Assessment of Gender-Based Violence Risks, Needs and Service Gaps during the 2026 Emergency in Lebanon

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List of Acronyms

BML: Beirut and Mount Lebanon

CFM: Complaints and Feedback Mechanism

CM: Case Management

CMR: Clinical Management of Rape

CS: Collective Shelters

CSO: Civil Society Organization

DRM: Disaster Risk Management

EMS: Emergency Medical Services

ERNA: Emergency Rapid Needs Assessment

FGD: Focus Group Discussion

FHH: Female-Headed Household

GBV: Gender-Based Violence

GBVIMS: Gender-Based Violence Information Management System

IDP: Internally Displaced Person

IOM: International Organization for Migration

IPV: Intimate Partner Violence

ITS: Informal Tented Settlement

KII: Key Informant Interview

LGBTQI+: Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, plus

MHPSS: Mental Health and Psychosocial Support

MoL: Ministry of Labor

MoSA: Ministry of Social Affairs

NGO: Non-Governmental Organization

PHC: Primary Healthcare Centre

PSEA: Protection from Sexual Exploitation and Abuse

SDC: Social Development Center

SOGIESC: Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics

SRH: Sexual and Reproductive Health

SRHR: Sexual and Reproductive Health and Rights

STI: Sexually Transmitted Infection

UXO: Unexploded Ordnance

WASH: Water, Sanitation and Hygiene

WGSS: Women and Girls Safe Space

WLO: Women-led Organizations

Executive Summary

Introduction

The escalation of hostilities in Lebanon beginning on 2 March 2026, following regional military developments and the conflict between the US and Iran, triggered large-scale displacement and a rapid deterioration of humanitarian conditions across the country. Within days, displacement exceeded one million people, with affected populations facing significant challenges in accessing safe and affordable accommodation, essential services, and basic infrastructure.

While a portion of displaced populations sought refuge in collective shelters, the vast majority, estimated at more than 85 per cent, resided outside formal collective sites, including in rented accommodation, hosted arrangements, unfinished buildings, informal settlements, and other precarious living conditions. The identification, registration, and service provision for displaced populations living outside collective shelters presented considerable operational challenges due to limited outreach capacity, fragmented coordination mechanisms, and the absence of comprehensive tracking systems.[1]

The conflict has significantly impacted the protection environment, exposing displaced Lebanese populations, Syrian refugees, Palestine refugees from Lebanon and Syria, migrant workers, and host communities to heightened protection risks, including increased exposure to gender-based violence (GBV).

Reports from GBV service providers and humanitarian partners indicated a deterioration in safety, increased stressors within households and communities, overcrowded living conditions, and reduced access to protection services. However, limited evidence existed regarding the specific experiences and risks faced by women and girls residing outside collective shelters. In response, UNFPA, CARE International in Lebanon, and HDA jointly conducted a dedicated assessment to better understand the evolving GBV risks, barriers to service access, and response priorities among conflict-affected populations.

The assessment was conducted following the announcement of the ceasefire on 17 April 2026. Data collection took place within a context marked by recent displacement, ongoing insecurity, and significant psychosocial distress among affected populations. Contextual information reflected in the report was updated through 15 July 2026.

Methodology

The assessment employed a purposive qualitative sampling approach to capture the lived experiences, protection concerns, and service access barriers of women and girls affected by conflict and displacement, with a particular focus on those residing outside collective shelters.

Data collection was conducted between 29 April and 18 May 2026 through:

- 33 Focus Group Discussions (FGDs);
- 19 Key Informant Interviews (KIIs); and
- 7 additional interviews facilitated by GBV Working Group partners.

Participants included displaced Lebanese women and girls, Syrian refugees, Palestine refugees, migrant women, women from host communities, service providers, and representatives supporting marginalized and at-risk groups. Analysis followed a hybrid qualitative methodology combining AI-assisted thematic analysis

[1] DRM Reports (March - 16 July 2026), and IOM Displacement Tracking Monitoring (July 2026)

with expert review and validation by GBV practitioners to ensure contextual accuracy, survivor-centred interpretation, and trauma-informed analysis.

Key Findings

Based on the qualitative data from the 33 focus group discussions (FGDs) and 19 key informant interviews (KIIs), the following key findings were identified:

1. **Conflict and displacement significantly increased exposure to GBV risks**

The conflict and mass displacement exacerbated pre-existing gender inequalities and created new protection threats for women and girls across all affected population groups.

Loss of privacy and dignity: Women and girls living in overcrowded accommodation arrangements, shared housing, informal settlements, or collective environments reported severe loss of privacy, personal autonomy, and dignity. The lack of gender-sensitive shelter arrangements and inadequate partitioning heightened discomfort, stress, and protection risks. Women and girls who wear hijab reported remaining fully covered at all times, including during sleep, due to the presence of unrelated men and their fear of harassment and shame within living spaces.

Unsafe accommodation and exclusion: Displaced Syrian, Palestinian, and migrant women reported actual or perceived discrimination when seeking accommodation, including denial of access to shelters, exploitation by landlords, and unequal treatment based on nationality or legal status.

Increased domestic violence and household tensions: Participants consistently reported an increase in intimate partner violence (IPV), emotional abuse, and family conflict. These trends were linked to income loss, unemployment, psychological distress, overcrowding, and prolonged displacement.

Movement restrictions and safety concerns: Women and girls reported restricting their movement to daylight hours due to inadequate street lighting, security concerns, fear of harassment, and perceived risks of kidnapping or sexual violence. These restrictions further reduced access to services, livelihoods, social networks, and support systems.

Heightened and systemic risks for groups facing intersecting vulnerabilities: Age, gender and diversity has a profound impact on exposure to risks and ability to cope or seek protection. Women and girls with disabilities faced particularly severe risks, including inaccessible evacuation routes, inadequate shelter infrastructure, and barriers to service access. Adolescent girls experienced increased isolation, interruption of education, and elevated risks of child marriage. Organizations supporting individuals with diverse gender identities and sexual orientations reported heightened isolation, targeted hostility, and limited access to trusted protection mechanisms.

2. **Conflict exacerbated barriers to GBV disclosure, reporting, and service access**

The assessment found that women and girls faced multiple, overlapping barriers that hindered access to GBV services and reduced opportunities for safe disclosure.

Physical barriers included:

- Insecurity and restrictions on movement;
- Damaged infrastructure and unsafe transportation routes;
- Lack of accessible facilities; and

- High transportation costs
- **Social and cultural barriers included:**
- Harmful gender norms;
- Survivor-blaming attitudes;
- Fear of stigma, discrimination, or retaliation;
- Dependence on abusive family members or partners; and
- Social isolation

Administrative barriers included:

- Lack of legal documentation;
- Limited awareness of available services; and
- Insufficient dissemination of information regarding GBV risks and referral pathways

These factors collectively reduced help-seeking behaviour, delayed access to life-saving services, and increased exposure to ongoing abuse.

3. GBV service providers experienced substantial operational disruptions

Workforce displacement and psychosocial strain: Many GBV personnel were themselves displaced and affected by the conflict. Service providers reported elevated levels of stress, burnout, secondary trauma, and compassion fatigue resulting from prolonged emergency response demands, high caseloads, and repeated cycles of escalation with limited opportunity for recovery.

Closure and destruction of service infrastructure: Hostilities resulted in the closure, relocation, or destruction of Women and Girls Safe Spaces (WGSS), field offices, and service delivery points, particularly in South Lebanon, Nabatiyeh, and the Southern Suburbs of Beirut. This reduced the number of safe and confidential spaces available for service provision and survivor disclosure.

Logistical and transportation barriers: Insecurity, transportation shortages, and limited financial resources restricted the ability of staff to reach hard-to-reach areas and hindered survivors' access to available services. Conflict-related security concerns also disrupted evacuation movements and reduced the availability of affordable transportation options.

Limitations of remote service delivery: While remote modalities supported continuity of services in some contexts, both survivors and service providers emphasized a strong preference for in-person services. Remote approaches often failed to provide adequate privacy and safety for confidential disclosure, particularly in overcrowded settings where survivors were living with family members or potential perpetrators.

Funding constraints and inability to scale response: Chronic underfunding significantly constrained service expansion during the emergency. Funding limitations affected case management capacity, protection cash assistance, integrated mental health and psychosocial support (MHPSS), mobile outreach deployment, staffing, and the provision of essential items such as dignity kits.

4. Coordination and outreach challenges limited protection coverage

Difficulty identifying and reaching displaced populations outside collective shelters: The response architecture heavily focused on populations residing in collective shelters despite the majority of displaced persons living elsewhere. As a result, many displaced women and girls residing in private accommodation, informal settlements, and hosted arrangements remained difficult to identify and underserved by humanitarian actors. More efforts should be made by all responsible response actors to address those challenges that created access gaps.

Referral pathway challenges: Key informants reported that referral pathways often remain overly technical and difficult for communities and non-specialized actors to navigate. Language barriers, excessive reliance on QR codes, and complex referral documentation reduced the effectiveness of community-based referrals and early identification efforts.

Administrative and coordination bottlenecks: Local organizations highlighted administrative burdens and lengthy approval processes for activities implemented outside collective shelters. These challenges limited the speed and flexibility of humanitarian responses.

Insufficient integration of protection across sectors: Participants reported that protection and GBV risk mitigation were frequently treated as secondary priorities compared to shelter, food assistance, and other immediate needs. This limited the systematic integration of GBV risk mitigation measures across humanitarian response sectors.

Key Recommendations

1. Prioritize and expand specialized GBV services

Maintain and scale up Women and Girls Safe Spaces (WGSS), mobile service delivery, and face-to-face case management to ensure survivors have access to confidential, safe, and survivor-centred support. Remote modalities should only be used when security conditions prevent in-person access.

2. Strengthen outreach to populations outside collective shelters

Invest in community-based identification, mobile outreach teams, door-to-door engagement, and localized service delivery models to systematically reach women and girls residing in hosted accommodation, rented housing, informal settlements, and other non-collective settings.

3. Ensure disability-inclusive, adolescent-responsive, and age-sensitive programming

Allocate dedicated resources to address the specific needs and risks faced by adolescent girls, older women, women and girls with disabilities, and other groups facing intersecting forms of vulnerability. Accessibility considerations should be integrated across all stages of service design and implementation.

4. Strengthen frontline workforce wellbeing and surge capacity

Expand staff care initiatives, psychosocial support mechanisms, supervision structures, and emergency surge capacity to address burnout, secondary trauma, and workforce depletion during periods of heightened emergency response.

For All Humanitarian Actors

5. **Institutionalize GBV risk mitigation across all sectors:** Ensure that GBV risk mitigation is systematically integrated into emergency shelter, WASH, food security, health, cash, and education interventions. Mandatory safety audits, participatory safety mapping, and "Do No Harm" approaches should be embedded throughout programme design and implementation.

6. **Apply conflict-sensitive and equitable aid allocation approaches**

   Ensure humanitarian assistance reaches both displaced populations and vulnerable host communities in order to reduce tensions, perceptions of inequity, and associated protection risks, including GBV.

7. **Simplify referral pathways and strengthen safe disclosures and referrals**

   Develop community-friendly referral mechanisms that are accessible, multilingual, and easy to navigate. Strengthen the capacity of non-specialized frontline workers to identify protection risks and facilitate safe, survivor-centred referrals.

For Donors

8. **Provide predictable, flexible, and multi-year funding**

   Increase dedicated funding for life-saving GBV programming, including case management, MHPSS, protection cash assistance, safe spaces, mobile outreach services, and emergency preparedness. Flexible funding mechanisms are critical to enable rapid adaptation during periods of escalation and displacement.

For Government Authorities and Municipal Actors

9. **Improve safety, accessibility, and public infrastructure**

   Prioritize the rehabilitation of public infrastructure, including street lighting, transportation networks, and public facilities in high-risk areas. Ensure WASH facilities are safe, well-lit, sex-segregated, accessible for persons with disabilities, and designed in consultation with women, girls, and marginalized groups.

10. **Facilitate humanitarian access and service delivery**

    Streamline approval processes and coordination procedures to facilitate timely humanitarian interventions, particularly for outreach and protection activities targeting displaced populations residing outside collective shelters.

Conclusion

The 2026 conflict and large-scale displacement crisis have significantly heightened GBV risks while simultaneously weakening the systems intended to protect and support women and girls. Those residing outside collective shelters remain particularly difficult to identify and reach, resulting in critical protection gaps. Addressing these challenges requires sustained investment in specialized GBV services, strengthened outreach and referral mechanisms, meaningful integration of GBV risk mitigation across all humanitarian sectors, and predictable multi-year funding. Without urgent action and adequate financial support, women and girls will continue to face elevated protection risks and reduced access to life-saving support and services.

1. Introduction

The escalation of hostilities in 2026 in Lebanon has resulted in widespread displacement, destruction of infrastructure, disruption of essential services, and heightened protection concerns. As consistently observed across humanitarian settings, emergencies exacerbate pre-existing gender inequalities and significantly increase the risk of GBV, particularly for women and girls. Attacks on civilians resulting in displacement, destruction and loss of housing and properties, economic hardship, reduced livelihood opportunities, overcrowded shelters, family separation, and the breakdown of community protection mechanisms contribute to heightened exposure to various forms of violence while simultaneously reducing survivors' access to life-saving services.

1.1 Context and Background

Crisis overview

Since the war onset on March 2, 2026, the humanitarian situation has severely worsened, marked by massive displacement and escalating hostilities. From the start of the escalation to 6 July 2026, the Disaster Risk Management (DRM) daily situation report indicates that a total of 26,782 hostilities have been recorded, resulting in 4,305 cumulative fatalities.[2] Between March and July 2026, the internally displaced person (IDP) population experienced significant fluctuations due to the political developments, peaking at over 1.2 million individuals in mid-April before declining to approximately 430,000 by early July following another ceasefire agreement being announced. Throughout this conflict, a staggering majority of these displaced individuals consistently between 80% and 93% have been residing outside of collective shelters.[3]

The geographic scope of displacement is widespread, with the majority of displacement originating from the El Nabatieh and South Governorates, Bekaa, Baalbeck-El Hermel and the Southern suburbs of Beirut. Most IDPs have moved toward Beirut and Mount Lebanon, the North or even to other areas in the South and the Bekaa. The humanitarian response is strained by the sharp change in the scale of the needs due to the large scale of the movement, including the displacement of humanitarian personnel. The vast majority of displaced people resided outside of collective shelters, often in host communities, overcrowded rented apartments, or informal public spaces.[4] Informal sites include unfinished buildings or collective centres not formally designated as shelters, etc.[5] Some people are also residing on the streets, the sidewalks or inside their cars.

Affected communities, including older persons, persons with disabilities, single caregivers, women and adolescent girls, and people with financial difficulties, also face a collapsing social support system, as

[2] DRM Daily Situation Report June 10th 2026
[3] International Organization for Migration. (2026, July). DTM Mobility Snapshot, Round 107, IOM Lebanon and MoSA Daily Situation Reports from March 3rd Until July 8, 2026
[4] UNHCR (2026). Middle East situation Lebanon - Flash update #3 16-22 March 2026
[5] UN Women. (2026). Rapid gender analysis: Gendered impacts of displacement outside collective shelters in Lebanon

prolonged displacement and shifting demographics continue to affect traditional community safety nets. Children and women make up the vast majority of individuals in need of protection given their heightened risks to violence, neglect, harassment and abuse.[6] Within this displaced population, roughly 16,000 pregnant women[7] are now enduring highly unstable environments, with many likely to go into labor under highly difficult conditions.[8] Reports and consultations with affected communities further highlighted the disproportionate exposure of persons with disabilities to protection risks, including significant barriers to accessing essential services. Among internally displaced persons (IDPs) residing in collective shelters, 1,200 individuals were identified with physical disabilities, while 661 were reported to have intellectual, hearing, or visual impairments. Of these, 386 women were reported with hearing impairments and 392 women with visual impairments.[9] While these figures reflect the situation within monitored collective shelters, similar challenges are likely experienced by IDPs living outside formal shelter settings, where conditions remain largely unmonitored. At the same time, the relatively low number of identified persons with disabilities may point to gaps in disability identification and referral mechanisms among service providers and site management teams, potentially resulting in unmet needs and barriers to accessing appropriate support.

Humanitarian situation

The humanitarian situation in 2026 has deteriorated significantly compared to the context following the 2024 conflict. [10] The response capacity was already weakened by substantial funding cuts throughout 2025, which led to a reduction in humanitarian assistance, the closure of facilities, and the suspension of critical and specialized services before the onset of the 2026 crisis. As a result, humanitarian actors entered the current emergency with diminished operational capacity and reduced resources to respond to growing needs. The situation has been further exacerbated by persistent funding shortfalls and resource depletion, creating an increasingly constrained operating environment. At the same time, protracted displacement has continued to place significant pressure on affected populations, particularly those unable to return to their areas of origin due to widespread destruction of housing and infrastructure or because their communities remain inaccessible. Collectively, these factors have deepened vulnerabilities and heightened protection risks, contributing to a more severe and complex humanitarian crisis than that experienced in 2024.

The 2026 crisis is characterized by displacement levels and destruction patterns that exceed those observed during the 2024 conflict. Across South and Nabatiyeh Governorates, at least 37,836 housing units have been destroyed or severely damaged,[11] while an additional 3,168 housing units in Beirut's Southern Suburbs were reportedly destroyed through targeted attacks[12], where a single day of

[6] PAMTF: Lebanon Protection Snapshot: Displacement Post Escalation, April 1-16, 2026
[7] UNFPA: Lebanon Situation Report, May 16 to June 8, 2026.
[8] UNFPA, Crisis Deepens for Women and Girls as Middle East War Enters Second Month (April, 2026).
[9] WHO: Lebanon Health Emergency Situation Update # 27, June 11, 2026
[10] IOM: Displacement Tracking Matrix Mobility Snapshot – Round 65 Report Production Date: 25 November 2024
[11] Libnanews: 37836 affected housing units in Lebanon - April 2026
[12] UNDP: Rapid Damage Assessment Estimates Over US$365 Million in Building Damage Across Beirut and Mount Lebanon, June 2026.

re-escalated hostilities in June 2026 alone forced an estimated 200,000 people to flee.[13] The scale and intensity of hostilities have triggered repeated waves of displacement, including an estimated 200,000 people displaced in a single day during the re-escalation of violence in June 2026.

This scale of destruction, combined with active evacuation orders affecting over 17 localities across the South, Nabatiyeh, and Bekaa Governorates, actively prevented many from returning. Furthermore, the established military buffer zone along the border remains inaccessible for returns, indicating a more protracted and prolonged displacement timeline than what was experienced during the 2024 crisis. Following the initial April 17, 2026 ceasefire announcement, Lebanon's protection environment remains highly volatile as attacks remained in most of the South and Nabatiyeh governorates as well as the South of West Bekaa. Although the diplomatic framework for pilot zones was renewed in early June, it remains extremely fragile, as persistent airstrikes and new evacuation orders frequently interrupt the ceasefire.

Consequently, displacement patterns are fluid, and movements remain cautious and uneven.[14] Based on the IOM Displacement Tracking Monitoring (DTM) which uses official resources to record and track movement of the displaced populations, about 646,107 displaced people have begun returning to their areas of origin, with the largest share heading to the South and Nabatiyeh governorates.[15] However, safe and sustainable returns are severely hindered by the presence of unexploded ordnance (UXO) and extensive damage to housing, infrastructure, and essential services.[16]

As a result, rather than returning permanently, many households are undertaking temporary "go-and-see" visits to assess destruction levels and security conditions.[17] This has its own operational risks; while some heads of households travel alone on these preliminary assessments, families who do return often find their homes uninhabitable, forcing them into secondary displacement within newly established shelters closer to their areas of origin. Meanwhile, the populations remaining in overcrowded hosting areas face severe challenges. These include persistent psychological distress, an increasing reliance on harmful coping mechanisms, and heightened risks of gender-based violence and exploitation.[18] This ongoing volatility and vulnerability necessitate a scaled-up, sustained humanitarian and protection response.

Gender-Based Violence (GBV) Risks and Vulnerabilities

Women and girls account for more than half of the displaced population.[19] Displacement conditions, including overcrowded shelters, inadequate lighting, limited privacy, and the absence of sex-segregated sanitation facilities, have significantly increased exposure to gender-based violence (GBV) and

[13] OCHA Lebanon: Flash Update #33 - Escalation of hostilities in Lebanon, June 8, 2026.
[14] Ibid
[15] IOM, DTM Mobility Snapshot Round 106 July 2, 2026
[16] UNFPA, UNHCR & UNICEF Lebanon 2026 Protection Emergency Response Situation Report #6 - Reporting period 2 March to 24 April 2026
[17] UNFPA Situation Report on the crisis in Lebanon (23 June - 7 July 2026)
[18] UNFPA, UNHCR & UNICEF Lebanon 2026 Protection Emergency Response Situation Report #6 - Reporting period 2 March to 24 April 2026
[19] OCHA, Lebanon: Flash Update #42 - Escalation of Hostilities in Lebanon (as of 9 July 2026)

reproductive health risks.[20] At the same time, the conflict has exacerbated existing GBV vulnerabilities while creating additional barriers to safe disclosure, timely referrals, and access to quality, survivor-centered services. In both collective shelters and shared housing arrangements, extreme overcrowding and a lack of privacy have intensified threats of GBV, exploitation, and isolation. These risks are further compounded for women, girls, and individuals of marginalized groups who face intersectional barriers, such as women with disabilities, migrant women, adolescent girls and individuals of diverse gender identities. Women and girls with disabilities are disproportionately at risk, as most shelters are inaccessible and lack essential services.[21]

In informal and precarious displacement sites, systemic safety deficits, including the lack of gender-segregated facilities, poor lighting, and the absence of locks in shared toilets, significantly increase exposure to the risk of GBV, while restricting personal autonomy and possibly increasing dependence on household members' support for an increased sense of safety.[22]

A retrospective analysis of the protection landscape reveals the depth of these pre-existing vulnerabilities. Data from 2024 demonstrates how the crisis, insecurity, displacement, economic collapse and service disruption interacted to exacerbate GBV risks.[23] Furthermore, the 2025 data highlights a subsequent increase in reporting, which may reflect lingering impact of the crisis on service access and delayed incident disclosures. Collectively, these data points demonstrate that prior to the 2026 escalation, Lebanon's protection framework was already severely compromised.[24]

Service Disruption

Driven by acute funding shortfalls and prolonged conflict since 2024, GBV services face significant disruptions. The 2024 GBV Safety Audit undertaken by the GBV WG in Lebanon[25] revealed major prevention and response gaps, with specialized care severely limited in rural and conflict-affected regions. Existing services frequently lacked necessary adaptations for persons with disabilities or other marginalized groups. Furthermore, the closure or phasing out of static facilities due to the emergency heavily disrupted case management, requiring complex transition planning to maintain continuity. Finally, distrust in legal frameworks and fear of retaliation deterred survivors from seeking support, a critical trend that requires further assessment within the 2026 crisis context.

The escalation of hostilities in 2026 has severely disrupted service availability and reporting pathways for Gender-Based Violence (GBV). According to the GBVIMS 2026 Q1 Report[26] and comparative narrative reports, a drastic 96% reduction in incidents reported by GBVIMS service providers in March was

[20] UNFPA, Situation Report on the Crisis in Lebanon (9 June-22 June 2026)
[21] UNFPA, Crisis Deepens for Women and Girls as Middle East War Enters Second Month (April, 2026)
[22] UN Women 2026 Rapid Gender Analysis
[23] UNHCR Lebanon: Protection Monitoring Findings - Q4 2024 (March 2025)
[24] GBVIMS Annual Report 2025
[25] Gender-Based Violence Working Group - Lebanon. (2024). GBV safety audit - Lebanon
[26] GBVIMS TF Lebanon: Impact of the Current Conflict on Gender-Based Violence (GBV) Risks and Needs in Lebanon, Q1 Analysis, 2026.

followed by a 76% increase in April.[27] These fluctuations do not reflect actual changes in incident rates, but may reflect structural barriers such as infrastructure damage, staff displacement, and survivors prioritizing immediate survival or delaying disclosure due to security concerns and a lack of service awareness or trust. This data also underscores that reporting is often delayed during the initial onset of a crisis as survivors face significant obstacles in accessing psychosocial, health, and legal support.

Furthermore, cross-border hostilities have severely compromised health sector logistics, resulting in 201 attacks on healthcare infrastructure, the deaths of 134 healthcare personnel on duty, and the injury of 391 between March and June 2026, shutting down critical referral points.[28] During the ceasefire period, eleven Emergency Medical Services (EMS) centers were targeted, 48 rescue vehicles were damaged, and 13 attacks on hospitals were reported. Since 2 March 2026, seventeen hospitals have sustained mild and massive physical damage, with some hospitals sustaining more than one attack. On 3 June 2026, a public warning was issued regarding the only remaining operational facility in the Bint Jbeil district, providing critical emergency, trauma, and referral services. The hospital hosts humanitarian actors and serves as a key emergency response hub. The reported damage, attacks, and subsequent evacuations have had far-reaching humanitarian consequences, significantly reducing access to essential healthcare services for affected populations and depriving communities of lifesaving medical care.[29] The destruction of health infrastructure further disrupts referral pathways for GBV survivors, creating additional barriers to accessing time-sensitive Clinical Management of Rape (CMR) and essential sexual and reproductive health services. As a result, survivor safety is compromised, access to critical care is delayed, and the collection of vital medical-legal documentation is significantly constrained.

Funding Situation

Under the 2026 Lebanon Emergency Flash Appeal (2 March-31 May), the Protection Sector requested USD 26.6 million to deliver critical protection interventions; however, by the close of the appeal period, only 47.8 per cent of the required funding had been secured. Within the sector, the GBV Working Group appealed for USD 11.4 million but received just 19.7 per cent of its funding requirements. This significant financing gap is particularly concerning given the heightened protection risks and increased exposure to GBV faced by women and girls during the crisis. While overall humanitarian funding coverage across coordinated response plans reached approximately 46 per cent, funding for GBV programming remained disproportionately low, highlighting a persistent underinvestment in services and interventions despite escalating needs.[30]

The substantial funding shortfall continues to jeopardize both the continuity and expansion of critical GBV prevention, risk mitigation, and response interventions. To sustain and scale up these services during the June-August 2026 response period, the GBV Working Group requested an additional USD 12.2 million under the revised Flash Appeal. These resources are essential to maintain lifesaving GBV case management and referral services, mobile outreach activities, women and girls' safe spaces, and the

[27] GBVIMS Lebanon: Comparative Narrative Analysis: March – April 2026, June 2026.
[28] OCHA Lebanon: Flash Update #33 - Escalation of hostilities in Lebanon, June 8, 2026.
[29] WHO: Lebanon Health Emergency Situation Update #26, June 4, 2026
[30] OCHA, Financial Tracking Services, Lebanon Flash Appeal 2026

distribution of dignity kits, while ensuring that the response remains accessible to the most vulnerable women and girls affected by the crisis. Despite severe funding constraints, GBV actors reached 73,063 individuals between March and May 2026, including through the distribution of 29,109 dignity kits, the provision of 477 emergency cash assistance grants, 40,199 awareness-raising and information sessions, and 3,278 mental health and psychosocial support (MHPSS) interventions, including community-based psychosocial support services. These achievements underscore both the scale of GBV-related needs and the importance of sustained investment to prevent service disruptions at a time when protection risks remain heightened.[31]

Even before the escalation of the conflict in 2026, the humanitarian response in Lebanon was operating under severe strain due to protracted funding shortfalls and a highly challenging operational environment. This chronic underfunding significantly weakened service delivery capacity across sectors, forcing the closure, suspension, or gradual phase-out of critical protection services, including Women and Girls Safe Spaces. As a result, vulnerable women and girls faced reduced access to safe entry points for support, information, and referrals, while the continuity of essential GBV prevention, risk mitigation, and response services was increasingly compromised. These constraints further limited the ability of humanitarian actors to adequately respond to rising protection needs and heightened GBV risks during the subsequent conflict escalation.

These funding shortfalls significantly constrained the Protection Sector's and GBV Working Group's ability to scale up interventions in response to conflict-driven needs. Limited resources affected the expansion of lifesaving GBV prevention, risk mitigation, and response services at a time when displacement, insecurity, and disruptions to essential services were increasing protection risks. The funding gap also reduced the capacity of partners to strengthen outreach, case management, safe spaces, referral mechanisms, and specialized support services for survivors, leaving many women and girls with unmet protection needs. As the crisis evolved, the mismatch between growing needs and available resources further challenged the subsector's ability to ensure timely, accessible, and survivor-centered assistance for affected populations.

1.2 Objectives of the GBV Assessment

This specialized GBV assessment aims to inform humanitarian programming and advocacy through an evidence-based qualitative analysis of the evolving protection environment, including GBV risks, priority needs, and service delivery gaps affecting displaced women and girls living outside collective shelters, as well as vulnerable members of host communities impacted by the 2026 escalation of hostilities.

Specific objectives include:

- **Assessing the impact of the conflict on women and girls at risk of GBV and GBV survivors**: Examine how the escalation of hostilities has affected the safety, wellbeing, and coping capacities of affected populations, and identify their priority needs, concerns, and barriers to accessing assistance and protection services.

[31] Activity Info Reporting - GBV Working Group June 2026

- **Identifying key GBV risks and populations at heightened risk**: Analyze prevailing and emerging GBV risks, risk drivers, and trends, with particular attention to population groups experiencing heightened vulnerabilities and intersecting forms of risk and exclusion.
- **Analyzing GBV service delivery and response capacity**: Assess the availability, quality, and continuity of GBV services, including organizational response capacity, geographic coverage, and service gaps, as well as the appropriateness, feasibility, safety, and perceived accessibility of different service delivery modalities.
- **Assessing barriers to accessing GBV services**: Identify the physical, financial, social, cultural, and safety-related factors that impede access to timely, safe, and survivor-centred GBV services and referrals.
- **Generating actionable recommendations**: Develop evidence-based recommendations to strengthen and adapt GBV and broader humanitarian programming, including geographic prioritization, resource allocation, service delivery modalities, and strategies to address identified protection risks and service gaps.

The findings are intended to inform humanitarian decision-making and support humanitarian actors, government counterparts, donors, and coordination mechanisms in strengthening evidence-based GBV prevention, risk mitigation, and survivor-centred response interventions throughout the emergency. Through the identification of priority needs, operational constraints, and emerging protection concerns, the assessment will contribute to more effective, targeted, and accountable humanitarian programming for women and girls affected by the crisis.[32]

2. Methodology

2.1 Data Collection

To support a diverse and intersectional qualitative understanding of GBV risks, the assessment employed a purposive sampling strategy to capture diverse demographic groups and nationalities, including displaced Lebanese, Syrian, Palestinian, and migrant populations residing outside collective shelters and host communities.

Specific emphasis was placed on highly marginalized and at-risk demographics, ensuring the inclusion of the below groups:

- Displaced Female-headed households (FHH)
- Displaced adolescent girls and boys
- Displaced older women

[32] This assessment employed a rigorous qualitative methodology to analyze the protection landscape, relying on data collected through focus group discussions and key informant interviews with diverse stakeholders. Initial drafting of the desk review took place before the ceasefire on April 17th, whereas data collection occurred afterwards from 29 April till 18 May 2026, affecting the interpretation and understanding of the findings. Furthermore, context updates and displacement figures were last updated on 15 July, 2026.

- Displaced women and girls with disabilities, and caregivers of persons with disabilities
- Displaced migrant domestic workers
- Displaced LGBTQI+ persons
- Host community members
- Men and the impact of the conflict on gender-norms

Because a vast majority of displaced individuals reside outside formal collective sites, the GBV Assessment targeted populations across various alternative accommodations, including rented apartments, hosted arrangements, street-based conditions, informal tented settlements, and precarious dwellings. By focusing on displaced women and girls residing outside collective shelters, the methodology focuses on the inclusion of marginalized cohorts that frequently remain invisible during standard shelter audits.

Data collection was conducted in Arabic and adhered to rigorous safeguarding procedures, including the implementation of distress protocols and the systematic provision of referral information to all participants. To maintain the highest ethical standards, all facilitators underwent specialized training to ensure the safe and trauma-informed management of sensitive disclosures.

The GBV Assessment employed a qualitative methodology comprising 33 focus group discussions (FGDs), 19 key informant interviews (KIIs), and 7 individual interviews. Data collection included 31 FGDs, 6 interviews with displaced women experiencing shelter insecurity, and 1 interview with an affected displaced adolescent girl. Additionally, 19 KIIs were conducted with caseworkers, GBV specialists, GBV focal points, coordinators, and local authorities. To further capture response and community perspectives, 2 additional FGDs were held with displaced caseworkers and representatives of women-led organizations.

A total of 348 respondents participated in the assessment and were grouped into two primary cohorts: **affected people** (292 individuals) and **other stakeholders** (56 individuals). Detailed respondent profiles are provided in Annex 1.

Data Collection was facilitated by 16 GBV WG partners including UNFPA, CARE International in Lebanon , UN Women, HDA, INTERSOS, Amel Association, Tabitha, LUPD, SIDC, Kafa, LECORVAW, AND, IRC, UNHCR, Abaad, Nabaa. Data Collection started on 29 April and was concluded on 18 May, 2026.

2.2 Data Analysis

A structured qualitative thematic analysis approach was employed to systematically synthesize and interpret the assessment findings. The analytical process comprised four main stages:

1. Data Processing and Preparation

Facilitators compiled structured debriefing notes and generated transcripts from all focus group discussions (FGDs) and key informant interviews (KIIs). To facilitate standardized analysis, concise two-page summary reports were developed for each FGD and KII using a uniform reporting template. Prior to analysis, all personally identifiable information was removed, and only anonymized and

de-identified data were utilized. AI-assisted processing was conducted exclusively on anonymized datasets, in accordance with data protection, confidentiality, informed consent, and data minimization principles.

2. Hybrid Qualitative Analysis

The assessment adopted a dual-stream analytical methodology that combined AI-assisted processing with independent human-led qualitative analysis. All anonymized FGD and KII datasets were processed using Gemini and NotebookLM to support the systematic review of large volumes of qualitative data.

AI tools were used to support the development of a Unified Qualitative Coding Framework and a Comparative Thematic Matrix, facilitating the identification of recurring patterns, thematic relationships, and variations across respondent groups and geographic locations. However, the interpretation of complex findings, particularly those related to socio-cultural norms, protection dynamics, trauma-informed analysis, and survivor-centred perspectives, remained firmly grounded in human-led review and validation.

This hybrid approach enhanced analytical efficiency and consistency while ensuring the contextual depth, critical reflection, and ethical sensitivity required for GBV-focused research.

3. Thematic Coding and Analysis

The dataset was subjected to inductive and deductive thematic coding to identify recurring patterns, emerging issues, and cross-cutting trends. The analysis focused on the following core thematic areas:

- **Displacement Dynamics and Housing Conditions:** Examination of how displacement patterns, overcrowding, inadequate shelter conditions, and loss of privacy contribute to increased GBV risks and protection concerns.
- **Economic Stressors and Negative Coping Mechanisms:** Analysis of the relationship between economic hardship, unemployment, rising housing costs, and resource deprivation, and the adoption of harmful coping strategies, including sexual exploitation, child labour, child marriage, and forced marriage.
- **Systemic Barriers and Service Delivery Gaps:** Assessment of challenges affecting access to GBV, legal, psychosocial, and sexual and reproductive health (SRH) services, including funding constraints, geographic disparities, inaccessible services, and disruptions in referral pathways.
- **Social Norms, Stigma, and Disclosure Barriers:** Exploration of how gender norms, stigma, survivor-blaming attitudes, fear of retaliation, and confidentiality concerns influence help-seeking behaviour and the reporting of GBV incidents.

4. Triangulation and Disaggregation

To strengthen the validity and credibility of findings, data were triangulated across multiple respondent groups, including internally displaced persons (IDPs), host community members, and service providers. Findings were further disaggregated by geographic location, displacement status, age, and other relevant

vulnerability factors to identify variations in risk exposure, service access, and protection needs across population groups.

An intersectional analytical lens was applied throughout the process to ensure that the distinct experiences and vulnerabilities of different groups of women and girls were adequately captured. This approach enabled the development of targeted, evidence-based recommendations tailored to identified protection risks, service gaps, and operational priorities.

2.3 Data Safety and Confidentiality

All data were systematically anonymized and de-identified prior to analysis to ensure the removal of any personally identifiable information. Only de-identified datasets were processed using AI-supported analytical tools. Throughout the assessment, data collection, storage, management, and analysis were conducted in strict adherence to data protection, confidentiality, and data minimization principles. Access to data was limited to authorized members of the assessment team, ensuring that participants' privacy and confidentiality were safeguarded in line with ethical standards for GBV research and the handling of sensitive information.

2.4 Limitations and Methodological Considerations

While this assessment provides an in-depth qualitative analysis of the evolving GBV and protection context, its findings should be interpreted in light of several methodological limitations and considerations. These limitations are inherent to rapid, emergency-focused qualitative assessments and should be taken into account when using the findings for strategic planning, program design, and resource allocation.

- **Qualitative Scope and Representativeness:**
  This assessment was designed to generate rich, contextualized insights into the experiences, perceptions, and priorities of affected populations rather than produce statistically representative findings. As such, the analysis reflects the specific social, cultural, and geographic contexts of the displaced and host community populations consulted. While the findings provide valuable evidence on emerging protection concerns, GBV risks, and service gaps, they are not intended to be generalized as representative of all affected populations across Lebanon.
- **Sensitivity of GBV and Risk of Underreporting:**
  As with all GBV-related research, the assessment is subject to a significant risk of underreporting. Social stigma, fear of retaliation, concerns regarding confidentiality, limited trust in reporting and service systems, and the desire to protect family or community reputation may discourage individuals from disclosing personal experiences or incidents known within their communities. Consequently, the findings should not be interpreted as an indication of GBV prevalence. Rather, they reflect participants' perceptions, experiences, and observations and are likely to underestimate the full scale, diversity, and severity of GBV-related risks and needs.
- **Variations in Data Collection Modalities:**
  Data collection employed a mixed-modality approach, combining in-person and remote

consultations to maximize coverage within the constraints of the emergency context. While remote interviews and discussions enabled participation from otherwise inaccessible locations, they were occasionally affected by power outages, connectivity challenges, and limited privacy. In overcrowded displacement settings, respondents may have been unable to speak freely about sensitive issues, potentially affecting the depth and richness of information collected through remote modalities compared with face-to-face consultations.

- **Reliance on Subjective Experiences and Perceptions:**
  The assessment intentionally prioritizes participants' lived experiences, perspectives, and self-identified priorities, recognizing affected women and girls as the primary experts on their own realities. Consequently, the findings reflect subjective viewpoints that may be influenced by individual experiences, local social norms, community dynamics, and varying levels of awareness and understanding of GBV-related concepts. While such perspectives are essential for contextual analysis, they should be interpreted within their respective social and cultural contexts.
- **Accessibility and Inclusion Constraints:**
  Despite deliberate efforts to engage marginalized and at-risk population groups, including persons with disabilities and undocumented migrants, some highly vulnerable individuals may remain underrepresented. Factors such as mobility restrictions, communication barriers, lack of safe access channels, social isolation, and concerns regarding safety or legal status may have limited their participation in the assessment process.
- **Limitations in Intersectional Representation:**
  The assessment sought to capture the experiences of diverse population groups, including persons with disabilities, adolescent girls, migrant domestic workers, LGBTQI+ individuals, and other marginalized communities. However, given the rapid assessment timeframe and operational constraints, the number of consultations conducted with some of these groups remained limited. As a result, while the findings identify important protection concerns, vulnerabilities, and service gaps affecting these populations, they should be considered indicative rather than exhaustive. Additional targeted research may be required to fully understand the diversity of experiences and needs within specific intersectional groups.
- **Rapidly Evolving Humanitarian Context:**
  Given the fluid nature of the conflict and displacement situation, the protection environment continues to evolve. Population movements, changing security dynamics, fluctuations in humanitarian access, and shifts in service availability may alter risk patterns and priority needs after the completion of data collection. The findings therefore represent a snapshot of conditions at the time of the assessment and should be interpreted alongside ongoing monitoring and subsequent assessments.

The assessment team sought to mitigate these limitations through methodological triangulation, data disaggregation, application of an intersectional lens, and validation of findings across multiple respondent groups and data sources. Nevertheless, the findings should be understood as providing

qualitative, context-specific evidence intended to inform humanitarian decision-making, rather than statistically representative estimates of needs or GBV prevalence.

3. Findings

The ongoing escalation of hostilities in Lebanon in 2026 has precipitated a multidimensional humanitarian crisis, with profound impacts on the physical, psychological, and socioeconomic well-being of affected populations. While displaced and host community members have experienced the crisis in different ways, both groups face interconnected challenges that have undermined access to safety, privacy, livelihoods, essential services, and community support networks. Assessment findings indicate heightened psychological distress, increasing economic hardship, overcrowded living conditions, and significant barriers to accessing humanitarian assistance, all of which contribute to elevated GBV risks and reduced access to survivor-centered services.

The crisis has also created a compounding cycle of vulnerability and distress. Displaced households are increasingly forced to adopt negative coping mechanisms, including sacrificing essential needs such as food, healthcare, and other basic necessities. At the same time, the limited reach of assistance to displaced populations residing outside collective shelters, coupled with the growing burden placed on host families and communities, has intensified stress and emotional exhaustion. These pressures disproportionately affect women and girls, further eroding their well-being, coping capacities, and access to protective environments and support systems.

3.1 GBV Risk Factors

The desk review of 2026 data demonstrate that displacement has disrupted informal community protection networks,[33] weakening the informal safety structures and community-based support systems that women and girls may rely on. Overcrowding in overstretched host communities has forced families into precarious, non-shelter environments (unfinished buildings, public spaces).[34] Additionally, the high rental prices and risk of eviction drastically heighten exploitation risks from landlords.[35]

In conflict-affected zones like the South, healthcare infrastructure has been severely impacted: five hospitals (four providing critical maternity services) are closed, nine are structurally damaged, and 51 primary healthcare centers are completely non-operational. As a result, pregnant women were facing increased risks of delayed, unsafe, or unsupported deliveries leading to heightened vulnerability during times of crisis and displacement.[36]

A March–April 2026 Safety Audit of 180 collective shelters in Lebanon conducted by GBV and Protection actors reveals that while the facilities are operational, they pose significant protection risks to women

[33] UNFPA Lebanon - Situation Report 26 March - 01 April 2026
[34] UNICEF Lebanon Humanitarian Flash Update No. 4 (Escalation of Hostilities 2026)
[35] UN Women 2026 Rapid Gender Analysis
[36] UNFPA Situation Report on the Crisis in Lebanon (April 2- April 16 2026)

and girls due to critical structural and informational gaps. Physical vulnerabilities are widespread, with nearly half of the sites lacking internal room locks (49.2%) and dedicated safe spaces (45%), alongside compromised hygiene facilities that frequently lack sex-segregation (21.8%), separate entrances (27.2%), and internal locks (20.2%). These safety hazards are exacerbated by nighttime power outages that plunge corridors and bathrooms into darkness, as well as a severe communication deficit; only half of the shelters display essential Gender-Based Violence (GBV) or Prevention of Sexual Exploitation and Abuse (PSEA) reporting information, highlighting an urgent need for accessible and inclusive awareness materials.[37]

The UN Women Rapid Gender Analysis (2026) report that women and girls residing outside of collective shelters face heightened GBV risks, primarily driven by overcrowded conditions that necessitate adjustments to basic routines. The lack of secured tenure and severe financial pressure increase exposure to exploitation and abuse, including risks of sexual exploitation in exchange for housing, requiring reliance on hosts, landlords, and informal intermediaries. Specifically, in hosted arrangements, overcrowding and depleted host resources escalate intra-household tension and conflict, often increasing GBV risks. In rented and private accommodation, female-headed households are highly vulnerable to financial exploitation by landlords due to rising costs, leading to severe financial strain that forces some to adopt harmful coping strategies.

The GBV Assessment findings revealed that overcrowding, economic pressure, documentation barriers, discrimination, unsafe mobility, and lack of privacy can increase exposure to GBV risks while reducing access to services, information, and support. The risk factors described below are primary findings drawn from the FGDs and should be understood as interconnected and mutually reinforcing.

A. Overcrowding and Lack of Personal Privacy

Intra-Household Density: Displaced women and girls reported that multiple families are often sharing spaces originally intended for one household, significantly affecting privacy, dignity, safety, and daily routines, particularly among displaced households. Host community Lebanese women in Saida who were hosting displaced families reported a reduced household privacy, particularly where hosting arrangements or increased household pressures affected use of shared spaces.

At the same time, displaced Lebanese women living in Beirut, North Lebanon, and Baalbeck-Hermel expressed deep distress over how cramped their current living arrangements are, noting that overcrowding reduced their sense of safety, privacy, and control over daily life. Displaced Syrian women with disabilities in Beirut and Mount Lebanon also reported a lack of privacy because they are sharing compressed living spaces with entirely unrelated families. This specific domestic pressure is captured by different displaced Lebanese women residing in different areas.

[37] Gender-Based Violence Working Group, UNFPA, UNHCR - Lebanon GBV Safety Audit Report - 2026, March-April

"I don't feel any privacy; we live all together, no personal space."

Displaced Lebanese Women, Beirut

This lack of privacy and severe overcrowding can increase the risks of GBV by potentially escalating intra-household tensions. It also can constitute a barrier to accessing GBV services as survivors have no confidential spaces to contact GBV hotlines, disclose incidents, and request help. Additionally, survivors exposed to GBV may refrain from reporting violence due to the fear that doing so will jeopardize their accommodation.

Reduced Autonomy and Changes to Daily Routines: Within these crowded family environments, the lack of physical and private space was reported to reduce women's and girls' autonomy and alter daily routines, including rest, clothing, movement, and access to hygiene facilities. Displaced Palestinian women in Saida and Ein El Helwe explained that sharing cramped and unsegregated spaces with male family members was reported to restrict their privacy, comfort, freedom of movement, and limit their personal autonomy, particularly their capacity to make choices affecting their daily routines and bodily privacy. This lack of independent movement and personal autonomy can restrict their freedom to seek GBV services and assistance, as they may face increased household surveillance, especially for those experiencing GBV in the households. This lack of boundaries closes in on adolescent girls as well; for displaced Lebanese adolescent girls in Baabda, North Lebanon, West Bekaa, and Beirut, the lack of private space is so severe that in Baabda specifically, girls reported needing to remain in their veils even while sleeping, due to the presence of unrelated men in shared accommodation.

"We were staying in a house with our relatives, and there were many of us in the house. We had no privacy, and we stayed in our clothes all the time and wearing the headscarf because there were young men with us, and we slept while fully clothed"

Displaced Lebanese Girl, Mount Lebanon

GBV Mainstreaming Gaps in informal tented settlements and residential shelters: GBV mainstreaming gaps affected the humanitarian response. Physical shelter conditions - particularly within informal tented settlements (ITSs) and substandard residential shelters for displaced Syrians - lack basic gender-sensitive safety features. Consequently, these environments present acute Protection and GBV risks, particularly regarding privacy and physical security for women and girls.

In Akkar, displaced Syrian women reported severe overcrowding and very limited privacy, particularly those in ITSs, who are living in overcrowded tents and sharing poorly lit latrines with limited privacy and safety. Women and girls residing in ITSs reported lacking the capacity to separate themselves from unrelated or unknown men, leaving them at higher risk of harassment. Furthermore, the risks associated with navigating potentially poorly lit, unsegregated latrines after dark compromise their physical safety. In substandard residential shelters.[38]

In Bekaa, displaced Syrian women reported the risks there stem from extreme indoor high-density living rather than outdoor exposure. In these facilities, up to 15 to 18 individuals are crammed into a single room, and up to 45 people are forced to share the same bathroom. Furthermore, these shelters suffer from a critical lack of physical security; individual family rooms lack basic locks or door handles, forcing women to resort to unreliable makeshift barricades, such as blocking doors with heavy objects or nailing them shut to separate themselves from unrelated individuals and secure their safety.

B. Intersectional Barriers and Discrimination

Intersecting barriers linked to gender, age, disability, nationality, legal status, displacement status, social status and SOGIESC may increase exposure to GBV risks and reduce access to support. Specifically, individuals with disabilities encounter heightened physical, environmental, and institutional barriers that restrict mobility and increase isolation. Concurrently, non-Lebanese women and girls, particularly displaced Syrians, face discrimination linked to their nationality and legal status, which restricts their access to safe shelter, decent work, and essential services, forcing many into insecure, undignified living conditions and exploitative agricultural labor that heightens their risk on physical safety and exposure to sexual harassment and workplace abuse. Furthermore, individuals with diverse SOGIESC face social exclusion, stigma, and legal insecurity that expose them to violence and limit safe access to formal protection or medical care. These challenges are mirrored among adolescent girls, who experience an intersection of gender and age-based vulnerabilities making them at high risk of early or forced marriage, sexual exploitation, and restrictions on autonomy, as well as female heads of households, who carry the sole burden of economic provision under severe financial pressures that could push them toward high-risk livelihood strategies.

> *"The visual impairment became a very difficult part in the new place of displacement because I had to learn the whole environment again"*
>
> Displaced Syrian Women With Disability, Beirut

[38] Residential shelters for Syrians were apartments rented by Syrian NGOs in Lebanon hosting displaced Syrians and not government shelters.

C. Deterioration in the Economic Situation and Insufficient Support

Both key informants and affected groups reported the crisis has caused a surge in the cost of living, rent inflation, and a massive strain on local infrastructure, such as water and electricity. In addition, a municipality member in Bekaa noted that significant increases in the prices of goods in local stores and rental costs may impose an additional economic burden on residents and increase the risk of opportunistic pricing. FGD Participants expressed frustration and perceived inequities in assistance coverage, noting that some host community households are also experiencing worsening poverty and service needs. These escalating community tensions introduce a critical layer of protection risk; the friction generated by scarce resources and perceived bias directly contributes to heightened harassment, social exclusion, and overall GBV risks for vulnerable women and girls in public spaces

Financial strain contributing to domestic tension: Findings from the Emergency Needs Assessment (ERNA) outside collective shelters rely on assistance, savings, and debt to meet their needs.[39] Many women and girls perceive the severe economic pressure and loss of income as a contributing factor for the increase in household tensions and intimate partner violence (IPV). The Lebanese women of the host community in Beirut and Aley emphasized that the daily conditions are acting as a primary trigger, driving a reported increase in domestic violence risks.

> *"I can no longer live alone at home with my son and husband. Now, 10 of my husband's relatives are staying with us. Expenses have increased a lot : gas, medicine, laundry, electricity, everything. I also have more cooking responsibilities and work. I can no longer use my bathroom freely as I want. My personal freedom has become very limited."*
>
> Women in host family (Host community)

Increased Rent and Social Tensions: Women from host communities in Mount Lebanon reported increasing fears of eviction as landlords raise rental prices or seek to replace existing tenants with households able to pay higher rents. Participants attributed these concerns to housing market exploitation amid the sharp increase in demand following the displacement crisis. Several women noted that landlords have explicitly justified rent increases by stating that displaced families are willing to pay higher rates, creating additional financial pressure on already vulnerable host community households.

These dynamics risk exacerbating social tensions between host and displaced communities, as some host community members increasingly perceive displaced populations as competitors for scarce housing opportunities. In parallel, displaced women in several locations reported experiencing tension with host communities and expressed fears of confrontation or discrimination, which in some cases discouraged them from seeking assistance beyond their immediate surroundings. This isolation may further constrain access to essential services, information, and support networks.

[39] AAWG, ERNA for IDPs Outside Collective Shelters Results, 2026

The exploitation of an inadequately regulated rental market also exposes both host community and displaced women to heightened protection risks. The constant threat of eviction and homelessness increases vulnerability to various forms of GBV, including exploitation by individuals seeking to take advantage of women's precarious housing situations and urgent need for shelter. Participants further reported that some landlords demand exorbitant rental payments from displaced families, forcing households to reduce spending on food, healthcare, and other essential needs in order to avoid eviction, thereby compounding existing protection and economic vulnerabilities.

> *"Rental houses feel increasingly unstable, as landlords may replace us for small amounts of money, leaving families worried about losing their homes and having no stability."*
>
> Participant from Mount Lebanon(Host community)

Assistance not reaching women and girls outside collective shelters: The rapid pace of displacement, combined with escalating humanitarian needs and overstretched response capacities, resulted in unintended gaps in assistance coverage. As a consequence, many displaced women and girls residing outside collective shelters, including those living in private rental accommodations, hosted arrangements, or informal settlements, reported limited access to humanitarian assistance. Compared with populations residing in organized collective sites, these households were often less visible to aid actors and more difficult to reach through established assistance channels.

This exclusion has heightened the vulnerability of affected households by increasing economic hardship and reducing access to essential support services. Participants reported that the lack of regular assistance has forced some families to rely on negative coping strategies, incur additional debt, or become increasingly dependent on landlords, community members, or informal support networks to meet their basic needs. Such dependency can exacerbate existing protection risks and increase the exposure of women and girls to exploitation, abuse, and other forms of GBV, particularly in contexts characterized by housing insecurity and financial distress.

Inaccessibility to livelihoods opportunities: Participants consistently reported widespread discrimination and exclusion within the labour market, which significantly limited women's access to livelihood opportunities. Women faced multiple barriers to employment, including discriminatory hiring practices and unequal treatment based on displacement status, nationality, and disability. Displaced women reported that employers frequently favoured local workers over internally displaced persons (IDPs), while displaced Syrian women faced additional restrictions and reduced access to employment opportunities. Women with disabilities were also reported to encounter persistent barriers to hiring despite the existence of legal protections.

Economic barriers further constrained access to work. High transportation and commuting costs often outweighed potential earnings, rendering employment economically unfeasible for many women. In the absence of viable livelihood options, severe financial hardship compelled some displaced Syrian women and girls to engage in exploitative, unsafe, and poorly remunerated agricultural labour as a means of securing basic necessities and supporting their households. These conditions increased their exposure to exploitation and other protection risks, further exacerbating existing vulnerabilities.

D. Challenges Accessing Basic Needs and Services

Basic Needs: Participants reported that current food aid is restricted to generic parcels and fails to meet the specific dietary needs of women and girls raising nutrition concerns, particularly for children, older women, pregnant and lactating women, and women with specific dietary needs. Shortages of essential non-food items (blankets, fuel, heating/gas, winter clothing, mattresses) is forcing many women and girls to sleep on the bare floor or use improvised bedding. For example, displaced women without shelter had a purely survival-focused routine, starting early to secure aid. Because women and girls bear the primary responsibility for preparing meals, and managing domestic care, these severe shortages might force them to engage in unsafe coping mechanisms and strategies to provide the needed goods, dramatically increasing their exposure to harassment and GBV.

Water Sanitation and Hygiene: The large-scale displacement crisis has placed significant strain on already fragile water, sanitation, and hygiene (WASH) infrastructure, resulting in deteriorating living conditions for affected populations. Some internally displaced women and girls residing in informal street tents reported having no access to water or electricity. This lack of basic services disproportionately affects women and girls, who typically bear primary responsibility for household chores, caregiving, and water collection, increasing both their daily burden and exposure to protection risks.

Concerns regarding water quality were also raised by displaced Syrian adolescent girls living in shelters in the Bekaa, who described the available water as unsafe or inadequate for daily use. Limited access to hot water further undermines personal hygiene and well-being, particularly during colder months. Some women reported reducing bathing to as little as once per week due to insufficient access to heated water, compromising their ability to maintain adequate hygiene and personal dignity.

Assessment participants and local authorities highlighted severe pressure on sewage and waste management systems, particularly in Bekaa and Mount Lebanon. Reports included overwhelmed infrastructure, inadequate waste disposal services, and, in some locations, a complete absence of sewage systems. Overcrowding has further strained sanitation facilities. Among displaced Syrians residing in collective and residential shelters in Bekaa, the ratio reached as many as 45 individuals per toilet, while displaced Lebanese households in residential shelters reported ratios of up to 13 individuals per toilet. These conditions result in long waiting times, heightened stress, and restricted access to sanitation facilities, undermining privacy and limiting women's and girls' ability to use them safely and comfortably.

Inadequate access to safe and gender-sensitive WASH facilities has significant implications for women and adolescent girls. The lack of privacy, cleanliness, and appropriate infrastructure poses serious challenges to maintaining safe, dignified, and private menstrual hygiene management. In addition, prolonged waiting times and the need to use shared facilities alongside unfamiliar individuals may increase exposure to harassment, exploitation, and other forms of gender-based violence (GBV).

Women without access to shelter face particularly acute challenges, including the complete absence of safe sanitation facilities. Many reported spending considerable time each day searching for locations where they could safely use a toilet or wash themselves. The lack of secure and private spaces not only compromises their physical safety but also undermines their dignity, autonomy, and overall well-being.

Health concerns linked to poor sanitation conditions were also widely reported. Women living in overcrowded settings expressed fears of disease transmission through shared and unhygienic sanitation facilities. In southern Lebanon, displaced women reported increasing urinary and gynaecological symptoms, including itching, irritation, and burning sensations, which they associated with overcrowding, heightened stress, and inadequate sanitation and hygiene conditions. These risks are further compounded by limited access to safe and private facilities. Such concerns warrant urgent follow-up by health and sexual and reproductive health (SRH) actors to prevent further health complications and ensure timely access to appropriate care.

Access to Dignity Items: Across all demographic groups, participants identified a critical and unmet need for essential dignity items, including quality sanitary pads, underwear, adult diapers for older persons, infant formula, and basic personal care products. Insufficient access to these items has compelled some women and girls to adopt unsafe coping mechanisms, such as using pieces of cloth as substitutes for sanitary pads. Such practices can cause significant discomfort, compromise menstrual hygiene management, and increase the risk of adverse reproductive and sexual health outcomes.

The shortage of appropriate menstrual hygiene supplies further undermines the dignity, well-being, and self-confidence of women and girls. Many reported experiencing anxiety and distress due to concerns about managing menstruation safely and discreetly, particularly in overcrowded displacement settings. Limited access to adequate dignity items can also restrict women's and girls' mobility and participation in daily activities, as fears of leakage, stigma, or embarrassment discourage them from leaving their shelters or engaging in community life. These challenges highlight the importance of ensuring consistent access to dignity kits and other essential hygiene supplies as a core component of humanitarian assistance and protection programming.

Health Services: The escalation of hostilities resulted in the closure of 42 Primary health care centres since the emergency onset.[40]

Displaced women and girls reported significant disruptions in access to essential healthcare services, including interruptions in the supply of chronic disease medications and other life-sustaining treatments. These challenges were further exacerbated by prohibitive transportation costs and consultation fees, which limited access to care for many vulnerable households. Participants also highlighted an increased

[40] Lebanon Health Sector Emergency Situation Report Issue # 13 - June 01, 2026

demand for psychotropic medications, reflecting the growing mental health and psychosocial impacts of the crisis.

At the same time, the escalation has disrupted the delivery of sexual and reproductive health (SRH) services, particularly in remote and hard-to-reach areas. Shortages of essential medications, contraceptives, and other SRH supplies have restricted access to critical services and increased the risk of unintended pregnancies. Concerns regarding the quality and safety of healthcare services were also reported, with some women declining referrals to public hospitals due to fears of infection and perceptions of inadequate standards of care.

Pregnant women living in informal settlements described heightened anxiety and distress arising from limited access to maternal healthcare and inadequate support during childbirth. These constraints increase the likelihood of unsafe delivery conditions and place both mothers and newborns at greater risk of adverse health outcomes.

Women and girls with disabilities face additional and intersecting barriers to accessing healthcare. Participants reported that the lack of assistive devices, coupled with inaccessible infrastructure and transportation challenges, significantly restricted their ability to reach and utilize essential health services. These structural barriers contribute to multiple layers of exclusion, increasing the risk of neglect, discrimination, and unmet healthcare needs among women and girls with disabilities.

Education: Participants across various regions expressed deep concern regarding the impact of educational disruptions on children's well-being and behavior. Prolonged school dropouts are often linked to an increased risk of child marriage or engagement in child labor. These unsafe environments place children, particularly adolescent girls, at a significantly higher risk of exposure to exploitation, abuse, and GBV. Education disruptions may also lead to greater isolation for adolescent girls surviving violence and in need for specialized support and services.

> *"Children are starting to create problems and learn inappropriate language because they spend a lot of time in the streets and crowded places."*
>
> Participant from Beirut (Host community)

3.2 GBV Risks and Trends

The findings presented in this section should be interpreted as qualitative and perception-based and have been triangulated, where relevant, with available service utilization data and information from key informants. They are not intended to measure the prevalence or incidence of gender-based violence (GBV). Rather, they provide insights into perceived risk patterns, emerging trends, and the experiences of affected populations, while highlighting barriers to disclosure, reporting, and access to services across different groups and geographic locations.

A. Intimate Partner Violence (IPV)

Participants across both displaced and host communities consistently reported perceived increases in intimate partner violence (IPV) and domestic violence, which they linked to escalating economic hardship, overcrowded living conditions, restricted mobility, and heightened household stress. However, women in several displacement settings remained reluctant to discuss experiences of violence due to stigma, fear of repercussions, and the sensitive nature of the topic, suggesting that the full extent of IPV risks may be underreported.

These qualitative findings are consistent with trends identified through the GBV Information Management System (GBVIMS) Q1 2026 analysis.[41] Among GBV incidents reported through the system, survivors' residences were frequently identified as the location where incidents occurred. GBVIMS trend analysis associates this pattern with the consequences of the conflict, including increased household stress, economic pressures, overcrowding, and movement restrictions, all of which can exacerbate tensions within the home and heighten risks of violence against women and girls.

Further evidence emerged from the GBVIMS Comparative Narrative Analysis for March-April 2026, which reported a marked increase in the proportion of incidents linked to IPV.[42] As noted in the report, “April data also showed a strong connection between reported incidents and Intimate Partner Violence (IPV), with 88% of incidents occurring within an IPV context compared to March findings (35%).” The analysis suggests that this increase may reflect improved opportunities for disclosure as access to services and safety conditions gradually stabilized following the widespread displacement and service disruptions experienced in March. Taken together, the assessment findings and GBVIMS data underscore the heightened risk of IPV within the current crisis context and the critical need to strengthen accessible, confidential, and survivor-centered prevention and response services.

FGDs participants reported emotional abuse as a prominent form of household violence within highly congested community settings, while participants also reported risks of physical violence perpetrated by spouses during active displacement. This qualitative reporting is also observed by GBVIMS incident data from April 2026, where psychological/emotional abuse constituted the highest reported type of GBV at 44%, followed closely by physical assault at 32%.[43] This upward trend in domestic instability was also noted by local women-led organizations operating in high-density areas. Participants observed an increase in IPV, linking it with intra-household tensions and psychological burdens, as compounding triggers for abusive behavior.

Additionally, field data shows that intimate partner violence was observed among women of diverse nationalities: Lebanese, Syrian and Palestinian. This reality is complemented by the GBVIMS Q1 2026 Report,[44] which highlights a gradual increase in the proportion of Lebanese survivors (reaching 35% in

[41] GBVIMS TF Lebanon: Impact of the Current Conflict on GBV Risks and Needs in Lebanon - Q1 2026 Analysis, June 2026
[42] GBVIMS Lebanon: *Comparative Narrative Analysis (March-April 2026)*, June 2026
[43] GBVIMS Lebanon: Comparative Narrative Analysis (March-April 2026) - June 2026
[44] GBVIMS TF Lebanon: Impact of the current conflict on GBV risks and needs in Lebanon- Q1 2026 Analysis - June 2026

March 2026) alongside a rising proportion of Palestinian survivors, linking both trends directly to deepening socioeconomic distress and conflict-related vulnerabilities.

B. Early and Child Marriage

Participants from several host communities and displaced groups reported increased concerns around child and forced marriage. According to participants, child marriage was frequently raised as a widespread and growing GBV risk, particularly for adolescent girls. Observers noted that economic pressure, insecurity, and restrictive gender norms may increase risks of child and forced marriage as a harmful coping mechanism, all of which have been heavily exacerbated by the ongoing crisis and conflict environment.

Local civil society organizations emphasize that child marriage remains a core protection risk perceived by some families as a protection or survival strategy, despite the serious protection harms involved. The GBVIMS Q1 2026 report recorded a lower proportion of child survivors among reported incidents compared to previous months.[45] However, this likely reflects reduced identification and referral capacities among child protection and GBV actors during periods of escalation, rather than a decrease in incidents affecting children. Nevertheless, the GBVIMS comparative analysis March and April 2026 reflected an increase in the reported incidents for forced marriage by 150% from March to April.[46]

C. Movement, Activity, and Social Restrictions

Displaced women and girls reported facing mobility and social participation constraints some of which predated the current crisis, but have been exacerbated by displacement, insecurity, overcrowding and social scrutiny. Restrictive treatment within families frequently targets adolescent girls, creating distinct barriers to their personal development. Some families restrict girls' freedom of movement and social interactions and activities in an attempt to shield them from perceived GBV risks outside the home, such as sexual harassment in public spaces or from strangers. Women from the host community and displaced Lebanese and Syrian women, indicated fear of kidnapping of adolescent girls as a main concern related to displacement. Concurrently, these restrictive measures severely heighten the girls' isolation, limiting the development of their peer and social support networks. They also decrease their opportunities to be aware of, safely contact, and reach essential GBV response services.

> *“Parents are afraid because they hear stories about girls going missing."*
>
> Women from the Host community, Beirut

[45] Ibid.

[46] GBVIMS Lebanon: Comparative Narrative Analysis (March-April 2026) - June 2026

> *“There were people using drugs beneath our house. A man carrying a weapon approached my daughter, and we became afraid he might kidnap her, so we fled."*
>
> Displaced Syrian Women, Beirut

Frontline organizations identified limited women’s participation in local decision-making as an institutional gap that may weaken the relevance, safety and accountability of the response in relation to these groups.

D. Sexual Exploitation, Harassment, and Public Safety Threats

FGD participants consistently identified sexual exploitation as key protection concerns, particularly in public and semi-public settings. Participants reported that taxi drivers, employers, and landlords were among the individuals perceived to pose heightened risks of exploitation, leveraging different forms of vulnerability experienced by women and girls. These risks were described as particularly acute for displaced women, female-headed households, women facing financial hardship, and those with limited social support networks.

Participants highlighted concerns regarding exploitative practices by some taxi drivers, which contributed to fear and insecurity while travelling and, in some cases, restricted women's mobility and willingness to access essential services, employment opportunities, and humanitarian assistance. Similarly, some women reported that employers may exploit severe economic hardship and unequal power dynamics by soliciting sexual favours in exchange for employment or income-generating opportunities. Landlords were also identified as a source of concern, particularly for displaced women and female-headed households who may have limited housing alternatives and reduced access to traditional family or community support structures.

In addition, displaced women and female heads of households reported heightened fears of sexual harassment, sexual assault, and rape when moving through poorly lit or unlit streets and public spaces, particularly during evening hours. These security concerns were reported to constrain freedom of movement, limit participation in community life, and create additional barriers to accessing services, livelihoods, and support networks. The findings underscore the extent to which environmental factors, economic vulnerability, and unequal power relations intersect to increase protection risks for women and girls in displacement settings.

As for adolescent girls, they reported perceiving public areas and routes as totally unsafe for moving alone, identifying these locations as the spaces where the risk of sexual violence is most acute. When discussing GBV concerns, displaced older women expressed these identical fears on behalf of their daughters and granddaughters, highlighting a shared anxiety regarding exposure to pervasive public safety threats. Displaced Syrian adolescent girls have reported to perceive themselves as facing high risk of sexual violence, driven by overlapping financial and social vulnerabilities. This reported fear in public

spaces is mirrored by broader system trends; for instance, the GBVIMS Comparative Narrative Analysis of March and April 2026 notes an 81% increase in formal reports of sexual abuse reported incidents from March to April. [47] Additionally, one key informant from a municipality in Mount Lebanon reported harassment incidents affecting women and girls in public spaces, accounting for approximately 4% of identified cases in the municipal square.

E. Intersectional Risks by Groups

Women and Girls with Disabilities: Individuals with disabilities were perceived by participants across both host and displaced communities as facing heightened exposure to exploitation, neglect, exclusion, GBV, and barriers to safe access to services. Inaccessible housing, transport, WASH and other services further compound these issues by reducing mobility, privacy, safe escape options, and access to overall assistance. This was highlighted from multiple perspectives: Syrian women with disabilities directly identified themselves as facing compounding threats, a reality exemplified by a visually impaired Syrian woman residing in Beirut who experienced severe difficulties adapting to her unfamiliar displacement environment, while displaced Lebanese female heads of households, older women, and Lebanese women across various groups categorized women and girls with disabilities as the most exposed to insecurity and GBV.

Mobility restrictions expose women and girls with disabilities to increased risks as, in some cases, they cannot flee the perpetrators and have a challenge to access services if needed.

For displaced women and girls with physical or visual disabilities in Beirut and Mount Lebanon, adapting to unfamiliar or overcrowded settings severely limits independent movement, the identification of safe routes, and the safe use of shared facilities. This introduces life-threatening challenges, particularly during emergency evacuations where inaccessible stairs and overcrowded elevators drastically hinder their ability to escape active bombing alerts. Disability-related impairments limit their ability to seek and receive critical information on available services and impede their ability to accurately assess and respond to protection-related threats, while displacement centers, informal shelters, and sanitation facilities are rarely equipped with ramps or proper infrastructure, leaving this population isolated and dependent on others to meet basic survival needs. Furthermore, participants emphasized that these individuals face distinct barriers to safe disclosure; their reliance on caregivers or family members, combined with social stigma, communication challenges, and the perceived risk of being disbelieved, significantly impedes their ability to seek help and report violations.

The GBVIMS Q1 2026 Report provides a complementary indication that the proportion of survivors with disabilities accessing services increased from 2% in January to 5% in March 2026. This trend should be interpreted cautiously, as it may reflect heightened risks, improved identification, changes in service access, or changes in reporting patterns among survivors with disabilities. [48]

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[47] GBVIMS Lebanon: Comparative Narrative Analysis (March-April 2026) - June 2026

[48] GBVIMS TF Lebanon: Impact of the current conflict on GBV risks and needs in Lebanon- Q1 2026 Analysis - June 2026

"Because of my mobility limitations and my nieces' disabilities, I did not want to flee the area, even though it had received an evacuation warning, because I cannot run."

Syrian Women with Disabilities, Beirut

Female Heads of Household, Single Women, Divorced Women, and Widowed Women: According to qualitative field observations, the intersection of displacement, limited family, community, or social support networks, gender, sole caregiving responsibilities, and in some cases, legal or economic marginalization, may increase exposure to violence, exploitation, housing insecurity, and barriers to assistance. Within host communities, participants in some areas identified divorced and widowed women as the most exposed groups during displacement. For displaced populations, single women, unaccompanied women, and female heads of household are categorized as groups facing heightened GBV risks. These women and female heads of household can face an increased risk of exposure to several types of GBV, such as sexual harassment by landlords and exploitation by employers within unsafe informal labor markets, as economic exclusion and unequal labor market access can restrict these women to the informal sector. This economic strain, combined with a lack of institutional protections, creates vulnerabilities that some employers or landlords could exploit through workplace harassment, economic discrimination, or demands for transactional sex.In some communities, participants reported that specific social restrictions, such as freedom of movement and ability to engage in social events are placed on divorced women regarding their integration into social life, alongside systematic barriers to accessing job opportunities.

"If a woman has a husband or older son with her, people sometimes feel there is protection. Women alone feel exposed"

Displaced female-headed household without shelter, Beirut

LGBTQI+ Community: Data collected from the field reveal that legal insecurity, nationality-based discrimination, displacement status, and diverse SOGIESC may create intersecting protection gaps in public and private spaces. Many displaced LGBTQI+ individuals perceive themselves as the populations most at risk of violence. Within the LGBTQI+ community, transgender individuals were perceived as facing particularly acute risks due to acute societal hostility.

"There is no safety at all. After everything, there is no sense of safety, not at work, not on the road, and not at home"

LGBTQI+, Mount Lebanon

Individuals of the LGBTQI+ community reported feeling exposed to physical assault and sexual exploitation across all environments, viewing themselves as easily targeted by perpetrators. They also reported facing persistent community-level discrimination, emotional abuse, and bullying, harassment in workplaces, public transport, and streets. Exclusion and discriminatory attitudes from the community strip away basic safety nets for individuals with diverse SOGIESC.

Displaced LGBTQI+ individuals in Mount Lebanon reported facing a lack of acceptance from some community members and local government bodies. This isolation, paired with hostile, discriminatory attitudes faced on a daily basis, directly increases their risk of facing severe types of GBV, such as sexual, physical and emotional violence. It also creates a psychological burden that is severely compounded by high residential density and overcrowding in shared housing. Syrian LGBTQI+ participants reported facing heightened safety concerns on public transport due to the combination of their gender expression, refugee status, discrimination, and a lack of legal identity documents.

Additionally, losing or lacking identification documents, which can particularly be experienced by the Syrian LGBTQI+ individuals, can increase fear of arrest, harassment, discrimination. Displaced LGBTQI+ individuals explain that losing their identity documents during the war has become a critical threat to their safety. Participants reported that passing through checkpoints was stressful and difficult, especially with no IDs, particularly for people with diverse gender expressions. Because LGBTQI+ individuals are already exposed to marginalization, navigating these checkpoints without official documentation can leave them at higher risks of harassment, arbitrary profiling and physical insecurity.

Migrant workers: Migrant women reported restricting movement and social interactions as risk-avoidance strategies in response to various types of violence. They have in fact reported facing discrimination, verbal harassment, and physical assault, perpetrated mainly by some employers, landlords, and taxi drivers. They also expressed fear of authorities and public safety concerns.

"We ask people not to raise their voices or show any signs of happiness,'please don't smile or laugh' so the police don't arrive."

Displaced Migrant women, Beirut

For displaced migrant women in Beirut, physical security is continuously threatened by hostile local surveillance and monitoring, by both local residents and municipal police, who subject them to intrusive interrogations, yelling, and verbal degradation. Consequently, these workers restrict their own mobility to avoid confrontation, further increasing their risk of isolation.

Migrant women reported a pre-existing and ongoing awareness of peers facing transactional exploitation in exchange for aid, essential services, and basic resources, a protection risk that was documented prior to the escalation of hostilities. This risk is compounded by significant barriers to assistance; displaced

migrant women workers reported discrimination and barriers to access linked to nationality, legal status, documentation, language, and exclusion from shelter options. Additionally, migrant women demonstrated a lack of awareness regarding available specialized GBV support services and PSEA reporting mechanisms, alongside a lack of trust in existing institutional reporting mechanisms. Furthermore, participants highlighted gaps in some of the current humanitarian aid distribution models, noting that a heavy reliance on community leaders for identification, outreach, and delivery often creates unequal access or exclusion. To mitigate these risks and ensure equitable access, migrant women explicitly expressed a preference for aid to be delivered directly to them rather than through intermediary community structures.

Many live-in domestic workers reported they have been left behind by fleeing employers or limited access to the collective sites. Consequently, some of them were forced to sleep in abandoned buildings, parking lots, or on the streets.

Discrimination linked to nationality and legal status was also identified in the desk review. The safety audit report mentioned that non-Lebanese displaced persons have been recorded as having no real access to the collective shelters.[49]

> *"Government shelters did not accept migrants, that's why we had to accommodate 8 to 10 household members per housing unit."*
>
> Displaced Migrant Women, Beirut

Adolescent Girls: As mentioned above, and due to the intersection of age, gender, conflict-driven insecurity, financial distress, and restrictive social norms, adolescent girls face compounding risks where public safety fears, such as sexual violence, prompt families to restrict their mobility. This confinement isolates girls from peer support networks and life-saving GBV services, while simultaneously driving an escalation in early, child, and forced marriage as families resort to it as a harmful survival mechanism. Additionally, and due to the limited legal and economic autonomy of adolescent girls, these intersecting barriers may restrict their decision-making power and dependency within households, leaving them with fewer resources to escape abusive environments. This also increases their exposure to GBV risks, including child marriage as a negative coping strategy.

3.3 Barriers to Accessing GBV Services

The analysis showed four main types of barriers to accessing GBV services including movement restrictions, societal perception and gender roles, logistical and information barriers and barriers related to safety and security.

[49] Gender-Based Violence Working Group, UNFPA, UNHCR - Lebanon GBV Safety Audit Report - 2026, March-April

A. Movement Restrictions

Restrictions on movement should be understood as a safety concern, a GBV risk factor, and a barrier to access because they limit access to services, information, livelihoods, education, social support, and confidential help-seeking. Across all consulted groups and regions, the vast majority of focus group discussion participants consistently reported feeling more comfortable and safe moving exclusively during daytime hours.

Daytime Mobility Preferences and Environmental Factors: Focus group discussions indicate that existing poor lighting and public infrastructure significantly add restrictions to the nighttime movement, reinforcing the preference for daytime movement. Displaced Lebanese adolescent girls in Baabda, North Lebanon, and South Lebanon prefer to move strictly during daytime hours. Displaced Lebanese women in North Lebanon perceive dark streets as unsafe and report discomfort moving after dark due to unlit paths and dark public areas. This discomfort is shared by displaced Lebanese female heads of household in North Lebanon, who avoid moving in dark streets, unlit neighborhoods, and using public transport after sunset. Displaced Syrian women with disabilities in Beirut and Mount Lebanon also indicate a clear preference for daytime mobility. In Saida, host community women and girls report avoiding movement at night due to concerns regarding risks of sexual violence and harassment. Displaced female migrant workers in Beirut reported limiting their movement, as much as possible as a risk-avoidance strategy. Furthermore, displaced LGBTQI+ individuals face specific safety challenges specifically when moving and utilizing public transportation. They reported concerns and accounts of emotional and physical abuse when using public transport.

Social Restrictions: Social norms, community surveillance, safety concerns, traditional expectations and family protection strategies were reported to restrict women's and girls' mobility and social participation. Displaced Syrian adolescent girls in West Bekaa report feeling uncomfortable moving outside of their shelters unless traveling in groups or accompanied by family members. Participants linked these restrictions to social norms, community perceptions, fear of harassment, social judgment, and parental concerns about safety. In Akkar, host community women reported facing societal restrictions imposed on women and girls in regards to leaving houses after sunset and are generally not allowed to go out late.

Availability of Safe Gathering Spaces identified by women and girls: Access to secure communal gathering spaces varies by geography and group, with some participants reporting that previously available spaces were no longer accessible after the escalation. This includes several WGSS that sustained infrastructure damage, disrupting the protection framework and severing survivors' access to multi-sectoral care.[50] Participants described different patterns of social gathering depending on location, safety concerns, cost, gender norms, and availability of safe spaces. In Aley, host community women socialize by gathering in each other's houses and inside NGO safe spaces. In Saida, host community women and girls utilize areas in front of houses, sports and social clubs, gardens, or public spaces,

[50] UNFPA, UNHCR & UNICEF Lebanon: Protection emergency response situation weekly situation report #3 - Reporting period 2 to 30 March 2026.

though their access is frequently hindered by safety concerns, traditional gender norms, and the financial costs of club participation. In contrast, host community women in Akkar reported a lack of available safe spaces to gather. Among displaced populations, adolescent girls in the North spend time in parks and at neighbors' houses. However, infrastructural gaps exist for marginalized groups: displaced Syrian adolescent girls in West Bekaa previously had access to a dedicated tent to safely meet, but it was reportedly later removed. Similarly, displaced migrant workers in Beirut report that the community spaces they formerly used to gather in are no longer available following the war. Displaced LGBTQI+ individuals reported relying on spaces provided by specialized,community-based organizations, to meet safely and maintain social support.

B. Social Perceptions and Gender Roles

Entrenched gender norms and prevailing social attitudes significantly shape the protection environment and influence survivors' ability to safely disclose incidents of violence and access support services. These social perceptions constitute a critical barrier to help-seeking, often translating into concrete risks that discourage disclosure and reinforce underreporting of gender-based violence (GBV). While such restrictive norms and reporting barriers predate the current crisis, conflict-related displacement and heightened socioeconomic vulnerabilities have intensified these dynamics, further increasing the perceived and actual risks associated with disclosure. As a result, harmful community attitudes continue to limit safe access to humanitarian, protection, and specialized GBV services for populations at heightened risk.

Survivor Blaming: Findings from focus group discussions indicate the continued prevalence of survivor-blaming attitudes across both host and displaced communities. Participants frequently linked responsibility for GBV incidents to survivors' clothing, behaviour, mobility, or perceived non-conformity with accepted social norms, thereby shifting accountability away from perpetrators and reinforcing harmful gender stereotypes.

Within host communities, perceptions regarding responsibility for GBV were mixed. While some participants expressed attitudes that attributed violence to survivors' conduct or appearance, others identified patriarchal gender norms, unequal power relations, and limited perpetrator accountability as key drivers of violence. In Saida, participants were notably divided between those who viewed survivors' behaviour and dress as contributing factors and those who recognized GBV as a manifestation of broader patriarchal structures. Similar views emerged among Lebanese adolescent girls in South Lebanon, where differing perceptions regarding survivor responsibility highlight the continued need for targeted awareness-raising and social norms interventions aimed at challenging harmful attitudes and strengthening understanding of GBV. Likewise, participants from host communities in Beirut and Aley reported the persistence of survivor-blaming attitudes within family and community settings, which negatively affect disclosure, help-seeking behaviours, and survivors' psychosocial wellbeing. In Akkar, perspectives were similarly polarized, with some community members expressing solidarity with survivors while others continued to attribute blame to those affected by violence.

Among displaced populations, survivor-blaming attitudes were reported as particularly influential within immediate family and community circles, shaping the environment in which survivors must navigate disclosure and support-seeking. Displaced Syrian women in Akkar described a context in which women who experience GBV are frequently blamed, stigmatized, and socially marginalized. This pressure was echoed by displaced Syrian women with disabilities in Beirut and Mount Lebanon, who emphasized that the judgement, blame, and social repercussions encountered within their families and communities can, at times, be more difficult to endure than the violent incident itself. These findings underscore the profound role that social stigma and discriminatory attitudes continue to play in limiting survivors' access to protection, support services, and pathways to recovery.

> *"Blame is harder than the violent incident itself"*
>
> Syrian Displaced Women with Disabilities, Beirut

This lack of domestic support is reinforced by displaced Lebanese older women in Beirut, who report that families frequently hold the survivor entirely responsible, a practice that leads to restricting survivors' movement or isolating them within the household and causing severe mental health distress.

Stigma and Social Rejection: Across nearly all consulted population groups, age cohorts, and nationalities, women and girls identified stigma and social rejection as common consequences faced by survivors of GBV, particularly survivors of sexual violence, rape, and sexual assault. Participants consistently reported that survivors are often subjected to social judgment, blame, and exclusion, which can result in diminished family and community support and contribute to feelings of isolation and marginalization. These perceptions reinforce harmful norms surrounding sexual violence and create an environment in which survivors may face significant social repercussions following disclosure.

Within host communities, participants in Saida highlighted the severe stigma associated with rape and sexual assault, noting that survivors frequently experience negative community perceptions and may receive limited support from family members and wider social networks. Similar concerns were raised among displaced Lebanese older women in Beirut, who reported that families often respond to incidents of sexual violence by imposing restrictions on survivors' mobility, increasing social isolation, or limiting their participation in community life. Participants associated these responses with heightened psychological distress and reduced opportunities for recovery and reintegration.

For marginalized populations, stigma and social exclusion intersect with broader patterns of discrimination and social vulnerability. Displaced LGBTQI+ individuals in Mount Lebanon reported experiencing low levels of social acceptance and discriminatory attitudes from members of the surrounding community, contributing to increased risks of isolation and exclusion. Similarly, displaced women migrant workers in Beirut described social rejection as manifesting through persistent hostile surveillance, profiling, and discriminatory treatment by local residents and municipal authorities, further constraining their sense of safety and belonging.

The fear of social stigma, public exposure, embarrassment, and community gossip emerged as one of the most consistently reported barriers to disclosure and help-seeking across consulted groups. Among host communities, Lebanese women and girls in Saida, Beirut, Aley, and Akkar identified concerns regarding social judgment and reputational harm as key deterrents to reporting incidents of violence. In Beirut, participants specifically highlighted feelings of shame and embarrassment as significant obstacles to disclosure and service utilization.

Among displaced populations, Lebanese women in Beirut, Mount Lebanon, Saida, Baalbek-Hermel, and North Lebanon reported concealing experiences of violence due to fears of social condemnation, family blame, and negative community reactions. Similar patterns were observed among displaced Lebanese adolescent girls in Baabda, North Lebanon, and South Lebanon, who described concerns regarding public scandal, parental punishment, and the possibility of being disbelieved as factors preventing disclosure within family settings. Displaced Syrian adolescent girls in West Bekaa further emphasized that fears related to family dishonour, social exclusion, and damage to future marriage prospects limit both disclosure and broader participation in social life. Likewise, displaced Syrian women in Akkar reported that concerns about community judgment, reputational harm, and being perceived as weak or vulnerable discourage them from seeking assistance following incidents of violence.

These findings underscore the pervasive role of stigma and social exclusion in shaping survivors' experiences and decision-making processes. Beyond their immediate psychosocial impacts, fear of social repercussions and community rejection significantly undermines disclosure, access to protection services, and engagement with available support mechanisms, thereby contributing to the continued underreporting of GBV and limiting pathways to safety and recovery.

Perceived Impunity and Lack of Accountability: Across several host and displaced community groups, participants expressed a widespread perception that formal justice and legal systems do not adequately hold perpetrators of GBV accountable, particularly individuals occupying positions of influence, authority, or power. Participants frequently described a sense of impunity surrounding acts of violence, reflecting limited confidence in the ability of formal institutions to provide protection, ensure justice, or enforce meaningful consequences for perpetrators. This perception may have been further reinforced by the temporary absence or reduced presence of localized security actors during the initial stages of the 2026 escalation, contributing to concerns regarding protection gaps and weakened accountability mechanisms.[51]

> *"The perpetrator's actions are justified; there are no rights"*
>
> Displaced Lebanese Women, Mount Lebanon

The perception of impunity emerged as a significant barrier to reporting and help-seeking across multiple population groups. Participants repeatedly indicated that a lack of confidence in legal and

[51] UNFPA Middle East Gender-Based Violence in Emergencies Snapshot - April 2026

security institutions discourages survivors from pursuing formal reporting pathways, as many believe that disclosure is unlikely to result in justice, protection, or legal consequences for perpetrators. This concern was explicitly raised by displaced Syrian women in North Lebanon, Lebanese female heads of household in North Lebanon, and displaced Lebanese women in Beirut and Mount Lebanon, all of whom reported limited trust in formal legal frameworks and law enforcement institutions. Participants expressed the belief that reporting incidents of violence rarely leads to effective accountability measures and, consequently, may expose survivors to additional risks without yielding meaningful outcomes.

Within host communities, participants in Aley and Ein El Helwe (Saida) similarly linked limited perpetrator accountability to perceived weaknesses in institutional and legal mechanisms. Participants highlighted concerns regarding inadequate enforcement of existing laws, inconsistent access to justice, and insufficient protection for survivors, all of which were perceived as contributing to the persistence of GBV and reinforcing a broader culture of impunity.

Among marginalized populations, perceptions of impunity appeared particularly acute. Displaced LGBTQI+ individuals in Mount Lebanon reported feeling that both societal actors and governmental institutions fail to adequately condemn or respond to acts of violence committed against them. Participants described this perceived lack of recognition and accountability as contributing to heightened fears of reporting incidents, as well as concerns regarding further violence, exploitation, retaliation, or blackmail. These findings suggest that experiences of discrimination and social exclusion may further compound barriers to accessing justice and protection mechanisms for already marginalized groups.

Overall, the findings indicate that perceived impunity and limited confidence in formal accountability systems constitute a critical structural barrier to disclosure, reporting, and service utilization. The belief that perpetrators are unlikely to face meaningful consequences undermines survivors' willingness to seek support, weakens trust in protection and justice mechanisms, and may contribute to the continued normalization and underreporting of GBV across affected communities.

> *"They see us as the easy target to intimidate"*
>
> Displaced LGBTQI+, Mount Lebanon

Decision-Making, Patriarchal Norms and Legal Barriers: Findings from focus group discussions indicate that entrenched patriarchal norms and discriminatory gender roles continue to shape household power dynamics, decision-making processes, and access to protection. Participants consistently described social environments in which men are perceived as primary decision-makers, exercising authority over major household matters as well as critical decisions affecting the lives of women and children. These dynamics were viewed as part of broader patriarchal systems that reinforce gender inequalities across domestic, economic, and community spheres, contributing to women's reduced agency, mobility, and participation in decision-making processes.

Participants further highlighted that fear of domestic repercussions constitutes a significant barrier preventing survivors from seeking support or reporting violence. This concern was particularly

pronounced among women who are financially, socially, or legally dependent on their partners. Lebanese women from host communities in Saida and Ein El Helwe, as well as displaced Lebanese women in Beirut, reported that dependency on intimate partners creates substantial fears of losing custody of their children, facing eviction from the family home, or being ostracized by relatives and community members if they disclose domestic violence. In Beirut, participants specifically associated these fears with perceptions that formal custody and guardianship systems favour fathers, thereby discouraging survivors from pursuing reporting or legal action.

These concerns are situated within a broader legal context in which personal status matters, including divorce, child custody, and guardianship, are governed by religiously based legal frameworks. Participants perceived these systems as limiting women's ability to safely exit abusive relationships and maintain custody of their children, thereby reinforcing dependence on abusive partners and reducing the feasibility of seeking protection through formal channels. Under these frameworks, custody arrangements are often determined according to age-specific provisions, while legal guardianship generally remains vested in the father, creating additional concerns for women considering separation or legal recourse.[52]

The threat of retaliation emerged as another critical barrier to disclosure and help-seeking. Women across host communities in Saida, Ein El Helwe, Beirut, and Aley reported significant fears of physical violence or reprisals from perpetrators and, in some cases, from perpetrators' family members. In Akkar, participants indicated that these concerns are further heightened when perpetrators are perceived to hold social influence, political connections, or authority within the community, increasing fears of retaliation against both survivors and their family members. Similar concerns were reported among displaced Palestinian women in Saida and Ein El Helwe, who identified fear of perpetrators and the desire to avoid escalating violence or family conflict as key factors contributing to underreporting.

Participants also described how patriarchal norms shape perceptions of women's roles and status within society. Across multiple locations, women and girls reported being viewed as dependent on men and subject to social expectations that restrict their autonomy, mobility, and ability to make decisions affecting their own lives. For displaced women with disabilities in Beirut and Mount Lebanon, these constraints are compounded by disability-related barriers, creating intersecting forms of exclusion. Participants explained that restrictive gender norms, dependence on male relatives, and inaccessible infrastructure frequently combine to limit their independent access to essential services, including protection and GBV support.

These restrictions on autonomy and movement were reported to significantly constrain safe disclosure pathways and access to assistance. Host community participants in Aley noted that traditional gender norms often position women in subordinate social roles, increasing their susceptibility to exploitation and violence while limiting their ability to independently seek safety or support. Among displaced populations in South Lebanon, Beirut, and Mount Lebanon, adolescent girls and women with disabilities described gender-based double standards that impose stricter controls on female mobility and

[52] Human Rights Watch, *Letter to Lebanese Prime Minister-Designate*, 30 January 2025.

participation in public life. Similarly, displaced Syrian women in Akkar characterized their environment as strongly male-dominated, where men's interests and perspectives are prioritized and women's voices are often marginalized. Such dynamics undermine women's and girls' capacity to independently access GBV and protection services and limit opportunities to seek information, assistance, and support.

Displacement-related challenges have further intensified these vulnerabilities by increasing the burden of unpaid care and domestic responsibilities borne by women and girls. Participants reported that daily routines are largely dominated by childcare, cooking, cleaning, sanitation-related tasks, and other household responsibilities, often under conditions of overcrowding, limited resources, and heightened stress. Displaced Lebanese women described spending the majority of their time managing household duties, preparing food, caring for children, and supporting children's remote learning. Similarly, displaced Lebanese adolescent girls reported assuming increased caregiving and domestic responsibilities, including caring for younger siblings and assisting with household management.

Among displaced Palestinian women residing with extended family members, participants described substantial pressures associated with performing unpaid domestic labour while navigating displacement-related uncertainty and dependency. These responsibilities were frequently linked to elevated levels of stress, psychosocial distress, and feelings of instability. Across affected populations, the accumulation of domestic and caregiving responsibilities may further reduce women's and girls' ability to access GBV and protection services by limiting available time, increasing dependence on household members, and prioritizing immediate household survival needs over help-seeking. In some cases, these dynamics contribute to physical and social isolation within the home, further restricting access to information, support networks, and available services.

Collectively, these findings demonstrate how patriarchal social norms, restrictive legal frameworks, fears of retaliation, and disproportionate caregiving burdens interact to create structural barriers to disclosure, reporting, and service access. These interconnected factors significantly constrain women's and girls' agency and reinforce conditions that heighten vulnerability to GBV while limiting pathways to protection, justice, and recovery.

Normalization of Violence, Harmful Coping Mechanisms, and Social Taboos: Across multiple population groups, participants frequently associated perceived increases in domestic violence and intimate partner violence (IPV) with the cumulative effects of conflict, economic deterioration, displacement-related stress, and challenging living conditions. Participants described how financial insecurity, loss of livelihoods, uncertainty regarding the future, and heightened psychosocial distress have intensified tensions within households, contributing to an increased risk of violence against women and girls.

> *"At the beginning of the war, GBV incidents increased due to life pressures and economic conditions"*
>
> Displaced Lebanese female head of household, Mount Lebanon

Several participants framed violence within the household as a consequence of external pressures faced by men, including unemployment, economic hardship, and conflict-related stressors. For example, displaced Syrian men in Akkar attributed perceived increases in domestic violence to the financial and social pressures experienced by male household members. While these perspectives reflect community perceptions regarding the drivers of violence, they also raise concerns regarding the potential normalization or justification of abusive behaviour by situating responsibility within broader socioeconomic circumstances rather than emphasizing perpetrator accountability.

Participants similarly described a range of restrictive practices affecting women and girls that were frequently framed as protective responses to insecurity. Across several discussions, limitations on women's and girls' mobility were portrayed as measures intended to shield them from harassment, violence, or broader security risks. Likewise, some participants identified child marriage as a coping mechanism adopted by households facing acute economic hardship, displacement, or protection concerns, despite its well-documented protection risks and recognition as a harmful practice.

> *"The event of early marriage depends on how each girl's safety is assessed, and it's justified as protection"*
>
> Displaced Syrian man, Akkar

These findings suggest that harmful practices may, in certain contexts, be socially legitimized through narratives of protection, family honour, or economic necessity. Such perceptions can contribute to the normalization of practices that further restrict the rights, autonomy, and wellbeing of women and girls while increasing exposure to additional forms of violence and exploitation.

Participants across multiple focus group discussions also demonstrated hesitation and discomfort when discussing protection concerns generally, and GBV specifically. Discussions revealed a prevailing perception that incidents of violence, particularly those occurring within the family, should remain private and be managed within the household rather than disclosed externally. This reflects broader societal norms that position GBV as a sensitive and stigmatized issue, limiting open dialogue and reinforcing barriers to reporting and help-seeking.

The normalization of violence and the persistence of deeply rooted cultural taboos were identified as significant factors undermining recognition, disclosure, and response to GBV. Host community Lebanese women in Beirut reported that the routine acceptance of violence within intimate and family relationships can prevent women from recognizing abusive behaviours as violations requiring support or intervention. Similarly, displaced Lebanese women in Beirut described considerable discomfort when discussing domestic violence, despite acknowledging a perceived increase in incidents following displacement. This reluctance suggests that entrenched social norms continue to inhibit open discussion of GBV and may contribute to underreporting.

Among displaced Palestinian women in Saida and Ein El Helwe, participants expressed particularly high levels of discomfort when discussing rape and sexual harassment, with several indicating reluctance to engage on these topics due to feelings of shame, stigma, and fear of social repercussions. These findings further underscore the powerful influence of social norms in shaping survivors' willingness to disclose experiences of violence and seek assistance.

Institutional Distrust and Exclusion: Discrimination, social exclusion, and limited trust in institutions emerged as significant barriers to disclosure, reporting, and access to services among marginalized population groups. Participants described experiences of stigma and unequal treatment within both community and institutional settings, contributing to feelings of insecurity, exclusion, and reluctance to seek support following incidents of violence.

Among displaced LGBTQI+ individuals in Mount Lebanon, participants reported widespread perceptions of exclusion and lack of acceptance within family, community, and institutional environments. They described experiencing discriminatory attitudes, judgment, and social rejection from family members, community networks, law enforcement actors, and service providers. Participants perceived these environments as unsupportive and, at times, unsafe, limiting their willingness to disclose experiences of harassment, discrimination, or violence. The anticipation of negative reactions, breaches of confidentiality, or further stigmatization was reported to discourage engagement with formal reporting and support mechanisms, thereby increasing risks of underreporting and unmet protection needs.

Similarly, displaced women migrant workers in Beirut reported limited trust in formal institutions and service providers. Participants attributed this distrust to repeated experiences of discriminatory, dismissive, or judgmental treatment, which undermined confidence in available support systems and reduced their willingness to seek assistance. These perceptions suggest that concerns regarding unequal treatment and lack of sensitivity to their specific circumstances may constitute significant barriers to accessing protection, GBV, and other essential services.

Displaced Syrian women in North Lebanon also highlighted institutional distrust as a key obstacle to reporting incidents of violence. Participants described feelings of discomfort and apprehension associated with their legal and social status in displacement settings, noting that fears related to their identity as "strangers" within host communities can discourage engagement with authorities and formal service providers. Concerns regarding potential discrimination, negative treatment, or adverse consequences were reported to contribute to reluctance to seek protection or pursue formal reporting pathways.

Overall, findings indicate that experiences and perceptions of discrimination within both community and institutional structures significantly affect help-seeking behaviours among marginalized populations. Institutional distrust, compounded by social exclusion and fear of unequal treatment, can limit access to protection services, weaken confidence in referral and response mechanisms, and further increase the risk of violence remaining undisclosed and unaddressed. These findings underscore the importance of strengthening inclusive, survivor-centred, and non-discriminatory approaches to service delivery to ensure that all affected populations can safely access protection and support.

C. Logistical & Information Barriers

Gaps In Awareness and Knowledge of Services: Focus Group Discussions (FGDs) highlighted a significant gap in awareness and information among participants regarding available GBV sub-sector services. This lack of knowledge was particularly present among women and girls displaced to unfamiliar geographic regions, who were often unaware of specialized interventions dedicated to women, girls, and survivors, including medical care, legal aid, psychosocial support, and Protection from Sexual Exploitation and Abuse (PSEA) pathways. These gaps, while most pronounced among displaced women and girls, are also reported by several host community groups. A lack of knowledge regarding formal reporting mechanisms, referral pathways, and specialized GBV services was reported by displaced Lebanese women in Beirut, Saida, North Lebanon, and Mount Lebanon, as well as displaced Lebanese older women in Beirut.

A total lack of awareness regarding Clinical Management of Rape (CMR) and Sexual and Reproductive Health and Rights (SRHR) infrastructure was observed among host community Lebanese women and girls in Saida and Ein El Helwe, and displaced Palestinian women in Saida and Ein El Helwe. Among displaced youth, Lebanese adolescent girls in Baabda, North Lebanon, and South Lebanon, alongside displaced Lebanese adolescent boys in Beirut, possess highly limited or no information on how or where to safely seek help, and access GBV services. Displaced Syrian women with disabilities in Beirut and Mount Lebanon, as well as displaced women migrant workers in Beirut, also experience an unfamiliarity with the work of humanitarian organizations and legal services. Conversely, distinct high levels of awareness are documented in certain areas due to targeted interventions: host community women and girls in Akkar are thoroughly familiar with GBV case management and referral processes, while displaced Syrian women in West Bekaa demonstrate high awareness driven by consistent field outreach visits from humanitarian and protection agencies. The primary barriers to obtaining this information stemmed from an information gap: any prior awareness women and girls had in their areas of origin does not translate to knowledge of available services in their places of displacement.

Financial constraints and transportation barriers: Economic hardship and transportation-related challenges were consistently identified as key barriers limiting access to humanitarian services, including specialized GBV services. Across both host and displaced populations, participants reported that deteriorating economic conditions significantly constrain their ability to travel to service delivery points, particularly where transportation costs compete with essential household expenditures. As a result, families are often compelled to prioritize limited financial resources toward basic needs, such as food, shelter, and other survival requirements, reducing their capacity to access available support services.

Participants from multiple communities highlighted the cost of transportation as a primary obstacle to service utilization. Lebanese women from host communities in Saida, displaced Lebanese female heads of household in North Lebanon, and displaced Syrian women in Akkar reported that high transportation expenses frequently prevent individuals from travelling to service locations, particularly when services are situated outside their immediate area of residence. These financial constraints were described as especially acute among households already facing heightened economic vulnerability.

Access challenges are further compounded by the geographic distance of service providers and the limited availability of safe and reliable transportation options. Host community women in Beirut and Aley, displaced Lebanese women in North Lebanon and Mount Lebanon, and displaced Syrian adolescent girls in West Bekaa reported that long travel distances, combined with inadequate transportation networks, significantly impede their ability to access support. For women and girls, these challenges also intersect with broader protection concerns, including safety risks associated with travelling alone or using unfamiliar transportation routes.

Collectively, these findings highlight how economic vulnerability and mobility constraints continue to undermine equitable access to GBV and other humanitarian services. Beyond limiting physical access to service delivery points, transportation costs, distance, and safety concerns create additional barriers for populations already facing heightened protection risks, contributing to delayed help-seeking, reduced service utilization, and unmet protection needs.

Infrastructural and structural access constraints: Operational gaps within service networks heavily restrict timely care. Lebanese women from host communities in Beirut and Aley, alongside displaced Lebanese women in North Lebanon, note a limited number of available WGSS in their respective locations. For remote or digital service options, host community women in Beirut note technical difficulties accessing them. Furthermore, participants reported difficulties reaching services that are inaccessible to older women and persons with disabilities across host communities in Saida, Beirut, and Akkar, as well as displaced Syrian women with disabilities in Beirut and Mount Lebanon. The lack of inclusive infrastructure and accessible GBV facilities forces these individuals to rely entirely on others to access services, increasing their dependence and isolation and consequently, their risk of exposure to GBV. Similarly, older displaced Palestinian women in Saida and Ein El Helwe experience a need to rely on family members for physical support, leading to dependency and neglect.

Language and Legal Documentation Barriers: Formal administrative frameworks create structural exclusions for non Lebanese populations. For displaced women migrant workers in Beirut, the Kafala system, combined with language barriers, cultural gaps, and a lack of legal documentation for some, operate as primary barriers to accessing services. This legal paralysis is mirrored by displaced Syrian women in Akkar, where the lack of valid legal identification and residency documentation prevents women from approaching formal state authorities to seek support. Similarly, accessing officials to report perpetrators is completely blocked for displaced LGBTQI+ individuals in Mount Lebanon due to the absence of identity documents, exacerbated by the lack of legal IDs for Syrian LGBTQI+ individuals and the physical loss of documentation during the war for some Lebanese LGBTQI+ individuals.

3.4 Evolving Coping Strategies and Communal Support Systems

Across most demographic groups, routine activities have been fundamentally reshaped by extreme economic instability, the loss of privacy, and heightened security concerns. These shifts, ranging from the necessity of survival-based schedules to the intensification of unpaid caregiving duties, illustrate the pervasive toll that displacement exerts on individual autonomy, social mobility, and mental well-being.

"The war resulted in massive changes in the style, needs, and the routine; we couldn't feel the spirit of Ramadan, and were bombarded by fear, stress, and many responsibilities."

FGD Participant from South (Host community)

Key informants indicated that the crisis has caused a surge in the cost of living, rent inflation, and a massive strain on local infrastructure, such as water and electricity. The large scale of the emergency, combined with the lack of safe shelters, severe overcrowding, and resource depletion, has led women and girls to resort to different types of coping strategies and resort to the traditional or available community support channels .

A. Coping Strategies

Confinement and Restrictive Mobility: Voluntary confinement and the self-imposition of strict mobility limits were reported as a primary safety mechanism across both host and displaced populations to mitigate perceived GBV in public space concerns. Women report limiting their physical movement and avoiding crowded locations as a way to protect themselves from exploitation.

Emotional and Psychosocial Coping Strategies: The compounded effects of conflict, displacement, economic hardship, and heightened protection risks have substantially increased psychosocial stressors and the need for mental health and psychosocial support (MHPSS) services across affected populations. In contexts where awareness of available MHPSS services is limited, or where access is constrained by social, financial, or geographic barriers, individuals frequently rely on self-developed coping mechanisms to manage distress and maintain emotional wellbeing.

Across displaced populations, women and girls reported adopting a range of individual and collective coping strategies aimed at preserving emotional stability amid protracted crisis conditions. These strategies include engagement in religious and spiritual practices, routine daily activities, caregiving responsibilities, and stress-management activities such as praying, walking, knitting, and teaching children. Such practices were described as important sources of resilience, structure, and emotional regulation in environments characterized by uncertainty and insecurity.

Among displaced Lebanese women in Saida, maintaining structured family routines and participating in collective religious activities were identified as key mechanisms for sustaining psychological wellbeing and reinforcing social connectedness. These findings suggest that family cohesion and community-based support systems continue to play an important protective role in mitigating the psychosocial impacts of displacement and crisis.

At the same time, some groups reported coping responses shaped by feelings of reduced agency and limited access to protective support mechanisms. Displaced Syrian women in Akkar described experiencing a sense of helplessness when confronted with abusive or harmful actors, reporting limited capacity to take proactive measures to enhance their safety or seek recourse. Similarly, displaced

LGBTQI+ individuals in Mount Lebanon reported employing protective coping strategies centred on selective social engagement, deliberately restricting interactions to individuals perceived as accepting and supportive. Participants indicated that this approach helps reduce exposure to discrimination, hostility, and psychological distress, while contributing to a greater sense of emotional safety.

These findings highlight the reliance on informal coping mechanisms among crisis-affected populations and underscore the need to strengthen access to inclusive, community-based MHPSS services that can support adaptive coping, reinforce resilience, and address unmet psychosocial needs among vulnerable and marginalized groups.

Concealment of GBV, Self-Imposed Mobility Restrictions, and Familial Protective Strategies: Within highly sensitive social environments characterized by stigma, fear of social repercussions, and concerns regarding family reputation, concealment and protective silence emerged as common coping and risk-management mechanisms. Participants described the non-disclosure of GBV incidents as a strategy adopted to avoid social scrutiny, protect family standing, and mitigate potential negative consequences associated with reporting or seeking support.

Among host community women and girls in Saida, silence and concealment were identified as deliberate responses to GBV incidents, reflecting efforts to manage risks while avoiding broader community exposure and social judgment. While these strategies may be perceived as protective within the immediate social context, they also contribute to underreporting and may limit access to available protection, psychosocial, and GBV response services.

In parallel, participants highlighted the role of family-based protective practices in mitigating perceived risks. Host community mothers in Saida reported actively providing safety guidance and awareness to their daughters regarding protection concerns present within their neighbourhoods and surrounding environments. Such guidance was described as an important mechanism through which families seek to strengthen girls' awareness of potential risks and promote precautionary behaviours.

Voluntary confinement and self-imposed movement restrictions were also reported across both host and displaced populations as common strategies for managing perceived safety threats in public spaces. Women and girls described limiting their mobility, avoiding certain locations, reducing participation in community activities, or restricting movement to specific times of day in response to fears of harassment, violence, and insecurity. While these measures may be intended to reduce exposure to risk, they can simultaneously restrict access to education, livelihoods, social networks, humanitarian services, and other essential resources.

The widespread adoption of concealment, restricted mobility, and family-driven protective practices demonstrates how perceived insecurity and harmful social norms continue to shape behaviours and coping strategies. These findings further illustrate the extent to which protection concerns influence daily decision-making and highlight the need for interventions that address both the underlying risks of GBV and the social dynamics that constrain safe disclosure, freedom of movement, and access to support services.

B. Community Support Structures

Primary Familial and Local Community Support: Immediate and extended family networks emerged as the primary source of support and protection for many women and girls, often serving as the first, and in some cases only, avenue for assistance in the absence of, or as an alternative to, formal service providers. Across both host and displaced populations, family structures play a central role in providing emotional support, facilitating conflict resolution, and assisting individuals in navigating protection concerns and periods of psychosocial distress.

Among host community populations, Lebanese women in Saida reported relying on family networks as a key protective mechanism when facing family or marital disputes. Participants described temporarily relocating from the marital home to stay with extended family members as a means of seeking safety, reducing tensions, or creating space for mediation. In addition to familial support structures, some women reported turning to traditional dispute-resolution mechanisms, including Sharia courts, local authorities, and religious leaders, to address domestic and marital concerns.

The prominent reliance on family-based support mechanisms was similarly observed among displaced populations, particularly among displaced Lebanese adolescent girls in Baabda and North Lebanon, who identified parents and close relatives as their primary source of protection, guidance, and support. Likewise, displaced Lebanese women in Saida, Baalbek-Hermel, and Beirut reported turning to immediate family members to cope with psychological distress and to address family conflicts through direct communication, mediation, and mutual support. These findings underscore the continued importance of family cohesion and social capital as protective factors within crisis-affected communities.

However, the predominance of informal support networks also highlights important protection concerns and potential gaps in access to specialized services. While family and community mechanisms can provide immediate assistance and emotional support, their capacity to effectively address GBV incidents may be constrained by prevailing social norms, stigma, and concerns related to family reputation. Among displaced Palestinian women in Saida and Ein El Helweh, participants reported relying primarily on family members for support; however, perceptions surrounding rape and sexual assault were identified as significant barriers to disclosure, reducing the likelihood that survivors would report incidents or access formal protection and GBV services through these channels.

The heavy reliance on family and community networks further suggests that GBV disclosures and requests for support frequently remain confined within informal structures. While these mechanisms represent an essential safety net, support provided through family and community channels is not always survivor-centred and may be influenced by social expectations, cultural norms, or concerns regarding community standing. Consequently, survivors may face pressure to prioritize family cohesion, confidentiality, or social reputation over their own protection needs and recovery. These dynamics can contribute to underreporting, delay access to specialized services, and limit survivors' ability to pursue safe and informed pathways to support.

Overall, the findings illustrate the dual role of family and community networks as both critical sources of protection and potential barriers to comprehensive GBV response. Strengthening community awareness,

promoting survivor-centred approaches, and enhancing safe referral pathways to specialized services remain essential to ensuring that informal support structures complement, rather than replace, access to appropriate protection and GBV assistance.

Seeking Support from Host Community and Local Municipalities: Findings indicate that displaced women in several regions of Lebanon actively rely on host community networks and local support structures to navigate displacement-related challenges and mitigate socioeconomic stressors. These informal solidarity mechanisms serve both practical and protective functions, facilitating access to information, resources, and social support while strengthening community-based coping capacities.

Among displaced Lebanese women in Beirut, particularly those displaced from southern areas, participants described the establishment of informal support networks through which women coordinate daily responsibilities, share information, and pool financial resources to manage rising living costs and inflation-related pressures. Similar patterns were reported in Mount Lebanon and Saida, where displaced Lebanese women have developed supportive relationships with host community members, drawing on shared resources, mutual assistance, and community solidarity to address immediate needs and enhance their sense of safety and belonging.

In North Lebanon, participants highlighted the importance of local municipalities, extended family networks, and supportive host community neighbours in facilitating adaptation to displacement and supporting access to essential services. Across several locations, host community members were reported to play an important role in disseminating information regarding available humanitarian assistance, service referral pathways, and safety-related resources. For many displaced women, these networks extend beyond logistical support and function as critical protective mechanisms that help reduce isolation, strengthen social connectedness, and mitigate some of the protection risks associated with displacement.

Key informants representing local authorities similarly emphasized the role of municipalities in supporting the safety, wellbeing, and protection of internally displaced persons (IDPs). Municipal representatives reported coordinating with the Ministry of Social Affairs (MoSA), humanitarian actors, and non-governmental organizations to facilitate access to assistance for displaced households, including cash support, medical services, dignity kits, assistive devices, and essential items. Municipalities also described their contribution to maintaining basic services, including water provision and waste management, which indirectly support protection outcomes by improving living conditions for affected communities.

In addition to service provision, municipalities were identified as important actors in promoting social cohesion and mitigating tensions between host and displaced populations. A municipal representative from the Bekaa highlighted efforts to raise awareness among local residents regarding displacement-related challenges and foster positive community relations. Participants reported that municipal authorities played a key role in responding to incidents of social tension, facilitating dialogue between affected groups, and coordinating with relevant authorities when necessary. Municipalities were also described as serving a mediation function in cases involving housing-related disputes, including situations of rental exploitation and risks of forced eviction.

Overall, findings suggest that host community solidarity, informal social networks, and municipal engagement constitute important community-based protective factors for displaced populations. By facilitating access to resources, strengthening social cohesion, and supporting peaceful coexistence, these mechanisms can help mitigate displacement-related vulnerabilities and contribute to safer and more supportive environments for women, girls, and other at-risk groups.

Horizontal Peer Support: Contrarily to the above, specific displaced populations, mainly marginalized and vulnerable women and girls, prefer to rely on peer networks for horizontal solidarity and support rather than seeking help from the host community. Displaced Syrian women in West Bekaa rely on self-built horizontal peer networks to share emotional weight and collectively manage displacement distress. This collective emotional interdependence is highly pronounced among displaced Syrian women with disabilities in Beirut and Mount Lebanon, who rely heavily on one another for emotional support, a protective factor that is significantly reinforced when they are displaced collectively with relatives or familiar families. Displaced women migrant workers in Beirut seek essential protection and support through personal friends and the broader localized migrant women's community. This localized reliance becomes essential for displaced LGBTQI+ individuals in Mount Lebanon, who report experiencing isolation and find no support whatsoever from the broader local community. Consequently, they rely exclusively on other LGBTQI+ individuals for safe survival and depend on specialized humanitarian organizations, such as Mosaic and Helem, as their sole source of acceptance, protection, and GBV response services.

3.5 Priority Needs of Affected Groups

Findings from the multisectoral needs assessment outside collective shelters showed that the top priority three needs for internally displaced persons were: shelter or cash for rent, food and cash assistance to meet basic needs.[53] These findings below reflect the immediate concerns reported by both displaced and host communities and perspectives from key informants. Participants emphasized the need for community informed programming. Priority needs for affected women and girls were categorized into four categories including basic needs, GBV risk mitigation needs, inclusion needs and recovery needs.

A. Basic Needs for Women and Girls

- **Adequate housing:** For groups facing the most acute shelter insecurity, particularly women without shelter or living in informal or street-based arrangements, adequate housing was consistently identified as a foundational priority for safety, dignity, privacy, and access to services. For those residing with host families or rented apartments, rent support was identified as a way to reduce eviction risks, overcrowding, household stress, and exposure to GBV-related risks. Moreover, due to severe overcrowding, there is a critical need for shelter arrangements that provide privacy, doors with locks, and safe, private sanitation facilities.

[53] AAWG, ERNA for IDPs Outside Collective Shelter Results, 2026

"Everything starts with shelter because without shelter there is no privacy, no safety, and no stability."

Displaced women without shelter (Beirut)

- **Cash and financial assistance:** Cash assistance was frequently identified as a priority need across participants. Affected groups urgently need money to cover exorbitant rental costs, food, transportation, and basic survival items. For women and girls, cash assistance provided within the case management action plan showed to be particularly critical as it can serve as a main asset that fosters a stronger economic independence, empowerment and strength and a protective factor against resorting to negative coping mechanisms.

"The only thing we want to change is the type of services we are receiving; we are not receiving any financial help."

Displaced Lebanese Women

- **Food:** While food parcels are currently the most common form of aid, participants reported the need for more diverse and appropriate food assistance, particularly for children, older persons, pregnant and lactating women, and people with specific dietary or health needs.
- **Medications and chronic care:** There are severe shortages of essential medicines. Displaced women and girls reported an urgent need for continuous access to medications for chronic illnesses, mental health conditions, and post-operative care. Specifically, older women often deprioritize their own chronic medication needs because they feel like a burden to their families.

"We want to know where and how to access medical services and what services are available for our families."

Syrian Displaced Women, North

- **Maternal and reproductive health:** Pregnant and lactating women require accessible maternal healthcare, safe transportation to clinics, and private spaces for breastfeeding and infant care.

"For me the biggest fear is health because I don't know what happens if labor starts suddenly."

Displaced women without shelter, Beirut

- **Clothing:** Although it was not a high priority like other needs, displaced groups indicated the need for culturally appropriate clothing (like hijabs) that they can use on a daily basis, as many of them fled their homes without taking anything.

Displaced Women and girls also indicated their urgent need for clear guidance on where and how to access basic humanitarian aid, particularly cash, food, health and adequate shelter as many of them do not know where to access these services.

"We need clear information about available assistance, like food, cash support, and how to register for it."

Syrian Displaced women FGD participants, North

B. GBV risk mitigation measures needed

- **Public Safety measures:** To mitigate risks of harassment and exploitation, communities requested better street lighting, community-based safety measures designed with women and girls, including safer routes, safe transport options, and accountable referral/reporting mechanisms, as some of the necessary public safety measures.
- **Safe water and sanitation:** Women and girls also reported the need for clean drinking water, and safe sanitation facilities. Men participants in informal tented settlements ranked clean water and safe toilets as top priorities, recognizing, along with women, that inadequate, shared, and poorly lit sanitation facilities severely compromise the physical safety and privacy of women and girls.
- **Hygiene and dignity Items:** There is a widespread need for personal hygiene materials. Women specifically requested quality menstrual hygiene materials, underwear, adult diapers, infant diapers, cleaning products.
- **Safety information, and emergency contacts** Given the ongoing conflict and displacement, populations, women and girls emphasized the necessity of practical guidance on navigating physical safety, insecure areas, and knowing who to contact in emergencies. Displaced Lebanese adolescent girls in the south prioritized safety and emergency preparedness, with girls specifically requesting general safety hints, emergency advice, and first aid information, Syrian displaced men in Akkar participants expressed the need for clear information during emergencies, including where to go and who to contact, especially in cases of violence or urgent incidents. Moreover, adolescent boys and displaced LGBTQ+ in Beirut identified safety guidance as their most critical information need, underscoring a collective demand for practical tools to navigate emergency situations

"We need information about safety, and who to contact if we face problems or need help"

Displaced Syrian Women, North

"The key information needed includes safety guidance to help people protect themselves, as well as information on available services and support."

Host community Women, Beirut

C. Specialized GBV Response

- **Awareness about GBV services:** A key priority need is increasing awareness regarding existing specialized GBV services. Participants reported a significant lack of knowledge on how and where to access support, necessitating targeted awareness campaigns to bridge this information gap. Particularly important seems awareness based on AGD-specific needs to ensure inclusion of all affected people at at-risk groups.
- **GBV Case management:** Participants reported the need for a comprehensive package of specialized assistance that covers safety, financial, psychosocial, and medical needs (including mental health and legal support) through dedicated GBV case management services and referrals.

"We need psychosocial and emotional support because we continue to live in fear and anxiety."

Women from the host Community Women (Beirut)

- **Women and girls safe spaces:** Women and girls urgently need dedicated, secure safe spaces where they can gather, socialize, receive support away from overcrowded living conditions, safely receive information on existing services, strengthen their support networks, participate in psychosocial support activities, and benefit from referrals.

"We want PSS, and some entertainment because we spend the whole day doing nothing so we get bored."

Displaced Lebanese Women, North

D. Recovery Needs

- **Job opportunities and vocational training:** Economic recovery and empowerment is viewed by participants as important for restoring dignity, reducing economic dependency, and mitigating some GBV risks, such as transactional exploitation, forced marriage, sexual exploitation linked to survival needs, and abusive dependence linked to IPV. Women frequently requested job opportunities, vocational training, and the means to become financially independent rather than relying solely on humanitarian aid.

> *"We do not have any income we cannot afford rent and the basic necessities, so information about jobs is what we need the most right now"*
>
> Displaced Lebanese female-headed household, North

> *"We would like to learn activities and vocational skills related to livelihoods."*
>
> FGD Participant, Host community Women, Beirut

- **Education and child-friendly activities:** It is critical to support girls to prevent prolonged school dropout that could increase risks of child marriage or engagement in child labor, it is important to support girl's education. There was a high demand for a return to in-person schooling reported by adolescent girls and boys to get back to their routines to avoid isolation. Mothers also heavily prioritized educational support (such as tablets for online learning), and recreational activities to protect their children from the trauma of war, reduce excessive screen time, and reduce isolation, restore routine, support wellbeing, and mitigate protection risks, including child labour and child marriage risks linked to economic pressure and disrupted education.

> *"In-person education helps us adapt during displacement and reduces psychological pressure."*
>
> Displaced Lebanese boy (Beirut)

E. Inclusion Needs

- **Women with disabilities and older women:** Women with disabilities stated they require physically accessible shelters (e.g., ramps, accessible toilets), assistive devices, mobility support, and targeted outreach, as they are often physically unable to reach distribution points or clinics. Older women

specifically requested information regarding how to access chronic medications and physical and mental health services.

- **Migrant domestic workers and LGBTQI+ individuals:** These populations reported facing discrimination and heightened risks. Their situation would require targeted legal protection, inclusive shelters, and confidential legal aid, safe, documentation support, and trusted referral pathways to reduce exposure to exploitation, blackmail, abuse, and concerns about their legal vulnerabilities . Migrant women indicated the need for sexual health services, and locations for mobile sexually transmitted infections (STI) testing.
- **Legal documentation, residency and assistance:** Displaced women and girls who lost essential documents (like IDs or birth certificates) due to the war or before urgently need clear guidance on emergency replacement procedures and their legal rights. The Lack of documentation blocks access to basic services. Undocumented displaced women and girls indicated the need to handle their legal status because it is vital for their freedom of movement and protection, particularly Syrian and Migrant displaced women.

3.6 Disrupted GBV Services and Referral Pathways

A. Disruption in Services

Desk Review findings showed that currently, severe funding deficits and ongoing conflict deeply disrupt service delivery. The services most affected include safe spaces for women and girls and general healthcare services[54].The number of operational safe spaces dropped to 44 (68% of the target) in 2025, leaving 168,000 women and girls without access.[55] For SRH specifically, support for institutional deliveries remains a gap with the demand exceeding the support available. Similarly, key informants reported that the physical infrastructure supporting the GBV response has been exhausted by both direct conflict damage and financial constraints as described below:

- **Closure of offices and facilities and damaged facilities:** International and National NGOs reported the closure of multiple field offices due to insecurity and staff displacement, specifically shutting down locations in Nabatiyeh, Dahye, Marjeyoun, Bint Jbeil, and Tyre. Several other centers in South Lebanon were also directly damaged or destroyed by the conflict. Therefore, organizations' access to these areas was limited. Even before the latest escalations, funding constraints led to the closure of approximately 16 Women and Girls Safe Spaces (WGSS) in 2025 as reported by key informants who are expecting further closures in 2026 limiting the geographical coverage of services.
- **Constrained life-saving CMR services:** Limited resources have directly constrained the provision of immediate, life-saving support, specifically CMR. Due to the conflict and evacuations, CMR services also had to be relocated from Tyre to Saida, limiting access for populations in the far South.

[54] UNICEF Lebanon Humanitarian Flash Update No. 4 (Escalation of Hostilities 2026), 19 March 2026 and UNFPA Middle East Gender-Based Violence in Emergencies Snapshot - April 2026

[55] Protection Sector Lebanon. (2026). 2025 end year sector dashboard

- **Limited Dignity Kits Availability:** While dignity kits are prioritized as a "key entry area" to establish trust and provide GBV/reproductive health outreach, the actual supply falls drastically short of the demand. Severe funding shortfalls combined with a surging displaced population have severely restricted the capacity of frontline workers and NGOs to distribute these life-saving materials.
- **Access barriers:** Humanitarian convoys face immense struggles to deliver essential Sexual and Reproductive Health (SRH) commodities such as antibiotics and contraceptives, and dignity kits to hard-to-reach areas in the South and Nabatiyeh, having to rely on very brief access windows. Ongoing insecurity, fear of airstrikes, and unpredictable road conditions severely restrict the movement of humanitarian staff and discourage women and girls from traveling to seek services.
- **Shift to remote modalities:** Continued operations under active strikes; transitioned to remote modalities for case management, online PSS, MHPSS, and legal consultations. In addition, the lack of funding has forced GBV actors to limit the implementation of mobile modalities. Consequently, organizations have been forced to pivot heavily toward remote service delivery (phone and online case management) as an emergency fallback to maintain continuity of care.
- **Legal services:** Although basic, remote advisory services remain functional enabling survivors to access critical information pertaining to divorce proceedings and extraction from abusive environments, actual judicial representation was very low in the emergency situation. The temporary suspension and reduced functioning of courts during the crisis limited access to justice, affecting the availability of legal remedies and services for GBV survivors.

B. Staff Displacement Affecting Service Provision

The ongoing crisis has profoundly impacted humanitarian personnel, blurring the lines between service providers and crisis-affected individuals. Key Informant Interviews showed that many frontline workers and caseworkers have themselves been displaced by the conflict, particularly across the South, Beirut, and Mount Lebanon. Staff have faced severe safety and movement risks during escalations, with some reporting that bombed roads and bridges left teams unable to travel by car, occasionally forcing them to flee on foot. According to GBV caseworkers, this displacement, combined with the high volume of the emergency, was associated with an overwhelming burden on remaining personnel. Displaced caseworkers are experiencing severe burnout and compassion fatigue, struggling to manage a high level survivor-to-caseworker ratios. Displaced caseworkers reported reduced concentration, disrupted work schedules, and challenges maintaining emotional presence during case management. Several indicated that displacement created logistical barriers such as unstable internet access, transportation difficulties, and lack of private workspaces. Some participants noted increased empathy towards clients because of shared experiences, while others expressed concerns about secondary trauma. In addition, in the south some employees with GBV service providers were forced to leave their jobs entirely due to insecurity, displacement, burnout, or the overall instability of the context. This had a direct impact on continuity of services and the ability of organizations to maintain stable field operations.

"I became a displaced person and a responder at the same time. I am supporting women during the day while trying to figure out where my own family will stay."

Displaced Caseworker

C. Disrupted Referral Pathways

The GBV referral pathways are generally considered active, updated, and functional as a tool, representing the only subsector with dedicated inter-agency and community-level pathways. Despite the pathways functioning on a structural level, their practical effectiveness is frequently hindered by actual service disruptions, geographic gaps, physical access issues, and security concerns. However, several significant functional challenges exist including the below:

- **Complex and technical design for community GBV referral pathways:** The pathways are perceived as being too complex and highly technical, making them difficult for community members and non-protection frontline workers to navigate. Key barriers include language issues, excessive text, and a heavy reliance on QR codes that require users to fill out specific information to access help.
- **Underutilization of static referral pathways by non-GBV actors:** GBV Frontline workers noticed that frontline workers in basic needs sectors (such as WASH or Food Distribution) often state they cannot read or understand the pathways, resulting in missed opportunities for safe referrals during their first point of contact with at-risk individuals. Coordinators emphasize that the referral pathway should serve as an accessible operational resource for all sectors rather than remaining a tool exclusive to Protection and GBV specialists.
- **Incomplete service mapping:** Formal online service mapping tools are often not practical or updated quickly enough in fast-moving emergencies. Because of delays in updating service functionality and shelter availability, some organizations have found that decentralized, live tracking methods such as continuously updated shared Google Sheets are much more effective for real-time frontline coordination than formal bureaucratic maps.
- **Need for targeted adaptation:** While there have been positive efforts to adapt referral pathways for marginalized populations, such as migrant communities, and to train community leaders on their use, stakeholders note these pathways still need further simplification and continuous, sustained training to be truly effective on the ground.
- **Shrinking service availability:** A referral pathway is only as effective as the services it connects to. Because of severe funding cuts, facility closures, staff displacement, and security restrictions, the availability of actual services has drastically decreased. Consequently, the pathway itself may function, but the service at the end of the referral may be absent, leading to delayed support or the reliance on waiting lists.

- **Unresponsive hotlines:** A major breakdown in the referral process is the reliance on multiple, fragmented hotline numbers that are frequently unanswered, temporarily inactive, or unmonitored. When survivors finally decide to reach out and receive no answer, it severely undermines their trust in the entire humanitarian response system.

3.7 Strong Preference for In-Person Over Remote Modalities

Desk review findings indicate that the availability and accessibility of in-person GBV services have been significantly affected by funding shortfalls, conflict-related disruptions, and damage to essential infrastructure. In 2025 alone, 19 static GBV facilities reportedly ceased operations due to funding constraints.[56] Since the escalation of hostilities in 2026, additional service points have reportedly suspended or reduced operations because of insecurity, restricted humanitarian access, infrastructure damage, and continued resource shortages.[57] Concurrently, sustained hostilities have resulted in the partial or complete destruction of numerous primary healthcare centres and hospitals, further reducing the availability of safe and accessible entry points for GBV survivors seeking support.[58]

Access to remaining services has also been constrained by ongoing security concerns. Available evidence indicates that many survivors experience heightened anxiety regarding movement and transportation due to road insecurity and conflict-related risks, creating additional barriers to reaching service providers and referral pathways.[59]

The analysis below evaluates the safety, feasibility, accessibility, confidentiality and acceptability of three primary service delivery modalities: remote support, mobile outreach, and static facilities. Findings indicate that while each approach serves specific situational needs, a clear preference for face-to-face interaction persists among affected populations. This preference underscores a critical tension between the practicalities of service accessibility and the fundamental requirement for a trusted, private, and secure environment for care.

A. Remote Modality

While remote services (such as phone calls, WhatsApp, and online sessions) served as a critical emergency adaptation to maintain the continuity of GBV case management and psychosocial support when physical access was restricted, they are widely viewed as a fallback rather than a preferred solution. Only 2 FGD participants were positive about remote support as it saves them transportation cost.

Desk review findings showed that remote modalities constraints were numerous**.** Overcrowded shelters often lack the privacy required for confidential psychosocial support[60],[61]. Delivery is frequently disrupted

[56] Protection Sector Lebanon. (2026). 2025 end year sector dashboard
[57] OCHA Lebanon. (2026). Flash update #10
[58] Protection Sector Lebanon. Lebanon protection snapshot: Displacement post-escalation (16-30 March 2026).
[59] Protection Sector Lebanon. (2026). Lebanon Protection Snapshot: Displacement Post-Escalation (16-30 March 2026).
[60] Protection Sector Lebanon (2026). Protection Emergency Response Weekly Situation Report #3
[61] Protection Sector Lebanon .Lebanon protection snapshot: Displacement post-escalation (16-30 March 2026).

by internet blackouts, poor connectivity, and restricted device access[62]. Migrant domestic workers faced employer surveillance and phone confiscation[63], while low digital literacy and a profound distrust in digital confidentiality deter older survivors[64], leaving overstretched caseworkers with massive high-risk caseloads.

Remote services were highly criticized by FGD participants and frontline workers due to safety, privacy, and technical limitations. Below are the details:

- **Severe lack of privacy and safety risks:** The most critical barrier to remote care is the extreme overcrowding in displacement shelters and shared apartments. Women and girls are rarely alone, making it difficult to speak freely about GBV or IPV. In addition, in ITSs setting there are no walls or acoustic barriers which makes it very difficult to have the needed privacy to report any GBV case or get a service. For survivors of IPV, phone calls create severe safety risks because the perpetrator or family members may be in the same room listening to the conversation. Many women indicated that they use shared non personal phones, which severely restricts women's privacy and prevents them from safely and confidentially accessing remote services or reporting abuse.
- **Confidentiality fears and mistrust:** Survivors frequently express suspicion regarding digital privacy. There is a common fear that phone conversations could be monitored, that personal data could be leaked, or that speaking with unidentified humanitarian workers over the phone is unsafe.
- **Technical and financial barriers:** Remote support is frequently disrupted by poor telecommunications infrastructure, unstable internet connections, and power cuts. Additionally, the high cost of mobile data and phone credit is a significant financial burden, and many women do not have access to a mobile phone or have to share a single mobile device with other family members.
- **Quality of care:** Caseworkers noted that remote modalities limit their ability to read non-verbal cues, making trust-building and comprehensive risk assessments difficult.

> *"Privacy can be a concern when trying to access services remotely because there is more than one family in each house"*
>
> FGD Participant Lebanese IDP Female-Headed Households, North

B. Face-to Face Modalities

Mobile and Outreach Modalities: Experiences with mobile and outreach modalities, on the other hand, show that they are highly requested by affected communities. Participants reported that mobile modalities allow them to overcome the challenges they face such transportation costs, distances, and

[62] Protection Sector Lebanon (2026), Protection Emergency Response Weekly Situation Report #3
[63] CARE International Lebanon: GBV Safety Audit Report on GBV, SRH, and Shelter Accessibility in Lebanon – June 2025
[64] GBV Working Group Lebanon (2024), Gender-Based Violence Safety Audit for Lebanon

physical mobility barriers, which is especially vital for older women, pregnant individuals, and persons with disabilities who cannot come to centres. Many women FGD Participants strongly emphasized that when services come to communities, women benefit more.

> *"For women like me, services coming closer would help much more"*
>
> Displaced Pregnant Woman without shelter, Beirut

> *"I would assume if we had mobile services it would be better than fixed locations because of the lack of transportation"*
>
> Lebanese Female-Headed Household

Desk review findings showed that destroyed road infrastructure and persistent airstrikes physically block mobile outreach teams from accessing conflict zones in the South and Bekaa[65]. Funding challenges also limited the availability of mobile teams. Staff also operate under intense security threats and psychological distress[66]. In addition, overcrowding in public spaces makes safe, confidential case management practically impossible[67].

However, mobile modalities also face significant operational challenges reported by affected groups and key informants, including the following:

- **Staff security and capacity:** Deploying mobile teams involves navigating security risks for staff, managing logistical constraints regarding staff availability, and securing community acceptance in unfamiliar or tense areas.
- **Field Confidentiality:** Securing discreet, acoustically private settings for sensitive case management is exceptionally difficult within densely populated informal camps or overstretched hosting environments.
- **Visibility and Privacy Risks:** Mobile outreach units frequently attract large crowds, compromising the anonymity of visitors and deterring women from disclosing sensitive protection concerns. For highly marginalized populations like migrant workers, humanitarian workers visits can also trigger local disputes or landlord surveillance.
- **Funding Availability:** Acute funding shortages serve as a primary bottleneck, severely restricting the deployment and operational scale of mobile modalities.

[65] UNHCR (2026). Middle East situation Lebanon - Flash update #3 16-22 March 2026
[66] Ibid and Protection Sector Lebanon (2026). Protection Emergency Response Weekly Situation Report #3
[67] Ibid

- **Community Resistance**: The effectiveness of mobile interventions is frequently influenced by the local social environment, with teams facing community resistance and varying levels of acceptance depending on the specific area they are attempting to serve which was reported by frontline caseworkers in South and Beirut and Mount Lebanon (BML) areas.

- **Safe spaces and Static Facilities**

Static locations, such as dedicated Women and Girls Safe Spaces (WGSS) or other facilities providing GBV services, remain a highly trusted modality. Participants reported static locations offer a guaranteed secure environment with closed doors, providing women and girls a much-needed physical escape from the stress, noise, and lack of privacy in their overcrowded living conditions. However, the primary barrier to accessing static facilities remains the high cost of transportation, the fear of moving through unsafe areas to reach the centers, and the closure of some of the WGSS during the emergency due to the funding or due to their locations in relatively non safe areas.

C. Affected Group Modality Preferences

Across the diverse demographics of displaced populations and host communities, there is an overwhelming preference for Static (in-person) and Mobile (outreach) services over Remote (phone/online) modalities. Face-to-face interaction is widely considered the "gold standard" because it fosters trust, ensures a higher degree of confidentiality, and allows caseworkers to read non-verbal cues that are critical in GBV risk assessments.

> *"In-person service access is strongly preferred over remote or phone-based delivery, as direct interaction reduces concerns about trust and privacy"*
>
> Lebanese Adolescent Boys, Beirut

> *"We like to see each other in person, and we value body language, which cannot really be conveyed in an online environment"*
>
> FGD Participant, LGBTQI+ Community, Mount Lebanon

Specific findings by group:

- **Elderly, Pregnant Women, and Persons with Disabilities:** For groups with physical mobility challenges or caregiving burdens, direct home visits and mobile outreach workers coming directly to their locations are absolutely essential.

- **Women without shelter:** Women living in the streets in Beirut strongly prefer visible outreach workers coming directly to them, noting that "services coming closer" is the only way they can benefit.
- **South Lebanon (Host & IDPs):** Due to heightened security fears and suspicion regarding remote data collection, populations in the South strongly prefer in-person community meetings and direct, face-to-face communication to verify the identity of the service provider.

3.8 Perceptions on Accountability to Affected Populations and Complaint Mechanisms in Humanitarian Interventions

Lack of Awareness and Trust in Complaints and Feedback Mechanisms for Humanitarian Misconduct:
Findings indicate a widespread lack of awareness of formal Complaints and Feedback Mechanisms (CFMs) intended to enable affected populations to report concerns, including incidents of exploitation, abuse, or misconduct by humanitarian personnel. Across a broad range of consulted groups, including adolescent girls, displaced women, and host community members, participants reported limited or no knowledge of available reporting channels, with many stating that they did not know how to submit a complaint or safely report inappropriate conduct by humanitarian actors. This lack of awareness significantly constrains the effectiveness of accountability mechanisms and limits affected populations' ability to seek redress.

Even among participants who were aware of the existence of complaint channels, such as hotlines, helpdesks, or complaint boxes, trust in these mechanisms was frequently reported as low. Concerns regarding confidentiality, fear of retaliation, and uncertainty about how complaints are handled emerged as key barriers to utilization. Participants expressed apprehension that reporting concerns could result in negative consequences, including reduced access to assistance, loss of eligibility for future aid, or strained relationships with service providers. These perceptions contribute to a reluctance to engage with formal reporting systems, particularly among individuals in highly vulnerable situations who depend on humanitarian assistance to meet basic needs.

Operational challenges further undermine confidence in existing mechanisms. Participants reported experiences of unanswered hotline calls, dropped connections, and a perceived lack of follow-up after complaints were submitted. Such experiences reinforced the belief that reporting concerns is unlikely to result in meaningful action or accountability. As a result, some participants expressed the view that "complaining changes nothing," reflecting low confidence in the responsiveness and effectiveness of current feedback and complaint processes.

Differences in awareness and reporting preferences were observed between host and displaced populations. While overall knowledge of formal humanitarian CFMs remained limited among affected Lebanese communities, some host community women in Beirut and Akkar demonstrated comparatively greater awareness of NGO-managed feedback channels and generally perceived them as confidential and accessible. However, where knowledge of humanitarian reporting mechanisms was limited or trust

in such channels was weak, participants indicated a preference for seeking support through familiar local structures, particularly municipalities and local authorities, which were often viewed as more visible, accessible, and accountable within the community.

These findings highlight significant gaps in both awareness of and confidence in accountability mechanisms. Strengthening community outreach on available CFMs, enhancing transparency regarding complaint handling procedures, and reinforcing safeguards related to confidentiality and protection from retaliation are critical to promoting safe reporting. Efforts to improve the accessibility, responsiveness, and perceived credibility of complaint mechanisms are essential to ensuring that affected populations can raise concerns, report misconduct, and engage meaningfully with humanitarian accountability processes.Displaced Syrians showed better awareness of CFMs than other groups, but trust remains low. Participants report unresponsiveness from hotlines, which often involve interrogations before disconnecting or depleting phone credit. Some migrant workers stated they do not know how to complain or report, citing a lack of trust in anonymity. Conversely, the LGBTQI+ community demonstrated awareness of confidential complaint boxes located within specific, specialized NGOs they trust.

> *"We do not feel that complaints are sufficiently anonymous, because your phone will show when you call, or your email"*
>
> *Displaced migrant woman, Beirut*

Among displaced Lebanese and some host community members in the south, there was a suspicion regarding remote data collection and CFMs in the South due to severe security fears. Participants explicitly showed lack of trust in remote phone calls that ask for personal biodata, names, or locations, with one IDP woman terminating a call from an organization out of fear that the information could be misused. Consequently, populations in the South demand in-person, transparent, and locally grounded mechanisms to ensure clarity of purpose and trust. Host communities there also stated they had never heard of reporting mechanisms for humanitarian workers. In Akkar, displaced Syrian women, particularly those living in ITS, feel isolated as hotlines often drain phone credit without yielding answers or providing support. Consequently, they often rely on passively waiting for NGOs to visit the camps to obtain reporting information. In contrast, host community women in the same region report better awareness and trust in mechanisms such as direct office visits, emails, and hotlines that were personally introduced by NGO staff. Additionally, participants reported concerns regarding extensive assessment and data collection by some organizations with little or no corresponding assistance provided.

Perceptions of Humanitarian Assistance and Barriers to Access: Across the displacement context, perceptions of and access to humanitarian assistance were reported to be uneven and fragmented. Participants from several marginalized and at-risk groups described experiencing barriers to accessing assistance, including perceived exclusion, inequitable treatment, and limited inclusion in aid distribution processes. These experiences were reported to contribute to mistrust toward humanitarian actors and to

reduce confidence in available support mechanisms. Perceived gaps in assistance coverage and inconsistencies in service provision further reinforced feelings of neglect among some crisis-affected populations, potentially discouraging future engagement with humanitarian services and referral pathways.

Populations Residing Outside Collective Shelters versus Inside Collective Shelters: Participants highlighted a perceived disparity in the allocation of humanitarian assistance based on displacement accommodation arrangements. Women and girls reported that humanitarian support is often perceived as being primarily directed toward individuals residing in formal collective shelters, while displaced populations living in rented accommodation, informal arrangements, or hosted by relatives and community members receive comparatively less attention and support. As a result, many displaced women and girls living outside formal shelter settings described feeling overlooked or insufficiently targeted by humanitarian interventions despite facing similar or heightened levels of vulnerability.

This perceived inequity in assistance distribution has contributed to frustration and heightened tensions within displaced communities. Participants reported that differential access to aid based on housing status can generate feelings of discrimination and exclusion, particularly among households that do not meet shelter-related targeting criteria but continue to face significant economic and protection challenges. These perceptions may be further exacerbated by limited information regarding eligibility requirements, assistance prioritization frameworks, and available referral pathways.

For women and girls, unequal access to humanitarian assistance can have broader protection implications, particularly where access to essential services, cash assistance, psychosocial support, or GBV response services is affected. The perception that certain groups are systematically prioritized over others may undermine trust in humanitarian actors, reduce service uptake, and weaken community acceptance of assistance programmes.

Overall, these findings underscore the importance of ensuring transparent communication on targeting criteria, strengthening outreach to displaced populations residing outside collective shelters, and promoting equitable access to humanitarian assistance based on vulnerability and protection needs rather than accommodation status alone. Addressing perceptions of exclusion and unequal treatment remains critical to fostering trust, enhancing service accessibility, and ensuring that assistance reaches all affected populations in a manner consistent with humanitarian principles.

> *"Most of the aid was going more to the shelters; most of those in houses didn't see anything"*
>
> Displaced Lebanese Adolescent Girl, Mount Lebanon

Host communities perceive a strong bias toward IDPs in the humanitarian response.

A recurring theme among host community participants was the perception that humanitarian assistance is disproportionately targeted toward internally displaced persons (IDPs) and other displaced populations, often at the expense of vulnerable host community members. Participants expressed concerns that humanitarian actors prioritize displaced households in the allocation of assistance, service provision, and livelihood opportunities, while the needs of economically vulnerable host community members receive comparatively less attention.

Among host community women, this perceived imbalance was closely linked to the deteriorating socioeconomic situation and growing competition over limited resources. Participants reported feeling overlooked despite experiencing many of the same hardships affecting displaced populations, including rising living costs, unemployment, reduced purchasing power, and difficulties meeting basic needs. As a result, some participants perceived humanitarian assistance frameworks as insufficiently responsive to the vulnerabilities present within host communities.

Displaced Non Lebanese and marginalized groups reported unequal access to assistance: Displaced Syrians reported severe, nationality-based exclusion from humanitarian aid. When attempting to access aid, migrant women report widespread favoritism, where organizations only provide assistance to migrants already known to them. Furthermore, migrant women expressed deep frustration with the corruption and abuse of power by informal community focal points, who sometimes "rob" the aid or send cash assistance back to their home countries instead of distributing it fairly to the affected women and girls. Transgender individuals specifically report discrimination from NGO staff. Women with disabilities feel entirely overlooked by the humanitarian database systems. Women with disabilities report officially registering their names in displaced persons databases through the relevant ministries but they did not receive assistance. Their access is further hampered by physically inaccessible service locations, long distances, and distribution points that lack ramps or accommodation

A. Communication Preferences

Effective humanitarian intervention depends on navigating the diverse landscape of how affected populations access and prefer to receive information. While communities currently rely heavily on informal peer networks and verified local authorities to stay informed, there is a distinct and overarching preference for WhatsApp for digital updates and face-to-face outreach for actual service delivery. Significant gaps exist in awareness of specialized GBV services and PSEA reporting mechanisms, largely due to geographic displacement and lack of trust in remote hotlines. Details about information sources and communication preferences across different demographic groups is provided in Annex 3 for future humanitarian outreach.

B. Assessment Exhaustion

A prevalent issue across displaced populations (including Lebanese, Syrian, and migrant women) is the deep frustration caused by repetitive humanitarian data collection that does not result in tangible aid. Displaced Lebanese women in the South expressed deep frustration that humanitarian responses heavily

focus on collecting information and conducting assessments, while the actual services and assistance provided remain extremely limited compared to their need. Similarly, displaced Syrian women in Bekaa reported that some NGO visits focus primarily on data collection without leading to any tangible improvements in their living conditions. Migrant women in Beirut also expressed deep dissatisfaction and exhaustion with the bureaucratic burden, citing the excessive documents required and "too many questions being asked to receive minimal aid". This practice of repetitive data collection without aid delivery was perceived by participants as actively harming the relationship between humanitarian actors and affected populations. The constant questioning without tangible assistance could help breeding suspicion and distrust with NGOs.

> *"When people only ask questions on the phone without helping, it makes us suspicious"*
>
> Displaced Lebanese woman, South

As a result, a key recommendation directly from these communities is for humanitarian organizations to "increase direct and tangible assistance rather than repeated assessments

Operational and Systemic Constraints Affecting the Humanitarian Response

Key informants reported that the effectiveness of the humanitarian response is frequently constrained by a combination of administrative, policy, and coordination challenges that limit the sector's ability to respond rapidly and effectively to evolving needs. These constraints were described as particularly significant within the context of large-scale displacement, increasing protection risks, and deteriorating socioeconomic conditions, where operational flexibility and timely service delivery are critical.

Several systemic gaps were identified, including challenges in reaching displaced populations residing outside collective shelters, the perceived deprioritization of GBV prevention and response within broader humanitarian priorities, restrictive administrative procedures linked to inflexible funding modalities, and barriers arising from the absence of legal documentation among affected populations. In addition, key informants highlighted coordination challenges among humanitarian actors that can result in fragmented service delivery, duplication of efforts in some locations, and insufficient coverage in others.

Collectively, these operational and structural barriers undermine the humanitarian sector's capacity to deliver timely, accessible, and survivor-centred assistance. They further constrain efforts to ensure accountability to affected populations, limit the responsiveness of protection interventions, and reduce the overall effectiveness of humanitarian programming in addressing the complex and evolving needs of crisis-affected communities. Addressing these challenges will be essential to strengthening the reach,

quality, and sustainability of humanitarian assistance, particularly for populations facing heightened vulnerability and protection risks.

A. Challenges Reaching Displaced Groups Outside Collective Shelters

Approximately 85% of displaced populations reside outside of formal collective shelters, scattering across host communities, rented apartments, and unfinished buildings. Reaching them was reported to be exceptionally difficult due to the reduction of mobile outreach teams caused by funding constraints, and the perceived lack of clear tracking data.

> *"The primary barrier to assistance provision is the difficulty in identifying IDPs living outside official shelters."*
>
> KI, National Coordinator

Key informants including service providers and local leaders indicated that assisting individuals inside formal collective shelters is operationally straightforward because these sites serve as centralized, highly visible hubs for humanitarian agencies. Populations within formal shelters are concentrated in shared locations, making it significantly easier to assess their needs and distribute aid efficiently. Yet, displaced families outside collective shelters are scattered across private residences or informal settlements who easily slip off the radar. Moreover, these structured environments provide clear entry points for established service providers, allowing organizations to implement comprehensive support programs without the massive logistical hurdles of tracking down highly dispersed communities. Furthermore, one local leader indicated that humanitarian assistance focuses on collective shelters assuming that families displaced within these shelters are the most vulnerable however it is not always the case. In addition, the lack of funding was also one of the reasons to prioritize displaced groups inside collective shelters for assistance.

> *"People outside formal shelters sometimes disappear from assistance systems."*
>
> KI, Local authority, South

B. Deprioritization of Protection and Funding Challenges

Key informants consistently reported that the emergency response has been largely driven by the imperative to address immediate life-saving and basic needs, resulting in the relative deprioritization of protection programming within the broader humanitarian response. While the scale and urgency of humanitarian needs necessitated rapid interventions focused on food security, shelter, health, and other essential services, respondents noted that protection concerns, including GBV risks, were not consistently treated as a core emergency priority from the onset of the crisis.

Informants further highlighted limited integration of protection principles and GBV risk mitigation measures across sectoral response frameworks. Despite the heightened protection risks associated with displacement, overcrowding, economic vulnerability, and insecurity, GBV risk mitigation was reported to be insufficiently mainstreamed within non-protection sectors, including Water, Sanitation and Hygiene (WASH), Shelter, and Food Security and Livelihoods. As a result, opportunities to identify, mitigate, and monitor protection risks through sector-specific programming were not systematically maximized.

According to key informants, non-protection sectors largely prioritized the delivery of emergency assistance and the fulfilment of immediate survival needs, often treating protection considerations as a secondary or standalone issue rather than a cross-cutting responsibility. This approach was reported to limit the adoption of integrated programming models capable of addressing both humanitarian needs and associated protection risks. In particular, the absence of consistent protection mainstreaming and GBV risk mitigation measures across sectors may increase exposure to harm, restrict safe access to services, and reduce the overall effectiveness and inclusiveness of humanitarian interventions.

The reported deprioritization of protection programming also has implications for the sustainability and quality of the humanitarian response. Key informants emphasized that failure to systematically incorporate protection considerations into emergency interventions risks overlooking the underlying vulnerabilities and coping constraints experienced by affected populations, particularly women, girls, persons with disabilities, and other groups facing heightened protection risks. Strengthening intersectoral collaboration and embedding protection and GBV risk mitigation measures throughout the response were therefore identified as critical priorities to ensure that humanitarian assistance remains safe, accessible, accountable, and responsive to the diverse needs of crisis-affected communities.

> *"Protection is not considered as a key frontline sector... there is no clear consideration actually of protection mainstreaming or GBV risk mitigation."*
>
> KI, National Coordinator

Limited Funding Availability

The GBV response is experiencing chronic and severe financial shortfalls, currently operating at an estimated less than 20% of its required budget.[68] GBV specialists and Coordinators reported that funding for dedicated GBV expertise has been on a downward trajectory for years, reaching an "ultimate low" during the current crisis. Furthermore, the prioritization of basic needs in the emergency over protection has left local GBV actors and Women-Led Organizations (WLOs) struggling with existing financial instability, ultimately compromising the quality and reach of vital protection interventions. According to Key informants, funding cuts are contributing to loss of institutional capacity to deliver services as well as institutional memory limiting organizations' ability to serve communities.

[68] This figure is relevant for the Initial Flash Appeal (March-May 2026)

> *“Funding limits not only services but also our ability to create trust and continuity with the community."*
>
> Key Informant, Caseworker, Bekaa

The lack of financial resources has severely restricted the deployment of mobile outreach teams and reduced geographical catchment areas. It has also constrained the provision of critical life-saving services and materials such as dignity kits.

> *"Funding shortfalls are currently limiting operational capacity, staffing, and the availability of life-saving services.”*
>
> Key Informant, Caseworker, South

Moreover, funding shortfalls have disproportionately halted livelihood activities, vocational training, and life-skills programs that are essential for women's economic independence and resilience. Humanitarian organizations are currently facing severe operational strain due to reduced capacity, forcing them to prioritize the highest-risk cases while eliminating critical transportation support for survivors.

> *"Due to lack of funding, there is no transportation allowance for survivors. which prevents many from benefiting from services."*
>
> Key Informant, Caseworker, Akkar

Limited Funding Flexibility

Key informants highlighted that limited flexibility within donor funding frameworks can constrain the ability of GBV actors, national and international NGOs, local organizations, and Women-Led Organizations (WLOs) to adapt programming in response to rapidly evolving realities on the ground. Participants noted that predefined project activities and results frameworks, while essential for accountability and planning purposes, may reduce operational flexibility during emergencies where needs, risks, and population movements change frequently.

As a result, organizations may face challenges in adjusting interventions, reallocating resources, or introducing new activities to address emerging protection concerns and community-identified priorities in a timely manner. Informants emphasized that this can affect the responsiveness of programming, particularly in rapidly evolving displacement contexts where protection risks and service needs may differ significantly from those anticipated during project design.

Strengthening funding flexibility and promoting adaptive programming approaches were identified as important enablers of a more responsive and context-driven humanitarian response. Key informants noted that increased flexibility in funding arrangements could enhance the capacity of GBV actors and local partners to tailor interventions to emerging needs, strengthen community-centred approaches, and ensure that assistance remains relevant, effective, and aligned with the priorities of affected populations.

C. Coordination Challenges

The humanitarian response continues to face a number of operational and coordination challenges that affect the efficiency, coherence, and timeliness of GBV service delivery and broader protection interventions. Key informants highlighted several issues that limit effective collaboration among partners and constrain efforts to ensure comprehensive coverage of affected populations.

Unclear Coordination Pathways for Populations Residing Outside Collective Shelters:

- Key informants reported ongoing challenges related to coordination mechanisms and operational procedures for activities targeting displaced populations residing outside collective shelters. Humanitarian actors noted uncertainty regarding the appropriate pathways for accessing data, obtaining approvals, and coordinating outreach activities for internally displaced persons (IDPs) living in rented accommodation, informal settings, or host community arrangements. Participants indicated that coordination processes and requirements often vary across geographic areas, creating inconsistencies in implementation and operational planning.
- In addition, partners reported administrative and procedural challenges when engaging with municipalities and other relevant local authorities to facilitate interventions outside formal shelter settings. These complexities were described as contributing to delays in outreach activities, service provision, and emergency response efforts. Key informants emphasized the need for clearer and more standardized coordination procedures to facilitate access to affected populations, strengthen interagency collaboration, minimize duplication of efforts, and ensure more consistent service coverage across locations.

Internal Communication and Operational Continuity Challenges:

- Key informants noted that the crisis significantly affected the operational capacity of humanitarian organizations, particularly as a result of staff displacement, increased workloads, and damage to infrastructure and facilities. These disruptions placed considerable pressure on humanitarian actors and affected their ability to maintain continuity of services during critical periods of response.
- Participants also identified internal communication and information-sharing gaps as an ongoing operational challenge. In several instances, staff attending coordination meetings were not directly involved in programme implementation, resulting in delays or inconsistencies in the transmission of key information between coordination and operational teams. According to informants, these communication gaps can affect planning, implementation, and follow-up actions, ultimately reducing operational efficiency and the ability to respond rapidly to evolving needs.

Resource Constraints and the Complexity of Coordination Structures:

- Key informants highlighted that the meaningful participation of local NGOs, civil society organizations (CSOs), and Women-Led Organizations (WLOs) within coordination mechanisms is often constrained by limited human and financial resources, time pressures, small staffing structures, and, in some cases, language barriers. These constraints can affect the capacity of local actors to regularly engage in coordination forums and contribute fully to strategic planning and decision-making processes.
- As a result, some local organizations remain insufficiently integrated into coordination structures despite their proximity to and knowledge of affected communities. Informants noted that limited participation of these actors may reduce opportunities for information sharing, resource optimization, and the identification of service gaps and overlaps.
- At the same time, several respondents observed that the coordination architecture can be challenging to navigate, particularly during large-scale emergencies involving a diverse range of stakeholders. While broad participation is essential to ensuring an inclusive and comprehensive response, informants reported that the volume and diversity of actors involved can, at times, slow decision-making processes and complicate coordination efforts. Strengthening coordination efficiency, clarifying roles and responsibilities, and supporting the engagement of local actors were identified as important measures for enhancing the overall effectiveness, complementarity, and responsiveness of humanitarian interventions.

Overall, these findings underscore the importance of streamlining coordination processes, strengthening communication channels, and promoting the meaningful inclusion of local actors to support a more coherent, timely, and accountable humanitarian response.

D. Refining National Pathways for Coordinated Strategic Oversight

Local authorities have similarly emerged as critical frontline responders throughout the crisis, expanding their traditional administrative functions to address urgent humanitarian and protection needs. Key informants described municipalities and local governance actors as important intermediaries between humanitarian organizations and affected populations, facilitating access to assistance and addressing immediate community concerns.

Beyond their routine responsibilities, local authorities have reportedly supported displaced households through the facilitation of financial assistance, medical consultations, housing support, and referrals to available services. Participants also emphasized the important role municipalities have played in reducing social tensions and mitigating risks of exploitation, particularly through mediating disputes between landlords and tenants, supporting formalized rental arrangements, and promoting peaceful coexistence between displaced and host communities.

In areas with limited humanitarian presence, municipalities and local leaders were reported to have relied extensively on established social, community, and family networks to mobilize rapid support and resolve emerging challenges. These localized mechanisms have enabled timely responses to immediate

needs and contributed to community-level conflict mitigation during periods of heightened displacement.

Despite demonstrating considerable resilience and adaptability, municipalities and mukhtars face growing operational constraints that may affect their ability to sustain support to affected populations. Key informants highlighted two primary challenges:

- **Lack of Structured Protection Capacity:** While municipalities frequently serve as first points of contact for vulnerable households, they are not specialized protection actors and often lack the technical expertise, systems, and protocols required to respond safely to complex protection concerns, including GBV. As a result, interventions are frequently managed through informal social networks and community mediation mechanisms rather than standardized protection approaches. Participants expressed concerns that the absence of formal protection procedures, referral pathways, and case management capacities may limit the effectiveness of local responses and increase risks for survivors requiring specialized support.
- **Severe Resource and Funding Constraints:** Municipal authorities reported operating under significant financial and infrastructural strain as a result of increased displacement pressures and limited resource availability. The large-scale influx of internally displaced persons (IDPs) has placed substantial pressure on public infrastructure and essential services, including water supply systems, wastewater management, and solid waste collection. Participants noted that deteriorating service delivery and inadequate maintenance of public facilities may indirectly heighten protection risks, including GBV risks, particularly where women and girls lack access to safe, private, and adequately maintained infrastructure.
- Several municipal representatives described operating with **insufficient financial resources** to sustain even basic services, with some staff reportedly contributing personal funds to maintain essential functions such as waste collection and transportation. These accounts illustrate the extent of resource depletion faced by local authorities and underscore the challenges of sustaining protective environments for both displaced and host populations in the absence of increased institutional and financial support.

Despite their active role in mediating housing-related disputes, local authorities acknowledged that their capacity to regulate or oversee private rental arrangements remains limited. Participants reported that municipalities and *mukhtars* frequently intervene informally to address tensions between landlords and displaced tenants, negotiate rental agreements, and prevent evictions; however, their authority to monitor private housing practices or enforce compliance with agreed terms is often constrained.

This limited regulatory influence creates protection concerns for displaced populations residing outside collective shelters, particularly women- and girl-headed households and other vulnerable groups. Key informants noted that, in the absence of effective oversight mechanisms, displaced households may be exposed to exploitative rental practices, arbitrary rent increases, insecure tenure arrangements, and risks of forced eviction. Such vulnerabilities can be further exacerbated by financial dependency, limited livelihood opportunities, and unequal power dynamics between landlords and displaced tenants.

For women and girls, insecure housing arrangements may increase exposure to a range of protection risks, including economic exploitation, coercion, harassment, and other forms of gender-based violence. Participants emphasized that while local authorities often play an important mediation role and seek to resolve disputes when they arise, the absence of formal authority over private market actors constrains their ability to provide sustained protection or address the structural drivers of housing-related vulnerabilities.

These findings suggest that, although municipalities remain critical actors in supporting displaced populations, additional measures are needed to strengthen housing protection mechanisms, improve monitoring of rental-related risks, and enhance coordination between local authorities, protection actors, and humanitarian partners to better safeguard displaced women and girls living in non-collective settings.

> *"Municipalities are dealing with an emergency that affects infrastructure, services, protection, and social cohesion at the same time... local systems cannot absorb prolonged pressure alone."*
>
> KII, Local authorities, South

Overall, findings indicate that both national and local authorities have played a critical role in sustaining humanitarian assistance and supporting displaced communities throughout the crisis. However, strengthening site management capacities, enhancing emergency governance systems, formalizing protection referral mechanisms, and increasing financial support to local authorities remain essential to improving the effectiveness, safety, and sustainability of the response.

5. Conclusions

The findings of this assessment reveal a highly fragile protection environment in which the 2026 escalation of hostilities has not only generated new humanitarian needs but has also significantly eroded existing community, institutional, and familial protection mechanisms. The analysis points to a compounding crisis, whereby the intersection of displacement, economic deterioration, infrastructure damage, and disruptions to essential services has created conditions that heighten vulnerability to GBV across affected populations. Within this context, GBV should not be understood as a series of isolated incidents but rather as both a consequence and symptom of broader structural vulnerabilities that have deepened throughout the crisis.

The escalation has disproportionately affected women and girls, Syrian and Palestinian refugees, migrant workers, persons with disabilities, and individuals with diverse sexual orientations, gender identities and expressions, and sex characteristics (SOGIESC). These groups face multiple, intersecting risk factors, including overcrowded living conditions, loss of privacy, economic hardship, social exclusion,

discrimination, restricted mobility, and legal insecurity. These risks are frequently compounded by documentation-related barriers, particularly among refugee and migrant populations, which further constrain access to services, assistance, and protection mechanisms.

Assessment findings indicate a perceived increase in intimate partner violence (IPV), with household stressors, economic pressures, and conflict-related uncertainty frequently cited as contributing factors. Participants also reported increased concerns regarding child and forced marriage as a harmful coping mechanism among households facing acute financial hardship, as well as heightened fears of sexual exploitation and abuse, particularly in interactions involving employers, landlords, and transportation providers. These trends underscore the extent to which economic deprivation and displacement-related vulnerabilities are shaping protection risks and influencing coping strategies.

Despite escalating needs, substantial barriers continue to undermine access to GBV services and support. Survivors face overlapping obstacles related to insecurity, mobility restrictions, harmful social norms, inadequate information, limited service availability, and concerns regarding confidentiality and safety. Furthermore, while the expansion of remote service modalities has enabled continuity of assistance in conflict-affected contexts, these approaches frequently remain inaccessible for survivors living in overcrowded shelters or unsafe domestic environments where privacy cannot be guaranteed. Compounding these challenges, significant funding shortfalls continue to constrain the response, reducing service coverage, limiting mobile outreach activities, and contributing to the closure or scaling back of Women and Girls Safe Spaces and other critical GBV services.

The Nexus Between Overcrowding and Vulnerability

One of the most significant findings emerging from the assessment concerns the central role of shelter conditions and housing insecurity as drivers of GBV risk. Qualitative data consistently demonstrate that overcrowding, lack of privacy, and insecure accommodation arrangements have become critical protection concerns rather than solely shelter-related challenges.

For many displaced women and girls, the loss of private living space has significantly reduced personal autonomy and increased exposure to violence, exploitation, and coercive control. Even within private homes, overcrowding resulting from hosting arrangements frequently undermines privacy and safety. These conditions create an environment in which women and girls have limited opportunities to seek support confidentially, manage personal safety risks, or escape abusive situations. The fear of losing shelter further compounds these risks, often discouraging survivors from reporting violence or seeking assistance, particularly where financial dependence and housing insecurity intersect.

The findings therefore highlight housing and shelter as fundamental protection determinants. Inadequate shelter conditions not only increase exposure to GBV risks but also reinforce barriers to help-seeking, recovery, and access to services.

Normalization of Violence and Vulnerability

The assessment reveals a concerning normalization of violence and exploitation across affected communities. Women and girls experiencing violence frequently face social environments in which

abuse is minimized, justified, or perceived as an inevitable consequence of conflict, financial hardship, and family stress.

The normalization of IPV emerged as a particularly significant concern. Participants often described violence within intimate relationships as a routine occurrence rather than a violation requiring intervention. Such perceptions are reinforced by patriarchal norms that legitimize male authority and discourage challenges to abusive behaviours. As violence becomes increasingly normalized, survivors may be less likely to recognize abuse, disclose incidents, or seek support.

This normalization is further reinforced by perceptions of limited accountability, weak enforcement of legal protections, and inadequate institutional responses. The combination of social acceptance of violence and low confidence in justice mechanisms contributes to a climate in which perpetrators operate with perceived impunity while survivors remain silenced. Consequently, violence becomes both hidden and perpetuated, contributing to cycles of abuse that remain largely unaddressed.

Legal and Administrative Precarity

Legal and administrative barriers emerged as key factors exacerbating protection risks and limiting access to assistance. The loss of civil documentation, residency permits, and identity papers functions as a gateway barrier that restricts access to services, legal protection, humanitarian assistance, and freedom of movement.

For refugees, migrant workers, and undocumented individuals, documentation-related challenges contribute to a cycle of vulnerability characterized by fear, dependency, and exclusion. Participants reported avoiding interaction with authorities or service providers due to concerns regarding arrest, detention, deportation, or discrimination. As a result, individuals may remain trapped in unsafe situations, unable to access healthcare, legal assistance, or protection services.

These vulnerabilities are particularly acute for women and girls experiencing violence. Without valid documentation, survivors may face significant challenges accessing protective services, pursuing legal remedies, relocating to safer environments, or safely moving through checkpoints and other control points. Legal insecurity therefore operates as both a protection concern and a significant barrier to GBV prevention and response.

The Service Delivery Modality Challenge

Findings highlight a significant disconnect between existing humanitarian service delivery modalities and the realities experienced by many survivors. While remote services, including telephone case management, online consultations, and digital information sharing, have become essential operational adaptations during periods of insecurity, they do not adequately meet the needs of all affected populations.

For many women and girls living in overcrowded shelters, shared accommodations, and controlling family environments, remote access can effectively equate to no meaningful access at all. The lack of private spaces, concerns regarding surveillance, and fear of retaliation from family members or perpetrators often prevent survivors from engaging safely with remote services.

Across population groups, face-to-face services remain the preferred modality because they are perceived to provide greater confidentiality, trust, and emotional support. This creates a persistent operational dilemma for humanitarian actors. While remote modalities are necessary to maintain coverage in inaccessible areas, survivors continue to express strong preferences for in-person services that facilitate safe disclosure and survivor-centred care. The challenge therefore lies in balancing accessibility and operational feasibility with survivors' needs for privacy, security, and meaningful engagement.

Systemic Inequalities in Access to Assistance

The findings further point to significant disparities in access to humanitarian assistance and protection services. Although the majority of displaced populations reside outside collective shelters, humanitarian support structures often remain concentrated in formal displacement settings where service delivery is operationally easier and more cost-efficient.

As a result, many of the populations facing the highest levels of vulnerability remain underserved. This includes migrant workers, persons with diverse SOGIESC, women and girls living in informal accommodation arrangements, and individuals experiencing homelessness or extreme social exclusion. These groups frequently face barriers not only to service access but also to information regarding available assistance and referral pathways. The exclusion of these populations has important GBV implications. Limited access to financial assistance and livelihood opportunities can increase dependency on intimate partners or other individuals who may control household resources. Economic dependence may subsequently become a mechanism of abuse, restricting survivors' ability to leave harmful situations or meet basic needs independently.

5. Recommendations

The following recommendations have been developed based on the assessment findings and validated through consultations with key stakeholders and sector specialists. They are intended to provide a strategic and operational framework for strengthening protection mainstreaming across sectors, enhancing the relevance and accessibility of specialized GBV services, and reinforcing accountability to affected populations. Collectively, these recommendations seek to reduce protection risks, address identified gaps in service delivery, and support the safety, dignity, and wellbeing of crisis-affected communities. To facilitate implementation and accountability, recommendations have been categorized by stakeholder group, including GBV actors, humanitarian actors across sectors, government and local authorities, and donors. In addition, a detailed recommendation matrix is presented in Annex 4, organizing recommendations by thematic area and directly linking them to the corresponding assessment findings and identified gaps. This matrix is intended to support prioritization, operational planning, and coordinated follow-up by relevant actors.

5.1 Specific Recommendations to GBV Actors

- **Maintain existing and establish additional dedicated safe spaces for women and girls (WGSS):** Maintain existing and dedicate additional accessible, secure, and physically safe communal spaces where women, girls and other at-risk populations can physically gather, escape shelter overcrowding, access life-skills sessions, build mutual support, and freely socialize away from public risks. These spaces must meet minimum accessibility, confidentiality, safeguarding and referral standards. *(Short to Medium -Term)*
- **Prioritize in-person service provision modalities:** Prioritize physical, in person staff presence and community-based service delivery over phone or remote modalities for protection, GBV and psychosocial services, whenever possible. GBV actors need to identify static and mobile (temporary) safe spaces easily accessible for all communities, at no extra cost. In-person services build necessary trust, safeguard confidentiality, ensure safety, and accommodate participants who face privacy risks, phone monitoring concerns, lack of internet and limited access to devices in overcrowded accommodation. *(Short-Term)*
- **Strengthen outreach activities:** Utilize mobile modalities, including home (door-to-door) visits[69] as necessary, and localized community workers to reach IDPs women and girls residing outside of collective shelters with information about available services. This is especially required for older women, pregnant women, and persons with disabilities who face physical mobility limitations, require physical accompaniment, or cannot afford high transportation costs to centralized centers. *(Short-Term)*

[69] Home visits and door-to-door activities are only suggested as an approach to outreach; provision of GBV services should not be done at the homes of women and girls unless in exceptional situations with previous consent and through arrangements, including safety planning.

- **Strengthen GBV prevention and response for adolescent girls:** Allocate dedicated funding and specialized human resources to design and implement gender and age-appropriate GBV services, from awareness rising and outreach to GBV case management and other PSS interventions. Community-based sensitization programs for adolescent girls across all nationalities are recommended as well. These interventions should utilize peer-to-peer and life-skills frameworks to address critical knowledge gaps regarding core GBV concepts, available multi-sectoral referral pathways, and legal rights. Programs must be designed to sensitively challenge harmful social norms, including survivor-blaming, the justification of violence, and child and forced marriage, with the goal of increasing safe disclosures and enhancing the protective environment for adolescent girls. *(Medium to Long-Term)*
- **Enhance integration of women and girls with disabilities within GBV initiatives:** Strengthen disability-inclusive programming, guaranteeing the full integration of at-risk individuals and survivors with disabilities across all prevention and response initiatives.
- **Ensure inclusive communication and frontline staff capacity building:** Re-train humanitarian frontline staff (GBV and non-GBV actors) to ensure safe and inclusive language when working with individuals of diverse SOGIESC, migrant workers and women with disabilities. This will help GBV and non-GBV actors to provide a safer and more inclusive intervention. Moreover, it is critical to ensure awareness and sensitization on PSEA and reporting mechanisms are integrated in all activities provided to people receiving assistance. *(Short-term)*
- **Simplify, update and localize GBV referral pathways:** Streamline community-level referral pathways by reducing technical complexity and heavy text; strengthen multi-sectoral coordination to ensure non-protection actors, particularly Health and SRH partners, can effectively identify and refer at-risk individuals. Revise the GBV flyers distributed during the crisis to include the main GBV case management (CM) and GBV services hotline numbers, organized by geographic area. This would make referral information more accessible and easier for individuals to use when seeking support and services (Short-Term).
- **Create flexible response approach for undocumented survivors and non-Lebanese population facing challenges to access services:** Adapt and utilize current available resources, means, and frameworks to safely accommodate individuals lacking formal legal identification or facing legal vulnerabilities. This approach should ensure these populations can report incidents of GBV and secure immediate, unhindered access to essential multisectoral services (such as healthcare/CMR, psychosocial support, and safe shelter). Response modalities should leverage existing flexible resources including targeted cash interventions, case management protocols, localized partner networks and other options to address specific barriers to access, eliminating bureaucratic delays and mitigating the risk of penalization or exposure to immigration authorities. (Short-term)
- **Enforce safe and affordable transportation for survivors:** Implement safer and more affordable transportation options to help displaced groups reach safe spaces, static and mobile service points. For services provided by humanitarian organizations and partners, cash for transportation could mitigate the affordability concern.*(Short to MediumTerm)*

- **Strengthen joint advocacy for sustainable GBV financing:** Humanitarian coordinators and local networks must lead coordinated advocacy efforts directed at the donor community to prioritize GBV response as a life-saving intervention. This advocacy should push for ensuring sustained political and financial commitments that outlast immediate emergency cycles. (Medium- to Long-Term)
- **Undertake holistic and integrated service delivery**: Implement a holistic and integrated service delivery approach by enhancing cross-sectoral collaboration and utilizing updated, consistent referral channels to deliver survivor-centered care. Service providers should integrate GBV, reproductive health (SRH), psychosocial support, and basic assistance into multisectoral safe spaces; addressing these needs holistically builds the trust necessary for survivors to report violence while ensuring ease of access to GBV services through both GBV and non-GBV service providers (*Medium to long-Term)*
- **Establish unified hotline[70] and national campaigns:** Establish a mechanism that potentially includes a single, nationwide, 24/7 GBV hotline rather than multiple fragmented numbers, while ensuring the prioritization of National and International Protection and GBV SoPs and guidelines for safe identification and referrals of GBV survivors. The unified national hotline infrastructure must be operationally backed by rigorous data-protection protocols to protect confidentiality, minimize data collection, and clearly communicate any limits to anonymity and prevent survivors' biodata from being compromised. Experts recommend that the Ministry of Social Affairs (MoSA) lead a massive national public awareness campaign to publicize the number. This campaign should utilize striking and impactful imagery prominently displayed across public spaces, streets, municipalities, and Primary Healthcare Centers (PHCs) to ensure maximum reach and visibility. The campaigns should be disseminated across all population groups, including clear information on data protection protocols to help them overcome possible institutional distrust and fear of local authorities. *(Long- Term)*.
- **Advocate for stricter legal accountability and stronger protection frameworks:** Advocate for stricter legal accountability through enforcing existing protection laws that protect women, girls and individuals at risk against GBV and safeguard against impunity of perpetrators. Advocate for state-enforced protection laws specifically designed to shield marginalized individuals including LGBTQI+ communities and migrant workers from public violence and systemic harassment (Advocacy target for the humanitarian sector).*(Long Term)*
- **Ensure staff wellbeing and support:** Recognize frontline workers as crisis-affected individuals. Invest further in staff MHPSS (Mental Health and Psychosocial Support), provide emergency financial support for displaced staff, and offer continuous one-on-one coaching rather than one-off training.*(Short to Medium-term)*

5.2 Recommendations for All Humanitarian Actors (GBV and non-GBV)

- **Institutionalize Cross-Sector Responsibility for GBV Risk Mitigation and Safe Referrals:** Enforce strict GBV risk-mitigation mapping across non-protection humanitarian sectors, such as Water, Sanitation, and

[70] If a unified hotline were to be an option, it requires feasibility assessment, governance arrangements, trained multilingual staff, accessible formats, service mapping, referral capacity, data-protection protocols, and sustainable financing.

Hygiene (WASH), health infrastructure, and general shelter provision, to proactively eliminate structural safety vulnerabilities. Mainstream safety measures, such as internal locks and adequate lighting, within WASH and Shelter interventions, and utilize distribution activities for sharing information on available GBV services. Construct safe, private, nearby, and accessible toilets and gender-segregated bathrooms inside informal settlements and informal shelter environments to reduce long wait lines and lower women and girls' daily fear of harassment near facilities. Additionally, it is important to use non-GBV services as entry points for linking survivors with specialized GBV services through safe, confidential, and consented referrals. (*Short to Medium -Term*)

- **Ensure inclusive reach and appropriateness of in-kind assistance and deploy community based distribution mechanism:** Ensure inclusive and regular distribution of hygiene kits, dignity kits, food parcels and baby kits (when relevant) to women and girls residing outside of collective shelters. Ensure kits distributed cover essential items such as high-quality sanitary pads (to prevent allergic reactions from low-quality materials), adult incontinence supplies, undergarments, age-appropriate clothing (including suitable choices for hijabi women and girls), diapers, infant formula[71] for women who cannot breast feed, and canned food items rather than grains. Utilize direct outreach through community workers and diverse local partners including municipalities, specialized organizations, religious groups, community focal points, and leaders to deliver in-kind and material assistance. This approach is essential for ensuring inclusive reach, particularly for older women, pregnant women, and women and girls with disabilities who face physical mobility limitations, require accompaniment, or cannot afford the high transportation costs to reach centralized service centers. Consider when possible providing cash rather than in kind- support as it was reported as a strong preference by all groups (Short-Term).
- **Adopt conflict-sensitive aid allocation to mitigate community tensions:** Enhance the attention for vulnerable host community members residing in conflict-affected areas while maintaining the focus on supporting IDPs. Most importantly, it is crucial to ensure that comprehensive aid also reaches displaced women and girls residing outside collective shelters (inside private apartments, rented rooms, and informal self-settlements). *(Short-Term)*
- **Target vulnerable women and girls with vocational training and capacity-building programs:** These practical, in-person courses should be based on options selected by the participants themselves, covering computer literacy, digital media tools, market-linked skills, hairdressing, sewing, and home-based crafts. By fostering financial independence, these programs will empower GBV survivors and at-risk women, directly reducing vulnerabilities linked to economic dependence such as transactional sex, child marriage, housing exploitation, and unsafe work environments. This will also enable female-headed households with dependents to generate income from home allowing them to provide the needed care for their dependents. *(N.B: This was reflected in the updated Flash Appeal) (Medium to long-Term)*
- **Implement participatory and community-informed programming:** Mandate direct consultations with displaced women before launching any humanitarian interventions. This ensures programs are built

[71] Under emergency protocols, infant formula is not a routine item, it's only provided with individual assessment and appropriate health safeguards.

entirely on the self-identified needs and explicit requests of the target population, rather than institutional assumptions. *(Short-Term)*

- **Leverage education as a protective environment through funded learning support** Establish structured educational support (e.g: remedial classes, language courses) for girls to mitigate school dropouts following displacement and school disruptions caused by crisis escalation. Provide electronic devices, internet capacity, and learning equipment to support adolescents struggling with online curriculum requirements and connectivity blockouts. Maintaining girls' engagement in education acts as a critical protection mechanism as it directly mitigates the heightened risks of isolation, unsafe informal labor, and child marriage. Furthermore, these educational settings serve as vital spaces for girls to build supportive social networks and act as safe entry points for frontline GBV and healthcare services *(Short to Medium term)*
- **Optimize communication methods based on local realities:** *(Continuous)*
  - *WhatsApp, Phone Communication, and Toll-Free Hotlines:* Utilize direct messaging via WhatsApp, direct phone calls, or free hotlines as direct, accessible communication tools to share updates on services without draining phone credit.
  - *In-Person Meetings, and Direct Home Visits:* Prioritize face-to-face community meetings, physical info sessions, or SMS lines in areas suffering from poor internet connectivity, data costs, or severe household overcrowding, as remote calls compromise confidentiality and raise security suspicions when detached from tangible aid.
- **Streamline channels for reporting staff misconduct and PSEA complaints:** Establish localized, secure, and physically accessible reporting mechanisms, such as in person focal appoints, physical complaint boxes at centers, or free hotline numbers that ensure total anonymity when reporting exploitation or inappropriate behavior by humanitarian workers in formal and informal collective shelters and safe spaces. All options should include documented referral and feedback procedures. In addition, it is highly recommended to ensure that awareness and sensitization on PSEA and reporting mechanisms are integrated in all activities provided to people receiving assistance. *(Short-Term)*.
- **Ensure frontline staff capacity building**: Train humanitarian frontline staff to ensure safe and inclusive language when working with individuals of diverse SOGIESC, migrant workers and women with disabilities. Ongoing mentorship, coaching, and supervision on safe identification and referral of GBV (moving away from one-off workshops) including training of frontliners on working with individuals with diverse SOGIESC should be followed. Moreover, ensuring all humanitarian staff are trained on PSEA, its implementation and the existing reporting mechanisms is critical to provide safer and more inclusive interventions. *(Short-term)*
- **Provide legal services for documentation losses :** Provide free legal services dedicated to handling documentation loss for displaced individuals who lost their documentation due to crisis. Mitigating this structural barrier is essential to enable GBV survivors and individuals at risk of GBV to safely have access to specialized legal, GBV, and SRH services. *(Short-Term)*

- **Provide and maintain recreational and sport activities for children and youth:** Ensure the presence and continuity of structured recreational, social, and psychosocial activities for adolescents to prevent them from gathering in unsafe streets. This must include the provision of dedicated, girls-only spaces and activities. These safe environments are essential to mitigate GBV risks, build trust, and serve as accessible, low-stigma entry points for adolescent girls to connect with specialized protection and GBV services *(Short- to Medium Term)*
- **Replace extensive data collection exercises with direct, rapid action:** Stop/decrease carrying out repetitive assessments exercises and focus instead on delivering rapid, practical, and meaningful assistance. *(Continuous)*

5.3 Recommendations for Government and Local authorities

- **Integrate safety and GBV mitigation into municipal infrastructure rehabilitation:** Prioritize the restoration of public infrastructure to reclaim safe civic spaces, having in mind specific GBV risks. Specifically, install and repair adequate street lighting in high-risk zones, including dark alleys, transit hubs, main roads, and public spaces. Restoring reliable lighting serves as a critical, immediate protection mechanism that reduces opportunities for harassment, exploitation, and abuse faced by women, girls, and marginalized groups during nighttime, while fostering a return to secure community life. *(short-term)*
- **Strengthen legal oversight of rental frameworks to mitigate housing-based GBV risks:** Implement and enforce strict, nationwide emergency rental regulations and arbitrary eviction freezes to stabilize the housing sector for all displaced populations. Mandating standardized, legally binding contracts and capping rent inflation across the board will secure housing tenure for vulnerable households. By removing predatory financial leverage from the rental market, these universal state protections directly mitigate the severe GBV risks that arise from housing insecurity, specifically shielding displaced women and girls from being forced into negative coping mechanisms, unsafe work environments, and sexual exploitation.*(Short- Term)*
- **Enforce non-discriminatory shelter access:** Strengthen implementation of MoSA's non-discrimination policy by continuing to promote equitable access to emergency shelters and schools for displaced individuals and families, regardless of nationality, race, or documentation status. For the humanitarian sector, continue advocating for non-discriminatory access across all emergency shelter settings.*(Short-Term)*
- **Improve coordination and administrative procedures to accelerate GBV service delivery**:

  Strengthen coordination and streamline approval processes, where feasible, through emergency-adapted mechanisms to facilitate the timely delivery of humanitarian assistance and GBV services, particularly for populations residing outside collective shelters. The Government and local authorities could continue strengthening their capacity at both collective shelter and community levels to facilitate coordination, expedite approvals where appropriate, and support humanitarian partners in reaching affected communities efficiently and in a timely manner. (Medium- to Long-Term)

- **Strengthen judicial accountability frameworks and institutional enforcement of GBV protection laws:** Ensure stricter legal accountability through enforcing existing protection laws that protect women, girls and individuals at risk against GBV. Establish robust oversight mechanisms to ensure stricter legal accountability for perpetrators and eliminate institutional bottlenecks within the judicial process. Guaranteeing that protection orders are issued rapidly and consistently, and that justice mechanisms are accessible to all GBV survivors, is a foundational requirement to deter gender-based violence, build public trust in state institutions, and secure a safe environment for women and girls. *(Long Term)*

5.4 Recommendations for Donors

- **Prioritize dedicated, core funding for life-saving GBV response and specialized services.** Donors must urgently allocate dedicated, non-fragmented funding to GBV actors to address critical resource deficits and ensure the uninterrupted delivery of life-saving interventions. These core resources should immediately scale up essential operational modalities, including Women and Girls Safe Spaces (WGSS) and mobile response teams. Furthermore, funding must be directed to sustain critical services such as comprehensive GBV case management tailored to vulnerable survivors, alongside both non-specialized and specialized Mental Health and Psychosocial Support (MHPSS). This targeted investment ensures that the immediate, multi-sectoral needs of survivors are met securely, equitably, and on a timely basis.
- **Adapt donor frameworks to enable rapid, life-saving redirection of GBV resources:** Ensure funding mechanisms are more agile during crises. Donors should simplify the process of shifting resources from regular long-term programming to emergency interventions, eliminating the lengthy negotiations and administrative bottlenecks that delay timely responses. (*Short to Medium -Term)*
- **Enable rapid crisis reprogramming and operational flexibility within existing grants**: Donors should build emergency-adapted flexibility directly into project designs, allowing humanitarian actors to modify pre-written activities based on community needs and findings when a crisis hits, rather than being bound to rigid project-driven mandates during critical emergency response phases. (*Medium -Term)*
- **Provide strategic, multi-year funding to center local women-led organisations in the GBV response:** Channel flexible, and multi-year funding to GBV actors, including Women-Led Organizations (WLOs) and local grassroots networks that demonstrate technical readiness and align with survivor-centered standards. By conditioning this multi-year funding on active participation in national coordination mechanisms, donors can not only secure the long-term sustainability of qualified local responders but also their leadership in a unified, non-duplicated, and technically accountable humanitarian response. .(*Medium -Term)*
- **Ensure GBV mainstreaming funds***:* Provide dedicated funding for GBV specialists within non-GBV organizations to ensure the effective integration of GBV mitigation measures across non-specialized and non-protection initiatives, as well as within internal institutional policies.

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Annex 1: Respondents' Profiles

Overview

The GBV Assessment engaged a total of 348 respondents across diverse geographic locations and demographic groups. Respondents included 322 female (92.5%) and 26 male respondents (7.5%). Respondents were categorized into two primary cohorts: **Affected People** (292 individuals) and **Other Stakeholders** (56 individuals).

- **Affected People (292 respondents):** Representing community members directly impacted by the crisis, this cohort comprises 242 displaced individuals and 50 host community members. These individuals were engaged through 31 focused group discussions (FGDs) and 7 interviews designed to capture the nuances of displacement, nationality, and intersectional vulnerability (e.g., elderly women, adolescent girls, persons with disabilities, and LGBTQI+ individuals).
- **Other Stakeholders (56 respondents):** This cohort provides institutional and frontline expertise that were interviewed through 19 KII and 2 FGDs These additional FGDs capture the operational realities, shifting resource gaps, and emerging GBV trends from embedded actors, including the unique challenges of responding while displaced. Respondents distribution was as follows
    - Women-Led Organizations (WLOs): 25 respondents.
    - Caseworkers / Frontliners: 16 respondents.
    - Coordinators: 7 respondents.
    - Service Providers (GBV Specialists): 4 respondents.
    - Local authorities (municipalities and Mukhtars): 4 respondents.

The table below shows the distribution of respondents by target group

Table 1: Distribution of total respondents per target group (348 respondents)

Target Group / Respondent Type	Percentage of Total Sample
Affected Groups	
Displaced populations	69.5%
Host Community	14.4%
Other Stakeholders	

Women-Led Organizations (WLOs)	7.2%
Caseworkers / Frontliners	4.6%
Coordinators	2.0%
Service Providers (GBV Specialists)	1.15%
Local Leaders	1.15%
Total	**100%**

Geographic Distribution

The assessment reached across all major regions in Lebanon to ensure a broad geographic coverage and diversity of perspectives of both displaced and host community needs

Table 2: Distribution of total respondents per respondent type and geographic region

Region	Total Respondents	Affected Population	Other Stakeholders
Beirut & Mount Lebanon (BML)	37.35%	36.2%	1.15%
North and Akkar	28.2%	20.1%	8.0%
South and Nabatiyeh	21.55%	20.4%	1.15%
Bekaa and Baalbek El Hermel	8.0%	7.2%	0.9%
National Coordinators and Displaced Caseworkers	4.9%	0%	4.9%
Total	**100.0%**	**83.9%**	**16.1%**

Detailed Information affected population and other stakeholders

To provide greater transparency into the assessment's qualitative reach, the following breakdown details the specific composition of the interviewed affected populations and key stakeholders.

Affected populations

Affected populations included both displaced and host communities groups. The FGD/interviews distribution were as following:

- **Displaced Group**
  - 1 FGD Elderly women (Mixed Nationalities)
  - 3 FGD adolescent girls (2 FGD Lebanese, 1 Syrian)
  - 1 interview with adolescent girls (Lebanese)
  - 1 FGD of Lebanese boys
  - 1 FGD LGBTQI+ (Mixed Nationalities)
  - 1 FGD Syrian men
  - 14 FGD adult women (7 FGD with Lebanese, 5 Syrian,1 Palestinian and 1 Migrant)
  - 3 FGDs with Lebanese women heads of households
  - 2 FGDs with women with disabilities
  - 6 interviews with displaced women without shelter (mixed nationalities)
- **Host Communities**
  - 5 FGDs with host communities (1 FGD Beirut, 1 FGD Mount Lebanon, 2 FGD South, 1 FGD Akkar)

The respondents were distributed as following by target group and nationality

Table 3: Demographics for affected groups by Nationality

	Nationalities of Affected Groups					
Target Group	Lebanese	Migrants	Mixed	Palestinian	Syrian	Total
Displaced girls	5.5%				3.1%	8.6%
Displaced Boys	2.1%					2.1%
Displaced Elderly Women			2.7%			2.75%
Displaced women without shelter	0.7%	0.3%		0.3%	0.7%	2%

Displaced LGBTQI+ individuals(Men)			2.1%			2.1%
Displaced Men					2.7%	2.75%
Displaced Women	20.5%	4.8%		4.8%	16.4%	46.5%
Displaced Women head of household	9.9%					9.9%
Displaced Women with Disabilities			3.8%		2.4%	6.2%
Host Community	17.1%					17.1%
Total	**55.8%**	**5.1%**	**8.6%**	**5.1%**	**25.3%**	**100.0%**

All FGDs/Interviews with affected groups were conducted in person except the adolescent boys which was conducted remotely.

Service providers and Other Key Stakeholders

There were 2 FGDs conducted for service providers including affected displaced caseworkers and women-led organizations with a total of 35 female participants.

- 1 FGD with women-led organizations in Akkar (Conducted in person)
- 1 FGD with Displaced caseworkers (National - conducted online)

19 KII were conducted (12 KIIs conducted online and 7 conducted in person) with 21 participants across Lebanon as follows:

- 4 KIIs local authorities including Mukhtars and Municipalities (Mount Lebanon, South, Bekaa, and Akkar)
- 6 KIIs with frontline caseworkers (2 South, 2 BML, 1 Bekaa and 1 Akkar)
- 4 KIIs with GBV Specialists from 4 different organization operating in BML, North/Akkar, Bekaa/ Baalbeck Hermel, and South
- 5 KII with national working group coordinators

Gender distribution of KII

Key Informants	Female	Male	Total
Frontliners	6		**6**

GBV Specialists	3	1	**4**
Coordinators	6	1	**7**
Local authorities	1	3	**4**
Total	**16**	**5**	**21**

Annex 2: Reported Priority Needs by Affected Groups Type

The following table provides a comprehensive overview of the specific priority needs identified across various affected population groups, beyond the scope of GBV services only. By disaggregating requirements by demographic, this analysis highlights the nuanced challenges ranging from the economic strain within host communities to complex legal protection barriers among marginalized refugee and migrant populations. This segmentation is intended to support humanitarian stakeholders in designing more targeted, effective interventions that address the unique vulnerabilities and stated rationales of each group.

Table 7: Priority Needs per Population Group

Group Type	Priority Needs	Rationale Provided by Affected Groups
Women from Host Communities	• Livelihood support, vocational training, and cash assistance • Accessible healthcare, medications, and psychosocial support	To cope with the economic strain of the crisis and the burden of hosting displaced individuals, and to manage daily stress.
Lebanese displaced women	• Cash for rent, medical care, hygiene kits, and other basic needs • Dignity items and appropriate clothing (such as hijabs and modest wear)	For basic survival, and for displaced women in overcrowded spaces to maintain privacy.
Adolescent Girls	• Education (in-person schooling and tablets for online learning)	In-person education helps them adapt to displacement, maintain a routine, and reduce severe psychological pressure.

Group Type	Priority Needs	Rationale Provided by Affected Groups
	• Safe recreational spaces, privacy, and personal hygiene items (like sanitary pads and deodorants)	Safe recreational spaces help address issues of isolation, boredom, and improve their emotional state.
Displaced Female-Headed Households (FHH)	• Cash assistance, job opportunities, baby formula, diapers, and food	Due to extreme financial vulnerability, their focus is on survival for their dependents.
Displaced Older women and women with disabilities	• Accessible health care, chronic medications, adult diapers, assistive medical equipment, physical accommodations, and disability-inclusive evacuation plans • Safe transportation	To address the mobility and health barriers faced.
Displaced Syrian Women	• Food, rent assistance, and basic winterization items (blankets, heating) • Regularization of their legal documents • Clean water and safe toilets (in tented settlements)	Facing severe poverty and discrimination. Regularization of documents is needed to allow them to move freely without fear.
Displaced Palestinian Refugee Women	• Personal hygiene materials • In-kind/cash support • Reproductive/mental health services	Facing severe psychological distress and fatigue due to extreme overcrowding, lack of domestic privacy, and heavy unpaid labor. Lacking consistent humanitarian coverage, they urgently require cash/in-kind support, basic hygiene supplies, and targeted reproductive and mental health services to manage cumulative stress.
Displaced Migrant Women	• Cash for rent • Legal protection (lawyers)	As a highly marginalized group, they need cash for rent to avoid eviction, and legal

Group Type	Priority Needs	Rationale Provided by Affected Groups
	• Basic items like gas, food • Confidential and accessible SRH services, including testing and treatment where relevant	protection due to Kafala system complications and undocumented status.

Differences in Priority Needs per Region

- **Beirut and Mount Lebanon:** In these highly urbanized areas, the cost of living and housing is a primary driver of needs. Participants heavily prioritized financial assistance for exorbitant rent prices, legal aid, and specialized healthcare. Due to severe overcrowding in apartments and collective shelters, there are loud demands for privacy interventions, safe alternative shelters, and disability-inclusive infrastructure.
- **The South:** In the South, needs are heavily concentrated on employment and livelihood opportunities, rental assistance for IDPs living outside of shelters, and access to chronic medications. Host communities here also highlighted a strong need for educational support and vocational training to prevent school dropouts.
- **North and Akkar:** These regions reflect extreme economic deprivation. Priorities are heavily weighted toward basic survival: food, basic hygiene supplies, baby formula, and medical coverage. For displaced Syrians in these areas, securing valid identification documents and UN files is an urgent priority to navigate the region safely.
- **The Bekaa:** Needs in this region, particularly among populations in informal or residential shelters, are heavily tied to WASH (Water, Sanitation, and Hygiene) and harsh weather. Priorities include winterization (heating, blankets), clean water, safe toilets, and hot water, alongside an acute need for basic dignity items like sanitary pads.

Annex 3: Reported Sources of Information and Preferred Communication Methods

Current Sources of Information

Populations generally rely on informal networks to gather information, primarily word of mouth, family members, friends, neighbors, and WhatsApp groups. Regarding trust, communities overwhelmingly trust

information when it is confirmed by local authorities, NGO staff and community volunteers, as rumors spread quickly and require reliable verification.

Specific findings by group:

- **Lebanese Host Communities & IDPs:** These groups exhibit high trust in local municipalities, local landlords, and host community neighbors as primary and reliable sources of information.
- **Migrant Workers:** Migrants frequently rely on community leaders and social media.
- **LGBTQI+ Community:** This group relies on trusted LGBTQI+ friendly organizations, listening support groups, and the internet. They specifically use social media and apps to verify the safety of locations before leaving the house.
- **Adolescent Girls:** They rely heavily on their parents and social media, with some specifically noting the use of AI tools like ChatGPT for information.
- **Syrian IDPs (Akkar/Bekaa):** Some Syrian women living in ITSs in Akkar indicated being highly isolated and passively rely on NGO visits for updates while others indicated staying informed through TV news, WhatsApp groups, and friends with direct experience. As per the Syrian men group, they mentioned actively seeking information via WhatsApp, Facebook, community leaders, family, and word-of-mouth. Syrian Women & Girls living in Residential Shelters indicated they actively consult local residents, including house owners, shelter focal points, shopkeepers, and relatives.

Preferred Communication Channels

Across all demographics (displaced populations, host communities, adolescents, migrants, and older women), there is a clear consensus on the preferred methods of communication for providing information and service delivery:

- **For Information on Services:**
    - **WhatsApp and SMS for Communication:** WhatsApp is overwhelmingly cited as the number one digital tool for receiving information, service updates, and communicating with organizations. SMS is also highly requested as a fallback option because internet connectivity is frequently poor or unreliable in displacement areas.
    - **Community Networks and Posters:** Adolescents and older populations also rely heavily on word-of-mouth through trusted community members, family, and physical posters placed in the community.
- **Face-to-Face (In-Person) and Outreach for service delivery:** For actual service delivery and support, face-to-face interaction is vastly preferred over remote (phone/online) modalities. Participants highly value direct home visits or community outreach by NGO workers, as it builds trust, ensures clear communication, and bypasses the severe transportation costs and mobility barriers many women face.

Annex 4: Recommendation Matrix

The following recommendation matrix provides a structured framework for addressing identified protection gaps and prioritizing multi-sectoral interventions for GBV survivors and at-risk populations.

Table 8: Recommendation matrix by target actors, priority level and timeframe

Recommendation	Target Actor	Priority Level[72]	Timeframe	Related Findings from Section 3
1. GBV Specialized Service Delivery & Referral Pathways				
Simplify, update, and localize GBV referral pathways	GBV Actors and Coordinators	High	Short-Term	3.6 C. Disrupted Referral Pathways (Technical Barriers); 3.3 C. Logistical & Information Barriers
Maintain existing and establish additional dedicated safe spaces (WGSS)	GBV Actors	High	Short to Medium-Term	3.1 A. Overcrowding and Lack of Personal Privacy; 3.7 Preference for In-Person Modalities
Prioritize in-person service provision modalities	GBV Actors	Medium	Short-Term	3.7 Strong Preference for In-Person Over Remote Modalities; 3.1 A. Privacy Concerns
Strengthen outreach activities	GBV Actors	High	Short-Term	3.3 C. Financial and Transportation Barriers; 3.1 B. Intersectional Barriers (PWD/Elderly)
Undertake holistic and integrated service delivery	GBV and Non-GBV Actors	High	Medium to Long-Term	3.6 C. Disrupted Referral Pathways;

[72] *Priority levels and timeframe feasibility were based on the report writer's judgment*

Recommendation	Target Actor	Priority Level[72]	Timeframe	Related Findings from Section 3
				3.9 B. Deprioritization of Protection
Establish unified hotline and national campaigns	GBV Actors / MoSA	Medium	Long-Term	3.6 C. Disrupted Referral Pathways; 3.8 A. Lack of Awareness/Trust
2. Intersectional Risks & Access Barriers				
Create flexible response approach for undocumented survivors and non-Lebanese population facing challenges to access services:	GBV Actors and Coordinators	High	Short-Term	3.1 C. Documentation Loss; 3.3 C. Logistical and Information Barriers; 3.2 E. Migrant Workers
Strengthen GBV prevention and response for adolescent girls	GBV Actors	High	Medium to Long-Term	3.3 B. Social Perceptions and Gender Roles (Survivor Blaming); 3.1 E. Education Gaps
Enhance integration of women and girls with disabilities	GBV Actors	High	Continuous	3.1 B. Intersectional Barriers (Persons with Disabilities)
Enforce safe and affordable transportation for survivors	GBV Actors	Medium	Short to Medium-Term	3.3 C. Logistical & Information Barriers (Financial Constraints)
Enforce non-discriminatory shelter access	Government / MoSA	High	Short-Term	3.1 B. Intersectional Barriers (Discrimination in Shelter Access)
3. Protection Mainstreaming & Risk Mitigation				

Recommendation	Target Actor	Priority Level[72]	Timeframe	Related Findings from Section 3
Institutionalize cross-sector responsibility for GBV risk mitigation	Humanitarian Actors / GBV Coordinators	High	Short to Medium-Term	3.1 E. WASH/Shelter Safety Risks; 3.9 B. Deprioritization of Protection
Integrate safety/GBV Mitigation into municipal infrastructure	Government / Local Authorities	High	Short-Term	3.3 A. Movement Restrictions (Poor Lighting); 3.5 Priority Needs
Adopt conflict-sensitive aid allocation to mitigate tensions	Humanitarian Actors	High	Short-Term	3.9 A. Invisibility of Groups Outside Shelters; 3.5 Priority Needs
Optimize communication methods based on local realities	Humanitarian Actors	Medium	Continuous	3.8 C. Communication Preferences; 3.2 E. Intersectional Risks
Implement participatory and community-informed programming	Humanitarian Actors	High	Short-Term	3.8 A. Lack of Trust in Mechanisms
4.Women and Girls Empowerment & Basic Needs				
Ensure inclusive reach and appropriateness of in-kind assistance	Humanitarian Actors	High	Short-Term	3.1 E. Challenges Accessing Basic Needs; 3.5 Priority Needs
Target vulnerable women and girls with vocational training and capacity-building programs	Humanitarian Actors	Medium	Medium to Long-Term	3.1 D. Economic Deterioration; 3.5 D. Recovery Needs (Jobs)
Provide recreational and sport activities for children and youth	Humanitarian Actors / Authorities	Medium	Short to Medium-Term	3.3 B. Movement Restrictions (Safe Gathering Spaces)

Recommendation	Target Actor	Priority Level[72]	Timeframe	Related Findings from Section 3
Leverage education as a protective environment through funded learning support	Humanitarian Actors	Medium	Short to Medium-Term	3.1 E. Challenges Accessing Basic Needs (Education)
5. Accountability, PSEA & Legal Frameworks				
Streamline channels for reporting staff misconduct and PSEA	GBV and Non-GBV Actors	High	Short-Term	3.8 A. Lack of Trust in CFM 3.6 A. Institutional Challenges
Strengthen legal oversight of rental frameworks to mitigate housing-based GBV risks	Government / Local Authorities	High	Short-Term	3.1 D. Rent Inflation and Housing Insecurity
Advocate for stricter legal accountability and stronger protection frameworks	Gov / Authorities / GBV Actors	Medium	Long-Term	3.3 B. Social Perceptions (Impunity); 3.2 E. Marginalized Groups
Strengthen judicial accountability frameworks and institutional enforcement of GBV protection laws	Government / Local Authorities	High	Long-Term	3.3 B. Social Perceptions (Impunity); 3.6 A. Institutional Challenges
Provide legal services for documentation loss	Humanitarian Actors	High	Short-Term	3.1 C. Documentation Loss
Improve coordination and administrative procedures to accelerate GBV services delivery	Government / Local Authorities	Medium	Medium to Long-Term	3.9 C. Unclear Coordination Pathways Outside Shelters
Replace extensive data collection with direct, rapid action	Humanitarian Actors	Medium	Continuous	3.8 A. Lack of Trust in Mechanisms

Recommendation	Target Actor	Priority Level[72]	Timeframe	Related Findings from Section 3
				3.8 D Perceived Assessment Exhaustion
6. Institutional Support, Funding & Staff Wellbeing				
Prioritize dedicated core and multi-year funding for GBV	Donors / GBV Actors	High	Medium-Term	3.9 B. Funding Challenges; 3.6 A. Service Continuity
Enable rapid crisis reprogramming and operational flexibility within existing grants	Donors	High	Medium-Term	3.9 B. Funding Challenges
Adapt donor frameworks to enable rapid, life-saving redirection of GBV resources	Donors	High	Short to Medium-Term	3.9 B. Funding Challenges: Lack of Donor Flexibility for Reprogramming
Provide strategic, multi-year funding to center local women-led organisations (WLOs)	Donors	Medium	Medium-Term	3.9 B. Funding Challenges
Strengthen joint advocacy for sustainable GBV financing	Humanitarian Coordinators / Local Networks	High	Medium to Long-Term	3.9 B. Funding Challenges
Provide GBV mainstreaming fund: dedicated funding for GBV specialists within non-GBV organizations	Donors	Medium	Medium-Term	3.9 B. Funding Challenges
Enable rapid crisis reprogramming and operational flexibility within existing grants	Donors	High	Medium-Term	3.9 B. Funding Challenges

Recommendation	Target Actor	Priority Level[72]	Timeframe	Related Findings from Section 3
Ensure staff wellbeing and support	Humanitarian Actors	Medium	Short to Medium-Term	3.6 B. Staff Displacement and Burnout
Inclusive communication and staff capacity building	GBV and Non-GBV Actors	High	Short-Term	3.1 B. Discrimination; 3.3 B. Stigma; 3.8 B. Perceived Bias