higher rates of physical and sexual assault, but not with transactional sex. Of the women who lack safe access to a clean toilet, 20% have experienced physical assault and 25% have been sexually assaulted by non-partners. In contrast, among women who have safe access to a toilet, 13% reported ever being beaten or threatened with a weapon by a non-partner and 19% reported ever being sexually assaulted. Similar proportions of women who live in areas lacking safety and protection have experienced physical or sexual assault by non-partners (19% and 25%) compared to women who live in safe areas, of whom 10% experienced physical assault and 16% sexual assault.

SAFETY AND SECURITY

Safety and security in their living area is another obvious concern for non-partner violence among women living in informal tented settlements and in more traditional settings.

RISK FACTORS FOR OTHER GBV

Figure 3: Environmental Vulnerabilities/Risk Factors Linked to GBV



PROTECTIVE FACTORS FOR FGD PARTICIPANTS

While the quantitative analysis focused more on exacerbating than on protective factors, participants in the FGDs highlighted some factors that might protect women from GBV. The most commonly reported protective factors were: first, raising awareness among men and women about violence and its consequences, second, getting a general education (i.e. attending school), and, third, gaining a greater access to resources or job opportunities. Apart from that, participants also pointed out the importance of protective laws, safe reporting systems for violence, community safety measures, respect, prevention of early marriage by family members, having fewer children, and respect between partners and from parents towards their children as factors that help to protect women from violence. During a FGD, a community member in the Bekaa stated that "when schools prepare for our needs,



like the transportation issue, especially for adolescents, like a car that can drive us to school and back, because schools are so far from the camps, and far from each other, it is highly important." A service provider in the Bekaa highlighted the importance of a "proper reporting system to flag people, where there is no fear about reporting."

MENTAL HEALTH

In the survey, mental health was measured using the K6+ assessment of psychological distress which, in its turn, uses a scale of increasing positivity to describe the frequency of six specific symptoms over the past 30 days, ranging from none of the days (1) to all days (5). A cut score of 19 out of 30 was used as the demarcation between severe psychological distress and mild to moderate distress as a dichotomous result: 19+ is severe, 18 and under means not severe. The FGDs applied a semi-structured, participatory approach of free listing. The section below addresses the types of mental health symptoms and mental health exacerbating factors detailed in the project's qualitative leg, as well as reported mental health and consequences of GBV in both the qualitative and quantitative data.

Mental Health Symptoms among FGD Participants

The most commonly cited mental health symptoms among FGD participants were pressure or worry, named as "daghet" (ضغط), depression and fear (mentioned about half as frequently), and finally, anger, irritability, or somatization⁴. Other reported symptoms include disrupted or increased sleep and anxiety, distress, stress, and suicidal ideation.

Pressure/worry, or "daghet," as referred to in Arabic, was most commonly reported as a result of deteriorating or compromised financial or social status, harmful social and gender norms, family stress, household responsibility including caretaking of children, inability to predict or plan for the future, being away from children who have migrated, and stigma against vulnerable populations. One participant described the difficulty in dealing with this "daghet," and if women "go on repressing themselves, [they] might suffer a stroke." Refugees and participants living in informal tented settlements indicated additional sources of worry such as the structure of their housing, the related issue of tension between their tents and the lack of privacy/space, tension between them and the police/army forces (fear of arbitrary detention), as well as lack of job opportunities that leave youth "[staying] in the camps" and "doing nothing" [Bekaa women community member].

Mental Health and Consequences of GBV

The mental health outcome was measured by women's and partners' characteristics, partnership circumstances, environmental vulnerabilities, and experience of violence in order to understand the main factors or drivers associated to poor mental health. This was comple-

mented by FGD participants' perceived relationship between different types of GBV and mental health symptoms.

In the descriptive analysis, all forms of GBV were also significantly associated with severe psychological distress. Women who have experienced sexual violence in particular have significantly higher rates of severe distress than those who have not experienced this type of violence, approximately 82% of women who have experienced sexual IPV or NPV versus about 67% among those who have not. In the multivariate analysis, all violence variables lost significance, except transactional sex. Women who have been offered money or other favors in exchange for sex were 4.2 times more likely to have severe psychological distress than women who have not had that experience, when controlling for all other significant variables.

Nationality. As expected with regard to the study population, the proportion of women with severe distress is high. Overall, 70% of women suffer from severe psychological distress. Syrian women have a significantly higher rate than Lebanese women do (80% vs. 55%), and are more than twice as likely to experience severe distress according to the results of the multivariate analysis.

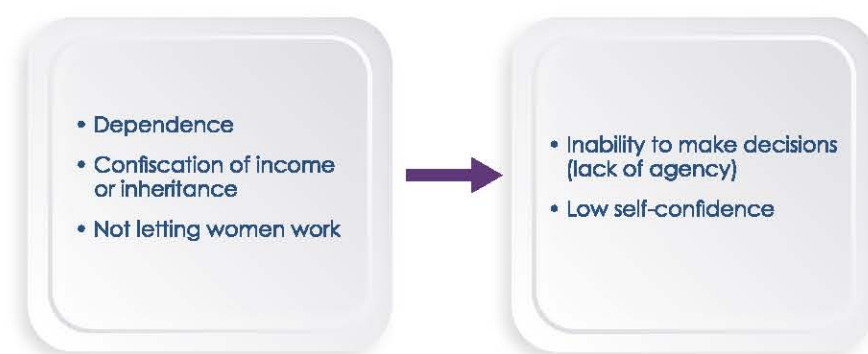
Violence. The experience of violence violates women's sense of safety and security, particularly when violence occurs in their homes or from someone who has control of needed resources, such as an employer. Women who have experienced any type of violence also experienced severe psychological distress at higher rates, compared to those who have not experienced violence. Moreover, all forms of IPV experienced at any point in a woman's life are significantly associated with increased rates of distress. Nearly 80% of women who have ever experienced each dimension of IPV had severe psychological distress in the past 30 days, compared to 65-68% of women who did not experience the same form of violence. The proportion of women who demonstrated severe psychological distress associated with the same forms of IPV in the past 12 months is nearly identical.

Economic Violence and Its Relation to MH

Of the women who reported that they had ever experienced economic IPV, 78% demonstrated severe psychological distress in the 30 days preceding the survey compared to 66% who had never experienced economic IPV. For those who experienced this violence in the past 12 months, 80% suffered from severe distress compared to 66% who did not experience economic violence within the year. While the FGD participants did not specify the perpetrator, they did list a series of associated mental health symptoms with economic violence. This included low self-confidence and an inability to make decisions.

⁴Somatization is the manifestation of psychological symptoms as physical symptoms, e.g., headaches, nausea, fainting, backache, cardiac arrhythmias, etc.

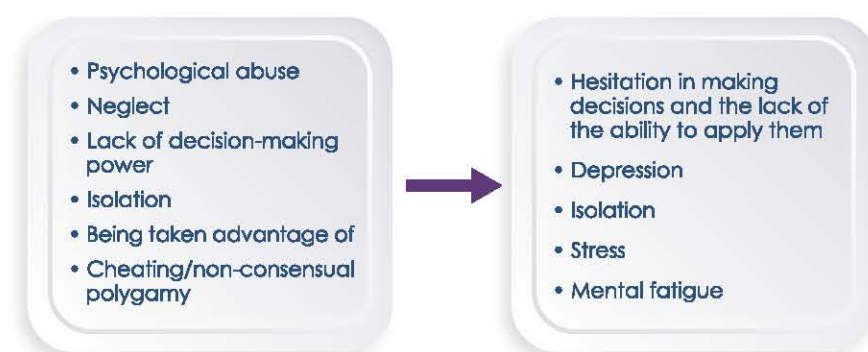
Figure 4: FGD Participants' Description of the Relationship between Economic Violence and Mental Health



Emotional/Psychological Violence and Its Relation to MH

Similarly, among women who have ever experienced emotional violence from a partner, 80% demonstrated severe distress while 65% of women who have never experienced such violence demonstrated the same level of distress. For those suffering current emotional violence, severe distress affects 81% in contrast to 69% of those who have not endured emotional violence from their partner during the same time period. FGD participants validated this, hinting at mental health symptoms such as depression and stress in association with emotional violence.

Figure 5: FGD Participants' Description of the Relationship between Emotional/Psychological Violence and Mental Health

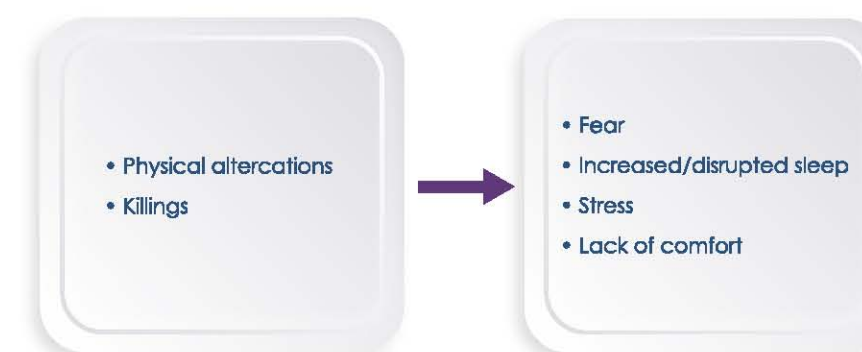


Physical Violence and Its Relation to MH

Violence that threatens women's bodily integrity has the same effect on mental health. Seventy-nine percent of women who have ever experienced physical IPV and 81% who have experienced physical IPV in the past 12 months also suffer from severe psychological distress,

compared to about 68% of those who have not experienced physical IPV during the same time periods. FGD participants indicated additional symptoms such as fear, increased or disrupted sleep patterns, stress, and discomfort.

Figure 6: FGD Participants' Description of the Relationship between Physical Violence and Mental Health



Sexual Violence and Its Relation to MH

As with physical violence, 81% of women who experienced sexual IPV in their lifetime or in the past 12 months suffered from severe distress compared to a smaller proportion of women who did not experience sexual violence in the same time periods (67%, 68% respectively).

Non-partner sexual violence experienced at any time in a woman's life is also significantly associated with increased rates of severe psychological distress. All women in the survey group who have experienced attempted or completed rape suffered from severe psychological distress compared to around 69% of women who did not report having these experiences.

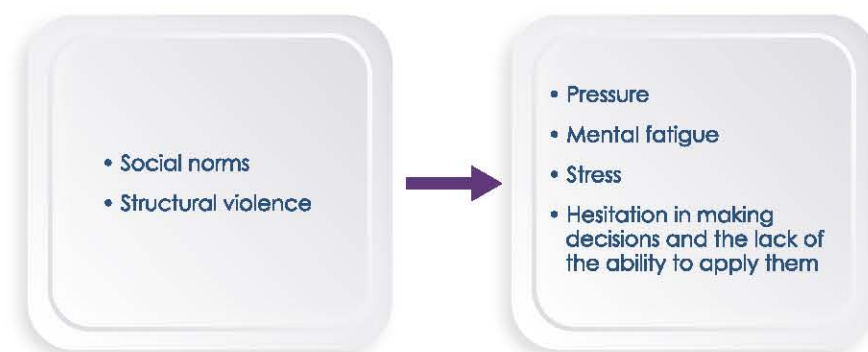
Women who have been propositioned for sex in exchange for access to resources (transactional sex) have nearly similar high rates of distress as those who have experienced rape. Of the women who have ever been exposed to such a proposition, 93% suffered from severe psychological distress compared to 68% of those who have never had such an experience. In the multivariate analysis, all violence variables lost significance, except transactional sex. Women who have been offered money or other favors in exchange for sex were four times more likely to experience severe psychological distress than women who have not had that experience, when controlling for all other significant variables. This may reflect a double emotional burden of sexual violence and the emergence of a complicity behavior in their own violation.

Social Norms and Social Violence and Their Relation to MH

While survey participants were not asked about harmful social norms or structural violence, FGD participants heavily emphasized the relationship between these types of violence and

mental health symptoms such as “daghet,” mental fatigue, stress, and hesitation in making decisions.

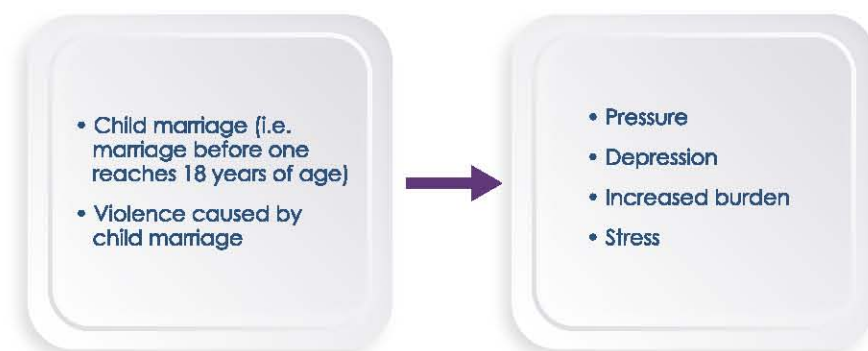
Figure 7: FGD Participants' Description of the Relationship between Social Norms/Violence and Mental Health



Forced child marriage. One of the highest rates of severe psychological distress is among women who experienced forced child marriage. Among these women, 89% have severe distress compared to 72% who married later with consent. Women who had experienced forced child marriage were three times as likely as those who did not to have severe psychological distress on bivariate and multivariate analyses with all other partnership characteristics. Forced child marriage is likely to impact mental health as a violation of trust and security within the parent-child relationship while also forcing girls into a sexual relationship they have no power to refuse. This was echoed among FGD participants, who pointed to a link between child marriage and “daghet,” depression, and stress.

Child Marriage and Its Relation to MH

Figure 8: FGD Participants' Description of the Relationship between Child Marriage and Mental Health



Other Types of GBV and Their Relation to MH

The FGD participants provided further insight into the MH consequences of GBV, pointing out the bidirectional relationship between GBV and mental health. Specifically, GBV can cause mental ill-health, and that mental ill-health can exacerbate or lead to violence. IPV was unambiguously reported to have this kind of reciprocal relationship with feelings of anger, pressure and irritability. The participants noted the cyclical nature of violence and mental health, saying, “Psychological health can be [both] a cause and a consequence [of violence].”

A service provider in the Bekaa observed that all types of GBV may coexist in one relationship, and that they all cause despair, exhaustion, worry, and mental fatigue, and a community member in the North emphasized the interplay of GBV and environmental stress, which triggers nervous breakdowns. While there were very few mentions of non-partner violence in relation to mental health, one woman in the Bekaa spoke about the fear she feels of someone sexually assaulting her daughter when she leaves the house, and another said that when a man sexually harasses a girl, the girl gets blamed and then becomes afraid of going out. This participant further stated that if a woman “went out to buy stuff and someone followed her, they wouldn’t say that the problem lies in his personality; they would [simply] claim this wouldn’t have happened if she wasn’t kind and soft and gave him her approval to do so.”

There was a heavy emphasis throughout the FGDs on intra-familial violence or parent-to-child abuse or child maltreatment and the effect of divorce on mental health, questions that were not asked in the structured survey. Some participants pointed out that interference and violence from parents (e.g. forced marriage) lead to divorce. A community leader in the North highlighted this, saying, “When I visit the religious court, I mostly hear about marriages ending because of parents forcing a certain man on their daughter. Also, parents force their 18-year-old daughters to marry much older men for their financial status.”

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Divorce is both caused by
and causes compromised
mental health.
FGD with service providers in the North

Environmental vulnerabilities relationship with MH.

Environmental vulnerabilities are an important factor influencing mental health among study participants. 77% of the women who reported experiencing any environmental vulnerability, demonstrated severe psychological distress compared to 22% among those who did not report any vulnerabilities. Furthermore, the proportion of women experiencing severe distress increased with each additional vulnerability, ranging from 22% of women with no environmental vulnerabilities to 94% of women who said they had serious problems due to all five.

Findings of the multivariate analysis showed that the number of environmental vulnerabilities – reflecting the amount of stressors on the woman and her household and challenging her ability to access resources – outweighed all other characteristics in their influence on mental health. Compared to women who reported no environmental vulnerabilities, women who reported one were more than five times more likely to suffer from severe psychological distress and women who reported having five environmental vulnerabilities were more than 100 times more likely.

Serious problems affecting women's ability to move safely in public and private spaces to attend to needs were associated with the highest rates of severe psychological distress among participants. Safety and security where they live was the most important single vulnerability in terms of mental health for women in the survey. Of those who reported having serious problems related to safety and security, 85% demonstrated severe psychological distress compared to 56% of women who did not list this as a serious problem. Similarly, 83% of women who said they have serious problems with physical health and 82% of women who have serious problems with safe access to a clean toilet demonstrated severe distress compared to 51% and 66%, respectively, among women for whom these vulnerabilities did not pose a problem. Notwithstanding the indicator for having any vulnerabilities, women who reported serious problems due to safety and security where they live or due to physical health or disability were significantly more likely to demonstrate severe psychological distress when controlling for all other variables, i.e. 2.8 and 2.4 times, respectively.

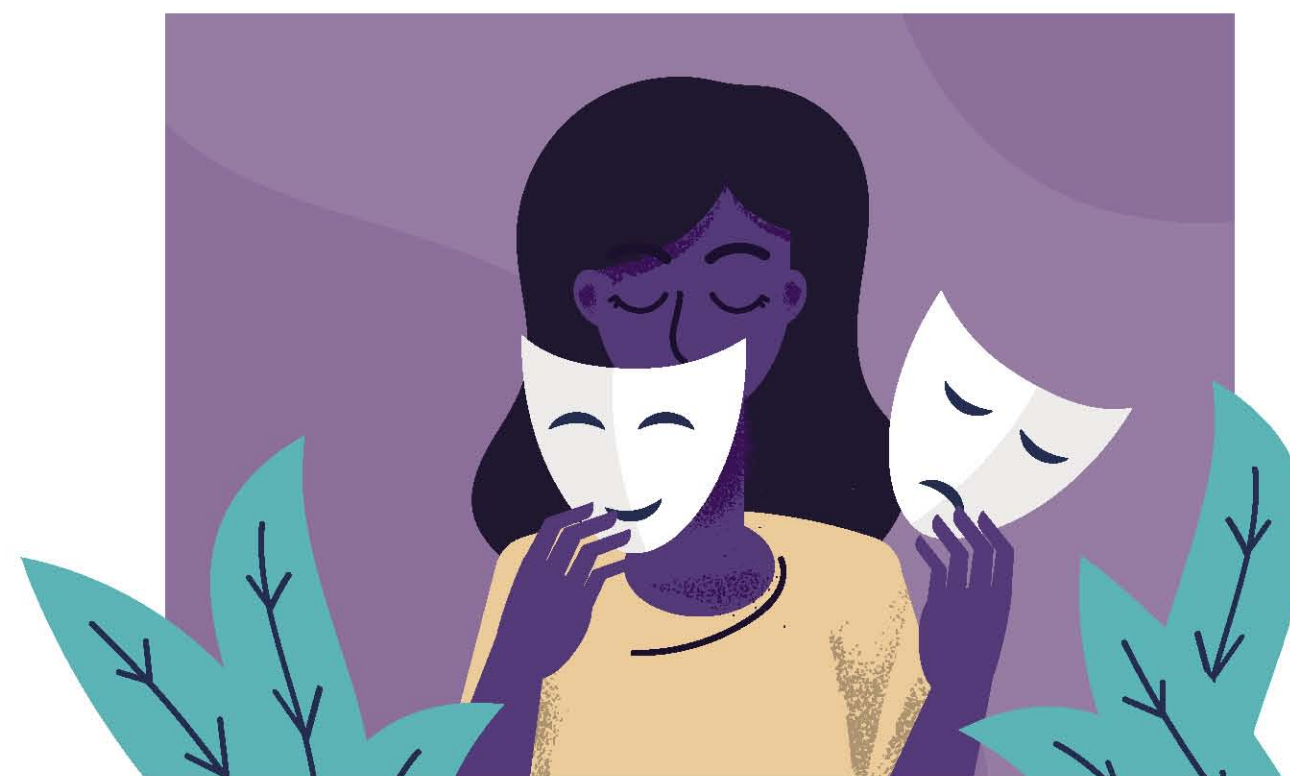
Though slightly less severe psychological distress was associated with food insecurity and separation from family, eight out of ten women who reported these as serious problems also had severe distress, compared to 51% of women who did not report problems with food insecurity and 59% who did not report serious problems due to separation.

Community members in both regions, as well as service providers in the North, noted that violence in the family or by parents toward their children is exacerbated by economic factors and often coincides with IPV and other forms of GBV, all of which affect the dynamics of the family as a whole, as well as the mental health of those who are being victimized. This includes the mental health of children, mothers, and fathers. These factors often occur with environmental vulnerabilities such as lack of access to financial resources, which cause tensions that can break up families and cause worry, anxiety, or overall compromised mental health. Male community leaders in the North also referred to the impact that divorce (and

the tension or fights that occur between spouses prior to divorce) "traumatizes" children. This, however, was discussed by the same group who said that women's financial stability (independence) gives her a sense of entitlement that allows her to get divorced when she and her husband fight. It is unclear if the "fighting" includes violence or is just limited to verbal arguments, and if this links back to rhetoric about controlling women through their children, or 'victim blaming' when women walk out of relationships because they are abusive.

To complement this, the qualitative data provided insight into how different forms of GBV (though not disaggregated by perpetrator), might affect mental health. The Figures 4-9 above show the reported relationship between social violence, emotional violence, physical violence, economic violence, and child marriage and mental health.

The interaction between the types of violence mentioned and their described effects on mental health were grouped, in the qualitative analysis, into the categories below. The way each type of violence manifests itself and its effects on one's mental health are outlined in the diagrams below. The multivariate analysis of the survey also demonstrated that environmental vulnerabilities constituted an important factor in women's mental health and outweighed most other characteristics when evaluating the risk for severe distress. This was echoed in the FGDs, where participants systematically referred to the devastating effect of poverty and lack of access to resources on their experiences of violence and mental health.





COPING AND SERVICE SEEKING

Both the qualitative and quantitative tools of the study asked women about different tactics used to help them cope with experiences of violence and services they have sought from ABAAD and other actors.

Coping

Most surveyed women (92%) said they tried to find comfort in their religion to cope with violence and around three quarters took active coping measures, seeking advice about what to do (78%) and emotional support from people close to them (72%). Fewer than half of the women (46%) said they try to accept that the violence has happened and cannot be changed. The survey, however, does not indicate the effectiveness or perceived helpfulness of these coping mechanisms. The FGDs provided more contextualized details than the survey about both the types of coping mechanisms that women tried to use to cope with violence, as well as their effectiveness (using the participatory approach of free-listing). Praying was the only reported overlap between the survey and FGD participants. While very few women reported relying on praying as a coping mechanism, one woman described her experience in using spirituality to cope with her day-to-day experiences: "I go up to the edge of the valley, and I talk to God. I sit down, drink a cup of maté, smoke a cigarette, scream my lungs out, and then go back."

Women community members cumulatively listed sixteen coping mechanisms, ranging from efforts that rely on one's ability to adapt (i.e. organizing, communicating, staying alone, sleeping, having inner convictions or "ane3a nafiyye," reading, listening to music, withstanding the situation, letting things out, or going out of the house), to efforts to change one's external environment (i.e. looking for jobs and calling ITS camp leader "shewish"), to unhealthy coping mechanisms such as projecting onto the children, using violence, smoking cigarettes or hookah "arguileh" (which some participants said "make you relax"), and using pain relievers or other medications.

The coping mechanisms that were reported as helpful by most participants were finding a job, calling the "shewish" or community leaders in the ITSs (who are responsible for the camp's security), and using pain relievers or other medications. Other coping mechanisms such as crying about it or letting it out were described as "of no use" because the "sorrow remains inside." One participant said that she finds "nothing beneficial."

Formal and Informal Service Seeking

Somewhat fewer surveyed women sought help from GBV and other actors than took active coping measures. Similar proportions of Lebanese and Syrian women sought help from any organization (69% and 71%, respectively). Among women who sought services, the type of service engaged was significantly different when analyzed by nationality and governorate.

A larger proportion of Syrian women (78%) engaged psychosocial support and MHPSS than Lebanese women (69%). This most likely reflects the sample's make-up, which comprised women, the majority of whom are Syrian, who have accessed psychosocial services.

The gap in MHPSS services was more pronounced by location, with 86% of women from the Bekaa region seeking these services compared to 61% on the North. Again, this reflects the sample distribution among ABAAD's service population in the two regions. The FGDs provided some insight into MHPSS services, where groups from both regions reported awareness about MHPSS services though it is unclear whether these services were accessed, since many participants in all groups also reported stigma related to these services. While Lebanese women and women in the North sought educational and vocational training more often (16% Lebanese vs. 8% Syrian, 22% women in the North vs. 8% women in Bekaa), Syrian women more often looked to healthcare providers (8% vs. 3% among Lebanese women). Healthcare engagement was similar in both regions.

Barriers to Service Seeking

Not knowing about violence support services was the primary barrier among women reporting they did not seek services in response to violence. Overall, 31% of women said they simply did not know about the available services. This lack of knowledge was more important in the Bekaa region where 35% of women listed it as their primary barrier, compared to 25% in the North. This was not reflected in the FGDs, where primary reported barriers related to social or legal barriers, financial barriers, or the structure and responsiveness of the services themselves (see diagram below).

A similar proportion of surveyed women (27%) said they did not believe they needed services. Lack of need as the primary barrier was more common in the North (30%) and among Lebanese women (32%) than in the Bekaa or among Syrian women (both 24%). Less common though related, 9% of women said the primary reason for not seeking help was because their condition was "not serious" enough to warrant taking such a step.

Though reported at much lower rates than knowledge and beliefs about services, 5% of women said they were prohibited by their family or husband and 6% chose not to seek help because they feared retaliation if they did. The FGDs yielded inverse results, where more participants reported that their husbands would not allow them to seek services than reported not knowing about these services. Lebanese women and, more specifically, women in North Lebanon, reported these as primary barriers far more frequently than did Syrian and women of the Bekaa region. Seven percent of Lebanese women said they were not allowed and 8% feared retaliation compared to 4% of Syrian women who reported either reason. When analyzing barriers by region, in the Bekaa 1% of women reported being prohibited and 4% said fear was a barrier compared to 12% and 8%, respectively, who cited these in the North. Given all women surveyed had accessed at least psychosocial support services from ABAAD, it is likely these barriers would be much more prevalent among the general population.

NOT KNOWING ABOUT
VIOLENCE SUPPORT SERVICES,
OR BELIEVING THEY DID NOT
NEED SERVICES, WERE THE
PRIMARY BARRIERS AMONG
WOMEN REPORTING THEY DID NOT
SEEK SERVICES IN RESPONSE
TO VIOLENCE.

“

There is lot of deficit in the services available to the people who are facing violence. You feel that there are some NGOs working towards stopping violence, but these services that are being provided either for women or girls do not covering all aspects of the problem. For example, you see a woman who needs help with a law matter, but the law protects the Syrians and not the Lebanese and vice versa. Even when it comes to psychological health, there isn't everything, like enlisting the help of psychiatrists, it's expensive as you know.

FGD with service providers in the North

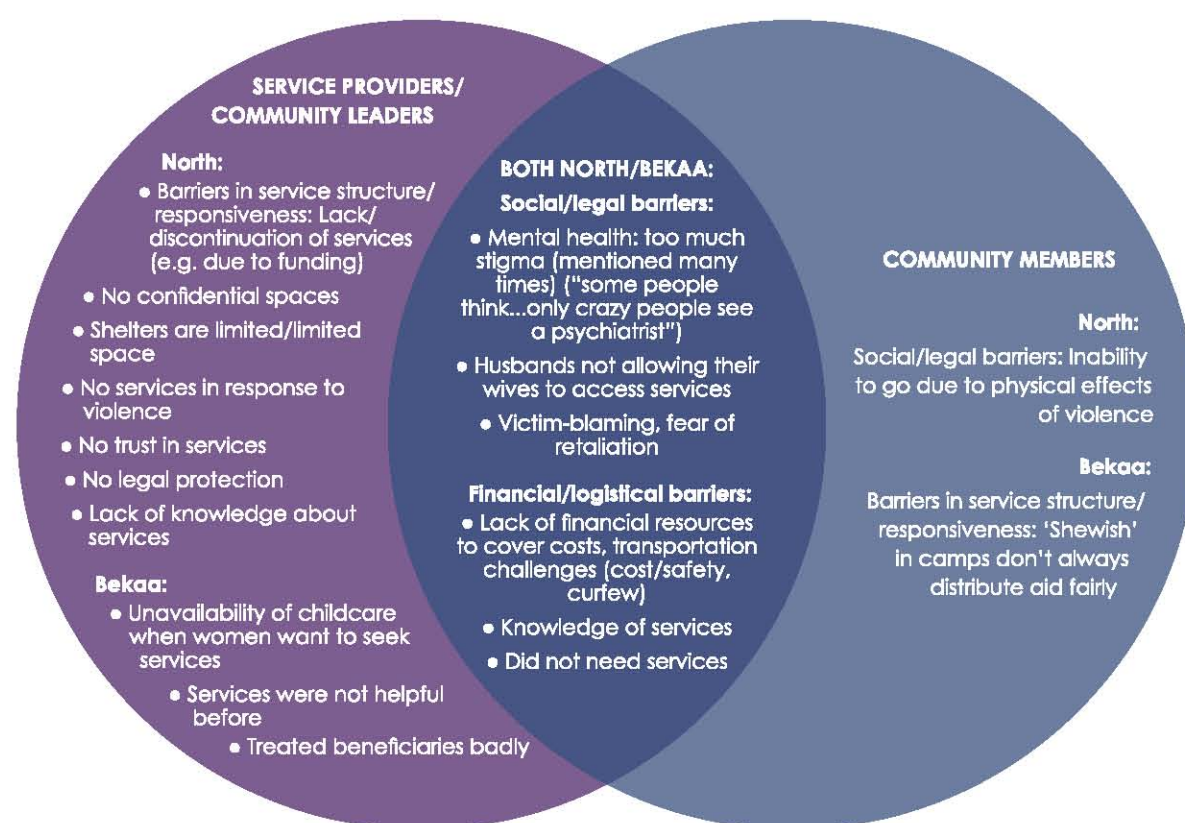
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These specialized service providers are often too quick to prescribe medications or relaxants such as benzodiazepines.

FGD with service providers in the North

Figure 9 below is a Venn diagram that highlights the barriers reported by study participants to GBV and MH services. The responses to the left are by service providers/community leaders; the responses by community members are to the right, and in the middle are responses shared by both. There was very little overlap in reported barriers between survey and FGD participants. The FGD responses are in black, the survey responses in blue, and the overlapping responses in orange.

Figure 9: Barriers to Service Access among FGD Participants



When asked about factors supporting service access, the largest proportion of women (47%) mentioned knowing about services targeted to people of their background and status as the primary support. This varied between women of different nationalities, with 52% of Syrian women naming this as the primary support compared with 39% of Lebanese women. Clear and accessible information was the primary factor for 15% of women, though information was more important among women in the Bekaa region (20%) than in the North (9%).

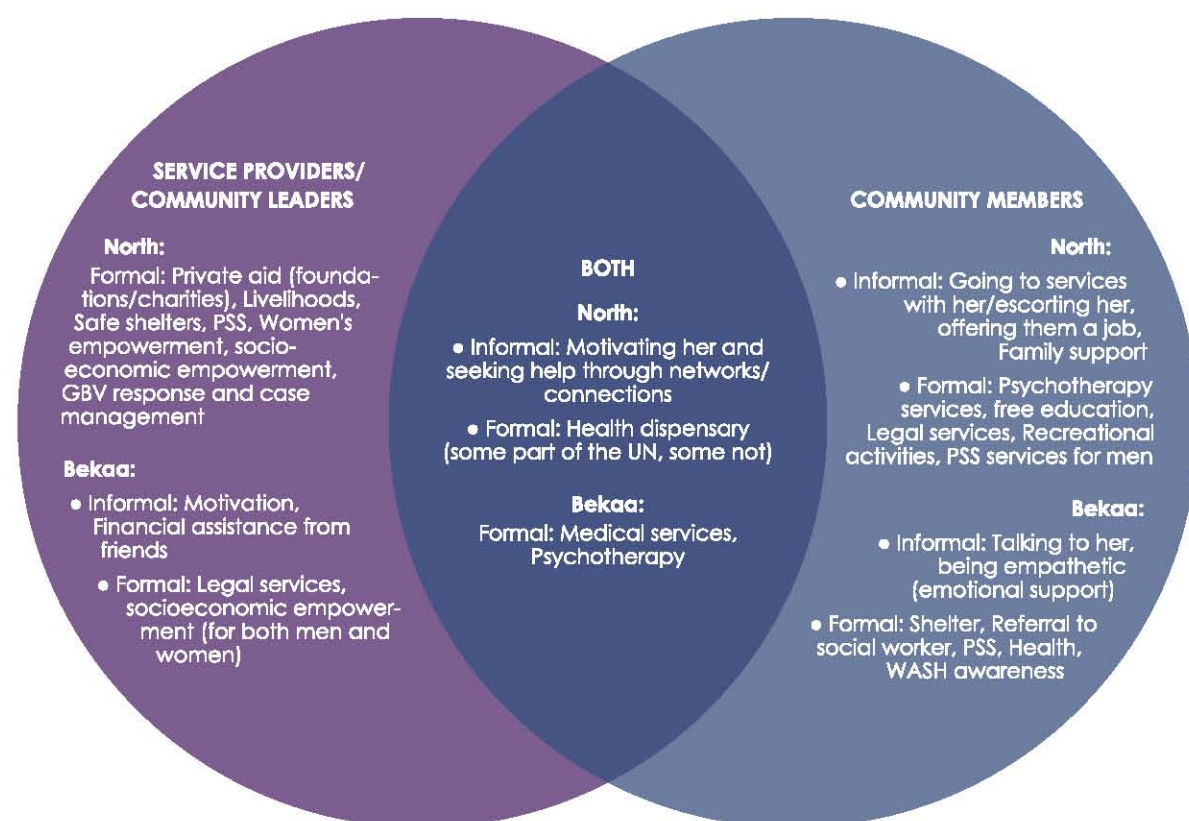
In terms of reported facilitating factors reported in the FGDs, all participants noted proximity, family support, holistic "one stop shop" services, and low- or no-cost services support access.

In addition, community members noted that availability of childcare and provision of transportation (Bekaa), in addition to increased service provider outreach, facilitated their access to services. Community leaders in the Bekaa and North noted the importance of direct referrals from one service provider to the next—with the client's consent—and which is preferable to only informing the client and expecting him or her to take the initiative of making the call. Confidential space and client escorting (if he/she requests/agrees) were also named as factors that make accessing services easier. A community leader in the Bekaa highlighted that it's necessary to provide survivors with a "private space, because she won't accept having this person in her house, so we would have to leave the tent and inform them [of the psychologist] in a safe place, with secrecy promised," and another noted that mental health specialists need to be "qualified. It's not easy, because sometimes the situations are turning upside down" as a result of unqualified practitioners.

Available services and service providers

Below is a Venn diagram showing awareness of all available formal and informal services (not limited to GBV/MH) by the different groups engaged in FGDs. For example, if a service was mentioned by both service providers/community leaders, and community members, it is in the middle ("Both") circle. While this is based on a small number of qualitative discussions, it is included herewith as it may be helpful in suggesting where awareness-raising activities have had success and where future activities should be targeted. See Annex for the list of cited service providers by region and type of participant, keeping in mind that these might not reflect population-level knowledge of service providers.

Figure 9: Barriers to Service Access among FGD Participants



Overall, service satisfaction was high among surveyed women who did engage services; 92% said they saw positive changes as a result. This rate was consistent when analyzed by both nationality and region. As all respondents were interviewed at centers of the NGO from which they had received services, this may in part reflect response bias.

Limitations

While the main purpose of this study was to gain a better understanding of this relationship amongst survivors in Lebanon, as well as how survivors' MH affects access to formal or informal services, it also aimed to navigate the safest and most ethical way to do so. Because of the sensitivity of the subject, lack of a national census or population database, and structure of ITSs in Lebanon, these constitute service-based data deriving from a random selection of ABAAD's clients, rather than from the general population. Collecting representative data on all women residing in Qobbeh and Northern Bekaa posed several challenges: 1) the last population census was conducted in 1932 [36] and 2) the systematic sampling in ITSs is not possible as a result of having multiple-family tents. For example, the data collectors who were instructed to choose every third tent to interview would meet with numerous hurdles in doing so systematically since tents are placed arbitrarily where there is enough space for them, and would have to choose which member of a multiple-family tent to interview, thus introducing biases into the collected data.

Collecting data on service users provides more action-oriented results that allow us to better understand, and thus serve, our specific population's needs. This study, however, should be viewed in light of its limitations. First, it targets ABAAD's service population in two areas: North Lebanon (Qobbeh) and Northern Bekaa (Labwe, Arsal, and Baalbek), both of which are highly underserved and at times difficult to access for security reasons. All participants were adult (>18) ABAAD's female service users in these areas accessing PSS services, but not case management services. Case management recipients were excluded because of the sensitive nature of these services and the high-risk of re-traumatization for right-holders with the most severe cases. This should be kept in mind, as the prevalence of GBV and mental ill-health might be greater or more severe in our service population than the results actually convey. It is also imperative to note that the rates of GBV and MH among our participants may have changed significantly since data collection in May 2019 as a result of the ongoing political and economic instability.



DISCUSSION

In terms of the sociodemographic results, many of the participants were married early, with the median age for marriage being 18. This may be the result of either social pressure to marry early in Lebanon, or financial pressure, as is the case with many refugee families. It is important to note that many of the refugee women who reported child marriage were married prior to their relocation to Lebanon, but that this does not necessarily reflect the reality in Lebanon, as many young child brides might not have access to ABAAD's services or to any other. There are also high rates of early child-bearing, as it is perceived that the role of the wife in a marriage is confined to bearing children. In some contexts in Lebanon, the greater the number of children borne by a woman, the "higher" that woman's value becomes. It is also to be noted that sexual and reproductive health and rights services in Lebanon are sparse, and that this might add to the young age for child-bearing as well as to the number of children borne by a woman.

While 15% of participants reported some form of employment, Lebanese participants reported higher rates than Syrians did. Additionally, the main income source for Lebanese participants was their husbands, while for Syrian participants it was humanitarian aid. This is a direct result of the legal labor framework in Lebanon, which restricts work for Syrians to three sectors, namely construction, agriculture, and cleaning [37]. It can also be attributed to sociopolitical factors that limit refugees' participation in the Lebanese labor force [31,32]. Recently, as a result of the declining economic situation, there have been further cuts with regard to work and income opportunities for both refugees and host community members, which participants in the FGDs already indicated as a primary source of concern.

This is linked to the reported environmental vulnerabilities of ABAAD's service population, 90% of which reported a serious problem with safety, food security, separation from family members, access to clean toilets, or physical health. As described in the FGDs, safety considerations included overcrowded tents, sometimes with multiple families, coupled with unemployment and "too much free time", safety in public spaces such as public transportation, as well as arbitrary detention. These considerations were reported mainly by Syrian refugees, whose legal and socioeconomic status prevents them from seeking formal shelter, and at times puts them at risk of detention by security forces [38]. Both Lebanese and Syrian women in the FGDs mentioned the cyclical nature of physical health and mental health, and how having chronic illnesses or physical ailments can prevent them from taking care of themselves, as well as how mental health can manifest as physical symptoms.

While Syrian refugees reported higher rates of environmental vulnerabilities than Lebanese women did, it is unclear how this has changed since the data were collected. Since May 2019, political and economic events such as the resignation of the Lebanese government, country-wide protests, and economic collapse have affected all those residing in Lebanon, whether the host or the refugee community.

Since much of the research in Lebanon mainly focuses on refugees, the types of vulnerabili-

ties among the Lebanese population require further investigation. Anecdotal evidence from ABAAD's staff indicates that vulnerabilities have significantly increased among all residents of Lebanon, with many losing their sources of income, and with women reporting higher rates of GBV (both IPV and NPV), as well as mental ill-health. This was further exacerbated by the COVID-19 pandemic, which accelerated the economic collapse, isolated GBV survivors with their perpetrators, and created physical barriers between affected persons and their support systems. In addition, many services were suspended or adapted during the pandemic, leaving survivors with limited access to life-saving services. Humanitarian services will also likely be scaled down as a result of the global health crisis and budget deficits in donor countries.

IPV differed slightly by nationality. Whereas the highest reported form of IPV was emotional among the Lebanese participants (54%), the economic form was the most highly reported among Syrian participants (55%), with all other forms of violence being reported in higher rates by Syrian participants than by the Lebanese ones. While the reported rate of economic violence among Syrian refugees may be attributed to social norms, legal status, or feelings of safety, higher rates of emotional violence among Lebanese respondents may be a result of priorities. Namely, Lebanese participants' husbands have more opportunities to be employed (for legal reasons), and thus do not necessarily have to engage in IGAs (as per gender norms in Lebanon), and might not experience denial by their husbands in the event they did so. Hence, the Lebanese participants might be more inclined to focus on emotional violations as types of violence, or as violations that are significant to report. It is unclear, however, why there is a significant difference in rates of physical and sexual violence among Lebanese participants (37% and 28%, respectively) while these rates are almost identical among Syrian participants (40% and 39%, respectively).

Factors pertaining to economic IPV raised an interesting question, particularly that of work and income. In a publication by the World Bank, Kiplesund and Morton (2014) [39] highlight the mixed impacts of economic empowerment on rates of GBV. A systematic review indicated that "five studies found protective associations and six documented a risk association between women's involvement in income generation and experience of past year violence." [40] While this study does not focus on economic empowerment and GBV, ABAAD's service users who engaged in IGAs were more likely to experience GBV, which could be attributed to gendered social norms and masculinities, and also to both the survivor and perpetrators' past engagement in "protective activities" such as gender sensitivity trainings.

Women working and controlling the household income reverses rigid social norms that cast men in a position of power through control of resources, threatening men's masculine identities and social standing particularly in an area of high male unemployment. Physical and sexual domination may be an attempt to regain power in these situations. Men's work status is one factor in meeting rigid norms of masculinity and a significant factor associated with physical and/or sexual violence. Almost half (47%) of women whose husbands were currently unemployed reported experiencing IPV during the past 12 months, compared to 38% of those who reported their husbands were employed at the time of the survey. Current unem-



ployment was not a significant factor in lifetime IPV, which may be due to violence varying with episodic work in a population that has high male unemployment.

As for NPV and its exacerbating factors, we found that participants in the North, as well as younger participants in both regions, reported higher rates of non-partner sexual assault. Participants in the North also reported higher rates of transactional sex. And while it's always challenging to know the 'true' prevalence due to stigma, fear, and other factors that lead to under-reporting, it is likely rates of non-partner physical and sexual violence – and particularly sexual violence – may be lower among this service-based sample than ABAAD's entire service population, as it excluded women accessing case management services.

The third dimension with regard to the results pertained to mental health. While the survey used a specific screening tool for psychological distress, the FGD guide offered participants a greater flexibility in describing mental health in their own words and through their own experiences. The survey showed that 70% of participants experience severe distress, and the FGD free-listing yielded contextualized results and phrases such as "daghet", which can loosely be translated into pressure or worry, and "ghadab," which can loosely be translated into "anger" or "fury." While in the English language, these terms may not translate to mental ill-health symptoms, it is crucial to take into account two features inherent in the Lebanese context. The first is that people tend to undermine, and thus understate, mental ill-health symptoms as a result of stigma and social pressure to "stay strong" or "pull oneself together" (culturally referred to as "shed halak/shedde halik"). As to the second one, participants' descriptions consisted of chronic experiences, and not the pressure or worry one feels for a moment, or the anger one feels in response to a specific incident.

It is worthwhile pointing out that Syrian participants reported higher rates of psychological distress (80%, versus 55% of Lebanese participants), and that they are twice as likely to experience distress. This can be attributed to unstable living conditions, legal status, as well as other socio-economic factors such as financial instability, though it is unclear how these dynamics have changed since the onset of the economic crisis in mid-2019. This aligns with other studies that highlight the importance of environmental factors for mental health. A 2018 study by Segal et al. [28] measured mental illness prevalence among Palestinian and Syrian refugees in Lebanon and found that over half of refugees experience serious mental illness, PTSD, or both. However, environmental factors similar to those listed by ABAAD's service users (e.g. stable housing and paid employment) accounted for a 79% and 66% reduction in the risk for mental illness, respectively.

The association between GBV and MH was noted by FGD participants as well as by ABAAD's staff as having a bidirectional relationship in which environmental factors also play a key role. Among these associations, the highest rates of distress were reported among women forced to marry under the age of 18 (89% have severe distress compared to 72% who married later with consent), though most (78%) of early married Syrian participants were married prior to the Syrian conflict. When controlling for other significant variables, such as environmental factors, forced child marriage (FCM) loses its statistical significance. While the

risk of mental ill-health symptoms is quite high for our population of forced child brides, other risk factors were associated with mental ill-health as well. It is important to note the co-occurrence of different types of violence, and to keep in mind that this study does not assess causality between GBV and MH, but tries to understand relationships and risk for distress. In Lebanon, financial instability and other environmental factors are reported to be a leading risk factor for child marriage and other forms of GBV; [41] hence, the mental health of GBV survivors should be considered in that framework since survey and FGD participants reported comparable environmental risk factors.

In order to gain a better understanding of the individual and structural response to GBV and MH, the survey and FGDs also focused on coping mechanisms and help-seeking behavior, specifically service-seeking. Interestingly, there was no significant relationship between coping and better MH among survey participants, though it might have been stronger if compounded with services. FGD participants echoed this—some stressors are better dealt with on a structural level than on an individual one. The survey asked participants to report coping mechanisms that they use, but did not ask if they were helpful, whereas the FGDs asked for both. There were also significant differences in the types of coping mechanisms listed in the survey versus in the FGD, suggesting that the types of coping in the survey might not have been helpful, but that the more "active" coping mechanisms suggested by FGD participants (e.g. actively seeking employment) are. As mentioned in the results section, the coping mechanisms that FGD participants found most helpful rely heavily on changing external factors such as employment status or personal safety or security, rather than on shifting internal perspective (e.g. acceptance), relying on a higher power for strength (e.g. praying), or using distractions such as reading, listening to music, or sleeping. This is unsurprising given the proven importance of environmental factors in determining GBV and MH outcomes.

When asked about other help-seeking behavior, almost 70% of participants referred to accessing services in response to their experiences of violence and mental health, with the primary hurdle being lack of knowledge about these services. This can be explained by the phrasing of question related to violence services (i.e. the survivor was asked to report services sought in response to experiences of violence or mental health, or to address issues related to these experiences⁵), and the manner in which ABAAD presents its services to people of diverse cultural backgrounds.

While ABAAD does offer services related to GBV and MH, it does not always frame its services using those terms. In some contexts in Lebanon, especially in the two research areas, it is not always culturally appropriate to talk about GBV or MH, so our services are framed as "support" services instead of GBV response or MH care service, and adapt the response to the right-holder's needs and cultural background. Another aspect that might have affected the response to these questions is stigma. This was validated by the FGD participants, who mentioned the availability of both GBV and MH services, but reported not being able or wanting to access these services as a direct result of stigma. Moreover, some of those who accessed these services might abstain from reporting.

⁵Question: We have discussed issues about women's health and about violence. Have you ever accessed services to help you address any of these issues?



The most highly reported facilitating factor for access to services was knowing that services target people of the same background. In Lebanon, humanitarian services are at times perceived by Lebanese communities as targeting Syrian refugees [42], which may serve as a barrier for Lebanese women. This may be mitigated in our sample population because women have greater access to information about other services. While 92% of the population reported a positive change as a result of services, this should be seen in light of response bias.

Recommendations to Improve Access to GBV and MHPSS Services



Humanitarian and Governmental Practitioners/Service Providers

1. Provide holistic, well-coordinated, low to no cost GBV and MHPSS services, with support for referral to tertiary care (i.e. in-patient or psychiatric care⁶)

Results presented in this report confirm the importance of a strengthened referral pathway between GBV and MH services, and community members' desire to create low to no cost "one-stop shops" for services. Some respondents indicated social, logistical, and financial barriers that may be overcome by providing holistic, diverse services at low to no cost and accessible in one space. This limits multiple visits, increased transportation costs, and time and energy spent moving from one provider to another. These holistic services should include GBV services for people with specific mental health considerations (and vice versa), and should be adapted to fit diverse age groups. Participants noted that services such as psychosocial support were often available to younger and middle-aged adults, but were not always accessible to children, adolescents, and older-aged people. Future programming should consider this and ensure that services are accessible to people of diverse age groups. Additionally, survivors accessing these services should be supported in accessing secondary and tertiary care when needed.

If consented by the service-user, referrals should be made directly to the service provider, through phone calls or in-person visits, rather than just providing information to the beneficiary about the service.

2. Conduct awareness sessions and campaigns on various forms of GBV, including victim-blaming and forced child marriage on community and service-provider levels.

A. Grassroots Awareness Campaigns and Sessions on Victim-blaming

Participants in the FGDs noted the effect of victim-blaming (blaming survivors of GBV for their experiences with violence and mental health) on their mental health and the perpetuation of further stigma. Service providers should continue to conduct community-level awareness sessions on gender and the root causes of GBV, as well as conduct trainings among service providers in order to mitigate victim-blaming on both levels. The community level sensitizations should be accessible to people of all genders, nationalities, ages, and locations. One utilized approach for this is using mobile services to reach the largest number of people. The service-provider trainings should be targeted towards all humanitarian actors, rather than just protection or mental health frontline actors, in order to encourage further access to both protection and mental health services. Management, programmatic, and support staff should be included in these trainings in order to make any necessary amendments to programs and be reminded of the importance of gender mainstreaming for all staff. Trainings should also include prevention and response to sexual exploitation and abuse. Given the current economic crisis, increased vulnerability of both host and refugee populations, and likely increased rates of GBV and mental health considerations, staff sensitization on GBV, PSEA, and survivor-centered approach is imperative to providing safe and accessible services.

B. Grassroots Awareness Campaigns and Sessions About the Physical and Mental Effects of Child Marriage on Young Girls

GBV service providers should continue to conduct community awareness sessions on the physical and psychological effects of forced child marriage on young girls, and how child marriage might be an indicator for future experiences of violence. Forced child marriage was one of the largest factors for psychological distress among survey participants. This was echoed by FGD participants, who referred to the immense pressure and burden of forced child marriage on girl brides, their relationship to the person they were married to, and their future children.

The service providers delivering sessions should have a contextualized understanding of their audience, and should preferably come from a similar background in order to foster trust and mutual understanding.

3. Engage with local communities when developing awareness and destigmatization campaigns on mental health

While there have already been campaigns by the National Mental Health Programme (NMHP) at the Ministry of Public Health (MoPH) on mental health, there should be more grassroots or community-based campaigns using terminology that is familiar and contextualized (e.g. "daghet" or "ta3ab nafse"). Our study found that the terms used to describe mental health (or ill-health) vary from the mainstream terminology (e.g. depression, "ikti'eb"). Many participants in the FGDs may understate their experiences with mental health by using softer terms or euphemisms (e.g. "daghet") to describe more severe symptoms (e.g. symptoms of severe anxiety). Campaigns by service providers, including humanitarian/civil society actors, private institutes, and governmental actors should tackle these issues in a contextualized manner and consult local communities on appropriate terminology.

4. Hire and train qualified, sensitive, and accessible service providers for mental health and other non-GBV related services (e.g. basic assistance, cash or food).

Service providers and governmental bodies should ensure that mental health services are low or no-cost, provide safe transportation and childcare for service users when necessary, and are geographically spread to cover vulnerable and underserved areas. FGD participants referred to the immense stigma related to seeking mental health services and to the lack of qualified service providers to support them with mental health considerations. One community leader in the Bekaa mentioned that safe spaces are often unavailable in the camps, and that mental health service providers are not taking sufficient measures to ensure confidentiality and comfort of the right-holders. One solution might be for service providers to create a mobile service that has a safe, confidential physical space for service provision.

Another issue is that some psychiatric service providers may be too quick to prescribe med-



ications such as benzodiazepines. Psychiatric services should be monitored for quality by technical mental health and psychiatric experts (within humanitarian or governmental bodies), and psychiatric services should be accompanied by psychotherapy when possible.

5. Assess and contextualize economic empowerment activities prior to implementation, and monitor service users throughout and subsequent to implementation

Given the conflicting nature of the effect of IGAs on GBV experiences, economic empowerment activities should only be conducted following a thorough assessment of the potential risks for GBV as a result of inverted gender roles. Previous research has highlighted that women who engage in IGAs may be at a higher risk of GBV because of existing gender roles, which dictate that men should generate income and women should engage in unpaid domestic labor. These inverted gender roles may put women at a higher risk of GBV. Therefore, economic empowerment activities should be paired with monitoring by GBV case or psycho-social support workers, particularly for non-residential services, or in case survivors still live with the perpetrators. And women's economic empowerment interventions conducted by non-protection actors – e.g. GBV actors – should integrate protection considerations into their programs and seek technical guidance from protection actors.

6. Target host, refugee, and migrant communities for GBV and MH outreach in case the project target allows for this, and mainstream social cohesion concepts into all activities so as to mitigate potential drop-out or low enrollment by host community members

If project targets allow, GBV and MH services should target all people residing in a country. This includes host, refugee, and migrant communities. Recent discussions between humanitarian partners highlight barriers to host and migrant community (e.g. migrant domestic workers) access to services, including limited knowledge about the services, as well as belief that these services do not target their demographic.

7. Ensure the availability of childcare services, particularly when targeting women

Participants pointed out that childcare was a barrier to accessing services, as they often do not feel safe or are unable to leave their children at home. On-site childcare services for children of all ages can act as a facilitating factor for women to access services.

8. Engage with more Syrian service providers, as Syrian right-holders have found it helpful in terms of relatability and comfort with the service provider

Refugees have specific vulnerabilities, and thus might feel more comfortable seeking support from service providers of a similar background when possible. This could take the shape of engaging Syrian members of humanitarian organizations in outreach or other services, or

working with other informal Syrian service providers or community leaders to build trust with refugee community members.

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