

Gender-Based Violence in Syria

Rapid Needs Assessment

December 2019



NORWEGIAN CHURCH AID



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ACKNOWLEDGEMENTS

We are grateful to each and every individual who contributed to the data collection process informing this rapid assessment: the consultants and field staff members who tirelessly coordinated and carried out the focus group discussion sessions, key informant interviews, and service mapping exercises; and all the service providers and local stakeholders who actively participated in and contributed to the discussion sessions and interviews.

Thank you all.

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DISCLAIMER

This study is based on quantitative and qualitative primary data collected directly from service providers working with women and men in Deir Ezzor and Hassakeh, as well as with women residents of Al Hol Camp in Hassakeh. Views expressed in this report belong to the individuals who shared them, and do not necessarily reflect the views of NCA, ABAAD, or GOPA-DERD.

Material and geographical designations in this report do not imply the expression of any opinion whatsoever concerning any political or legal status of Syria, its territory, or area, or the delimitation of its frontiers or boundaries.

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ACRONYMS

ABAAD	Dimensions
CM	Case Management
CMR	Clinical Management of Rape
CP	Child Protection
FGD	Focus Group Discussion
FI	Food Items
GBV	Gender-Based Violence
GOPA - DERD	Greek Orthodox Patriarchate of Antioch and all the East - Department of Ecumenical Relations and Development
IDP	Internally Displaced Person(s)
IED	Improvised Explosive Device
INGO	International Non-Governmental Organisation
IPV	Intimate Partner Violence
IRC	International Rescue Committee
ISIS	Islamic State of Iraq and al-Sham
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
NCA	Norwegian Church Aid
NES	North-East Syria
NFI	Non-Food Items
NGO	Non-Governmental Organisation
PTSD	Post-Traumatic Stress Disorder
PWD	People with Disabilities
SARC	Syrian Arab Red Crescent
SDF	Syrian Democratic Forces, alliance of Kurdish, Arab, and Assyrian militias
SCI	Save the Children International
SOPs	Standard Operating Procedures
SPs	Service Providers
SRH	Sexual and Reproductive Health
UASC	Unaccompanied and Separated Children
UN-OCHA	UN Office for the Coordination of Humanitarian Affairs

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EXECUTIVE SUMMARY

OVERVIEW AND METHODOLOGY

ASSESSMENT OVERVIEW

This report comes as an annexure to the “GBV Rapid Assessment in Syria¹,” also conducted by NCA, ABAAD, and GOPA-DERD in December 2018 and published in January 2019. Following secondary data review and informal field surveys with experts working on the ground, it was concluded that there were no noteworthy changes throughout the majority of Syrian governorates; findings from the “GBV Rapid Assessment” remained largely relevant, except in NES, where the latest developments resulted in numerous contextual changes. As such, this report’s particular focus is on the governorates of Deir Ezzor and Hassakeh (especially Al Hol Camp), to capture the resulting consequences.

GEOGRAPHICAL SCOPE AND SAMPLING OVERVIEW

A total of 18 FGDs took place with 146 individuals, of whom 80% were female and 20% were male. Discussions at Al Hol Camp took place with 33 women residents, aged between 19 and 65 (average age 36 years old).

Governorate	Location	Participants	# of FGDs
Hassakeh	Al Hol Camp	Women community members	4
	Khashman	Female/Male SPs	4
	Nashweh	Female SPs	4
	Hassakeh City Centre	Female/Male SPs	2
Deir Ezzor	Al Joura	Female/Male SPs	2
	Jubaila	Female/Male SPs	2
Totals	6	146	18

Simultaneously, a total of 89 Key Informants (52 working with women, and 37 working with men) were interviewed either directly in the field by GOPA-DERD, or through an online survey circulated by ABAAD, based on accessibility and availability.

SOURCES OF INFORMATION

- Available Studies and Assessments (secondary data)
- Validation Interviews with Local Experts (primary data)
- Key Informant Interviews (primary data)
- Focus Group Discussions (primary data)
- Debriefing of Field Teams

LIMITATIONS

- Limited scope of assessment and primary data reach due to very tight time frame
- Necessary censorship of certain sectoral and politically sensitive terminologies in the data collection tools to facilitate implementation on the ground
- Seeming hesitance around discussing taboo topics during FGDs

¹ Public executive summary available at this link: <https://www.abaadmena.org/documents/ebook.1550218420.pdf>

KEY FINDINGS

MAJOR SAFETY CONCERNS

Women: Attacks while conducting business outside the household, especially on the way to latrines, the market, or to receive services; domestic violence; sexual violence; and no safe spaces. At Al Hol Camp, domestic violence and other women (especially Hisba Women) were the most critical issues, followed by lack of safe spaces, camp authorities, attacks, no access to services, and sexual violence.

Girls: Sexual and domestic violence, deprivation of education. In Hassakeh, forced marriage and attacks while outside the household were also significant issues.

Boys: Major concerns in Hassakeh were deprivation of education, child labour, and domestic violence, while in Deir Ezzor, militarisation/forced conscription was most frequently cited.

Men: Forced conscription, violence by armed groups or at checkpoints, and violence in detainment.

MOST VULNERABLE GROUPS

In general, FGD participants emphasised the fact that no residents are safe, regardless of gender, elaborating that the safest practice is to avoid going out of their houses, shelters, or tents past the set curfew.

Women: In Hassakeh, women and girls with disability were at highest risk, while in Deir Ezzor adolescent girls were the most targeted group. Households with no adults were also at significant risk. In Al Hol, women working or dealing with NGOs were considered apostates and at risk of extreme violence or death.

Men: Men with Disability and young boys were at high risk in both governorates, while IDPs were at higher reported risk in Hassakeh than in Deir Ezzor. Men belonging to the LGBTQI community or men who did not conform to stereotypically masculine norms also faced high levels of social, domestic, familial, psychological, physical, and verbal violence. Reported to a lower extent, they were also victims of sexual violence, trafficking, and forced conscription.

MAIN TYPES OF VIOLENCE

Women: Physical, sexual, psychological, and verbal violence. Women at Al Hol mentioned high levels of economic exploitation, polygamy, and men marrying widows or divorcees and divorcing them after 2 weeks at most. To note is that while SPs said that there were significantly high cases of rape, the women were not as vocal about reporting rape, and one group was particularly insistent that “rape did not exist, and women initiated contact with men and offered sex in exchange for assistance or smuggling.”

Children: Physical, sexual and verbal were extremely high in Deir Ezzor, while physical, psychological and sexual were more common in Hassakeh. Deprivation of education occurred due several factors, namely economic, fear for safety, distrust of organisations, and closure of schools.

Men: Psychological, physical, forced conscription, and familial domestic violence (as opposed to IPV at a lower incidence).

CONTEXTS OF VIOLENCE

In general, both community members and service providers vocally expressed that security risks were omnipresent, in communities and camps alike. However, there were certain contexts or situations that were admittedly more dangerous, principally latrines and bathing facilities, conducting business outside the household (being found outside the house for any reason), and educational settings.

Factors contributing to the insecurity at Al Hol Camp were, in addition to the Turkish offensive, as reported:

- The presence of ISIS families
- Strangers accessing the camp at night

- The extremely strict laws in the camp that result in consistent clashes between the residents and the camp authority
- The high IDP influx and overcrowding of the camp, especially with ‘foreigners’ and people from different backgrounds
- No means for ensuring safety at the camp
- Weak safety and security strategies, if any, which are not implemented

VIOLENCE-INDUCED PROBLEMS ON SURVIVORS

Women and men survivors of violence in both governorates faced the same types of challenges, to somewhat varying degrees. Health complications (especially resulting from physical and sexual violence), and psychological challenges and PTSD were the two major issues. Survivors also faced problems with community, familial, and spousal rejection – although these were much more severe issues for women than for men. Economic challenges and thus difficulties securing income.

Men resorted to negative coping strategies like perpetrating violence against their families and increased use of alcohol and tobacco.

REPORTING GBV CASES

There were certain channels survivors could turn to in order to report violence, such as the local authority, police or security forces including Asayish and Women Asayish, and community centres.

However, there was a consensus that reporting never yielded positive results, neither in the sense of providing the survivor with justice, nor in terms of the almost certain backlash the survivor might face if she does report, especially in cases of rape or domestic violence.

AVAILABLE SERVICES

Several types of multi-sectorial assistance were reported, but in general, there were no specialised services for survivors of GBV, neither social nor medical.

Additionally, it was difficult to access even the existing services, due to the risks associated with travelling to the service points and concerns over leaving children on their own.

Women residents of Al Hol added that they were not permitted to leave the camp to seek medical services at the city hospital, and the medical units at the camp only provided consultations and painkillers.

COMMUNITY SYSTEMS FOR PROTECTION

Some community efforts comprised community patrols, where the families and local community members would take shifts to ensure a greater level of protection (Hassakeh City Centre), the Asayish guard collective shelters (Khashman and Nashweh) or the camp authority assigns night duty shifts to guards. Women in Al Hol have also taken steps to form their own safety groups, and usually take rotating shifts staying awake at night to guard sleeping members of the family.

COMMUNITY ATTITUDES, PRACTICES, AND NORMS

Overall, attitudes towards survivors of violence were largely negative, intolerant, and unsupportive, where they faced the rejection of their husbands, families, and community. This stigmatisation is not *“a product of the crisis; it existed before and continues now, especially in cases of rape.”* A few service providers in Jubaila and Hassakeh City Centre mentioned that *“in some exceptional cases, there is a slight improvement in the community’s outlook towards survivors, but it is still weak and very insufficient.”*

OBSTACLES HINDERING ACCESS TO SERVICES

Top barriers hindering access to services among women and men were survivor stigma, not being permitted by families to do so (women), patriarchal ideology that real men do not seek support (men), perceived lack of privacy and confidentiality, the lack of adequate services (medication, staff qualifications), priority being given to men (women), and no sufficient awareness of the available

services, or that they should seek them. There were no significant differences at Al Hol, but some respondents mentioned that women were afraid of the Hisba Women (ISIS female 'police') who considered people who associated with NGOs to be "infidels worthy of death."

RECOMMENDATIONS

SERVICE IMPROVEMENT

- Establish specialised centres that provide holistic care for GBV survivors
- Set up local networks that can provide referrals and reporting assistance
- Work towards organising local protection response
- Organise distribution processes to reduce incidence of violence
- Equip mobile units for outreach and service provision
- Increase awareness about safe shelters for survivors in life-threatening situations

CAPACITY DEVELOPMENT

- Build service provider capacities on quality SGBV response and confidentiality
- Train doctors, forensic doctors, and medical staff on CMR
- Avail community volunteers of capacity building opportunities

POLICY AND LOBBYING

- Raise awareness "for the community, by the community"
- Support local authorities or judicial bodies to develop clear-cut legislation and penal codes related to violence
- Public campaigning on rights of survivors

PUBLIC OPINION/BEHAVIOURAL CHANGE

- Regularly communicate available services and related updates
- Early prevention and community awareness
- Increase SRHR awareness
- Target men survivors and perpetrators through contextually sensitive "packaging" of services
- Raise awareness on the harms of child marriage
- Raise awareness on the importance of education

ACCOUNTABILITY AND COMMUNITY COHESION

- Donor agencies are recommended to carry out due diligence when allocating support
- Establish effective reporting mechanisms, and ensure beneficiaries are informed of them
- Provide assistance to host and IDP communities alike
- Implement economic empowerment activities and cash for work projects "to reduce risk of violence"

METHODOLOGY

ASSESSMENT OVERVIEW

Within the framework of the partnership between NCA, ABAAD, and GOPA-DERD, this *Rapid GBV Assessment in Syria* was conducted with the aim of understanding the reality on the ground with respect to gender-based violence perpetrated against women and girls as well as men and boys. Assessment findings aimed to provide a clear overview that would inform accurately targeted responses and programme design. The assessment extracted information from Syrian specialists providing direct services to local communities, and from community members themselves. This ensured that the rapid assessment would capture both, community perceptions, and service provider attitudes and practices, which would further reflect capacity building needs.

This report comes as an annexure to the “GBV Rapid Assessment in Syria,” also conducted by NCA, ABAAD, and GOPA-DERD in December 2018 and published in January 2019. Following secondary data review and informal field surveys with experts working on the ground, it was concluded that there were no noteworthy changes throughout the majority of Syrian governorates; findings from the “GBV Rapid Assessment” remained largely relevant, except in NES, where the latest developments resulted in numerous contextual changes. As such, this report’s particular focus is on the governorates of Deir Ezzor and Hassakeh (especially Al Hol Camp), to capture the resulting consequences.

GEOGRAPHICAL SCOPE AND SAMPLING OVERVIEW

Between November 20 and 24, 2019, GOPA-DERD staff and ABAAD consultants conducted Focus Group Discussions in a total of 6 locations: 4 in Hassakeh (*Al Hol Camp, Khashman, Nashweh, and Hassakeh City Centre*) and 2 in Deir Ezzor (*Al Joura and Jubaila*).

A total of 18 FGDs took place with 146 individuals, of whom 80% were female and 20% were male.

Each group had an average of 8 participants (between 7 – 9 participants per group), and were as follows:

Governorate	Location	Participants	# of FGDs
Hassakeh	Al Hol Camp	Women community members	4
	Khashman	Female/Male SPs	4
	Nashweh	Female SPs	4
	Hassakeh City Centre	Female/Male SPs	2
Deir Ezzor	Al Joura	Female/Male SPs	2
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The discussions at Al Hol Camp took place with 33 women residents, aged between 19 and 65 (average age 36 years old).

Simultaneously, a total of 89 Key Informants (52 working with women, and 37 working with men) were interviewed either directly in the field by GOPA-DERD, or through an online survey circulated by ABAAD, based on accessibility and availability.

SOURCES OF INFORMATION

This rapid assessment collated information from secondary and primary data sources.

Available Studies and Assessments (secondary data): Available credible and relevant previous assessment reports published mainly by UN agencies or inter-agency consortia dealing with GBV in Syria or within humanitarian or emergency settings. The assessment also heavily relied on UN-OCHA's *"Humanitarian Response Plan Monitoring Report"* (October 2019) for humanitarian contextual background.

Key Informant Interviews (primary data): KIIs were the main source of quantitative data, and focused on collecting feedback of service providers working with women and with men who were aware of the local demographics and contexts in their communities, as well as with the different types of GBV and protection-related services.

Focus Group Discussions (primary data): FGDs were the main source of qualitative data, which provided further background information to be triangulated with the quantitative findings. The FGDs in Al Hol Camp were conducted with women residents, while all other FGDs targeted service providers. Findings provided better insights on GBV perceptions, reporting, service delivery, needs, and gaps.

Debriefing of Field Teams: reports and semi-structured conversations with the field teams who carried out the data collection activities. The debriefing played a role in data validation and, where needed, in providing additional clarification and context.

TOOLS

The data collection tools related to the sources of information above were developed by NCA, contextualised for local and gender specificities and translated by ABAAD, reviewed by GOPA-DERD and approved by NCA prior to testing and implementing.

TRAINING AND DATA ANALYSIS

Prior to beginning the data collection phase, all contracted ABAAD consultants and GOPA-DERD staff members were trained on the use of the tools. ABAAD consultants were trained remotely over Skype and kept regular contact with ABAAD's focal points, while GOPA-DERD staff took part in face-to-face trainings carried out by GOPA-DERD technical staff.

LIMITATIONS

- **Limitations related to time constraints:** The allocated time for conducting the rapid assessment was extremely short due to submission deadlines, and took place within 15 days. As such:
 - o On the Whole of Syria level, the "GBV Needs Assessment in Syria" (published January 2019) was rapidly validated through key informant interviews with one local expert per location, rather than holding discussion groups with a larger number of service providers and front-liners, and is annexed to this NES-specific report.
 - o NES geographical locations were limited to Hassakeh and Deir Ezzor
 - o Limited participant reach due to the short notice, which affects acquiring a more comprehensive overview of services, practices, and behaviours within the surveyed communities.
- **Censorship of sectoral and politically sensitive terminology within the tools:** In order to avoid putting the data collection teams at risk, and to ensure the ability to implement in certain

locations, especially Al Hol Camp, certain key terms related to GBV (for example issues concerning rape, sexual assault, humiliation, and torture) and concepts that could be politically-sensitive (detainment, torture, and the use of the term “militias”) had to be referred to in a “milder” manner.

- **Discussion of taboo topics during FGDs:** During data analysis, it was noticed that key informants who filled in the questionnaire online mentioned sexual assault, rape, marital rape, sexual violence and humiliation as a tool of war and during detainment/torture. However, during FGDs, service providers and women from Al Hol insisted that they had not heard of any cases of rape. As such, there is a possibility that the FGD respondents may not have been comfortable speaking with complete and frank openness.

SITUATION OVERVIEW

Towards the end of 2018, the security situations and living conditions in Hassakeh and Deir Ezzor had begun to stabilise. While the economic situation was still weak, basic necessities were generally available.

After the military campaigns to push ISIS out of Deir Ezzor, humanitarian and development organisations were able to access the governorate and begin providing assistance and services to residents – albeit being minimal and insufficient. During December 2019, the governorate is reported to enjoy much more stability, security, and availability of resources.

In Hassakeh, some cities had faced destruction after offensives to free them from ISIS, but the rest of the governorate had generally enjoyed a stable security situation where resources were available, areas were accessible to NGOs for service provision, and cities were overall “flourishing.” During October 2019, with the onset of the Turkish offensive against the SDF, the security situation quickly plummeted, as did the economic situation, where there was significant inflation due to boycotting Turkish goods. On the humanitarian level, the offensive resulted in high death tolls, 300,000 IDPs, and new last-resort camps. Crime rates also increased, with kidnapping, murder, theft, feuds, and revenge killing becoming commonplace.

According to OCHA’s *2019 Humanitarian Response Plan*, between December 2018 and March 2019, Al Hol Camp, whose population stood at approximately 8,000 residents, saw an influx of almost 69,000 individuals fleeing military operations and airstrikes against ISIS in Deir Ezzor. As of mid-June 2019, the camp demographics comprised 91% women and children (67% under 18 years old). The camp’s population is 43% Iraqi, 42% Syrian, and 15% third country nationals.

Under ISIS control, access to essential services was limited to non-existent, which resulted in numerous IDPs arriving to Al Hol Camp in dire need of services. Despite the reduced waves of displacement since March 2018, coupled with intra-camp resident relocation, departures, and third-country residents being repatriated, the camp remains overcrowded with a gap of around 3,000 shelter plots.

At the camp, there are approximately 35 organisations delivering around 50 types of services, and three field hospitals providing in-patient support to 100 people, but several needs such as Protection and WASH remain critical (for example maintaining/upgrading latrines and water tanks, locating additional water sources due to its lack, and providing more specialised protection and GBV services). However, overall emergency thresholds are still within SPHERE standards.

KEY FINDINGS

SAFETY CONCERNS OF WOMEN, GIRLS, MEN, AND BOYS

Main Safety Concerns - Women

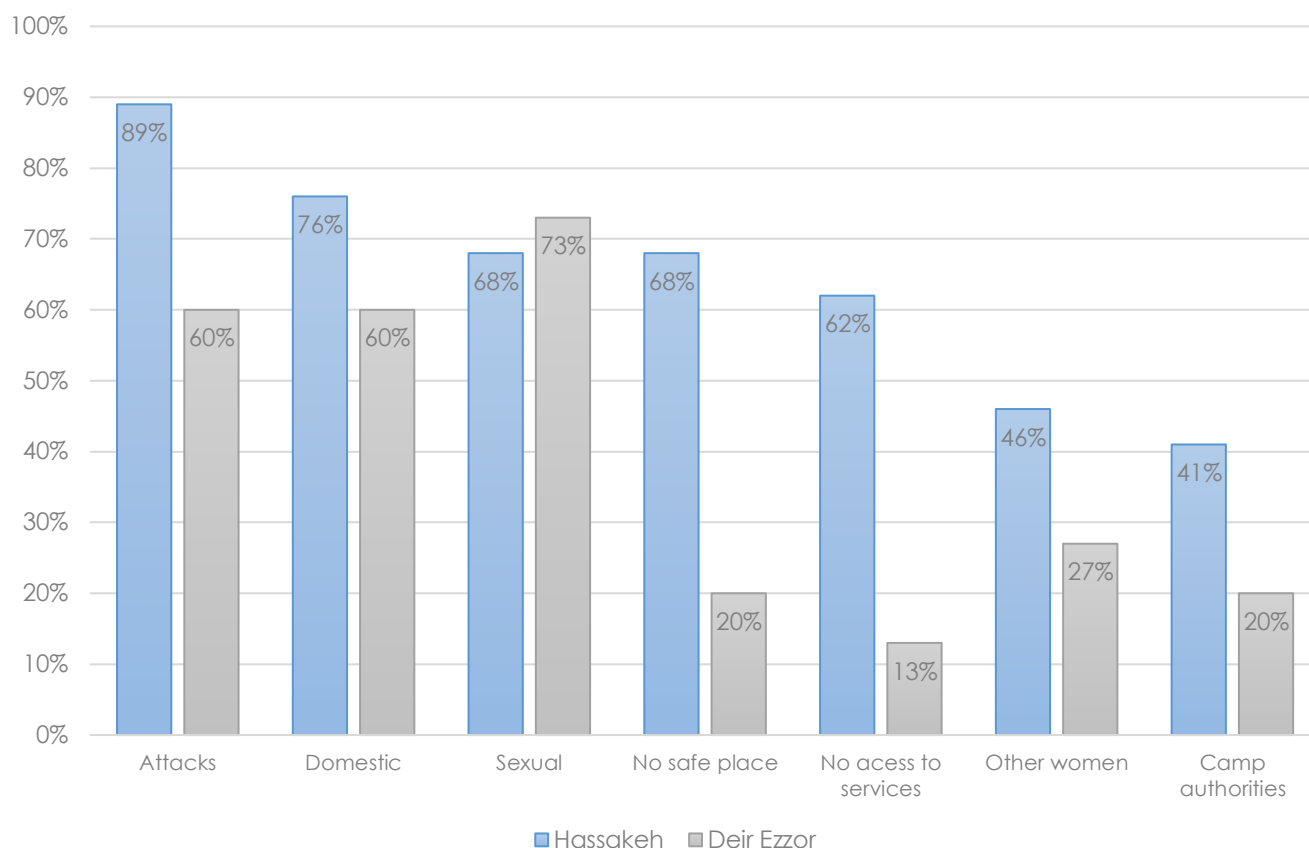


Figure 1 Main safety concerns - women (source: KIIs)

The most frequently reported security concern among women in Hassakeh was getting attacked while on the way to latrines, the market, or to receive services (themselves or accompanying a child), followed by domestic abuse, sexual violence, no safe spaces in the community, no access to necessary services or resources, other women in the community/camp/collective shelter, and violence perpetrated by camp authorities or other authority figures.

In Deir Ezzor, sexual violence was the most commonly cited issue (including harassment, assault, rape, or marital rape), followed by attacks when outside the household, domestic violence, violence from other women or camp authorities, and no safe spaces.

Main Safety Concerns - Women at Al Hol

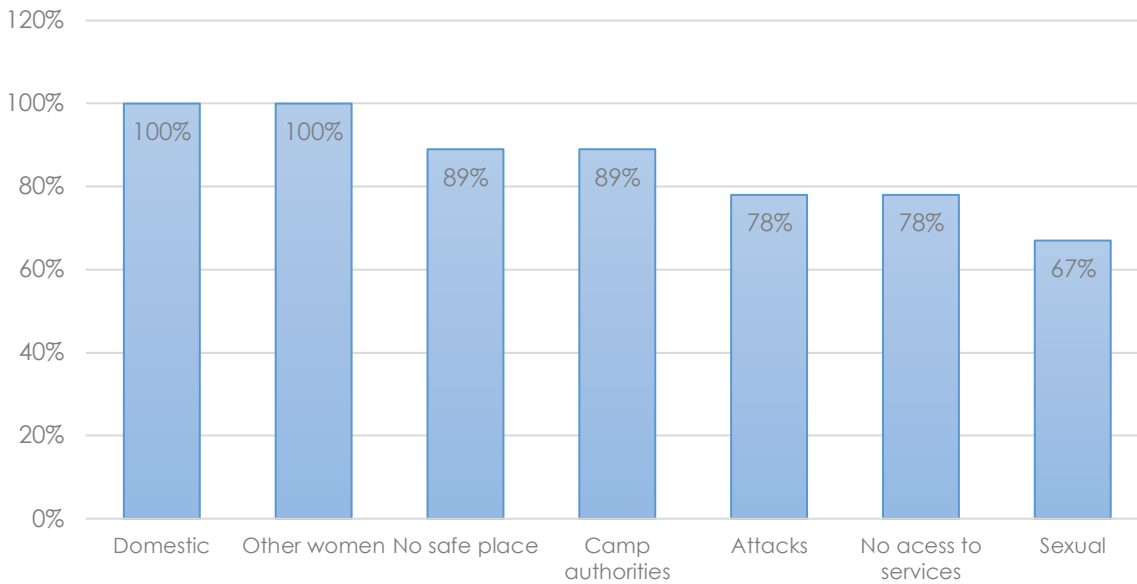


Figure 2 Main safety concerns - women at Al Hol Camp (source: KIIs)

While women at Al Hol naturally face the same issues as women in other areas, it is noteworthy to mention that the most significant sources of concern were domestic violence and violence, incitement, or threats from other women. A lack of safe spaces, exploitation by camp authorities (including threats of escalation and/or murder if the woman attempted to report), an inability to access services (either because they do not exist, or because it is not safe to do so), and sexual violence were also significantly common problems. Service providers working in Al Hol also said that polygamy was a problem, as well as men marrying women for 1 – 2 weeks and then divorcing them.

Main Safety Concerns - Girl Children

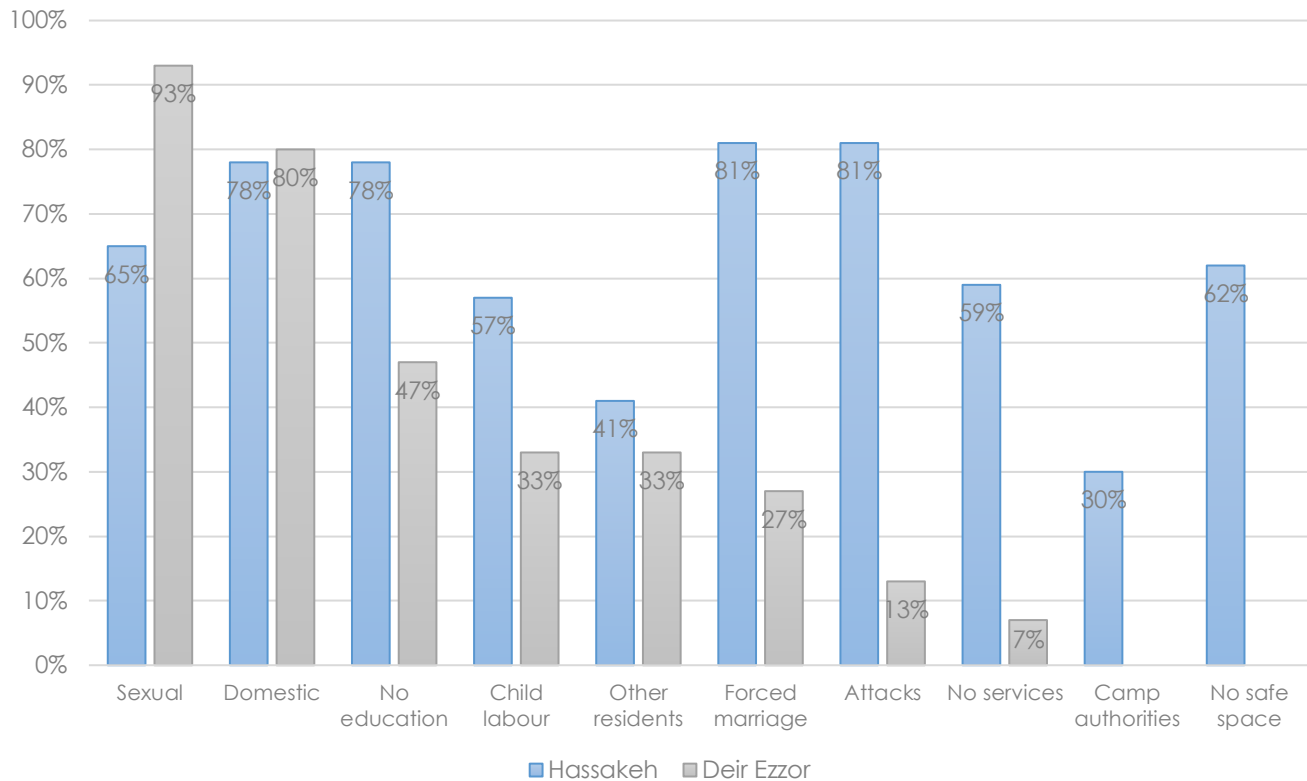


Figure 3 Main safety concerns - girls (source: KIs)

In addition to the issues that women are subject to, children also faced forced marriage, child labour, and deprivation of education. Some respondents reported that children were often not allowed to access the child friendly spaces (for a number of reasons that could include fear for their safety, or preventing them from reporting abuse).

Kidnapping and consequent human and/or organ trafficking were also reported by some FGD participants, especially in specific phases of Al Hol Camp, such as Phase 5.

Among girls, there were alarmingly high rates of forced child marriage (reported by a major 81% in Hassakeh and 27% in Deir Ezzor) and sexual violence in both Deir Ezzor (93%) and Hassakeh (65%).

As for boys, the highest concern cited by KIs in Hassakeh was deprivation of education (84%) followed by child labour (65%) and domestic violence, while in Deir Ezzor, it was militarisation or forced conscription (80%).

While concerns for children at Al Hol did not differ from those in other areas, service providers reported all types at a high rate. The full sample reported domestic (100%) and sexual (78%) violence, deprivation of education (78%), no safe spaces in the camp (56%), attacks on their way to latrines or other locations outside their tents (56%), child labour (33%), and forced marriage (33%).

Main Safety Concerns - Boy Children

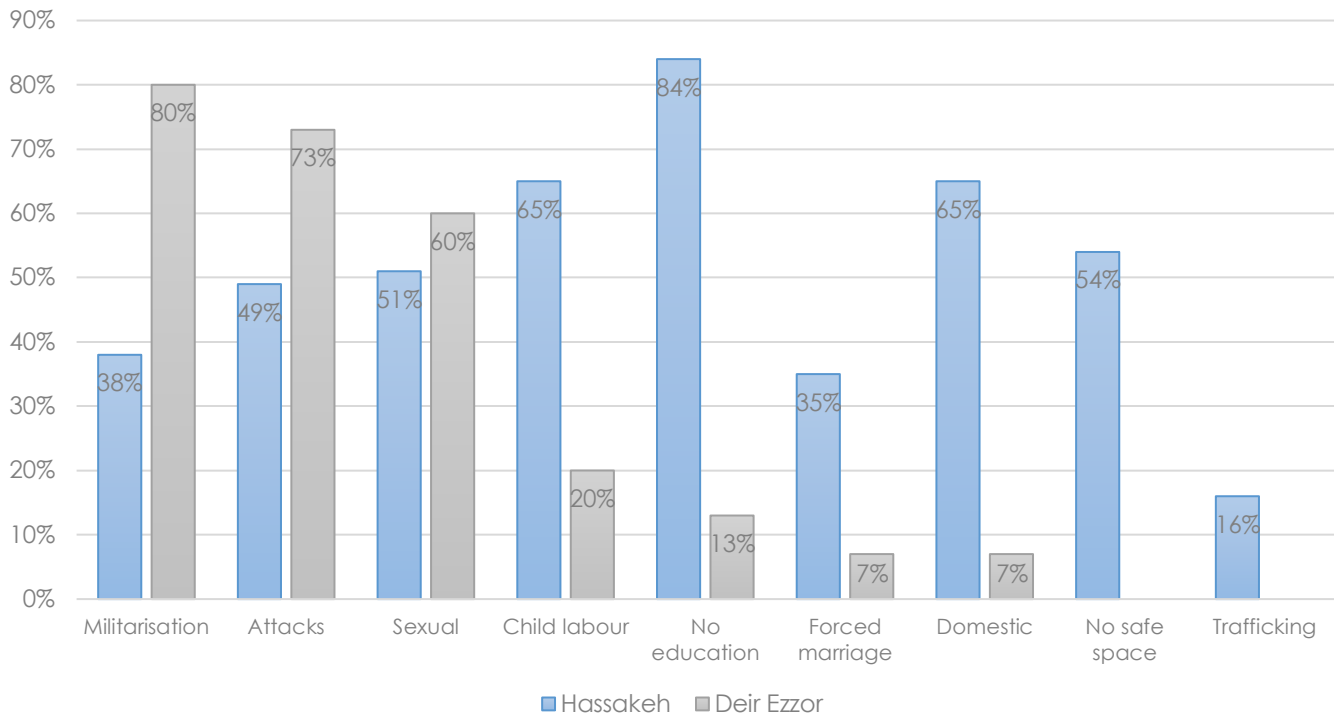


Figure 4 Main safety concerns - boys (source: KIIs)

Main Safety Concerns - Men

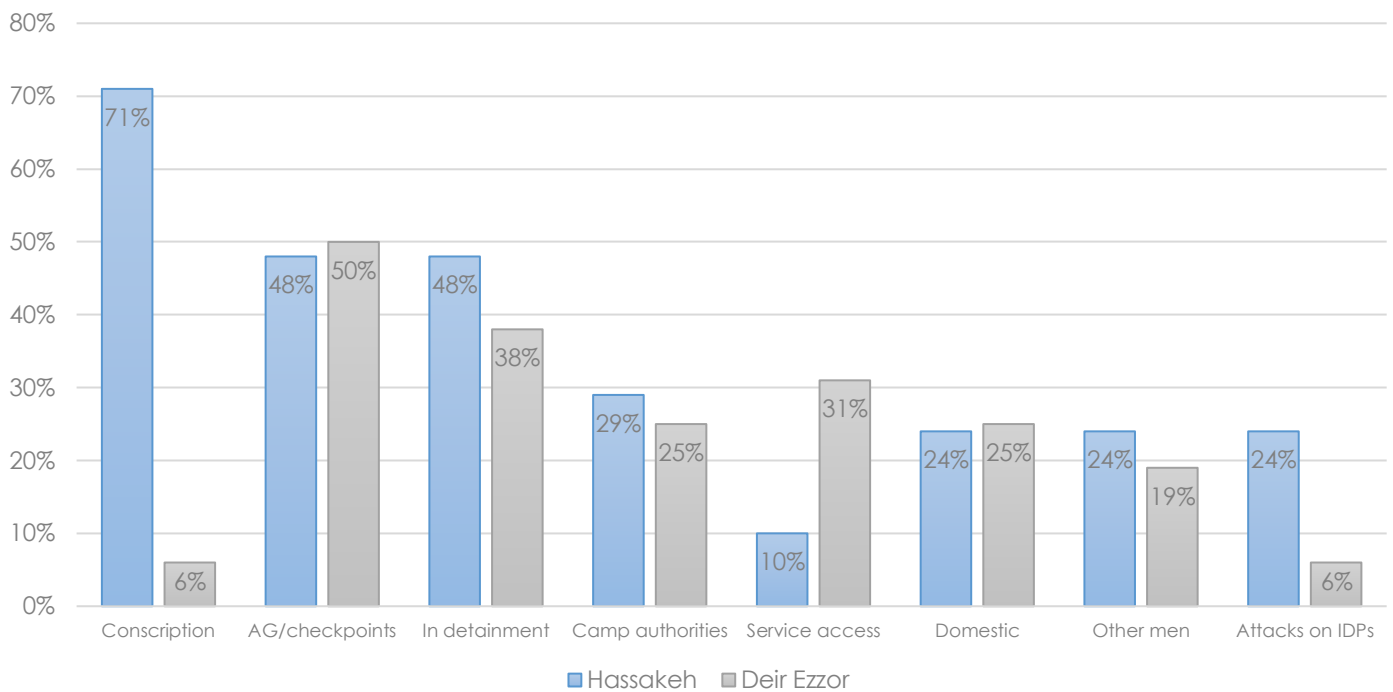


Figure 5 Main safety concerns - men (source: KIIs)

Forced conscription was a significant concern for both men and boys as reported by KIs in Hassakeh, while only one respondent from Deir Ezzor mentioned it as a security fear. Other comparatively differing issues were the lack of access to services (31% in Deir Ezzor versus 10% in Hassakeh), and the risk of attack on IDP groups (24% in Hassakeh versus 6% in Deir Ezzor).

Violence at the hands of armed groups or at checkpoints, in detainment, by camp authorities, domestic violence, and violence practiced against men by other men were mentioned at similar frequencies.

The most commonly cited concerns against men at Al Hol were violence by camp authorities or other men, and sexual, domestic, and in-detainment violence.

Situational Changes and Risks since the October 2019 Turkish Offensive

“Since the Turkish Offensive, all areas in Hassakeh are now unsafe. We try not to go out after 18:00 (curfew time) because of the instability of our neighbourhoods and the high influx of ‘foreigners’ into our communities. There is an increased fear of indiscriminate shooting, bombing during the day, and kidnapping at night. Many areas are rife with sexual harassment and assault, especially Nashweh and Ghuwayran.”

Service Providers, Khashman and Hassakeh City Centre

With the Turkish offensive, several contextual shifts occurred in NES. Among those changes came increased concerns towards all residents.

In Deir Ezzor, 80% of respondents said that women and girls were at increased risk of violence, while all Hassakeh respondents except one from Nashweh reported the same.

On the other hand, all service providers working with women from both governorates said that men and boys were now at even higher risk. Noteworthy to mention was that a significant number of service providers working with men declined to respond to this question. Out of the 6 who answered in Deir Ezzor, 4 said that men were at increased risk, while 2 said no. In Hassakeh, 52% reported no increased risk, while 33% said there was (all 5 from Al Hol said yes, as well as 1 from Qamishli and 1 from Nashweh). The rest did not respond.

In regard to an increase in sexual violence and rape, all KIs from Deir Ezzor with the exception of one respondent from Al Joura said that there had been a noticeable rise in such violence. In Hassakeh, 60% of respondents said sexual violence had increased, while 56% of respondents working in Al Hol confirmed the same.

VULNERABLE GROUPS, TYPES OF GBV, AND SPECIFIC RISK FACTORS

VULNERABLE GROUPS

In general, FGD participants emphasised the fact that no residents are safe, regardless of gender, elaborating that the safest practice is to avoid going out of their houses, shelters, or tents past the set curfew.

In specifying the most at-risk categories, key informants in Hassakeh report women and girls with disability to be at highest risk (93%), while most KIs from Deir Ezzor believed that adolescent girls were the most targeted group (84%). Households with no adults were also at significant risk, with many also noting that families with no husband/father to provide protection also faced significant difficulties and “*had to fend for themselves on their own.*”

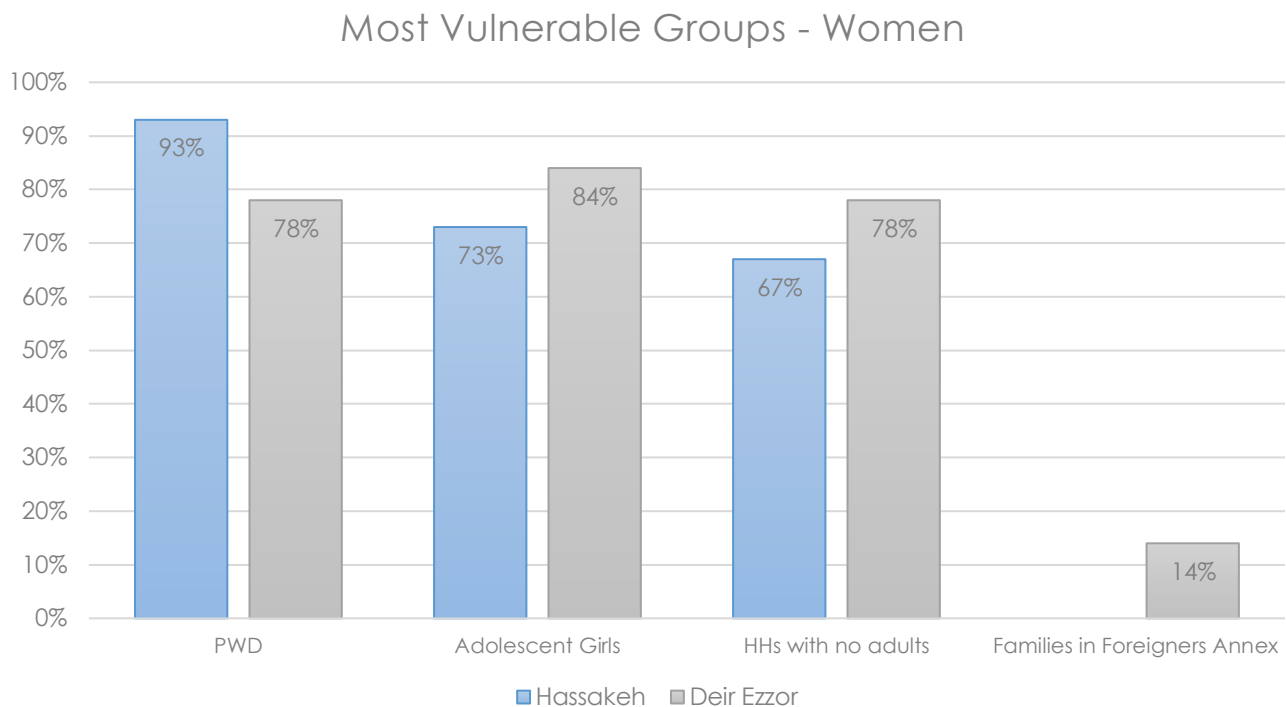


Figure 6 Groups at highest risk of violence - women (source: KIs)

Other at-risk groups mentioned in FGDs included:

- **Women:** elderly, with infants, with no providers, divorced, with missing husbands, or widows. Married women were also subject to domestic violence and marital rape.
- **Adolescents and children:** adolescent girls with no parents, children who have a stepfather due to their mothers' remarrying, girls with no education, UASC, street children (including child heads of households who turn to begging in order to secure their families' basic needs).

In camp settings:

- Women working with or even receiving support from NGOs were at risk because they were considered “apostates.”
- At Al Hol, one group of community respondents mentioned that young girls in Phase 5 of the camp are at high risk of kidnapping and organ trafficking.
- More recently, residents have been facing violence because of religious beliefs or geographical origin at the hands of people who belong to certain factions. This danger is magnified in the cases of young girls, especially based on religion/sect.

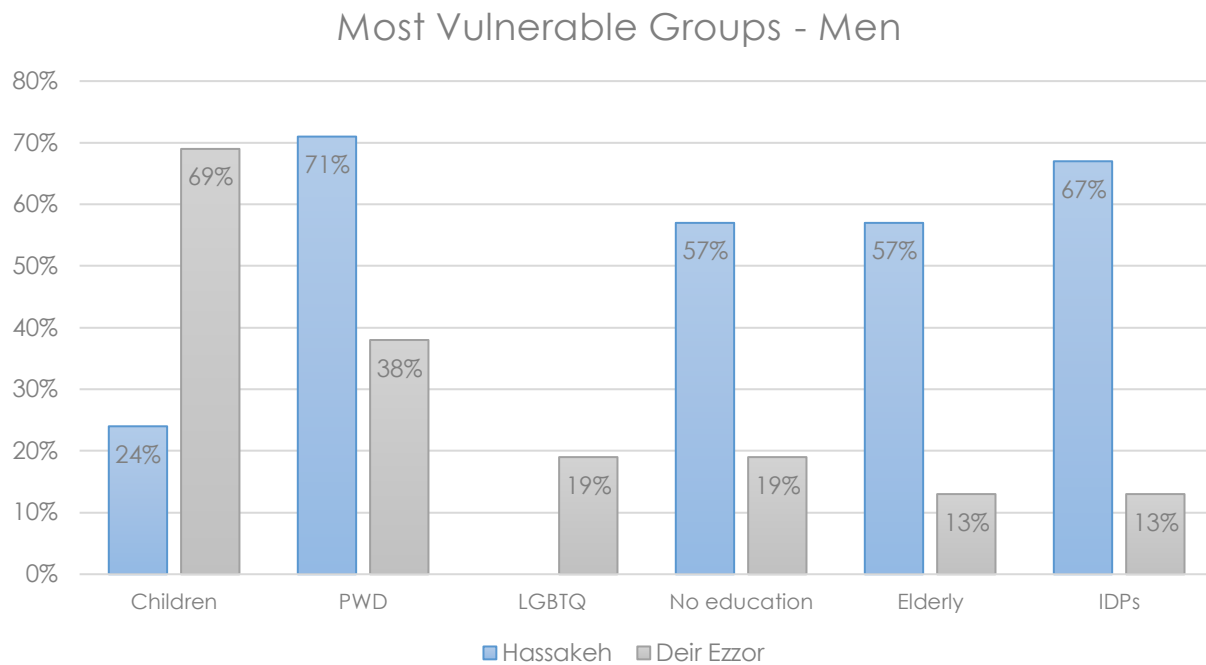


Figure 7 Groups at highest risk of violence - men (source: KIIs)

Similar to women, men with disability were also frequently mentioned as a vulnerable population at risk of violence, but more in Deir Ezzor than in Hassakeh. While SPs in Deir Ezzor mentioned children as the most at-risk category (69%), in Hassakeh, only respondents from Al Hol Camp said that younger boys were vulnerable.

Men belonging to the LGBTQI community were only mentioned as an at-risk population in Deir Ezzor. However, when specifically asked if LGBTQI and men who do not confirm to stereotypically masculine norms face more violence, 81% of respondents in Deir Ezzor and 81% in Hassakeh affirmed that they did. Types of violence were mainly social, domestic/familial, emotional and psychological, physical and verbal. Additionally, in Hassakeh, 29% mentioned forced conscription, 2 respondents added that they face sexual violence (rape or humiliation), and 2 others mentioned trafficking.

MAIN TYPES OF VIOLENCE

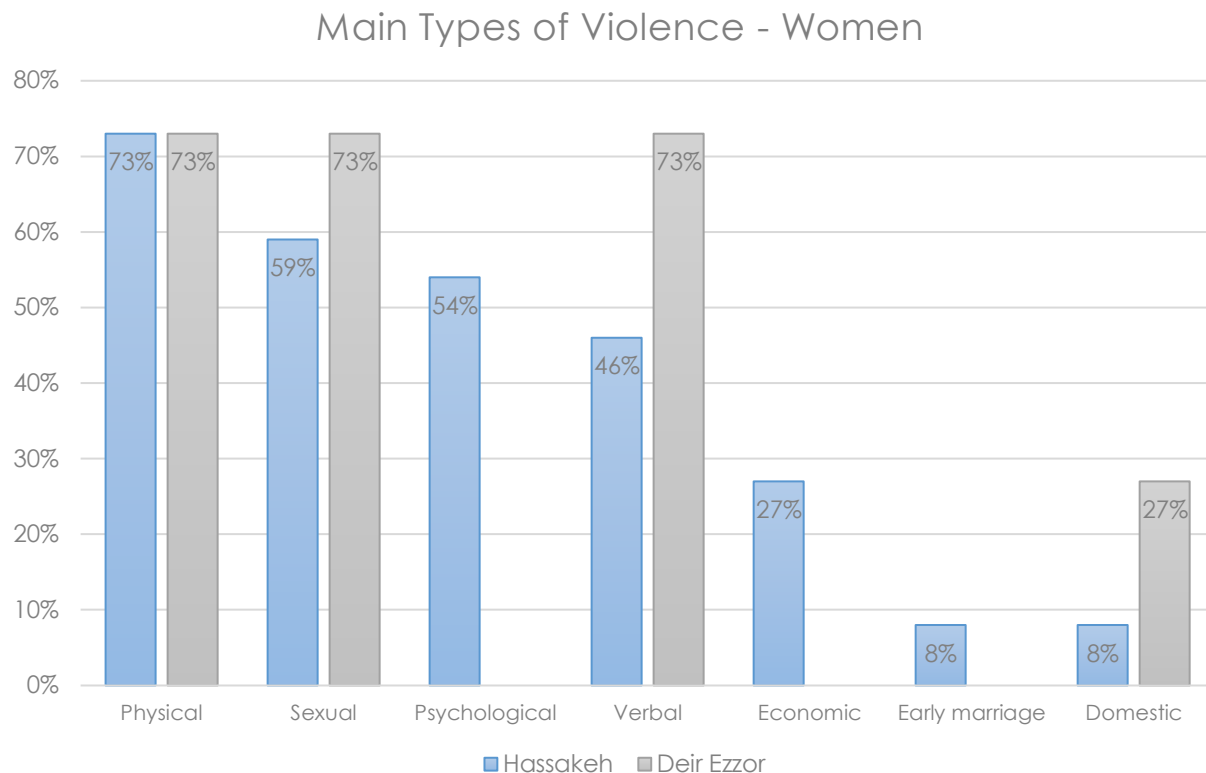
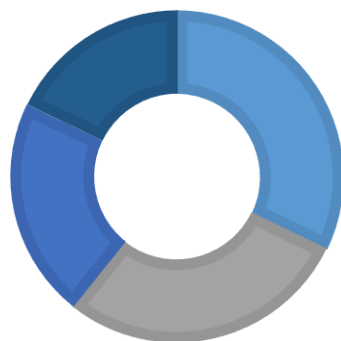


Figure 8 Main types of violence towards women (source: KILs)

Violence in Al Hol Camp

■ Sexual ■ Physical ■ Economic ■ Psychological



All SPs from Al Hol mentioned some form of sexual violence (sexual harassment, assault, rape or marital rape, and sexual exploitation in exchange for assistance). Physical (including domestic) violence was mentioned by all except one.

Economic violence was also frequent, with an emphasis on exploiting the women's limited resources in exchange for providing them with services or assistance. This was especially the case when it came to smugglers promising women that they would take them out of the camp, but not delivering.

Women residents of Al Hol echoed the above and said that "all types of transgressions" occurred against women because most of them were there without family or a husband, and lacked sufficient protection. This included physical violence by a husband, if present, or other women in the camp, especially the Hisba Women. Sexual exploitation for humanitarian assistance and verbal violence during aid distribution (especially as a result of overcrowding and related tension) were common. Restricted freedom of mobility and forced detainment in the camp with no permission to leave, not even for medical reasons – which is violence in itself – also paved the way for smugglers to exploit

women. One group mentioned that “widowed and divorced women have become ‘a game in men’s hands,’ where they would marry them and divorce them after 1 – 2 weeks.



One major difference was repeatedly emphasised by one group of Al Hol women residents throughout the entire duration of their FGD: “*We have not heard of cases of rape. Some women will exchange sex with men for assistance or to be taken out of the camp. They do it out of their own will to secure assistance. We never speak or consort with such women.*” The same group later mentioned that “women residing in Al Hol stayed in their tents and did not mingle with men. If they initiated contact, then it was their own fault for exposing themselves to danger.” This is a critical finding in regard to the need for “carefully planned and packaged” awareness-raising among camp residents, particularly about the stigma associated with survival sex.



In addition to the ‘usual’ types of violence, many women are subject to abuse at the hands of other women in the camp. This can include “branding them as infidels,” stoning them, and threatening them with death – main targets of this type of violence are women who work with NGOs or seek out their services and visit the available safe spaces.

Service Provider, Al Hol Camp

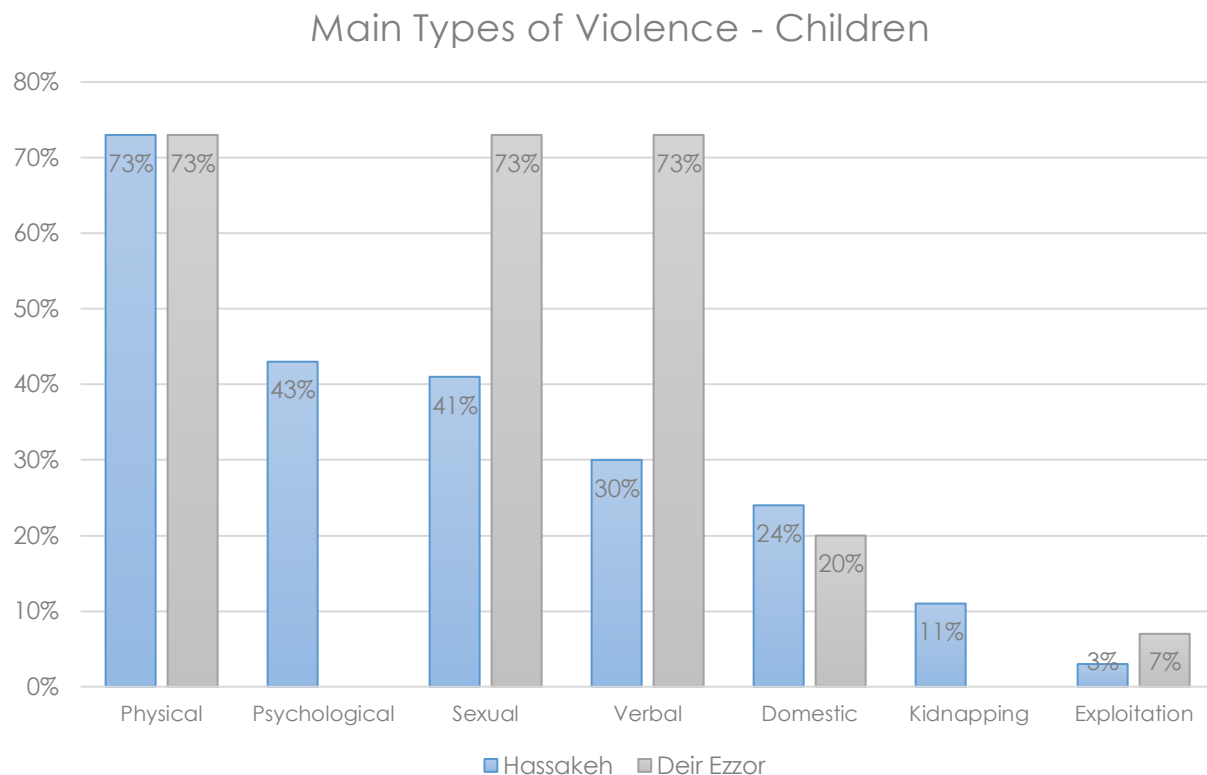


Figure 9 Main types of violence towards children (source: KILLS)

Children in all surveyed communities were prone to physical violence in different spheres, including domestic, educational, and public.

In Deir Ezzor, they were also reported to heavily face sexual and verbal abuse (among other types of violence), while in Hassakeh, there were reports of psychological, sexual, and domestic violence.

Other forms of violence mentioned by respondents were young men being abused by their families due to unemployment, child neglect, separation from families outside the camp (especially in Al Hol, where mobility is restricted), inability to access basic needs, deprivation of education, child labour, and child marriage. Several cases also reported that children whose mother or father remarry are at risk of abuse by their new stepparent.

The underlying factors of children being forced to drop out of school were the following:

- i) **Economic:** the need to seek employment or beg to secure the families' needs.
- ii) **Force majeure:** Schools being closed by the relevant authorities in some areas.
- iii) **Fear for safety:** Violence was reported to occur within or on the way to schools/non-formal educational settings.
- iv) **Distrust of organisations:** Many community members tended to believe that NGOs were 'infidels,' which would make going to their schools and child-friendly spaces 'sacriligious.'

Main Types of Violence - Men

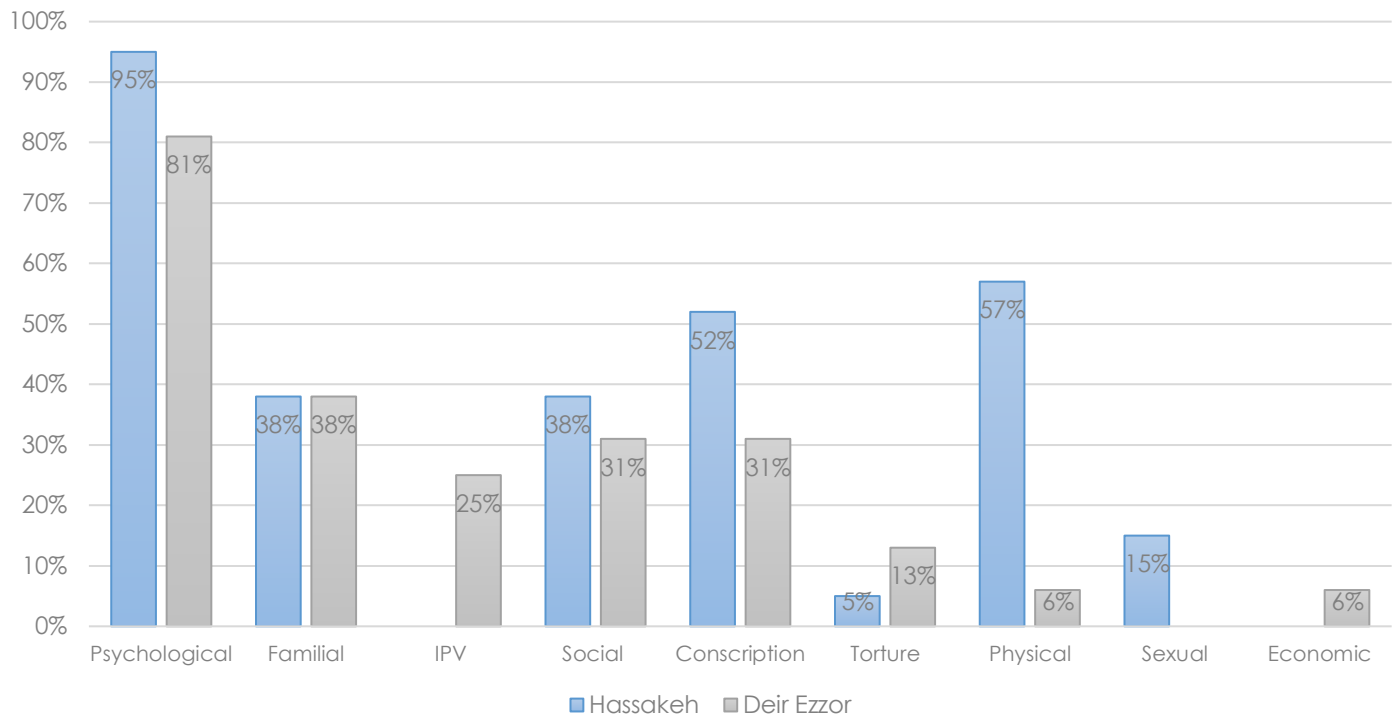


Figure 10 Main types of violence towards men (source: KII's)

The main type of violence that men faced in both Hassakeh (mentioned by 95% of respondents) and Deir Ezzor (81%) was psychological. Physical (57%) and social (38%) violence as well as forced conscription (52%) were also common in Hassakeh, while Deir Ezzor had more social violence (31%) and forced conscription (31%).

Domestic violence was also reportedly somewhat common, but violence perpetrated by parents was more common than intimate partner violence (IPV).

Sexual violence in Hassakeh was either within workplace settings, or practiced by militias for humiliation as a tool of war.

Most incidents of sexual abuse or exploitation of boys and men were unanimously reported to be by local militias in Deir Ezzor, while in Hassakeh one mentioned that some NGO workers also practiced this type of abuse against community members.

CONTEXTS OF VIOLENCE

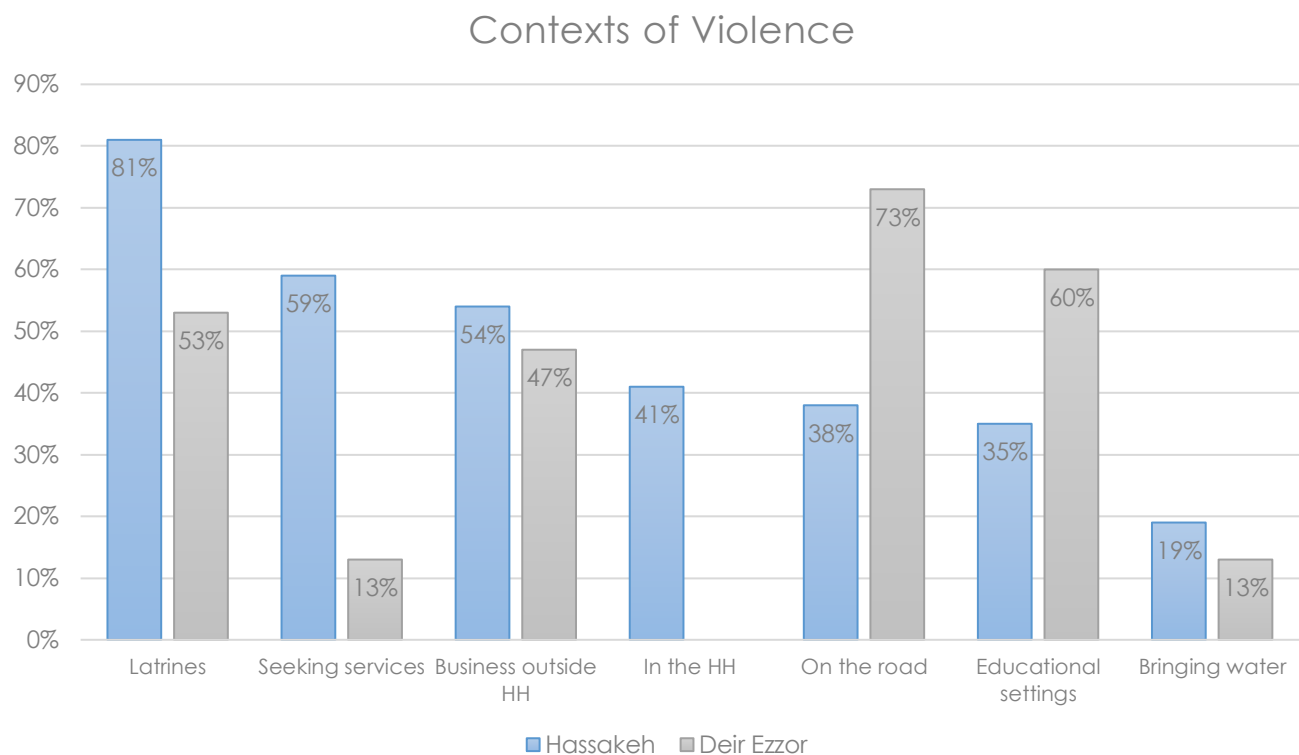


Figure 11 Main contexts in which violence occurs (source: KIs)

In general, both community members and service providers vocally expressed that security risks were omnipresent, in communities and camps alike. However, there were certain contexts or situations that were admittedly more dangerous, principally latrines and bathing facilities, or on the way there from tents or rooms in collective shelters. One group of service providers in Nashweh said that at the school collective shelter, the women's and men's bathrooms were adjacent, which provided no privacy and higher risk of assault.

Especially but not limited to Al Hol, women faced significant issues while on the way to seek out services, whether for themselves or their children. In general, KIs were of the opinion that women and children conducting any business outside the household were at risk of violence.


Educational settings were unsafe spaces for children, as reported by 60% of the KIs in Deir Ezzor, and 35% in Hassakeh.

In Hassakeh, 41% of respondents said that the household was also an unsafe space where women, children, and men faced domestic violence.

Contexts of violence at Al Hol, as reported by service providers working there, were as follows: in the household (89%), when going to seek services (89%), at latrines (67%), when conducting any business outside the household (56%), and in school or informal educational settings (44%). One respondent added that most cases of sexual assault took place at night in areas where there were no guards or patrols, such as Phases 5 and 6.

PARTICULAR RISK FACTORS

When asked about dangerous locations to avoid during the day and night, responses were similar throughout Al Joura and Jubaila in Deir Ezzor, and Hassakeh City Centre, Nashweh, and Khashman in Hassakeh.

 *“Locations that are unsafe during the day are also unsafe at night, and during night-time, no civilian feels safe being outside of the confines of their dwelling. ...That is not to say that people’s households are necessarily always safe.”*

Service provider, Qamishli

There was a general lack of safety reported throughout the communities – even being in the street could mean exposure to harassment or assault, indiscriminate shooting by local militias and armed factions, bombings, and kidnapping.

At night, if women and girls had to be outside of their homes for urgent reasons, it was crucial to avoid unlit public locations or streets, unrehabilitated roads, and newly repopulated areas. Problems were exacerbated during electricity outages.

Based on frequent comments, it was understood that local residents had a fear of IDPs and “unknown foreigners” residing in their areas. Additionally, residents of some collective shelters and camps were only allowed to leave at certain times – if at all – due to *“the instability of the neighbourhoods and the IDP influx.”*

During both the day and night, unsafe locations included public locations such as gardens and school buildings, crowded markets, service and assistance distribution points, and collective shelter toilets/camp latrines. Women living in collective shelters also faced a complete lack of privacy and other issues associated with having more than one family per room.

At Al Hol, a small group of women said they felt safe in Phase 1 *“because we have our men with us and we feel safe with them,”* and in Phase 4 *“because there are night guards and Asayish patrolling the area.”* One woman *“only felt safe in her tent.”*

With the exception of the above, all women said that there were no safe locations at the Camp, noting that some phases were worse than others, especially Phase 5, *“where children are kidnapped and women are subject to violence and exploitation, especially at night.”*

Factors contributing to the insecurity at Al Hol Camp were, as reported:

- The presence of ISIS families
- Strangers accessing the camp at night
- The extremely strict laws in the camp that result in consistent clashes between the residents and the camp authority

- The high IDP influx and overcrowding of the camp, especially with ‘foreigners’ and people from different backgrounds
- No means for ensuring safety at the camp
- Weak safety and security strategies, if any, which are not implemented

They added that the Turkish offensive had resulted in even less security.



The whole camp is unsafe, and it has become even worse since the Turkish offensive. We do not leave our tents except when absolutely necessary, and only in the company of our husbands or mahram. At night there is no sufficient lighting, which makes things all the worse.

Woman resident of Al Hol Camp

GROUPS WITH ACCESS TO THE COMMUNITIES/CAMPS

In Deir Ezzor, all respondents said that police forces or military groups had access to the communities or camps, while a smaller percentage mentioned local militias or peacekeepers. Hassakeh mainly reported local militias, followed by police (some specifying Asayish) or military groups, and peacekeepers. In Al Hol, most said ‘non-governmental forces’ and Asayish.

CONSEQUENCES OF VIOLENCE ON SURVIVORS

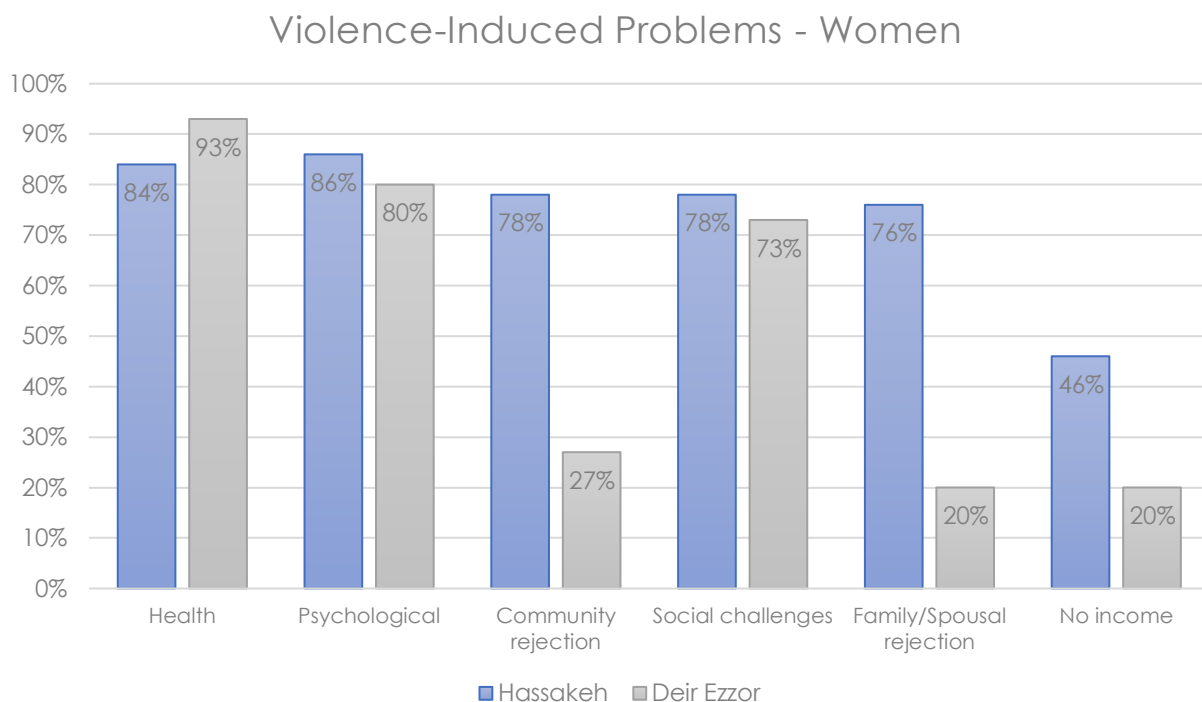


Figure 12 Main consequences of violence on women survivors (source: KIIs)

Women and men survivors of violence in both governorates faced the same types of challenges, to somewhat varying degrees. Health complications (especially resulting from physical and sexual violence), as well as psychological challenges and PTSD were the two major issues.

Survivors also faced problems with community, familial, and spousal rejection – although these were much more severe issues for women than for men.

Social challenges significantly affected members of both sexes, and these challenges coupled with being ostracised by their communities also affected their ability to secure income (not being accepted by employers, the community not purchasing items they have produced, and other).



The main issue is that there are no actual necessary services that any stakeholders have been able to provide to survivors. What is the purpose of the survivors all starting to raise their voices and report any form of violence they experience if there is no actual protective response or intervention?

Service Provider working with Women, Jubaila

Violence-Induced Problems - Men

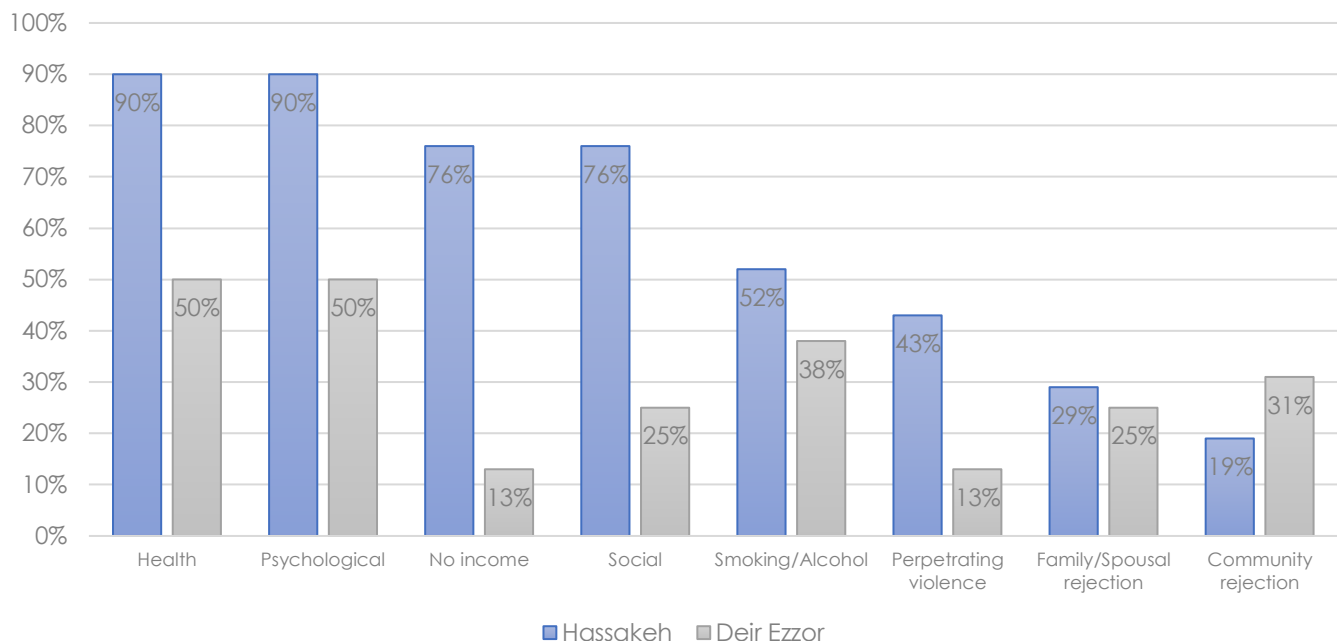


Figure 13 Main consequences of violence on men survivors (source: KII)

Men survivors of violence were reported to resort to negative coping strategies, which were harmful both on the personal and the familial/community levels. One such issue was the increased use of tobacco and/or the consumption of copious amounts of alcohol.

The other coping strategy was an increase in their violent tendencies, which they often “took out” on their parents, wives, and children, further contributing to GBV in their households and communities.



Men survivors often lose confidence in themselves and their surroundings. They feel inferior and victimised, and this results in perpetuated cycles of violence: either continued violence against them, or them increasingly perpetrating violence themselves, particularly against their own families.

Service Provider working with Men in Hassakeh

EXISTING CHANNELS OF REPORTING AND RESPONSE TO GBV CASES

REPORTING GBV CASES



By law, violence and rape are penalised. However, a certain community practice prevails above the law to exonerate perpetrators of violence against women: families attempt to cover up any such instances to preserve their and the woman's reputation. As such, for fear of scandal, the majority of cases go unreported.

SP working with women in Hassakeh City Centre

Service providers mentioned that reporting can be done to the local authority/self-administration, police or security forces (wide mention of Asayish and Women Asayish), and community centres. Respondents from Al Joura and Jubaila said that “perpetrators are only persecuted if they are reported to the police, security forces, and community centres,” and women might report the case to an NGO and receive PSS. Reporting in Hassakeh City Centre was to the local authority or to the “legitimate security forces,” in Khashman and Nashweh to the Asayish, and in Al Hol either to the camp authority or to the Asayish.

However, some noted that “there are many areas that do not have set laws, and sometimes there are no specific authorities to whom a woman can report violence,” and that “there is no actual barrier (police or judicial) that provides the survivors with justice for the violence they experienced, so there is neither a “reason” for the violence to stop, nor for the woman to report it.”



*If a woman faces **physical** violence, she might turn to her parents, a support team member at the collective shelter, a friend, and maybe a tribal leader or party member. She could report to the Women Asayish, or go to the Kurdish ruling authority. She does not receive any support though, so she might ultimately decide not to speak to anyone.*

SPs in Khashman

Despite the existence of some channels, all respondents emphasised that women do not report exploitation or different types of violence, and especially not rape – marital or otherwise.

- **Domestic violence:** while there are some actors responsible for protecting women, often, the consequences are not in her favour. The situation will usually result in family problems (especially with the woman's in-laws), and the man divorcing or abandoning her “as revenge for reporting him.”
- **Violence by authority figures or armed group members:** Often, when the perpetrators of any form of violence are influential, high-ranking, or armed individuals, the women are threatened with “worse fates than the violence they have already experienced,” including threats of death or imprisonment. As such, the women are too afraid to speak, let alone report.
- **Uncertain response:** There is no guaranteed punishment exercised against reported perpetrators. For example, at Al Hol, a group of women said that a man had worn a burqa,

entered a tent, and raped a woman inside. He was surrendered to Asayish, but they released him the next day. Similarly, women who had been exploited or robbed reported the thieves to the camp authority who investigated and then released them after a few days.

- **No encouraging environment:** Generally, there is a lack of confidentiality when it comes to related cases. The nature of the violence coupled with the local customs and traditions do not foster a safe environment that encourages a culture of speaking out and reporting to seek justice.

Penalties depend on both, the type of perpetrated violence, and on the awareness of the survivors and the actor to whom they have reported the case. However, there is generally no punishment because women rarely ever report cases.

“ Women usually do not seek support unless the incident took place publicly and did not need to or could not be hidden. They might go to Asayish. But there is nobody who will actually help. Women in Al Hol Camp

AVAILABLE SERVICES

AVAILABLE SERVICES - WOMEN	
HASSAKEH	DEIR EZZOR
HIGHER AVAILABILITY	HIGHER AVAILABILITY
Food assistance (92%), hygiene or dignity kits (84%), clean water (78%), NFI and healthcare including reproductive health (76%), latrines (70%), women-friendly spaces (68%)	NFI (mattresses, blankets, kitchen utensils, cleaning detergents) and education (100%), hygiene or dignity kits (87%)
MHPSS case management and individual consultations (62%)	MH drop-in centres (100%)
LOWER AVAILABILITY	LOWER AVAILABILITY
Shelter (49%), education (38%), PSS and women empowerment (3%)	Healthcare (40%), shelter, women-friendly spaces, clean water, and latrines (27%)
MH drop-in centres (49%), capacity building (46%), economic empowerment – either income generation or vocational training (41%), mental health referrals (32%), education (30%), peer support groups (24%)	MH case management, individual consultations, and referrals (20%), capacity building (20%), economic empowerment – either income generation or vocational training (20%) ²

Female medical staff (doctors, nurses, and/or midwives) were generally available at all health facilities in Deir Ezzor, and most in Hassakeh, including in Al Hol Camp. The reported exceptions in the latter were 2 SPs in Nashweh and 2 from Hassakeh City Centre.

² The 20% reporting the lower-availability MH services were all employees of Syria Pulse in Al Joura.

At Al Hol Camp, case management and individual consultations were widely available according to the respondents. Economic empowerment was reported by 67%, drop-in centres by 56%, capacity building and MH referrals by 44% each, and peer support groups by 33%.

KIs and FGD participants mentioned that there were some organisations providing services, but they were few. The most prominent were the Amelioration of Sanitary and Social Level Society, Al Barr, GOPA-DESD, Mar Ephraim, MedAir, SARC, and Syria Pulse.

At Al Joura and Jubaila, there were few collectives of women who held meetings, but only sporadically and rarely.

In Khashman, there were no safe spaces for women residents of collective shelters to meet – sometimes they had gatherings in the school courtyard or in one another's rooms, but only if the men were absent. Sometimes, NGOs held sessions in one of the classrooms of the school collective shelter. The SPs also mentioned that there were some collectives that provided services and assistance to the Kurdish community.

In Hassakeh City Centre, FGD participants reported that survivors mainly go to community centres and churches for support, but they can talk more about their problems at the community centres. They elaborated that while there were several centres that offered services to women, men, children, and families, **there were no specialised centres specifically dealing with women survivors of violence.**

Women attended some centres, but the nature of the group conversation depends on the level of trust in the location and facilitators on one hand, and on the other, on the level/extent of services that the women and girls could receive after divulging information.

One important issue that a service provider in Hassakeh City Centre raised was that:

“ *There are no medical or specialised services for survivors, and no holistic programmes that offer medical, psychosocial, and empowerment assistance to women. The majority of services provided by organisations are all sporadic efforts that depend on the donor, and whatever they are willing to fund at a given point in time. What makes matters worse is that there is no coordination between local actors to identify gaps, work on addressing them, and avoid duplication of the few existing services.*

At Al Hol, residents of Phase 5 of the camp said that while women's safe spaces existed and they used to visit them before (for PSS, vocational training such as sewing and waving, and group sessions on self-confidence and dealing with pressure), they could no longer do so because the security situation has degenerated.

They also could not leave their children alone for long periods of time, and even if there were CFS providing recreational activities to which they could take them, they all could not be outside their tents for long, and only exited them when absolutely necessary. At times, they managed to meet in their own tents, and when they had to go to the market, toilets, or to receive assistance, they did so in groups.

When it came to medical support, the women reported that they could not always access healthcare because of the lack of specialised centres. A few organisations, such as the Kurdish Red Crescent, Mar Assia al-Hakim, the Red Cross, IRC, SCI, and Alyamama were operating some medical units, but even those that existed operated for very few hours per day, and only provided consultations and painkillers. The women generally could not get permission to leave the camp, so they could not visit the hospital in the city.

AVAILABLE SERVICES - CHILDREN	
HASSAKEH	DEIR EZZOR
HIGHER AVAILABILITY	HIGHER AVAILABILITY
Food assistance (86%), hygiene kits (78%), Clean water (76%), Shelter (70%), Healthcare and safe spaces (65%), Latrines (62%), NFI and education (59%) MHPSS safe spaces (65%), %, case management and individual consultations (54%)	Food assistance and educational material (93%) and clean water (60%) MHPSS safe spaces (93%)
LOWER AVAILABILITY	LOWER AVAILABILITY
MHPSS peer support groups and capacity building (49%), mental health referrals (35%), education (11%), awareness-raising activities (3%)	Hygiene kits (47%), safe spaces, shelter, and latrines (27%) MHPSS capacity building (27%), case management and individual consultations (20%), mental health referrals (13%)

Other mentioned services included mobile healthcare units, and support to children with special needs (crutches, wheelchairs, etc.).

Services for children were reported to be provided by Alkawada, Alyamama, ICRC, Red Cross, SARC, UNFPA, UNHCR, and UNICEF.

AVAILABLE SERVICES - MEN	
HASSAKEH	DEIR EZZOR
HIGHER AVAILABILITY	HIGHER AVAILABILITY
Healthcare and medical services (90%), individual consultations and collective shelters (62%), mental health and referrals (52%)	Healthcare and medical services (94%)
LOWER AVAILABILITY	LOWER AVAILABILITY
Drop-in centres (48%), education and awareness-raising (33%), capacity building (14%) MHPSS case management and individual consultations (46%), MH drop-in centres (43%), MH referrals (24%), income generation/vocational training activities and peer support groups (14%), education (8%), psychiatry (5%) ³	Collective shelters (44%), individual consultations (38%), mental health and referrals (31%), education and awareness-raising (19%), capacity building (13%), drop-in centres (6%) MHPSS drop-in centres, psychiatry, peer support groups, and income generation/vocational training (26%) ⁴

³ While psychiatry was only mentioned as a mental health support option in Nashweh, the majority of respondents who had reported no adequate MHPSS services for men were from Nashweh.

⁴ Only 26% said there were MHPSS services for men, and all were employees of Syria Pulse in Al Joura. The rest believed there were no such services.

SAFE SHELTERING FOR SURVIVORS OF VIOLENCE

In general, no safe shelters were reported to be available in Deir Ezzor for any of the target groups. However, 54% in Hassakeh reported that such shelters existed for women and children, noting that responses regarding shelter availability were mixed across all areas, which renders disaggregating the figures per geographical location useless. While this may be an issue when it comes to identifying safe sheltering during case management or emergency referrals, it may also be a result of attempting to maintain secrecy around the relevant shelters in order to ensure a higher level of safety.

Service Mapping

For a detailed list of the different types of available services offered by local and international NGOs working in Hassakeh and Deir Ezzor, see *Annex 1 - Service Mapping* and *Annex 2 - KII Service Assessments*.

COMMUNITY SYSTEMS FOR PROTECTION

According to service providers in Deir Ezzor and Hassakeh, prior to the crisis, there were laws, customs, and traditions that provided protection from rape. Violence did exist, but to a lesser extent, especially in light of an existing authority that implemented the law. The availability of basic needs was also a factor in protecting women, girls, and even boys from different types of violence.

Currently, women have few options to minimise risk: they can visit some community centres that provide them with support (case management and consultations), stay in their collective shelter rooms or tents, avoid going out of their houses except in necessary cases, attempt – to the extent possible – not to walk alone (especially not in dangerous locations or at night), and go to public toilets/latrines in groups only.

Some community efforts comprised community patrols, where the families and local residents would take shifts to ensure a greater level of protection (Hassakeh City Centre), the Asayish guard collective shelters (Khashman and Nashweh) or the camp authority assigns night duty shifts to guards. Women in Al Hol have also taken steps to form their own safety groups, and usually take rotating shifts staying awake at night to guard sleeping members of the family.

However, informants believed that there were more initiatives that could be undertaken within the community to reduce the security risks and GBV that women face:

- Establish GBV community centres and safe spaces that employ specialised, trained personnel who can provide quality holistic care, as well as awareness-raising, empowerment, and reintegration of survivors into their communities.
- Engage men and boys to become active participants in preventing rape through raising their awareness of related topics
- Activate the role of the local community, especially community leaders, to play a more visible and active role in preventing GBV, while raising awareness about the different types of violence and how to end them
- Form a community network that comprises local stakeholders and works on reporting, protection, and awareness about the contributing factors to increased violence against women and girls
- Engage local residents in creating community patrols
- Set adequate legislation, security strategies, and apply protective laws in all communities and camps to ensure that women are safe even when outside the confines of their own “homes” – especially at humanitarian distribution points and latrines

- Improve camp infrastructure to promote a feeling of safety (peacekeeping patrols, applied laws that protect women and girls)

An additional note was that when the basic needs of local families are covered, women and children would be at less risk of violence, especially economic.

HELP-SEEKING BEHAVIOUR

Groups Women and Girls Seek for Support

In Deir Ezzor, after being subjected to violence, women most frequently sought out the support of any female aid worker (53%), followed by the police or local security forces and NGOs working with women. To a much lesser extent, they could confide in a friend or relative.

In Hassakeh, the first gateway to ask for support were female aid workers or NGOs (equally reported at 22%), and a family member or community leader (both 19%). There were very few sporadic mentions of a friend, UN agency, medical worker or doctor, camp authorities, and police or security forces.

In Khashman and Nashweh, SPs said that women in collective shelters may sometimes seek out support from the Education and PSS teams, but in secret – for example, a social worker may pretend to be a doctor or a nurse who is visiting the woman to provide her with medication for a health issue.

There were no notable differences at Al Hol, where the majority said the survivor would seek out help from an NGO or UN agency. A very minor number said the women would turn to the camp authority, police/security forces, or a family member.

Girls in both governorates primarily sought out support from a family member or a friend, followed by seeking out an NGO working on child protection.

Groups Men Seek for Support

Responses to this question were answered with difficulty by both service providers working with men, and those working with women. A significant percentage said they did not know, or said there were no groups or individuals that men sought out for support after experiencing violence.

Those who did respond in Deir Ezzor reported that men would seek out medical workers or doctors, camp authorities, an NGO or UN agency providing related services, and traditional leaders or a friend. In Hassakeh, they were said to seek out support from a community or religious leader, an NGO or UN agency providing related services, or a friend.

Most service providers working at Al Hol said they did not know, but the few who replied said the men would either turn to the camp authority or the komin for support.

COMMUNITY ATTITUDES, PRACTICES, AND NORMS

Overall, attitudes towards survivors of violence were largely negative, intolerant, and unsupportive, where they faced the rejection of their husbands, families, and community. This stigmatisation is not *“a product of the crisis; it existed before and continues now, especially in cases of rape.”* A few service providers in Jubaila and Hassakeh City Centre mentioned that *“in some exceptional cases, there is a slight improvement in the community’s outlook towards survivors, but it is still weak and very insufficient.”*

FAMILY ATTITUDES

Should a survivor’s family learn that a woman has been raped or sexually assaulted, “their reaction would depend on their level of awareness,” according to the vast majority of participants from all locations. Some families may support the survivor and accompany her to receive services, and possibly – albeit rarely – to report the incident. On the other hand, there are families (parents or spouse) who might ostracise the survivor, imprison her in the home *“because she brought shame upon them,”* or even kill her in order to “restore the family’s tarnished honour.”

A service provider in Khashman mentioned that families sometimes force the woman or girl to get married in order to preserve her reputation.

“When there is a supportive family member, they are always extremely discreet about getting the survivor to service points to receive assistance. In very rare cases, some might turn to the law, or to vengeance against the perpetrator. This depends on the family’s background and customs.

Service provider from Jubaila

“Families might support, depending on the level of awareness, and survivors might speak – but only depending on how ‘serious’ they perceive the service providers to be, and the types of services they provide. It is an embarrassment to share details of such sensitive cases for ‘no reason,’ so survivors only speak when they know for a fact that they will receive adequate help.

Service provider from Hassakeh City Centre

Women from Al Hol said that generally, a woman who has been raped is socially ostracised, shamed, and considered at fault because *“she is a woman and she is the one who provoked it.”* A small percentage of families might be supportive and assist the survivor with reporting and getting help to overcome this crisis, while others will not because of the stigma and dishonour associated with rape.

COMMUNITY ATTITUDES

Wider community attitudes towards survivors were no different from their families’: survivors were scorned, ostracised, and blamed. Even if the community was “sympathetic” towards a survivor, they would still not get involved in supporting her to avoid “scandal.”

Some service providers in Khashman said that the rapist may be *“asked to marry his victim in order to ‘right his wrong’.”* They added that there were some Kurdish organisations that offered relief, healthcare, or food assistance, but they did not have any specialised GBV services.

“Survivors of rape are generally scorned, unless it is an exceptional case where the survivor is found not to ‘hold blame’ - for example, in cases of kidnapping and rape. In these cases in light of the aforementioned, it can be said that the community has a somewhat changed outlook, but this change is still minor and insufficient in regard to the actual magnitude of the problem.

Service provider from Jubaila

GBV PREVENTION AND RESPONSE ACTION MULTI-SECTORAL SERVICES

BARRIERS HINDERING ACCESS TO SERVICES

Service Access Obstacles - Women and Girls

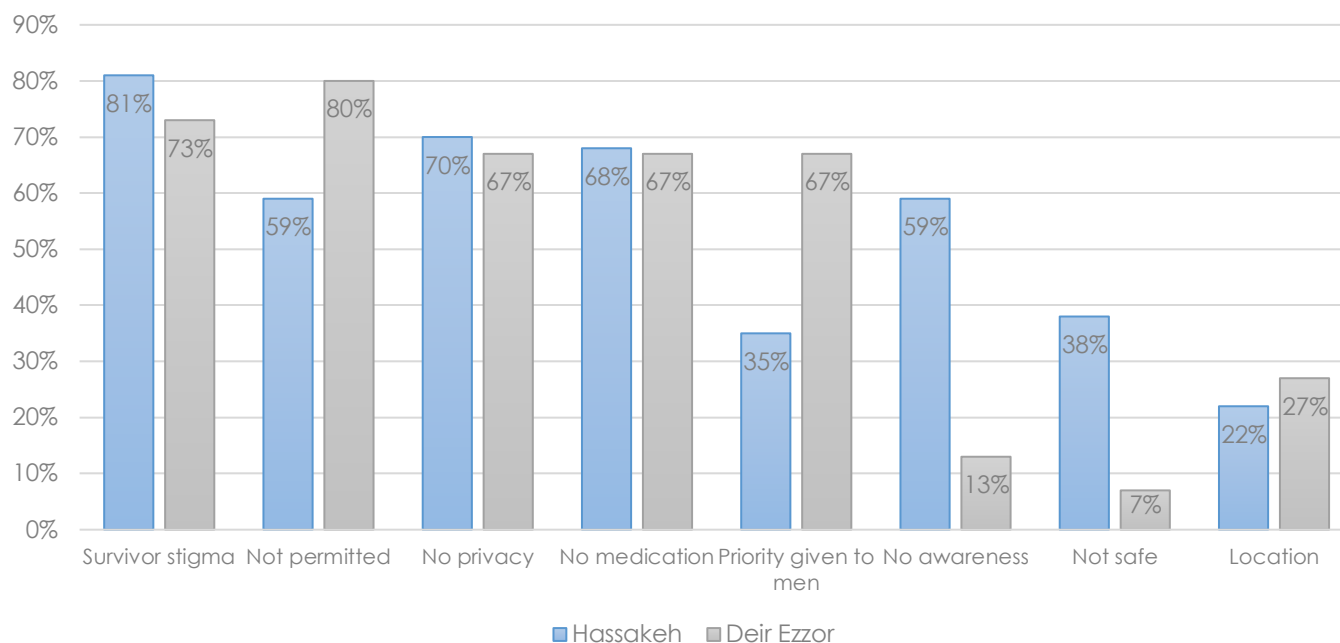


Figure 14 Obstacles hindering access to services - women and girls (source: KIIs)

The top barriers affecting women and girls' access to services were their fear of being stigmatised and "branded as survivors (81% in Hassakeh and 73% in Deir Ezzor), their not being permitted to do so by their families (80% in Deir Ezzor and 59% in Hassakeh), no feeling of privacy and confidentiality (70% in Hassakeh and 67% in Deir Ezzor), no sufficient or adequate medication at healthcare units – which only provided painkillers and medical consultations (68% in Hassakeh and 67% in Deir Ezzor), and priority being given to men and boys (67% in Deir Ezzor and 35% in Hassakeh).

Two other issues in Hassakeh were a lack of awareness of the available services and/or the unawareness that they should seek out certain services – especially medical after sexual assault, as well as the safety challenges associated with making the trip to the service points.

In some cases, the location where services were provided was too distant from the women and they could not secure transportation to reach. Hours of operation were generally limited in most cases, which meant that women did not have immediate access to services at any time in case of emergency or need.

SPs in Khashman and Nashweh said that the community does not accept women seeking PSS services after experiencing violence, especially if the violence is domestic (physical or marital rape). Survivors also fear the reaction of their parents if they speak to an aid worker, as "this is considered divulging private family affairs." The idea of receiving MHPSS was also "rejected by the women, possibly because of the limited effects or types of MHPSS services offered."

In cases of rape, women in all governorates avoided reporting in fear of the associated stigma and to preserve their reputation and that of their children, to protect themselves from the harsh judgment and blame of the community around them, and to escape potential household imprisonment or honour killing. Additionally, they neither had sufficient knowledge about the related legal, judicial, or social services, nor about who they could report to.

The main issues mentioned by service providers working in AI HoI were insufficient amounts and types of medication at healthcare units, community lack of awareness of existing services, women and girls not being allowed to access services by their families, priority given to men and boys, and the lack of safety associated with accessing services (including inadequate locations and hours of operation of the service points). Women were also unable to leave their children alone in their tents while they sought services, and some parents were unaware that they should accompany their children to receive services. Finally, the low availability of female service providers obstructed attempts to receive support.

Service Access Obstacles - Men

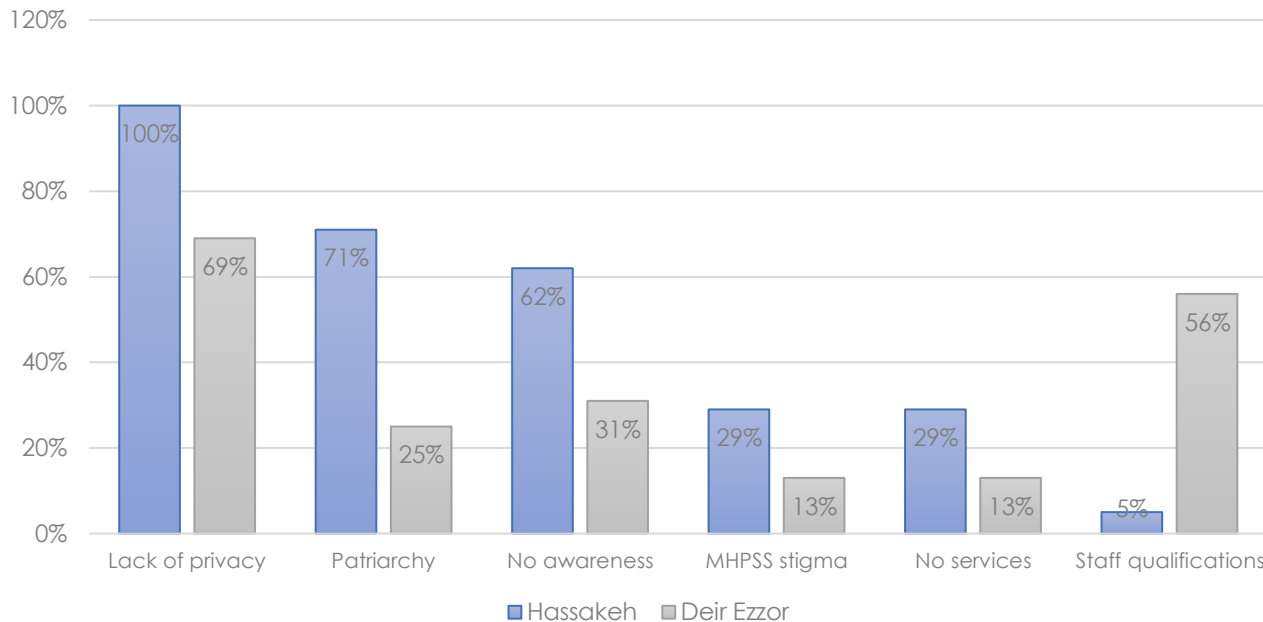


Figure 15 Obstacles hindering access to services - men (source: KIIs)

The perceived lack of privacy and confidentiality when it comes to receiving services was a concern shared by both women and men alike. This issue can be related to the lack of privacy the service point offers (conversations may be audible, third parties may be present in the room, women or children may be accompanied by husbands or parents and not feel comfortable talking, locations could be conspicuous, which could raise questions about why a person is visiting the service centre) or fears regarding whether what a survivor reports will remain confidential (the service provider or centre staff could be members of the same community or know people from the survivor's circles, the SP's behaviour or lack of qualification may not inspire sufficient trust, reporting or referral procedures may raise fears about the information spreading, and other such issues).

Another main social issue hindering men from seeking services was the patriarchal ideology that “men who seek support are not ‘real’ men or are weak men,” “men are the ones who perpetrate violence,” and similar. This was especially the case when it came to receiving mental health support, which held further stigma, because it was associated with “instability and insanity.”

A lack of awareness of the available services, as well as the fact that specialised services were neither widely available nor adequate (low number of specialised staff, low availability of medication, limited services offered).

Respondents at Al Hol said that service hours of operation “clash with the monthly distribution schedule,” and the main reported reasons were patriarchy, stigma, lack of confidentiality and of services.

OBSTACLES TO ACCESSING MHPSS SERVICES – WOMEN AND MEN

The main reasons in both Hassakeh and Deir Ezzor were the fear of “being branded a victim of violence” and the stigma associated with receiving mental health support, the perceived lack of privacy and confidentiality, and the lack of awareness of services and the importance of seeking them out. Low staff capacities and qualifications as well as distance of service provision points were also deterrents. Among men, patriarchy played a significant role.

There were no significant differences at Al Hol, but some respondents mentioned that women were afraid of the Hisba Women (ISIS female ‘police’) who considered people who associated with NGOs to be “infidels worthy of death.”

CONCLUSION

Despite the existence of some services, community members and even some service providers appear to have limited to no awareness about them. There were neither specialised centres and front-liners, nor holistic GBV services that could provide adequate services to survivors. Not all areas had legislation related to penalising perpetrators of violence, and even when perpetrators were brought forth, there were little to no consequences. Women who reported domestic violence were usually divorced by their husbands or faced problems with their extended families. The aforementioned, coupled with the stigma, ostracisation, dishonour, and harsh consequences associated with being “branded a survivor,” especially of rape, discouraged survivors from reporting violence.

Actors working on the ground were not part of any organised efforts, and none of the respondents mentioned coordination groups or clusters concerned with managing humanitarian, protection, or emergency response. Service delivery projects were reported to be unstructured, and heavily dependent on donor agendas rather than the most pressing community needs.

In order to improve the GBV situation, it is important to launch wide-scale community awareness-raising efforts with the participation of influential community leaders and men and boys, build capacities of front-liners and service providers, and establish coordination, referral, and reporting networks which would foster a supportive positive environment that encourages survivors to seek justice by reporting violence, and to seek out medical and mental health services.

RECOMMENDATIONS

SERVICE IMPROVEMENT

- **Establish specialised centres that provide holistic care for GBV survivors:** Currently, services for GBV survivors are weak and limited to case management and individual consultations which “make no actual difference” to survivors. Within the healthcare field, there are no special CMR or survivor-specific considerations. As such, it is recommended to establish service points or mobile units that provide holistic care for GBV survivors, including referrals to essential services within a network of trained service providers. To note is that there should always be female staff and specialists available both to ensure survivor comfort, and out of respect for contextual specificities. Where feasible, it is a best practice to employ specialists who are not from the same community to ensure that they are not acquainted with the survivors or their immediate surroundings.
- **Set up local networks that can provide referrals and reporting assistance:** In relation to essential service provision, local networks should be set up to ensure the provision of interlinked services: this includes judicial and security stakeholders for reporting, investigation, and persecution, and other medical/social/mental health actors for relevant referrals.
- **Work towards organising protection response:** As mentioned by some service providers, there is no coordinated response to prevent the duplication of services within what is a very limited number of actors and implemented projects. Establishing a working group that meets regularly for networking, updates, and planning responses, to the extent feasible, would improve local response.
- **Organise distribution processes to reduce incidence of violence:** Where possible, especially but not limited to Al Hol, it is recommended that distribution processes are organised in a manner that would avoid excessive crowding. Gender considerations should be taken into account, where women should have separate queues, and should preferably be assisted by female distribution staff. Where possible, protection officers can be present at distribution sites to facilitate women reaching them.
- **Equip mobile units for outreach and service provision:** In several cases, survivors reported difficulty accessing services, either due to distance, or to the dangers and risks associated with travelling to reach service centres. Providing services through mobile units that survivors can more easily access without having to go far from their tents/shelters/homes will increase their ability to seek support. While these units should have specialised teams who can assist survivors, these services should be discreet and provided with other types of care. For example, a unit can provide medical, MH, and case management support. As such, women would be able to claim they are receiving the “less taboo” services.
- **Increase awareness about safe shelters for survivors in life-threatening situations:** A very minor percentage of respondents reported the existence of safe sheltering for women survivors of violence. It is recommended, through community networking, that service providers are informed of existing safe shelters – but not of their exact locations, in order to ensure their continued ability to provide women survivors with protection.

CAPACITY DEVELOPMENT

- **Build service provider capacities on quality SGBV response and confidentiality:** Personnel to be employed at survivor service provision points should receive training on topics related to their roles such as survivor-centred approaches, case management and holistic care provision, Do No Harm principles, ethical humanitarian principles and minimum standards, and PSEA. Additionally, the concepts of beneficiary consent need to be widespread, especially if any audio-visual documentation needs to take place, and prior to any referral. Privacy and confidentiality should be emphasised as critical issues, as a major deterring factor among all survivors – women, men, and children – was the fear of their reports not being kept confidential. A sustainable method of capacity building that promotes ownership can include conducting TOTs for qualified staff members who can convey the trainings to their colleagues. At a first stage, this should include technical support and overseeing by the trainers (on-the-job or remote coaching), and can potentially include incentives, if deemed adequate and feasible.
- **Train doctors, forensic doctors, and medical staff on the Clinical Management of Rape,** as well as on the medical ethics and standards of confidentiality, anonymity, and non-disclosure. It is recommended to look into partnering with a UN agency (mainly UNFPA) to provide post-exposure prophylaxis (PEP) kits for survivors of rape.
- **Avail community volunteers of capacity building opportunities:** Training opportunities and experience-sharing platforms for volunteers working on own initiatives to support their communities can play an important role in improving societal response to GBV and survivors. This can be done through an online platform if it is not feasible or sustainable to implement in the field. A database of available tools can also be created and circulated to facilitate the access of any volunteers and PSS/GBV staff looking to increase their skills. Volunteer-led peer support groups can also be a viable option if directly trained and mentored by relevant experts, and at a later stage empowered to feel a sense of ownership in regard to continuing activities post end of support.

POLICY AND LOBBYING

- **Raise awareness “for the community, by the community”:** Several SPs and women living in Al Hol mentioned that in some cases, there is strong rejection towards engaging with NGOs, who are viewed as “western” or “infidels.” As such, working with key stakeholders, religious or tribal leaders, and dignitaries from the local communities so that they themselves spearhead efforts geared towards accepting and reintegrating survivors, and raising awareness about the importance of seeking out services and allowing other family members to receive services.
- **Support local authorities or judicial bodies to develop clear-cut legislation and penal codes related to violence:** The clear impunity of perpetrators within the different communities has played a major role in creating a culture of silence and non-reporting, where survivors feel that not only is there no purpose in reporting, it is also a dangerous practice given that perpetrators are not penalised and can retaliate. Developing clear laws that are applied by the authorities would be an important step in encouraging survivors to seek justice.
- **Public campaigning on rights of survivors:** Empower community change-makers and local stakeholders to lead public campaigns aiming to inform survivors and the community at large of women’s human rights and survivors’ rights. This can follow training security forces and establishing proper reporting channels, to encourage women to report.

PUBLIC OPINION/BEHAVIOURAL CHANGE

- **Regularly communicate available services and related updates:** Based on primary data, there was an insufficient level of awareness about available services. Regularly informing residents and service providers of offered support and any respective changes will ensure wider coverage and referral.
- **Early prevention and community awareness:** In order to address GBV, extensive work needs to be done with the communities and with individuals, engaging both perpetrators and survivors alike, as well as children via early prevention activities. However, to avoid being marked as provocative or “importing Western ideas,” it is important to take any contextual specificities into consideration when designing programmes and activities, ensuring a participatory grassroots design that builds upon the opinions of experts, and the self-identified needs of the communities the work is intended to serve. This can be coupled with targeted training for youth and other community members to become change-makers who will promote tolerance, acceptance and ending stigma and victim-blaming.
- **Target men survivors and perpetrators through contextually sensitive “packaging” of services:** Raise awareness among men regarding service provision and potential locations for help. Given the patriarchy-induced social taboos associated with men seeking services, it is important to establish community centres that provide anger management support and group discussion sessions. Through those sessions, service providers can build rapport with the men, and gradually begin introducing awareness topics related to masculinities, support-seeking behaviour, and the perpetration of violence.
- **Increase SRHR awareness** – where feasible – among both adults and adolescents, especially in educational settings. The sessions need to target girls separately to teach them about their rights and how to protect themselves and ward off unwanted advances and attacks; and boys separately to engage them in ending the cycle of violence and harassment against women and girls, and in learning about positive masculinities.
- **Raise awareness on the harms of child marriage:** Given that the phenomenon is on the rise for numerous reasons, it is important to address the topic, and explain to parents the harmful consequences of marriage under the age of 18.
- **Raise awareness on the importance of education:** There were numerous reports of children being forced to drop out of school. These are almost always followed by child labour, early marriage, or militarisation, all of which pose severe risks to the lives of the children.

ACCOUNTABILITY AND COMMUNITY COHESION

- **Donor agencies are recommended to carry out due diligence when allocating support:** In order to limit the implementation of unnecessary or redundant activities, it is recommended that donors perform their due diligence through in-depth multi-sectorial needs assessments and community mapping exercises, thus ascertaining that their support goes to fill the most pressing existing gaps.
- **Establish effective reporting mechanisms, and ensure beneficiaries are informed of them:** SPs and community members alike mentioned the incidence of sexual exploitation by aid workers in exchange for services or assistance. In order to address this issue, it is important to ensure that community members are aware of available complaint reporting mechanisms. Additionally, fears of retaliation and loss of aid result in underreporting even when beneficiaries are aware of the mechanisms. As such, complaints systems need to be protect beneficiary confidentiality and anonymity (for example, the complaint should not reach a field office, but rather a management office or HQ and which is run by a staff member who is not acquainted with the field team to ensure

that all complaints, particularly those with an SEA nature, are conveyed and adequately investigated). To the extent possible, apply a strong vetting process that avoids contracting individuals who do not have the skills, knowledge, or ethics to be working with beneficiaries.

- **Provide assistance to host and IDP communities alike:** Risk factors included attacks on IDP communities, and reports of host communities blaming IDPs for increased problems. To ensure that assistance neither creates intra-community tensions nor affects organisational credibility, it is important to ensure that any established services target both IDP and host communities – if not equally, at least with a fair percentage towards host communities, who are often also suffering from similar issues and poverty levels.
- **Implement economic empowerment activities and cash for work projects “to reduce risk of violence”:** Some SPs and community members believed that if basic needs were secured and residents’ economic power was increased, this would reduce the risks of exploitation and physical attacks with the intent of stealing needed items or money. Economic empowerment activities such as vocational training, seed grants for small businesses, and cash for work projects (which can be combined with efforts to increase security through contracting residents to form community patrols at camps, collective shelters, and residential areas).

