GBV Safety Audit Report on GBV, SRH, and Shelter Accessibility in Lebanon

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Table of Contents

Executive Summary

This study was conducted to assess the availability, accessibility, and quality of gender-based violence (GBV) services, sexual and reproductive health (SRH) services, and safe shelter options for marginalized groups in Lebanon. It aimed to identify barriers, service gaps, and opportunities for strengthening humanitarian response systems for survivors of violence. A qualitative methodology was employed, combining key informant interviews, focus group discussions, and in-depth interviews. The research engaged Lebanese women, Syrian and Palestinian refugee women, migrant domestic workers, LGBTQI+ individuals, Lebanese men, and persons with disabilities across Beirut, Mount Lebanon, Bekaa, Akkar, and South Lebanon, as well as security officers and ten NGOs/UN Agencies operating in protection, health, and humanitarian sectors. Disaggregated findings illustrate how age, disability status, sexual orientation, and legal status intersect to shape survivors' access to services and exposure to violence.

The study revealed significant gaps across the GBV, SRH, and shelter sectors. Awareness of shelter services remained extremely low among communities, and shelters themselves often lacked sufficient privacy, security, and survivor-centered practices. Structural barriers such as documentation requirements, transportation costs, and discrimination—particularly against undocumented migrants and LGBT individuals—severely restricted access to services. SRH services were fragmented, costly, and not adequately inclusive of unmarried women, LGBTQI+ individuals, or persons with disabilities. Trauma-informed care, survivor-centered practices, and cross-sectoral coordination between healthcare, legal, and shelter services were largely inconsistent and insufficient. Economic crisis, displacement, and legal insecurity further compounded survivors' vulnerabilities, particularly among refugees, migrant workers, queer individuals, and single-headed households.

Participatory methods were used to involve LGBTQI+-led, refugee-led, and migrant worker-led organizations not only as respondents, but as co-designers of outreach strategies and interpreters of local context.

Key findings include: low awareness and access to shelters; exclusionary and fragmented SRH services; systemic discrimination against LGBTQI+ and migrant survivors; and inconsistent trauma-informed care. The report recommends expanding inclusive shelter options, strengthening survivor-centered service provision, ensuring cross-sector training and coordination, and partnering with marginalized communities to drive protection, health, and advocacy efforts.

Key Recommendations

- Strengthen trauma-informed and survivor-centered service delivery across sectors.
- Improve shelter availability, accessibility, and privacy for marginalized groups.
- Enhance mandatory training for security forces, healthcare providers, and shelter managers with a focus on GBV dynamics, non-discrimination, LGBTQI+ inclusion, and disability rights.
- Expand and decentralize SRH services, ensuring they are gender-sensitive, queer-inclusive, and accessible to rural and underserved areas.
- Foster greater collaboration with migrant-led and LGBTQI+ focused organizations to enhance outreach, protection, and service delivery.
- Advance urgent advocacy for legal reforms, including comprehensive anti-discrimination laws, kafala system dismantling, and refugee protection frameworks.
- Launch targeted public awareness campaigns to reduce stigma and promote help-seeking behaviors among survivors.
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- Advocate for integrated and flexible funding models to donors.
- Develop more integrated and robust indicators for monitoring progress.
- Expand after-hours access to critical services.

Through an intersectional and survivor-centered lens, this study highlights the urgent need for humanitarian actors to recalibrate their approaches to better protect and empower the most vulnerable communities in Lebanon.

Abbreviations

FGD — Focus Group Discussion
GBV — Gender-based Violence
GBV IMS — Gender-Based Violence Information Management System
IPV — Intimate Partner Violence
IOM — International Organization for Migration
ISF — Internal Security Forces
JRS — Jesuit Refugee Service
KII — Key Informant Interview
LECORVAW — Lebanese Council To Resist Violence Against Women
LGBT — Lesbian, Gay, Bisexual, Transgender
LGBTQI+ — Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex
MdM — Médecins du Monde
MOSAIC — MENA Organization for Services, Advocacy, Integration and Capacity-building
NGO — Non-governmental Organization
PEP — Post-exposure Prophylaxis
PHCC — Primary Healthcare Center
PrEP — Pre-exposure Prophylaxis
PSEA—Protection from Sexual Exploitation and Abuse
RDFL — Lebanese Women Democratic Gathering
SIDC — Society for Inclusion and Development in Communities
SOGIESC — Sexual Orientation, Gender Identity and Sex Characteristics
SRH — Sexual and Reproductive Health
STI — Sexually Transmitted Infection
UN — United Nations
UNHCR — United Nations High Commissioner for Refugees
WG — Working Group

Introduction

Background and Rationale

Across the last 2024 armed conflict, vulnerability to gender-based violence (GBV) and sexual exploitation has sharply increased. According to UNFPA's Flash Report from February 2025, displaced women and girls residing in overcrowded and unsafe collective shelters face heightened risks of GBV, while rising psychological distress, widespread family separation, and a growing number of women-headed households have further elevated protection concerns.[1] Similarly, the IOM Lebanon Crisis Response Plan 2025 confirmed that the escalation of conflict has significantly worsened protection risks, particularly among displaced migrants and refugees.[2] Displacement has deepened physical insecurity and psychosocial distress, with IOM emphasizing that women and girls in informal shelters face limited access to essential services and heightened exposure to violence.[3] Although GBV risk mitigation measures, protection mainstreaming, and protection from sexual exploitation and abuse (PSEA) efforts have been integrated across interventions, the combination of displacement, poverty, and weakened public services continues to amplify GBV risks.

Beyond the immediate effects of the conflict, structural and systemic drivers of violence against women remain deeply entrenched. According to a report by the Lebanese Center for Policy Studies (LCPS), Lebanon's ongoing political and economic crises, compounded by the armed conflict since 2024, have fueled an increase in violence against women. Data from the Internal Security Forces (ISF) recorded a 241% increase in reported domestic violence cases during the COVID-19 period compared to earlier years.[4] The Gender-Based Violence Information Management System (GBV IMS) Annual Report for 2024 further revealed that 98% of GBV survivors were women, with marginalized groups, including transgender individuals, reporting increased feelings of insecurity.[5] Despite some legislative reforms, cultural norms, legal discrimination under religion-based personal status laws, and a lack of effective enforcement mechanisms continue to perpetuate high rates of violence against women and girls across the country.

[1] UNFPA (2025), Lebanon: Gender-Based Violence (GBV) Information Management System (IMS) - Annual Report 2024, https://reliefweb.int/report/lebanon/lebanon-gender-based-violence-gbv-information-management-system-ims-annual-report-2024

[2] IOM (2025), Lebanon Crisis Response Plan 2025, https://crisisresponse.iom.int/response/lebanon-crisis-response-plan-2025

[3] Ibid

[4] El-Helou, Z. (2025), Strengthening Protections: An Analysis of Violence Against Women Legislation in Lebanon, Lebanese Center for Policy Studies, https://www.lcps-lebanon.org/en/articles/details/4914/strengthening-protections-an-analysis-of-violence-against-women-legislation-in-lebanon

[5] UNFPA (2025), Lebanon: Gender-Based Violence (GBV) Information Management System (IMS) - Annual Report 2024, https://reliefweb.int/report/lebanon/lebanon-gender-based-violence-gbv-information-management-system-ims-annual-report-2024

In November 2024, the GBV Working Group—Lebanon conducted a comprehensive GBV Safety Audit to assess risks, service gaps, and the protective environment for women, girls, and marginalized groups across Lebanon.[6] The findings from that audit highlighted significant protection concerns, barriers to services, and rising vulnerabilities due to the compounded effects of economic collapse, displacement, and ongoing conflict dynamics.[7]

Building on the foundational safety audit conducted by the Working Group (WG), and as the report in question does not cover the period following the escalation of the armed conflict in Beirut and other areas, the present Gender Audit was undertaken as a complementary exercise, developed in close coordination with the WG to emphasize realities in the critical period that followed. It seeks to deepen and expand the analysis by focusing specifically on the lived experiences of diverse community groups, the accessibility and responsiveness of GBV and sexual and reproductive health (SRH) services, and the challenges surrounding safe shelter access. Recognizing the shifting protection landscape and the evolving needs of marginalized communities, this audit aims to generate additional community-driven insights to support programmatic adaptations, advocacy efforts, and strengthened coordination among service providers and policy actors.

Objectives of the GBV Safety Audit

The primary objective of the GBV Safety Audit is to assess the current GBV risks and protection concerns experienced by women, girls, queer individuals, migrant domestic workers, and other vulnerable groups across Lebanon. It seeks to identify key barriers and gaps in GBV response services, SRH services, and safe shelter access, with a particular focus on the needs of marginalized communities. Another key aim is to examine the role of various actors—including NGOs, migrant-led organizations, LGBTQI+ organizations, healthcare providers, and security forces—in the prevention, response, and provision of GBV-related services. By capturing community perspectives and coping strategies, the audit strives to better understand how individuals navigate risk, access support, and seek safety within the current humanitarian and protection landscape. Ultimately, the audit seeks to strengthen the evidence base necessary to support survivor-centered, inclusive, and trauma-informed programming, while guiding future interventions by humanitarian actors, service providers, and policymakers.

[6] Gender Based Violence Safety Audit for Lebanon: GBV Working Group - Lebanon (November 2024), https://reliefweb.int/report/lebanon/gender-based-violence-safety-audit-lebanon-gbv-working-group-lebanon-november-2024
[7] Ibid

Scope: Communities, Groups, and Sectors Covered

This GBV Safety Audit draws from extensive consultations with a wide range of stakeholders and community members across Lebanon (See Annex for regional breakdown). It engaged Lebanese women from diverse socioeconomic backgrounds, exploring their experiences with GBV, SRH access, and shelter safety. Syrian refugee women living in urban and rural settings, informal settlements, and shelters were consulted to examine how displacement and legal status shape their vulnerabilities and access to essential services. The audit also captured the perspectives of migrant domestic workers—both documented and undocumented, live-in and live-out—assessing their exposure to workplace abuse, GBV, health service barriers, and protection challenges.

Additionally, LGBTQI+ individuals, particularly those at risk of or surviving GBV, were engaged to better understand their access to SRH services, the availability of safe spaces, and the discrimination they face within existing systems. Lebanese and refugee men were consulted to explore their perceptions of GBV, their role in prevention efforts, and their attitudes toward SRH. Service providers, including local and international NGOs, healthcare professionals, shelter managers, migrant-led organizations, and LGBTQI+-led organizations, contributed insights to help map current capacities, identify service gaps, and assess coordination efforts. Finally, security officials were interviewed to assess law enforcement responses to GBV, the mechanisms available to protect survivors, and the specific challenges faced in handling cases involving refugees, migrants, and LGBTQI+ individuals.

This broad and intersectional scope ensures that the Gender Safety Audit captures the complex and layered realities of GBV, SRH access, and shelter safety across different populations. It builds on the momentum of the 2024 GBV Safety Audit by offering additional deep, community-centered insights for more targeted and inclusive action.

This study employed a qualitative methodology combining key informant interviews, focus group discussions (FGDs), and in-depth individual interviews as well as a comprehensive desk review (see Annex for a detailed breakdown of data collection). Data was collected across diverse regions of Lebanon, including Beirut, Mount Lebanon, the Bekaa, Akkar, and South Lebanon. Participants were recruited through community outreach and collaboration with NGOs operating in the fields of GBV, SRH, and protection services—namely UNHCR, MOSAIC, RDFL, Médecins du Monde, KAFA, the LGBTQI+ Taskforce, IOM, LECORVAW, the Jesuit Refugee Service (JRS), Nabad for Development and Tres Marias. This multi-sectoral approach enabled the study to capture a wide range of experiences related to GBV risks, SRH needs, shelter access, and service provision barriers across marginalized communities.

GBV Risks, Experiences, and Responses

Types of GBV Faced by Different Groups

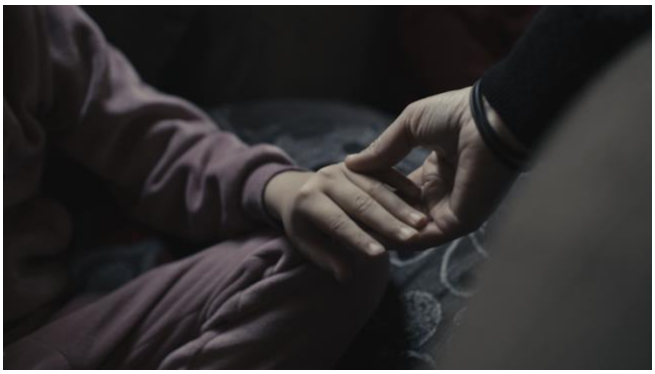
The findings across organizations highlight the wide-ranging and intersectional nature of gender-based violence (GBV) experienced by women, girls, queer individuals, persons with disabilities, and migrant domestic workers in Lebanon. Various forms of GBV—physical, sexual, emotional, economic, and digital—were reported across diverse social, legal, and geographic contexts. These patterns are influenced by factors such as age, gender identity, refugee or migration status, socio-economic background, and disability. Notably, quarterly trend analyses indicate a concerning 25% increase in reported cases of sexual exploitation between Q2 and Q3 of 2024, coinciding with periods of displacement from South Lebanon, the Bekaa, and the Southern Suburbs.[8]

Domestic violence remains one of the most pervasive and entrenched forms of GBV, affecting Lebanese, Syrian refugee, Palestinian refugee, and migrant communities alike. Physical assault, sexual coercion, and emotional abuse within intimate partnerships were frequently cited. Financial hardship, protracted displacement, and systemic impunity were consistently identified as drivers that exacerbate domestic violence. As one Syrian refugee woman from Bekaa shared, *"Even if we are silent at home, the violence does not stop—it is the stress of poverty that explodes on us."* Echoing this, a key informant at KAFA highlighted that fear of femicide—the ultimate expression of domestic violence—prevents many women from seeking help, stating,

> **"ALMOST EVERY MONTH, A WOMAN IS KILLED, AND MANY MORE STAY IN SILENCE OUT OF FEAR THEY WILL BE NEXT."**

Sexual harassment in public spaces was described as a near-universal experience for women, girls, and LGBTQI+ individuals, though its manifestations differed depending on perceived gender conformity, nationality, and socio-economic status. Syrian refugee women reported being particularly targeted, subjected to racialized and sexualized stereotypes that frame them as sexually available or "exchangeable" for material favors. A refugee woman in South Lebanon recounted, *"Bus drivers think because we are Syrian women, we will accept anything for a free ride—but we are human, we want to live with dignity."* Trans women and visibly queer individuals similarly reported heightened harassment in streets, transportation hubs, and even humanitarian aid distributions, facing both sexual and physical threats.

[8] Ibid



Child, Early and forced marriage continues to affect both Lebanese and refugee communities, with its growing prevalence closely linked to economic desperation. Data from the GBVIMS indicates a notable rise in forced marriage in the Bekaa, increasing from 14% in Q3 to 27% in Q4 of 2024.[9] Partners have confirmed that displacement and conflict have driven families to adopt harmful coping mechanisms, exposing adolescent girls to heightened risks—including forced and child marriage. Some families perceive marriage as a form of protection against threats such as homelessness, lack of access to basic needs, or the risk of deportation, particularly for displaced Syrians. Girls as young as 11 to 13 are being married off, often framed as a protective measure but largely motivated by the need to reduce household expenses or secure dowries. In both the North and the Bekaa, women reported that early marriage is often culturally normalized, though financial hardship has accelerated its acceptance. As one RDFL informant observed, *"Many girls do not see it as violence—they believe marriage is their only chance at security."*

Workplace abuse, including sexual harassment, unpaid labor, forced confinement, and physical assault, was especially acute among migrant domestic workers under the kafala system. Migrant women described living in conditions akin to imprisonment, where confiscation of passports and restricted movement made escape from abusive employers nearly impossible. One woman testified,
"They lock the door on me; they take my papers. I cannot leave even when I am sick." Moreover, migrant workers working informally after escaping abusive households often encountered further exploitation, facing sexual violence, blackmail, and police harassment without recourse to legal protection.

Trafficking and survival sex surfaced as critical concerns among LGBTQI+ individuals and undocumented migrant workers. Participants revealed that after fleeing abusive situations, lack of shelter, work opportunities, or legal status often forced them into unsafe labor or sexual exploitation networks. Networks of coercion were particularly noted around informal migrant shelters and LGBTQI+ "underground" communities, where perpetrators prey on vulnerability through extortion, threats, and physical assault.

[9] Ibid

Emotional abuse and cyber violence were also recognized as rapidly growing forms of GBV. Survivors—particularly Syrian refugee women and LGBTQI+ individuals—described experiencing blackmail through social media, online harassment, and threats of outing or shaming. Digital abuse often served to extend the control of intimate partners, traffickers, or abusers beyond physical spaces, deepening survivors' isolation and fear. As a key informant from the LGBT Taskforce emphasized, *"Survivors are afraid to speak even online. Screens are not safe anymore; they can be weaponized."*

Differences Across Gender, Age, Nationality, and Legal Status

Across all groups, GBV was described not as a series of isolated incidents, but as an ongoing condition shaped by legal disenfranchisement, economic precarity, social stigma, and intersecting systems of oppression. The violence was often cyclical and multi-sited, affecting survivors in their homes, workplaces, public spaces, shelters, service centers, and online.

The nature, severity, and frequency of GBV experienced by individuals in Lebanon varied markedly according to gender identity, age, nationality, and legal status. These factors intersected to shape survivors' exposure to violence, their capacity to seek help, and the types of harm they endured.

Gender and Age: Younger women, and visibly queer individuals were consistently identified as facing heightened risks of sexual harassment, exploitation, trafficking, and early and forced marriage. According to informants, adolescent girls, especially Syrian refugees aged 11–17, were highly vulnerable to child marriage, often framed by families as a protective or economic coping mechanism amid deepening poverty and displacement. As one service provider noted, *"Many girls view marriage not as violence but as a pathway to survival."* Visibly queer individuals, particularly gender-nonconforming lesbians, transmasculine people, and transfeminine individuals, faced targeted violence in public and private spaces. Transgender individuals, regardless of age, reported disproportionate exposure to physical assault, sexual violence, and harassment—often not only from strangers but also from family members, neighbors, and service providers. One LGBTQI+ advocate emphasized that for many trans individuals, *"the simple act of existing outside the home is an act of resistance—and an act of risk."* Older women, by contrast, often faced neglect and overlooked within GBV response systems. GBV actors highlighted the difficulty of finding shelters willing to accept women over 60 years old, compounding the dangers they faced when experiencing violence in the home. Women and girls with disabilities faced a dual burden of invisibility and exclusion. Participants with mobility, sensory, and cognitive disabilities reported near-total absence of adapted GBV services. A Lebanese woman with visual impairment stated, 'They tell me to go here or there—but how can I, when I cannot even see the street signs?' Many survivors noted that SRH providers did not accommodate disabilities or were unwilling to explain care in accessible ways.

Nationality: Nationality emerged as a critical axis of vulnerability. Syrian and Palestinian refugee women, migrant domestic workers, and LGBTQI+ refugees bore the brunt of acute and compounded risks. Syrian and Palestinian women, already marginalized by displacement, faced normalized patterns of domestic violence, sexual harassment, and economic exploitation. These vulnerabilities were exacerbated by discriminatory attitudes toward refugees and rising anti-refugee rhetoric in Lebanon.[10] As one refugee woman explained, *"No one wants to hear what happens to us. We are not Lebanese, so we are not protected."* Migrant domestic workers, predominantly from African and Asian countries, experienced GBV at the intersection of race, gender, labor exploitation, and migration status.[11] Under the kafala system, many faced forced confinement, wage theft, sexual assault, and physical abuse.[12] Their racialized status, as they described, often dehumanized them further, stripping them of both worker rights and basic dignity. As a migrant woman shared, *"To them, we are not even workers—we are property."* For LGBTQI+ refugees—especially those from Syria, Iraq, and Sudan—the combination of statelessness, displacement, and queerphobia produced an extreme vulnerability to violence, blackmail, and exclusion from formal support services.

Legal Status: Legal status was one of the most powerful determinants of exposure to GBV and of survivors' ability to seek protection. Individuals with irregular legal status—including Syrian refugees without valid residency, undocumented migrants, and queer refugees—lived under constant threat of arrest, detention, or deportation. This legal precarity often silenced survivors, preventing them from reporting violence or accessing health, legal, and protection services. One Syrian LGBTQI+ participant reflected starkly, *"When I was attacked, I knew if I called the police, I would be arrested because I am Syrian and queer."* Undocumented migrant domestic workers—whose legal status is tied to their employer under the kafala system—were trapped in cycles of violence and exploitation with almost no viable means of escape or access to justice.[13] Fear of retaliation, blackmail by employers, and lack of independent legal standing left them profoundly vulnerable. Even when severe abuse was reported, the burden often fell on survivors to prove their victimization while still facing potential detention for immigration violations.

[10] Diab, J. L. (2023), On Prosecution, Persecution and Protection: Unpacking Anti-Refugee Narratives, Kinopolitics and Selective Outrage in Lebanon, Refugee Law Initiative, University of London, https://rli.blogs.sas.ac.uk/2023/05/16/on-prosecution-persecution-and-protection-unpacking-anti-refugee-narratives-kinopolitics-and-selective-outrage-in-lebanon/

[11] Diab, J. L. et al (2024), The gender dimensions of sexual violence against migrant domestic workers in post-2019 Lebanon, Frontiers in Sociology 7, https://www.frontiersin.org/journals/sociology/articles/10.3389/fsoc.2022.1091957/full

[12] Ibid

[13] Yimer, B et al (2025), Access to justice for Ethiopian migrant domestic workers: unveiling legal, structural, and gendered violence in Lebanon, Frontiers in Sociology 11, https://www.frontiersin.org/journals/sociology/articles/10.3389/fsoc.2024.1486769/full

Geographies and Spaces of Heightened Risk

Across Lebanon, survivors consistently identified specific spaces and geographies where the risk of GBV was heightened, reflecting the intersection of physical insecurity, social exclusion, and systemic discrimination.

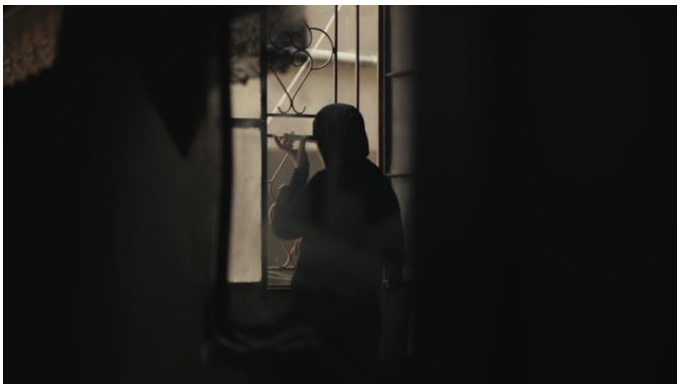
Urban informal settlements[14] such as those in Tripoli and vulnerable neighborhoods in Beirut were repeatedly cited as hotspots for harassment, intimate partner violence (IPV), and public assaults, particularly targeting women and girls. Overcrowded living conditions, weakened community structures, and pervasive poverty created environments where women, as they self-described, were "highly visible" yet lacked any meaningful protection. As one Lebanese woman living in Tripoli shared, *"In these places, you are a woman first and everything else second—everything you are makes you easy to hurt, control and abuse."* Displacement fatigue and rising anti-refugee sentiment further compounded the threats facing refugee women and girls in these urban areas, according to key informants.

Rural areas, notably in the Bekaa Valley, Akkar, and South Lebanon, saw higher incidences of early marriage, honor-based violence, and normalized IPV. Community norms favoring the control of women's mobility and sexuality, combined with economic desperation, reinforced harmful practices such as child marriage. In these regions, violence within the home was often perceived as a private matter, making it even more difficult for survivors to seek external support. Service providers noted that *"reporting IPV in some villages still carries greater stigma than enduring the violence in silence."* A Lebanese woman from South Lebanon further added, *"[…] some things are simply private matters—let's not assume that we are in the same circumstances as women in Beirut."*

Private homes and workplaces emerged as primary sites of violence for migrant domestic workers. Under Lebanon's kafala system, employers' homes became spaces of confinement, abuse, and exploitation, with domestic workers isolated from external support networks. Survivors described experiences of forced labor, sexual harassment, confiscation of identification documents, and restricted mobility. One domestic worker recalled, *"They took my passport the day I arrived. From that moment, I am a prisoner."* The intersection of employer authority, racialized labor hierarchies, and lack of legal protection rendered homes deadly spaces for many.

[14] Urban informal settlements refer to residential areas within cities where housing has been constructed on land to which the occupants have no legal claim, or which does not comply with current planning and building regulations.

Public transportation and streets were also repeatedly identified as unsafe environments across both rural and urban areas, particularly for women of all nationalities and LGBTQI+ individuals. Syrian refugee women described being especially vulnerable to sexual harassment and exploitation while using public transportation, a necessity for many to reach work, aid distributions, or health services. Public spaces were often sites of daily negotiations for safety, where survivors spoke of enduring constant verbal abuse, groping, and threats. A trans woman living in Beirut noted, *"Every day, the street reminds you that you are not safe here."*



Online spaces emerged as increasingly dangerous arenas for refugee participants, as well as for queer youth, migrant women and LGBTQI+ individuals. Participants reported high rates of cyber harassment, blackmail, non-consensual outing, and digital stalking. Perpetrators often exploited survivors' lack of legal protections around privacy and identity, leveraging threats of exposure to coerce, manipulate, or extort them. The rapid growth of surveillance tactics targeting LGBTQI+ organizing and activism online further compounded digital insecurity, especially for queer refugees and stateless individuals already facing severe offline risks.[15]

Government-run shelters, paradoxically, also appeared in the findings as spaces of exclusion rather than guaranteed safety. While shelters provided refuge for some survivors of GBV, access remained severely limited for LGBTQI+ individuals and migrant domestic workers. Many mainstream shelters either explicitly refused to admit queer and trans survivors or created unsafe environments requiring concealment of identity.[16] Migrant workers seeking shelter after escaping abusive employers often faced discrimination, restrictions, and rejection based on their nationality, legal status, or perceived "risk".[17] Many migrant women highlighted their lack of clear information regarding the availability of these shelters.[18]

[15] Diab, J. L. & Samneh, B. (2024), On the margins of refuge: Queer Syrian refugees and the politics of belonging and mobility in post-2019 Lebanon, International Journal of Discrimination and the Law 24(3), https://journals.sagepub.com/eprint/CXQGUCGS7BUAD8IMDHZR/full

[16] Diab, J. L. (2024), The moral imperative to protect Lebanon's LGBTIQ+ displaced, The New Humanitarian, https://www.thenewhumanitarian.org/opinion/2024/11/04/moral-imperative-protect-lebanon-lgbtiq-displaced

[17] Diab, J. L. & Janmyr, M. (2024), Unprepared and Unsupported: Lebanon's Migrant Workers amid Surging Israeli Attacks, Al-Rawiya Magazine, https://al-rawiya.com/unprepared-and-unsupported-lebanons-migrant-workers-amid-surging-israeli-attacks/

[18] Ibid

Coping Strategies and Reporting Mechanisms

Across all communities interviewed, **silence and self-protection** emerged as the predominant coping strategies in response to GBV. Survivors overwhelmingly cited fear of retaliation, stigma, shame, and social ostracization as major deterrents to seeking formal help or disclosing their experiences. As one Lebanese woman from Akkar explained, *"Better to stay silent than to be blamed for ruining the family."* In many cases, and indiscriminately, cultural norms across all regions covered placed the burden of maintaining family honor on women and girls to varying extents, making disclosure tantamount to "social suicide".

Women and LGBTQI+ individuals employed a range of adaptive survival tactics to manage daily risks: attempting to de-escalate abusive encounters through negotiation, avoidance, endurance, or calculated submission. Rather than confronting violence directly, many survivors adopted strategies aimed at minimizing harm while preserving the fragile social or economic ties they depended upon. A trans woman in Beirut described this painful calculus: *"Sometimes survival means smiling at someone who insults you—because what other choice do you have?"*

Among **refugee women and migrant domestic workers,** economic precarity and legal vulnerability forced many into accepting mistreatment to avoid even harsher consequences—eviction, deportation, detention, or loss of their only income source. The intersection of poverty, displacement, and legal invisibility left little room for resistance. A Syrian woman living in Bekaa summarized the dilemma:

> **"IF YOU COMPLAIN, YOU LOSE YOUR SHELTER. IF YOU STAY SILENT, YOU LOSE YOURSELF."**

Engagement with NGO-operated hotlines and community-based support centers offered critical, if limited, alternatives. Survivors who managed to access such services reported feeling safer, heard, and more empowered to explore options for protection or justice. Organizations offering confidential case management, psychosocial support, and legal aid were seen as lifelines, particularly when survivors could bypass stigma-laden governmental systems.

However, significant **logistical barriers** persisted, particularly for live-in migrant domestic workers. Restricted mobility, employer surveillance, confiscated phones, and language barriers rendered even remote access to hotlines or online reporting mechanisms virtually impossible. For these workers, even basic knowledge of available support services was often out of reach. As one domestic worker confided, *"Even if I knew who to call, they keep my phone. I cannot even say that I am suffering."*

Among **LGBTQI+ individuals and refugees,** a profound distrust of governmental services—including police, judicial institutions, and health providers—shaped coping and reporting behaviors. Survivors feared that approaching authorities would not only fail to secure justice but might instead expose them to criminalization, outing, blackmail, or deportation. For many, trusted NGOs, community networks, or word-of-mouth referrals remained the only viable avenues for seeking help. Yet even within NGO spaces, survivors expressed ongoing fear of confidentiality breaches, judgment, and secondary victimization, particularly if their gender identity, sexual orientation, or migration status became known.

In this context, **informal coping mechanisms**—such as forming peer support groups, sharing safety information through encrypted messaging apps, or quietly relocating away from perpetrators—emerged as key survival strategies. These self-organized networks often filled critical gaps left by formal protection systems, illustrating both the resilience and the vulnerability of marginalized communities navigating violence largely without institutional support. Ultimately, survivors' coping strategies reflected not a lack of agency, but a rational negotiation with an environment offering few safe choices.

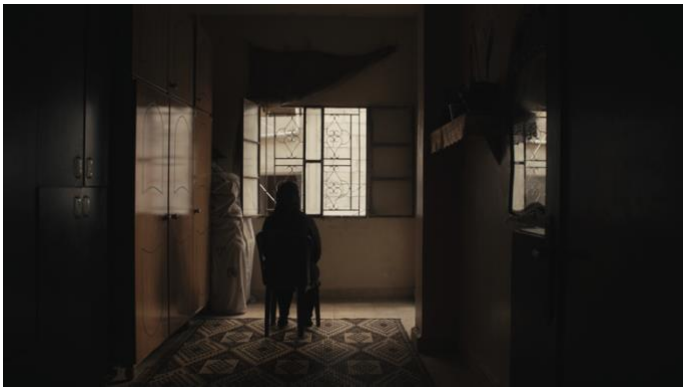
Barriers to Reporting GBV: Legal, Social, Cultural, and Logistical

Survivors of GBV across Lebanon navigated a dense web of intersecting barriers that prevented them from seeking protection, justice, or support. These barriers were legal, social, cultural, and logistical, each reinforcing the others and compounding survivors' isolation.

Quantitative data from the 2024 Gender-Based Violence Information Management System (GBV IMS) underscores the compounded challenges facing survivors amid conflict and displacement. A 38% national decrease in reported GBV incidents was recorded between Q2 and Q3, with Bekaa/El Hermel and the South witnessing sharper drops of 68% and 37%, respectively, due to service disruptions. While 98% of reported GBV survivors were women and girls, reporting was significantly hindered by insecurity, underfunded services, and a widespread deprioritization of protection needs. Only 2% of all survivors were referred to safe shelter services, and legal and security referrals were among the most declined, at 27% and 23%, reflecting survivors' distrust in institutions and fear of retaliation. Notably, 44% of survivors waited more than a month to report incidents. Across all reported cases, physical assault (31%), emotional abuse (30%), and forced marriage (18%) were most prevalent, with adolescent girls, persons with disabilities, and those in collective shelters at heightened risk.

Legal Barriers: Fear of interaction with the legal system was a consistent deterrent, particularly among migrant domestic workers, refugees, stateless persons, and LGBTQI+ individuals. Survivors feared that reporting violence could trigger arrest, deportation, detention, or the loss of fragile residency statuses. For undocumented migrants or refugee women without legal residency, the risk of seeking help often outweighed the possibility of protection. One Syrian LGBTQI+ refugee shared, *"If I report, I lose everything: my freedom, my case with UNHCR, maybe even my life."* The selective criminalization of same-sex relations under Article 534 of the Penal Code further deepened this fear, making legal institutions themselves agents of potential harm.

Social Barriers: Family and community norms heavily discouraged survivors according to key informants—especially women, adolescent girls, and queer individuals—from disclosing violence. Testimonies from focus groups echoed these sentiments. Survivors risked disownment, forced isolation, or social death if they were perceived as bringing shame or dishonor to their families. For many, reporting was seen not merely as a personal choice but as a betrayal of the collective. In close-knit refugee communities, women emphasized that speaking out often meant being permanently labeled as "disgraced," with lifelong repercussions for marriage prospects, employment, and community standing.



Cultural Barriers: Cultural narratives surrounding honor, purity, and obedience served to silence survivors, particularly in cases of sexual violence and intimate partner violence (IPV). A Lebanese caseworker explained, *"For many families, it is better to hide the violence than admit that a daughter or wife was 'dishonored'—even when she is the victim."* Reporting was often framed as airing private matters in public, a transgression that could be punished with further violence, forced marriage, or complete abandonment.

Logistical Barriers: Even when survivors overcame fear and stigma, practical obstacles blocked access to help. Key challenges included:

- Transportation costs: Survivors in rural areas like Akkar, Bekaa, or South Lebanon often lacked affordable or safe means of reaching GBV services concentrated in Beirut and Mount Lebanon.
- Lack of shelters: As multiple participants noted, shelters accepting LGBTQI+ individuals, migrant workers, or mothers with teenage sons were almost non-existent.
- Language barriers: Migrant workers, especially those from African and Asian countries, struggled to communicate their needs and faced exclusion from Arabic- or English-only services.
- Disability inaccessibility: Women and girls with disabilities faced an almost complete absence of disability-friendly GBV services, further isolating an already marginalized group.

Deep-rooted Distrust: Even when services were nominally available, survivors often hesitated to access them due to distrust of NGOs, fear of confidentiality breaches, or perceptions of inequitable treatment. Lebanese women, in particular, expressed resentment that humanitarian services appeared to prioritize refugees over nationals. As one Lebanese survivor put it, *"When I needed help, they told me there were no places left. But for Syrians, they find space."* This perception, whether real or perceived, further fueled reluctance to engage with formal support systems.

Role of Stigma, Fear of Authorities, and Discrimination

Stigma, fear, and discrimination formed an interconnected web that not only silenced GBV survivors but also perpetuated cycles of violence and impunity across Lebanon's marginalized communities.

Stigma: Across refugee, migrant, Lebanese, and LGBTQI+ groups, stigma operated as a powerful tool of social control. Survivors were often blamed for the violence they endured, viewed as bringing shame upon themselves or their families. As one Lebanese woman from Tripoli shared,

> **"IF YOU SPEAK OUT, THEY SAY YOU DESERVED IT. IT IS EASIER TO BE SILENT THAN TO BE HUMILIATED AGAIN."**

In communities where honor, reputation, and female obedience are culturally entrenched values, survivors risked being labeled as "troublemakers" or "bad women," not only by perpetrators but by their own families and neighbors. According to key informants, this stigmatization often resulted in survivors losing marriage prospects, jobs, housing, and critical community support systems.

Fear of Authorities: Mistrust and fear of state authorities—particularly the police and security forces—were especially acute among undocumented refugees, migrant workers, LGBTQI+ individuals, and stateless persons. For Syrian refugees, reporting violence carried the real risk of arrest, detention, forced return to Syria, or deportation. Migrant domestic workers under the kafala system feared retaliation by employers, arrest for "absconding," or criminalization for false accusations lodged against them. Queer individuals, particularly transgender refugees, described being treated as suspects rather than victims when approaching police, often facing harassment, moral policing, or even physical violence during so-called investigations. As one Syrian LGBTQI+ refugee summarized: *"The police are not for us. They are there to protect the others from us."*

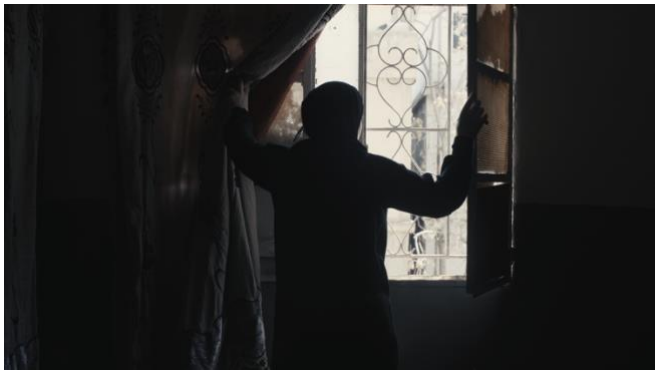
Dehumanization and Invisibility: Migrant domestic workers were frequently perceived not as rights-holders or survivors, but as property or labor units belonging to employers. Their experiences of GBV—whether physical assault, sexual harassment, or psychological abuse—were often minimized, dismissed, or ignored entirely. This invisibilization, according to key informants, extended into humanitarian spaces, where domestic workers rarely featured as priority groups in GBV response frameworks, despite facing some of the highest risks.

Discrimination in Services: Even where GBV-related services such as legal assistance, psychosocial support, clinical management of rape (CMR), safe shelter, and case management existed, discriminatory practices at service delivery points further marginalized survivors. LGBTQI+ individuals reported being denied entry to safe spaces, misgendered during psychosocial intake, or outed when accessing legal or health services. Undocumented refugees were turned away from hospitals or denied legal aid due to their lack of residency papers. Women with disabilities described GBV case management offices that were physically inaccessible, or were told that their needs were “too complicated” or did not fall within the organization's service mandate. These patterns of exclusion were not isolated incidents, according to informants; they reflected systemic biases embedded across multiple service modalities, often unaddressed by staff training, inter-agency referral systems, or funding priorities within humanitarian coordination structures.

Compounding Layers/Intersectional Vulnerability: For many survivors, these factors—stigma, fear, and discrimination—did not operate separately but compounded one another. A young undocumented Syrian trans woman fleeing domestic violence, for example, faced: Stigma from her community; fear of arrest if she approached authorities; discrimination at the shelter refusing her because of her gender identity. Thus, survivors were repeatedly forced into a paralyzing calculation of risks, where seeking help could lead to further violence, exposure, or criminalization.

Role of Men, Community Perceptions, and Attitudes Toward Violence

The findings reveal how deeply patriarchal norms and entrenched gender roles across Lebanese, refugee, and migrant communities continue to shape the dynamics of GBV—both in its perpetuation and in society's response to survivors.



Male Dominance and the Normalization of Violence: In many Lebanese and refugee communities, male dominance remained socially and culturally sanctioned. Men were widely perceived as the primary enforcers of family honor, with acts of GBV often framed not as violence, but as legitimate forms of "correction," discipline, or maintenance of social order. Informal mechanisms, such as male-led mediation of intimate partner violence (IPV), were common. However, these interventions rarely prioritized survivors' safety or agency; rather, they sought to preserve family unity and male authority. As a Lebanese woman from South Lebanon described, *"They call it reconciliation, but it means going back to be beaten in silence."* While some individual men supported survivors—particularly when linked to broader family wellbeing or children's interests—male involvement in genuine GBV prevention or gender-transformative efforts remained rare. Community-led initiatives aiming to empower women were often dismissed or demonized, portrayed as threats that would "wreck families" or "encourage women to oppress men." One male refugee from Bekaa expressed a widely shared sentiment: *"When women become stronger, families fall apart."*

Displacement, Masculinity, and Violence Among Refugee Men: Among Syrian and Palestinian refugee men, the compounded pressures of forced displacement, trauma, poverty, and loss of social status further intensified risk factors for GBV. According to key informants, unemployment and economic marginalization eroded traditional masculine roles as providers and protectors, contributing to crises of identity that frequently manifested through increased IPV, emotional abuse, and rigid enforcement of gender norms at the household level. While some refugee men recognized and supported women's need to access psychosocial or humanitarian services, especially when framed as beneficial for family survival, deeply transformative shifts in gender relations remained largely absent. Instead, violence was often minimized as a regrettable but understandable outcome of financial stress, displacement, or male frustration. This was echoed across focus group discussions with men from South Lebanon, the Bekaa, Tripoli, and Beirut, who did not hesitate to question what "really constitutes abuse?" and who insisted "sometimes, it's just an argument."

Community Attitudes Toward Violence Against Women and Girls: Across refugee communities, and observed among participants in focus group discussions with participants from South Lebanon and the Bekaa more strongly, violence against women was frequently normalized, excused, or minimized. Survivors were routinely blamed for provoking abuse—accused of dressing improperly, speaking out of turn, neglecting domestic duties, or challenging male authority. Domestic violence was rarely seen as a crime in itself; rather, it was considered a private family matter, only meriting external intervention when it endangered community cohesion or public honor. Economic hardship was often invoked as a partial justification, reinforcing the notion that violence was an unfortunate but inevitable coping mechanism for men facing poverty and powerlessness.

Extreme Vulnerabilities and Societal Rejection of LGBTQI+ Individuals: The situation was even more severe for LGBTQI+ individuals, for whom violence was not only perceived to be normalized but often seen to be encouraged by families, religious institutions, and broader society. Transgender individuals, in particular, faced lethal risks. Survivors recounted multiple assassination attempts by family members, blackmail, forced isolation, and systemic community rejection. One transgender woman from Beirut shared chillingly: *"My family tried to kill me three times—they still look for me."* Rather than seeing violence against queer individuals as a violation of rights, many communities framed it as a necessary act to "restore honor," "save souls," or "protect society from corruption."

Normalization of Abuse Against Migrant Domestic Workers: For migrant domestic workers, they expressed feeling that violence was systemically embedded within the kafala sponsorship system itself. Abuse by employers—including physical assault, sexual harassment, emotional manipulation, and economic exploitation—was seen by them to be widely trivialized or outright ignored by the state and the public. Domestic workers were viewed not as full human beings but as extensions of household labor, lacking individual rights or dignity. Within this framework, neither employers nor the government recognized violations against domestic workers as legitimate forms of GBV. As one Ethiopian worker bluntly stated,

> **"HERE, WE ARE FURNITURE. YOU DON'T ASK FURNITURE HOW IT FEELS."**

Convergence of Structural and Social Violence: Ultimately, the findings, particularly from key informants, underscore that GBV in Lebanon is not simply the product of individual deviance or criminality—it is the result of deeply rooted systems of power imbalance between male and female , racialized labor hierarchies, and social norms and patriarchal society that legitimize violence under the guise of protection, discipline, or tradition. This convergence of structural and social violence leaves survivors—especially those at the intersections of gender, nationality, class, and sexuality—exposed to harm, isolated from support, and largely abandoned by legal and communal institutions.

Against this backdrop, Lebanon's police response to GBV has significant shortcomings, especially for refugees, migrant domestic workers, and LGBTQI+ individuals. Survivors from these groups cited discrimination or even criminalization when seeking protection. For example, migrant domestic workers experiencing abuse frequently find that police and courts fail to treat offenses against them as crimes. Those who flee abusive employers risk being arrested for "illegal" status due to the restrictive kafala sponsorship system. Refugee women have similarly reported avoiding the police after GBV incidents, citing a lack of confidence that authorities would help and fearing detention for expired residency permits. LGBTQI+ survivors are among the least protected—human rights reports note that transgender women facing violence are often denied police protection and instead threatened with arrest under morality laws (such as Penal Code Article 534). These patterns indicate that many vulnerable survivors encounter bias, stigma, or even victim-blaming from law enforcement, undermining their access to justice and safety.

According to their own testimonies, Lebanese authorities have taken some steps toward a more survivor-centered policing approach, but gaps remain. The Internal Security Forces (ISF) have established a domestic violence hotline and designated officers to handle family violence cases, and the ISF's Human Rights Department has worked with NGOs to train police on GBV issues. Specialized "family protection" units or procedures exist on paper, but their effectiveness is limited by resource constraints and inconsistent implementation. As an ISF officer shares: *"The processes and mechanisms are there, but there are challenges to enforcing them. Not all officers across all regions receive the same training on these issues, and importantly, not all officers 'feel' the same about these issues. But our officers are good men and women, dedicated to improving their knowledge in this area, as well as people's protection. We continue to work on this."*

Reports continue to highlight lapses such as breaches of confidentiality and lack of gender sensitivity in handling cases. Even in recent years, experts have urged continued training for police on GBV case documentation and follow-up to improve accountability. While ongoing projects (often led by UN agencies and local NGOs) aim to build capacity on GBV response, LGBTQI+ inclusion, and refugee protection, these initiatives have yet to fully institutionalize survivor-centered practices. According to informants and focus group participants, Lebanon's police still struggle to provide unbiased, confidential, and supportive services to GBV survivors, particularly those from marginalized groups.

SRH Needs, Access, and Barriers

SRH Needs and Available Services

The findings reveal a broad but fragmented landscape of SRH services across Lebanon, particularly for marginalized groups including women, girls, LGBTQI+ individuals, migrant domestic workers, refugees, and persons with disabilities. Available services typically include maternal care, antenatal check-ups, family planning counseling, basic contraception provision (mostly male condoms and oral contraceptives), STI prevention and treatment, and limited emergency obstetric care. Some NGOs and primary healthcare centers (PHCCs) have offered sexual health awareness sessions and distributed self-testing kits for STIs. Specialized NGOs focused on LGBTQI+ communities also provided HIV testing, voluntary counseling, and access to pre- and post-exposure prophylaxis (PrEP and PEP).

Despite the existence of these services, access remains highly stratified along lines of legal status, **cost**, geography, and perceived social acceptability. For many, particularly Syrian and Palestinian refugees, undocumented migrant domestic workers, and LGBTQI+ individuals, cost was the most frequently cited barrier—both direct costs (such as consultation fees, medicines, or lab tests) and indirect costs (such as transportation expenses or lost income from time off work). A Lebanese woman in Tripoli explained, *"We rely on health campaigns because regular check-ups are too expensive. But these campaigns come only every few months and are not enough."*

Legal status further restricted access. Undocumented migrants and refugees reported fearing interaction with health institutions that might demand identification papers or alert authorities. A Syrian LGBTQI+ refugee shared, *"I was diagnosed with syphilis through an NGO, but I cannot afford the treatment—and I'm too scared to seek help elsewhere."*

Geographic isolation, particularly in rural areas like Akkar, Bekaa, and parts of South Lebanon, also severely limited access to quality SRH care. Participants described long travel times, lack of reliable or affordable transportation, and limited availability of specialized providers. As a Lebanese woman from Akkar put it, *"I have to wait for my husband to accompany me to the dispensary because he doesn't want me to see a male doctor alone. And even when I get there, they often don't have what I need."*

Even where services were technically available, the **quality and inclusivity** varied dramatically. Women and LGBTQI+ individuals alike reported negative experiences with healthcare providers, citing discrimination, lack of gender-sensitivity, and judgmental attitudes. A Lebanese participant with a disability emphasized that health services did not accommodate her needs, explaining, *"They make me wait for hours even though I can't sit for long because of my condition. There should be priority services for people like me."* Similarly, many refugee women in focus groups recounted incidents where they felt mistreated due to their nationality, with one Syrian woman noting, *"At some clinics, once they know you're Syrian, they either raise the price or refuse to give you an appointment."*

Furthermore, **stock shortages and service disruptions** were common. Lebanese and refugee women in Bekaa and Akkar reported multiple instances where they traveled to clinics only to find that contraceptives, emergency contraception, or essential medicines were out of stock. As one Lebanese woman from Akkar shared, *"I went for contraceptive pills, but they were out. I had paid to get there, and I couldn't even call ahead to check. It's humiliating."*

Menstrual health also emerged as an overlooked but critical part of SRH. Several participants across regions described poor-quality menstrual hygiene products distributed through NGO campaigns, causing skin irritation and dissatisfaction. *"The pads they give cause rashes. We have to layer them just to feel comfortable,"* explained a Lebanese woman from Tripoli.

Barriers to SRH Access

Across all groups, survivors and service providers emphasized that structural, systemic, social, and cultural barriers critically constrained equitable access to SRH services. These barriers, according to participants and informants, intersected and compounded vulnerabilities, particularly for refugees, migrant domestic workers, LGBTQI+ individuals, persons with disabilities, and unmarried adolescents.

Structural Barriers: Affordability emerged as the most persistent obstacle. Participants repeatedly described having to forgo medical care, contraceptive access, STI treatment, and maternal health services due to unaffordable consultation fees, high medication costs, and expensive transportation. A refugee woman from Bekaa shared, *"We work in agriculture just to eat—where will we get money for doctors?"* Similarly, a Lebanese woman from Tripoli explained, *"I paid for a check-up, but they had no vitamins. I still had to pay even though I got nothing."*

The availability of services was another major barrier. While Beirut and Mount Lebanon offered relatively better service coverage, rural and peripheral areas such as Akkar, Bekaa, and South Lebanon faced acute shortages of gynecologists, SRH clinics, and midwives. A Lebanese woman from Akkar reflected, *"The dispensary doctor only comes once a week. If you're sick any other day, you have to pay much more to go to a hospital."* Confidentiality concerns further deterred survivors, particularly LGBTQI+ individuals and unmarried women. Fear of being exposed or stigmatized dissuaded many from seeking services. A transgender participant noted, *"Even if the clinic is queer-friendly, being seen there is risky. You can be outed just by walking in."* For persons with disabilities, physical inaccessibility and inadequate accommodation in health centers compounded these barriers. As a Lebanese participant with a physical disability shared, *"I have to wait for hours at the doctor's office even though I am in pain—they don't care about our needs."*

For LGBTQI+ individuals, SRH services were even less accessible. Financial barriers persisted, but fear of stigma and visibility compounded exclusion. A trans participant explained, *"Even if the service is queer-friendly, just being seen walking into the center can put you at risk. So sometimes we just don't go at all."* Another participant added, *"I couldn't afford the 50 USD for an HPV test. We don't even ask for luxuries—basic care is out of reach."*

Finally, gaps in community outreach and health education were evident. Several unmarried women, particularly among refugee populations, said they did not know what SRH services were available to them or considered SRH concerns "irrelevant" until marriage. As a young Syrian woman stated, *"I'm not married, so I don't know anything about these services. They are not for me yet."* Overall, the findings underscore that while SRH services technically exist, marginalized groups experience profound structural, financial, and cultural barriers that limit both access and quality of care.

Social and Cultural Barriers: Cultural stigma heavily shaped access to SRH services. Seeking contraception, STI treatment, or post-assault care was seen as shameful, particularly for unmarried women and LGBTQI+ individuals. In South Lebanon, Lebanese and refugee women described the social shaming they faced when attempting to purchase contraceptives: *"Even buying birth control at the pharmacy feels humiliating if a man is behind the counter."* Many survivors reported that even when SRH services were technically available, they were socially inaccessible due to judgmental attitudes from providers. Several refugee women in Akkar and the South shared experiences of discriminatory behavior at clinics, with one Syrian woman recounting, *"They look at us as if we don't deserve care—as if we are stealing from the Lebanese."* Awareness of CMR services was limited among many survivors, particularly outside urban centers, and several participants expressed confusion about what support was available or how to access it. Even those who knew about CMR cited barriers such as fear of being blamed, costs of transportation, or distrust in providers as key deterrents to seeking post-rape care.

Gender norms continued to reinforce male authority over women's bodies. Married women reported needing explicit spousal approval to access contraception, maternal care, or even to attend medical appointments. Male participants in focus group discussions echoed this sentiment. On this, a woman from Bekaa explained, *"If my husband cannot take me to the doctor himself, I have to wait—otherwise, he won't trust what I am doing."* Among LGBTQI+ individuals, fears of discrimination, forced outing, and violence were pervasive. One participant noted, *"I skipped getting tested for HPV because I couldn't afford it—and I didn't want anyone to see me at the clinic anyway."* Migrant domestic workers faced an additional layer of exclusion. Many were either forbidden by their employers to seek SRH care or were denied access entirely based on the assumption that, as workers under the kafala system, they had no legitimate sexual or reproductive lives. As an informant from the LGBT Taskforce emphasized, *"Migrant women are seen as bodies for labor, not as bodies with needs, desires, or rights."* For persons with disabilities, barriers were compounded by a lack of disability-adapted services and a general perception that their SRH needs were irrelevant. As a Lebanese woman with a mobility impairment described, *"They don't even think we might have SRH needs. We are invisible to them."*

Regional differences in attitudes toward sexual and reproductive health were stark. Women and men from Beirut and Mount Lebanon generally expressed more liberal views on contraception and SRH services. Many Lebanese and refugee women from these areas reported feeling relatively comfortable accessing contraception, even as some acknowledged facing judgmental attitudes—particularly when seeking services while unmarried. As a Lebanese woman from Mount Lebanon explained, *"At the pharmacy, you sometimes get a look, but it doesn't stop you—you just move past it."* Men from these areas participating in focus groups similarly demonstrated more progressive views, supporting women's access to SRH services as a personal right rather than a family-controlled matter. However, in more rural areas such as the Bekaa, Akkar, and parts of South Lebanon, restrictive gender norms remained deeply entrenched. Here, women more commonly described needing spousal approval for contraception, maternal care, and even basic health consultations, while men viewed control over women's mobility and bodies as a marker of family honor.

Experiences of Discrimination

Discrimination within SRH services was described as widespread, deeply embedded, and highly damaging—particularly for LGBTQI+ individuals, migrant domestic workers, refugees, and persons with disabilities.

LGBTQI+ individuals faced some of the most acute forms of mistreatment. Participants described experiences of being mocked, misgendered, judged, or outright denied care. Even when medical professionals provided services, invasive and stigmatizing questions about sexual behavior, gender identity, or morality were commonplace. One trans woman shared, *"They treated me like I was mentally ill, not like someone who just needed a doctor,"* while an informant from the LGBT Taskforce, emphasized, *"Trans people avoid the health system unless they absolutely have to. The cost of humiliation is often higher than the cost of untreated health issues."* Fear of being publicly outed, ridiculed, or discriminated against continued to deter many LGBTQI+ individuals from seeking essential SRH services.

Migrant domestic workers similarly faced discrimination layered along racial, class, and gender lines. Health providers often presumed that migrant women were engaged in transactional sex or "immoral" behavior, leading to substandard or delayed care. One migrant woman described being ignored in a waiting room for hours while Lebanese patients were prioritized, explaining, *"They look at me like I don't belong there."*

Refugee women, particularly Syrians in Bekaa and Akkar, reported discriminatory practices in local clinics and dispensaries. Several participants shared that once their nationality was known, service providers increased fees, refused appointments, or treated them dismissively. One Syrian refugee woman from Akkar recounted, *"I traveled far and waited for four hours. They didn't even look at me. They told me to come another day without even examining me."* This exclusion was not just emotional—it had real health consequences, with many refugees missing out on timely SRH care.

Lebanese women in Mount Lebanon added that discrimination often appeared in more subtle but equally harmful ways. While cost was a major barrier, participants also recounted feeling judged when seeking family planning services or contraception. One Lebanese participant shared, *"In our town, even asking for birth control feels like you're doing something wrong. The pharmacist looks at you like you should be ashamed. She gives it to you, of course. But you feel ashamed."* Among unmarried women, stigma around sexual activity severely limited willingness to seek SRH services even when they were urgently needed.

According to key informants, **adolescent girls** in both Lebanese and refugee communities faced intense scrutiny and shaming when trying to access SRH information or care. They insisted that across regions, services were rarely adapted to the needs of younger people, and providers often reinforced conservative gender norms rather than offering youth-friendly care. Female participants echoes this from their own past experiences and community practices. As a young Lebanese woman in Bekaa shared, *"If a girl goes to a clinic alone, people talk. They say she must be doing something wrong."*

Persons with disabilities faced both logistical and attitudinal discrimination. As one Lebanese participant with a physical disability explained, *"Even when I show them my disability card, they make me wait for hours, like my needs don't matter."* The lack of disability-friendly spaces and services further marginalized an already vulnerable group.

A serious and persistent gap across all service providers was the **lack of gender-sensitive, trauma-informed, and inclusive approaches.**[19] Few clinics or NGOs offered staff trained in trauma care, LGBTQI+ inclusion, refugee sensitivity, or disability accommodation. Survivors of sexual violence described re-traumatizing experiences when seeking post-rape clinical care, including insensitive questioning, delays in emergency responses, and lack of access to emergency contraception or HIV prevention. As a Lebanese female participant from Bekaa highlighted, *"If you're raped, you are still treated like you must have done something to deserve it."*

Despite the ongoing efforts of some NGOs and community organizations, systemic barriers persisted. As a key informant from RDFL summarized, *"Awareness sessions can only do so much. Without real system-wide change—at the legal, cultural, and service delivery levels—we are just putting band-aids on deep wounds."*

[19] Diab, J. L. et al (2023), Gender identity as a barrier to accessing adequate and inclusive healthcare for Syrian refugees in Lebanon's Northern regions, Frontiers in Human Dynamics 5, https://www.frontiersin.org/journals/human-dynamics/articles/10.3389/fhumd.2023.1205786/full

Table 1. Priority areas for interviewed organizations

Organization	Focus Area	Special Emphases
UNHCR	National Refugee GBV Response	Refugee women's access to services, barriers
IOM	Migrant-led Displacement Shelters	Migrant shelter mapping, survival strategies
LECORVAW	GBV in North Lebanon	IPV, early marriage, reporting barriers
MOSAIC	LGBTQI+ GBV Protection	Case management, cash assistance, trans refugee vulnerabilities, informal shelters for migrants and refugees
Médecins du Monde	Health Services (North)	Early marriage, SRH gaps for refugee women
KAFA	GBV and Shelter Access	Femicide, IPV, migrant worker risks, systemic discrimination
RDFL	Transitional Shelter and GBV Response	Early marriage, IPV, transitional shelter model
LGBT Taskforce	LGBTQI+ Coordination	SOGIESC mainstreaming, GBV service gaps, cash-based interventions, shelter exclusion
SIDC	SRHR	Harm reduction, outreach, peer-to-peer education, referral

Safe Shelter Access and Protection Challenges

Availability and Accessibility of Safe Shelter

Across the board, the availability and accessibility of safe shelters for survivors of GBV remain limited, and access varies significantly by nationality, legal status, gender identity, and socioeconomic background. While some Lebanese, refugee, and migrant women had heard of shelters operated by NGOs like KAFA, ABAAD, or Himaya, the majority were either unaware of their existence or unclear about how to access them. *"I didn't even know safe shelters really existed,"* shared a Lebanese woman from Mount Lebanon, reflecting a broader lack of outreach even within Lebanese communities.

Among refugee women, knowledge was slightly more widespread but still limited. Some participants from Bekaa and South Lebanon recognized NGOs like Nabad and KAFA, but emphasized that awareness was often confined to women with existing exposure to humanitarian services. Many refugee women stressed that others in their communities, especially those isolated by poverty or social norms, *"only know their husband's house as a shelter,"* reinforcing harmful dynamics that keep survivors trapped.

Migrant domestic workers and LGBTQI+ individuals reported even lower levels of awareness and access. Migrant women emphasized that while migrant-led organizations like Tres Marias and Egna Legna provided some community support, formal safe shelters remained almost completely out of reach. LGBTQI+ participants uniformly reported never having heard of any shelters specifically serving queer survivors. One participant noted, *"Housing is a luxury. For us, survival comes first."*

Where shelter services did exist, access was often highly conditional, restricted by documentation requirements, intake assessments, and perceptions of "worthiness" based on marital or family status. Single women, LGBTQI+ individuals, and undocumented migrants were especially excluded according to their own testimonies.

Barriers to Accessing Shelter

Multiple intersecting barriers prevented survivors from accessing shelter safely and equitably:

Documentation requirements emerged as a major hurdle, particularly for refugees, migrant domestic workers, and queer individuals. Refugee women in South Lebanon and Bekaa stressed that fleeing violence often meant leaving without IDs, making shelter admissions nearly impossible. As one refugee participant noted, *"When you leave to save your life, you don't think about grabbing your documents."* For queer individuals, especially those estranged from their families or living under assumed identities, the lack of official documentation was compounded by fear of exposure—making it nearly impossible to access shelters without risking being outed or denied entry altogether.

Safety also posed significant challenges. Participants across Lebanese, refugee, and migrant groups consistently emphasized that even when shelters were available, survivors feared being located by their abusers. *"The shelter might be safe inside,"* said a Lebanese woman from Bekaa, *"but the fear never leaves that he could find you."*

Affordability was less about the shelters themselves—which were often free—and more about the costs associated with leaving: transportation, living expenses after leaving shelter, and potential job loss. As a Syrian refugee woman in Akkar explained, *"Shelter is not enough if you have no way to live after."*

Discrimination—based on nationality, race, gender identity, or marital status—further narrowed access. Migrant domestic workers feared racial profiling or being turned away. LGBTQI+ survivors reported fearing additional violence or outing if they sought support through mainstream shelters. *"If you're assaulted once and call the police, you could end up being assaulted twice,"* a queer participant grimly noted, underscoring widespread fear of state institutions.

Capacity issues were reported across regions. Even those who knew of shelters remarked that spaces were extremely limited, admission procedures cumbersome, and stays temporary. *"Shelters exist but are more like a ticking clock,"* shared a key informant from RDFL, *"women worry about where to go next before they've even recovered or healed."*

Specific gaps for migrants and LGBTQI+ survivors were particularly glaring. Migrant domestic workers faced the double bind of employer-tied residency under kafala, making any attempt to leave an abusive household fraught with legal risk. LGBTQI+ participants emphasized that no safe shelters were tailored to their needs; even general shelters were often religiously affiliated or culturally conservative, creating unwelcoming or outright hostile environments.

Shelter Conditions and Privacy

Even where survivors gained access to shelters, the conditions frequently compromised their safety, dignity, and psychological wellbeing. Participants described shelters as "overcrowded". Privacy was minimal: women shared rooms and bathrooms, with little ability to control their personal space according to their own testimonies. A Lebanese woman from South Lebanon likened shelters to "an orphanage" where "privacy is a dream." A refugee woman in Bekaa noted, *"Across the last year, no matter who was running the shelter, you had to live your pain openly there; there's no space to heal quietly."*

Lack of emotional privacy was also a recurring concern. Survivors expressed that within shelters, there was often implicit pressure to share their stories with other residents, even if they were not ready. As one Syrian refugee woman put it, *"If you don't tell, people start asking. If you do tell, you lose your own secret."*

Safety concerns were not confined to the threat of abusers finding them. Poor management within shelters sometimes led to tensions, conflicts among residents, and a lack of trained staff to ensure women's protection. Trust in shelter staff and management was flagged as critical; several participants said they would only feel safe if "the staff were truly trained, ethical, and on our side," as one refugee woman in the South expressed. She adds, *"we don't know if these were government run, or NGO run, or if the staff were NGO staff or worked for someone else. I am simply telling you about my experience. It's a roof over our head, yes. But that's all."*

Women and queer participants across groups stressed the need for more trauma-informed shelters and spaces: shelters with private rooms, lockable doors and bathrooms, child-friendly spaces, and rules that guarantee respect for survivors' confidentiality and boundaries.

Needs and Suggestions for Improvement

Survivors offered consistent and urgent suggestions for improving existing shelter conditions, as well as for shelters under works:

- **Guarantee privacy and dignity:** Private rooms, private bathrooms, clear rules around confidentiality, and no mandatory sharing of personal stories.
- **Provide psychosocial and empowerment programs:** Education, vocational training, and psychological support were repeatedly emphasized as vital to helping women and queer survivors rebuild autonomy.
- **Expand eligibility and inclusivity:** Open more shelters to unmarried women, LGBTQI+ individuals, and undocumented migrants without discrimination.
- **Strengthen targeted community outreach:** Increase targeted awareness about shelters' existence and processes in ways that do not stigmatize women for leaving abusive homes.

- **Invest in long-term solutions:** Survivors stressed that shelters should not be temporary holding spaces but gateways to independence—offering pathways to employment, legal assistance, housing, and continued protection.

As one Lebanese woman from Akkar concluded: *"Shelter is not just a roof over your head. It's a place that should give you back your dignity, your strength, and your right to live without fear."*

Role of Service Providers and Organizations

NGO, Migrant-Led, and LGBT-Led Organizations

Contributions to GBV Prevention, Response, SRH Services, and Shelter Support: Across Lebanon, a diverse ecosystem of NGOs, migrant-led groups, and LGBT-led organizations plays a vital role in filling the gaps left by a largely absent or exclusionary state system. These organizations act as first responders for survivors of GBV and as primary providers of SRH information and services for marginalized communities.

Organizations like KAFA, RDFL, and LECORVAW offer essential psychosocial support, case management, legal aid, and emergency shelter referrals for survivors of GBV. As an informant from KAFA explained, *"We are not a service center—we are a support center. We walk alongside survivors, not in front of them, and we offer 24/7 emergency reception when others are closed."* RDFL operates one of the only transitional shelters in Lebanon, providing short-term safe housing for women fleeing violence, while LECORVAW focuses heavily on empowerment programs and legal accompaniment for survivors, particularly in rural areas like the North and Bekaa.

Migrant-led initiatives, while often informal, offer solidarity-based forms of support among migrant workers who are otherwise structurally excluded from mainstream services. For instance, IOM emphasized the critical but under-supported role of migrant community networks in referring survivors to NGOs or providing initial emotional support. However, as one IOM representative noted, *"Most migrant-led initiatives lack registration and funding, which severely limits their ability to provide structured or consistent services."*

The LGBT Taskforce has been pivotal in mainstreaming LGBTQI+ needs across humanitarian sectors. By creating a national service mapping of queer-friendly health and protection services, and advocating for inclusive shelter policies, the Taskforce has helped LGBTQI+ survivors access safer spaces. As an informant from the Taskforce highlighted, *"When queer individuals experience violence, they don't trust the mainstream system. Our work ensures that even if the mainstream remains discriminatory, alternatives exist."* MOSAIC similarly stepped in during the armed conflict, organizing emergency distribution of hygiene kits and food assistance for LGBTQIA+ individuals after many services collapsed.

Médecins du Monde (MdM) contributes significantly to SRH service delivery, particularly through mobile medical units and reproductive health clinics targeting refugee and underserved populations. MdM also integrates SRH with GBV case management, an innovation that ensures survivors are treated holistically rather than compartmentalized into separate systems.

Groups like the Sudanese Women's Association and Tres Marias played an instrumental role in connecting researchers to otherwise unreachable communities. These CBOs helped shape interview framing, ensured culturally sensitive approaches, and should be included in all future planning and implementation processes.

Observed key innovations in service delivery include:

- **24/7 emergency intake** (KAFA) to bridge gaps created by other organizations' limited operating hours, accepting individuals for protection at all hours.
- **Service mapping and coordination for LGBTQI+ survivors** (LGBT Taskforce) to ensure safer referral pathways.
- **HYPE application** (SIDC), a chat application where diverse groups can chat with outreach workers about SRH, GBV and mental health, as well as seek referrals.
- **Online awareness on dating apps** (SIDC) specifically for the LGBTIQ+ community, with peer education on SRH, GBV and mental health.
- **Mobile SRH services** (MdM) reaching rural, underserved areas.
- **Mobile units** (SIDC**)** conducting outreach, peer education, counseling and testing for STIs including HIV.
- **Transitional shelter model** (RDFL) bridging the gap between immediate rescue and long-term shelter placement.
- **Community mobilization and fiscal sponsorships** (MOSAIC) to unregistered organizations operating across the gender, SRH and GBV spaces.
- **Psychosocial first aid integration** into GBV and SRH services across several NGOs, recognizing the emotional toll of trauma at every access point.

Additionally, organizations such as MOSAIC and IOM have piloted cash-for-protection programs, offering direct financial support to survivors of violence—a critical lifeline, especially for migrant workers and LGBTQI+ individuals facing eviction or economic violence.

Gaps in Capacity, Funding, and Coordination: Despite their critical work, organizations face persistent limitations. Across interviews, lack of sustainable funding was repeatedly cited as the most significant constraint. As KAFA's team noted, *"We don't say no to any woman who knocks on our door, but it means we are constantly stretching our team and our resources beyond capacity."* RDFL similarly reported that its transitional shelter could only host two survivors at a time, a stark mismatch against growing needs.

LECORVAW emphasized that short-term donor funding often pressures NGOs to prioritize hitting numerical targets over responding to actual community needs. As one staff member explained, *"Funding is tied to the number of cases served, not to the quality or depth of services provided."*

Migrant-led groups lack legal recognition and material support, preventing them from expanding their reach. LGBTQI+ organizations, already heavily underfunded, are facing shrinking spaces for operations, especially after recent political and societal crackdowns. Additionally, while innovative service models exist, fragmentation remains a problem. As a staff member from Médecins du Monde shared, *"Mobile clinics work well, but referrals to follow-up SRH or GBV services can fall apart if the survivor has to travel long distances or disclose sensitive information multiple times."*

Coordination Between Sectors

Referral Pathways Between NGOs, Healthcare, Police, and Shelters: Coordination across sectors has improved modestly but remains inconsistent. Some areas, particularly Beirut and Mount Lebanon, benefit from relatively strong referral systems between NGOs, health providers, and legal actors. KAFA and RDFL both reported that when survivors come to them, they are able to coordinate shelter placement, legal support, and clinical referrals relatively quickly—"as long as it's within working hours and if the survivor fits shelter criteria," as noted by RDFL.

The LGBTQI+ Taskforce has created specific referral pathways for LGBTQIA+ survivors, but uptake among mainstream shelters and health facilities remains limited. Many providers still refuse to receive transgender individuals or queer survivors, leading to a reliance on a small number of safe spaces that are rapidly overwhelmed.

Police remain largely disconnected from coordinated GBV or SRH referral systems. KAFA and UNHCR representatives both stressed that *"survivors often experience further harm when engaging with police, who may trivialize domestic violence or blame survivors for sexual assault."* In cases involving Syrian refugees or migrants, police are also perceived as agents of deportation rather than protection.

Healthcare actors, particularly public clinics, often require survivors to navigate multiple bureaucratic hurdles independently. As one participant summarized, *"There's no handoff—if you're raped, you need to find your own way to the hospital, your own way to the forensic doctor, your own way to the court."*

According to informants, key barriers to more effective multi-sectoral collaboration include:

- **Lack of standardized protocols** for inter-agency referrals, especially for LGBTQIA+ survivors and persons with disabilities.
- **Limited after-hours services,** with shelters and legal aid often closing mid-afternoon.

- **Legal risks** for shelters accepting undocumented individuals, particularly Syrian refugees and migrant workers.
- **Stigma and bias** within service providers themselves, affecting LGBTQI+ individuals, unmarried women, migrant workers, and disabled survivors.
- **Funding siloes,** where donors fund SRH, GBV, livelihoods, or mental health separately, discouraging integrated case management.

As a representative from LECORVAW emphasized, *"We can have perfect referral forms and hotlines, but if survivors are judged or turned away at the entry point, the system is broken."* Overall, while the NGO ecosystem has made critical strides in providing lifesaving services, the findings highlight a pressing need for deeper collaboration, long-term funding, and transformative shifts in both attitudes and institutional practices across all sectors.

Cross-Cutting Themes

Intersectionality of Risks: Gender, Legal Status, Ethnicity, Class, and Sexuality

The experiences of survivors revealed how deeply intersecting identities—gender, legal status, ethnicity, class, and sexuality—shape vulnerability to violence and access to services. Lebanese women, Syrian and Palestinian refugees, migrant domestic workers, LGBTQI+ individuals, and persons with disabilities each faced specific, layered risks that were compounded by the structures of discrimination embedded in Lebanese society.

For refugee and migrant women, the intersection of nationality and legal precarity profoundly shaped experiences of both GBV and barriers to protection. As a Syrian woman from Bekaa noted, *"When you don't even have papers, you're not thinking about finding justice—you're thinking about survival."* Migrant domestic workers, especially under the kafala system, were often viewed not as survivors with rights but as property. As one participant stated starkly, *"Authorities see us not as people, but as labor."*

LGBTQI+ individuals, especially queer refugees and migrants, faced even steeper barriers, with gender identity and sexuality placing them at risk of both interpersonal violence and institutional neglect. Participants emphasized that there were no safe shelters specifically for queer survivors, and that seeking police protection often escalated rather than alleviated danger. *"Asking the police for help,"* a queer Syrian participant said, *"means inviting another assault."*

Class stratification also played a critical role. Whether Lebanese or refugee, women from lower-income backgrounds reported significantly less access to SRH services, legal support, and safe housing. Even within urban centers, class differences dictated who could afford to live in neighborhoods where discrimination was less overt, as LGBTQI+ participants shared: *"Inclusive areas like Hamra are unaffordable. We end up trapped where hate is cheaper."*

Impact of Economic Crisis, Displacement, and War on Vulnerabilities

Lebanon's prolonged economic collapse, compounded by the Syrian displacement crisis and periodic conflict—including the recent escalation between Hezbollah and Israel—exacerbated every vulnerability participants described. Inflation, currency devaluation, and crumbling public services meant that even basic SRH services became unaffordable or inaccessible. As one refugee woman explained, *"Before, the UN would cover some costs. Now we pay everything or we don't go at all."*

Displacement patterns from the most recent 2024 escalation among refugees and poorer Lebanese communities also worsened women's exposure to unsafe living conditions. Many participants reported living in overcrowded, substandard housing, often without private rooms or bathrooms, increasing the risk of harassment, exploitation, and GBV within their own homes and neighborhoods. Widowed or divorced women were especially vulnerable, with one refugee woman recounting how she "pretended to have a husband" just to rent a room safely.

For LGBTQI+ individuals, displacement due to discrimination was a constant. As one participant said, *"I move not because I want to, but because neighbors force me to."* The economic collapse has made safe housing for queer individuals—already rare—almost entirely unattainable. The collapse of public trust in institutions further eroded any confidence survivors might have had in the police, judiciary, or even healthcare providers. As a Lebanese woman from Mount Lebanon put it, *"The system has failed us one too many times."*

Trauma-Informed Approaches and Their Gaps

Although many NGOs and humanitarian actors have adopted the language of trauma-informed care, implementation on the ground remained inconsistent and often superficial. Survivors frequently reported re-traumatizing experiences when accessing GBV or SRH services. As one refugee woman described, *"You run from violence at home and find new violence at the clinic—through judgment, questions, shame."*

Shelters often lacked both physical and emotional safety structures: crowded living arrangements, lack of private spaces, coercive demands to share personal histories, and insensitive handling of residents' needs were recurrent themes. For persons with disabilities, gaps in trauma-informed services were even starker.

As one Lebanese participant with physical disabilities shared, *"Even at clinics, they make me wait hours though I explain I can't. They don't see our needs. We are invisible."*

Queer survivors similarly found trauma compounded rather than addressed when seeking services. *"Before you get help for your wounds, you get wounded by judgment,"* said a gay refugee participant. Fear of being outed, mocked, or criminalized led many to avoid services altogether. Thus, while trauma-informed care is increasingly cited as a best practice, true survivor-centered, rights-based approaches remained rare.

Need for Inclusive Policies and Survivor-Centered Responses

The overwhelming consensus across all participants was the urgent need for more inclusive, intersectional, and survivor-centered policies. Survivors emphasized that existing services too often assumed a normative model—heterosexual, Lebanese, legally documented—leaving vast numbers of people underserved or outright excluded.

Participants called for:

- **Expanding shelter access** to include queer survivors, undocumented migrants, and survivors without children.
- **Guaranteeing confidentiality and dignity** in all GBV and SRH services, with trauma-informed and rights-based training for frontline workers.
- **Removing documentation barriers** for emergency shelter, medical, and legal services.
- **Strengthening economic empowerment** through vocational training, access to employment, and sustainable financial support.
- **Investing in inclusive SRH services** that are affordable, non-judgmental, and available to all individuals regardless of marital status, nationality, or sexual orientation.
- **Community-based awareness raising** to dismantle stigma around GBV reporting, seeking SRH care, and using shelters.

As one Lebanese woman from Akkar summarized,

> **"IT'S NOT ONLY ABOUT HELPING A WOMAN AFTER SHE'S HURT. IT'S ABOUT BUILDING A SYSTEM WHERE SHE DOESN'T HAVE TO BE HURT TO BEGIN WITH—AND IF SHE IS, SHE CAN STAND BACK UP WITH DIGNITY, NOT SHAME"**

Box 1. Gaps in GBV Response, SRH Services, and Shelter Access

- **GBV Response:** Survivors consistently reported distrust in law enforcement, lack of trauma-informed service provision, and absence of accessible, survivor-centered reporting pathways. Shelters, healthcare providers, and police were often described as judgmental, dismissive, or unsafe, particularly for marginalized groups.
- **SRH Services:** While some services exist through NGOs and clinics, they remain financially, geographically, and socially inaccessible for many. Stigma, cost barriers, lack of confidentiality, and shortages of female or gender-sensitive providers further restricted access. Services for unmarried women, LGBTQI+ individuals, migrants, and persons with disabilities were especially limited or exclusionary.
- **Shelter Access:** Safe shelters were largely unknown, inaccessible, or unsuitable for many survivors. Challenges included lack of information, documentation requirements, overcrowding, fear of social stigma, and discriminatory attitudes within shelters. Privacy and safety concerns were repeatedly raised, particularly by queer individuals and migrant women. For many, shelters felt more like temporary containment than spaces for healing and empowerment.

Box 2. Intersectionally Vulnerable Groups

- **Undocumented Migrants:** Fear of deportation, legal invisibility, and extreme economic precarity compounded their exposure to violence and prevented access to health, legal, and protection services.
- **LGBTQI+ Refugees and Migrants:** Faced dual discrimination based on nationality and sexuality, with no specialized safe shelters available. Seeking protection often resulted in additional harm from authorities or landlords.
- **Single, Widows, and Divorced Women:** Experienced heightened vulnerability to exploitation, social ostracization, and barriers to securing independent, safe housing.
- **Persons with Disabilities:** Largely excluded from accessible services and protections, facing both physical and systemic barriers in reporting violence and accessing SRH care.

Recommendations

1. **Short term: Strengthen Trauma-Informed and Survivor-Centered Humanitarian Service Delivery:** Humanitarian actors must integrate trauma-informed approaches that prioritize survivors' emotional safety, autonomy, and dignity across all sectors—health, protection, shelter, and livelihoods. This requires regular, mandatory training on trauma impacts, survivor agency, active listening, confidentiality, and non-judgmental engagement. Programs must be adaptable to diverse survivor needs, particularly for LGBTQI+ individuals, migrant women, and persons with disabilities, and ensure that services are survivor-led wherever possible. Additionally, trauma-informed and survivor-centered training of ISF officers who work with survivors remains crucial.

2. **Medium term: Transition to Local Actors and Sustainable Capacity-building:** Integrate sustainability plans that center community ownership and local capacity. This includes training CBOs and survivor networks, transferring knowledge to grassroots actors, and supporting peer-led initiatives that can endure beyond external funding cycles.

3. **Medium term: Expand and Adapt Safe Shelter Access for Marginalized Groups:** Shelter programming must urgently expand to include accessible, rights-based options for refugees, migrant domestic workers, LGBTQI+ individuals, and persons with disabilities. Shelters must guarantee physical safety, privacy (through secure, individualized spaces), culturally sensitive psychosocial support, and gender-sensitive staffing. Trust-building efforts are essential: many survivors are unaware of available shelters, or distrust them. Outreach campaigns, based in communities and migrant/queer networks, should increase visibility without compromising security.

4. **Medium term: Enhance Humanitarian Actor Training Across Sectors:** Cross-sector actors—including security personnel, healthcare providers, NGO caseworkers, and shelter managers—require consistent training on GBV dynamics, survivor-centered response principles, LGBTQI+ inclusivity, and disability accommodation. Training must go beyond basic awareness to include practical, scenario-based exercises, and must embed accountability mechanisms so survivors can safely report mistreatment. Key informants stressed that untrained frontline workers often retraumatize survivors or discourage disclosure.

5. **Long term: Expand, Fund, and Decentralize SRH Services with Inclusive Outreach:** SRH services must be accessible, free or affordable, decentralized to rural areas, and meaningfully inclusive of LGBTQI+ individuals, unmarried women, adolescents, and migrant communities. Services should integrate gender-sensitive and queer-inclusive care, guarantee confidentiality, and address specific fears voiced by survivors (e.g., being judged, reported, or outed). Outreach must actively challenge misinformation and cultural stigma, working closely with migrant- and youth-led initiatives to ensure messaging resonates.

6. **Long term: Foster Greater Collaboration with Migrant-Led and LGBT-Led Organizations:** Migrant- and LGBTQI+-led organizations provide trusted, culturally competent support where traditional humanitarian structures often fall short. Humanitarian actors must meaningfully partner with these groups—not only as referral points but as equal partners in service design, implementation, and evaluation. Funding streams must prioritize locally led initiatives, and humanitarian clusters must formally include migrant- and queer-led organizations in coordination mechanisms.

7. **Long term: Advocate for Integrated and Flexible Funding Models:** Donors should be urged to prioritize integrated GBV, SRH, and shelter programming that reflects the intersecting realities of survivors' lives, rather than funding siloed sectoral responses. This includes supporting multi-sectoral service delivery across protection, health, and livelihoods in both formal and informal settings. Additionally, while not always explicitly raised by participants, field insights suggest a critical gap in resourcing grassroots and informal support networks—especially those relied upon by marginalized groups such as LGBTQI+ individuals and undocumented refugees. Greater donor flexibility in funding informal, non-registered initiatives can strengthen localized response systems and ensure more inclusive, community-embedded support.

8. **Short term: Improve Cross-Sectoral Coordination and Referral Pathways:** Gaps in inter-agency communication and fragmented referral systems often leave survivors unsupported. Humanitarian actors must strengthen cross-sectoral coordination between health, protection, shelter, and livelihood sectors to ensure survivors experience seamless referrals. Standardized, survivor-centered referral protocols should be adopted across NGOs and UN agencies, ensuring confidentiality, rapid response, and inclusivity for marginalized groups. Migrant, LGBTQI+, and disability rights organizations must be fully integrated into these pathways.

9. **Medium term: Advance Advocacy for Rights-Based Policy Reforms:** Humanitarian agencies must continue to advocate for urgent legal reforms to protect displaced and marginalized communities. Priorities include the enactment of comprehensive anti-discrimination and anti-violence laws; the establishment of clear, survivor-centered procedures to access justice and protection regardless of legal status; and strengthened refugee protection frameworks ensuring access to services without fear of detention, deportation, or status loss. Develop a targeted advocacy brief summarizing urgent legal and policy reforms—such as enacting anti-discrimination laws, abolishing the kafala system, and securing protection for undocumented migrants and queer refugees—to be shared with donors, national policymakers, and international stakeholders.

10. **Medium term:** **Proposed Indicators for Monitoring Progress:** To ensure accountability and track the implementation of this report's recommendations, the following indicators are proposed for regular monitoring: (1) Percentage of GBV survivors accessing trauma-informed support services; (2) Percentage of shelters that have adopted inclusive policies for LGBTQI+ individuals and migrant populations; (3) Percentage of healthcare facilities offering SRH services accessible to persons with disabilities; (4) Average wait time for referrals and referral success rate within inter-agency GBV/SRH pathways. These indicators can be monitored on a quarterly basis through existing inter-agency coordination mechanisms, with supplementary input from survivor feedback tools.

11. **Short term:** **Expand After-Hours Access to Critical Services:** Donors and implementing agencies should prioritize the expansion of GBV shelter and legal aid services beyond standard working hours to ensure urgent, life-saving support is accessible when survivors need it most. Many participants highlighted the inability to access safe shelter or emergency legal counsel during evenings or weekends—timeframes when incidents often occur. Strengthening 24/7 response capacity, including through mobile teams or on-call legal advisors, is essential to preventing harm and ensuring timely protection for those at risk.

Annex 1. Data Collection Sample

List of Stakeholders Interviewed and Solicited:

- UNHCR; GBV Working Group
- IOM
- SIDC
- Médecins du Monde
- LECORVAW
- MOSAIC
- LGBTQI+ Taskforce
- KAFA
- RDFL
- Jesuit Refugee Service
- Nabad for Development
- Tres Marias
- Sudanese Women's Association
- Internal Security Forces Officers

Total: 13

List of Focus Groups and In-depth Interviews Conducted:

North Lebanon

- 1 FGD with Lebanese women (7 participants), Tripoli
- 1 FGD with refugee women (7 participants), Tripoli
- 7 in-depth interviews with refugee women, Akkar
- 7 in-depth interviews with Lebanese women, Akkar

Beirut

- 5 in-depth interviews with Lebanese women
- 5 in-depth interviews with refugee women
- 10 in-depth interviews with LGBTQ+ individuals

Mount Lebanon

- 6 in-depth interviews with Lebanese women
- 5 in-depth interviews with refugee women

South Lebanon
- 1 FGD with Lebanese women (8 participants)
- 1 FGD with refugee women (7 participants)

Bekaa
- 1 FGDs with refugee women (6 participants)
- 7 in-depth interviews with Lebanese women

Various/Nationwide
- 2 FGDs with migrant women (15 participants from Ethiopia, Sudan and Philippines)
- 1 FGD with refugee men (6 participants)
- 1 FGD with Lebanese men (6 participants)
- 6 in-depth interviews with persons with disabilities

Total: 114 individuals

Annex 2. Data Collection Tools

Tool 1: Key Informant Interviews (KIIs)

Target respondents: Local and international NGOs, service providers, healthcare professionals, shelter managers, migrant-led organizations, and LGBT organizations.

Section 1: General GBV and SRH Landscape

- Can you describe the main GBV risks faced by women, queer individuals, and migrant domestic workers in the communities you serve? Are there differences across age and gender in your observation?
- What are the main gaps in GBV response services in this area? Probes: Accessibility, affordability, stigma, intersectionality, availability—including 24/7 services and referrals (e.g., migrant, queer, refugee status).
- How safe do women and girls feel living in this community? Please explain. Probes: Are there specific actors/reasons that make them feel unsafe?
- Are there areas in Lebanon where girls, women, and different groups are at increased risk for assault/harassment? If yes, where?
- Who are the main perpetrators of violence against women and girls?
- What coping strategies, if any, do women and girls use to improve their safety?
- What are the primary barriers preventing survivors from accessing SRH services? Probes: Awareness, cost, legal restrictions, discrimination.

Section 2: Role of Organizations in GBV and SRH Response

- How does your organization currently respond to GBV cases? Probes: Coordination with shelters, healthcare providers, legal aid.
- How do migrant-led organizations contribute to GBV response and support services?
- How do LGBT-led organizations contribute to addressing GBV?
- What resources or capacity does your organization lack in effectively responding to GBV cases?
- How does your organization address SRH needs among the communities you serve? Probes: Access to contraception, maternal health services, STI prevention and treatment.
- How do LGBT-led organizations contribute to addressing SRH needs?
- What resources or capacity does your organization lack in effectively responding to SRH needs?

Section 3: Safe Shelter Accessibility and Challenges

- What are the biggest challenges in providing safe shelter to GBV survivors? Probes: Funding, capacity, stigma, legal status (for refugees, migrants, and queer individuals).
- How are shelters currently funded, and what are the biggest funding gaps?
- What are the main challenges in coordinating shelters for different groups (Lebanese, refugees, queer individuals, migrant workers)?

Tool 2: FGDs with Syrian Women

Target respondents: Syrian refugee women living in urban/rural areas, informal settlements, or shelters.

Introduction: Hello, and thank you for being here. We want to learn about the challenges Syrian refugee women face with safety, health, and shelter. Your answers will stay private, and you can skip any question or stop at any time. We will talk about gender-based violence (GBV)—like domestic violence, harassment, early marriage, or trafficking—sexual and reproductive health (SRH)—like pregnancy care, contraception, and post-rape care—and shelter access, meaning safe places to stay. There are no right or wrong answers; we just want to hear your experiences. Feel free to ask if anything is unclear.

Section 1: GBV Experiences and Risks

- What types of behaviours or action do you consider to be gender-based violence
- What are the most common forms of GBV affecting Syrian refugee women in your community? Probes: Domestic violence, sexual harassment, early marriage, trafficking.
- How do women usually respond when experiencing GBV? Probes: Reporting mechanisms, seeking medical or legal support, coping strategies. + in case they answer I do not know to probe about knowing someone who might have been through this and what they did (maintaining confidentiality).

- Would you tell us some of the GBV prevention and response mechanisms/services in your community?
    - Do you think survivors of GBV feel safe reporting to GBV Service centers/authorities? Why or why not?
    - What barriers do you think prevent people from seeking help for GBV?
    - How does your legal status in Lebanon affect your access to safety, healthcare, and other services? Probes: Lack of residency permits, risk of arrest or deportation, movement restrictions, ability to report violence or seek legal aid.

Section 2: SRH Needs and Barriers

- What are the biggest challenges in accessing SRH services? Probes: Cost, transportation fees, distance to the nearest facility, availability of PHCCs, waiting times, lack of female healthcare providers, legal restrictions, discrimination, or language barriers.
- Are there any cultural or social barriers that prevent you from seeking SRH services? Probes: Stigma around certain services (e.g., contraception, post-rape care), family or community disapproval, fear of judgment from healthcare providers, religious beliefs, or misinformation.
- What SRH services are available in your community? Probes: Are there clinics or organizations providing maternal care, contraception, STI treatment, or emergency support? Are these services free or affordable? Are they available for all women, including unmarried women or survivors of violence?
- What are the biggest gaps in SRH services in your community? Probes: Lack of specific services (e.g., family planning, mental health support for survivors), shortage of trained professionals, limited operating hours, lack of confidentiality, or absence of women-friendly spaces.

Section 3: Shelter Access and Safety

- Do you know that there are safe shelters?
- What are the biggest challenges in finding shelter (community/apartment/safe shelter) for refugee women facing violence? Probes: Documentation, cost, safety, discrimination, availability.

    - How safe do women and girls feel inside their shelters/homes?
    - Do shelters/homes provide enough privacy? Please explain.
    - What do women and girls lack in their shelter/home that would contribute to them having more privacy/safety? Please explain.
    - Discussion Prompts: What support do women and girls need to feel safe and have privacy in their shelter/home? Additional service? Additional NFI?

Tool 3: FGDs with Lebanese Women

Target respondents: Lebanese women from different socioeconomic backgrounds.

Introduction: Hello, and thank you for being here. We want to learn about the challenges Lebanese women face with safety, health, and shelter. Your answers will stay private, and you can skip any question or stop at any time. We will talk about gender-based violence (GBV)—like domestic violence, harassment, early marriage, or trafficking—sexual and reproductive health (SRH)—like pregnancy care, contraception, and post-rape care—and shelter access, meaning safe places to stay. There are no right or wrong answers; we just want to hear your experiences. Feel free to ask if anything is unclear.

Section 1: GBV Experiences and Risks

- What types of behaviours or action do you consider to be gender-based violence
- What are the most common forms of GBV affecting women in your community? Probes: Domestic violence, sexual harassment, early marriage, trafficking.
- How do women usually respond when experiencing GBV? Probes: Reporting mechanisms, seeking medical or legal support, coping strategies. + in case they answer I do not know to probe about knowing someone who might have been through this and what they did (maintaining confidentiality)
- Would you tell us some of the GBV prevention and response mechanisms/services in your community?
    - Do you think survivors of GBV feel safe reporting to GBV Service centers/authorities? Why or why not?
    - What barriers do you think prevent people from seeking help for GBV?

Section 2: SRH Needs and Barriers

- What are the biggest challenges in accessing SRH services? Probes: Cost, transportation fees, distance to the nearest facility, availability of PHCCs, waiting times, lack of female healthcare providers, legal restrictions, discrimination, or language barriers.
- Are there any cultural or social barriers that prevent you from seeking SRH services? Probes: Stigma around certain services (e.g., contraception, post-rape care), family or community disapproval, fear of judgment from healthcare providers, religious beliefs, or misinformation.
- What SRH services are available in your community? Probes: Are there clinics or organizations providing maternal care, contraception, STI treatment, or emergency support? Are these services free or affordable? Are they available for all women, including unmarried women or survivors of violence?
- What are the biggest gaps in SRH services in your community? Probes: Lack of specific services (e.g., family planning, mental health support for survivors), shortage of trained professionals, limited operating hours, lack of confidentiality, or absence of women-friendly spaces.

Section 3: Shelter Access and Safety

- Do you know that there are safe shelters?
- What are the biggest challenges in finding shelter (community/apartment/safe shelter) for women facing violence? Probes: Documentation, cost, safety, discrimination, availability.
    - How safe do women and girls feel inside their shelters/homes?
    - Do shelters/homes provide enough privacy? Please explain.
    - What do women and girls lack in their shelter/home that would contribute to them having more privacy/safety? Please explain.
    - Discussion Prompts: What support do women and girls need to feel safe and have privacy in their shelter/home? Additional service? Additional NFI?

Tool 4: FGDs with Queer Participants

Target respondents: LGBTQI+ individuals at risk of or experiencing GBV.

Section 1: GBV Risks and Protection

- Have you heard of incidents of GBV targeting queer individuals in your community? Probes: Family violence, community-based violence, partner violence, discrimination.
- How do queer individuals navigate reporting violence or seeking support?
- Do you think Queer people are safe to receive services in this community? If Not Why?

Section 2: SRH Barriers and Discrimination

- Have you experienced discrimination in SRH services because of your gender identity/sexuality?
- What challenges exist in accessing gender-sensitive care, STI services, or reproductive health care?

Section 3: Safe Shelter and Community Support

- Are there any safe shelters for queer survivors of GBV?
- What challenges do LGBTQI+ individuals face in accessing housing or protection services?
- Do LGBTQI+ individuals feel comfortable seeking protection from security officers/police? Why or why not?
- How do LGBT-led organizations support survivors, and what additional resources do they need?

Tool 5: FGDs with Migrant Domestic Workers

Target respondents: Women migrant workers (documented, undocumented, live-in, and live-out).

Introduction: Hello, and thank you for being here. We want to learn about the challenges migrant women and migrant domestic workers face with safety, health, and shelter. Your answers will stay private, and you can skip any question or stop at any time. We will talk about gender-based violence (GBV)—such as domestic violence, harassment, early marriage, trafficking, and workplace abuse—sexual and reproductive health (SRH)—including pregnancy care, contraception, post-rape care, and access to healthcare—and shelter access, meaning safe places to stay. There are no right or wrong answers; we just want to hear your experiences. Feel free to ask if anything is unclear.

Section 1: GBV and Workplace Abuse

- What are the most common forms of GBV faced by migrant domestic workers?
- Probes: Employer abuse, sexual violence, labor exploitation.
- What types of behaviours or action do you consider to be gender-based violence
- What legal or social barriers prevent you from seeking protection from GBV?
- What are the most common forms of GBV affecting women in your community?
- Probes: Domestic violence, sexual harassment, early marriage, trafficking.
- How do women usually respond when experiencing GBV?
- Probes: Reporting mechanisms, seeking medical or legal support, coping strategies. + in case they answer I do not know to probe about knowing someone who might have been through this and what they did (maintaining confidentiality)
- Would you tell us some of the GBV prevention and response mechanisms/services in your community?
    - Do you think survivors of GBV feel safe reporting to GBV Service centers/authorities? Why or why not?
    - What barriers do you think prevent people from seeking help for GBV?

Section 2: SRH Services and Access

- Do migrant domestic workers face challenges in accessing SRH services?
- Are there any cultural or social barriers that prevent you from seeking SRH services? Probes: Stigma around certain services (e.g., contraception, post-rape care), family or community disapproval, fear of judgment from healthcare providers, religious beliefs, or misinformation.
- What SRH services are available in your community? Probes: Are there clinics or organizations providing maternal care, contraception, STI treatment, or emergency support? Are these services free or affordable? Are they available for all women, including unmarried women or survivors of violence?
- What are the biggest gaps in SRH services in your community? Probes: Lack of specific services (e.g., family planning, mental health support for survivors), shortage of trained professionals, limited operating hours, lack of confidentiality, or absence of women-friendly spaces.

Section 3: Shelter and Protection

- Do you know of cases where women from your community sought any type of shelter due to violence or abuse?
- What are the barriers migrant women face in accessing safe housing?
- Are migrant-led organizations involved in supporting women in abusive situations?
- Are you comfortable reporting violence to the police? Why or why not?

Tool 6: FGDs with Men

Target respondents: Lebanese, Syrian refugee, and migrant men.

Introduction: Hello, and thank you for being here. We want to learn about the challenges Lebanese, Syrian refugee, and migrant men face regarding safety, health, and access to support services. Your answers will stay private, and you can skip any question or stop at any time. We will talk about gender-based violence (GBV)—including physical violence, harassment, workplace abuse, and detention risks—sexual and reproductive health (SRH)—such as access to healthcare, mental health support, and information on contraception and STIs—and safety and shelter, including access to housing and protection from violence or exploitation. There are no right or wrong answers; we just want to hear your experiences. Feel free to ask if anything is unclear.

Section 1: Perceptions of GBV

- What types of behaviours and actions do you consider to be gender-based violence?
- How do men in your community perceive violence against women?
- How do men in your community perceive violence against queer individuals?
- What are the main causes of GBV in your opinion?
- Do you think men experience GBV? Why or why not?
- If yes, what type of GBV do men experience?

Section 2: Men's Role in GBV Prevention

- What role do men play in preventing GBV?
- Are there any programs or community efforts engaging men in GBV prevention?
- What do you think are the challenges that men might face while working to prevent GBV in your community?

Section 3: SRH Awareness and Attitudes

- How do men in your community view women's access to SRH services?
- Do men access SRH services (e.g., STI testing, contraception counselling)? Why not?
- How do you perceive awareness on SRH?

Section 4: Safe Shelter and Support

- Are men aware of any shelters for (women or men) GBV survivors?

Tool 7: KII with Security Officials/Police

Target respondents: Local police, Internal Security Forces (ISF)

Section 1: General Perceptions of GBV

- From your experience, what are the most common types of GBV cases reported to security forces?
- Probes: Domestic violence, sexual violence, harassment in public spaces, trafficking, violence against queer individuals.
- How has the frequency of GBV cases changed in recent years?
- Probes: Increased reporting? Underreporting? Impact of economic crisis or displacement? Impact of war?

Section 2: Response to GBV Cases

- Can you describe the standard procedures followed when a GBV case is reported to the police?
- Probes: Investigation process, survivor protection, referral pathways to social or medical services.
- What challenges do security forces face when handling GBV cases?
- Probes: Survivor reluctance, legal gaps, lack of resources, community pressure, lack of knowledge.
- What measures are in place to ensure that survivors of GBV feel safe and protected when reporting violence?
- Probes: Confidentiality, gender-sensitive officers, coordination with shelters or NGOs.
- Are there specialized police units or officers trained to handle GBV cases? If yes, what kind of training do they receive? If no, why not?

Section 3: Interaction with Specific Vulnerable Groups

- How does the police respond to GBV cases involving refugees, migrant domestic workers, and queer individuals?
- Probes: Are there differences in how cases are handled? Are certain groups less likely to report?
- Do migrant domestic workers face challenges in accessing protection from security forces?
- Probes: Do legal status or employer influence the police response? Any specific protocols for MDWs?
- Are LGBTQI+ individuals comfortable reporting violence to the police? Why or why not?
- Probes: How do officers handle cases of violence targeting queer individuals? Are there biases in police response?

Section 4: Coordination and Referral Systems

- How does the police coordinate with NGOs, shelters, and health providers in responding to GBV cases?
- Probes: Are there structured referral mechanisms? Are survivors referred to SRH services?
- What are the main barriers to effective coordination between security forces and service providers?

Section 5: Safe Shelter and Protection

- What role do security forces play in ensuring safe shelter for GBV survivors?
- Probes: Are survivors escorted to shelters? Are there legal barriers preventing certain groups from accessing shelter?
- What challenges exist in providing protection for survivors of GBV who fear retaliation or honour-based violence?

Section 6: Gaps and Recommendations

- From a law enforcement perspective, what policies or practices need improvement to better protect GBV survivors?
- What additional resources or training would help police officers respond more effectively to GBV cases?
    - Have there been efforts to increase women's representation in security forces to handle GBV cases?
    - How do security officials handle cases involving minors experiencing GBV?
    - Do security forces receive any training on trauma-informed approaches for GBV survivors?