MORE THAN HALF

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GLOBAL ONE RESEARCH REPORT

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GLOBAL ONE

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ACRONYMS

GBV: Gender Based Violence

IDP: Internally Displaced Persons

INGO: International Non-Government Organisation

LBP: Lebanese Pound LCRP: Lebanese Crisis Response Plan

NGO: Non-Governmental Organization

OCHA: Office for the Coordination of Humanitarian Affairs

PEER: Participatory Ethnographic Evaluation and Research

RHS: Reproductive Health Services

SYP: Syrian Pound

UN: United Nations

UTI: Urinary Tract Infection

UNHCR: United Nations High Commissioner For Refugees

URDA: Union of Relief and Development Associations

SDAID: SAWA for Aid and Development

SRN: Syria Relief Network

WASH: Water, Sanitation and Hygiene

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FOREWORD

Syrian women are more than half of the refugee and internally displaced Syrian population. Their needs are great, and show no signs of stopping. In the Charter of Faith-Based Humanitarian Action, developed and affirmed by over 150 faith-based actors during the World Humanitarian Summit, they committed to "ensuring that women and girls' rights are protected, their needs are met, and that their ability to engage in decision making is enhanced; as this is a proven strategy for increasing the effectiveness of humanitarian action as a means of building resilience for all members of families and communities". [1]

This report presents a unique perspective on the needs of Syrian women, showcasing intersecting cultural dynamics, gender relations, identities and religion. The consortium involved, Global One, Union of Relief and Development Associations, SAWA for Development Aid and Syria Relief Network have worked together to produce a report which addresses the specific needs of Syrian refugee women across the region. The report calls for a more focused and context-specific understanding of Syrian women, highlighting issues often overlooked by many humanitarian actors.

Before the conflict Syrian women lived comfortable lives. But when they fled their homes they left all of their sources of comfort and security, behind. They are now suffering from a lack of their basic necessities, and with that, an absence of a sense of dignity. Water, health care and hygiene support have been lost, amongst a long list of gender-specific issues. These women have been subjected to violence and intimidation from the moment they left their homes, and are continually experiencing this in their displacement. This report seeks to highlight the intersectionality of their concerns, in much of the planning and structuring of humanitarian assistance.

Donor support for this endeavour has been generous, with funding from Penny Appeal and Global One's own community fundraising campaign; 'Dining For Dignity'. As the conflict continues to surpass any predictions by the international community, there is a moral imperative to continue to work and respond together. Careful planning and joint assessment of all programmes is required to ensure that the needs of all vulnerable populations are met, while placing girls and women's realities, voices and aspirations, at the centre.

Global One and its partners' efforts in making this report a reality are to be commended, Their strong partnership - itself a gold standard in international humanitarian efforts - has produced an important, necessary and timely assessment which highlights the ongoing intersectionality of Syrian women's needs.

Azza Karam

Author of Realizing the Faith Dividend: Religion, Gender, Peace and Security in Agenda 2030

1 (http://www.agendaforhumanity.org/initiatives/4012)

EXECUTIVE SUMMARY

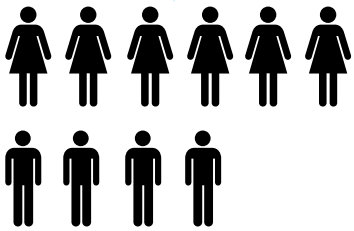
'One in every 122 humans is now either a refugee, internally displaced, or seeking asylum';[2] women make up more than half of this population. This number is ever increasing, and if we consider that the average refugee will spend 17 years away from their home, it is imperative we look towards long-term, sustainable interventions.

The current crisis in Syria has resulted in over 4 million people fleeing to neighbouring countries. Leaving over 6 million more people displaced inside Syria. This high level of displacement is having overwhelming effects on humanitarian, government and international organisations; who are struggling to provide the basic necessities and resources people need. Syrian refugee women are disproportionately affected by the strain on services, as displaced women and girls now lack the basic resources they once had in Syria before the conflict began.

"More Than Half..."

52.8%

...Of Refugees, Internally Displaced Peoples & Individuals Seeking Asylum Are *Women.*



In order to assess this disproportionality, Global One led a consortium of organisations to carry out a gender-focused, religio-cultural assessment amongst displaced Syrian women living in Lebanon and Syria. The research was funded in-part by our community fundraising campaign 'Dining for Dignity', and we were also delighted to receive a contribution from Penny Appeal. This allowed us to undertake two separate surveys were conducted in Lebanon and Syria, by SDAID and SRN respectively, with a total of 836 women being surveyed overall. Each woman was provided with a female hygiene kit, as a token of our appreciation for their participation; each kit was provided and delivered by URDA in Lebanon.

Lebanon was chosen as it currently hosts the largest number of Syrian refugees in relation to its population size. Syria was chosen in order to compare the currents needs of IDPs, in relation to their counterparts in refugee camps. Qualitative and quantitative research was conducted through questionnaires and individual interviews with displaced women in June 2016. The overall objective was to explore the diverse and unequal effects of statelessness on refugee women. The areas analysed included: water, sanitation and hygiene, menstrual health, health and psychosocial support and, religious and cultural beliefs.

Whilst the research provides a unique perspective into the experiences of Muslim women, as displaced persons, the limited scope of the research (in terms of location and sample size), can only offer a fragment of Syrian women's current situation. As a focused assessment, the analysis places WASH at the fore of this analysis compared to the various other issues which are affecting refugee women. Whilst the research did not outwardly analyse data from host communities; the report takes into account the needs of host communities, and aims to create recommendations which integrate their needs.

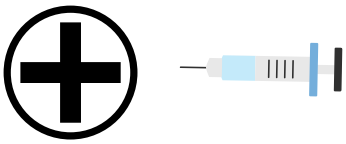
This report presents the findings and analysis from the assessment carried out in Lebanon and Syria. It aims to contribute to an improved understanding of the gendered impact of the Syrian conflict on displaced women, and the intersection of religious and cultural traditions within these issues. It concludes with detailed recommendations for international agencies, local and international NGOs and national governments; with the aim of aiding them in the planning and implementation of gendered and religio-culturally sensitive programmes, which address the specific needs of women. The recommendations are derived from the findings of our data, and highlight the current limitations within humanitarian response strategies.Global One aims to illustrate how collaborative work on programmes, which focus on gender from a religio-cultural perspective can improve the lives of both refugee and host communities in the region.

2 Fiddian-Qasmiyeh, E. (2016)

MAIN ISSUES

1. The lack of access to drinking water is often a completely new experience for women; most of the population in Syria had well-established water supply systems and water direct to households.[3] This is no longer the case as women face huge disparities in their access to water.

2. Limited resources continues to have a huge impact on the lives of displaced persons. The limited access to healthcare, water infrastructure and humanitarian aid; following multiple attacks on these services, could, worryingly, result in the rise of communicable waterborne diseases in IDP settlements.



3. The lack of support from humanitarian actors in terms of menstrual hygiene illustrates the promotion of menstrual products as a luxury item. The adoption of a menstrual hygiene and health programme amongst displaced persons is an intervention which must be regarded.

4. Islam plays a huge role in shaping women's lives during and after their displacement. During such an unstable period in their lives, their religious beliefs and practices represent a beacon of hope. Humanitarian strategies are currently failing these religious needs.

3 Oxfam,. Shifting Sands: Changing Gender Roles Among Refugees In Lebanon. RESOURCE CENTRE for GENDER EQUALITY, 2013. Web. 17 Nov. 2016. Oxfam Research Reports.

INTRODUCTION

The entire Syrian population has felt the effects of the ongoing conflict and insecurity in the Middle East. Over 10 million people have been displaced internally or into refuge settlements in neighbouring countries. The UNHCR estimates that more than 4.1 million refugees have been displaced into temporary settlements in neighbouring countries, including 1.5 million into Lebanon.[4] Refugees now make up 25% of the Lebanese population.[5] A further, 6.5 million people have been internally displaced. Over 50% of those who have been displaced are women; making up more than half of the entire displaced population.

The ongoing conflict in Syria has reached a stalemate and continues to show signs of a deep rooted and protracted conflict".[6] Despite efforts by the international community, the conflict continues to displace people across the region every day. Thousands of Syrian refugees continue to enter Lebanon each week. [7] This ongoing displacement to Lebanon has inevitably negatively impacted the host communities too at various levels including increasing demographics, regressing economy, exhausting social services, complicating politics, and decreasing security.[8]

Similarly, inside Syria, continual airstrikes and related clashes, continue to have a negative impact on humanitarian access and delivery of humanitarian assistance.[9] As the conflict continues, humanitarian organisations are struggling to keep pace with the urgent needs which continue to escalate beyond the anticipated needs. As infrastructure, water supplies and health facilities all continue to be attacked during the violence, and restrictions begin to be imposed by the Assad regime, access to Syria remains almost impossible; leading to an increased flow of displacement.

An understanding of the impact of statelessness from previous conflicts, emphasises the need to focus on the specific needs of women. The situation for Syrian women, both as IDPs and refugees, must be understood in the context of the religio-cultural and gender realities on-the-ground. In addition to the basic necessities needed by all refugees, refugee women have special needs that reflect their gender. More so, as Muslim women they have needs which intersect gender, culture and religion. These needs are often overlooked in emergency situations; but at a time of such hopelessness promoting stability in terms of religious practice, and comfort in terms of womanhood can have an immensely important impact on the lives of women.

As in all humanitarian emergencies the Syrian crisis is affecting refugee women more harshly. In order to understand the impact of the Syrian conflict on women's needs, Global One and its local partners, SDAID and SRN, conducted an assessment in Lebanon and Syria, to gain a greater understanding of displaced persons specific needs as Muslim women. Each of the following sections offer insights and recommendations for those responsible for funding, designing, and implementing humanitarian and development responses; with the mission of contributing to early recovery and long-term, sustainable change.

4 Al, S. et M. (2014)

5 Syrian Regional Factsheet: March 2016. (2016)

6 Oxfam, 2016. Refugee Perceptions Study: Za'Atari Camp And Host Communities In Jordan. Oxfam, 2014. Web. 15 Nov. 2016. Research Reports. Pg.3

7 Oxfam,. Shifting Sands: Changing Gender Roles Among Refugees In Lebanon. RESOURCE CENTRE for GENDER EQUALITY, 2013. Web. 17 Nov. 2016. Oxfam Research Reports.

8 Cherri, Z., González, P.A. and Delgado, R.C. (2016) 'The Lebanese–Syrian crisis: Impact of influx of Syrian refugees to an already weak state', 9.

9 Syria Crisis Monthly Humanitarian Highlights & Results: Including data regarding WASH in Lebanon refugee camps. (2015). 1st ed. [ebook] UNICEF. Available at:

10http://unicef.org.tr/files/bilgimerkezi/doc/Syria%20Crisis%20Humanitarian%20Situation%20Report%20September%202015.pdf [Accessed 10 Nov. 2016].

Guidelines on the Protection of Refugee Women (1991) Available at: http://www.unhcr.org/publ/PUBL/3d4f915e4.pdf (Accessed: 10 November 2016).

INTRODUCTION

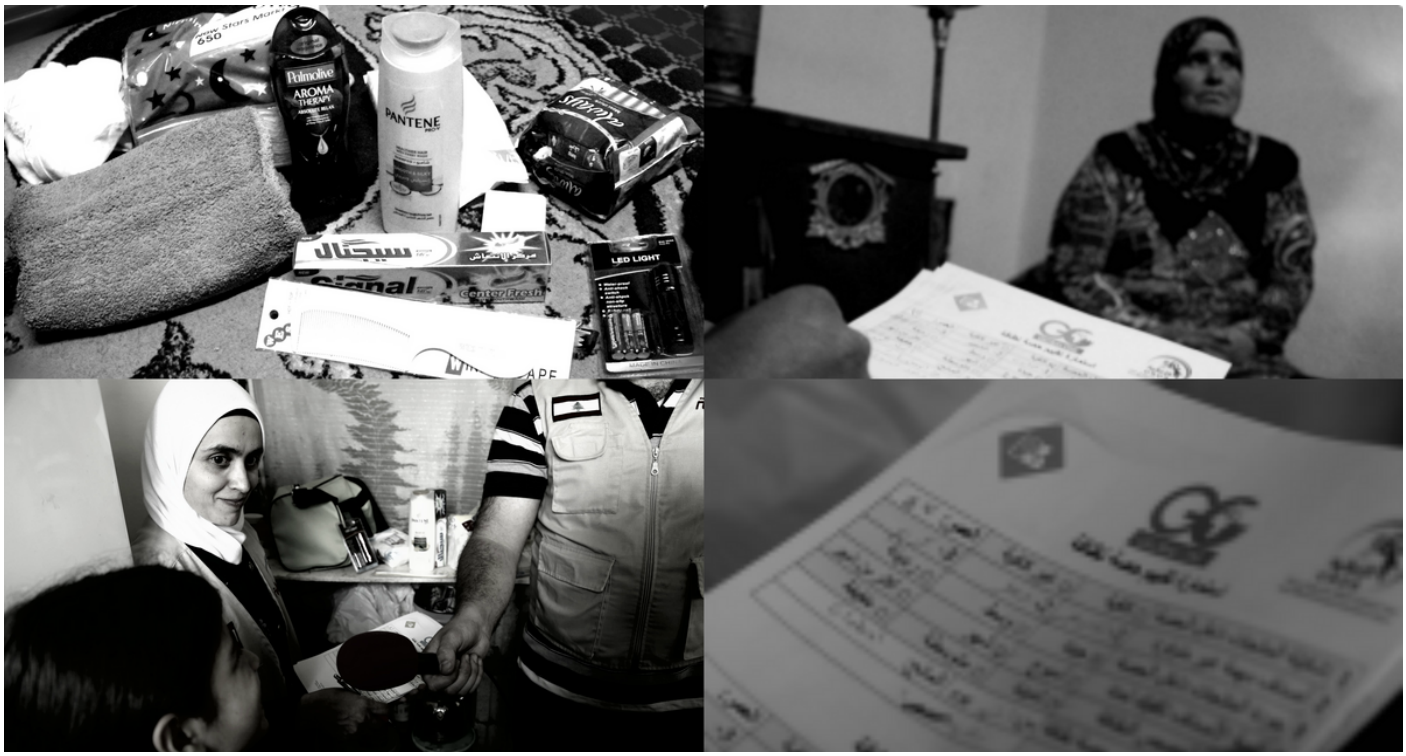
This report presents findings and analysis from our assessment, focusing on recommendations for four key areas of Syrian women's lives:

1. Water, sanitation and hygiene
2. Menstrual hygiene management
3. Health and psychosocial support
4. Religious and cultural beliefs

THE PROJECT

In 2015, Global One attended the 'Save their Boat' conference, hosted by our partner URDA. The conference outlined the issues affecting Syrian refugees across the region, and promoted areas of intervention. Over the course of the conference, however, it became to clear to Global One that the specific needs of Muslim women were not being met; and so, in June 2015 Global One began its own intervention.

In 2015, Global One conducted an analysis on the WASH needs of Syrian women in Lebanon and Syria. Utilising three local partners; SDAID, URDA and Syria Relief Network, Global One gained data from 836 women in refugee and internally displaced persons camps. In line with the research, Global One delivered female hygiene kits, containing products for one month's menstrual hygiene, to all women who participated in the research.



Global One initiated a community fundraising campaign to raise awareness about the needs of Syrian women in displaced person camps globally. The delivery of the hygiene kits were made possible by Penny Appeal's funding and our 'Dining for Dignity' campaign. Each kit which was delivered under a larger pilot project to provide women with comfort until larger scale projects could be realised. The following report, builds on this distribution as a foundation for recommendations and further project implementation.

THE CONSORTIUM

GLOBAL ONE

Global One is a UK-based charity founded in October 2013 after a group of driven and passionate women recognised that there was a need for more women to come forward as change-makers in positions of leadership in the third sector. This was done with a particular emphasis on Muslim women who are too often considered to be side-lined and disempowered. We believe that the key to prosperous communities lies in sustainability and understanding. Our unique faith-based and culturally sensitive approach is effective because it appeals to the personal and strongly-held beliefs of the communities and individuals we work with, and puts sustainable development firmly within a framework aligned with their beliefs.

UNION OF RELIEF AND DEVELOPMENT ASSOCIATIONS

URDA is a network of 100 humanitarian committees and organisations which joined efforts under the umbrella of URDA in order to coordinate charity work in Lebanon, especially to support Syrian refugees fleeing the plight of war and destruction in their home country. URDA seeks to be an influential reference for humanitarian work in Lebanon and the leading umbrella for model organizations with sustainable capabilities working professionally to develop the society under international standards.

SYRIA RELIEF NETWORK

Syria Relief Network is an umbrella of Syrian humanitarian NGOs working inside Syria and neighbourhood countries to provide relief to Syrians in desperate need of assistance. SRN exists to serve and facilitate the work of Syrian NGOs in order to efficiently and effectively address the humanitarian needs of the Syrian people.

SAWA FOR DEVELOPMENT AID

SAWA was among the first initiatives on the ground, in Lebanon, encompassing a variety of actors from diverse nationalities and multiple backgrounds, united by a common aim: that humanitarian relief and development is a matter of social justice, and to raise the living standards of Syrian refugees particularly, and the families in need from all nationalities more generally, to the basic standards of a dignified life.

DISPLACED PERSONS IN LEBANON

SYRIAN REFUGEE POPULATION

Lebanon has the highest rate of Syrian refugees in the region, hosting approximately 1.2 million Syrian refugees. [11] At least 78% of those registered were women and children.[12] Despite its high refugee population, the Lebanese government considers refugees who crossed its borders since 2011 as "displaced",[13] reinforcing the government's long-standing stance that Lebanon is not a state for refugees. The government has, therefore, refused to establish camps, and adopted a policy paper to reduce refugee numbers in October 2014.[14]

Due to its standpoint, the Lebanese Government has restricted the establishment of formal camps, leading to the dispersal of refugees across the country. The largest population of refugees are concentrated in Bekka District and North District; where the most vulnerable and poor Lebanese communities are based, and where the majority of our assessment was undertaken. The impacts of large numbers of refugees are harder to deal with in these areas where overcrowding, inadequate access to basic services and poverty were already present. As the conflict continues, both the social and economic impact of the Syrian crisis in Lebanon has created large amounts of instability amongst refugees and host communities.[15]

Given Lebanon's relatively small population, the large number of refugees has placed enormous pressure on both host communities and aid agencies, to provide refugees with support. In response to these issues, the Lebanese government and the UNHCR initiated the LCRP in 2016.[16]The plan "merges a focused humanitarian response with a larger plan in order to boost stabilisation in Lebanon". The following sections highlight the current situation in relation to the LCRP's response to the following sectors.

WATER AND SANITATION

Prior to the conflict in Syria, Lebanon's water and sanitation infrastructure were in need of large scale investment. The high increase of refugees, has presented new infrastructural demands; overburdening the national water and wastewater systems. The lack of such services, together with poor hygiene practices, means that refugees are continually confronted with waterborne diseases. Everyday 'thousands of Syrian refugees living in Lebanon's informal settlements face a growing risk of getting sick each time they take a drink of water'.[17] The effects of these poor sanitation and contaminated water supplies have contributed to high death rates in many refugee camps.[18]

In 2014, the Ministry of Environment posted a research report outlining the vulnerabilities of Lebanon's water and wastage systems. 'It indicated that municipal spending on waste disposal, particularly in Akkar and Bekaa increased by 40%, and 92% of sewage [was] running untreated into water sources'.[19] These high levels are a consequence of the increased demand for land, water resources, electricity, and waste disposal since the Syrian conflict.

11 UNHCR Syria Regional Refugee Response". UNHCR Syria Regional Refugee Response. N.p., 2017. Web. 18 Nov. 2017

12 Cherri, Z., González, P.A. and Delgado, R.C. (2016) 'The Lebanese–Syrian crisis: Impact of influx of Syrian refugees to an already weak state', 9.

13 Cherri, Z., González, P.A. and Delgado, R.C. (2016) 'The Lebanese–Syrian crisis: Impact of influx of Syrian refugees to an already weak state', 9

14 Ibid.

15 Cherri, Z., González, P.A. and Delgado, R.C. (2016) 'The Lebanese–Syrian crisis: Impact of influx of Syrian refugees to an already weak state', 9.

16 Cherri, Z., González, P.A. and Delgado, R.C. (2016) 'The Lebanese–Syrian crisis: Impact of influx of Syrian refugees to an already weak state', 9.

17 Syrians face water crisis in Lebanon (2015) Available at: https://www.iocc.org/get-updated/newsroom/lebanon-syria-refugees-water-crisis (Accessed: 10 November 2016).

18 Guidelines on the Protection of Refugee Women (1991) Available at: http://www.unhcr.org/publ/PUBL/3d4f915e4.pdf (Accessed: 10 November 2016).

19 Cherri, Z., González, P.A. and Delgado, R.C. (2016) 'The Lebanese–Syrian crisis: Impact of influx of Syrian refugees to an already weak state', 9.

DISPLACED PERSONS IN LEBANON

HEALTH & OTHER SERVICES

The healthcare system reflected similar issues to those of the water and sanitation infrastructure. Even before the conflict occurred in Syria, the Lebanese public healthcare system was failing to provide sufficient prevention, planning and accessibility programmes. Since 2011, the Ministry of Public Health has 'spent over 54% of its national budget on the private healthcare industry',[20] leading the majority of Lebanese citizens to pay higher rates for medical care. The Lebanese public healthcare system was unprepared to accommodate the large number of Syrian refugees, increasing the ministries' lack of access and expense for medical care.

These issues in the healthcare system, have had serious implications for Syrian refugee women's health, specifically their menstrual, sexual and reproductive health. But, health issues are also widespread amongst children and families in the camps. There have been serious outbreaks of scabies, lice and leishmaniasis, predominantly in Bekaa District. The LCRP has placed this as a strategic priority for 2017, noting the importance of ensuring that 'the most vulnerable Lebanese and displaced Syrians can access affordable healthcare, with a focus on accessibility and quality of services and controlling disease outbreaks'. However, the sector remains massively underfunded and over the past five years the UN has significantly decreased its funding within the health sector. [21]

20 Yasmine, R. and Moughalian, C. (2016) 'Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions', Reproductive Health Matters, 24(47), pp. 27–35. doi: 10.1016/j.rhm.2016.04.008.

21. Cherri, Z., González, P.A. and Delgado, R.C. (2016) 'The Lebanese–Syrian crisis: Impact of influx of Syrian refugees to an already weak state', 9.

DISPLACED PERSONS IN SYRIA

INTERNALLY DISPLACED PERSONS

Since the conflict began in March 2011, Syria has been undergoing political crises and instability forcing many Syrian's to flee to neighbouring countries. However, the OCHA estimates that at least 6.6 million people were internally displaced inside Syria, with over 1.3 million displaced in 2015 alone (OCHA, December 2015)[22]. In 2015, over 7 million of those who were displaced, were people who were victims of repeated displacement, having fled their homes previously.

The continuous siege of cities, and the movement of people means that humanitarian aid is inaccessible. This has a great impact on the ability of organisations to collect data, which results in an underreporting of displacement. According to the OCHA, in 2015 there were an 'estimated 4.5 million Syrians in need in out-of-reach areas, and about 400,000 in besieged cities'. [23]

HUMANITARIAN ASSISTANCE

In 2016, despite numerous attempts to employ a nationwide cessation of hostilities, humanitarian assistance was still restricted. For the millions of displaced persons living in collective shelters, camps or makeshift settlements, humanitarian assistance is their only source for basic necessities. As neighbouring countries reduce the number of Syrian refugees they provide asylum to, hundreds of thousands of people remain beyond the reach of humanitarian actors.

Those displaced persons living in besieged cities, are denied their basic rights, including freedom of movement and access to adequate food, water, and health care. [24] The denial of humanitarian assistance to these areas, means that many Syrians are unable to get the healthcare and basic necessities they need.

WATER SUPPLY

Water shortages across Syria have been persistent since the beginning of the conflict in 2011. Water is intermittently cut off, and damage from the conflict has caused massive destruction to the country's main water supplies. This "damaged [water] infrastructure, a lack of maintenance, and limited power supply has resulted in a 50% reduction in access to safe water [in Syria]".[25]

This water insecurity continues to have a huge impact on the lives of displaced persons. The limited access to water infrastructure and humanitarian aid, alongside limited healthcare; following multiple attacks on these services, could, worryingly, result in the rise of communicable waterborne diseases in IDP settlements.

22 Syria IDP figures analysis (2016) Available at: http://internal-displacement.org/middle-east-and-north-africa/syria/figures-analysis (Accessed: 10 November 2016).

23 Syria IDP figures analysis (2016) Available at: http://internal-displacement.org/middle-east-and-north-africa/syria/figures-analysis (Accessed: 10 November 2016).

24 Jadaliyya Reports,. Humanitarian Needs Overview Of Syria. Jadaliyya, 2016. Web. 5 Jan. 2017. Jadaliyya Reports.

25 Vidal, J. (2016) Water supplies in Syria deteriorating fast due to conflict, experts warn. Available at: https://www.theguardian.com/environment/2016/sep/07/water-supplies-in-syria-deteriorating-fast-due-to-conflict-experts-warn (Accessed: 10 November 2016).

SCOPE AND METHODOLOGY

The gender and religio-cultural assessment carried out with Syrian refugees and Syrian IDPs covered the following geographical regions (see Figure 1):

- Lebanon (Bekaa);
- Syria (Aleppo and Idlib);

These areas were selected because they provide a solid representation of Syrian women's lives. Lebanon overall, has the world's largest number of refugees per capita; with the majority concentrated in Bekaa Valley. In Syria, the assessment was focused on besieged areas most affected by the conflict. International NGOs and UN agencies, including our own partners, are providing assistance to Syrian refugees and IDPs in these locations. In addition to the data collected through the assessment, this report draws on information from other international organisations.

FIGURE 1: REGIONS COVERED BY THE ASSESSMENT

OBJECTIVES

The assessment was designed to collect data on the following key research questions:

1. What are the effects of statelessness on Syrian women's water, sanitation and hygiene needs?
2. How does faith intersect the water, sanitation and hygiene of Syrian women?
3. What are the current gaps in government, NGO and humanitarian assistance programmes, in refugee and internally displaced person camps?
4. How can sustainable development intersect current humanitarian approaches to refugee women's needs?

These questions were specifically answered by a focus on the following key areas in displaced persons lives:

Water, sanitation and hygiene: including women's access to water supplies and hygiene infrastructure, and how their specific female needs are met by humanitarian programmes, currently. Hygiene practices are also analysed.

Menstrual health: across the various locations in which the assessment took place. Practices, access and perceptions to menstrual health were also assessed.

Health and psychosocial support: including analysis of the current access women have to these services. Gender-based violence, and women's safety were also assessed.

Religious and cultural beliefs: this dimension was assessed based on people's beliefs and experiences in the above aspects. This analysed how women's needs were currently being met in terms of religion-cultural needs.

SCOPE AND METHODOLOGY

METHODOLOGY

Two separate surveys were conducted in Lebanon and Syria, with a total of 836 women being surveyed overall. Lebanon was chosen as it currently hosts the largest number of Syrian refugees in relation to its population size. Syria was chosen in order to compare the currents needs of IDPs, in relation to those displaced persons in refugee camps.

In Lebanon, 400 women were chosen via probability sampling, from 10 camps in the Bar Elias region. This provided an accurate sampling of the differing situations Syrian refugee women currently experience in Lebanon. The data was collected through one-on-one interviews with the women, and took place over the space of five days.

In Syria, 436 women were interviewed in 13 IDP camps in the North of Syria. The survey used a random sampling technique, to select sampling sizes which were reflective of the total number of women in each of the camps. The data was collected through in person focus groups, consisting of face-to-face interviews. There were 12 women per focus group, and utilised PEER research methods to gather information.

DATA COLLECTION TOOLS

A comprehensive survey was developed for those conducting the assessment in both locations. This included questions on key sectors, alongside open-ended questions to allow a comparison of women's experiences before the conflict in Syria and their current situation. The questions were separated between general sectoral questions and in-depth emotion-based questions. The same questionnaire was utilised by partners in Syria and Lebanon.

The data collection process in both locations utilised the KoBo data system, via the use of mobile technology. During the interviews, data was inputted directly into the digital KoBo server, where it was stored securely and downloaded daily to a virtual server. The data was then analysed by the Global One team in London, who utilised the Stata analysis tool to gain precise data comparison and detailing.

LIMITATIONS OF THE ASSESSMENT

Whilst the research provides a unique perspective into the experiences of Muslim women, as displaced persons, the limited scope of the research (in terms of location and sample size), can only offer an insight into the lives of Syrian women. Due to the project's small budget, Global One carried out a focused assessment, mainly highlighting issues with WASH. This, however, only scratches the surface of the numerous issues which refugee women are currently facing.

The sensitive nature of the assessment questions meant that some participants did not respond candidly, or at all to some questions. Geographical participation was restricted to the above locations. As an assessment focused on Muslim women, the different experience of other groups (e.g. Druze, Kurds and Alwites), were not ascertained. Were we to have a greater capacity in the following years, Global One would like to conduct further assessments into the health and maternal aspects of statelessness.

FINDINGS

This section of the report presents the main findings from the assessments in Lebanon and Syria, conducted by SDAID and SRN.

DEMOGRAPHIC AND SHELTER INFORMATION

HOUSEHOLD DEMOGRAPHICS

As described in the methodology section, 836 female participants from Syria and Lebanon completed the survey, in 3 locations across both countries. Nearly all respondent were of reproductive age; 43% were of average reproductive age (ages 18-30) or later pregnancy ages (between 31-40) (32%). 15% were aged 41-50; and less than 1% were in the estimated menopausal stage (age 50+). 99% of those surveyed were Muslim women.

The majority of participants in Lebanon and Syria had attended some form of schooling (87%) (81%). However, participants tended towards low levels of education; 52% women had completed only primary level education, and a further 16% had never attended school. Only, 14% of women had attended higher education.

On average respondents lived with one adult male, and had less than three children within their care. The average household size of participants was 4.25 in Lebanon, and 4.5 in Syria. The majority of participants lived with one other adult female family member (22%). Although, Syrian respondents were more likely to live with no other adult female family member (56%). Approximately 26% of participants had one female child under their care; and, on average, households of respondents, had 2 female family members.

Over three quarters of participants have resided in Lebanon for more than 3 years (76%); whilst the majority of those in Syria, had been living inside IDP camps for more than two years (83%). On average, the time between participants leaving Syria and arriving in their settlement in Lebanon, was on average 16 months. In Syria, the average period between participants leaving their home and arriving in their settlement was 8 months.

Of those respondents in Lebanon, 65% noted that general medical care was available; but gender-specific services such as reproductive health services (11%), and female hygiene services (10%) were minimal. When asked directly, 75% of women said that more specialised medical care for women was needed; 70% noted a need for reproductive health services and 81% highlighted the need for female hygiene services.

There were large variations in the availability of services between respondents in Lebanon and Syria. Three quarters of women in Lebanon had access to general medical care, in comparison to 46% in Syria. Amongst participants, there was a common need for female-specific services; with women in Lebanon and Syria, noting a lack of reproductive health, and female hygiene services. Only 7% of women in Syria, and 11% of women in Lebanon reported having access to RHS. Only 10% of women in Lebanon, and 4% in Syria, reported having access to female hygiene services. These services were listed as the most needed amongst all participants.

FINDINGS

SHELTER TYPOGRAPHY

The Lebanese government has restricted the creation of formal camps throughout Lebanon, leading displaced Syrians to seek refuge within informal settlements in Lebanese host communities. Similarly, the lack of formal settlements for displaced persons in Syria means that there is a large diversity of accommodation contexts. This has made WASH and health interventions more difficult to coordinate and poses challenges for the communities which host displaced persons.

To facilitate comparative analysis on WASH interventions in Lebanon and Syria, the accommodation typology was simplified, as such, in the analysis presented in this report:

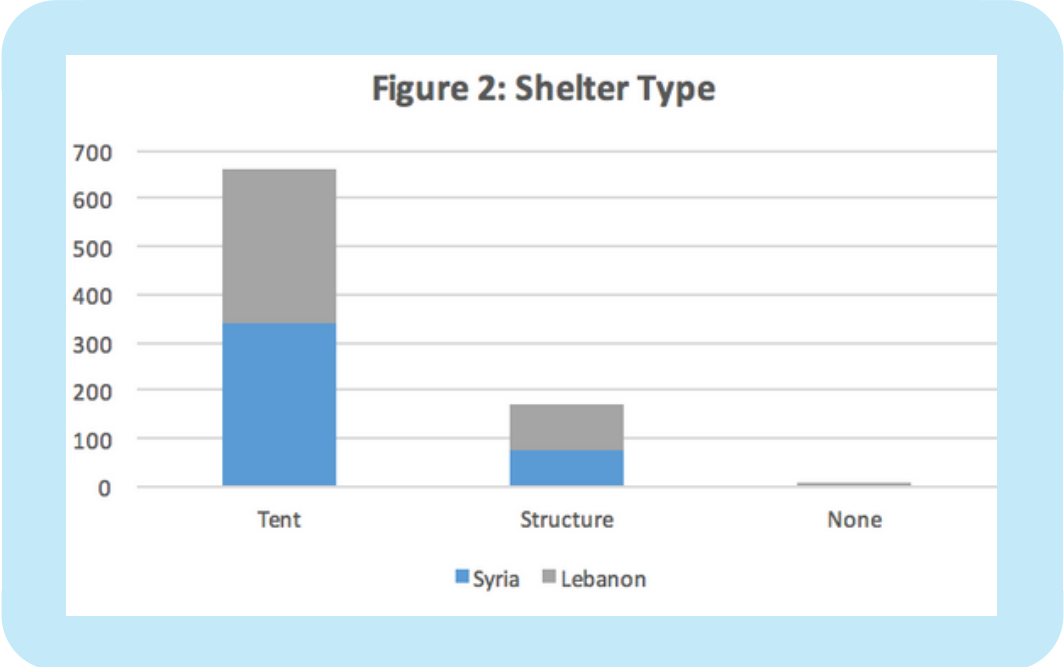
Tented settlements: Tented settlements were the most common settlement of participants, compromising 79% of shelters.

Caravans: Caravans were the second most common settlement amongst respondents from Lebanon, with 16% of respondents living in one.

Substandard buildings: Our study found that 8% of Syrian respondents lived in an unfinished building. A further 6% resided in a one room structure, or handmade shelter (3%).

Houses or apartments: A small percentage of Syrian respondents lived in independent houses or apartments (8%).

The remaining participants lived in other types of accommodation ranging from collective centers to no shelter at all.



FINDINGS

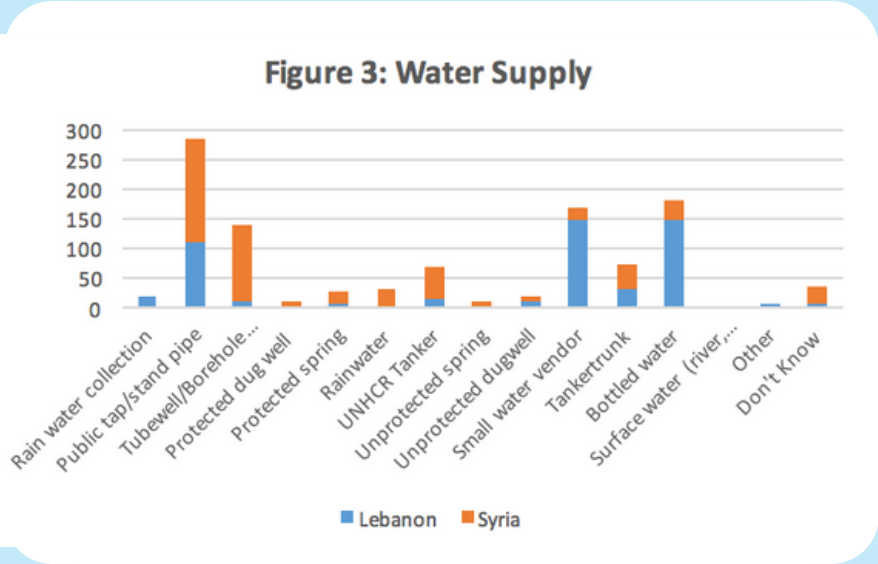
WATER

The Lebanese water supply and infrastructure was grossly underfunded and in disrepair before the beginning of the Syrian crisis in 2011. With an estimated one million people seeking asylum there has been a large strain on services, leading to an increased lack of access to water amongst refugee and host communities.

The lack of clean water poses numerous risks to refugees and intensifies issues already faced by host communities. More research needs to be undertaken to understand how the lack of access to water supplies, storage and treatment are increasing the prevalence of waterborne diseases. This report aims to provide some insight from its findings.

WATER SUPPLY

This assessment found great disparities in the access of water amongst displaced persons in Lebanon and Syria. Overall, 75% of Syrian refugees in Lebanon relied on purchased water for drinking water. Whilst the majority of those in Syria had access to free-flowing water sources such as public stand pipes (37%) and borehole pumps (28%).



There were slight differences between the sources of water for drinking and for cooking amongst women in Lebanon. The most common source of water for cooking, in Lebanon, was similar to that for drinking; 31% of participants utilised small water vendors for their source. Although, some participants in Lebanon utilised rain water collection as a source for cooking (22%). Similarly, those in Syria were more likely to use the same water sources for drinking and cooking; public stand pipe (33%); and borehole pumps (24%).

There were great differences in the water sources used for consumed and non-consumed water, by participants in Lebanon. Women in Lebanon were more likely to use public water sources for these activities; with boreholes and unprotected dug wells being the most common water sources for non-consumed water. In Syria, however, there were steady data similarities between the types of water sources being used by participants for both non-consumed and consumed water sources.

Of those residing in tents in Lebanon, the majority purchased water for drinking water. 29% used bottle water, and a further 29% purchased water from a small water vendor. Contrastingly, the most common source of water, amongst women in Syria who resided in tents, were public taps (22%).

FINDINGS

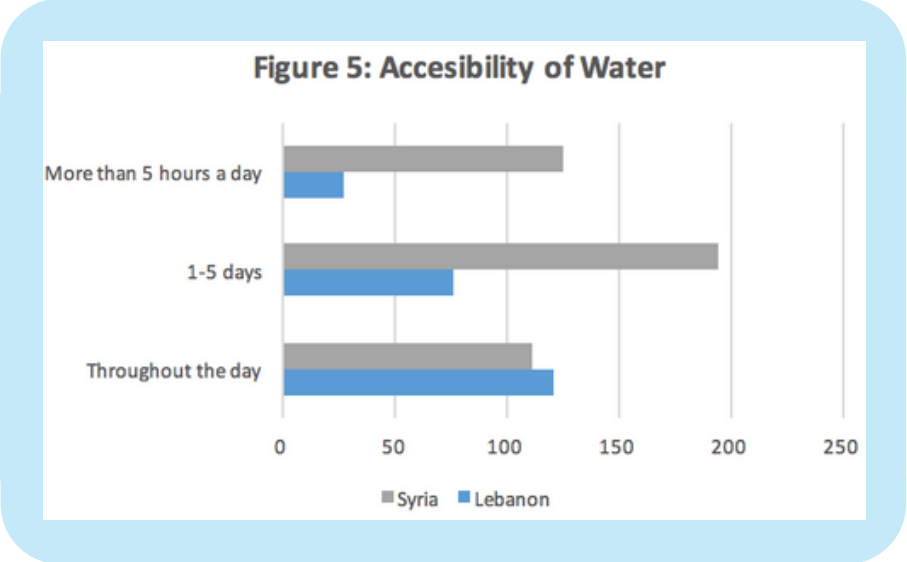
WATER

FIGURE 4: OVERALL WATER SOURCES BY USE

	Handwashing	Cooking	Cleaning
Rain water collection	4%	2%	5%
Public tap/stand pipe	23%	28%	23%
Tubewell/Borehole Pump	25%	14%	25%
Protected dug well	4%	1%	1%
Protected spring	1%	2%	1%
Rainwater	3%	3%	6%
UNHCR Tanker	5%	5%	5%
Unprotected spring	2%	1%	10%
Unprotected dugwell	11%	3%	2%
Small water vendor	4%	14%	5%
Tankertrunk	7%	6%	7%
Bottled water	5%	16%	4%
Surface water (river, pool)	0%	0%	0%
Other	0%	1%	2%

ACCESS TO WATER

There were huge variations, in women's access to water between Syria and Lebanon. Nearly half of participants in Syria (47%), took less than 15 minutes to collect. A further, 8% of participants reported taking 30 minutes to one hour for water collection. Similarly, the majority of participants in Lebanon (40%) were able to retrieve water within 15 minutes. The majority of respondents water was available to them for most of the day. Women in Syria, reported that they could obtain water for 1-5 hours of the day (44%), or for more than five hours a day (28%). Similarly in Lebanon, the majority of women could access water throughout the day (30%); although 44% noted that water was not readily available throughout the day.



FINDINGS

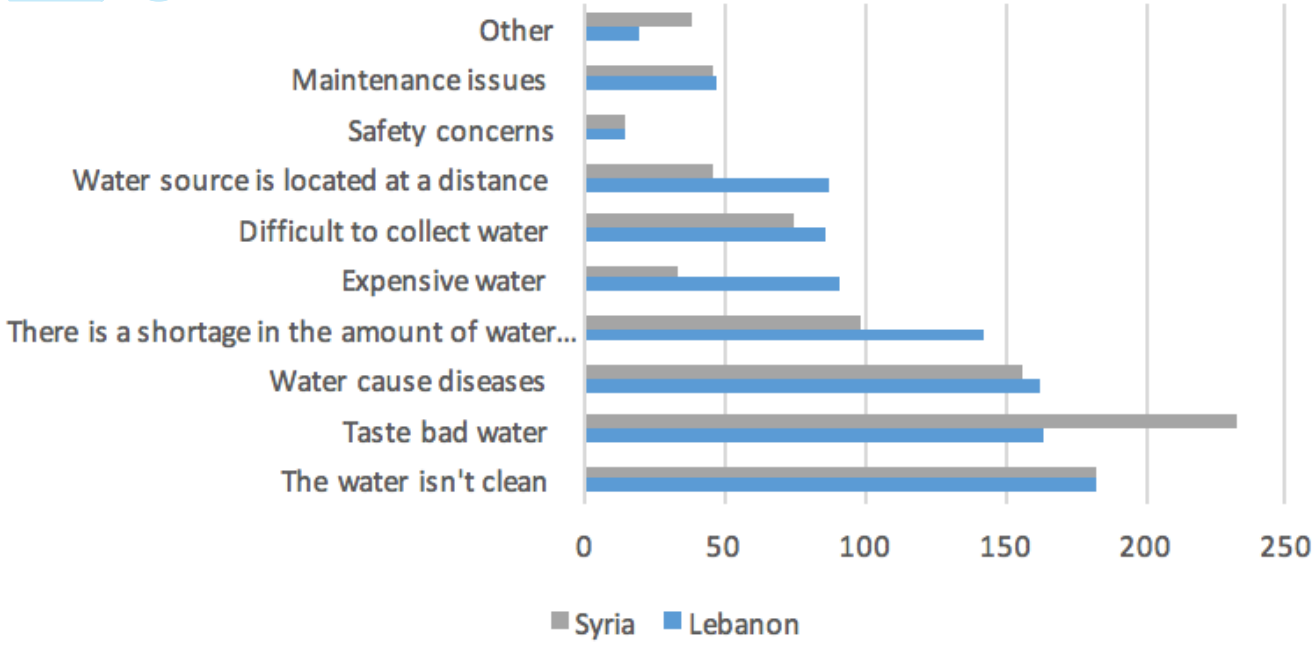
WATER

More than half of the participants from Syria, stated that they did nothing to purify their water (59%). Similarly, 48% of participants in Lebanon stated that they used nothing to purify their water before using it. The most common use of purification was boiling by participants in Lebanon (25%), whilst in Syria the preferred method, by participants, was to keep the water in a closed container (23%).

All participants faced difficulties with their water supply. The most common difficulties amongst all respondents were; unclean water (44%), bad taste (48%), and, disease (38%). Water shortage, expense and difficulty in accessing were all listed as problems too.

Those reporting difficulties in Lebanon most commonly noted unclean water (47%). They also noted that the water tasted bad (42%) and caused disease (42%). Shortages were reported by 37% of women in Lebanon, as an issue in obtaining water, whilst the expense of the water was only reported by 24%. Similarly, in Syria, women reported unclean water (42%), bad taste (53%) and disease (36%) as the biggest challenges with their water source.

Figure 6: Issues with Drinking Water

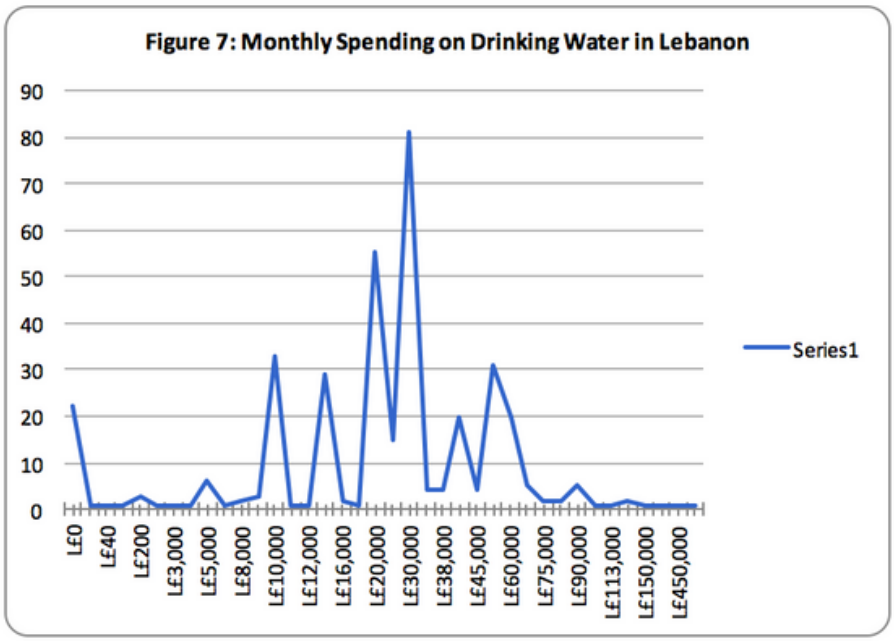


FINDINGS

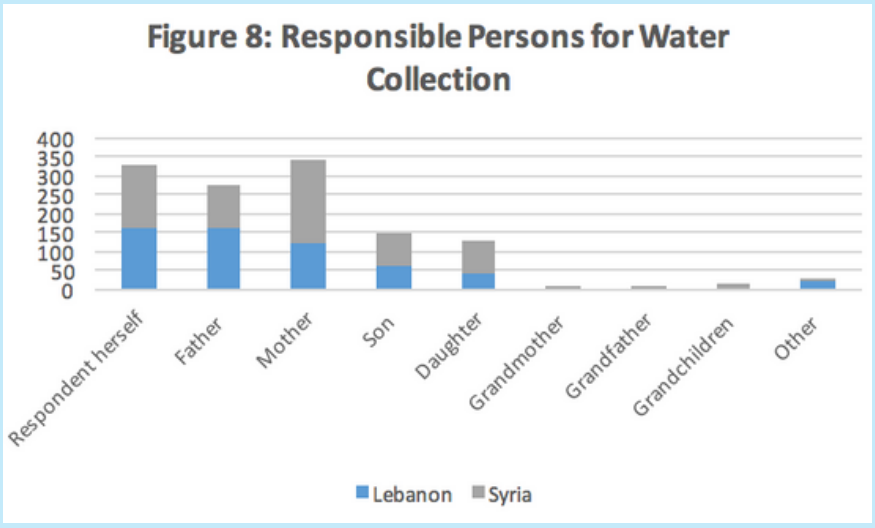
WATER

99% of respondents in Lebanon paid for their water source. Those who did purchase water were likely to pay between LBP 10,000- LBP 60,000 (approx. £5.42-£32.57) per month; and, the majority (22%) spent LBP 30,000 (approx. £16.29) per month on drinking water. Those who purchased water at this price, purchased their drinking water, from either a small water vendor (25%) or purchased bottled water (43%).

More than half of participants in Syria, had free access to water (51%). Those who did spend money on water, were likely to pay between SYP 30,000-60,000 (approx. £115.41- £230.82) (80%). Participants in Lebanon, who had free access to water, used this water only for non-consumable mean (26%).



WATER STORAGE & TREATMENT



With few exceptions, the majority of participants stored water in their house. The predominant storage containers were jerry cans (67%) and water tanks (46%). Women were more likely to collect and store water than men. Overall, 96% of respondents listed a female family member as the person responsible for water collection and storage; with the respondent herself (39%), or the mother of the family (41%), being responsible for the collection and storage of water.

FINDINGS

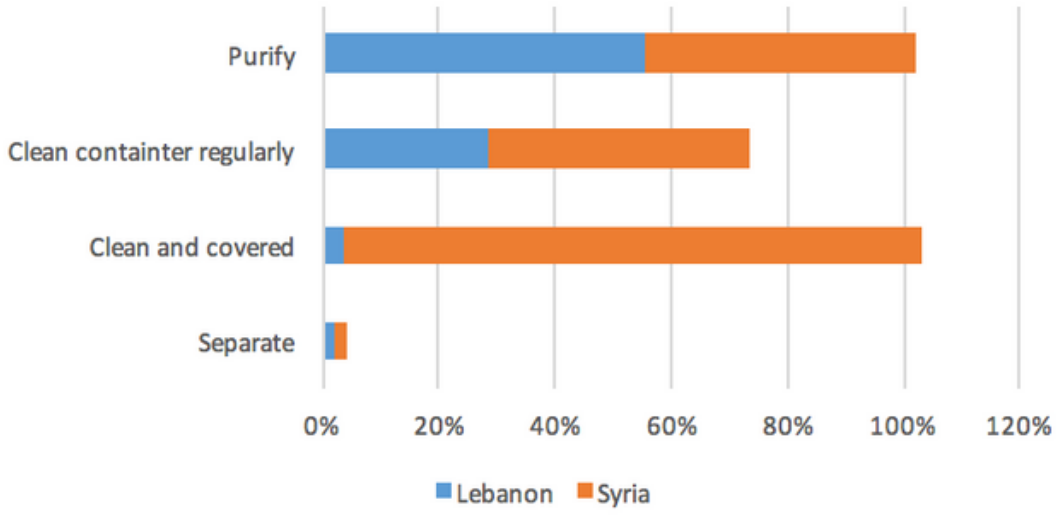
WATER

Cross-contamination of drinking water, with other water sources, is a leading cause of disease. Almost all participants (99% in Syria, and 95% in Lebanon), reported storing their water in a clean and covered place. However, 93% of women stated that they did not separate non-drinking from drinking water.

Further, more than half (59%) of the participants from Syria, stated that they did nothing to purify their water. Similarly, 48% of participants in Lebanon, stated that they used nothing to purify their water before using it. For those who did purify, the most common method was boiling (25%) amongst participants in Lebanon. Women in Syria preferred to keep the water in a closed container (23%).

The cleaning of water containers, is an important factor in preventing waterborne diseases. Only, 1% of participants noted that they did not clean their container; a far higher rate than those who did not treat their water. 37% of participants cleaned their water container every day; whilst 30% reported cleaning their container twice a week. Respondents in Lebanon were more likely to clean their container only, once or twice a month (18%). The majority of respondents (60%), used water and soap to clean their container; and a further 37% used chlorine.

Figure 9: Safe Water Usage



FINDINGS

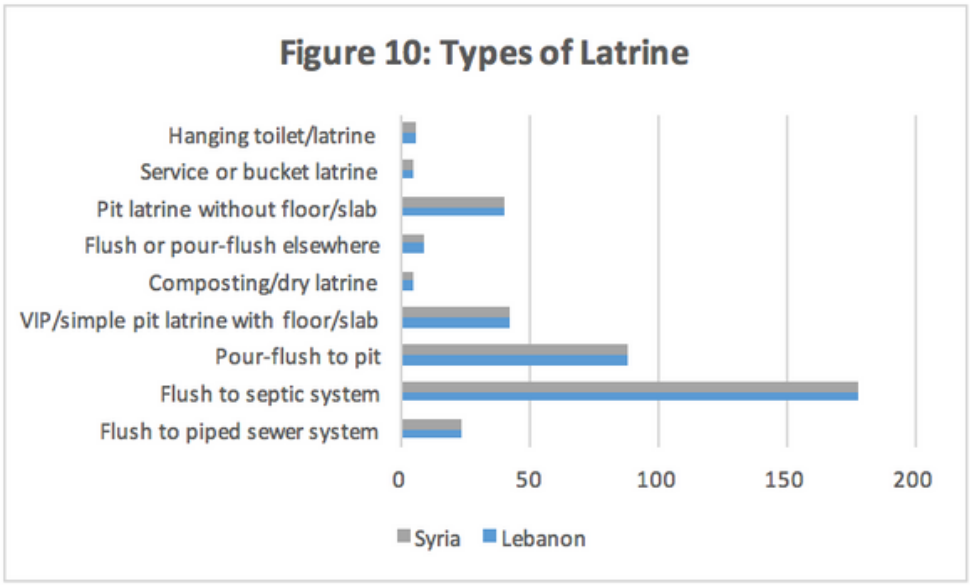
WATER

WASH INFRASTRUCTURE

A lack of access to sanitation facilities disproportionately affects women due to their specific gendered needs. Lack of access to such facilities can have a dramatic impact on women's health and hygiene, specifically their reproductive and sexual health. Further, issues with GBV within displaced person camps also leave women vulnerable to assault. This section aims to highlight the effect such facilities have on women's day-to-day lives, as displaced persons.

ACCESS TO LATRINES

Almost all respondents in Lebanon had access to a latrine in their settlement (99%), in comparison to the 49% of respondents in Syria who did. Flush to piped sewer systems were the predominant latrine type amongst Syrian women (61%). Flush to septic systems were the most common type of latrine amongst women in Lebanon (45%).



The recommended number of people to share a latrine is listed as twenty. In Lebanon, latrines were most commonly shared by 1-8 people (88%). Whilst in Syria, on average, women shared with 11 people; but there was a large percentage, 44% in Syria, who reported sharing with over 20 people; with some reporting the existence of 150+ people communal latrines.

The majority of respondents from Syria noted that they had access to water, after urination and defecation; to wash their hands (81%) and wash themselves (60%). Correlatively women in Lebanon, also had water to wash their hands (81%) and wash themselves (75%) after using the toilet.

Both sets of respondents, most commonly used a latrine for defecation. 99% of women in Lebanon used a latrine in their settlement, for 51% of women in Syria this was communal. 7% of women in Syria reported defecating near the house; of those who did 68% were unhappy with their latrine.

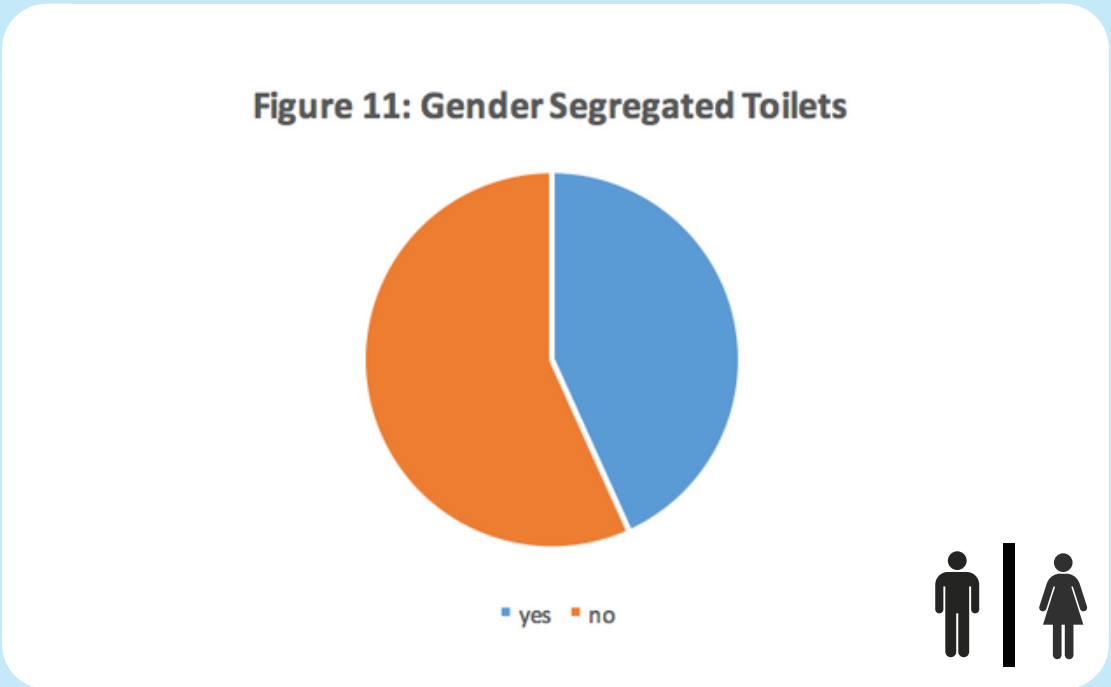
FINDINGS

WATER

More than half of Syrian respondents stated that they disposed of children's stools in latrines (56%), or with the garbage (26%). Disposal of children's stools in latrines (46%) and with the garbage (34%), were also the most common methods amongst respondents in Lebanon. However, issues with garbage disposal were also noted. Of those respondents, from Lebanon, who disposed of children's stools in the garbage, 27% noted an issue with waste disposal. Only 9% of respondents in Syria who disposed of children's stools in the garbage, noted an issue with waste disposal.

Over half of respondents in Syria stated they were happy with their latrine (54%). Two-thirds of respondents were unhappy due to a lack of privacy (66%); 63% noted distance as a major issue; and, 59% listed a lack of water, to wash their hands. A smaller minority, 4% listed gender-segregation as an issue. This differed greatly from respondents in Lebanon; where only 31% were happy with their latrine. A lack of cleanliness (25%), lighting (16%) and privacy (41%) were amongst the main reasons for dissatisfaction. Over two-thirds of respondents, in Lebanon, noted a need for maintenance. Gender segregation (12%), and distance (1%) were minimal issues amongst respondents.

The majority of women in Syria had access to a gender segregated toilet (79%). This was not true of women in Lebanon. 98% of respondents, in Lebanon, did not have access to a gender segregated toilet. Women in Lebanon who did not have access to a gender segregated toilet were more likely to reside in a tent (79%).



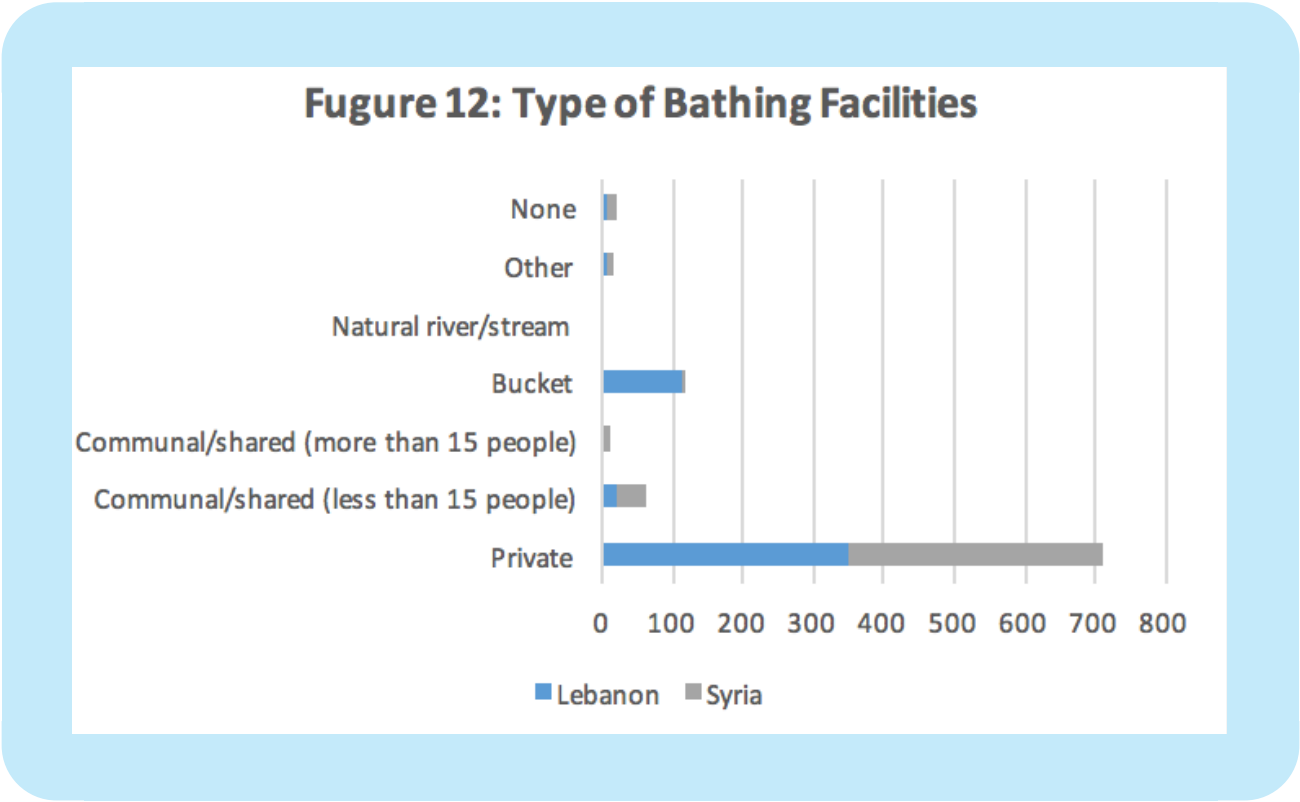
FINDINGS

WATER

BATHING FACILITIES

Bathing facilities were accessed by almost all participants in Lebanon. The majority of those with access, had access to some form of shower (75%). However, 23% of participants in Lebanon reported using a bucket as their bathing facility. Similarly, access to a shower for respondents in Syria was possible (94%); only 3% of respondents noted using a bucket to bathe. The majority of women in Lebanon and Syria reported access to private facilities (64%)(83%). However, 28% of those who had a private facility in Lebanon used a bucket.

From respondents who felt uncomfortable using the shower in Syria, 67% had facilities which were out of order. Likewise, 46% of respondents from Lebanon, who were uncomfortable using their showers, had facilities that were in need of repair. Facilities in disrepair were reported by women in both Lebanon and Syria; with 41% of participants, in both countries, noting their facilities were completely out of order.



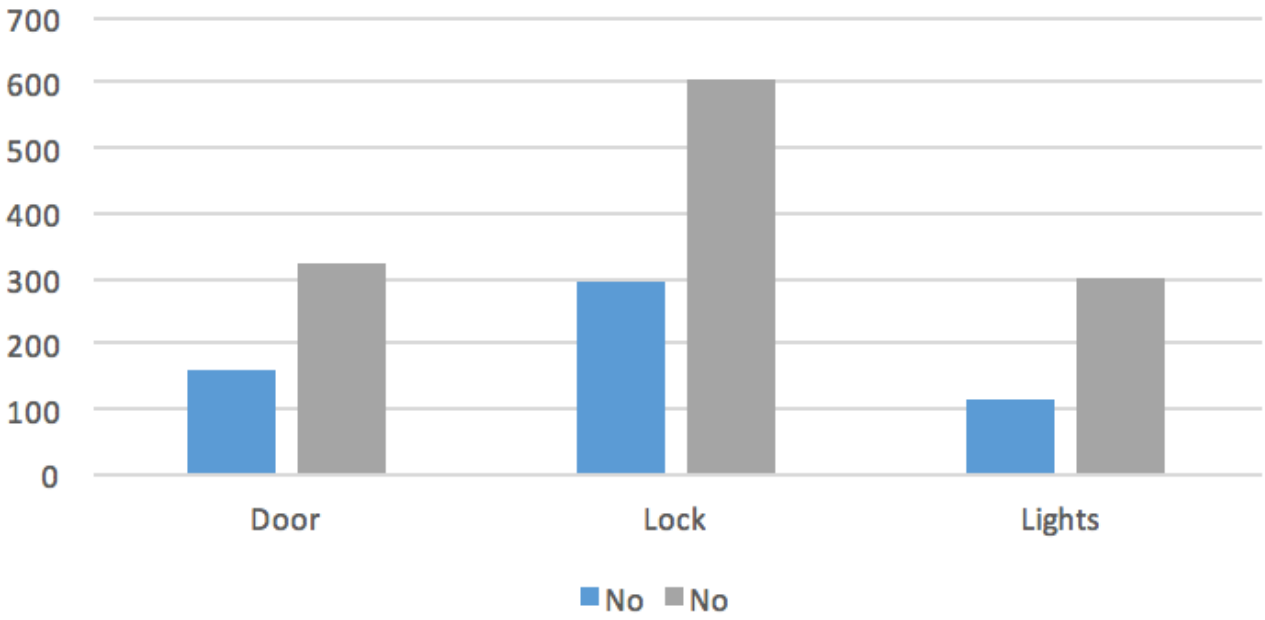
FINDINGS

WATER

It was more common for respondents in Syria to have gender segregated facilities. 53% of respondents from Syria noted that they had access to gender segregated bathing facilities, in comparison to the 6% of respondents who stated the same in Lebanon. In Lebanon 94% of respondents stated that their shower facility was not gender segregated.

In Lebanon, 41% of women did not have a door to their bathing facility; 76% did not have a lock; and 30% did not have lights. This corresponds with reports from women in Syria where 38% of women had no door on their bathing facility; had no lock (70%), and no lights 43%.

Figure 13: Secure Bathing Facilities



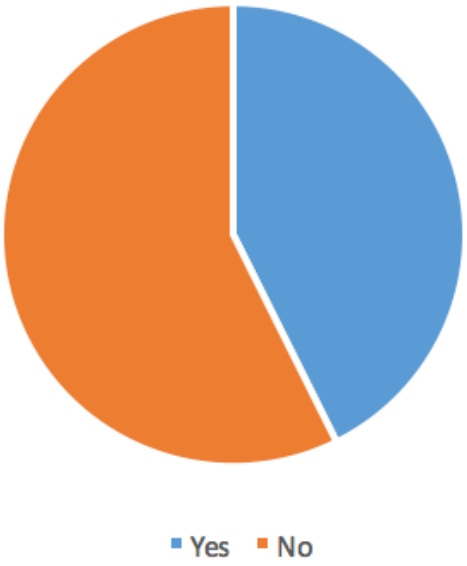
FINDINGS

WATER

SAFETY CONCERNS

Over half of all participants did not feel comfortable when using the bathing facilities; although discomfort was more common amongst women in Lebanon. 65% of respondents in Lebanon did not feel comfortable using the showers, compared to 50% of respondents from Syria.

Figure 14: Comfort and Bathing Facilities



With few exceptions, those who did not feel comfortable using the showers in Lebanon, did not have access to gender-segregated facilities (94%). However, women listed a lack of space and privacy as the most prominent issue (43%). The lack of a lock, made 27% feel uncomfortable; and this, alongside a lack of privacy was a major factor of discomfort (12%). Women in Lebanon also felt uneasy due to the lack of adequate lighting (10%). A lack of privacy and locking mechanism were also the biggest causes of uneasiness amongst women in Syria. 44% of respondents stated that the lack of privacy made them feel uncomfortable and 24% noted the lack of a lock.

Overall, those who did not feel comfortable using the showers, 48% did not have a door; 84% did not have a lock; and, 34% did not have lights. Respondents from Syria who felt uncomfortable using the facilities, also did not have access to; a door (54%), a lock (83%), or lights (57%). Of those who stated a lack of privacy as an issue with latrines, 54% of participants stated feeling unsafe when using the toilets. Similarly in Lebanon 60% of participants who stated a lack of privacy, also noted feeling unsafe when using the facilities.

FINDINGS

HEALTH AND HYGIENE

This section of the assessment attempted to understand the knowledge, attitudes and practices of Syrian women, in regards to various health and hygiene concerns. The negative effects of statelessness have manifested themselves in bad hygiene practices, emboldened by a lack of access to WASH facilities.

HYGIENE PRACTICES

FOOD & WASTE

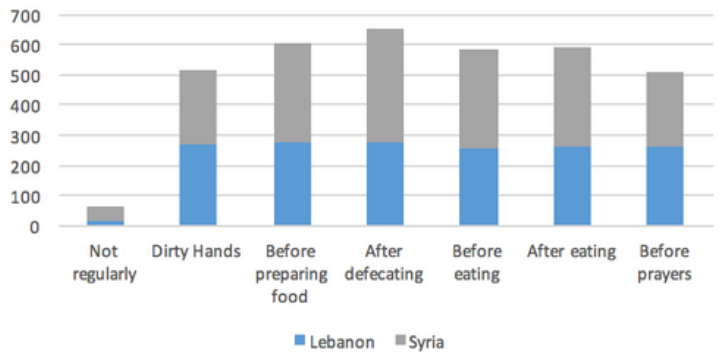
Washing fruit and vegetables was ubiquitous amongst the women. Nearly all of the women, 99% in Syria and 100% of participants in Lebanon, washed their fruit and vegetables before use. The methods varied, but the use of only water and, water and salt were the most popular methods of sterilisation.

Most respondents, from Lebanon and Syria, reported disposing of solid waste daily (98%). The use of a waste bin for garbage disposal was the most common disposal method among all participants. 42% of women in Syria, and 75% of women in Lebanon reported disposing of garbage in a waste bin. Placing rubbish near the road (27%), or in an open area (13%) was also common amongst respondents from Syria. The vast majority of respondents in Syria (92%), stated that waste disposal was not an issue. However, 23% of respondents from Lebanon, noted that waste disposal was an issue. In Lebanon, a lack of collection was the major problem listed (43%); whilst, in Syria a lack of containers for rubbish (48%), followed by a lack of collection (34%), were the biggest issues.

HAND WASHING

A high majority of participants washed their hands at key preventative times, and almost all participants used water and soap to do so (95%). In Lebanon, 69% of participants washed their hands before preparing food; 70% after defecating; and, 66% before eating. This was the same for women in Syria. 76% participants washed their hands before preparing food; 85% after defecating; 74% before eating.

Figure 15: Hand Washing Practices



Water source, played a big role in the hand washing practices of participants. Women in Syria, were 76%, more likely to only wash their hands when they were dirty, when the distance to their water source took more than one hour to collect from; in comparison to those who took less than half an hour to collect theirs.

FINDINGS

HEALTH AND HYGIENE

HEALTH CONCERNS

The most common water-borne diseases women were affected by were; amebiasis (27%) and skin diseases (21%). In Lebanon, 12% of respondents suffered from both amebiasis and skin diseases. Respondents from Syria, had a higher percentage of communicable water-borne diseases such as; salmonellosis (7%), typhoid (2%) and E-Coli (3%).

There was little variance in the levels of water-borne diseases amongst family members. Amebiasis (26%)[26] and skin diseases (23%) remained the most prominent. Skin diseases were far more prominent amongst women in Lebanon 30%; with respondents reporting family members uffering from these types of diseases in the past three months.

Again, contractable diseases were far more common amongst women in Syria; 3% stated that a family member had suffered from Typhoid, and a further 5% noted that their family member had suffered from Hepatitis A.

Figure 16: Diseases amongst Respondents

Amebiasis, Cryptosporidiosis, Cholera, E. coli, Giardiasis, Hepatitis A, Legionellosis, Salmonellosis, Typhoid, Skin diseases, None

Figure 17: Diseases amongst Respondent's Family

Amebiasis, Cryptosporidiosis, Cholera, E. coli, Giardiasis, Hepatitis A, Legionellosis, Salmonellosis, Typhoid, Skin diseases, None

26 Parasitic infection of the intestines which causes stomach pain and abdominal cramping.

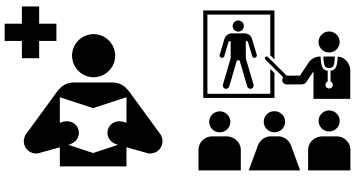
FINDINGS

HEALTH AND HYGIENE

AWARENESS AND BELIEFS

In both sets of respondents there was a high level of understanding about the determinants of diarrhoea and dyspepsia. 58% of women noted contaminated food as a determinant of the above; 84% highlighted unsafe drinking water; and, 35% listed poor hygiene practices, as a major cause of diarrhoea and dyspepsia. However, only 8% of respondents understood the correlation of open-air defecation to diarrhoea and dyspepsia. In both sets of respondents there was a high level of understanding about the determinants of diarrhoea and dyspepsia. 58% of women noted contaminated food as a determinant of the above; 84% highlighted unsafe drinking water; and, 35% listed poor hygiene practices, as a major cause of diarrhoea and dyspepsia. However, only 8% of respondents understood the correlation of open-air defecation to diarrhoea and dyspepsia.

There was little variance in the understanding of water-borne disease prevention amongst all participants. When asked about the factors which led to only diarrhoea, the majority of women listed correctly; unsafe drinking water (84%), contaminated food (66%) and poor hand-washing (38%). Again, open-air defecation was minimally noted as a factor, with only 11% of women noting this as an issue.



In relation to the relatively high percentage of understanding, amongst participants, of the factors leading to diarrhoea and dyspepsia; participants were confident in their understanding between the links of hygiene behaviour and waterborne diseases. With few exception, participants from Syria (94%) and Lebanon (95%) stated that there was a connection between hygiene practices and disease prevention. Further, the participants had a seemingly good understanding of how to prevent waterborne diseases. 66% participants listed hand washing as a preventative measure; alongside 85% who highlighted the need for treated water. Cooking food properly (63%) and clean latrines (59%) were also listed, correctly, as preventative measures against water-borne disease.

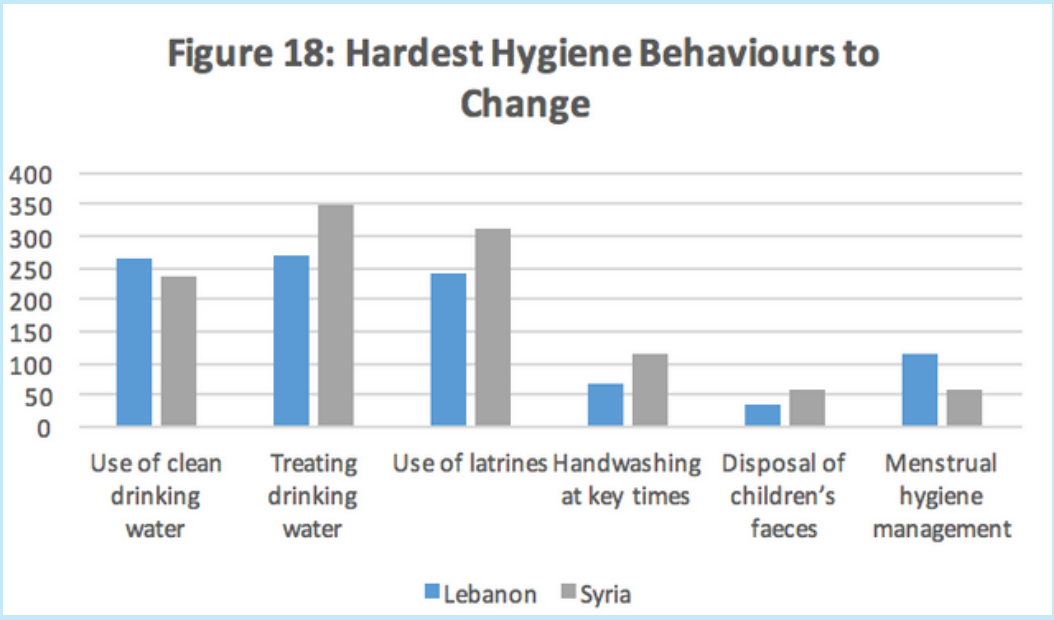
FINDINGS

HEALTH AND HYGIENE

CHANGING BEHAVIOURS

Although there was a good level of understanding amongst participants on water-borne disease prevention; nearly all participants, reported issues with practicing hygiene behaviours. There was an overall consensus that; clean drinking water (61%), treating drinking water (74%) and, the use of clean latrines (66%), were the hardest behaviours to change. Respondents from Lebanon, listed menstrual hygiene management as one of the hardest hygiene behaviour to change (29%). Women in Syria, found hand washing at key times a greater challenge (27%).

Indicatively, 63% of women noted that they did not have the means to change the above behaviours, and 39% stated that the means to changing those behaviours was too expensive. Women in Syria, were more likely to lack knowledge on how to change these practices. 36% of respondents from Syria stated that they did not know how to change these hygiene practices, compared to 21% of the respondents from Lebanon, who stated the same.



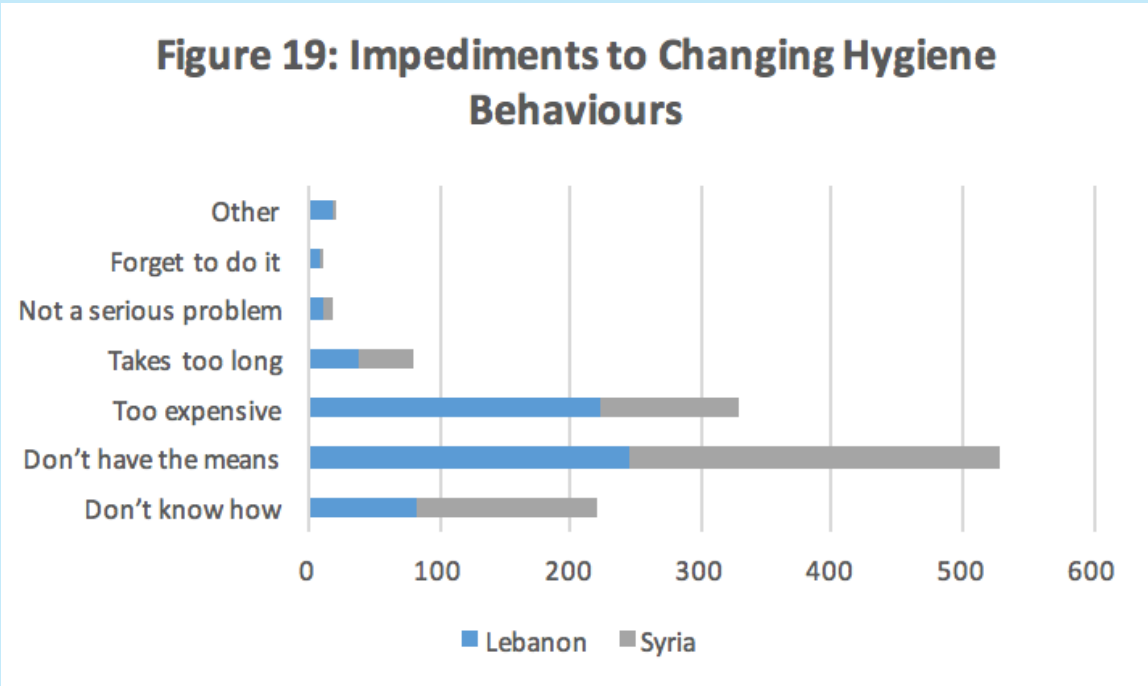
The data suggests that bad hygiene practices are correlative to a lack of access to hygiene services and products. When asked why women are unable to keep water clean (72%) and keep food covered (66%), participants from Lebanon noted a lack of resources as their main prevention. Correspondingly, 63% of participants in Syria noted a lack of resources as the main preventative factor for purifying water.

FINDINGS

HEALTH AND HYGIENE

A lack of resources was listed as the main prevention of; toilet use (46%), hand-washing with soap before cooking (31%) and drinking clean water (55%) amongst participants in Syria. There was a slight variance in the data between Lebanon and Syria. Participants in Lebanon, listed the expense of clean drinking water as the major issue they faced (54%). However, in agreement with participants in Syria, the respondents from Lebanon, listed a lack of resources as the main preventative factor of; toilet use (50%), hand-washing with soap before cooking (46%) and drinking clean water (67%).

Women in Syria were more likely to lack knowledge of preventative techniques. Women in Syria noted that a lack of knowledge was a main preventative factor for purifying water (36%) and keeping food covered (39%). They also stated that a lack of knowledge (31%) and forgetting (29%), were contributing factors to women not washing their hands with soap before cooking.



FINDINGS

HEALTH AND HYGIENE

RAISING AWARENESS

An Educational health promotion varied drastically between Lebanon and Syria. 52% of women in Lebanon had received information on water and sanitation, compared to only 37% of women in Syria. Health workers and volunteers were the most common source of education. 49% of respondents in Lebanon, and 59% in Syria, were provided information by health workers and volunteers. In both cases, the role of NGOs in the promotion of best WASH practice remained minimal; although greater in Lebanon. 13% of women in Lebanon, compared to less than 1% of participants in Syria, had received information from an NGO.

Figure 20: WASH Information Providers

- Media (TV, newspaper, radio)
- Health clinic/hospital
- Poster/billboard
- School
- Health workers/volunteers
- Place of worship/mosque
- Family or friends
- NGO

FINDINGS

MENSTRUAL HYGIENE MANAGEMENT

MENSTRUAL HYGIENE MANAGEMENT

Women in emergency situations are heavily affected by a lack of water and resources specifically in relation to menstruation. Women often lose their usual coping strategies for menstruation, and remain in close proximity to men; often causing embarassment and discomfort amongst women. This section outlines women's coping mechanisms, and their beliefs towards menstruation.

PRODUCTS

Sanitary pads were the most common product currently used amongst women. The majority, of women in Lebanon (90%) and Syria (86%), used sanitary pads. The use of cloth was less prominent, although, 7% of participants in Syria and 5% in Lebanon, reported using cloth/rag for menstruation. Women who used cloth did not list this as their preferred product, and instead preferred to use sanitary pads (79% of respondents in Syria and 75% of women in Lebanon). 2% of participants, in Syria, used no product at all to manage their periods. This was not the preferred method for 76% of those who used nothing.

Figure 21: Preffered Sanitary Products

There was some variation amongst women's access to a supply of underwear.[27] Women in Lebanon, were less likely to have access to underwear; 71% of women did not have access to a supply of underwear, compared to 57% of women in Syria who did not either. It was common for those who did not have a supply of underwear to use sanitary pads. Women in Lebanon (89%), and Syria (80%) who did not have a supply of underwear were most likely to use sanitary pads. 10% of women in Syria who did not have access to a supply of underwear, utilised cloth/rag.

The majority of women in Lebanon had access to painkillers for menstrual cramps; 76% of respondents noted having access to medicine during menstruation. This varied from women in Syria, whose access was less; 62% of women reported having access to painkillers during menstruation.

27 In this respect underwear is defined as knickers. A supply is defined as owning more than one pair and the item being readily available.

FINDINGS

MENSTRUAL HYGIENE MANAGEMENT

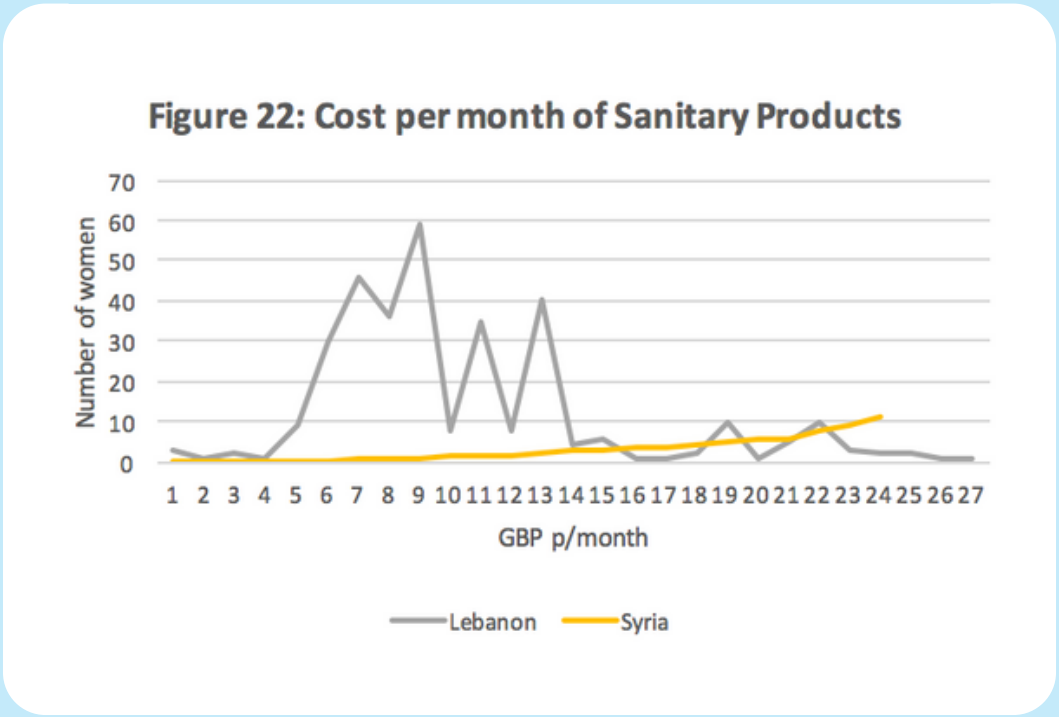
ACCESS TO HYGIENE TOOLS

PRODUCTS

Although the majority of women used sanitary pads, the product was never available to 16% of women in Syria, and 28% of women in Lebanon. A further, 61% of women in Syria, and 51% of women in Lebanon, reported that sanitary pads were only sometimes available to them.

This lack of access, forced some women to use other products such as cloth. Of those in Lebanon who used cloth or rags (5%); 75% did not favour this product. But, cloth and rag was readily available for 50% of those who used it. This was also true of women in Syria. Although 7% of participants, from Syria, used cloth, 79% of those who used it preferred to use sanitary pads. Cloth and rag was always available to 31% of participants who used this product; compared to 24% of women who always had access to sanitary pads.

The cost of menstrual hygiene products differed greatly between respondents in Lebanon and Syria. Women in Lebanon spent on average LBP2,195 (equal to approximately £1.20) per month on sanitary items, whilst women in Syria on average spent 44 SYP (approximately £0.16). Whilst the majority of women in Lebanon spent less than LBP10,000 (equal to approximately £5.40) on sanitary items per month (69%); women in Syria, on majority, spent either 500 SYP (approx. £1.90) (25%) or 1000 SYP (approx. £ 3.81) (20%) per month.



FINDINGS

MENSTRUAL HYGIENE MANAGEMENT

More than half of respondents in Lebanon (54%), purchased their items outside of the camp. Women who purchased their sanitary products outside of the camp, spent on average LBP2,260 (approximately £1.22) per month; in comparison to the LBP4,655.88 per month (approximately £2.55), spent by those who purchased their products inside the camp spent per month. There was also great disparity in the pricing of sanitary products, dependent on where they were purchased, in Syria. On average those who purchased their product outside of the camp spent 69.95 SYP (approx. £0.27) per month on sanitary items; compared to the 91.79 SYP (approx. £0.35) spent by those who purchased their products inside the camp.

A large number of women did not receive a hygiene kit when they arrived in their camp or settlement. Only 44% of women in Lebanon, and 56% of women in Syria, received a hygiene kit upon arrival. Those who did receive a hygiene kit, were mostly provided so by an NGO. 61% of women who received a kit in Syria, and 93% of respondents in Lebanon, were provided a hygiene kit by an NGO.

WATER

Water plays a big role in women's accessibility of menstrual hygiene practices; women's lack of access in Lebanon and Syria, has great affects on women's menstrual choices. The majority of women without a supply of underwear would have to travel between fifteen minutes to half an hour, to retrieve water to clean them (36%). Whilst, half of the women in Syria without a supply of underwear would have to travel less than an hour to retrieve water to clean them (50%).

Of those who used water and soap to wash menstrual products such as cloth and rag, the majority got the water to do so, from a free-flowing water source. In Lebanon, the majority of women sourced the water for cleaning products from; boreholes (21%), piped water sources (9%) and public taps (9%). The majority of women in Syria got the water to do so from; tubewells (22%), public taps (35%), UNHCR tankers (7%).

FINDINGS

MENSTRUAL HYGIENE MANAGEMENT

MENSTRUAL HYGIENE PRACTICES

HAND WASHING

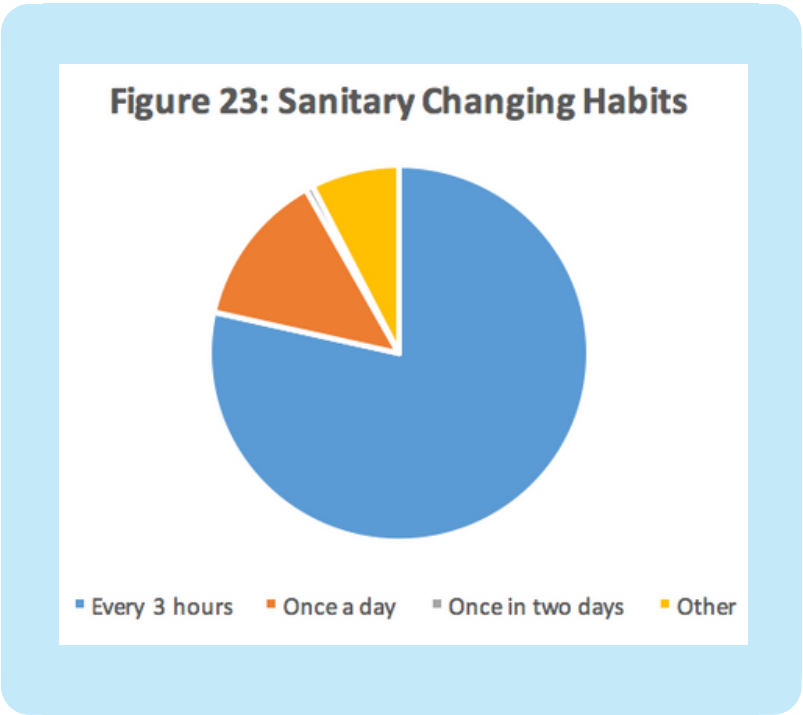
Nearly all respondents from Lebanon stated that they washed their hands after changing their sanitary products (99%). This differed from the 89% of respondents in Syria, who noted that they always washed their hands after changing their product.

The majority of women used clean, free-flowing water sources to wash their hands. Participants in Lebanon who noted that they always washed their hands after use, were most likely to gain their water for hand washing from a tube-well/borehole (22%); respondents from Syria were most likely to use water from a tube-well/borehole (20%). However, 21% of women in Lebanon used an unprotected dug well.

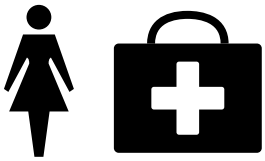
MENSTRUAL HYGIENE

The majority of women changed their sanitary product within the recommended time frame. 84% of respondents in Lebanon, and 74% in Syria, noted that they changed their menstrual products regularly (every 3-5 hours). However, a smaller minority, 9% in Lebanon and 17% in Syria, stated they only changed their product once a day.

Of those respondents in Lebanon who changed their pad once a day, 48% only had limited access to products. Similarly, for those in Syria who changed their product once a day; 50% could only access their product sometimes, and 15% could never access their product.



FINDINGS



MENSTRUAL HYGIENE MANAGEMENT

RELIGIOUS PRACTICES

Many women faced difficulties in performing religious ablution after menstruation, though this issue varied greatly between women in Lebanon and Syria. Only 11% of respondents in Syria found it difficult to perform *ghusl* after menstruation; compared, to 31% in Lebanon. 25% of respondents in Syria and, 40% in Lebanon faced issues with hair removal after menstruation; a religious obligation in Islam.

Bathing facilities, and women's feelings towards these facilities, affected women's ability to carry out religious ablution. Of those women who were unable to perform *ghusl* in Syria, 61% did not feel comfortable using the showers in their camp. Similarly, 77% of the respondents from Lebanon, who were unable to perform *ghusl* did, also not feel comfortable using their showering facilities.

CLEANING AND DISPOSAL

For the vast majority, women used water and soap to clean their underwear. Of those women in Syria, who did not have access to a supply of underwear 85% used soap and water to wash the underwear they owned. Similarly, those who didn't have a supply of underwear in Lebanon, were more likely to wash the pieces they did have with water and soap (92%).

The disposal of sanitary products was done with ease for the majority of women. 91% of participants in Lebanon, and 97% of women in Syria, stated that they could dispose of sanitary materials discreetly. The majority of participants in Syria, disposed of their products either in the garbage (85%), or by burning the products (8%). Correspondingly, 84% of participants in Lebanon disposed of their sanitary waste in the garbage.

Of those, in Lebanon, who disposed of their sanitary waste in the garbage, 25% stated that they had issues with waste disposal; because no-one collected the waste (45%), or there were no containers (15%). Similarly those in Syria, who disposed of their sanitary waste in the garbage, stated that they had issues with waste disposal because there were no containers (43%).

FINDINGS

MENSTRUAL HYGIENE MANAGEMENT

EFFECTS OF MENSTRUATION

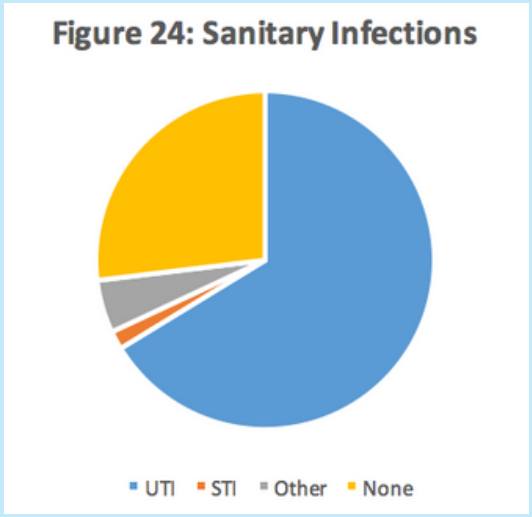
SELF-AWARENESS

When asked whether they felt ashamed during menstruation, 37% stated that they did. Of those participants who felt ashamed during menstruation in Lebanon, 55% were unhappy with their latrines; and, 51% felt uncomfortable using the showers. Similarly, those participants who felt ashamed during menstruation in Syria, 68% were unhappy with their latrines; and, 55% felt uncomfortable using the showers.

Bathing facilities, and women's feelings towards these facilities, affected women's ability to carry out religious ablution. Of those women who were unable to perform ghusl in Syria, 61% did not feel comfortable using the showers in their camp. Similarly, 77% of the respondents from Lebanon, who were unable to perform ghusl did, also not feel comfortable using their showering facilities.

Respondents noted an inability to perform daily tasks due to the physical effects of menstruation. 38% of women, from Syria, noted being unable to perform household activities; and, a further 31% of respondents noted not being able to perform household activities or go to work. Similarly, in Lebanon, 63% respondents noted their household activities were affected by menstruation.

HEALTH



Bad menstrual hygiene practices lead to various gyno-urinary infections and illnesses in the genital area. 74% of respondents from Syria, and 54% of participants from Lebanon, had all suffered from urinary tract infections recently.[28] Of those in Syria who contracted the infection, 33% did not receive treatment; and those who did, paid privately for the treatment (64%). In Lebanon, of those who contracted a UTI, 51% did not receive treatment. Those that did receive treatment, did so privately (51%).

28 Infection relating to the bladder, kidney and other urinary organs.

FINDINGS

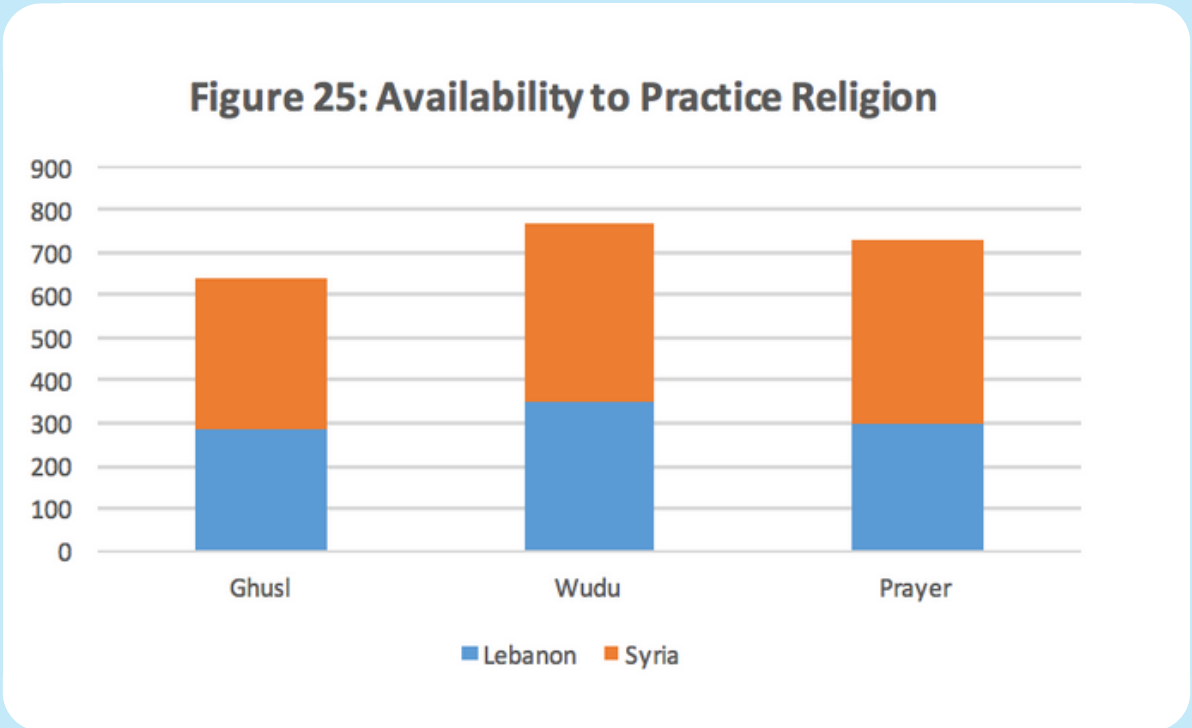
RELIGIOUS BELIEFS AND PRACTICES

With few exceptions Islam played a huge role in shaping women's lives before and after their displacement. During such an unstable period in their lives, their religious beliefs and practices represent a beacon of hope. This section aims to outline these religious beliefs, and the current failings of humanitarian organisations to meet these needs.

RELIGIOUS NEEDS

Considering that 99% of respondents were Muslim women, it is important that their religio-cultural context is understood. However, over 50% of women in Syria (52%) and Lebanon (54%), did not feel their needs as Muslim women were being met. This was due to a lack of cleanliness and religious facilities within the camp. Although, 99% of women had access to a clean prayer space, the majority of women in both Syria, and Lebanon prayed at home (98%).

A large majority of respondents in both Lebanon, and Syria, noted that cleanliness was important for purification in Islam; 57% and 31% respectively. For 20% of respondents in Syria, cleanliness was an important part of the Islamic faith; alongside the need for purification before prayer (14%). Similarly, 12% of women in Lebanon noted the need for cleanliness before prayer, as a form of ablution.



FINDINGS

RELIGIOUS BELIEFS AND PRACTICES

WASH AND ISLAM

Overall, those who did not feel their needs were met as a Muslim woman were less likely to have access to appropriate hygiene facilities. 39% of women were unable to perform *ghusl*, and 15% were also unable to perform *wudu*. Of those whose needs were not met, 67% did not have access to a specific WASH facility for wudu; leading 17% of those respondents to practice *tayyamum* in replacement of *wudu*. A large number of participants who did not feel their needs were met as Muslim women, were also only able to have a bath before *Jummah* prayer sometimes (55%).

In Lebanon, 74% of participants were able to carry out *ghusl*, and a further 90% were able to carry out *wudu*. But, the majority of participants (58%) did not have access to a specific facility for *wudu* in their camp. Due to the lack of a *wudu* specific facility, 16% of participants conducted *tayyamum* sometimes; although overall, 83% of participants never carried out *tayyamum*. Overall, women only had access to a bath before *Jummah* prayer sometimes (51%).

20% of the women in Syria were unable to perform *ghusl*, and a further 3% were also unable to perform *wudu*. Of those whose religious needs were not met, 64% did not have access to a specific WASH facility for *wudu*. Which lead 20% of those respondents to sometimes practice *tayyamum*, and a further 4% to practices it always, in replacement of *wudu*. A large number of participants whose religious needs were not met, were unable to have a bath before *Jummah* prayer sometimes (60%).

Most women washed their hands before prayer. 69% of participants in Lebanon, and 56% of women in Syria noted that they washed their hands before prayers. Interestingly, women in Lebanon were 62% more likely to wash their hands before prayer, if their water source was fifteen minutes away; in comparison to participants whose water source was more than an hour away.

FINDINGS

EMOTIONAL AND PHYSICAL SUPPORT

The psychological trauma of war, displacement and statelessness are great amongst Syrian women. Having been inflicted with unimaginable torture, physically and emotionally, refugee women and their families need great support during this time. The following section aims to illustrate what resources and support mechanisms are currently in place for Syrian refugee women by humanitarian actors.

GENDER BASED VIOLENCE

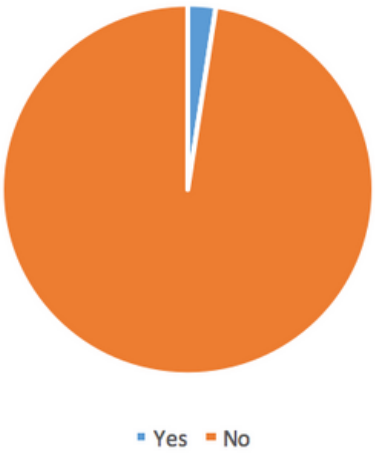
Of the participants surveyed in Syria, 35% stated that they did not feel safe when using the WASH facilities. Of those who did not feel safe; 48% did not have a door to their facilities, 83% of participants did not have a lock and, 40% did not have lights. Further, those who did not feel safe when using WASH facilities, noted feeling uncomfortable due to a lack of privacy (65%). 91% of participants who felt unsafe had a latrine which was gender segregated; and a further, 54% had a bathing facility which was also segregated.

Of those surveyed in Syria, 2% were aware of assaults taking place in WASH facilities. Of those who were aware, 57% stated that the assault was reported. The assault was either reported to the police (50%) or a friend (50%). Almost all of the participants who were aware of an assault taking place, noted that the victim did not tell her family (71%). 29% of those who were aware, noted that the victim did not get tested for infectious diseases after her assault.

Whilst the majority of participants in Lebanon felt safe using the WASH facilities (66%); 34% stated that they did not. Of those who did not feel safe, 97% did not have a gender segregated toilet, or a gender segregated bathing facility (95%). Further, those who did not feel safe did not have access to a; door (48%), light (40%), or lock (82%), when using their WASH facilities. Similarly, to participants in Syria, those in Lebanon who did not feel safe when using WASH facilities, noted feeling uncomfortable due to a lack of privacy (78%).

Over 3% of the participants in Lebanon, had been assaulted when using the WASH facilities. Of those who had been assaulted, 50% had been assaulted more than once. Due to various reasons, 90% of those who were assaulted did not report the assault. In both Lebanon and Syria, 8% of women knew other women who had been a victim of assault in their camp.

Figure 26: Prevalence of GBV



FINDINGS

EMOTIONAL AND PHYSICAL SUPPORT

SUPPORT FROM HUMANITARIAN ACTORS

Only 6% of participants in Syria had received support from faith-leaders in regards to their WASH needs. Of those who did receive support, more than half received hygiene promotion sessions (56%). Moreover, only 14% of those surveyed noted received support with WASH needs from an NGO. Of those who did, almost all received a hygiene basket 84%. Almost no participants received help from the government in regards to WASH (3%). Of those who did, the majority received a hygiene basket (20%), or financial aid (27%).

10% of participants in Lebanon received support from faith-leaders in regards to their WASH needs. Moreover, over 77% of those surveyed noted that they did not receive support in regards to WASH needs from an NGO. Of those who did, the majority received; education (21%) or a hygiene pack (17%). Only a small minority of participants received help from the government in regards to WASH (6%). Of those who did, the majority received a hygiene kit (29%), or cleaning products (29%).

GAPS

One of the hardest aspects of statelessness is having to cope with a sudden reduction in your basic necessities. Previously, Syrian women and their families had access to education, health care, water, as well as other basic services.[29] Since their departure from Syria, they are now coping with a drastically different reality.

WATER, SANITATION AND HYGIENE

WATER SUPPLY

Women are more likely to take on the burden of the failings in the water infrastructure. Women are usually the caregivers for family members who become sick from waterborne diseases. And, it is women who will be responsible for water collection; carrying container that are too heavy, to sources which are inconveniently located.

The majority of women identified a major gap in the provision of water. Respondents in, both Lebanon and Syria, faced major issues with their water supply. Although, there were great disparities in women's access to water in the two countries, women in Syria were more likely to have free access to all sources of water including drinking water; whereas, women in Lebanon paid high prices for their drinking water.

Women in Syria had access to free-flowing water supplies such as boreholes and public stands, whilst, those in Lebanon purchased water. The high cost of consumable-water amongst participants in Lebanon has detrimental effects on women's hygiene; leading them to unsanitary practices which increase the risk of infection. The use of disposable water supplies in Lebanon remain costly not only for women, but also the host country's government. The cost of plastic wastage collection, alongside the delivery of such products to refugee camps, increases the overall expense of refugee settlement in the host community.

Statelessness also adapts the roles and responsibility of women in relation to water. Women are more likely to become the main person responsible for water collection, and the majority of women will spend between 15 minutes to an hour collecting water every day. This task, especially during menstruation, will have damaging effects on women's health and abilities. The distance to a clean water source has dire implications for women's hygiene practices and their psychological state. Women were more likely to disregard hygiene practices, such as hand washing, when water was more expensive and a further distance to travel. This differentiation between their current lives and lives in Syria (in which access to water would have been relatively simple), has a profound effect on women's physical and mental health.

29 Oxfam,. Shifting Sands: Changing Gender Roles Among Refugees In Lebanon. RESOURCE CENTRE for GENDER EQUALITY, 2013. Web. 17 Nov. 2016. Oxfam Research Reports.

GAPS

Despite a high-level of waterborne disease, the data illustrates that women understand the correlation between unclean water and disease. This is highlighted by their varied use of water, depending on its level of consumption. However, the majority of women were highly unlikely to purify their water; and, when purification did take place, the method used was not appropriate to the reduction of disease. For most of those who have been displaced, an understanding of unclean water and disease is applicable, due to their educational levels. However, a lack of access is the underlying factor which prevents women in promoting hygienic water practices.

This lack of access to drinking water is often a completely new experience for women; most of the population in Syria had well-established water supply systems and water direct to households.[30] This complete differentiation from their norm, will have profound effects on their psychological well-being. That displaced persons, in both locations, suffered the same issues with their water supply is indicative of; poorly managed infrastructural planning, and a lack of comprehensive supply chains and services.

WASH INFRASTRUCTURE

There is a need to improve infrastructural access and quality in terms of WASH, specifically focusing on the needs of women. For displaced persons living in Lebanon and Syria, problems regarding basic access still remain an issue. Privacy was listed as the main issue impacting women's latrine infrastructure. Although, almost all women had access to a flush toilet, nearly half had to share this infrastructure with more than 20 people.

In Lebanon, the majority of women did not have access to any gender segregated facilities. However, despite previous scholarship, the data suggests that segregation was not an issue, but rather the lack of privacy it brought with it. In this sense, women were more concerned about the provision of lighting, security and doors, than whether men could also use the same facilities. This lack of security for latrine facilities, remains a major issue for women.

Similar issues also overarch bathing infrastructure, leaving the specific needs of women unrepresented. For the majority of women communal showers were common. If women had access to a private bathing facility, it usually related to a bucket in their settlement. With few exceptions, women accessed facilities which were in disrepair or completely out of order. This, alongside a lack of privacy and the far travelling distance, ensured that women felt uncomfortable when using the facilities.

More impending was women's feelings of insecurity when using their bathing facilities. Large majorities of women did not have access to simple security measures such as; locks, lights and doors. In addition to this, women often shared their facilities with large numbers of people, including men. It was found that women who suffered from gender based violence, were almost 100% more likely to have lacked access to the above security measure. It is therefore imperative that urgent interventions are made, to provide women with a secure environment for their WASH needs. Such lack of access to WASH facilities also affects women's reproductive health; that respondents noted experiencing menstrual and gyno-urinary issues and infections, is indicative of an inability to access WASH services properly. [31]

30 Oxfam,. Shifting Sands: Changing Gender Roles Among Refugees In Lebanon. RESOURCE CENTRE for GENDER EQUALITY, 2013. Web. 17 Nov. 2016. Oxfam Research Reports.
31 Oxfam,. Shifting Sands: Changing Gender Roles Among Refugees In Lebanon. RESOURCE CENTRE for GENDER EQUALITY, 2013. Web. 17 Nov. 2016. Oxfam Research Reports.

GAPS

MENSTRUAL HYGIENE MANAGEMENT

Women lack access to the basic products which sustain their menstrual period. Women were either, never able or only sometimes able, to gain access to their menstrual product of choice. This lack of access, has been shown in the data, to force women to use products such as cloth and rag, or sometimes no product at all. The hygiene implications of using no product, or cloth and rag, during menstruation can have detrimental effects on women's health. The correlation between those who changed their pads once a day, and had limited or no access to menstrual products, is indicative of the way in which a lack of access can lead to bad sanitation practices.

Despite this, a high percentage of women, stated that they always washed their hands after changing sanitary material; highlighting a good level of understanding of menstrual hygiene practices amongst women. However, for the majority, women used water from free-flowing sources such as unprotected dug-wells. The use of water from such sources, especially for the use of menstrual hygiene practices, has the potential to lead to genital infections and cross-contamination. It is not surprising then, that the rate of UTIs was high. The contraction of UTIs illustrate a lack of unhygienic practices and infrastructure within the camps. UTIs are contracted due to bacteria, entering the urethra, usually because of dirty underwear, unclean toilets and an inability to wash oneself.

Further, the fact that most respondents did not have access to a supply of underwear, yet still used sanitary products highlights a major issue. The use of such menstrual products, can often cause soiling of the underwear; if women are unable to clean their underwear properly, and have to continually reuse the same pair, this will lead to infection. Soiling of the underwear, without an ability to change them will also have larger impacts on women's mental well-being, promoting feelings of shame and embarrassment. [32]

Lack of access also has further implications on women's psychosocial state. Without access to their preferred menstrual hygiene product, women's confidence, comfort and ability decreases. Further, when women have to spend a large percentage of their already limited income on sanitary items, this can cause unnecessary stress for women. Firstly, in a displaced persons setting the high cost of sanitary items can impact greatly on the finances of a family. Secondly, as the male heads of households usually have control of the finances, during menstruation women must consult with their husbands before purchasing the items, causing further distress and embarrassment.

32 Oxfam,. Shifting Sands: Changing Gender Roles Among Refugees In Lebanon. RESOURCE CENTRE for GENDER EQUALITY, 2013. Web. 17 Nov. 2016. Oxfam Research Reports.

GAPS

Women highlighted these feelings of embarrassment and shame during their responses. Some of the women noted feeling this way due to the lack of space in their settlements and bathing facilities. Women also felt this way, due to their inability to treat their menstrual period in comfort, using their preferred product. These feelings of shame which respondents noted will have profound effects on the self-confidence and psychology of the woman. As displaced persons, women have to take on new roles within their households; for many their inability to deal with menstrual cramps (due to having no painkillers) made daily household tasks very difficult. In this sense, it is important to overcome barriers to dialogue about menstruation, in order for women to gain support from their partners during this period.

In a general manner, there is a need for humanitarian actors to focus more solely on menstrual hygiene. Around half of women received a hygiene kit on arrival, and then received little or no support in the period following this. The hygiene kits provided only hold hygiene provisions for one month, and after this period women are expected to provide their own sanitary materials each month. Women inside camps, spent more on average than women who purchased products outside of their camps. This alongside, a lack of supportive structures from humanitarian actors illustrates the promotion of menstrual products as a luxury item. The adoption of a menstrual hygiene and health programme amongst displaced persons is an intervention which must be regarded.

GAPS

HEALTH AND PSYCHOSOCIAL SUPPORT

HEALTH AND HYGIENE

The main health concerns amongst women were usually attached to water, sanitation and hygiene. Diarrheal and dyspepsia related diseases, alongside skin disease, were the most prominent amongst women and their families. However, a small minority of women also suffered from communicable diseases such as typhoid and hepatitis A. These diseases are all directly linked to hygiene and water conditions, illustrating a lack of considered infrastructural planning. That, even a slight percentage of participants have suffered, from such communicable diseases; illustrates major failings in the WASH infrastructure of displaced persons camps, and a need to improve current facilities.

Whilst there appears to be an understanding between hygiene practices and disease prevention, this awareness is not always enacted by women. For example, women were more likely to wash their fruit and vegetables, than their hands; although, the majority of women noted that there was a link between poor hygiene practices and waterborne diseases. Similarly, very few households took measures to ensure that their water was purified and safe before drinking it. This highlights a linkage between access and poor hygiene behaviour; suggesting that inaccessibility to water often leads to an overlooking of hygiene practices. The high cost of water means that, for a large number of participants, barriers to hygiene practices exist.

However, whilst a lack of access to water may prevent poor hygiene practices in some cases, a lack of knowledge is to blame in others. For example, women lacked an understanding of open air defecation, and its connection to waterborne diseases. Although only a small percentage practiced open air defecation, it is important that they understand its link to life-threatening communicable diseases. In this sense, it is important not to see displaced persons as one homogenous group. Distinguishing between the appropriateness of different types of interventions, dependent on resources and the awareness levels of the beneficiaries, is fundamental to designing effective interventions.

GAPS

PSYCHOSOCIAL SUPPORT

Gender based violence was high amongst participants. Women had either been a victim themselves, or knew someone who had been, a victim of GBV. Of the respondents who had been victims of GBV, more than three-quarters did not have access to locks or doors on their WASH facilities; suggesting a correlation between a lack of security measure in bathing facilities and incidents of GBV. Women in Lebanon who had been victims of GBV, did not have access to gender-segregated toilets. However, the data indicates that gender-segregation does not reduce uneasiness amongst participants. Rather, the use of security measures such as locks, doors and lights in facilities would substantially increase women's comfort when using facilities.

GENERAL SERVICES

Women received little support from NGOs and on-the-ground actors in terms of WASH and female hygiene. The majority of women did not receive a hygiene kit, or WASH information during their time in the settlements. Those in Syria, noted that they were mostly informed by friends on issues of water, sanitation and hygiene. Further, women-specific services within the camp were lacking. Most women noted a need for reproductive, gynecological and female hygiene services. That, the vast majority of women who suffered from hygiene related infections, did not receive treatment indicates a major gap in the services offered to women. This information, is indicative of the need to implement women-focused approaches to humanitarian and development processes amongst Syrian refugees.

GAPS

RELIGIOUS AND CULTURAL BELIEFS

Displaced person's lifestyles and traditions in Syria, that once defined their identities and social roles, are changing due to their situations as refugees and IDPs. Religious and cultural practices which were once at the foundation of day-to-day life have become difficult to sustain; and consequently, refugees are dealing with increased emotional and psychological stress.

The lack of access to WASH facilities, which are clean and in good maintenance presents many challenges for Muslim women. It is a religious obligation, for Muslim women to perform ablution which are known as wudu. After menstruation ghusl particularly important. Women are expected to take a bath, remove hair and cleanse oneself, for ritual purification. However, for most women these rituals were impossible to undertake.

The majority of women did not feel that their needs were met as a Muslim woman. First and foremost, the lack of religious infrastructure within humanitarian camps, indicates a drastic denial of the religious rights of participants. Due to women's inability to access faith-based WASH facilities to perform ablution rituals, a percentage of women adhered to the religious ritual of tayumum. Due to the conditions within the camps, the effects of performing such a ritual could have a detrimental impact on the health of women, and their families.

Whilst most women indicated a clean space to pray, they also stated that they performed prayer at home. Whilst it is not a religious obligation of women, in Islam, to pray at mosque; the inaccessibility of such religious institutions has an adverse impact on the sense of unity and community which women will feel. Such denial of these institutions can have a profound effect on women's feelings of isolation, impacting their mental wellbeing drastically. Without the ability to perform religious obligations, including ablution, women will face many issues in their well-being and psychosocial state.

Women noted the inherent importance of Islam within their day-to-day lives. For many, wudu, ghusl and performing prayer is a form of ritual purification and the inability to carry out their religious obligations can cause them a sense of injustice and a denial of their religious belief and expression. The need to promote an environment, in which women can freely express their religion is pressing. The denial of religious freedom and access, has great affects on women's mental health and well-being; and more so, negates their religious needs at a time when faith can be a beacon of hope in their lives. This data indicates a greater need for the integration of faith-based approaches within the humanitarian planning process.

OPPORTUNITIES

This section highlights areas of opportunities, in which interventions should be actualised by International Institutions, NGOs, and local governments. These opportunities feed directly into the recommendations in section 5.

WOMEN FOCUSED SERVICES

The human rights of women and girls include the right to health (Article 12 of the Convention on Economic, Social and Cultural Rights - CESCR) the right to an adequate standard of living (Article 11 CESCR) and the right to participate in cultural life (Article 15 CESCR). They are also entitled to freedom of religion (Article 18 of the International Covenant on Civil and Political Rights). Women and girls are entitled to these rights without discrimination, according to Article 3 of the ICCPR and Article 3 of the ICESCR, and the provisions of the Convention on the Elimination of Discrimination against Women (CEDAW) as a whole. Gender-based violence against women has been identified as a form of discrimination under Article 1 of the CEDAW. This constellation of human rights obligations requires that gender-appropriate water and sanitation provision is made for women and girls in refugee camps, and effective methods to prevent gender-based violence.

These declarations highlight the specific needs which affect female refugees. In addition to the basic necessities shared by all displaced persons, female refugees and IDPs have special health, hygiene, protection, and religious needs, which reflect their gender. Therefore, services must take into consideration these specific needs, by understanding gendered approaches to current refugee strategies. Further, governments, donors and international organisations must hold implementing agencies accountable for ensuring that programmes are gender sensitive; and ensure that programmes and resources are equally available to women and men.

OPPORTUNITIES FOR POSITIVE SOCIAL CHANGE

The current situation opens up important opportunities for gender justice within communities. Were humanitarian organisations committed to promoting gender justice, and were able to embed this goal into all aspects of programming, positive social structures could be created in incredibly difficult situations. Such situations can in fact be perfect entry points for challenging attitudes about women's status and participation in social, economic and political life. [33]

If followed in line with a religio-cultural sensitive framework, long established social norms which have restricted women's empowerment, could be overturned. For communities that are now reporting a closer relationship with their faith than even before, faith can be used to reintroduce principles and teachings that empower both women and men to reorganize and restructure their roles in a way that allows women to be key actors for change in their families and communities. It is important to recognize the Islamic theological response to crises, and to acknowledge the central role it is playing in providing hope to the most vulnerable communities. As it is through this understanding that effective psychosocial support services can be used to mitigate harmful psychological impacts on affected communities, that not only plague individuals in the midst of conflict, but also after it.

During this turbulent experience identities become fluid. Female displaced person's roles and responsibilities change substantially. Whilst this can create anxiety for some, taking on a new leadership role can also empower many female displaced persons. If these opportunities in leadership and household roles are developed within interventions and programmes, securing genuine change in gender justice and gender roles, could be actualised.

33 Oxfam,. Shifting Sands: Changing Gender Roles Among Refugees In Lebanon. RESOURCE CENTRE for GENDER EQUALITY, 2013. Web. 17 Nov. 2016. Oxfam Research Reports.

OPPORTUNITIES

ROLE OF LOCAL WOMEN'S GROUPS

The important role of women's groups should not be overlooked in the planning and implementation of development amongst displaced persons. To fully understand the needs of displaced females, they must have the ability to participate fully in the planning of programmes. This participatory approach, should involve local women's groups, to ensure the effective sampling of women's needs. These groups should work in collaboration with gender-sensitive consultants, who can inform female specific programme planning. Women's groups provide displaced women with a space to promote their own issues, and make a change from within their settlements. By empowering women in this way you achieve a culturally and religiously sensitive framework, which will provide women with confidence and make serious social change. Only through women's genuine participation can organisations be confident that the response will fully meet women's needs. [34]

GENDER-INTEGRATED PLANNING

Gender-integrated planning must work on three levels, in order to fully satisfy women's needs:

1. Data collection and participatory approaches must be increased in the humanitarian sector. Through analysis of this data, organisations are able to map existing risks and issues within facilities and other infrastructure within the settlements.

2. Capacity building of organisations to increase the recognition of insecure and uncomfortable environments f for women. This would require a multi-sectoral and educational approach, which would develop partnerships and knowledge amongst agencies and organisations to promote cooperation on gender-integrated planning. This would work alongside training on gender-focused approaches, to ensure that all actors had a comprehensive understanding of women's specific needs.

3. Women centered facilities should be promoted by humanitarian and development organisations. As women have specific needs that are incomparable to men's, their needs should act as a central point in any WASH facility planning. This will involve the integration of doors, well-lit facilities, secure locking devices and gender-segregated facilities where necessary. [35]

34 bid.
35 For IRC examples of best practice see: Berger, Miriam. "The Radically Simple Way To Make Female Refugees Safer From Sexual Assault: Decent Bathrooms". Quartz 2016. Web. 10 Nov. 2016.

OPPORTUNITIES

RELIGIO-CULTURAL APPROACH

Whilst many organisations in conflict settings aim to understand the religio-cultural settings of the displaced persons they work with, this can often rely on a superficial understanding.[36] Programming and interventions may reflect the cultural biases of the officials and an inadequate understanding of the specificities of traditional cultures and religious beliefs which displaced women hold. It is therefore imperative that a religio-cultural approach is taken when planning strategies towards displaced persons.

A religio-cultural approach derives its framework from the specific teachings of the community's religion; interlacing these religious beliefs and practices with the nuances which each individual culture brings with it. In order to execute such an approach research must be undertaken to understand how culture traditions intersects religious practice. However, more importantly, there is a need for the involvement of religious scholars and leaders to provide information on the specific needs of the religious community. In this sense, organisations should work in collaboration with experts and religious organisations to inform the specific needs of women, from a faith-based approach.

INTEGRATED HOST COMMUNITY INTERVENTIONS

Within the assessment areas, displaced Syrians and Lebanese host communities share the same hardships which have arose since the Syrian conflict. A lack of services in relation to WASH, health and employment are all major issues for those living in Lebanon. Whilst Syrian refugees are provided with humanitarian assistance, the impoverished Lebanese communities which host them are provided with no assistance at all. These interventions have therefore caused great tension amongst the two communities, promoting feelings of hostility and resistance.

Organisations should adopt a multi-sector approach which works to support displaced and local communities together. This should be actualised through local and community-based organisations which will provide goods and services to all vulnerable members of society. This approach will reduce tensions over resources amongst the communities; and also empower local actors to increase the sustainability of services within their communities. Organisations must be sensitive over hostilities due to resources, by ensuring ongoing communication between refugee and host communities. The involvement of focus group discussions, to promote a social space which engages the two communities in dialogue is an important aspect of this type of intervention.

Guidelines on the Protection of Refugee Women (1991) Available at: http://www.unhcr.org/publ/PUBL/3d4f915e4.pdf (Accessed: 10 November 2016).

OPPORTUNITIES

COLLABORATIVE APPROACHES AND PARTNERSHIPS

Partnerships can improve the efficiency of coordinated responses to refugee women, by integrating various approaches and specialist knowledges. When these partnerships work within an evidence-led approach, the results of such collaboration can significantly improve the outcomes, not just of the current community, but future stateless communities. In this sense various sectorial actors should work together to improve the lives of women refugees globally.

These collaborative approaches should involve the following actors:

- INGOs should work in collaboration with local governments to improve the capacity of municipalities in dealing with conflict crises.
- Collaboration between Muslim-led humanitarian agencies to create religio-cultural sensitive programmes; and collaboration between faith organisations with secular institutions for the same outcome.
- Between humanitarian and development agencies to understand how the two can be integrated to provide sustainable programmes to refugees whose environments and situations may be long-lasting.
- Between development practitioners and advocacy and policy experts to ensure that the right recommendations are being brought forward and the right approaches are being invested in. This should work in collaboration with international institutions to implement global humanitarian frameworks and accords.

ENVIRONMENTAL SUSTAINABILITY

1. Electricity and water sources: the use of solar energy, which can be integrated into the host community post-crisis, would present a more cost-efficient and sustainable resource system.
2. Hygiene Products: the use of reusable menstrual hygiene products, such as menstrual cups, present a solution to the issues of sanitation wastage.
3. Waste management: the implementation of recycling management, and the capacity building of municipalities to be efficient in doing so would improve the living standards of communities greatly.
4. WASH Facilities: implementing latrine systems which have multi-purposes such as eco-san and biofuel toilets could offer important change.

RECCOMENDATIONS

Regional government agencies and international institutions (II's), in collaboration with local NGOs, faith organisations and larger Western NGOs, should look to implement the recommendations posited by Global One's evaluation of the current strategies. The first challenge will be to effectively translate the findings from the evaluation into meaningful infrastructural, developmental and legislative change. The following recommendations are made:

WATER SUPPLY

MAJOR NEEDS:

1) Women are the main caretakers for water, therefore their needs must be at the fore of humanitarian planning.
2) Women in Lebanon use plastic bottled, high-cost water as their main source of water.
3) Women understand hygiene and sanitation needs in regards to water, but do not have the resources to undertake these needs.

GOVERNMENTS:

- As the LCRP notes, municipals spending on garbage disposal increased by 40% since the displacement of refugees to Lebanon. The Lebanese government should therefore work towards reducing the use of plastic bottles within refugee camps. This would reduce wastage costs and damage to the environment; whilst improving access for Syrian refugees.

NGOS:

- Utilising an integrated host-community approach NGOs should implement solar powered water pumps. Free at the point of use, little maintenance and free to run; these pumps could provide refugee and host communities long-lasting, sustainable supplies of water.
- Under SDG 6.B and 6.1.1 NGOs have a duty to ensure that everyone has access to safely managed drinking water supplies. Therefore NGOs should provide different options for purifying water on arrival to refugee and IDP camps. These methods should include filtration systems and water carriers to ensure that everyone is able to sanitise their water appropriately.
- NGOs should reduce the wastage of plastic water bottles by utilising them to provide ecologically sustainable and cost-free lighting. This should involve the use of plastic water bottles to create solar bottle bulbs which can be used in toilets and shelters.

INTERNATIONAL INSTITUTIONS:

- Under UN Resolution 64/292, clean water is constitued as a human right. Therefore II's should improve systematic water supply frameworks and discuss the use of a uniformed model amongst refugee camps, to promote equitable sanitised water sources between camps.
- Under the United Nations Human Rights Council Resolution on Human rights and access to safe drinking water and sanitation II's have a duty to ensure that everyone has equal access to water. As the primary collectors of water women are disproportionately affected by a lack of access. II's should therefore implement a gender-focused framework through which all organisations are accountable; to ensure that women's specific needs are at the forefront of WASH issues.

RECOMMENDATIONS

INFRASTRUCTURE

MAJOR NEEDS:

1) Women are affected by a lack of security measures when using bathing and latrine facilities.
2) Whilst most women have access to facilities these facilities are more often than not, either out of order or in disrepair.
3) The lack of accessible infrastructure is a leading cause in disease promotion and the practice of open air defection.
4) A gender-lens needs to be placed within WASH infrastructure frameworks to ensure that women's safety and hygiene needs are not overlooked.

GOVERNMENTS:

- Within the LCRP it states that 'capacity-building to the risks of gender-based violence where women lack access to segregated, safe toilets'. To ensure that this is achieved the Lebanese government should ensure that all WASH facilities have three basic security measures: lock, lights and doors.

NGOS:

- NGOs should promote resource based programmes rather than awareness raising projects. These resource based programmes should involve the provision of solar powered torches and individual locks to all women within the camps in the NGOs remit. Projects could also involve psychosocial and vocational training through the use of carpentry and art to improve facilities within the camps.
- The main issue women faced was the disrepair of facilities within the camps. Therefore NGOs should work with the facilities which are available and ensure the maintenance of these facilities through various means. One suggestion is to promote cooperatives amongst women, through local women's groups, to ensure the maintenance of certain facilities.

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RECOMMENDATIONS

MENSTRUAL HYGIENE MANAGEMENT

MAJOR NEEDS:

1) Women do not have access to necessary hygiene products such as underwear or menstrual hygiene products.
2) This lack of access has had a huge impact on women's genito-urinary health and their psychosocial wellbeing.
3) Women's religious freedoms are being restricted in relation to menstrual hygiene practices.

GOVERNMENTS:

- The LCRP mentions menstrual health once within the plan, although it outlines the need to implement a gender-sensitive strategy to WASH. The Lebanese government should therefore implement a more focused strategy to menstrual health. An example of how this could work would be through the implementation of a system which logs the reproductive age of registered female refugees by the government. This would ensure that these women receive the information and resources needed to manage their periods.
- The psychosocial support element of menstrual health is often overlooked. The LCRP outlines the need for specialised mental health services for women. When implementing these gender-based services the Lebanese government should intertwine faith-based healing with psychosocial support to improve women's mental health during menstruation.
- he Lebanese government should alocate a portion of the LCRP's health budget to gyno-urinary medical care and prescriptions. This would improve the issues which are related to poor menstrual health within the camps.

NGOS:

- Under SDG 3.3.7 NGO's have a responsibility to ensure 'universal access to sexual and reproductive health-care services'. This means that NGOs should include menstrual health within their programmes in humanitarian settings. In order to accomplish SDG 3 NGOs should:
- Promote, advocate and provide free access to sanitary products within refugee camps, ensuring that all women have access to underwear and monthly sanitary items.
- Encourage the use of and disseminate reusable sanitary products, such as menstrual cups and reusable pads, within camps to reduce the financial burden of menstrual products on refugee women.
- Ensure that every woman who enters a settlement, as a displaced person, receives a hygiene kit with menstrual hygiene products, to ensure a comfortable and hygienic period every month.
- Improve access to underwear within camps, and increase women's household income, by implementing vocational tailoring programmes amongst women. Through these programmes women can produce underwear and sanitary items for women in the camps.

INTERNATIONAL INSTITUTIONS:

- Article 12 (4) of the 1949 Geneva Convention I states: "Women shall be treated with all consideration due to their sex". As women, refugee women, experience exceptional monthly circumstances, in the form of menstruation, that men do not experience. Therefore to treat women in consideration of their sex menstrual health must be at the forefront of international humanitarian planning and services. To secure this II's should legislate for menstrual health to be written with in international humanitarian law.
- Rule 104 of International Humanitarian Law states that 'the convictions and religious practices of civilians and persons hors de combat must be respected'. Therefore II's should implement a religio-cultural sensitive framework for sanitation facilities, which places religious practices for menstrual health within this framework.

RECOMMENDATIONS

RELIGIOUS & CULTURAL BELIEFS

MAJOR NEEDS:

1) The specific WASH needs of religious communities are not being met by international institutions and humanitarian actors.
2) Women's religious freedoms are being hindered by the lack of religious spaces available for practice.
3) Women's mental wellbeing is being affected by the lack of religious freedom they possess within IDP and refugee camps.

GOVERNMENTS:

- Under international human rights law governments have a duty to ensure that everyone has the right to manifest his religion or belief in teaching, practice, worship and observance. Despite this the LCRP does not outline any plan towards religion or religious practice. In this sense, the Lebanese government should ensure that religious practice and worship, including specific facilities for this are outlined within their crisis response strategy; and are integrated into their approach to humanitarianism.

NGOS:

- NGOs should ensure that their humanitarian approach is not constricted to a homogenous framework. Planning for humanitarian situations should involve consultation with religious and cultural grassroots organisations, who can offer support in ensuring that facilities are better suited to the refugee community. Some points which NGOs should focus on are:
- Introducing faith sensitive approaches to WASH facilities which provide specific spaces for ritual ablutions such as *ghusl* and *wudu*.
- Ensuring that religious communities have specific spaces in which to attend religious ceremonies, practice prayer and congregate for religious observance.
- To offer products and resources which allow all faith groups to observe their religion accurately. Including hygiene items, clothing and specific religious materials (such as prayer mats).

INTERNATIONAL INSTITUTIONS:

- The Refugee Convention 1951 accords that 'states shall accord to refugees within their territories the same treatment as is accorded to nationals with respect to freedom to practice their religion'. To fulfil this convention II's should enhance frameworks and planning to implement a religio-cultural approach. This should involve religious and cultural grassroots actors who can offer advice and specialist knowledge of how to tailor projects to specific refugee communities.
- Post-conflict situations can open entry points to discuss gender justice, and practices which inflict violence against women. II's should therefore utilise these environments to develop religiously and culturally sensitive mechanisms for improving knowledge about and attitudes toward maternal, mental and sexual, reproductive health.

RECOMMENDATIONS

HEALTH AND PSYCHOSOCIAL SUPPORT

MAJOR NEEDS:

1) Women are disproportionately affected by violence within refugee and IDP settlements. This violence is predominately sexual and gender-based.
2) Health interventions which rely on awareness raising are not resolving the resource-based issues which women are facing.
3) The impact of statelessness is having a huge impact on women's mental wellbeing.

GOVERNMENTS:

- To ensure that the LCRP's strategy for health is met, the Lebanese government should dedicate a percentage of national reproductive health budgets to promote maternal and women's health issues within refugee camps. This will ensure that women have the same entry points to healthcare as Lebanese nationals.
- The Lebanese government should reduce its spending on sexual and reproductive health by building the capacity of local NGOs and female refugees within Lebanon, through training of trainers in maternal, reproductive and women's health services. This would provide refugee women and local organisations with vocational skills for later life, but also improve the current situation of these healthcare indicators in Lebanon.

NGOS:

- Under SDG 3.3.7 NGOs have a duty to ensure that ensure universal access to sexual and reproductive health-care services, and 3.3.4 which promotes mental health and wellbeing. Therefore NGOs should prioritise the following areas:
- Focus health interventions to improve access and resources, rather than focus on encouraging awareness and demand amongst community members.
- Incorporate faith into psychosocial support activities and counselling, through training of trainers programmes for local mental health agencies.
- Promote psychosocial support and rehabilitation for women affected by gender-based violence during their journey or within settlements.
- Ensure that women health workers are available to ensure more appropriate practitioners are accessible to women in the community.
- Strengthen gynecological and maternal health frameworks (in Syria and host countries) and invest in human resources to respond to maternal health and women's health needs.

INTERNATIONAL INSTITUTIONS:

- II's should implement a specific gender-focused framework which will outline the specific health needs of women. This would focus specifically, but not be limited to, maternal, sexual and reproductive, mental and gyno-urinary health. In implementing such a strategy government and humanitarian actors should be held accountable to these accords; ensuring the implementation of gender-specific health programmes.

CONCLUSION

The widespread human suffering in Syria continues to enforce one of the largest humanitarian crises of our generation. This crisis has displaced millions of people both inside Syria, and across the region. This displacement shows no signs of reduction, as the conflict in Syria continues to cause widespread human suffering. The international community must now work together to strengthen current interventions and meet the needs of the millions of Syrian people who have been affected by the conflict. It must not be forgotten that more than half of displaced Syrian's are women. Women with specific needs, wants and desires. Before the conflict these women lived comfortable lives, but when they fled their homes they left all of the sources of comfort behind. They are now suffering from a lack of water, health care and hygiene support. These women have been subjected to violence and intimidation from the moment they left their homes, and continue to experience this in their settlements. These experiences have led to considerable levels of anxiety, stress and depression amongst women. At this time their connection to religion provides them with an inherent support structure; but for the majority of women their religious beliefs and practices are not met. This crisis has placed great strain on humanitarian actors and host communities. Settlement areas of refugees are often placed in areas where host communities are underprivileged and marginalized; and given that the average refugee will remain stateless for 17 years, the strain on these communities will only increase. The international community must now bridge the gap between humanitarian intervention and sustainable development. This must take into account the specific religious, cultural and gendered needs of refugees, to ensure that women are empowered and prepared to face their lives in statelessness.

GLOSSARY

Amebiasis	Parasitic infection of the intestines.
Cholera	An infectious and often fatal bacterial disease of the small intestine, typically contracted from infected water supplies and causing severe vomiting and diarrhoea.
Cryptosporidiosis	An intestinal condition caused by infection with cryptosporidium, causing diarrhoea and vomiting.
Dyspepsia	Vomiting.
E.coli	a bacterium commonly found in the intestines of humans and other animals, some strains of which can cause severe food poisoning.
Female Hygiene Services	Services and products relating to a woman's menstrual cycle.
Gender-based violence	Physical, sexual or psychological harm or suffering to women.
Ghusl	Ritual washing of the whole body, as prescribed by Islamic law to be performed in preparation for prayer and worship, and after sexual activity, childbirth, menstruation.
Giardiasis	Infection of the intestine with a flagellate protozoan, which causes diarrhoea and other symptoms.
Hepatitis A	A form of viral hepatitis transmitted in food, causing fever and jaundice.
Internally Displaced Persons (IDPs)	Someone who is forced to flee his or her home but who remains within his or her country's borders.
Jummah	A congregational prayer (ṣalāt) that Muslims hold every Friday, before midday.
KoBo Data System	An online cloud platform tool for field data collection for use in challenging environments.
Legioellosis	A respiratory disease caused by Legionella bacteria.
Person focus group	Demographically diverse group of people whose reactions are studied.
Random Sampling Technique	A method of selecting a sample from a statistical population that members of a 'population' have equal chances of being selected.
Refugees	A person who has been forced to leave their country in order to escape war, persecution, or natural disaster.
Religio-cultural Approach	A framework which utilises the cultural and religious beliefs of a specific community to implement sensitive programmes.
Reproductive Health Services	Services relating to the reproductive processes, functions and system at all stages of life.
Salmonellosis	A common cause of food poisoning.
Stata Analysis tool	A general-purpose statistical software package for data analysis.
Tayyamum	The Islamic act of dry ablution using a purified sand or dust, which may be performed in place of ritual washing.
Typhoid	An infectious bacterial fever with an eruption of red spots on the chest and abdomen and severe intestinal irritation.
UTI	An infection in any part of your urinary system.
Wudu	Ritual washing to be performed in preparation for prayer and worship.

BIBLIOGRAPHY

1. al, S. et M. (2014) 'Ongoing epidemic of Cutaneous Leishmaniasis among Syrian refugees, Lebanon1 - volume 20, number 10—October 2014 - emerging infectious disease journal', . doi: 10.3201/eid2010.140288.

2. Benage, M., Greenough, P., Vinck, P., Omeira, N. and Pham, P. (2015) 'An assessment of antenatal care among Syrian refugees in Lebanon', Conflict and Health, 9(1), p. 8. doi: 10.1186/s13031-015-0035-8.

3. Berger, M. (2016) The radically simple way to make female refugees safer from sexual assault: Decent bathrooms. Available at: http://qz.com/692711/the-radically-simple-way-to-make-female-refugees-safer-from-sexual-assault-decent-bathrooms/ (Accessed: 10 November 2016)

4. Cherri, Z., González, P.A. and Delgado, R.C. (2016) 'The Lebanese–Syrian crisis: Impact of influx of Syrian refugees to an already weak state', 9.

5. DailySabah. (2016). Syrian women in refugee camps informed of their rights. [online] Available at: http://www.dailysabah.com/nation/2016/08/26/syrian-women-in-refugee-camps-informed-of-their-rights [Accessed 10 Nov. 2016].

6. Doocy, S., Lyles, E., Hanquart, B. and Woodman, M. (2016) 'Prevalence, care-seeking, and health service utilization for non-communicable diseases among Syrian refugees and host communities in Lebanon', Conflict and Health, 10(1). doi: 10.1186/s13031-016-0088-3.

7. El-Khatib, Z., Scales, D., Vearey, J. and Forsberg, B.C. (2013) 'Syrian refugees, between rocky crisis in Syria and hard inaccessibility to healthcare services in Lebanon and Jordan', Conflict and Health, 7(1), p. 18. doi: 10.1186/1752-1505-7-18.

8. Fiddian-Qasmiyeh, E. (2016) 'Repressentations of displacement from the middle east and north Africa', Public Culture, 28(3 80), pp. 457–473. doi: 10.1215/08992363-3511586.

9. Gigliarano, C. and Wieser, C. (2015) The welfare of Syrian refugees: Evidence from Jordan and Lebanon. 1st edn. Washington DC: World Bank.

10. Global Research. (2016). What Is It Really Like To Be A Syrian Refugee?. [online] Available at: http://www.globalresearch.ca/what-is-it-really-like-to-be-a-syrian-refugee/5553492 [Accessed 10 Nov. 2016].

11. GlobalGiving. (2016). Washable Feminine Hygiene for Syrian Refugees. [online] Available at: https://www.globalgiving.org/projects/reusable-feminine-hygiene-for-syrian-refugees/updates/ [Accessed 10 Nov. 2016].

12. Guidelines on the Protection of Refugee Women (1991) Available at: http://www.unhcr.org/publ/PUBL/3d4f915e4.pdf (Accessed: 10 November 2016).

13. Gulland, A. (2013) 'Syrian refugees in Lebanon find it hard to access healthcare, says charity', BMJ, 346(feb08 1), pp. f869–f869. doi: 10.1136/bmj.f869.

14. http://www.reach-initiative.org/wp-content/uploads/2015/02/reach_lbn_akkar_report_washhouseholdassessmentakkar_dec2014_1.pdf. (2016). 1st ed.

15. Jiménez Sánchez, C. (2016) 'Refugee women in the Sahrawi camps: Towards gender equality', International Journal of Gender Studies in Developing Societies, 1(4), p. 317. doi: 10.1504/ijgsds.2016.10000756.

BIBLIOGRAPHY

16. JOHNSSON, A.B. (1989) 'The international protection of women refugees A summary of principal problems and issues', International Journal of Refugee Law, 1(2), pp. 221–232. doi: 10.1093/ijrl/1.2.221.

17. Kazour, F., Zahreddine, N., Maragel, M., Almustafa, M., Soufia, M., Haddad, R. and Richa, S. (2016). Post-traumatic stress disorder in a sample of Syrian refugees in Lebanon. Comprehensive Psychiatry, 72, pp.41-47.

18. Krummel, S, Refugee Women and the Experience of Cultural Uprooting (Geneva: Refugee Service, World Council of Churches, n.d.).

19. LLC, P. (2016) The most vulnerable refugees are not in Europe. Available at: http://search.proquest.com/openview/0d0204ed2ddb6d4c54663fa5103ce585/1?pq-origsite=gscholar&cbl=2040978 (Accessed: 10 November 2016).

20. Lyles, E., Hanquart, B., Woodman, M. and Doocy, S. (2016). Health service utilization and access to medicines among Syrian refugee and host community children in Lebanon.

21. Naja, W.J., Aoun, M.P., El Khoury, E.L., Abdallah, F.J.B. and Haddad, R.S. (2016) 'Prevalence of depression in Syrian refugees and the influence of religiosity', Comprehensive Psychiatry, . doi: 10.1016/j.comppsych.2016.04.002.

22. Obradovic, M. (no date) Protecting female refugees against sexual and gender-based violence in camps. Available at: https://ourworld.unu.edu/en/protecting-female-refugees-against-sexual-and-gender-based-violence-in-camps (Accessed: 10 November 2016).

23. Parkinson, S.E. and Behrouzan, O. (2015) 'Negotiating health and life: Syrian refugees and the politics of access in Lebanon', Social Science & Medicine, 146, pp. 324–331. doi: 10.1016/j.socscimed.2015.10.008.

24. Pfortmueller, C., Schwetlick, M., Mueller, T., Lehmann, B. and Exadaktylos, A. (2016). Adult Asylum Seekers from the Middle East Including Syria in Central Europe: What Are Their Health Care Problems?. PLOS ONE, 11(2), p.e0148196.

25. Rabaia, Y. (2014). 'Not who we are ...' A documentary about the lives of Syrian refugee women in Lebanon. Intervention, 12(2), pp.298-300.

26. Reese Masterson, A., Usta, J., Gupta, J. and Ettinger, A.S. (2014) 'Assessment of reproductive health and violence against women among displaced Syrians in Lebanon', BMC Women's Health, 14(1), p. 25. doi: 10.1186/1472-6874-14-25.

27. Regional Water, Sanitation and Hygiene (WASH) programme for Syrian refugees and host communities (2016) Available at: http://ec.europa.eu/enlargement/neighbourhood/countries/syria/madad/20160526-ad-2nd-board-wash.pdf (Accessed: 10 November 2016).

28. Ruiz, R. (2016) The unique challenges of being a young, female Syrian refugee. Available at: http://mashable.com/2016/03/28/female-syrian-refugees/#_xwx0viv0gq6 (Accessed: 10 November 2016).

29. Saadallaoui, B. (no date) Competing for scarce resources: The new concern for Syrian refugees and host communities in Lebanon. Available at: http://www.ennonline.net/fex/48/competing (Accessed: 10 November 2016).

BIBLIOGRAPHY

30. Syria Crisis Monthly Humanitarian Highlights & Results: Including data regarding WASH in Lebanon refugee camps. (2015). 1st ed. [ebook] UNICEF. Available at: http://unicef.org.tr/files/bilgimerkezi/doc/Syria%20Crisis%20Humanitarian%20Situation%20Report%20September%202015.pdf [Accessed 10 Nov. 2016].

31. Syria IDP figures analysis (2016) Available at: http://internal-displacement.org/middle-east-and-north-africa/syria/figures-analysis (Accessed: 10 November 2016).

32. Syrian Regional Factsheet: March 2016. (2016). 1st ed. [ebook] CARE International. Available at: http://www.care-international.org/files/files/CARE_Syria%20Crisis%20FactSheet_2016_03%20%5Bweb%5D.pdf [Accessed 10 Nov. 2016].

33. Syrians face water crisis in Lebanon (2015) Available at: https://www.iocc.org/get-updated/newsroom/lebanon-syria-refugees-water-crisis (Accessed: 10 November 2016).

34. The Huffington Post. (2016). [online] Available at: http://www.huffingtonpost.com/shoshanna-howard/refugee-women-feminine-hy_b_9806872.html [Accessed 10 Nov. 2016].

35. The world Factbook — central intelligence agency (no date) Available at: https://www.cia.gov/library/publications/the-world-factbook/fields/2194.html (Accessed: 10 November 2016).

36. UNHCR population statistics - data - overview (2016) Available at: http://popstats.unhcr.org/en/overview (Accessed: 10 November 2016). 6. UNICEF Syria crisis situation report - September 2016 (2016) Available at: http://reliefweb.int/report/syrian-arab-republic/unicef-syria-crisis-situation-report-september-2016 (Accessed: 10 November 2016).

37. Usta, J., Masterson, A.R. and Farver, J.M. (2016) 'Violence against displaced Syrian women in Lebanon', Journal of Interpersonal Violence, . doi: 10.1177/0886260516670881.

38. Vidal, J. (2016) Water supplies in Syria deteriorating fast due to conflict, experts warn. Available at: https://www.theguardian.com/environment/2016/sep/07/water-supplies-in-syria-deteriorating-fast-due-to-conflict-experts-warn (Accessed: 10 November 2016). 9. WFP Lebanon Country Brief. (2016). 1st ed. [ebook] WFP. Available at: http://reliefweb.int/sites/reliefweb.int/files/resources/Lebanon_CB_Sept%202016%20OIM.pdf# [Accessed 7 Nov. 2016].

39. Yasmine, R. and Moughalian, C. (2016) 'Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions', Reproductive Health Matters, 24(47), pp. 27–35. doi: 10.1016/j.rhm.2016.04.008.

40. Margesson, R. & Chesser, S. G. (2014). Syria: Overview of the Humanitarian Response. Congressional Research Service. http://www.fas.org/sgp/crs/mideast/R43119.pdf

41. WASH (2015) Available at: https://www.humanitarianresponse.info/en/operations/whole-of-syria/wash (Accessed: 10 November 2016). 13. Fanack Water. (2016). Water Infrastructure in Lebanon - Fanack Water. [online] Available at: https://water.fanack.com/lebanon/water-infrastructure/ [Accessed 11 Nov. 2016].

42. King, M.D., 2015. The Weaponization of Water in Syria and Iraq. The Washington Quarterly, 38(4), pp.153-169.

43. Yasmine, R. and Moughalian, C., 2016. Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions. Reproductive Health Matters.

BIBLIOGRAPHY

44. Margesson, R. & Chesser, S. G. (2014). Syria: Overview of the Humanitarian Response. Congressional Research Service. http://www.fas.org/sgp/crs/mideast/R43119.pdf

45. WASH (2015) Available at: https://www.humanitarianresponse.info/en/operations/whole-of-syria/wash (Accessed: 10 November 2016).

46. Fanack Water. (2016). Water Infrastructure in Lebanon - Fanack Water. [online] Available at: https://water.fanack.com/lebanon/water-infrastructure/ [Accessed 11 Nov. 2016]. 4. King, M.D., 2015. The Weaponization of Water in Syria and Iraq. The Washington Quarterly, 38(4), pp.153-169.

47. Yasmine, R. and Moughalian, C., 2016. Systemic violence against Syrian refugee women and the myth of effective intrapersonal interventions. Reproductive Health Matters.

48. Dionigi, F., 2016. The Syrian refugee crisis in Lebanon: state fragility and social resilience.

49. Sleiman-Haidar, R., 2016. The long-term challenges of forced migration: Perspectives from Lebanon, Jordan and Iraq.

50. Ager, A. and Ager, J., 2016. Religion, Forced Migration, and Humanitarian Response. In Intersections of Religion and Migration (pp. 285-310). Palgrave Macmillan US.

51. Rand.org. (2016). The Precarious State of Syrian Refugee Women, Children in Lebanon | RAND. [online] Available at: http://www.rand.org/blog/2016/09/the-precarious-state-of-syrian-refugee-women-children.html [Accessed 22 Nov. 2016].

52. Al-Monitor. (2016). How the war on Syria left its mark on Lebanon's economy. [online] Available at: http://www.al-monitor.com/pulse/business/2016/05/lebanon-syria-war-economy-repercussions-banking-sector.html [Accessed 22 Nov. 2016].

53. 2016 Humanitarian Needs Overview: Syrian Arab Republic. (2016). 1st ed. [ebook] UN Office for the Coordination of Humanitarian Affairs. Available at: http://reliefweb.int/sites/reliefweb.int/files/resources/2016_hno_syrian_arab_republic.pdf [Accessed 30 Nov. 2016].

54. Annual Report 2016. (2016). 1st ed. [ebook] iDMC. Available at: http://internal-displacement.org/assets/publications/2016/201607-annual-report-2015-en.pdf [Accessed 30 Nov. 2016].

55. ARGIS, (2014). Locations of internally displaced persons camps within Syria. [image] Available at: https://www.arcgis.com/home/webmap/viewer.html?webmap=2d256aed15224ccb89971a1b11129c18 [Accessed 30 Nov. 2016].

56. Council, I. (2016). IDMC » IDP Database. [online] Internal-displacement.org. Available at: http://internal-displacement.org/database/ [Accessed 30 Nov. 2016].

57. Data.humdata.org. (2016). Syria IDP Sites - Humanitarian Data Exchange. [online] Available at: https://data.humdata.org/dataset/syria-idp-sites [Accessed 30 Nov. 2016].

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