

GBV and mental health among refugee and host community women in Lebanon

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Underlying gender and power imbalances that put displaced women and girls at risk of gender-based violence (GBV) are exacerbated by vulnerabilities related to legal status, economic security, access to services, and living conditions.

ABAAD, a Lebanese organisation working on all aspects of GBV prevention and response,¹ and the US-based Global Women's Institute (GWI)² conducted a survey of Lebanese, Palestinian and Syrian refugee women in Lebanon in order to understand their experiences of GBV and mental health and psychosocial support (MHPSS) provision. The survey was undertaken in May 2019 in collaboration with Lebanese GBV and MHPSS service providers and academics. It was complemented by qualitative data collected through focus group discussions with community leaders, GBV and MHPSS practitioners, and community members to further understand both their perceptions of well-being and any barriers to and factors supporting coordinated services across these two sectors.³

Of the 969 women interviewed, 90% reported having serious problems due to one or more environmental vulnerabilities: food insecurity (71%), physical health (62%), being separated from family (56%), and safety and security where they live (50%). Participants in focus group discussions identified lack of access to financial resources as the main cause of these vulnerabilities among both host and refugee communities. GBV is common among this population; over one-third of women indicated having been married before the age of 18 and over three-quarters of women who had or had had a partner reported having experienced intimate partner violence (IPV), about half within the previous year. Eight in 10 women who experienced IPV met the criteria for severe distress.⁴ Coercive control is also an important risk factor for psychological distress. Forced or child marriage was one of the largest factors for psychological distress with immense pressure

on girl brides, affecting their relationship to the spouse and their future children.

More Syrian women than Lebanese women met the criteria for severe psychological distress. This difference was explained in focus groups as stemming from pressure or worry (expressed in Arabic as *daghet*) resulting from financial and family stress, uncertainty about the present and future, family separation, and stigma associated with refugee status. Having a serious problem in even just one dimension of environmental vulnerability was associated with a significantly higher rate of severe psychological distress compared with those who had no serious problems. The number of vulnerabilities causing serious problems was significantly associated with increased rates of severe psychological distress.

Both Lebanese and Syrian women mentioned the mutually reinforcing nature of physical health and mental health, and how having chronic illnesses or physical ailments can prevent them from taking care of themselves, as well as how mental health can manifest as physical symptoms.

Women's responses

More Syrian women sought services in response to violence, primarily psychosocial support or mental health services, whereas Lebanese women sought more education and vocational training. The primary barrier to seeking services was that women simply did not know services were available, followed by the belief that they did not need services to address violence. Similarly, the primary supporting factor for seeking help was to have services clearly targeted to people of their background or status, particularly for the Syrian women. This

relates to how services are advertised, where they are located (for example, whether they are located in town centres or close to the settlements where refugees live), and how they are structured (for example, whether offered as standalone centres or within government-run 'one-stop' centres alongside a number of other service providers).

Most of the women looked for comfort in their religion to cope with violence. Prayer was the only common coping mechanism among survey and focus group participants. One woman described her experience in using spirituality to cope with daily experiences: "I go up to the edge of the valley, and I talk to God. I sit down, drink a cup of herbal tea, smoke a cigarette, scream my lungs out, and then go back."

Coping mechanisms reported as helpful were finding employment, engaging community leaders responsible for security in the informal tented settlements, and using pain relief or other medication. About three-quarters reported seeking advice about what to do and found emotional support from people close to them helpful. Crying or letting it out were described as "of no use" because the "sorrow remains inside."

Anecdotal evidence from ABAAD's staff suggests that vulnerabilities have significantly increased among all residents of Lebanon since data collection in May 2019, with many losing their income, and women reporting higher rates of GBV and psychological distress. This has been further exacerbated since the explosion in Beirut on 4th August 2020 and the outbreak of the COVID-19 pandemic, which accelerated Lebanon's economic collapse, isolated GBV survivors with their perpetrators, and created physical barriers between affected persons and their support systems. In addition, many services have been suspended or adapted during the pandemic, leaving survivors with limited access.

The focus group discussions yielded words such as *daghet*, which can be loosely translated as pressure or worry, and *ghadab*, anger or fury, as feelings associated with poor mental health. While in English these terms may not indicate mental health

struggles, in this context people tend to understate their symptoms because of stigma and social pressure to "stay strong" or "pull oneself together" (*shedde halik*).

Recommendations

Service providers should seek to provide holistic, low- or no-cost GBV and MHPSS services, with support for referrals, in safe locations, and co-locating them as appropriate (to reduce transport costs). Safe transportation and childcare should be provided whenever possible. Referral pathways between GBV and MHPSS providers can be further augmented by ensuring age-appropriate services. Services such as psychosocial support were often available for younger and middle-aged adults, but were not always accessible to children, adolescents and older people.

Focus group participants referred to the immense stigma related to seeking mental health services, the lack of qualified service providers, and absence of confidential safe spaces in the camps as barriers to care. Novel approaches, such as mobile services with safe, confidential physical space for service provision, may address these concerns.

Awareness sessions are needed to address victim-blaming (blaming survivors of GBV for their experience – which further negatively impacts their mental health and also perpetuates stigma) and to target not only community members but also service providers themselves. GBV actors should continue to conduct community-level awareness sessions on gender and GBV, as well as recognising and responding to psychological distress, and offer supportive coping mechanisms. Trainings should include prevention and response to sexual exploitation and abuse, especially given the current economic crisis. GBV actors should continue to conduct awareness sessions on the negative physical, psychological and social effects of forced and early marriage. Community-based campaigns should undertake to de-stigmatise conversations about mental health using locally relevant terms. The terms used to describe mental health (or ill-health) among this population deviate from the mainstream

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terminology (such as depression, *ikti'eb*). Many participants in the focus groups understated their experiences with mental health by using softer terms or euphemisms (such as *daghet*) to describe more severe symptoms, for example of severe anxiety.

Ensuring services are clearly accessible to all can help address barriers to host community members, refugees and migrant domestic workers' access to services; many will have limited knowledge of such services and/or believe that they do not target their demographic.

Economic empowerment activities are important to counteract the effect of environmental vulnerabilities. Such programmes should actively minimise the risk of GBV resulting from the challenge that a woman's income may pose to dominant gender roles by undertaking a thorough gender and GBV assessment to inform programme design, monitoring and evaluation, with technical guidance from GBV actors.

Finally, it is important to recognise that refugees have specific vulnerabilities,

and may be more comfortable seeking support from service providers of a similar background when possible. Engaging Syrian members of humanitarian organisations in outreach or other services, or working with informal Syrian service providers or community leaders to build trust with refugee community members, could help address this.

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1. See also www.fmreview.org/detention/anani
2. Research institute based at the George Washington University <https://globalwomensinstitute.gwu.edu/>
3. Peer-reviewed publication of full results forthcoming.
4. The K6+ assessment tool was used to measure psychological distress. See Segal S P, Khoury V C, Salah R and Ghannam J (2018) 'Contributors to Screening Positive for Mental Illness in Lebanon's Shatila Palestinian Refugee Camp', *The Journal of Nervous and Mental Disease* 206(1) <https://pubmed.ncbi.nlm.nih.gov/28976407>