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Reproductive Health And Gender-Based Violence In Syrian Refugee Women

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REPRODUCTIVE HEALTH & GENDER-BASED VIOLENCE IN SYRIAN REFUGEE WOMEN

by

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ABSTRACT

Background: The current conflict and humanitarian crisis in Syria continues to displace thousands of Syrians to neighboring countries, including Lebanon. There is a lack of information available to provide adequate health and related services to this displaced population, particularly women and adolescent girls, who comprise the majority of registered refugees. **Methods:** We conducted a rapid needs assessment from June-August 2012 in Lebanon by administering a cross-sectional survey in six health clinics and conducting three focus group discussions. Information was collected on reproductive and general health status and needs of displaced Syrian women, including exposure to violence and help-seeking behaviors. **Results:** We interviewed 452 displaced Syrian women ages 18-45 who had been in Lebanon for an average of 5.1 (± 3.7) months. Additionally, 29 women participated in three focus group discussions. Reported gynecologic conditions were common, including: menstrual irregularity, 54%; severe pelvic pain, 52%; and vaginal infections, 53%. Of our sample, 74 were pregnant at some point during the conflict, 40% of the currently pregnant had experienced pregnancy complications, and 37% of those who completed their pregnancies experienced delivery or abortion complications. The prevalence of adverse birth outcomes were: low birth weight, 12%; preterm delivery, 27%; and infant mortality, 3%. Of the entire sample, 31% experienced violence and 3% experienced sexual violence from armed people. Of those exposed to violence, 28% reported physical injury and 71% reported psychological difficulties. The majority of those exposed to violence did not seek medical care (65%). In multivariate models, exposure to violence was associated with menstrual irregularity ($p=0.002$), severe pelvic pain ($p=0.005$), and vaginal infections ($p=0.002$). In focus groups, participants revealed lack of access to basic services (including reproductive health care), high levels of stress in the home, and cases of intimate partner violence. **Conclusions:** This study contributes to a better understanding of health needs among conflict-affected women. High occurrence of pregnancy-related complications and gynecologic conditions, in addition to barriers to accessing care, indicate a need for better targeting of reproductive health services. The association between violence and reproductive health indicates a need for GBV-related and psychosocial services alongside standard reproductive healthcare.

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INTRODUCTION

This rapid assessment of reproductive health and gender-based violence (GBV) was conducted during June-August 2012 due to the growing numbers of displaced Syrian women and adolescent girls in Lebanon, and the need for information in order to improve health and SGBV-related services offered to them. The survey was carried out in health clinics in North Lebanon and the Bekaa Valley run by the Rafik Hariri Foundation, Makassed, and the Ministry of Public Health. Focus group discussions (FGDs) were carried out in community centers run by local NGOs and supported by the Danish Refugee Council.

This assessment was supported by the United Nations Population Fund (UNFPA) in Lebanon and Yale School of Public Health (YSPH), Okvuran Fund for International Support. The survey was conducted in cooperation with UNFPA, International Medical Corps (IMC), the Rafik Hariri Foundation, the Makassad Foundation, the Ministry of Public Health, and the Danish Refugee Council (DRC) in Lebanon, by researchers from Yale School of Public Health (YSPH) and the American University in Beirut (AUB).

Background

The current crisis in Syria began during March 2011 and continues to displace Syrians from many towns and cities across the country. The number of Syrians who have fled to nearby Lebanon is over 400,000 (as of April 23, 2013), up from the approximately 48,000 displaced Syrians in Lebanon when data collection for this study began in summer 2012 (UNHCR 2013). The majority of these refugees are women and children. The mountainous border region of North Lebanon (in the areas of Akkar and Wadi Khaled) and the Bekaa Valley along Lebanon's eastern border host the majority of Syrian refugees in Lebanon (30% and 26%, respectively) (UNHCR 2013).

Research shows that in conflict settings and refugee crises, women may be more susceptible to GBV, including sexual and gender-based violence (SGBV), and to poor reproductive health outcomes (IAWG 2010, Al Gasseer et al. 2004, Gagnon and Robinson 2002, McGinn 2000, Jamieson et al. 2000, Lederman 1995). SGBV has been found to occur surrounding armed conflict both as a weapon of war and in the form of intimate partner violence, particularly in refugee settings (McGinn 2000). There is evidence that SGBV can have direct health consequences such as injury, psychological conditions, and gynecological problems (Campbell 2002; Al Gasseer et al. 2004). Numerous anecdotal and agency reports and media accounts describe violence (including SGBV) and healthcare shortages surrounding the Syrian conflict, and measurement of these issues is critical (MSF 2012; Tuysuz 2011; Amnesty International 2012; Human Rights Watch 2012; International Rescue Committee 2012).

More research is needed to help clarify the association between conflict-related risk factors, including SGBV, and the type and prevalence of reproductive health outcomes. In addition to contributing to the larger body of literature on reproductive health in conflict settings, this study builds on local understanding of reproductive health needs among Syrian refugee women for the purpose of informing humanitarian response. The goals of this study align both with the mission of the United Nations Population Fund (UNFPA), an agency active in the reproductive health response for Syrian refugees in Lebanon, and with research priorities set by the Interagency-Working Group (IAWG) on Reproductive Health in Crisis (IAWG 2011).

UNFPA and NGOs – such as International Medical Corps (IMC), Médecins Sans Frontières (MSF), Médecins du Monde (MDM), and others – are active in providing

reproductive healthcare services for Syrian women and adolescent girls, as well as women and girls from within the host communities who are also affected as a result of this crisis. When data analysis for this study was conducted in August 2012, several steps had been taken to address the reproductive health needs and experiences of GBV/SGBV among displaced Syrians. Two MISP (Minimum Initial Services Package) training workshops were conducted jointly by UNFPA, IMC, the Ministry of Public Health (MOPH), and the Lebanese Society for Obstetrics and Gynecology (LSOG). Selected RH kits (mainly Rape kits, oral and injectable contraception kits, treatment of STI kits, and IUD kits) were procured and distributed to four primary health care clinics in the Bekaa Valley and North Lebanon for use among patients. Social workers in Akkar and Tripoli were trained on sensitivity to GBV, including in humanitarian settings.

UNHCR was in the process of establishing a referral system for cases of GBV/SGBV among the Syrian population. Other NGOs (including International Medical Corps and the Danish Refugee Council) had conducted case management training on GBV, and were offering social counseling and community services to survivors. International Rescue Committee was conducting a situational assessment of GBV among Syrian refugees in Lebanon. There was no GBV sub-working group among the humanitarian actors, however they all expressed the need to establish one in order to better strategize and plan joint interventions.

Study Objectives

The overall goals of this study are to increase understanding of reproductive health outcomes and SGBV in post-conflict settings by assessing the experiences and needs of displaced Syrian women who have fled from the current conflict in Syria to Lebanon, and to inform local humanitarian programs for Syrian women. The specific aims of the research are to a) describe current reproductive status and needs of displaced Syrian women living in Lebanon; b) identify factors associated with poor reproductive outcomes, including health service availability and access; c) describe the type and characteristics of violence, including SGBV, experienced by Syrian women; and d) identify the coping strategies and behaviors of Syrian women survivors of violence.

PART 1: SURVEY ASSESSMENT

METHODOLOGY

Research setting

This rapid needs assessment was conducted in Lebanon between June and August 2012, one year after the conflict erupted in Syria, as refugee numbers were rapidly escalating in Lebanon. Using a cross-sectional design, the survey was carried out in six primary healthcare clinics in North Lebanon and the Bekaa Valley (Fig. 1). Clinics were selected based on the number of displaced Syrian women attending per month (at least 100) and the provision of reproductive health services. Clinics with the highest number of Syrian women patients attending during the month just prior to this assessment were selected. In order to avoid bias related to clinic selection, we chose a mix of clinics supported by government and non-government sources. Three clinics were supported by a private foundation, two clinics were jointly run by the Lebanese Ministry of Public Health (MOPH) and a private foundation,

and one clinic was run solely by the MOPH. This study was approved by the Human Subjects Committee at Yale School of Public Health (YSPH) and by United Nations Population Fund (UNFPA).

Sampling framework, study participants, and recruitment

We used a proportional sampling method with the aim to recruit 400 displaced Syrian women ages 18-45 attending local health clinics located in two regions of Lebanon: three clinics in North Lebanon and three clinics in the Bekaa Valley. We specified that each clinic recruit the number of participants out of 400 that was proportional to the number of Syrian women attending the clinic during the month prior to the study. All female, displaced Syrians presenting to these six clinics within the month of July 2012 were approached for recruitment, screened for eligibility, and asked if they would like to participate in the study until the target number was reached. Eligibility criteria included: 1) ability to speak Arabic, 2) identity as a Syrian national, 3) having come to Lebanon since the conflict in Syria began in March 2011, and 4) age between 18 and 45 (inclusive). Once screened, women were escorted into a separate room where an IRB-approved consent form was explained and signed prior to questionnaire administration.

Data collection

The interviewer-administered questionnaire was adapted from the "Gender-based Violence Tools Manual - For Assessment & Program Design, Monitoring & Evaluation in Conflict-Affected Settings" (RHRC 2004) and the "Reproductive Health Assessment Toolkit for Conflict-Affected Women" (CDC 2007). The questionnaire was designed in English, discussed with the various stakeholders, translated into Arabic and pilot tested among Syrians in Lebanon, and administered in Arabic by trained research assistants. It included six sections addressing the following topics: 1) individual characteristics and displacement history; 2) general health status; 3) reproductive history and current status; 4) exposure to violence, including SGBV; 5) coping strategies and stress; and 6) pregnancy-related information (among a subset of those who were pregnant at any time during the conflict) (see Appendix 2). Of the 489 eligible Syrian women approached to participate, 29 declined to participate and 460 (94.1%) completed the interviews. Eight participants were excluded after completing the interview, as they did not meet study criteria, resulting in a final sample size of 452. At the end of the interview, all participants received a UNFPA "dignity kit" containing basic sanitation supplies and clothing to compensate for their time (see Appendix 4 for contents).

Figure 1. Clinic study sites

Clinic name	Town, region	Relevant health services offered	No. Syrian women during past month	Goal No. interviews
Wadi Khaled Health Center (Makassad and Ministry of Public Health)	Heshha, North Lebanon	OB/GYN, provision for normal deliveries, ultrasound, antenatal care, social worker	152/month	100
Bireh Community Health Center (Rafik Hariri Foundation)	Bireh, North Lebanon	OB/GYN, ultrasound, antenatal care, social worker	175/month	50

Michha Health Center (Ministry of Public Health)	Michha, North Lebanon	OB/GYN, ultrasound, antenatal care, social worker	200/month	50
Bekaa Community Health Center in Taanayel (Rafik Hariri Foundation)	Taanayel, Bekaa Valley	OB/GYN, ultrasound, mammography, routine lab tests, antenatal care, social worker	111/month	50
Baalbek Community Health Center (Rafik Hariri Foundation)	Baalbek, Bekaa Valley	OB/GYN, ultrasound, mammography, routine lab tests, social worker	123/month	75
Irsal Community Health Center (Rafik Hariri Foundation and Ministry of Public Health)	Irsal, Bekaa Valley	OB/GYN, ultrasound, antenatal care, social worker	122/month	75

Training of interviewers

All interviews were conducted by university students who underwent special training prior to data collection on how to approach patients in clinic waiting rooms, check for eligibility criteria, obtain informed consent, and then administer the questionnaire. All data collectors were supervised on their first day of data collection to ensure proper administration of the questionnaire. The PIs checked their work periodically, and consulted with them on site.

Data analysis

We conducted bivariate analysis to examine associations between variables of interest, using X^2 test for categorical variables and Student's t-test for continuous variables. Multivariate logistic regression was used to examine the relationship between exposure to violence, stress, and gynecologic conditions. The following covariates were examined and were controlled for in multivariate models as appropriate: region in Lebanon, clinic and clinic type (government funded or not), urban versus rural place of origin, age, education level, marital status, food insecurity, anemia, hypertension, diabetes, contraceptive use, months in Lebanon, cigarette smoking, and work status. Data were analyzed using Statistical Analysis Software (SAS) v 9.2.

RESULTS

Individual characteristics & displacement history

The two samples of Syrian women – one in North Lebanon and the other in the Bekaa Valley – were almost identical in individual characteristics, with the sample in the Bekaa Valley being slightly younger ($p=0.0342$) and less likely to have been married ($p=0.0143$) (Table 1). The majority of women overall were married, and there was a high rate of consanguinity. Participants were evenly split between urban and rural places of origin in Syria, and this did not differ by region ($p=0.8569$). More than three quarters of the population has less than a High school education, which may indicate low socio-economic status.

Table 1. Individual characteristics of 452 Syrian refugee women by region in Lebanon[1]

	North Lebanon (n=251) N (%) or Mean (SD)	Bekaa Valley (n=201) N (%) or Mean (SD)	P[2]
Age			
18-24	53 (21)	64 (32)	0.0342
25-34	111 (44)	83 (41)	
35-45	84 (33)	54 (27)	
Marital Status			
Married	222 (88)	159 (79)	
Widowed	7 (3)	4 (2)	0.0143
Separated/Divorced	3 (1)	3 (1)	
Never Married	19 (8)	35 (17)	
Husband is a relative	99 (43)	73 (45)	0.6380
Avg. age at first marriage (yr)	19 ± 3.8	19 ± 4.3	0.4549
Avg. duration of marriage (yr)	12 ± 7.9	11 ± 8.0	0.1158
From a city in Syria (urban)	124 (49)	97 (49)	0.8569
From a village in Syria (rural)	126 (50)	92 (51)	
Education			
No education	37 (15)	26 (13)	
Less than High school	154 (62)	127 (64)	0.7487
High school	43 (17)	29 (15)	
Greater than High school	16 (6)	16 (8)	

1. Numbers may not sum to total due to missing data, and percentages may not sum to 100% due to rounding
2. P-values are for t-test (continuous variables) or X^2 test (categorical variables)

The three most common reasons reported for leaving Syria were security concerns or fear (98%), lack of daily necessities (68%), and lack of healthcare (62%) (Table 2). Reasons for leaving differed by region, with those in North Lebanon more likely to report lack of daily necessities (p<.0001) and lack of healthcare (p<.0001). Other reasons include their monetary situation and the need for work, as well as their homes being destroyed in Syria. The average time living in Lebanon differed between displaced Syrian women in the North (6.0 months) and those in the Bekaa Valley (4.5 months) (p=0.0011).

The majority of respondents were living in some type of formal housing at the time of the interview, with those in the Bekaa Valley significantly more likely to be living in informal housing (p=0.0004). A formal home is defined as a relative's home, friend's home, rented apartment, or free house (paid for by someone else). An informal residence includes: a tent, camp, group housing, school building, abandoned house, mosque or religious institution, office, shop, or moving from place to place.

With regard to humanitarian services received in Lebanon, more women in the Bekaa Valley reported receiving services (food, blankets, medicine, and sanitary supplies) than in North Lebanon (Table 2). None of the women interviewed in the North was working, whereas 6% in the Bekaa Valley were working. Participants reported lack of access to basic household amenities, with similar responses between regions. Food insecurity is a concern among this sample, with higher prevalence in North Lebanon than in the Bekaa Valley (p=<.0001).

Table 2. Displacement history of 452 Syrian refugee women by region in Lebanon[1]

	North Lebanon (n=251) N (%) or Mean (SD)	Bekaa Valley (n=201) N (%) or Mean (SD)	P[3]
Top 3 reasons for leaving Syria			
Security concerns/ fear	250 (99)	195 (97)	0.0269
Lack of daily necessities (inc. food)	221 (88)	85 (42)	<.0001
Lack of healthcare	217 (86)	62 (31)	<.0001
Avg. time in Lebanon (mo.)	6.0 ± 3.9	4.5 ± 3.4	0.0011
Avg. time in current home (mo.)	5.5 ± 3.8	3.6 ± 3.0	<.0001
Type of residence in Lebanon			
Formal Home	229 (92)	160 (80)	0.0004
Informal Residence	21 (8)	40 (20)	
Avg. # children (<18) in residence	4 ± 3.1	3 ± 2.3	0.0001
Avg. # adults (≥18) in residence	4 ± 3.6	3 ± 3.9	0.1120
Services received			
None	93 (37)	23 (11)	<.0001
Food	153 (61)	160 (80)	<.0001
Blankets/bedding	16 (6)	109 (54)	<.0001
Clothes	20 (8)	25 (12)	0.1148
Medication	41 (16)	74 (37)	<.0001
Sanitary supplies	66 (26)	110 (55)	<.0001
Working status			
Not working/do not want work	217 (86)	116 (83)	0.0008
Currently seeking work	34 (14)	23 (12)	
Currently working[2]	--	11 (6)	
Primary source of Income			
No income	114 (46)	39 (20)	<.0001
Husband	66 (26)	105 (53)	<.0001
Family	34 (14)	27 (14)	0.9887
Self	1 (<1)	13 (7)	0.0002
Charity/assistance	36 (14)	62 (31)	<.0001
No access to the following in place of residence in Lebanon:			
Piped water for drinking	76 (30)	68 (33)	0.4206
Water for other uses	61 (24)	56 (28)	0.3908
Bathing facilities	52 (21)	41 (20)	0.9165
Soap, body cleansers	71 (28)	48 (24)	0.2905
Sanitary napkins, pads	70 (28)	55 (27)	0.9013
Food insecurity:			
Worry about enough food	175 (70)	109 (54)	<.0001
Eating non-preferred foods	180 (72)	84 (42)	<.0001
Skipping meals	180 (72)	69 (34)	<.0001

1. Numbers may not sum to total due to missing data, and percentages may not sum to 100% due to rounding
2. Type of work includes farming, daily labor, housekeeping, factory, and professional work
3. P-values are for t-test (continuous variables) or X^2 (categorical variables)

General health status

Syrian women in both regions cited a range of health problems. The majority of participants in the North (44%) rated their overall health as fair/acceptable, while the majority in the Bekaa Valley rated theirs as good (35%) with fair/acceptable as a close second (33%). This sample is largely a non-smoking sample, with high percentages of women in both regions saying they never smoke cigarettes or water pipe (see Table 3).

The most prevalent condition cited by women in both regions is anemia, with 31% prevalence among participants in the North and 24% in the Bekaa Valley (Table 3). Hypertension and diabetes followed. In addition to these three diseases directly addressed in the survey, 20% of women in the North and 36% in the Bekaa Valley reported other diseases or conditions, including 10 women citing gynecological issues.

196 (43%) women were taking medications at the time of the survey. The eight most cited conditions for which they were taking medication are listed (Table 3). Medication for reproductive infections was high on the list, with 14% in the North and 6% in the Bekaa Valley taking such medication at the time of the interview.

Table 3. General health status of 452 Syrian refugee women by region in Lebanon[1]

	North Lebanon (n=251) N (%) or Mean (SD)	Bekaa Valley (n=201) N (%) or Mean (SD)	P[3]
Self-rated overall health			
Excellent	10 (4)	26 (13)	0.0023
Good	88 (35)	69 (35)	
Fair/Acceptable	110 (44)	66 (33)	
Poor	35 (14)	29 (15)	
Very poor	7 (3)	9 (5)	
Cigarette smoking			
Every day	41 (16)	28 (14)	0.7634
Some days	12 (5)	9 (5)	
Never	197 (79)	163 (82)	
Water pipe smoking			
Every day	14 (6)	5 (2)	0.2444
Some days	24 (10)	22 (11)	
Never	211 (85)	174 (87)	
Reported diseases/conditions			
Anemia	78 (31)	46 (24)	0.0766
Hypertension	35 (14)	20 (10)	0.2131
Diabetes	10 (4)	4 (2)	0.2197
Others	50 (20)	69 (36)	
Musculoskeletal issues	15 (26)	17 (21)	
Cardiovascular issues	13 (23)	6 (7)	
Abdominal issues	9 (16)	3 (4)	
Mental health issues	5 (9)	10 (12)	
Vaginal infections	3 (5)	7 (9)	
Urinary tract infections	4 (7)	6 (7)	

Reported use of medication[2]		
Cardiovascular	20 (18)	11 (13)
Vitamins	19 (17)	14 (16)
Reproductive infections	15 (14)	5 (6)
Mental/ psychosomatic	12 (11)	12 (14)
Analgesics/ painkillers	12 (11)	8 (9)
Abdominal pain	9 (8)	5 (6)
Anemia	5 (5)	8 (9)
Musculoskeletal	7 (6)	6 (7)

1. Numbers may not sum to total due to missing data; percentages may not sum to 100% due to rounding
2. 111 women in the North and 85 in the Bekaa Valley (p=0.2440) were on medication.
3. P-values are for t-test (continuous variables) or X^2 (categorical variables). P-values are only given for closed-ended questions.

At the end of the survey interview, women were asked to identify their three "biggest health concerns." We grouped these issues into loose categories and listed them below in order to portray health priorities among Syrian women themselves. Among the responses, concerns about reproductive health were common. Additionally, 26 women raised issues related to pregnancy or breastfeeding, with delivery costs and services highlighted as an important issue to address (Figure 2).

Figure 2. Syrian women's "biggest health concerns" (based on open-ended question)

Health concern	Description	# Times Cited
Reproductive health needs	genital infections, infertility, pelvic pain, and OB/GYN services	57
Musculoskeletal issues	injuries and musculoskeletal pain	37
Needs of children	milk, diapers, childcare, doctor's visit	40
General relief services	range of daily items needed for survival	30
Pregnancy issues	delivery, maternal issues, breast feeding	26
Cardiovascular issues		24
Abdominal issues		24
Headaches and general pain	issues for which women are taking basic painkillers	20
Access to care & medication		17
Nutritional issues		12
Mental health	depression, anxiety, psychological issues	12
Urinary issues	UTI, kidney stones, renal problems	11
Medical testing/surgery		11
Psychosomatic issues	stress, fatigue, dizziness, loss of appetite, repeated vomiting, need for sedatives, sleeping issues	9
Anemia	self-report, often iron-deficiency	8
Contraception		1

Pregnancy

Out of the 452 survey participants, 74 were pregnant at some point during the conflict, 43 were pregnant at the time of the interview (currently pregnant), and 38 had delivered or had an abortion since the conflict began. Eight women were included in both categories because they delivered or aborted since the conflict, and then became pregnant again.

The average age of currently pregnant women was 26 years (± 6.7), and 30% of them were primiparous (Table 4). The majority had single-infant pregnancies, but there were three cases of twins. At the time that they fled Syria, 26% were in their first trimester, 23% in their second trimester, and 12% in their third trimester (33% were not pregnant at the time of leaving Syria). 70% of currently pregnant women received any antenatal care, primarily in Lebanon.

The most common pregnancy complication among currently pregnant women was symptoms of anemia (26%), followed by abdominal pain (16%), vaginal bleeding (9%), and fever (5%). Other pregnancy complications cited include: swelling face and hands, blurred vision, vaginal infection and preeclampsia.

Table 4. Characteristics of 43 currently pregnant Syrian refugee women[1]

	N (%) or Mean (±SD)
Average age	26 ± 6.7
Primiparous	13 (30)
Trimester when left Syria	
Not pregnant when fled	14 (33)
1st Trimester	11 (26)
2nd Trimester	10 (23)
3rd Trimester	5 (12)
Trimester at time of interview	
1st Trimester	8 (19)
2nd Trimester	13 (30)
3rd Trimester	17 (40)
Received antenatal care	30 (70)
Pregnancy complications	
Anemia	11 (26)
Abdominal pain	7 (16)
Vaginal bleeding (inc. miscarriage)	4 (9)
Fever	2 (5)
Swelling (hands, face)	2 (5)
Blurred vision	1 (2)
Others (vaginal infection, preeclampsia)	4 (9)

1. Numbers may not sum to total due to missing data, and percentages may not sum to 100% due to rounding or multiple-response questions.

Among those who completed a pregnancy since the conflict began, there were four cases of abortion (spontaneous or induced) and one case of infant mortality (Table 5). Heavy bleeding was cited as the most common complication during labor and delivery (or during abortion), with 29% prevalence. Preterm birth was found to be at 26% prevalence, reported low birth weight (LBW) was at 11%, and there was one case of infant mortality reported. Most women chose to deliver or have an abortion in a hospital (71%), with 24% home delivery.

Table 5. Characteristics of 38 Syrian refugee women who delivered or had an abortion during the conflict

	N (%) or Mean (±SD)
Average age	27 ± 6.0
First pregnancy (primiparous)	6 (16)
Trimester when left Syria	
Not pregnant when fled	10 (26)
1st Trimester	9 (24)
2nd Trimester	9 (24)
3rd Trimester	9 (24)
Antenatal care	
0 visits	6 (16)
1-2 visits	11 (29)
3+ visits	15 (39)
Abortions	4 (11)
Infant mortality	1 (3)
Delivery/ abortion complications	
Heavy bleeding	11 (29)
Abnormal vaginal discharge	3 (8)
Others: convulsions, fever, blood pressure, separation of wound, baby's heart	5 (14)
Preterm birth	9 (26)
Low birth weight (LBW)	4 (11)
Country of delivery/ abortion	
Lebanon	24 (63)
Syria	14 (37)
Place of delivery/abortion	
Home	9 (24)
Hospital	27 (71)
Clinic or doctor's office	2 (5)
Post Delivery/ abortion Complications	
Severe bleeding	4 (11)
Abdominal pain	4 (11)
Anemia	3 (8)
Others (tired/dizzy, back pain, abnormal vaginal secretion)	5 (13)

The overall prevalence of complications during labor/delivery or abortion was 37% (Table 6). Most women who sought care for complications learned about the health facility through a clinical referral or from a friend. 52% of women who delivered during the conflict had an infant who experienced complications within the first 40 days of birth, including: sickness and abdominal pain, respiratory distress and infections, mental disability, calcium deficiency, injury, umbilical hernia, and issues related to premature birth (requiring a stay in the ICU. Only 48% of women who delivered breastfed their infant at all during the conflict. Reasons for not breastfeeding included: lack of milk or the child refusing, sickness or poor health, constant displacement, or the child died.

Table 6. Health-seeking behavior of 74 Syrian refugee women who were pregnant at some point during the conflict

	N (%)
At least 1 antenatal care visit	54 (73)
Antenatal services received	
Blood test	32 (59)
Blood pressure	25 (46)
Weight	31 (57)
Fetal heart	27 (50)
Ultrasound	32 (59)
Medication	22 (41)
Antenatal vitamins	39 (72)
Iron supplements (separate)	29 (54)
Did not receive antenatal care	20 (27)
Reason for no antenatal care	
No healthcare provider available	14 (70)
Could not afford	7 (35)
Distance/ transportation	5 (25)
Others: planning to go, security concerns, I am healthy, not treated well previously, female doctor is traveling	6 (30)
Pregnancy complications among currently pregnant (n=43)	17 (40)
Sought care for pregnancy complication	9 (53)
Facility where sought care:	
Clinic	7 (41)
Hospital	3 (18)
Traditional healer	2 (12)
Delivery/ abortion complications (n=38)	14 (37)
Sought care for delivery/abortion complication	9 (64)
Facility where sought care:	
Clinic	3 (21)
Hospital	3 (21)
Others (traditional healer, family, self)	3 (21)
Infant complication 40 days post-birth (n=33)	17 (52)
Sought care for infant complication	15 (88)
Facility where sought care:	
Clinic	6 (40)
Traditional healer	3 (20)
Family	3 (20)
Others (hospital, self, Al-Azhar)	4 (26)
Health check-up within 40 days of delivery/ abortion	6 (16)
Received family planning information during check-up	4 (67)
Breastfed baby during conflict	16 (48)
Reasons did not breastfeed	
Not able to/ not enough milk	6 (35)
Others: sickness, constant displacement, child died	11 (65)

Reproductive health

Gynecological conditions or symptoms

The majority of women reported gynecologic conditions during the conflict, with 54% having menstrual irregularity, 52% having symptoms of dysmenorrhea, and 53% having symptoms of vaginal infections (Table 7). About a quarter of the women reporting one of these gynecological conditions sought help from a doctor (27%). Among those who did not suffer from any gynecological symptoms, 15% said they would not seek help if they had such a condition. Of the 85% who said they would seek help, 70% said they would seek help from a clinician, 8% from a relief agency, and 6% family, neighbors, or the pharmacy.

Table 7. Reproductive history, current reproductive status, and perceptions and use of services among 452 Syrian refugee women[1]

Reproductive History	N (%) or Mean (±SD)
Age at menarche	15 ± 11.1
Age at first pregnancy	20 ± 4.4
Number of pregnancies	5 ± 3.5
At least one miscarriage	126 (28)
At least one abortion (induced)	11 (2)
At least one cesarean section	111 (25)
At least one child death	80 (18)
Current Reproductive Status	
Pregnant at some point during the conflict	74 (16)
Currently pregnant	43 (10)
Reported gynecologic issues during conflict	
Menstrual irregularities	242 (54)
Severe pelvic pain/dysmenorrhea	233 (52)
Symptoms of vaginal infection	241 (53)
Perception and Use of Reproductive Health Services	
Perception of RH services availability:	
Available	202 (45)
Unavailable	171 (38)
Don't know	76 (17)
Perception of RH services accessibility:	
Easily accessible	146 (32)
Inaccessible/difficult to access	177 (39)
Don't know	47 (10)
Perceived barriers to access (n=177):	
Price	88 (50)
Distance/transport	45 (25)
Fear of mistreatment	14 (8)
Security concerns	11 (6)
Shame/embarrassment	11 (6)
Other	8 (5)
Use of RH services during past 6 months:	
Visited OB/GYN doctor for any reason	118 (26)
Diagnosed with reproductive tract infection	123 (27)

Use of Family Planning Method /Contraception:	
IUD	86 (19)
Contraceptive pill	39 (9)
Rhythm method	16 (4)
Surgical method	11 (2)
Condoms	8 (2)
Injection	1 (0.2)

1. Numbers may not sum to total due to missing data.

Barriers to reproductive health services

Participants were asked whether they thought women's health services were available and accessible for Syrian women. While 45% perceived reproductive health services to be available to them, 32% reported that these services were accessible. The most commonly reported barriers to access price (50%) and distance/transport (25%). Other barriers to accessing reproductive health services included: fear of mistreatment, security concerns, shame, no female doctor available, and insufficient provision of services (*taksir*) (Table 7).

26% of women (118) responded positively that they had visited an OB/GYN in the past 6 months for any reason, and 27% reported being diagnosed by a healthcare professional with a reproductive tract infection (RTI) in the past 6 months. The majority of those who had been diagnosed with an RTI did not know the type of infection they were diagnosed with, but were able to describe symptoms. 47% said they had received medication or treatment for this RTI, 85% of whom received this treatment from a doctor. The remaining 15% were either self-treated or received treatment from another healthcare professional, a pharmacy, or a family member. The top three reasons for not receiving treatment for this RTI were insufficient funds (42%), not knowing where to go (20%), and unavailability of medical care (10%). Interestingly, 60% of respondents had never visited a gynecologist in their lives except during pregnancy.

Contraceptive use

Although 69% of women had heard of contraception, only 35% were using some type of contraceptive method. IUD was the most commonly used type of contraception, with 19% use overall. Other common methods cited were the contraceptive pill (9%) and the rhythm method or "natural birth control" (9%). Other birth control methods used included: surgery (2%), condoms (2%), and injection (<1%). Of those using contraceptives, the primary sources were clinics (44%), a hospitals (35%), and self/pharmacy (11%).

We asked those who reported having no access to contraception why this is the case. From the answers we have, the most common reasons were expense, distance or transport, running out, type of contraceptive preferred was unavailable, fear, and procrastination. Some women who are not currently using contraceptives expressed the desire to have a family planning method, but the majority of those who desire contraceptives said they are not receiving them due to lack of access.

Table 8. Associations between exposure to violence and stress with gynecologic outcomes among non-pregnant Syrian refugee women, June-August 2012 (N=409)

Characteristic	N	% with menstrual irregularities	OR (95% CI) [1]	% with severe pelvic pain	OR (95% CI) [2]	% with infection symptoms	OR (95% CI) [3]
Exposure to violence:							
No	276	50.2	Ref.	45.7	Ref.	48.5	Ref.
Yes	132	71.3	2.19 (1.33-3.60)**	71.2	2.74 (1.35-5.54)**	67.4	2.13 (1.31-3.46)**
Stress symptoms (> usual):							
Constantly tense	365	59.6	2.35 (1.12-4.95)*	55.9	1.18 (0.42-3.33)	57.0	2.79 (1.33-5.82)**
Feel sick & tired	336	59.3	1.60 (0.91-2.84)	55.1	1.15 (0.50-2.63)	56.6	1.49 (0.86-2.59)
Worried/concerned	338	59.4	1.73 (0.97-3.08)	56.8	1.63 (0.69-3.83)	56.9	1.68 (0.96-2.95)
Irritable/in bad mood	322	59.3	1.36 (0.80-2.30)	55.6	1.17 (0.59-2.32)	55.3	1.15 (0.69-1.93)
Loss of sleep/ disorders	327	60.9	2.27 (1.29-4.00)*	56.3	2.27 (1.01-5.09)*	57.1	1.69 (0.99-2.89)
Beating child	310	60.7	1.93 (1.14-3.28)*	57.1	1.87 (0.91-3.83)	57.1	1.59 (0.96-2.63)

1. Adjusted for: clinic, age, education, marital status, and food insecurity; 2. Adjusted for: clinic, age, education, marital status, number of pregnancies, and anemia; 3. Adjusted for: clinic, marital status, food insecurity, diabetes; *p-value <.05, **p-value <.01, ***p-value <.001

When looking at risk factors for gynecological symptoms, age was significantly correlated with menstrual irregularity, but not with other gynecological symptoms; 25-34-year-olds were more likely to have menstrual irregularity than those younger (18-24) or those older (35-45) (p=0.005). Additionally, those in the 25-34 age range were slightly more likely to have dysmenorrhea and genital infection symptoms than their younger or older counterparts, but this finding was not statistically significant. We examined more closely the relationship between violence and gynecological symptoms, as well as stress and gynecological symptoms in non-pregnant Syrian women (Table 8). Those who suffered from an experience of violence were more likely to have symptoms of menstrual irregularity, dysmenorrhea, and genital infections than those who did not (p-values <0.01), controlling for other variables. Some stress symptoms were significantly correlated with menstrual irregularity, including being constantly tense, loss of sleep, and child beating (p-values <0.05). Only loss of sleep was associated with severe pelvic pain/dysmenorrhea (p<0.05), and only being constantly tense was associated with symptoms of vaginal infection (p<0.01). Loss of sleep was marginally associated with symptoms of vaginal infection (p=0.06).

Exposure to violence

Women were asked about violence either experienced by a female direct relative or experienced personally, the type of violence experienced, the perpetrator, and what services they sought help from. Overall, 200 (44%) knew of a female direct family member who experienced violence, 139 (31%) experienced violence personally, and 125 (28%) experienced more than one type of violence personally.

Exposure of a direct female family member to violence

According to respondents, the only 29% of female family members they are aware of who experienced the types of violence listed sought help. 20% sought help at a clinic, 11% at a hospital, 7% from family, and the remaining approximately 14% sought help from traditional healers, neighbors or friends, the Red Cross, self, or they died from the violence. The vast majority of female family members who experienced violence were reported the perpetrator as armed people in Syria, with only four cases of violence perpetrated by a husband. This

number is likely low, however, as respondents may be unaware of intimate partner violence suffered by their female family members.

Table 9. Exposure to violence among 452 Syrian refugee women respondents and respondents' direct female family members

	N (%)
Female family member exposure to violence	200 (44)
Slapped or hit	96 (21)
Choked	29 (6)
Beaten or kicked	45 (10)
Threatened with a weapon	140 (31)
Shot at or stabbed	158 (35)
Detained against your will	77 (17)
Deprived of food, water or sleep	156 (35)
Subjected to improper sexual behavior (SGBV)	32 (7)
Respondent exposure to violence	139 (31)
Slapped or hit	37 (8)
Choked	15 (3)
Beaten or kicked	16 (4)
Threatened with a weapon	101 (22)
Shot at or stabbed	112 (25)
Detained against your will	36 (8)
Deprived of food, water or sleep	116 (26)
Humiliated/emotionally abused	111 (25)
Deprived of money	119 (26)
Subjected to improper sexual behavior (SGBV)	14 (3)
Result of exposure to violence	
Suffered physical injury	18 (28)
Suffered psychological difficulties	46 (71)
Told someone about exposure to violence	
No one	33 (51)
Husband	16 (25)
Friend	6 (9)
Family member	5 (8)
Others: clinician/social worker, NGO, religious authority	8 (12)
Sought medical care after exposure to violence (n=19)[1]	
Hospital	11 (58)
Clinic	3 (16)
Others: traditional healer, family, pharmacy	4 (21)
Did not seek medical care after experience (n=51)	
Did not need	12 (24)
Had insufficient funds	18 (35)
Did not know where to go	10 (20)
Medical care not available	7 (14)
Others: useless/futile, embarrassed, afraid	10 (20)
Want to talk with someone about the experience	19 (29)

1. All but one case sought medical care in Lebanon (not in Syria).

Respondent exposure to violence

Of the 139 respondents who were exposed to some type of violence most was war related, and the majority identified the perpetrator as an armed person in Syria. Two women disclosed that their husbands were hitting them, one in Lebanon and the other did not specify. One woman reported being "humiliated" by family members or acquaintances in Lebanon. Only 14 women (3%) reported cases of sexual violence, and all were perpetrated by armed people in Syria. We expect that this number is low based on likely underreporting of sexual violence due to shame or stigmatization.

Out of all those who experienced violence, 15 were pregnant at some point during the conflict. Direct physical violence – such as hitting, slapping, or choking – were reported only among three pregnant women. One woman who was pregnant during the conflict said that she had been detained. The relationship between pregnancy complications and violence could not be assessed, however, given the small number of pregnant women with direct exposure to violence.

Of all those exposed to violence, 28% suffered physical injury, and 71% suffered psychological difficulties. 51% of those who experienced violence did not tell anyone about it, while 25% told their husbands, and the remaining women told friends, family, medical practitioners, relief agency staff, or religious authorities (Table 9).

Out of the 49 women who chose not to tell anyone about their experience of violence, the most cited reason for this was that they "thought nothing could be done" (41%). The second reason for not telling anyone was that they did not trust anyone (33%), followed by feelings of shame (12%) and fear of stigmatization (4%). 8% responded that they do not know why they did not tell anyone.

Of the 19 women who sought medical care after their experience of violence, only one sought care in Syria and the rest sought care in Lebanon. The majority of women, 78% (51 women), did not seek medical care after their experience of violence. This was due to not needing it, having insufficient funds, not knowing where to go, unavailability of medical care, and other reasons. We asked those who were not subjected to violence, where they would seek help if they were subjected to any of the above abuses. 53% said they would seek care from relief agencies, 15% said relatives or family, 10% said the municipality, 8% said from their husband, and 8% said they would escape or flee.

Coping strategies & stress

The survey explored coping mechanisms that women used as a response to violence; however, of the 139 women who were exposed to violence, only 65 responded to coping strategies questions (due to interviewer error). Of those who responded, 42% said they did not cope yet with their experience. The others mentioned the following ways of coping: talking to someone (friend or relative), trying to forget, and reading Quran or praying. Additionally, although 71% of those who experienced violence said they suffered from psychological difficulties, only 9% of those who experienced violence reported receiving mental health assistance (Table 10).

Table 10. Coping strategies among Syrian refugee women who were exposed to violence (N=139)

	N (%)
Did not cope yet	27 (42)
Talking with/ being with family	10 (15)
Mental health assistance	6 (9)
Trying to forget	4 (6)
Talking with friends	4 (6)
Others: reading Quran, praying, nothing (want to return to Syria), don't know	6 (9)

1. All but one case sought medical care in Lebanon (not in Syria).
2. 11 responses were missing.

When asked to rate stress related symptoms over the past month, relative to normal or usual levels, the majority of women responded that they experienced feeling tense, sick and tired, worried, irritable and losing sleep more than usual or much more than usual (Table 10). Beating children was included in this list of stress responses based on information found in focus group discussions. To be noted, 74% of women reported beating their children more than usual and 8% reported beating their children as normal. Only 16% of women said that they never beat their children.

Table 10. Reported stress responses among 452 Syrian refugee women during the past month

Symptoms of Stress	Never N (%)	As normal N (%)	More than usual*, N (%)
Feel tense	13 (3)	31 (7)	403 (89)
Feel sick and tired	29 (6)	48 (11)	370 (82)
Feel worried	19 (4)	57 (14)	369 (83)
Feel irritable or in a bad mood	24 (5)	66 (15)	356 (79)
Loss of sleep/ sleep disorders	30 (11)	37 (8)	361 (80)
Beating children	69 (16)	34 (8)	334 (74)

* This column collapses responses: "slightly more than usual" and "much more than usual."

PART 2: QUALITATIVE ASSESSMENT

METHODOLOGY

Focus Group Discussions

The aim of conducting focus group discussions (FGDs) was to better understand and characterize challenges facing displaced Syrian women in Lebanon, Syrian women's awareness and use of reproductive health and GBV-related services, exposure to violence (including GBV, SGBV, and intimate partner violence), and responses to violence. We used this method alongside our survey interviews for the purpose of informing the final survey

development, further describing findings, and to hearing perspectives from a group of Syrian women outside of clinics.

Field Observation
Throughout the data collection period, research staff were present in clinics and interacted with clinic staff, survey participants, data collectors, and the local population in the clinic neighborhoods. This section summarizes researchers' field notes and gives descriptions and observations gained from the study sites and surrounding neighborhoods, as well as observations and anecdotal reports on topics of reproductive health, access to health services, and experiences of violence (including GBV) among the Syrian population.

Study Design & Sample
For focus group discussions, we adapted a focus group discussion guide based on the "Focus Group Topic Guide" put forth by the Reproductive Health Response in Crisis Consortium (RHRC 2004). Our guide was adapted for the specific cultural context of displaced Syrian women living in Lebanon, and covered the following topic areas: 1) life in Syria before the conflict, 2) life in Lebanon, 3) services in Lebanon and barriers to access, 4) general health issues, 5) reproductive health issues, 6) violence, with a focus on violence experienced as a refugee in Lebanon, and 7) coping strategies (Appendix 1).We aimed to conduct three focus group discussions (FGDs) in community centers in both North Lebanon and the Bekaa Valley, ranging in size from 8-12 women. Informed consent was offered at the beginning of each FGD, and participants signed or marked the consent form, indicating their understanding of the study, desire to participate, and agreement to be audio-recorded. Dignity kits provided by UNFPA were given to participants at the end of the FGDs (Appendix 5). Each FGD lasted approximately one hour.

Data Analysis
The three FGD audio-recordings were transcribed verbatim in Arabic, translated into English, and reviewed by two researchers to identify major themes. Researchers then manually coded each transcript for the presence of themes, as well as identifying quotations that exemplified these themes. Any differences of opinion were discussed and resolved. The following main themes were identified based on all three FGDs: 1) needs and problems encountered, 3) general health issues, 4) reproductive health issues, 5) barriers to accessing healthcare, 6) violence, and 7) coping strategies. Quotes were then organized by theme and subtheme to create this report.

RESULTS
Results are based on three FGDs (29 displaced women from Syria) held in three community centers: Heshha (Wadi Khaled, North Lebanon), Irsal (Bekaa Valley), and Baalbek (Bekaa Valley).

Participant Characteristics
Each FGD was conducted in a community center run by a local NGO. The study population for the FGDs consisted of 29 displaced women from Syria recruited by the Danish Refugee Council and its affiliated local NGOs running the community centers in Wadi Khaled (North Lebanon) and Baalbek and Irsal (Bekaa Valley). All focus group participants were women displaced during the ongoing conflict in Syria. Of the 29 total participants, 26 were Syrian women and 3 were women with Lebanese nationality (married

to Lebanese husbands) who were living in Syria before the conflict and were also displaced. Many of the participants were registered with UNHCR as refugees, but not all. All focus group participants were Muslim, with the majority being Sunni. All women consented to being audio-recorded.

Descriptions by study site

The FGD conducted in Wadi Khaled (North Lebanon) consisted of eight Syrian women living primarily in the villages of Awadeh and Heshha. All women in this group were married, two had husbands who were detained by the Syrian regime, many had sons or husbands who worked far away, and one was pregnant. The average time they had lived in Lebanon was four months.

In the Bekaa Valley, nine women participated in the Irsal focus group, three of whom were Lebanese women who were displaced by the conflict in Syria. All nine were married, but some were living alone in Lebanon as their husbands were living or working back in Syria. The average time they had been in Lebanon was four months. Many young children were present, several of whom were still breastfeeding. The Baalbek focus group was the largest, with 12 women participating. This group was a self-identified mix of Sunni and Shia Muslims. Some of the Shia women said that they were directed to move to Baalbek due to the Shia population already living there. At least two of the 12 women were pregnant at the time of the FGD.

Needs & problems encountered

When asked about daily life in Lebanon, the participants discussed differences between their lives before the conflict and their lives now. They voiced several primary needs that they wished to be met through humanitarian programs or targeted assistance. They also spoke of problems encountered as refugees in Lebanon.

Food

Participants from all focus groups said that the food distributed was of good quality, but lacked variety and highlighted a need for basic food items (such as bread, chick peas, vegetables etc.). Women were also concerned about getting milk for their older children, as the UN does not distribute milk to families with only children over three years old. One participant said: *"Food for kids is not available, so we have to buy it. Kids above 3 years don't get milk."* On the other hand, some women emphasized that they need other services more than food. A woman in Irsal said, *"We don't want food, we need health care, wish you can secure healthcare for us and help us."* Needs such as money for rent, healthcare services, activities for children, and water seemed to take precedence over the need for food aid for many women.

Water

Water for drinking, bathing, and laundry is a priority among displaced Syrians in both the North and the Bekaa Valley. Lack of running water in the homes during many hours of the day (if not all) results in inability to bath, wash the children, and do laundry. One woman said, "*In Syria it was better, even during the conflict. We used to go out. We had water, so if the kids wanted to play they could wash*." In addition to lack of accessible running water, women complained of dirty, "hard", or contaminated water, as well as a shortage of drinking water. One woman said, "*The available water in the pipelines is causing kidney stones for the kids*." Another spoke about the expense of purchasing bottled water in place of piped drinking water, "*One*

plastic water bottle here is 1,000 L.L. [$0.66] This is expensive!" Some Syrian women get water from a nearby well, which involves walking a long distance, using an electric pump (when there is electricity), and carrying full containers home. Others received bottled of water from neighbors.

Activities for children

Women highlighted that their children are becoming "*bad tempered*" and "*difficult to manage*" because "*they are constrained most of the time.*" Children are prevented from play either due to limited space as the neighbors often do not allow their children to play outside, or due to lack of water sufficient to wash the children and do the laundry. Additionally, the men are often away and so cannot take the children out "*as it used to happen in Syria.*" There are also many problems with living space that prevent children from playing indoors, including: crowding, structural issues, humidity and mold, lack of walls, and stress or tension in the household.

> *"We are all living in a tin house. We are six families with 13 children playing around, and we are not able to control them. There are no toys, games, or playing groups."*
> *– Focus Group Participant*

Almost all women spoke about the need for activities to occupy their children's time. Participants repeatedly brought up the difficulty of living with large numbers of children in the home, little outdoor space for play, few toys, and limited or no children's programs. The children's programs offered by Save the Children and by the Norwegian Refugee Council in Wadi Khaled were mentioned. Women said that the summer program in Wadi Khaled was not consistent: *"For the summer sessions, my kids go there but then they were asked to return back home telling them there is nothing for them."* Others said that local children were taking the place of their children in such programs: "*the children of Wadi Khaled occupied [all of] the places. Our children were not accepted."* Yet, the women commented positively on the schooling provided to their children in winter. The programs were considered "*rigorous and serious,*" but different from the schooling offered in Syria: "*children in Syria are not necessarily taught French.*" This has presented challenges for them in the Lebanese school system, but "*the school principles are taking these differences into consideration.*"

Financial needs

Another major theme repeated in each FGD was lack of money for housing and basic necessities. Women seemed shocked by the cost of living in Lebanon, compared to Syria, and pointed to high rent and costly food and water (which is further complicated by insufficient or contaminated household water supply). One participant said, *"What we used to spend in one month in Syria, we are spending here in one week."*

> *"What we used to spend in one month in Syria, we are spending here in one week." – Focus Group Participant*

Participants reported that men are often absent from the household due to work far away, trips to oversee property in Syria, employment in the Free Syrian Army, detention, or in some cases death. One woman said: *"Everything is expensive and difficult financially. Most of the men are not around. They are in the war."* To secure an income, many women are engaging in daily work (such as making mana'eesh and "*earning 5000 LL a day*"), or sending their male children for work either as manual laborer or in a shop: "*I had to take my son out of school.*" Other sources of income included salaries from the Free Syrian Army, charity or aid, and selling food aid. Women highlighted the need to secure an income, and said that it would be good if the UN could provide either money or programs for women to find work, saying: "*If*

they distribute money it is better, as life here is very expensive," and, "*If you can develop a project where we can work [it would be good]."*

Household assistance

There were marked differences in the daily needs mentioned by women in North Lebanon versus those in the Bekaa Valley. For example, Wadi Khaled (North Lebanon) participants said several times that they need clothes, bed sheets, and soap. Participants in Baalbek and Irsal (Bekaa Valley), on the other hand, repeatedly voiced a need for refrigerators, especially to store food out of the heat and away from insects for Ramadan. They also mentioned needing fans, kitchen utensils and mattresses. Many need home repairs as they live in half-constructed houses or old, unstable homes. Some are receiving help for home repairs from the municipality.

Problems with accessing services

Women reported receiving aid from various UN Agencies, the Municipality, religious charities, and NGOs. However, most focus group participants voiced frustration at perceived discrimination in the distribution of aid along religious, ethnic, and political lines. One woman said that she was refused aid by a local NGO because she let a woman from a minority sect into her home. She responded to the aid worker, "*That lady is nice to me, and I don't kick anyone out of my house.*" There is also frustration at aid being diverted. Women expressed a concern that "*those who want to help us shouldn't give the aid to the Mukhtar [mayor of the village], because in that case we either don't receive it, or they make us feel like beggars*."

Discrimination seems to be contributing to divisions among the Syrian refugee community. Focus group participants illustrated this point by telling stories about local NGOs withholding services from certain religiously or politically affiliated groups of refugees, and even harassing them. Additionally, services channeled through local mukhtars (governors) were reportedly diverted or withheld from Syrian refugees in some cases. One woman said, "*Those who are getting the privileges are looking down on the others.*" Women also expressed that "*there was no difference between Shia, Sunni, or Christian before the war. But now we're all being divided."* Another woman confirmed this, "*We used not to have sectarian thinking before in Syria, now they are making us think this way. It is bad."*

Some women pointed to transport as a major barrier to accessing both basic services and healthcare. For many, it is necessary to pay for transport in order to receive the services offered to them, yet transport is expensive. Additionally, some women said that the long distance they would need to walk in the heat in order to receive aid was prohibitive. These barriers are discussed further below in the context of access to healthcare.

Whether it is inability to register as a refugee with UNHCR, fear, or lack of desire, many participants said that their main barrier to accessing services was the fact that they were not registered. Echoing fears of others, one woman said, "*I'm not registered. I'm Syrian, and am afraid to register, our names may reach the Syrian regime*" (Irsal, Bekaa Valley). Another explained why she was not registered, "*I tried to get registered in UNHCR but I forgot my papers in Syria. We had to run and couldn't bring things with us; when I went to register they started questioning me and asked about the car that drove me from Syria and I couldn't recall anything, we were frightened and didn't pay attention*."

Additionally, there is a group of women who were displaced by the conflict in Syria, but cannot register as refugees in Lebanon because either they or their husbands do not have Syrian nationality. Some are Lebanese, but were living in Syria before the conflict. Others are Syrians who married Lebanese husbands. One such woman voiced her concerns: "*My family*

is in Syria. I haven't seen my husband. My girl is sick and needs medicine but cannot get it. The Lebanese are suffering here. We're not Syrian refugees so we can't get services from the UN or other organizations." Another said: *"We just request that if you want to help, you help the Lebanese like the Syrians."*

General health issues

When women were asked about how they perceive their health, several health-related concerns emerged.

Anemia

Three focus group participants reported having anemia, two of whom were pregnant. They also said that anemia is not uncommon among Syrian refugees. Women with anemia, and particularly those who were pregnant, were requesting more health services to address this issue.

Mental health

Psychological issues were common among both women and their children. Several mothers talked about developing their own psychological or psychosomatic problems at having to watch their children suffer from mental health problems. One women said, "*My son, who used to hear the shooting sound in Syria, freaks out, runs and plugs his ears whenever he hears a sound. Furthermore, he became nervous and doesn't respond. He keeps saying 'stay away from me!' I will either die or become crazy. I took him to a neurologist, but he said he doesn't have a problem."* Women also talked of their own psychological issues, saying things like, "*We no longer have personalities*," and *"Here in Lebanon, we feel lost.*" One women said, *"I had a nervous breakdown, and now I take medicine."* Another women said that she has a second personality that she talks to occasionally. *"I feel that I need a psychiatrist before my condition gets worse."* Women made the connection between their own mental health difficulties and violence in the home. One said, *"I have a psychological condition and so I need a psychiatrist. When I remember how we used to be and then think about how we became, I get a headache and become angry. And in addition, I reflect it on my children and beat them."* Others spoke about suffering from great fear related to safety concerns, even in Lebanon.

Children's health concerns

In addition to the psychological and psychosocial needs of children, women talked about the need for general medicine and health services for children. One said, *"My daughter has a hearing problem and needs hearing aids. I have registered my name to get hearing aids and didn't get them yet."* Another said, *"I have a boy with renal problems, and I was treating him in Hotel Dieu Hospital. Now no one covers the expenses, and I was told they will make contacts for me. But no reply so far."* A few women mentioned a shortage of diapers, as well as the problem of children having diaper rash and skin infection. Others talked about acute illnesses, such as colds or coughs, for which they did not have the money to get proper treatment.

Reproductive health issues

When asked about gynecological problems, women expressed that they have been neglecting themselves while prioritizing other members of the family, mainly their children. The discussion revealed that many women have reproductive health issues, are aware of reproductive health services, but face barriers preventing them from seeking or accessing care. Women faced three main types of reproductive health issues: pregnancy complications, menstrual problems, and reproductive tract infections.

Pregnancy

The major health issues surrounding pregnancy were anemia, decreased access to antenatal vitamins, and possible negative effects of the stress endured while pregnant on the fetus, including: the stress of conflict, being displaced, living in crowded settings, and worrying about basic necessities. A woman in Baalbek (Bekaa Valley) expressed helplessness by saying in a low voice, *"I am pregnant, had an ultrasound, and was told the pregnancy is difficult and I should rest,"* and then raised her hands in a gesture indicating there was nothing she could do.

In addition to these complications, many pregnant participants were unable to obtain antenatal care for various reasons. One woman said, *"I'm pregnant and need medication for 'pregnancy fixation,' and I have iron deficiency. But, [the OB/GYN doctor], has traveled."* Another tried to get a consultation to find out whether she would be delivering vaginally or by cesarean section, but was repeatedly told that the OB/GYN doctor was traveling or busy. There is also worry about paying for antenatal services and delivery. One participant voiced this concern: *"I went to Hariri clinic, but it was 2000 L.L. [$2.32] for services for pregnant women there."* She went on to say that this was too expensive for her. Another woman in Wadi Khaled (North Lebanon) said that she and her husband are intentionally delaying pregnancy due to the high cost of delivery. Others expressed facing problems when entering the hospital for delivery. A pregnant Syrian woman told us that she is planning to deliver her baby under her sister's name (who has Lebanese citizenship) in order to make it easier to access services.

"I'm pregnant and need medication for 'pregnancy fixation,' and I have iron deficiency. But, [the OB/GYN doctor], has traveled." –Focus Group Participant

Menstrual problems

Many women brought up problems surrounding menstruation, symptoms of dysmenorrhea, and irregular cycles occurring post conflict. One woman said, *"I have an IUD so my period was heavy anyway, but now (since leaving Syria) the period is even heavier than before."* Another woman talked about her experiences when the Syrian regime detained her husband. She said, *"When they took my husband, my menses stopped. When I relaxed, it came back as usual."*

"I have been having discharge and itching for more than three months, I didn't go for treatment… I do not have enough money for transport." –Focus Group Participant

Reproductive tract infections

Participants also raised the issue of vaginal infections, including long standing discharge that a few of them related to a decrease in water supply and wearing conservative clothing in a hot weather. One woman who was suffering from itchiness and abnormal vaginal discharge, said that she has had a genital infection for three months, but that the expense of transport to the clinic has prevented her from seeking treatment. This expense, coupled with the expense of the healthcare visit and medication, limits the number of trips women are making to seek reproductive healthcare.

Barriers to accessing healthcare

Financial barriers
A commonly mentioned barrier to accessing healthcare was the expense of transportation. Some women (primarily those in Baalbek) mentioned walking long distances in the heat to reach the health clinic: *"We're all very tired because [the clinic] is far from Baalbek."* Another said, *"I have been having discharge and itching for more than 3 months, I didn't go for treatment, I didn't even treat my child who has been coughing for more than 3 months. I do not have enough money for transport."* Women talked about having to spend all of their money to go and return from the health clinic. This expense, coupled with the expense of the healthcare visit and services, naturally limits the number of trips women are making to seek healthcare. In the words of one participant, *"In Syria it [healthcare] was very cheap; here the doctor visit is expensive."*

Obstetrician-gynecologist not available
The most frequently cited barrier to accessing reproductive health services was that the OB/GYN doctors – and particularly female doctors – are not always available in the clinic. Many participants said that they went to the clinic in their area, some more than once, and were told that the woman doctor was traveling or delivering a baby elsewhere. All three focus group discussions highlighted this issue as a major barrier. One woman said, *"I am 3 months pregnant and didn't go for a check-up yet. Went there [to the clinic] and was told the doctor is on travel, or is delivering. There is no one there in Hariri center. There's nothing else but Hariri clinic."* Another woman confirmed this, *"I am one month pregnant and the situation is difficult. I went a few times to the clinic and was told different things every time. 'The woman doctor is traveling,' or 'the woman doctor is not here,' or 'when she arrives we will call you.' But they don't call. There is no one else besides her."* One participant was pregnant and had anemia, but said that she buys the medication she needs for herself because she cannot access the female doctor.

Mistreatment at health clinics
Several women said that they felt like beggars when they went to the health clinic. Although some services are offered at reduced rates for them at the Rafik Hariri clinics in the Bekaa Valley at the clinic in Wadi Khaled (North Lebanon), prices are still prohibitive for many services. One woman said: *"The assistance (i3aneh) is as if we are begging. If we want diapers, they say this is enough for one. We pay for blood tests; 15% is covered. The transport is expensive around 10,000 L.L. [$6.60]. The money I have, I use to go and come back"* (Baalbek, Bekaa Valley). Another woman in Irsal (Bekaa Valley) started saying, *"We are being humiliated …"* but her friends pressed her arm in a sign requesting her to stop talking.

Violence
When we raised the topic of violence there were loud sighs, a few cynical laughs, and comments like: *"there's as much as you want,"* and "*everyone lets go on us.*" Several types of violence could be identified:

> *"Men here are more stressed, but we have to accept the situation… some let go on us." –Focus Group Participant*

Intimate partner violence (IPV)
Regarding violence in the home, women said that their husbands frequently release their stress by hitting or beating them, or breaking things. Women said: "*Men here are more stressed, but we have to accept the situation… some let go on us.*" One woman reported having a neck problem in the beginning of the discussion. When the topic of violence came up, she

admitted that her neck problem was due to beating from her husband. Women were generally open to talking about IPV, and they referred to spousal abuse as their husbands "*letting go on us*" or "*letting out the stress on us*." When asked about the reaction they have to this violence, most women said they stay quiet. "*He threatened to take me back to Syria if I raise my voice.*"

Violence against children
As a reaction to the stress they are living under, women admitted that they frequently "*let go of their stress*" on their children. One woman reported, *"I feel like I need a psychiatrist, I've been beating my child abnormally, and when he sleeps I regret it and cry, yet, the next day I get tense and beat him again."* Another echoed this sentiment saying, *"Anger has spread… If a child moves, we slap them on their face due to our decreased tolerance level. Then, we think, regret what we have done, and ask ourselves 'why did we hit them?' Yet, we feel that we have no more energy to run after them, and so we hit them again and can't control ourselves."*

Sexual violence
When asked about experiences of harassment, improper sexual behavior, or sexual violence, most women reported that they were unaware such incidents. Many blamed women or girls for bringing sexual harassment upon themselves. One woman said that she *"worries about the boys here more than the girls, since we can restrict the girls, but not the boys."* Others agreed with this sentiment. When probed further, women told stories of verbal sexual harassment. Two women had experienced sexual propositions from Lebanese men in exchange for services, but had avoided any encounter. Others had experienced verbal harassment on the street. Many women said that they avoid going in the streets alone to avoid exposure to such harassment. Women were primarily reflecting on the situation in Lebanon, not Syria, when discussing sexual violence.

Hostile environment
Women mentioned that the host community they are living in is not always welcoming. Sometimes the Lebanese community blames the Syrian refugees for the shelling that is entering Lebanon from Syria. One woman said that young Lebanese men rode around on motorbikes yelling "*Assad is coming to kill you all!*" The Syrian children were also experiencing bullying and taunting from Lebanese children. To avoid such conflicts, women are restraining their kids. One woman said that whenever there is a conflict between children, *"We hit our kids and tell them they are wrong, in order to avoid problems with them [the host community]."*

While discussing the different types of violence mentioned above, women provided explanations of <u>contributing factors</u> to the increase in violence they are subject to:

a. Crowding

Every focus group brought up the issue of crowding in the home. Women reported that the crowding in homes is a major source of stress. There are sometime 70 or more people living in one rented home. This may contribute to violence, as men tend to take the stress out on their wives, and women tend to take the stress out on their children. One woman said, *"There are many people in one room. We are covered (mu7ajabeen). There is no privacy*." And another added, "*Can you imagine the noise and children jumping all around? It gets to you.*"

Yet, crowding was found by some women to be a positive factor in relation to IPV. Women said that when other men are present, their husbands are less likely to beat them due

to embarrassment or shame. Women reported: *"They behave when there are other men around. They are intimidated if they misbehave or treat us badly,"* and, *"Men try to control themselves when there are other men. We live several families in one place; men control their temper when there are strangers."*

b. Boredom

Focus group participants said that daily life in Lebanon was turning into a *"boring routine, nothing to do."* They said in Syria they used to go out, and the kids had places to go or the men would take them out, but here they stay in the home all day with very little to do. This alos may be a contributing factor to stress or tension in the home.

c. Unstable housing in Lebanon

Women complained about not having a stable place to live in, and being forced sometimes to move the family from place to place. Focus group participants talked about their experiences of moving around within Lebanon:

- *We move a lot from one place to another.*
- *If we don't pay the rent, they will throw our things to the street.*
- *Some people are nice and provide us a place to stay for free, but then for how long can we stay there?*
- *We were thrown out of the house because the landlord had his eye on a relative of mine, and we were all living in a house together. When the wife of the landlord found out, she threw us all out of the house.*
- *It's better to keep us in one place. But, the owner of the house wants his house back or wants more rent every now and then.*

d. Unemployment and insufficient Income

Women pointed to the lack of work and inability to provide for the family as a major factor contributing to stress among men. Some had daily work or returned to Syria to work. Others were sick or injured and could not work. One woman said that, *"The men sleep most of the time, they help [in the home] sometimes… sometimes they get water from the well."* Others said that even the men who have work are not able to make enough to cover the high cost of living in Lebanon. A participant explained, *"My husband works day and night and earns 5000 L.L a day. We can't pay rent. We understand that this makes them stressed. They have to support us."*

Coping strategies

Women mentioned several approaches – both positive and negative, passive and aggressive – that they use to help them cope with their situation and survive the stress or violence in their homes.

Community and family support

The most commonly used positive coping method was spending time with members of the community. Syrian women said that in some way the experience of displacement had brought them closer to each other. Friends, neighbors, and relatives are helping each other through the difficult times, lending each other kitchen utensils, sharing experiences and providing solutions to each other's problems. One woman said, "*All Syrians help each other. We are a group. Everyone helps everyone.*" Some women spoke also of supportive Lebanese neighbors who help them with basic necessities. *"Neighbors can sometimes be nice. We ask them to give us cold*

water and they do." They also expressed appreciation for the help that they are getting from the UN.

Taking out stress through violence
A commonly cited way to vent the stress endured by Syrian women was, as mentioned above, "*letting go of the stress*" on their children (as discussed above).

Justification of IPV
One way that Syrian women cope with IPV is to justify it to themselves. Women expressed this, *"Men are stressed because they should be financial supporters,"* and, *"Men are really working hard to secure a living for us. It is ok if they are stressed a bit."* This explanation for the stress and tension in the home seemed to help them deal with it.

Avoiding conflict/keeping quiet
Another way that participants cope with IPV is by staying quiet in order to avoid aggravating the situation. Syrian women expressed that there is nothing they can do, so they keep quiet when their husbands use violence against them. Below are some of the responses from participants:

- *If we say a single word they say we'll take you back to Syria, so we shut our mouth and accept.*
- *There is nothing to do, we have to accept.*
- *We can't do anything to distract our mind or vent. We just cover ourselves and sleep.*
- *Where do we go in case of violence? There is no place to go. We just need to be left alone."* (They used the expression, *"bidna elsotra,"* meaning that they want to avoid trouble and keep a low profile).

Field Observations

Taanayel (Bekaa Valley)
The Rafik Hariri Foundation clinic in Taanayal was large in size, supplied with modern medical technology, and offered a range of services. Survey interviews were conducted in a large meeting room on the second floor, where the clinic's social worker had a desk in one corner. Women were interviewed at the opposite side of the room so that privacy could be maintained. The clinic did not have long operating hours, opening around 8:00 am and closing around 3:00 or 4:00 pm (and earlier during the fasting month of Ramadan), thus limiting the number of interviews we were able to carry out in one day.

Baalbek (Bekaa Valley)
Similar to the Taanayel clinic, the Rafik Hariri Foundation clinic in Baalbek was large, well-equipped, and well-maintained. This clinic also did not had relatively short operating hours, opening around 8:00 am and closing around 3:00 or 4:00 pm. Some Syrian patients expressed nervousness about coming to the clinic, however, as it was located quite visibly on the top of a hill in the middle of a predominantly Shia' neighborhood in Baalbek (many Syrian participants were Sunni). It was not possible for patients to enter in a very private manner.

During the first day of data collection in Baalbek clinic, there was news of the National Security Council Headquarters in Damascus being bombed. Syrian patients

crowded around the television in the waiting room and seemed very concerned. This event may have raised tensions on the first day of data collection there. The first two women that we approached refused to participate in the survey due to safety concerns. They said that they supported the Assad regime and were afraid to participate in the survey for this reason. Other Syrian women who were apprehensive at first decided to participate after looking through the survey and understanding that it contained no questions regarding political affiliation.

From survey results we found that Baalbek clinic had the lowest number of participants reporting violence (only two out of 75). When we asked the data collectors in Baalbek about this after the survey, one data collector said that women may have been hesitant to answer questions about violence given the political affiliation of the center (political photos and insignia of the Lebanese Future Party, a Sunni party, were apparent). The other data collector said that most women reported they had not experienced violence because they escaped Syria before the violence reached them. Women in Baalbek did mention that their male family members had experienced violence, and they had heard of female neighbors and friends who had experienced violence as well.

Irsal (Bekaa Valley)

The Irsal clinic, co-run by the Rafik Hariri Foundation and the Ministry of Public Health, appeared clean and well equipped, and was smaller than the clinics in Taanayel and Baalbek. A nurse in the clinic said that around 20 Syrian patients seek care there per day, approximately five of whom are women. This number increases, however, when the reproductive health doctor is present (which seemed to be somewhat rare). The OB/GYN doctor was on vacation during the entire data collection period at Irsal clinic. For this reason, there were fewer Syrian women attending the clinic than normal.

The nurse also reported that public transportation is not easily available to and from the clinic, so most Syrians walk. There are 15,000 Syrians on file at this clinic, and the International Medical Corps covers some 85% of lab and x-ray services for Syrians. A single visit costs approximately 2000 L.L. ($1.32), Syrian children and pregnant women receive free visits, and medicine in free to Syrians. The data collector reported that all Rafik Hariri clinics, at least in The Bekaa Valley, have similar prices. The nurse also reported that Syrians in Irsal are eligible to receive a food box every month, and fresh vegetables and meat every week.

Michha (North Lebanon)

The Michha clinic is run by the Ministry of Public Health, and was the only solely government-run clinic included as a study site. As such, appointments and medicine are completely free to Syrians. International Medical Corps and the United Nations support the clinic, in addition to the regular MoPH support. This clinic serves as the only clinic for all of Michha and the five surrounding areas, which include 545 displaced Syrians (106 families) in Michha alone (according to the head nurse). 70 Syrian women and their children attended the Michha clinic the day we conducted data collection, and we were able to interview 50.

This clinic was very small compared to the others, with only three exam rooms, and a small pharmacy. The clinic has an OB/GYN doctor and full antenatal care services. Though less well-equipped than some of the other clinic study sites, the Michha clinc had much longer working hours and staff expressed devotion and care for the patient population. The clinic director was present the entire day, and assisted the data collection process by directing women to us to be interviewed, and providing plastic bags for the women to carry home the UNFPA dignity kits. The director and head nurse opened up all

three exam rooms to us to carry out interviews in private when they were not in use by a patient.

Bireh (North Lebanon)

At the Rafik Hariri Foundation clinic in Bireh, the head nurse seemed well connected and well known within the Syrian patient community. She told us that 10-15 Syrians come to the Bireh clinic per day, and of these approximately 7 are women, 6 are children, and 2 are men. The head nurse reported they were receiving 3-4 cases of Syrian women with vaginitis out of the approximately seven women that visit each day, indicating that around half of the Syrian women patients attending this clinic suffer from vaginitis. Bireh clinic has an OB/GYN doctor working every day (unlike the other clinics), so Syrians were not obliged to wait or return another day in order to receive reproductive health services. The clinic also has ultrasound services, family planning services (including IUD insertion), papsmear, full antenatal care services, and medication for most important issues.

Prices at Bireh clinic are the same for Syrians as they are for Lebanese (as is the case for all clinics in the Akkar region in North Lebanon). To give a sense of clinic costs, a consultation is 5000 L.L. ($3.30), an ultrasound is 10,000 L.L. ($6.60), and an IUD is 15 L.L. ($9.90). The head nurse in Bireh said that hospitals in Akkar have support from UNHCR and the government, but delivery services for pregnant women are not free.

Wadi Khaled (North Lebanon)

The Wadi Khaled clinic, co-run by the Makassad Foundation and the Ministry of Public Health, was much larger than the MoPH clinic in Michha and appeared well equipped and well maintained. In addition to normal clinic services, Doctors Without Borders (MSF) has an office in this clinic for ophthalmology and cardiology services.

Characteristics of homes

We visited four homes of Syrian women while in Bireh (North Lebanon). A Lebanese woman escorted us around the neighborhood and introduced us to the Syrian women living there. There was a shelling in this neighborhood the day before we were there, and many of the women we interviewed mentioned this incident during the home visit. Residents reported that there had been 10 shellings total in Bireh at the time of data collection.

The homes that we visited varied greatly. The first one was a modest house, with orchards surrounding it. This is where the Lebanese woman lived, hosting two Syrian families in her home. The next two homes were part of a subdivided cement ground-floor of a larger building. The walls had been hastily constructed of cement blocks to create apartments for Syrians, each with two rooms. The rent was $250 per month, which the women felt was very expensive. The water worked, but electricity did not. The final home we visited was a bigger home, where two Syrian families were sharing rent.

Additionally, we spoke with women living several group housing or refugee camp arrangements. The refugee camp in Irsal (Bekaa Valley) housed 40-50 families, and was funded by a Qatari donor. It was constructed surrounding a mosque on a hillside very near the clinic. The Irsal group housing facility had 11 families residing in one building, and was funded by a Norwegian company. The group housing facility in Wadi Khaled (North Lebanon) housed around 300 Syrian refugees, and was cement warehouse-like structure, subdivided into two-room apartments and funded also by a Qatari donor.

Pregnancy-related issues

Women participants brought up many pregnancy-related issues outside of the interviews, including: lack of affordable delivery services, premature contractions, and the need for medication. We conducted informal interviews with two Syrian women living in a group housing facility for Syrian refugees in Wadi Khaled (North Lebanon). When asked about pregnancy-related issues, they said that if a woman is pregnant in Syria she is less likely to flee. They went on to say that they and other women they know are avoiding pregnancy in Lebanon because it is too expensive. Out of the 300 Syrians living in this group housing facility, there were no pregnant women.

One story from the Makassad Foundation clinic in Wadi Khaled provides anecdotal evidence of the need for delivery services. During one day of data collection, a pregnant survey participant started going into labor. The data collectors called the PI to find out about free delivery services, as the clinicians did not know of such a thing. We started making calls to IMC, UNHCR and MSF, with no clear responses on where the woman could deliver for free in or near Wadi Khaled. The woman ended up going to Halba hospital some distance away, and was able to deliver there (it was unclear whether someone paid for her, or they let her deliver for free). The major issues at play in this situation seemed to be clinician lack of knowledge regarding delivery service providers for Syrian refugees, transportation costs and the difficulty of traveling long distances during labor, and the high expense of delivery services in Wadi Khaled.

The head nurse in Michha clinic (North Lebanon) said that there are free delivery services for Syrians in Michha hospital. She thought that Halba hospital and Tripoli hospital did not offer free delivery services. The head nurse at the Bireh clinic (North Lebanon) confirmed that delivery services are not free at any hospitals in the northern region of Akkar. A nurse in Irsal (Bekaa Valley) told us that the price of delivery in there is 20,000 L.L. ($13.20) at the government hospital, and around $100 at a private hospital. A hospital with delivery rooms and inexpensive or free delivery services was under construction at the time of data collection in Irsal.

Intimate partner violence

Several women spoke of intimate partner violence outside of the survey. One participant in Taanayel clinic (Bekaa Valley) was crying after the interview, and explained that her husband beats her and has forced her to have four abortions. She was worried about infertility and asked what could be done for her. She was referred to a clinician. Another participant, in Baalbek clinic (Bekaa Valley) was talking openly with her friend about being beaten by her husband. She said: "*We are Syrian, of course our husbands beat us*." She told us that she was beaten often and her friend tries to intervene. The first woman wanted a number she could call if this happened again. She went on to say that she was very strong, and did not suffer any injuries. She was smiling, and did not seem afraid to speak about this experience. Finally, in the Bireh clinic (North Lebanon), one woman approached us after an interview and asked where she could go or who she could call if she was having problems with her husband. We referred her to the UNHCR protection hotline.

Stress and fear

Outside of the interviews, several women expressed extreme fear. Reasons for this fear included: concern for family members back in Syria, concern over lack of services in Syria (specifically lack of food), and worry about what will happen to them. Several women said that they felt extremely guilty for leaving family members, specifically sisters, behind in Syria.

When we asked one woman at the group housing facility in Wadi Khaled (North Lebanon) whether she felt safe, she responded immediately: "*People do not feel safe here. The Syrian regime army targets this building."* She said that bullets were shot into the building two days before we visited. Shelling of the building usually happens during the night, so the residents flee into the surrounding countryside and often sleep there. Reports of shelling were frequent during the data collection period in Wadi Khaled, and were a source of both fear and tension with the local population.

DISCUSSION & SYNTHESIS

Several consistent themes emerged from the quantitative and qualitative results. First, our findings indicate that women displaced to Lebanon during the current humanitarian crisis in Syria experience various indicators of poor reproductive health: various gynecologic conditions, pregnancy complications, and poor birth outcomes. The high rates of menstrual irregularity, severe pelvic pain, and vaginal infections reported among our sample align with previous research on gynecologic outcomes in settings of violence or refugee settings (Gagnon et al. 2002, Campbell 2002).

Additionally, among the pregnancy subset, report of preterm birth was high. Based on previous research, Syrian refugee women may be at greater risk for preterm birth for a number of reasons, including: their status as refugees, inadequate antenatal care (Hamad et al. 2007), bacterial vaginosis, or economic hardship (Kramer et al. 2002). Previous studies of low birth weight among refugee women show mixed results, with some finding and increase in low birth weight among refugee populations, and some finding no change or an actual improvement among refugees compared to non-refugees (McGinn et al. 2000; Gagnon et al. 2002; Hynes et al. 2002). Improvements cited in the literature may be due to having comparatively better reproductive health services in refugee camps than in the general population (especially in resource-poor settings) (Hynes et al. 2002). This hypothesis does not apply to the context of Syrian refugees in Lebanon, however, as they are not living in stand-alone refugee camps equipped with relief services. Our results show that the prevalence of low birth weight was somewhat high at 11%. Contraceptive use was low in our sample, with only 35% using any type of family planning method, compared to 58% reported in pre-conflict Syria (UNICEF 2006). Our study confirms data from Syrian national statistics showing that the IUD is the most commonly used method of birth control among Syrian women (UNICEF 2006).

Several general health issues were also reported during this study, including anemia and hypertension, both of which may be related to complications surrounding pregnancy and delivery (Yanit et al. 2012, Scholl et al. 1992, Garn et al. 1981). In addition to direct report of anemia, many women reported feeling abnormally weak and tired during their pregnancy, which is symptomatic of anemia (CDC 2007). Food insecurity, which was identified among more than half of respondents, may be contributing to anemia prevalence, though anemia from multiple causes is highly prevalent among women in the Eastern Mediterranean under normal conditions (de Benoist et al. 2008).

Exposure to violence, abuse, and/or SGBV was reported by over a quarter of Syrian refugee women. Many women experienced multiple types of violence during the current conflict. While several cases of sexual violence were reported, all allegedly perpetrated by armed people in Syria, we believe this number is much higher based on systematic

underreporting of sexual violence due to shame or stigmatization. Multivariate analyses revealed significant positive associations between exposure to violence and gynecologic conditions. These findings align with results by Campbell (2002) who reports that the most consistent difference between battered and non-battered women is gynecologic problems, including: vaginal bleeding or infection, genital irritation, pain on intercourse, chronic pelvic pain, and urinary-tract infections. Despite our focus on conflict-related violence compared to Campbell's focus on intimate partner violence, risk factors and reported outcomes are similar.

In focus group discussions, the issue of intimate partner violence was raised. Syrian women talked of intimate partner violence primarily as a result of stress and tension in the home. Among the coping strategies women employed to deal with such violence, many chose to keep quiet or avoid the issue and justified it as a result of the pressure on husbands to provide for their families. Several women did approach research staff seeking a hotline or someone they could go to in case of intimate partner violence, indicating a need for such services.

Availability of and access to reproductive health services and services for survivors of violence were limited among this refugee population. Humanitarian services, including limited support for healthcare and reproductive services, are available to Syrian refugees registered with the UN. Some clinics are supported by aid agencies and able to offer discounted medications and clinic visits to Syrian refugees. Reproductive health kits (rape kits, contraception kits, and treatment of sexually-transmitted infection kits) were available for use by refugees in four clinics at the time of data collection. Also at the time of this study, agencies were discussing a referral system for cases of SGBV. While some services are in place for Syrian survivors of violence in Lebanon, the women we spoke with were unaware of such services.

Gagnon et al. (2002) explain that limited access or delayed entrance to antenatal care is one of the key determinants of pregnancy outcomes in refugee populations. There are often significant disparities in access to and use of antenatal care among refugee populations compared to non-refugee populations (Carolan 2010). Our study supports this finding, and contributes to the literature on access to reproductive healthcare in refugee settings by identifying perceived barriers to access among a conservative population in the Middle East. The majority of Syrian refugee women had never visited an obstetrician-gynecologist except for pregnancy care, indicating low baseline rates of gynecological exams in this population. While costs and long distances were the primary barriers to accessing gynecologic care, one unique barrier reported in our survey was lack of availability of a female doctor. We gathered from focus group discussions that the schedule of the female reproductive health doctor in many clinics is either not clear to patients or changes frequently, which could be explained by increased vacation time during the month of July when these focus groups were carried out. It seems, however, that increased hours of a female OB/GYN doctor would improve access for Syrian refugees.

Finally, participants clearly indicated in both the survey and focus group discussions that they are suffering from a lack of basic services and daily necessities (e.g. housing, food, water, hygiene supplies, blankets, etc.). Poor reproductive health outcomes, and poor health outcomes in general, may be related to living conditions among Syrian refugee women in Lebanon. With limited or no income, lack of access to water and sanitation, crowding, and food insecurity, Syrian women may be at a higher risk for a variety of health-related conditions. Focus group participants highlighted this lack of access as a source of daily stress. Those living in North Lebanon expressed greater need for such services than those

living in the Bekaa Valley, which could be related to the higher likelihood among those in North Lebanon of living in formal housing where relief agencies are less likely to operate. Refugees living in organized camps or group housing supported by a relief agency or religious entity may be receiving more direct aid.

Again, cost and distance to service delivery site were commonly reported barriers to accessing basic services. Additionally, our focus group discussions revealed that discrimination in service distribution was another important barrier. Women felt that they were discriminated against both for being Syrian, and for their religious or political identities. Lebanon is a very sectarian society, and services are highly decentralized. It is common for religiously or politically affiliated local NGOs to be the main service delivery mechanism for Syrians in certain areas. Syrian women identified several such service providers who either withheld resources, discriminated in resource distribution, or in some cases harassed Syrian beneficiaries due to religious or political affiliation. This discrimination may also be contributing to the difference in access to services between the two regions; however, we do not have the data to show this.

This study has several limitations. First, although we selected a proportionally representative sample for the survey, this was not a statistically representative sample and results cannot be generalized to all Syrian refugee women in Lebanon or elsewhere. Randomization was not possible due to the sensitivity of this conflict setting and the variability in numbers of refugees in Lebanon during the time of the study. Second, due to the self-report nature of the survey, we are unable to rule out fear of stigmatization or social desirability bias in responses. This may have resulted in underreporting of sexual violence. To address this issue, all surveys were conducted in a private room with a trained female interviewer, though complete privacy was not always possible. Third, the choice of survey location at primary health care centers poses a limitation on generalizability of the results, as women presenting to these centers may differ from the general population with respect to knowledge about health services or health behaviors. Finally, with regard to the focus group discussions, the qualitative nature of this portion of the study means that information collected cannot be generalized to the rest of Syrian refugee women in Lebanon. Rather, results serve to help us better understand and characterize their situation.

Despite limitations, this study provides important information about a vulnerable population that is growing in number as the current humanitarian crisis shows no signs of abating. In addition, information gained from this event may help inform programs offered for Syrian refugees, and assist in planning for future humanitarian crises involving large numbers of displaced women and children.

CONCLUSIONS & RECOMMENDATIONS

Based on our study goal of informing humanitarian programs and services for Syrian refugee women in Lebanon – particularly in the areas reproductive health and violence (including GBV/SGBV) – we present a set of recommendations for UNFPA and the broader community of humanitarian agencies and organizations in Lebanon.

Recommendations regarding health services for Syrian women

Increase availability and access to reproductive health services among Syrian women. The biggest barrier to access of reproductive health care and care during pregnancy is absence of the reproductive health doctor and/or unavailability of a woman reproductive health doctor ("*the woman doctor was traveling*"). Clinic administrative staff should be aware of this need. Additionally, reasons for this unavailability of the reproductive health doctor or female reproductive health doctor need further exploration and clear steps in place to address this gap in services.

Provide reproductive health as part of mobile clinics. Distance and transportation cost is another major barrier keeping Syrian women from accessing the reproductive healthcare they need. Mobile clinics providing reproductive health and family planning services could help significantly in addressing this barrier. Several mobile clinics are already in place, and adding a stronger reproductive health component may increase effectiveness of these mobile clinics in addressing women's health needs.

Establish a protocol at the clinic level for referring pregnant women to pregnancy-related services, and train staff on the use of this protocol. Each health center is advised to have a list of secondary or tertiary reproductive health services available in the area, including cost and subsidy for displaced Syrians if available. This can be accomplished by mapping the services available, potentially through a UNFPA initiative, and updating clinician standard operating procedures to include referral to these services.

Increase community awareness and management of anemia. Anemia is a common self-reported condition among displaced Syrian women, and may be contributing to ill health and poor pregnancy outcomes. Prevention and management of anemia includes improving access to antenatal care, consideration of anemia in planning food distribution for this population, and addressing related reproductive health problems identified among Syrian women, including: hemorrhage, menstrual irregularities, and poor nutrition, etc. One suggestion for addressing iron-deficiency anemia among pregnant women is to include antenatal vitamins in the regular food aid distribution boxes received by pregnant Syrian women.

Increase health education and awareness surrounding symptoms and treatment of gynecological issues, including vaginal infections. We recommend increased health education for Syrian refugee women surrounding symptoms and treatment of common gynecological conditions, both at the clinic level and through outside programs as appropriate. Vaginal infections, menstrual irregularity, and severe pelvic pain or dysmenorrhea were reported by many Syrian women. Some suggestions for programming to address these issues include:

- Organization of weekly or bi-monthly education sessions, put on by a nurse or midwife, on how to prevent and treat vaginal and reproductive tract infections.
- Utilization of mobile clinics to reach more women both with prevention messaging, sexually-transmitted infection testing, medication for those who require it, and ongoing monitoring of severe cases of gynecological conditions.

Increase preventive services to address preterm birth, including efforts to reduce stress during pregnancy and improve access to professionals providing reproductive health services and antenatal care. Preterm birth can be related to stress or trauma or obstetric causes that could be prevented through antenatal care. We therefore recommend increasing access to full antenatal services and professionals providing reproductive health at the clinic level (see recommendation above on increasing availability and access to reproductive health services).

Increase access to family planning services. While the pregnancy rate is high among Syrian women responding to this survey (16% of women were pregnant during the conflict), a finding supported by observations from relief agencies, Syrian women spoke anecdotally of wanting to prevent pregnancy while in Lebanon due to cost and other difficulties. Contraceptives could be distributed either by mobile clinics or during the women's health education sessions given by nurses or other clinicians (see previous recommendation).

Establish UN-level monitoring system of discrimination in the distribution of aid on the ground. When selecting partners to distribute services to Syrian refugees, the UN should ensure that local partners do not have political or religious agendas that could inhibit or bias distribution of services, as well as taking steps to ensure that harassment or misuse of power will not occur. We recommend that a mechanism for monitoring discrimination be put in place at the field level. Much discrimination could be prevented through increased oversight. Finally, establishing a hotline for complaints could help reduce discrimination in access to services by giving Syrian refugees the power to communicate instances of discrimination. Currently, refugees feel unable to effectively express their frustration with this issue.

Improve services provided for Syrian children. Although this research did not assess the services provided for Syrian refugee children, the findings reveal that they are of major concern to women. Medical and recreational services should be made available to children, and monitored to avoid discrimination or interception.

Recommendations related to violence

Increase services available to women survivors of GBV/SGBV, including intimate partner violence. Psychosocial services available to Syrian women are limited, and there is little awareness of the psychosocial services that are available. These services should be provided at the clinic and community levels. When providing these services, caution must be taken in order not to disrupt families. Considering that many women are accepting and justifying violence due to the man's status as the basic provider for the family, it is important to highlight among women that GBV-related services are not meant to disrupt families or accuse perpetrators, but to improve family functioning and relationships.

This recommendation includes multiple steps:

- Offering increased psychosocial services for survivors at the clinic level
- Training clinical staff and social workers, on how to ask about violence, on counseling skills, and on referral of cases identified
- Training clinical staff and social workers, on sensitivity to cases of sexual violence
- Making services for survivors of violence more visible (tactful posters, flyers, etc.). Once these services become more visible among the Syrian community in Lebanon,

we expect the numbers of those requesting the services to increase (based on the number of cases and the need for such services expressed thus far).

- Training NGO-based community outreach workers in SGBV sensitivity and referral

Establish and promote a hotline for survivors of GBV/SGBV, with a special focus on promoting use among those experiencing intimate partner violence. Such a hotline could be integrated into the current UNHCR hotline numbers that are given to refugees, but should direct callers to someone they can speak with specifically for GBV-related issues (rather than general protection issues). UNFPA and others should promote awareness of these hotlines for survivors of intimate partner violence specifically, as women may not understand that such a hotline can be used in the case of violence perpetrated by their husbands.

Establish women's support groups among the Syrian communities. Due to the ongoing nature of the conflict, and the amount of stress that Syrian women face in Lebanon, a support group could provide a place to talk about experiences of violence, receive support from other women in their community in Lebanon, and cope with ongoing stress. A large number of the women who said they experienced violence also said that they are not yet coping with this experience (42%). Though one-on-one psychological and psychosocial services are available to women, we feel that women would benefit from women's support groups. Whereas one-on-one counseling may be both difficult to access on a regular basis and associated with social stigma, a women's support group can be more accessible in this context. We recommend selecting 10-15 women from each community and training them on the skills of facilitating a women's support groups in their own communities.

As evidence for the usefulness of such a program, those who reported helpful coping mechanisms in the survey interview said that talking with friends or relatives was a primary way of coping with violence. Additionally, focus groups participants expressed great appreciation for the chance to sit with other women and discuss the issues they are facing, indicating the need for a women's support group.

Consider offering men's support groups. Though we did not collect data from Syrian men, many women reported that their husbands suffered from intense stress related to providing for their families, unemployment, and the situation in Syria. Syrian women reported that men are "*taking their stress out on us*" through violence. Men's support groups may be useful in instigating discussion between Syrian men on topics related to stress, including violence as an outlet for stress. Though this study did not address experiences of violence among men, it is clear that many Syrian men have suffered from conflict-related violence, and it is likely that some have been victims of SGBV as well.

Improve coordination and information sharing between various UN and international relief agencies. As there are a number of agencies and organizations operating in the field of reproductive health and gender-based violence, serious confusion regarding roles was observed among the health care workers, directors of clinics, and organizations themselves, let alone among refugees. Such confusion can lead to overlap in services as well as gaps. Coordination of these services by a lead agency is highly recommended, with delineation of services offered by each organization.

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Appendix 1: Focus Group Discussion Guide

FOCUS GROUP DISCUSSION GUIDE:

I am interested in learning about some of the concerns and needs of people in this community. I am especially interested in trying to understand some of the issues that women and girls have to deal with here. I hope that your answers to my questions will help improve services for women, girls, and families in this community. I expect our discussion to last about one hour.

Before we begin, I am going to pass around this Informed Consent Form, and read it aloud. This will tell you more about the purpose of this discussion, and will provide you with the opportunity to consent or decline to participate. (Read Consent Form.)

First, I would like to ask you some general questions about your community:

How did you spend time in Syria (before the conflict)? What were your days like?

How do you spend your time here in Lebanon? What is a typical day like for you?

Who is responsible for making decisions in the family? Who controls the resources in the family?

What people or groups in your community are involved in helping those most in need?

Who do women go to when they have problems?

Now I'd like to ask you some questions about the safety and security of women and girls:

What types of problems have women in your community been facing since the crisis in Syria began? Why do you think this is so?

Are you aware of problems with the safety and security of women and girls in this community?

What are the circumstances that cause problems of safety and security for women and girls in this community? (Ask for examples.)

What has been done here to improve the safety of women and girls?

What about specific forms of violence against women and girls? (Examine definitions of forced sex/rape, sexual harassment, sexual manipulation, etc.)

When and where does sexual violence occur, if at all?

Without mentioning names or indicating anyone specific, who are the perpetrators of sexual violence?

Without mentioning names or indicating anyone specific, which groups of women do you think feel the least safe, or feel at most risk for violence? Which groups of women do you think feel the most safe?

Has the problem of sexual violence gotten worse, better, or stayed the same in the last year? If there has been a change, what has caused it?

Without mentioning names or indicating anyone, do you know women who have been forced to have sex with armed people (e.g. soldiers, armed gangs, etc.) against their will? If yes, how do you know who they are? What problems do they have? How are they treated by the community?

Without mentioning names or indicating anyone, do you know of women in this community who are forced to have sex when they didn't want to? Where do these things happen? How do you know about them? How does the community respond to this?

Do women look for help when they experience violence? Do they tell anyone? (Examples: family members, other women, health worker, community leader, security people, someone else).

How do women cope with violence against their family members or friends?

How do men cope with violence against their daughters, sisters, mothers, wives, friends?

How do families and communities cope with violence against women and girls?

What social or legal services exist to help address problems associated with violence? (Examples: health, police, legal counseling, psychosocial counseling, women's support groups, etc.)

Thank you for your important feedback. I know these are difficult questions about topics that people don't usually talk about. I'd like to pause now and ask some questions about marriage, relationships, and pregnancy:

When women are pregnant in this community, do they usually see a health worker? If so, what type? (Doctor, nurse, midwife or traditional birth attendant, traditional healer.) Where?

If you are married, in your opinion, what do you think has been particularly challenging for your husband since the conflict began? How, if at all, does this differ from before the conflict?

What kinds of conflicts occur in marriages and what are the reasons? How are they resolved?

Without mentioning names or indicating anyone specific, what types of physical and emotional abuse of women by their husbands are you aware of? Why do you think these happened? What do you think are the causes of the abuse?

Before we finish, I would like to hear what you think should be done to address violence against women and girls in this community, particularly in Lebanon?

Thank you all for your time and ideas. This has been extremely helpful. As I said in the beginning, the purpose of this discussion was to help me learn about what women want and what women need here. As more services are developed here, we want to be sure they help you address the problems your community is facing.

Appendix 2: Survey Questionnaire

BACKGROUND CHARACTERISTICS		
1	What is your age? (in years)	__ __ Don't know 88 Refuse 99
2	What is your current marital status? *If not married, skip to question 6.*	Married 1 Widowed 2 Separated/divorced 3 Never married 4 Refuse 99
3	Is your husband a relative of yours?	No 0 Yes 1 Refuse 99
4	How long have you been married to your current husband?	List years __ __ Don't know 88 Refuse 99
5	Is your husband in Lebanon with you?	No 0 Yes 1 Not all of the time 2 Refuse 99
6	How many months have you been in Lebanon?	List months __ __ Don't know 88 Refuse 99
7	Are you registered with the United Nations here in Lebanon?	No 0 Yes 1 Refuse 99
8	Were you living in a city or a village in Syria?	City 1 Village 2 Don't know 88 Refuse 99
9	What was your main reason for leaving your home in Syria? (you may choose more than one)	Threat to security/safety of family 1 Fear 2 Lack of health care 3 Lack of food 4 Lack of daily living facilities (water, electricity) 5 Other (specify) _____ 6 Refuse 99
10	Where are you staying in Lebanon?	Within a school 1 At a relative's home 2 At a friend's home 3 In a rented apartment 4 In a tent / camp 5 Other (specify)_____6 Refuse 99
11	How long have you lived in your current location?	Number of months __ __ Don't know 88 Refuse 99

12	How many children currently live with you (17 years or younger)? This includes children of your host family.	List number __ __ Don't know 88 Refuse 99
13	Not including yourself, how many adults currently live with you (18 years of age or older)? This includes adults of your host family.	List number __ __ Don't know 88 Refuse 99
14	Do you or your family receive any assistance, such as food vouchers, blankets, clothes, meditcation, etc.?	No 0 food assistance 1 blankets 2 clothes 3 medicine 4 sanitary supplies 5 Other (specify) _____ 6 Refuse 99
15	Are you currently working for money (wages)?	Not working & do not wish to work 0 Not working but looking for work 1 Working in trade or business 2 Working for money 3 Other (specify) _____ 4 Refuse 99
16	What kind of work do you do?	Not working 0 Farming 1 Daily laborer 2 Business 3 Housekeeping services 4 Other (specify) _____ 5 Refuse 99
17	What is the main source of income for the family?	No income 0 Support from husband/partner 1 Support from other relatives 2 Money from own work 3 Social services/welfare 4 Other (specify) _____ 5 Refuse 99
18	Who in your family currently makes the final decision regarding the following:	You 1 Husband 2 You and your husband jointly 3 Your parents or your husband's parents 4 Your brother 5 Someone in your host family 6 Someone else (specify)_____ 7 Not applicable 8 Refuse 99
	A. Your own health care?	A. 1 2 3 4 5 6 7 8 99
	B. Your children's health care?	B. 1 2 3 4 5 6 7 8 99
	C. Making large household purchases (such as rent)?	C. 1 2 3 4 5 6 7 8 99
	D. Making daily household purchases (such as groceries)?	D. 1 2 3 4 5 6 7 8 99
	E. Visiting family or relatives?	E. 1 2 3 4 5 6 7 8 99

	F. Deciding what to prepare for daily meals?	F. 1 2 3 4 5 6 7 8 99			
19	Can you read easily, with difficulty, or not at all?	Not at all 0 With difficulty 1 Easily 2 Don't know 88 Refuse 99			
20	Have you ever attended school, and if so what was the highest level of school you attended?	Did not attend school 0 Primary 1 Secondary 2 High school 3 University 4 Other (specify) _____ 5 Don't know 88			
21	Do you mind if I ask you about your religion? Again, this information will remain confidential. *If they say they don't mind, ask:* What is your religion?	Muslim 1 Christian 2 Other (specify) _____ 3 Refuse 99			
GENERAL HEALTH STATUS					
22	How would you rate your overall health? (excellent, good, acceptable, poor, very poor)	Excellent 1 Good 2 Acceptable/ fair 3 Poor 4 Very poor 5			
23	Do you suffer from any of the following illnesses:	Yes	No	Don't know	Refuse
	A. Hypertension?	1	0	88	99
	B. Diabetes	1	0	88	99
	C. Anemia	1	0	88	99
	D. Other diseases? (specify) _____	1	0	88	99
24A	Are you currently smoking every day, some days, or not at all? *If NO, skip to question 25A.*	Every day 1 Some days 2 Not at all 3 Refuse 99			
24B	If you are currently smoking, did your smoking increase from how much you used to smoke in Syria?	No 0 Yes 1 Don't know 88 Refuse 99			
25A	Do you now smoke a water pipe every day, some days, or not at all? *If NO, skip to question 26A*	Every day 1 Some days 2 Not at all 3 Refuse 99			
25B	If you do smoke a water pipe, did your water pipe smoking increase from how much you used to smoke in Syria?	No 0 Yes 1 Don't know 88 Refuse 99			

26A	Are you currently on any medications?	No 0 Yes 1 Refuse 99
26B	If so, medications for what condition?	List_____ _____
REPRODUCTIVE HISTORY		
27	How old were you when you had your first menstrual period?	Age in years __ __ Don't know 88 Refuse 99
28	*If married*: How old were you when you were first married?	Age in years __ __ Don't know 88 Refuse 100
29	Have you ever been pregnant? *If NO, skip to question 66 (the section on "Current Reproductive Health Status & Services").*	No 0 Yes 1 Don't know 88 Refuse 99
30	How old were you at your first pregnancy?	Age in years __ __ Don't know 88 Refuse 99
31	What is the total number of pregnancies you have had, including those that did not result in live birth?	List number __ __ Don't know 88 Refuse 99
32	Have you had any miscarriages, and if so how many?	No 0 Yes, list number __ __ 1 Don't know 88 Refuse 99
33	Have you ever voluntarily ended a pregnancy (induced abortion)? If so, how many times?	No 0 Yes, list number __ __ 1 Refuse 99
34	Have you had any cesarean sections, and if so how many?	No 0 Yes, list number __ __ 1 Refuse 99
35	How many pregnancies resulted in children who were born alive, but are not living now?	List number __ __ Refuse 99
INFORMATION ON THE CURRENT OR MOST RECENT PREGNANCY DURING OR SINCE THE CONFLICT		
36	Have you become pregnant since the crisis in Syria began in March 2011? If no, were you ever pregnant during the conflict?	No, not pregnant during or since the conflict 0 Yes, was pregnant when the conflict began 1 I became pregnant after the conflict began 2 Don't know 88 Refuse 99
37	Are you currently pregnant?	No 0 Yes 1 Don't know 88 Refuse 99
	If NO to both questions 36 and 37, skip to question 65 (the section on "Current Reproductive Health Status & Services).	

38	Is this / was this your first pregnancy?	No 0 Yes 1 Don't know 88 Refuse 99
39	Is / was the pregnancy a single baby or twins / triplets?	Single infant pregnancy 1 Multiple-infant pregnancy 2 Don't know 88 Refuse 99
40	In what month of pregnancy were you when you fled Syria?	List month of pregnancy __ __ Not applicable (Was not pregnant when left Syria) 77 Don't know 88 Refuse 99
41	What was the result of this pregnancy?	Currently pregnant 1 Live birth 2 Spontaneous or induced abortion 3 Sillbirth (born dead) 4 Born alive but died shortly after birth 5 Other (specify)_____ 6 Refuse 99
42A	Did you receive antenatal care for your current or recent pregnancy? If so, was this in Syria, in Lebanon, or both? *If NO, did not receive antenatal care, skip to question 42D.*	Did not receive antenatal care 0 Syria only 1 Lebanon only 2 Both Syria and Lebanon 3 Refuse 99
42B	In relation to this pregnancy, how many antenatal visits have you had?	Number of visits __ __ Don't know 88
42C	*If received any antenatal care:* what services were you offered during your antenatal visit(s) during your pregnancy? (circle all that apply)	Blood test 1 Blood pressure 2 Weight 3 Fetal heart 4 Ultrasound 5 Given medication 6 Given antenatal vitamins 7 Given special iron supplements 8 Don’t know 88 Refuse 99
42D	*If no antenatal care:* What are the reasons that you did not receive antenatal care in relation to this pregnancy? (circle all that apply)	Planning to go, but have not yet 1 No health care provider available 2 Could not afford it financially 3 Distance too far / Lack of transportation 4 Security concerns / fear 5 Husband / partner woud not permit 6 Afraid of doctor, nurse, etc.7 Have never used doctor, nurse before 8 I have always been healthy 9 Not treated well previously 10 Embarrassed or ashamed 11 Other (specify) _____12 Refuse 99

	If currently pregnant, ask questions 43A-46 below. *If not currently pregnant, skip to question 47.*	
43A	Have you had any problems or complications during the pregnancy thus far? *If NO, skip to question 45.*	No 0 Yes 1 Don't know 88 Refuse 99
43B	If so, what problem(s) or complication(s) did you have? (circle all mentioned)	Feeling very weak or tired (anemia) 1 Sever abdominal pain (pain in the belly) 2 Bleeding from the vagina 3 Fever 4 Swelling of hands and face 5 Blurred vision 6 Other (specify)_____7 Don't know 88 Refuse 99
44A	Did you seek help for the problem(s) or complication(s)? And if so, in what country?	Did not seek treatment 0 Syria only 1 Lebanon only 2 Both Syria and Lebanon 3 Other (specify)_____ 4 Refuse 99
44B	If so, where did you seek help? (circle all that apply)	Traditional healer 1 Neighbor/Friend 2 Hospital 3 Health center or clinic 4 Your family 5 Self-treated 6 Other (specify)_____ 7 Refuse 99
45	In what country do you plan to deliver the baby?	Lebanon 1 Syria 2 Other country 3 Don't know 88 Refuse 99
46	Where (in what type of facilty) do you plan to deliver the baby?	At home 1 Hospital or Doctor's clinic 2 Primary health clinic 3 Other (specify)_____ 4 Don't know 88 Refuse 99
	If any delivery or abortion occurred during or since the conflict, ask questions 47-64B (the following questions). If still pregnant, skip to the next section ("Current Reproductive Health Status & Services").	
47	Did you deliver the baby (or have an abortion) in Syria, Lebanon, or another country?	Syria 1 Lebanon 2 Other country 3 Did not deliver (miscarriage or abortion) 4 Refuse 99

48	Where did the delivery (or abortion) take place (what type of facility)?	At home 1 Hospital 2 Primary health clinic or Doctor's clinic 3 Somewhere else 4 Refuse 99
49	If the delivery (or abortion) happened in a healthcare center, how did you learn about this health center?	Referral from a health professional 1 Family member 2 Friend 3 Advertisement 4 Other (specify) _____ 5 Don't know 88
50	Who attended the delivery (or abortion), if anyone?	No heathcare professional (delivered alone) 0 Doctor 1 Nurse/midwife 2 Traditional birth attendant 3 Family member 4 Other (specify) _____5 Refuse 99
51	Were there any complications during the labor and delivery (or the abortion)? If so, what complications did you have? (circle all that apply) *In the case of abortion (not delivery) skip to question 54.*	No complications 0 Heavy bleeding 1 Prolonged (>12 hours) or obstructed labor 2 Vaginal tearing 3 Convulsions 4 Fever 5 Green or brown water coming from the vagina 6 Other (specify)_____ 7 Refuse 99
52	Was your baby born preterm or too early?	No 0 Yes 1 Don't know 88
53	Was your baby born underweight, normal weight, or overweight?	Underweight 1 Normal weight 2 Overweight 3 Don't know 88 Refuse 99
54	During the 40 days after birth (or abortion), did <u>you</u> have any problems or complications? Is so, what? *If NO, skip to question 59.*	No 0 Yes, specify_____ 1 Don't know 88
55	If so, did you seek help for the problem(s) or complication(s)? In what country?	No 0 Yes, in Syria 1 Yes, in Lebanon 2 Yes, in both Syria and Lebanon 3 Other (specify) _____ 4 Refuse 99

56	If you sought help for the problem(s) or complication(s), where did you seek help?	Traditional healer 1 Neighbor/Friend 2 Hospital 3 Health center or clinic 4 Your family 5 Self-treated 6 Other (specify) _____ 7 Refuse 99
57	If you sought treatment from a health care facility, how did you learn about this health facility?	Referral from a health professional 1 Family member 2 Friend 3 Advertisement 4 Other (specify) _____ 5 Don't know 88
58	*In the case of abortion (not delivery) skip to question 62.* During the 40 days after birth, did <u>your child</u> have any problems or complications? If so, what?	No 0 Yes, specify _____1 Don't know 88
59	If so, did you seek help for the problem(s) or complication(s) of your child?	No 0 Yes 1 Refuse 99
60	Where did you seek help for the problem(s) or complication(s) of your child?	Did not seek treatment 0 Traditional healer 1 Neighbor/Friend 2 Hospital 3 Health center or clinic 4 Your family 5 Self-treated 6 Other (specify) _____ 7 Don't know 88
61	If you sought treatment from a health care facility, how did you learn about this health facility?	Referral from a health professional 1 Family member 2 Friend 3 Advertisement 4 Other (specify) _____ 5 Don't know 88
62	During the 40 days after birth or abortion, did you go to the health center to check <u>your</u> health? (regardless of problems or complications) *If NO, skip to question 64A in the case of birth, or 65 in the case of abortion*	No 0 Yes 1 Don't know 88
63	During this visit to the clinic after birth (or abortion), did you receive information or counseling about family planning?	No 0 Yes 1 Don't need, my husband is absent 3 Don't know 88

64A	*In the case of abortion, skip to question 65.* Did you breastfeed your baby that was born since the conflict?	No 0 Yes 1 Refuse 99
64B	If you did not breastfeed, why not?	Not able to/Not enough milk 1 Did not want to 2 You were in poor health/sickness 3 You were constantly being displaced 4 It was difficult to be alone 5 Other (specify) _____ 6 Don't know 88 Refuse 99
CURRENT REPRODUCTIVE HEALTH STATUS & SERVICES		
65	Are there any women's health services (such as for pregnancy, STIs, family planning, etc.) available to displaced Syrian women or girls here in Lebanon? *If NO, skip to question 67.*	No 0 Yes 1 Don't know 88 Refuse 99
66	Do you think these services are easily accessible to most displaced Syrian women living in Lebanon? If not, why? (circle all that apply)	Yes, they are easily accessible 1 No, the price is too high 2 No, distance too far / lack of transportation 3 No, security concerns / fear 4 No, they are embarrassed or ashamed 5 No, they are afraid of maltreatment 6 No, family would not allow 7 No, they don't feel that they need the services 8 No, there was no female doctor available 9 Other (specify) _____10 Don't know 88 Refuse 99
67	Have you ever (in your life) visited a gynecologist when you were not pregnant?	No 0 Yes 1 Don't know 88 Refuse 99
68	In the past 6 months, have you visited a gynecologist or reproductive health specialist for any reason?	No 0 Yes 1 Don't know 88 Refuse 99
69	In the past 6 months have you been diagnosed by a healthcare professional with any type of reproductive tract infection? *If NO, skip to question 71.*	No 0 Yes (specify) _____ 1 Don't know 88 Refuse 99
70A	Did you receive medication or treatment for this infection?	No 0 Yes 1 Don't know 88 Refuse 99

70B	If so, who prescribed this medication or treatment for you?	Self-treated 1 Neighbor/Friend 3 Family member 4 Nurse or other healthcare professional 5 Doctor 6 Pharmacist 7 Don't know 88 Refuse 99
70C	If you haven't received medication or treatment, why not?	Did not need medical care 1 The infection went away without treatment 2 Did not know where to go 3 Medical care not available 4 No use/ would not do any good 5 Embarrassed 6 Had insufficient funds 7 Had no transport 8 Other (specify) _____9 Don't know 88 Refuse 99
71	Have you ever heard of family planning or contraceptives?	No 0 Yes 1 Refuse 99
72	If you were not pregnant, have you used any form of family planning or contraceptive since the conflict in Syria began? *If NO, skip to question 74A.*	No 0 Yes 1 Refuse 99
73A	If so, what type of family planning or contraceptive?	Rhythm method or count days in cycle 1 Condom 2 IUD (intrauterine device) 3 Birth control pills 4 Injection 5 Tubal ligation or hysterectomy vasectomy) 6 Other method (specify) _____ 7 Refuse 99
73B	If so, from where did you obtain it?	Traditional healer 1 Neighbor/Friend 2 Hospital 3 Health center or clinic 4 Your family 5 Got it myself / pharmacy 6 Don't know 88 Refuse 99
73C	If so, in what country did you obtain the family planning or contraceptives?	Lebanon 1 Syria 2 Other (specify): _____3 Refuse 99

74A	If not, do you want to be using a form of birth control or contraceptive? *If NO, skip to question 75.*	No 0 Yes 1 Don't know 88 Refuse 99			
74B	If you want to, do you have access to birth control/oral contraceptives?	No, why? (specify)_____ 0 Yes 1 Don't know 88 Refuse 99			
74C	If you do not have access to birth control/family planning, why?	Specify _____ Refuse 99			
75	Since the conflict in Syria began, have you experienced any of the following conditions:	Yes	No	Don't know	Refuse
	A. skipping periods without being pregnant?	1	0	88	99
	B. more frequent periods than normal?	1	0	88	99
	C. heavy menstrual bleeding?	1	0	88	99
	D. bleeding between menstrual cycles?	1	0	88	99
	E. spotting between menstrual cycles?	1	0	88	99
	F. increased pain with menstruation?	1	0	88	99
	G. severe lower abdominal pain?	1	0	88	99
	H. pain or burning when you urinate?	1	0	88	99
	I. pain or burning during sexual intercourse?	1	0	88	99
	J. unusual vaginal discharge? (prompt: excessive or foul-smelling)	1	0	88	99
	If the answer to all of the questions was NO, skip to question 78.				
76	Are you currently experiencing any of the conditions mentioned above?	No 0 Yes (specify) _____ 1 Don't know 88 Refuse 99			
77	Have you consulted anyone about this issue? If so, who did you consult? *Skip to question question 79 (next section, "Experiences in Syria/Lebanon")*	Did not consult anyone 0 Doctor 1 Nurse or other healthcare professional 2 Family member 3 Neighbor/Friend 4 Don't know 88 Refuse 99			
78	If you had a complication or problem related to women's health in Lebanon, where would you seek help?	Wouldn't seek care 0 Specify _____ 1 Refuse 99			
EXPERIENCES IN SYRIA / LEBANON					
79	Since you left Syria, were you usually able to access the following in the place where you were staying:				
	A. piped water for drinking?	No 0 Yes 1			

	B. water for use other than drinking?	No 0 Yes 2
	C. bathing facilities?	No 0 Yes 3
	D. soap/body cleansers?	No 0 Yes 4
	E. sanitary napkins?	No 0 Yes 5
80	Since the conflict in Syria began, did you ever worry that your household would not have enough food? If so, how often?	Never 0 Rarely 1 Sometimes 2 Often 3 Refuse 99
81	Did you or any household member eat food that you did not prefer to eat because of lack of resources? If so, how often?	Never 0 Rarely 1 Sometimes 2 Often 3 Refuse 99
82	Did you or any household member eat fewer meals in a day because there was not enough food? If so, how often?	Never 0 Rarely 1 Sometimes 2 Often 3 Refuse 99

83	Since the conflict began until now, were any of your female family member (including daughters, sisters, or mother) subject to any of the following?	Never	1-2 Times	Frequently	If so, who did this? Armed people 1 Husband 2 An acquaintance or family member 3 Other (specify) 4 Refuse 99	If so, where did this occur? In Syria only 1 In Lebanon only 2 In both Syria & Lebanon 3 Other (specify) 4 Refuse 99
	A. Slapped or hit	0	1	2		
	B. Choked	0	1	2		
	C. Beaten or kicked	0	1	2		
	D. Threatened with a weapon of any kind	0	1	2		
	E. Shot at or stabbed	0	1	2		
	F. Detained against your will	0	1	2		
	G. Intentionally deprived of food, water or sleep	0	1	2		
	H. Subjected to improper sexual behavior	0	1	2		

	If the answer to all of the above was NO, skip to question 86.

84	If yes to any of the above items, did your fmaily member receive medical treatment? And if so, from whome?	Did not seek treatment 0 Traditional healer 1 Neighbor/Friend 2 Hospital 3 Clinic 4 Your family 5 Self-treated 6 Other (specify) _____ 7 Don't know 88 Refuse 99
85	If so, in what country did they receive treatment or care?	Syria 1 Lebanon 2 Both Syria and Lebanon 3 Other (specify) _____ 4 Don't know 88 Refuse 99

86	Since the conflict began until now, were <u>you</u> subject to any of the following?	Never	1-2 Times	Frequently	<u>If so, who did this?</u> Armed people 1 Husband 2 An acquaintance or family member 3 Other (specify) 4 Refuse 99	<u>If so, where did this occur?</u> In Syria only 1 In Lebanon only 2 In both Syrian & Lebanon 3 Other (specify) 4 Refuse 99
	A. Slapped or hit	0	1	2		
	B. Choked	0	1	2		
	C. Beaten or kicked	0	1	2		
	D. Threatened with a weapon of any kind	0	1	2		
	E. Shot at or stabbed	0	1	2		
	F. Detained against your will	0	1	2		
	G. Intentionally deprived of food, water or sleep	0	1	2		
	H. Humiliation/emotional abuse					
	I. Lack of money					
	J. Subjected to improper sexual behavior	0	1	2		

	If the response to all of the above question was NO then skip to question 87, otherwise move to question 88.	
87	If you were subject to any of the above abuses, where would you seek help here in Lebanon? *Now move to question 101.*	I would not seek help 0 Specify _____1 Don't know 88 Refuse 99

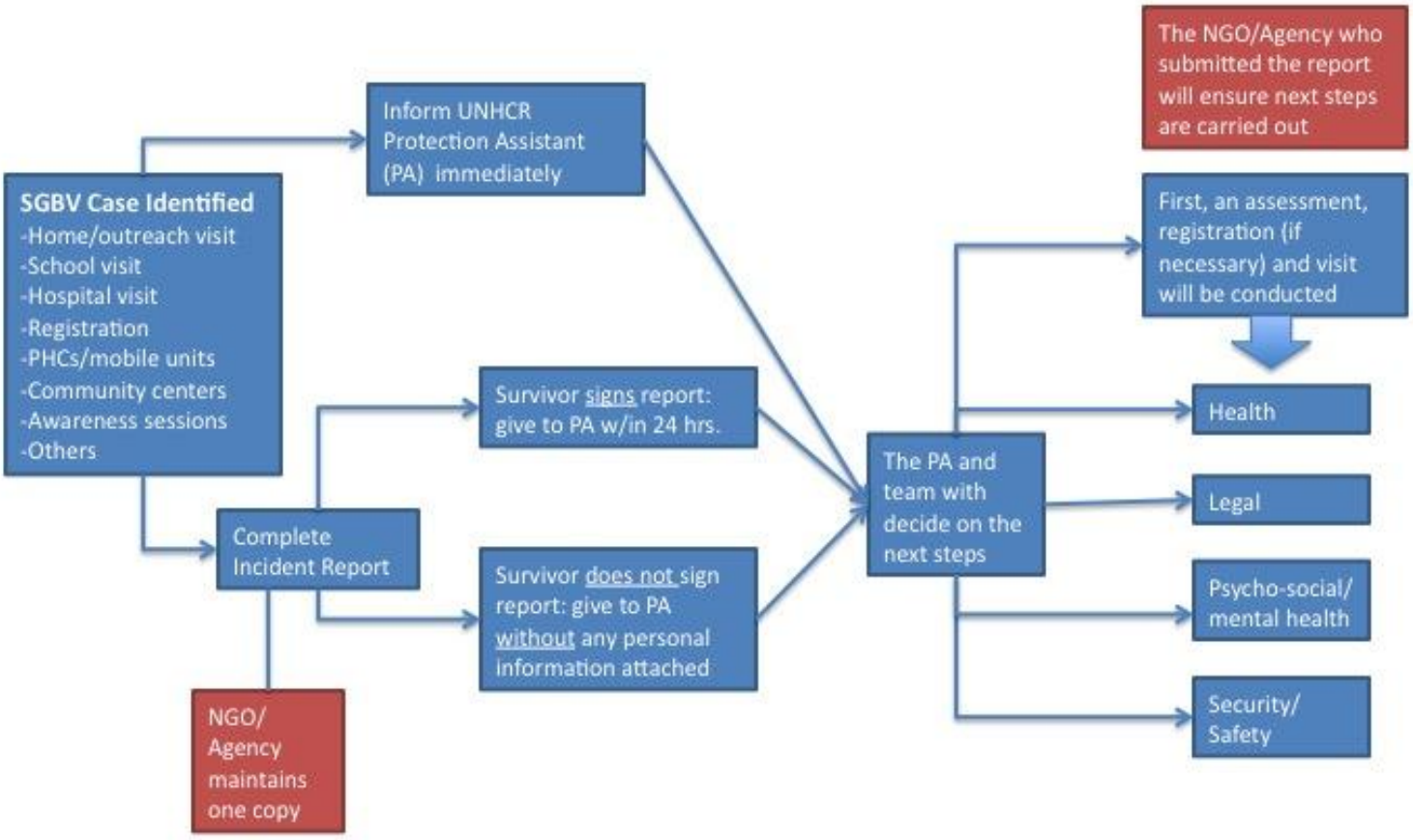
88	Did you experience any of the following as a result of the abuse that you suffered (Read choices and response)?	Yes	No	DK	Refuse
	A. Bruises, scrapes, welts, loss of consciousness, sprains or dislocations, knocked out teeth, deep wounds or cuts, broken bones or fractures.	1	0	88	99
	B. Phsychological difficulties such as nightmares, intrusive memories, significant changes in sleep patterns	1	0	88	99
	C. Other (specify) _____	1	0	88	99
89	Did you tell anyone about what happened during the episode? If you told anyone (other than the people who were with you during the episode), whom did you tell? (circle mentioned) *If did NOT tell anyone, skip to question 93.*	Did not tell anyone 0 Husband 1 Male family member 2 Female family member 3 Friend 4 Medical practitioner 5 social worker 6 NGO/UN worker 7 religious authorities 8 women's group 9 Other (specify) _____ 10 Don't know 88 Refuse 99			
90	What was the reaction of the person or people you told? (circle all mentioned)	Stigmatized me 1 Ignored me, no response 2 Took the information, but nothing happened 3 Provided psychosocial or medical support 4 Referred me to an NGO 5 Referred me to a religious authority 6 Other (specify) _____ 7 Don't know 88 Refuse 99			
91	Of the people you told about the episode, who was most helpful? (circle all mentioned)	No one was helpful 0 Husband 1 Male family member 2 Female family member 3 Friend 4 Medical practitioner 5 social worker 6 woker in an international organizationr 7 religious authorities 8 women's group 9 Other (specify) _____ 10 Don't know 88 Refuse 99			
92	How did he or she help you?	Specify _____ _____ _____			

93	*If did not tell anyone:* Why did you not tell anyone about what happened?	Feelings of shame 1 Fear of being stigmatized 2 Fear of rejection by family or friends 3 Did not trust anyone 4 Thought nothing could be done 5 Other 6 Don't know 88 Refuse 99
94	Did you seek medical care for your injuries? If you sought medical care for your injuries, whom did you consult for medical assistance? *If NO (did not seek treatment), skip to question 96.*	Did not seek treatment 0 Traditional healer 1 Neighbor/Friend 2 Hospital 3 Your family 4 Self-treated 5 Other (specify) _____ 6 Don't know 88 Refuse 99
95	If so, in what country did you seek medical care?	Syria 1 Lebanon 2 Both Syria and Lebanon 3 Other (specify) _____ 4 Don't know 88 Refuse 99
96	*If you did not seek care:* What was the main reason you did not seek medical care for your injuries?	Did not need medical care 0 Did not know where to go 1 Medical care not available 2 No use/ would not do any good 3 Embarrassed 4 Afraid of further violence 5 Would not be believed or taken seriously 6 Afraid of blame 7 Bring bad name to your family 8 Bring bad name to husband's family 9 Had insufficient funds 10 Had no transport 11 Other (specify) _____12 Don't know 88 Refuse 99
97	Do you want to speak with a healthcare professional here in Lebanon about your experiences or injuries? *If YES, tell the respondent that you will give them a card with resources available to them at the end of the survey.*	No 0 Yes 1 Don't know 88 Refuse 99

98	What has been must helpful to you so far in coping with your experiences in Syria or in Lebanon? (circle all that apply)	Support group for women 0 I did not adjust or cope with this yet 1 Talking it over with friends 2 Talking it over with family 3 Assistance from NGO workers 4 Legal advice/traditional justice 5 Mental helath counseling 6 Medical assistance 7 Trying to forget about experience 8 Reading religious book or praying 9 Other 10 Don't know 88 Refuse 99			
99	Are there other things that you think might be helpful to you in coping with your experience(s)?	Specify _____ _____			
100	I would like to ask you the following questions regarding the past month:	Much more than usual	Slightly more than usual	As usual	Never
	A. Do you feel constantly tense?	4	3	2	1
	B. Do you feel sick or tired?	4	3	2	1
	C. Do you feel concerned for any reason recently?	4	3	2	1
	D. Do you feel that you are irritable or in a bad mood?	4	3	2	1
	E. Are you able to go about your normal tasks alright?	4	3	2	1
	F. Do you suffer from loss of sleep or sleep disorders?	4	3	2	1
	G. Do you beat your children/take out your anger on your children?				
101	I have asked you about many difficult things. How has talking about these things made you feel?	Good/better 1 Bad/worse 2 Same/no different 3 Don't know 88 Refuse 99			
102	Can you name three health-related things that concern you or for which you would like to seek help?	1._____ 2._____ 3._____			
103	Is there anything that I did not cover today that you would like to tell me about?				
	Interviewer Comments:				

Appendix 3: Flow Chart of SGBV Referral System

At the time of writing this report, UNHCR was establishing and assessing Standard Operation Procedures (SoPs) for identification and referral of SGBV cases among the displaced population. This flow chart is based on these SoPs (specifically for North Lebanon), and on additional information provided in coordination meetings and informal meetings.



Appendix 4: Contents of UNFPA "Dignity Kit"

Each UNFPA "Dignity Kit" included the following items:	
1	Shirt
2	Head scarf/hijab
3	Feminine sanitary napkins
4	Underwear
5	Flashlight
6	Hygiene supplies: soaps, scrub