Reaching Refugee Survivors of Gender-Based Violence:

Evaluation of a Mobile Approach to Service Delivery in Lebanon

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ACRONYMS

DRC	Danish Refugee Council
FGD	Focus Group Discussion
GBV	Gender-based Violence
GBVIMS	Gender-based Violence Information Management System
GOL	Government of Lebanon
ICRW	International Center for Research on Women
IRC	International Rescue Committee
ITS	Informal tented settlement
NGO	Non-governmental organization
PRM	U.S. Department of State Bureau of Population, Refugees, and Migration
PSS	Psychosocial Support Services
RRT	Rapid Response Team
SIDA	Swedish International Development Cooperation Agency
WPE	Women's Protection and Empowerment
UNHCR	United Nations High Commissioner for Refugees

EXECUTIVE SUMMARY

In October 2014, the International Rescue Committee (IRC)'s Women's Protection and Empowerment (WPE) Lebanon program began implementing an innovative mobile approach to gender-based violence (GBV) response and mitigation service delivery in Akkar district. With support from the U.S. State Department's Bureau of Population, Refugees, and Migration (PRM), the NoVo Foundation, and the Swedish International Development Cooperation Agency (SIDA), the approach aims to reach non-camp based Syrian refugee women living within Lebanese communities with GBV case management and psychosocial support (PSS) services.

In 2015, the International Center for Research on Women (ICRW) collaborated with IRC to assess this approach. The purpose of the evaluation was to assess the extent to which the mobile approach is able to (1) meet the safety and support needs of refugee women and girls and (2) meet international standards to guarantee safety of GBV survivors and quality of services (including community engagement, safe spaces, a survivor-centered approach, safe referrals, confidentiality of services, and accessibility of services).

The evaluation consisted of two components: (1) a one-time qualitative assessment in Lebanon and (2) ongoing collection and analysis of programmatic monitoring data from the WPE Lebanon program. Interviewers conducted semi-structured, in-depth interviews with 38 Syrian refugee women, 26 Syrian refugee adolescent girls, and 11 IRC staff members as well as observations of safe spaces and PSS activities. IRC staff collected monitoring data on the mobile service delivery approach using internal site and activity trackers that were developed with ICRW, the Gender-based Violence Information Management System (GBVIMS), and a case management satisfaction survey.

Evaluation findings indicate that the safety and support needs of refugee women and girls in Akkar district were acute: at the *interpersonal* level, they experienced social and financial marginalization, loss of social networks, inequitable gender power dynamics, GBV, and limited access to essential services. At the *individual* level, they experienced emotional distress and a reduced sense of self. The mobile services contributed to improved wellbeing of Syrian refugee women and girls by:

- Broadening Syrian women and girls' social networks and building social cohesion
- Increasing their access to support in the form of social relationships and the emotional support they provided as well as advice, information, and some material resources
- Improving Syrian women and girls' communication skills and coping mechanisms, thereby ameliorating family relations
- Breaking down barriers between Syrians and Lebanese and combatting stigma against refugees
- Providing Syrian women and girls with an opportunity to have fun and relieve stress
- Increasing their knowledge of safety-promoting strategies, healthy coping techniques, effective communication skills, and management of their own health and that of their families and;
- Helping Syrian women and girls regain a sense of self and purpose and bolstering self-worth.

Despite the challenging context within which the GBV mobile service delivery approach operated, the evaluation also found that it was an approach that centered on survivors and met many international standards to guarantee safety and quality of GBV service delivery including community engagement, assurance of confidentiality, and for the most part, accessibility of services. Identification of safe spaces and provision of referrals were two of the approach's primary challenges.

A number of key features of the mobile service delivery approach facilitated its ability to effectively and ethically provide services to women and girl refugees embedded in host communities. These included:

- The flexibility and adaptability of the approach
- Identification of appropriate safe spaces for service delivery
- Employment of highly qualified staff
- Staggered delivery of services
- A flexible approach to case management

Findings suggest that the IRC's GBV mobile service delivery in Lebanon is a promising approach for accessing hard-to-reach populations of women and girls, and in particular refugees, with GBV response and mitigation services. Below are recommendations for practitioners, donors, policymakers, and advocates that may enhance dissemination and future implementation of the GBV mobile service delivery approach in Lebanon and globally.

Practitioners

1. Engage community leaders, service providers, and affected populations early and often.
2. Set the foundation for a replicable program model.
3. Identify core program elements and phase them in as trust is built.
4. Remain flexible and adaptable to changing circumstances.
5. Expand the approach to integrate additional service providers and activities over time.
6. Build the capacity of local community members to foster sustainable outcomes.
7. Conduct rigorous evaluation and testing of mobile approaches to GBV service delivery.

Donors and policymakers

1. Support more innovative and flexible mobile approaches to reach the hard-to-reach.
2. Scale up proven programs with longer-term investments to encourage sustainability.
3. Leverage influence with other donors and policymakers to support mobile service delivery in tandem with static services.
4. Ensure funding utilized in mobile service delivery supports holistic services that prioritize the safety and confidentiality of women and girls seeking services.

Advocates and other non-GBV actors

1. Raise awareness of the availability of mobile services in the communities in which they operate.
2. Mobilize local community leaders and members to advocate for social norms change.
3. Advocate for changes in policies and laws that inhibit women's and girls' access to services.

I. INTRODUCTION

The global number of refugees, asylum-seekers, and internally displaced people has reached an all-time high.[1] As of 2014, 59.5 million people had been forcibly displaced as a result of conflict, violence, and human rights violations.[2] This increase has been driven largely by the war in the Syrian Arab Republic (Syria) which has resulted in 4.8 million refugees, over half of whom are female.[3]

Only 10 percent of all registered Syrian refugees across the Middle East and North Africa live in camps[4], with the rest embedded in host communities in urban, peri-urban, and rural settings. In Lebanon, which now has the largest concentration of refugees per capita in the world,[5] 18 percent of the displaced Syrian population lives in informal tented settlements (ITS), while the majority reside in houses and shelters in host communities. The United Nations High Commissioner for Refugees (UNHCR) has deemed most of these shelters "substandard", meaning they lack adequate privacy, safety, and access to water, sanitation, hygiene, and basic utilities like electricity. Overall, 54 percent of the refugee population in Lebanon requires support for shelter conditions to meet minimum standards.[6]

In these settings, the risks to refugee women and girls are exceptionally high. Refugees are torn from the traditional safety nets provided by friends and family and disconnected from neighbors and the larger community. Women and girls, in particular, may be isolated within their homes, further limiting their access to social networks and essential services. The stress and vulnerability created by displacement and these circumstances can lead to physical, sexual and emotional abuse, including physical assault, verbal threats and intimidation, rape and early and forced marriage.[7,8] Beyond physical injury, these experiences can cause depression, stress and anxiety, and reduced self-efficacy in survivors.[9,10,11]

Psychosocial support services (PSS) and case management services can be life-saving in this context, protecting women and girls from future harm and promoting their social and emotional wellbeing.[12] However, survivors are often difficult to reach with essential services due to stigma and inherent gender inequalities that leave women and girls less likely to attend services. This challenge is further

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[1] United Nations High Commissioner for Refugees (UNHCR) (2016). Syrian Refugee Regional Response: Inter-Agency Information Sharing Portal. Retrieved from http://data.unhcr.org/syrianrefugees/regional.php

[2] United Nations High Commissioner for Refugees (UNHCR) (2014). UNHCR Global Trends: Forced Displacement in 2014. Retrieved from http://unhcr.org/556725e69.html

[3] UNHCR (2016).

[4] UNHCR (2016).

[5] UNHCR. (2015, March). Refugees from Syria: Lebanon. Retrieved from: https://data.unhcr.org/syrianrefugees/download.php?id=8649

[6] Ministry of Social Affairs, UNHCR and UN-Habitat. (1 June 2016). Lebanon Crisis Response Plan 2015-2016. *UNHCR Syria Regional Refugee Response: Inter-Agency Information Sharing Portal.* Retrieved from http://data.unhcr.org/syrianrefugees/country.php?id=122

[7] Stark, Lindsay, and Alastair Ager. (2011). A systematic review of prevalence studies of gender-based violence in complex emergencies. Trauma, Violence, & Abuse 12.3: 127-134.

[8] Charles, Lorraine, and Kate Denman. (2013). Syrian and Palestinian Syrian refugees in Lebanon: the plight of women and children. Journal of International Women's Studies 14.5: 96.

[9] Hobfoll, Stevan E. (2001). "The influence of culture, community, and the nested-self in the stress process: advancing conservation of resources theory." Applied Psychology 50.3: 337-421.

[10] Pico-Alfonso, M.A., Garcia-Linares, I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. Journal of Women's Health, 15(5), 599-611.

[11] Zlotnick, C., Johnson, D. M., & Kohn, R. (2006). Intimate partner violence and long-term psychosocial functioning in a national sample of American women. Journal of Interpersonal Violence, 21(2), 262-275.

[12] Sullivan, C.M. (2012, October). Examining the Work of Domestic Violence Programs Within a "Social and Emotional Well-Being Promotion" Conceptual Framework, Harrisburg, PA: National Resource Center on Domestic Violence.Retrieved 5/1/2016, from:http://www.dvevidenceproject.org

compounded for those living outside of camps given the dispersed nature of the population and their often restricted mobility.

The International Rescue Committee (IRC) has been implementing the Women's Protection and Empowerment (WPE) program in Lebanon since 2012, providing GBV response and mitigation services as well as community mobilization activities through five static Women's and Girls' Community Centers. In order to bring services to "hidden" and isolated refugee women and girls in Lebanon, and with support from the U.S. State Department's Bureau of Population, Refugees, and Migration (PRM), the NoVo Foundation, and the Swedish International Development Cooperation Agency (SIDA), the IRC started implementing an innovative approach to mobile service delivery, including GBV response and risk mitigation, in Akkar district, Lebanon in 2014. In 2015, the International Center for Research on Women (ICRW) and the IRC collaborated to evaluate this approach. The purpose of this evaluation was to assess the extent to which the mobile service delivery approach is able to meet (1) the safety and support needs of refugee women and girls and (2) international standards to guarantee safety of GBV survivors and quality of services.

IRC's GBV Mobile Service Delivery Approach in Lebanon

The mobile service delivery approach developed by the Lebanon WPE program is intended to complement the GBV services that are located in static centers and cater to women and girls who are able to travel to them. Mobile services strive to meet women and girls who cannot access existing services, whether due to limited mobility, distance to services, or reduced access linked to insecurity or other obstacles. In Lebanon, the IRC uses a mobile service delivery approach consisting of two models designed to be adaptable to the context:

1. The ***mobile team model***: designed to provide holistic services in each identified community on a weekly basis for a period of approximately six to twelve months
2. The ***rapid response team (RRT) model***: designed to quickly respond to referrals and acute emergency situations, visits communities for approximately six weeks, one to five times per week

The mobile teams and RRTs consist of three women: one community mobilizer, one caseworker, and one adolescent girls assistant. A male community mobilizer rotates amongst the three teams. Together, these staff members provide a variety of services to Syrian and Lebanese community members, including PSS activities, community mobilization activities, and case management in-person and by phone (Table 1).

All services take place in "safe spaces" which are central locations in the community, identified by community members, that are comfortable, safe, and familiar for women and girls such as mosques, clinics, and community halls. IRC Lebanon identified a number of minimum standards for safe spaces including the ability to physically close off the space to non-participants, a private case management room co-located to the activity room, simple furniture available, and an easily accessible bathroom.[13]

[13] IRC. (2015). Increasing Access, Increasing Healing: Mobile Approach to GBV Service Provision and Community Mobilisation in Lebanon. Retrieved from: http://gbvresponders.org/wp-content/uploads/2015/09/Inception-Learning-Document-Report_Mobile-Approach_Final.pdf

The mobile teams and RRT additionally identify focal points in each community who are tasked with engaging community members, disseminating information about the mobile services, and providing support (e.g., referrals) to GBV survivors when needed. For additional details regarding the mobile service delivery approach in Lebanon see IRC's report, *Increasing Access, Increasing Healing: Mobile Approach to GBV Service Provision and Community Mobilisation in Lebanon.*[14]

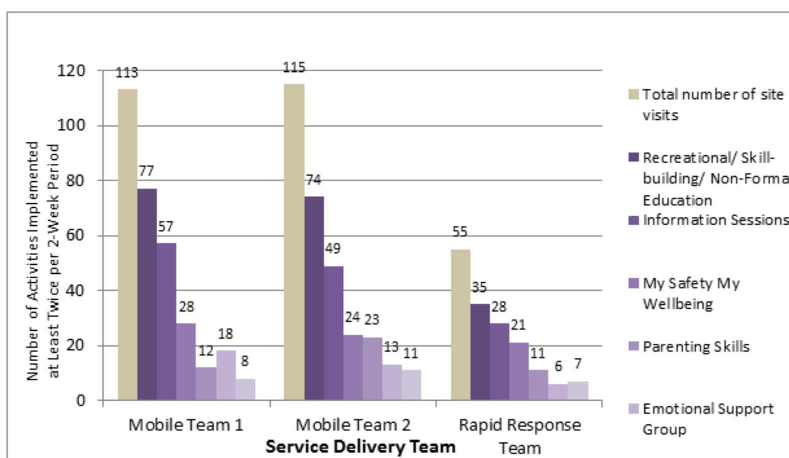
Table 1. Services provided through the mobile service delivery approach

Type of Service	Activities
Psychosocial Support	Recreational activities including henna, tray decoration, hijab decoration and knitting Educational sessions (e.g., parenting skills, literacy classes) Empowerment classes (e.g., Arab Women Speak Out) Life skills classes (e.g., My Safety My Wellbeing) Emotional support groups
Community Mobilization	Focus group discussions to understand the needs of women and adolescent girls Safety planning activities to increase women and adolescent girls' awareness of safety risks Safety audits Mapping activities (i.e., health service, service, and community mapping) to pool community members' knowledge and raise awareness about high-risk locations and access points for support services Community safety planning, in which groups of men, women, and adolescent girls meet in groups to identify safety risks and put in place simple measures to protect women and girls
Case Management	Counseling Referrals to medical, legal, and other essential services

Overview of Activities Included in IRC's GBV Mobile Service Delivery Approach in Lebanon

Between March 2015 and April 2016, the IRC's WPE program worked in twenty-five different communities, including urban settings in which refugees are living amongst the local community, ITS, and shelters using the mobile service delivery approach. The mobile teams and RRT visited each community for an average of six months (range: 1- 12 months). Safe spaces varied based on the community and included family halls, municipality halls, schools, mosques, clinics, tents, and private homes. The mobile teams and RRT conducted a total of 283 site visits between March 2015 and April 2016, implementing over 1,000 PSS activities and 100 community mobilization activities.

Figure 1. Total number of site visits and PSS activities implemented at least twice per two-week reporting periods by team, March 2015 - April 2016

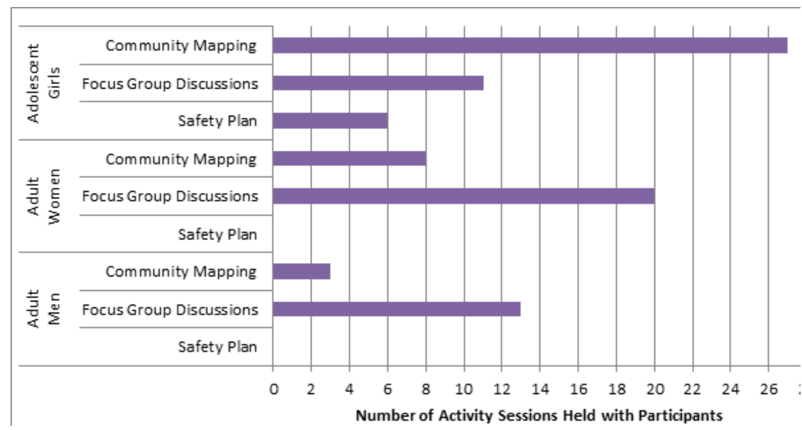


[14] IRC. (2015). Increasing Access, Increasing Healing: Mobile Approach to GBV Service Provision and Community Mobilisation in Lebanon. Retrieved from: http://gbvresponders.org/wp-content/uploads/2015/09/Inception-Learning-Document-Report_Mobile-Approach_Final.pdf

Psychosocial Support Activities

The most common PSS activities implemented in communities were recreational and skill-building activities including henna, tray decoration, hijab decoration, and knitting, followed by information sessions on health and safety-related topics (Figure 1). The teams delivered 73 sessions of My Safety, My Wellbeing, an adolescent life skills curriculum, 46 parenting skills sessions, 37 Emotional Support Group sessions, and 26 sessions of Arab Women Speak Out[15], an empowerment curriculum targeted for women in the Near and Middle East that has been tailored for Lebanon by the IRC.

Figure 2. Subset of community mobilization activities implemented by demographic group, March 2015 – April 2016



Community Mobilization Activities

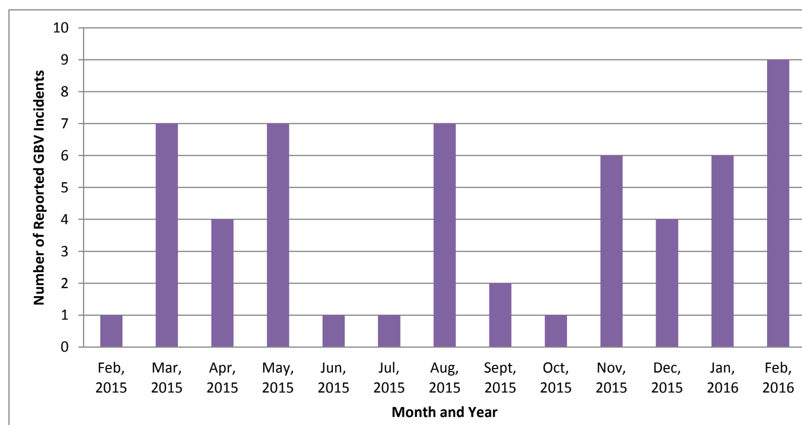
Focus group discussions (FGDs) were the most commonly implemented of the community activities (44 sessions), followed by community mapping (38 sessions), and safety audits (30 sessions). Service mapping (8 sessions), safety planning (6 sessions), and health service mapping (5 sessions) were each implemented by the mobile teams and RRT fewer than 10 times.

The number and types of community mobilization activities implemented by the teams varied by demographic group, with community mapping most common among adolescent girls and FGDs most common among adult men and women (Figure 2).

Case Management

From February 2015 to February 2016, mobile service caseworkers saw 50 unique clients regarding 56 incidents of GBV. Clients were 76% Syrian and 24% Lebanese. The majority (76%) were adults, 22% were adolescents, and 2% were children under eleven years old. Clients accessed mobile case management services through self-referrals (86%), other humanitarian organizations (10%), other IRC programs (2%), and psychosocial/counseling services (2%). The number of GBV incidents reported to mobile service caseworkers varied greatly by month and, according to IRC staff, generally dipped when the mobile teams first entered a set of communities but had not yet introduced case management to program participants (Figure 3). Once

Figure 3. Number of GBV incidents reported to mobile services caseworkers, by month, February, 2015- February, 2016



[15] K4Health. Arab Women Speak Out (AWSO). Retrieved from https://www.k4health.org/toolkits/jhcp/arab-women-speak-out-awso

case workers had established trust in the community, women and girls generally felt more comfortable disclosing experiences of GBV.

International Standards to Guarantee Safety and Quality of GBV Service Delivery

Although one standard set of guidelines for GBV service delivery does not exist, within the international GBV service provision and advocacy community, there is general consensus around a number of core service delivery and program design principles that should guide all GBV response and mitigation programming. These include community engagement, safe spaces, a survivor-centered approach, safe referrals, confidentiality of services, and accessibility of services.[16, 17, 18, 19, 20, 21]

Community engagement: Members of the targeted community, including women and girls and men and boys, should be involved in all elements of the program cycle, from assessment and program design to monitoring and evaluation.[22,23] Before mental health and PSS programming can be undertaken, initial and rapid assessments are recommended to provide service providers with an understanding of existing resources, threats to individuals' physical and psychosocial wellbeing and existing attitudes towards GBV among community members.[24, 25, 26, 27] Among the recommended strategies to engage and mobilize communities are to build on existing community-based initiatives, to use awareness-raising campaigns targeting the whole community, to involve men in community-based initiatives to help them understand the impacts of GBV, to strengthen social support networks within the community, and to support women's roles as community leaders and equal decision makers within their households.[28, 29, 30, 31] Further, organizations involved in service delivery on the ground should work to build the capacity of local staff, like healthcare workers and social workers, to sustainably carry on service provision.[32]

Safe spaces: Safe spaces are "places where women, adolescent girls and (other) child survivors can go to receive compassionate, caring, appropriate and confidential assistance".[33] Mental health or PSS programming should be inclusive of survivors of GBV without explicitly targeting these

[16] United Nations High Commissioner for Refugees (UNHCR). (2003, May). Sexual and gender-based violence against refugees, returnees and internally displaced persons: Guidelines for prevention and response. Geneva: UNHCR.
[17] The Inter-Agency Standing Committee (IASC). (2015). Guidelines for integrating gender-based violence interventions in humanitarian action: Reducing risk, promoting resilience and aiding recovery. IASC.
[18] IASC Taskforce on Gender in Humanitarian Assistance. (2005). Guidelines for gender-based violence interventions in humanitarian settings: Focusing on prevention of and response to sexual violence in emergencies. Geneva: IASC.
[19] World Health Organization (WHO). (2012). Mental health and psychosocial support for conflict-related sexual violence: Principles and interventions. Summary of report from meeting: *Responding to the psychosocial and mental health needs of sexual violence survivors in conflict-affected settings.* World Health Organization, with United Nations Population Fund and United Nations Children's Fund, on behalf of United Nations Action against Sexual Violence in Conflict. 28–30 November 2011, Ferney-Voltaire, France.
[20] The Sphere Project. (2011). Humanitarian charter and minimum standards in humanitarian response. Third reprint, July 2013. Rugby, UK: Practical Action Publishing.
[21] The Gender-Based Violence Area of Responsibility Working Group (GBV AoR). (2010, July). Handbook for coordinating gender-based violence interventions in humanitarian settings. GBV AoR.
[22] Inter-agency Working Group on Reproductive Health in Crises (IAWG). (2010). Inter-agency field manual on reproductive health in humanitarian settings. 2010 Revision for Field Review. IAWG.
[23] UNHCR (2003).
[24] The Sphere Project (2011).
[25] IASC. (2007). IASC guidelines on mental health and psychosocial support in emergency settings. Geneva: IASC.
[26] IASC (2015).
[27] IASC (2005).
[28] UNHCR (2003).
[29] The Sphere Project (2011).
[30] WHO (2012).
[31] IASC (2015).
[32] WHO (2012).
[33] WHO (2012).

individuals, which could put survivors at risk for stigmatization or unintentional disclosure of experiences. As such, services should be provided in safe, private social spaces like women's activity or support groups, wellness centers, and drop-in centers.[34, 35, 36]

Survivor-centered approach: A survivor-centered approach means that, when providing services to survivors, their rights, needs, and wishes are prioritized. When GBV survivors seek support in safe social spaces, their privacy, confidentiality, best interests, and wishes must be respected; this includes informing the survivor of his or her rights when receiving services including the right to decline services at any point.[37, 38, 39, 40] Additionally, service providers should respect a woman's choices and preferences when it comes to referrals and accessing services, including the choice not to seek additional support.[41, 42]

Safe referrals: In 2015, United Nations agencies called for a coordinated set of essential services, including health, justice and policing, and social services for survivors of GBV.[43] This includes a functioning, confidential referral system between providers.[44] A regularly-updated resource list of organizations, focal points, and services for GBV prevention and response should be available to organizations and community members[45] and referrals should be done confidentially, with the consent of the survivor, and in a way that respects that individual's wishes and dignity.[46, 47, 48, 49, 50]

Confidentiality: Providers should avoid exposing GBV survivors to further harm by protecting their confidentiality. To ensure confidentiality, organizations should develop clear policies and procedures and train staff members not only on the policies in place, but also on appropriate reporting procedures should they become aware of disclosures of confidential information. Policies that protect confidentiality of the survivors and their families include sharing only information survivors have consented to share, sharing only the necessary information with other service providers and keeping all de-identified documentation in secure, locked files.[51, 52, 53, 54, 55] Further, survivor-specific services should be integrated into other programming to avoid drawing attention to or accidentally prompting disclosure of GBV survivors.[56]

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[34] The Sphere Project (2011).
[35] WHO (2012).
[36] IASC (2007).
[37] WHO (2012).
[38] UNHCR (2003).
[39] IASC (2015).
[40] IASC (2007).
[41] IASC (2007).
[42] UNHCR (2003).
[43] UN Joint Programme on Essential Services for Women and Girls Subject to Violence (2015). Essential Services Package for Women and Girls Subject to Violence. Retrieved from http://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence#view
[44] IASC (2005).
[45] IASC (2005).
[46] WHO. (2007). WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies. Geneva: WHO.
[47] The Sphere Project (2011).
[48] IASC (2005).
[49] IASC (2015).
[50] UNHCR (2003).
[51] The Sphere Project (2011).
[52] WHO (2007).
[53] IASC (2007).
[54] UNHCR (2003).
[55] IASC (2015).
[56] IASC (2015).

Accessibility of services: Psychosocial and mental health support services for GBV survivors should be safe and accessible to community members. Ensuring the accessibility of services involves assessing and addressing the broader factors that may prevent individuals from seeking help (e.g., community norms around violence, limitations to women's and girls' ability to leave the home, and gender inequality).[57, 58]

II. METHODS

Study Site

The location of this evaluation was Wadi Khaled, Lebanon, an enclave located on the border of Syria in Lebanon's northern Akkar district (Figure 4)[59]. There are over 1.2 million Syrian refugees in Lebanon[60] –a quarter of the country's total population.[61] As of January 2015, over 100,000 Syrian refugees were registered with UNHCR in Akkar district, though the actual number of Syrians living in the district is likely higher due to UNHCR's inability to register additional refugees. In May 2015, the Government of Lebanon (GOL) directed UNHCR to stop registering new refugees, thereby preventing some Syrians from accessing such benefits as legal, health, and shelter services to which registered refugees have access.[62] As a result of this step by the GOL, Syrian refugees in Lebanon without proper documentation face greater insecurity and an increased risk of arrest, leading refugees to limit their travel for fear of encountering army checkpoints and leaving them vulnerable to abuse and exploitation.[63, 64]

Figure 4. Map of Lebanon and Syria, with Marker on Wadi Khaled

A 2015 vulnerability assessment, conducted by UNHCR, WFP, and UNICEF, of Syrian refugees across Lebanon found that households in the Akkar district owned among the fewest basic assets and that Akkar had the lowest secondary school attendance rate for children aged 15-17 years, the second-

[57] The Sphere Project (2011).
[58] IASC (2015).
[59] Google Maps. https://www.google.com/maps
[60] Gallart, O. A. (2015, May 30). Syrians in Lebanon: Glass cannot fit one more drop.' Al-Jazeera. Retrieved from: http://www.aljazeera.com/news/2015/05/syrians-lebanon-glass-fit-drop-150529082240227.html
[61] UNHCR (2016).
[62] Gallart. (2015).
[63] UNHCR. (2015). Refugees from Syria: Lebanon.
[64] Alabaster, O. (2016, January 22). Syrian refugees in Lebanon live in fear of deportation. Al-Jazeera. Retrieved from: http://www.aljazeera.com/news/2016/01/syrian-refugees-lebanon-live-fear-deportation-160117102350730.html

highest rate of child labor, and the highest rate of both illiterate heads-of-household and child marriage compared to other districts. The Akkar district had a high proportion of food insecure households and among the highest rates of reliance on food vouchers as refugees' main source of livelihoods. Moreover, the district had among the highest unemployment rates in Lebanon and the highest proportion of households sharing a latrine with 15 or more people.[65]

In Wadi Khaled, Syrian refugees are particularly vulnerable. The border areas experience intermittent gunfire and shelling, refugees have limited access to the rest of Lebanon due to fears of being stopped without proper documentation at Lebanese army checkpoints, and those who have been unable to register with UNHCR since the GOL's new rules went into effect have limited access to basic services and assistance. In addition, women and girls in Wadi Khaled experience particularly conservative social norms, which may limit their capacity to protect themselves against GBV and seek GBV services when needed. In a 2012 study of displaced Syrian women living in Lebanon, 31% reported experience of physical, sexual, and/or psychological violence, likely a vast underestimate.[66]

Study Design and Sample

This evaluation consisted of two components: (1) one-time qualitative field research in and around Wadi Khaled, Lebanon and (2) ongoing collection and analysis of programmatic monitoring data.

Qualitative Assessment

The qualitative assessment took place in October 2015 at data collection sites in and around Wadi Khaled, Lebanon. Interviewers conducted semi-structured, in-depth interviews with 38 Syrian refugee women (aged 18 or over), 26 Syrian refugee adolescent girls (aged 14-17), and 11 IRC staff members, as well as observations of safe spaces and PSS activities.

Six communities (four mobile team sites and two RRT sites) were purposively sampled from the areas that the IRC's GBV mobile service delivery approach had served to attain variation in geography (e.g., proximity to the Syrian border), living situation of refugees (i.e., embedded within Lebanese communities in urban areas, ITS, shelters), and mobile model that serviced the community (i.e., mobile team, RRT). Within each community, IRC program staff purposively recruited women and adolescent girls to achieve a balanced distribution across the frequency with which they attended IRC's activities (high frequency, low frequency, never attended). Five of the Syrian refugee participants also served as focal points for the IRC's mobile services. Table 2 describes characteristics of the Syrian refugee study participants.

Two female Lebanese research consultants conducted the interviews face-to-face in Arabic accompanied by a Syrian refugee woman who served as note-taker. Prior to conducting the interviews, the research consultants took part in a three-day training and pilot-testing, led by ICRW's Principal Investigator. Before each interview, adult participants were read a consent form explaining the purpose of the research, the interview process, the precautions taken to safeguard privacy, safety, and confidentiality, and their right to refuse to participate or answer a question. Participating adolescents took part in a similar process but could only assent to participate (as they were not of consenting age) after their mother or another legal guardian had given consent. The interviews discussed participants' daily lives, services available in their communities, social networks and

[65] UNHCR, WFP, UNICEF. (2015). Vulnerability Assessment of Syrian Refugees in Lebanon: 2015 Report. Retrieved from: https://data.unhcr.org/syrianrefugees/download.php?id=10006

[66] Usta, Jinan, and Amelia Reese Masterson. "Women and health in refugee settings: The case of displaced Syrian women in Lebanon." Gender-Based Violence. Springer International Publishing, 2015. 119-143.

support, and experience with IRC's mobile approach in Lebanon. Interviews lasted 30 minutes to one hour and were audio-recorded when participants consented. They were followed by a short, quantitative survey that collected basic demographic information.

ICRW's Principal Investigator interviewed all current IRC staff members involved in implementing the mobile service delivery approach including management staff, community mobilizers, caseworkers, and adolescent girls assistants. Staff interviews focused on job duties, safety concerns of communities, challenges and successes implementing the GBV mobile service delivery approach, and perceived effects of the program on participants and communities. All but three interviews were conducted in English with an Arabic translator. Interviews lasted 60 to 90 minutes and were audio-recorded. Informed consent was obtained from all participants.

Last, the study team conducted structured observations of safe spaces and PSS activities in six communities currently being served by the mobile teams and RRT. Observations assessed the physical structure of the safe spaces (including the spaces for case management and PSS activities) and content and flow of PSS activities.

The qualitative assessment was approved by ICRW's Institutional Review Board and, as no in-country Institutional Review Board was available for ethical review, a panel of three Lebanese GBV experts.

Table 2. Characteristics of Syrian Refugee Study Participants (N=64)

Characteristics	Percentage
Participation in IRC Services	
Participant	70%
Non-Participant	22%
Focal Point	8%
Type of Mobile Service Site	
Mobile Team Site	75%
Rapid Response Team Site	25%
Age (mean, range)	24 (14-50)
Marital Status[a]	
Married	46%
Single	48%
Widowed	1.5%
Engaged	1.5%
Number of Children (mean, range)	1.5 (0-9)
Years of Education (mean, range)	7.7 (0-13)
Years Living in Lebanon (mean, range)	3.3 (1.6-12)
Years Living in Current Community (mean, range)	2.4 (0.25-12)

[a] Two participants did not report their marital status.

Collection of Monitoring Data

Beginning in February 2015, IRC staff collected monitoring data on the mobile service delivery approach based in Wadi Khaled, Lebanon using four different tools: the site tracker, the bi-weekly monitoring spreadsheet, the Gender-Based Violence Information Management System (GBVIMS), and the case management satisfaction survey.

The site tracker and bi-weekly monitoring spreadsheet were internal documents that recorded the activities of the mobile teams and RRT. IRC staff updated the site tracker continuously throughout program implementation. It contained information on sites opened (i.e., where activities are conducted) and closed (i.e., where activities had ceased). It also included site characteristics as well as documentation of start-up and close-out activities. On a bi-weekly basis, IRC staff also input data into the bi-weekly monitoring spreadsheet. The spreadsheet was developed collaboratively between

IRC and ICRW and collected both quantitative and qualitative data. Information collected included: names of sites where the mobile teams and RRT worked, number of activities implemented, successes and challenges associated with each activity, services identified through health and service mapping activities, and safety risks identified through community-based focus group discussions and safety audits. It included no client-specific or identifiable information.

The GBVIMS is an information management system for tracking GBV incidents that is used to compile data amongst humanitarian actors that provide services for survivors of GBV.[67] It collects anonymous, quantitative information on GBV incidents, including type and location of incident, alleged perpetrator and survivor characteristics (e.g., sex, age, marital status, country of origin), and referrals. The IRC has been using the GBVIMS in Lebanon since 2013 including an intake and assessment form, consent form for services and data sharing, and incident recorder.

Last, the case management satisfaction survey was conducted with case management clients who had attended two or more case management sessions with the WPE mobile team caseworkers. The short survey was administered in-person or over the phone by the WPE Case Management Officer who oversees all caseworkers in Akkar, including the case workers who are part of the mobile teams and RRT. The survey collects information on clients' duration of time in case management and overall satisfaction with the case management experience (e.g., privacy of the case management space, experience with referrals).

Data Analysis

Qualitative Evaluation Data

Interviews with Syrian refugee women and girls were transcribed and translated into English by the Lebanese interviewers. Data were analyzed using a deductive approach, in which themes were established a priori based on the interview guides and relevant theory, as well as an inductive approach, in which themes emerged from the data itself.

The research team used Sullivan's "Social and Emotional Well-being Promotion" Conceptual Framework[68] (Figure 5) for domestic violence programs as an analytical framework to help conceptualize the needs of refugee women and girls and the effects of their participation in the GBV mobile services. Sullivan defines wellbeing as a combination of individual (i.e., intrapersonal) and social factors. Individual wellbeing is satisfaction with life combined with experience of high levels of positive emotion and low levels of negative emotion. Social wellbeing is the extent to which an individual has the material and social resources needed to be happy, healthy, and safe. His framework posits that both individual (e.g., self-efficacy, hopefulness) and interpersonal factors (e.g., social connectedness, social and economic opportunity, safety, and access to services) predict wellbeing and that effective GBV response programs should target these predictors through a range of strategies aimed at creating individual and social change (e.g., increased knowledge and skills, reduced distress, and increased access to community resources).

A detailed coding scheme was developed based on a cross-section of three interviews to serve as the basis for interpretative analysis. Three study team members conducted the coding using Nvivo

[67] IRC, UNHCR, UNFPA, and UNICEF with WHO. (2016). GBVIMS Background. ***GBVIMS: Gender-Based Violence Information Management System***. Retrieved from http://www.gbvims.com/what-is-gbvims/gbvims-background/

[68] Sullivan, C.M. (2012, October). Examining the Work of Domestic Violence Programs Within a "Social and Emotional Well-Being Promotion" Conceptual Framework, Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved from: http://www.dvevidenceproject.org

qualitative data analysis software under the supervision of a senior qualitative research expert. Additional codes were added during the coding process as new themes emerged. Data were compared both within and across interviews with special attention to differences based on the age of the participant, type of mobile team that served the community, and frequency of participation in the GBV mobile service activities.

Data from observations and semi-structured interviews with IRC staff were condensed into Excel matrices and analyzed for recurring themes and concepts.

Monitoring Data

The timeframe for analysis of monitoring data varied based on the data source and is noted in the sections below. However, all data were limited to entries dated from February 2015 through April 2016. Quantitative analyses included generation of counts, descriptive statistics (e.g., averages, proportions), and ranges as well as graphs and figures. Qualitative entries were analyzed for recurring themes and concepts. All analyses were conducted in Microsoft Excel.

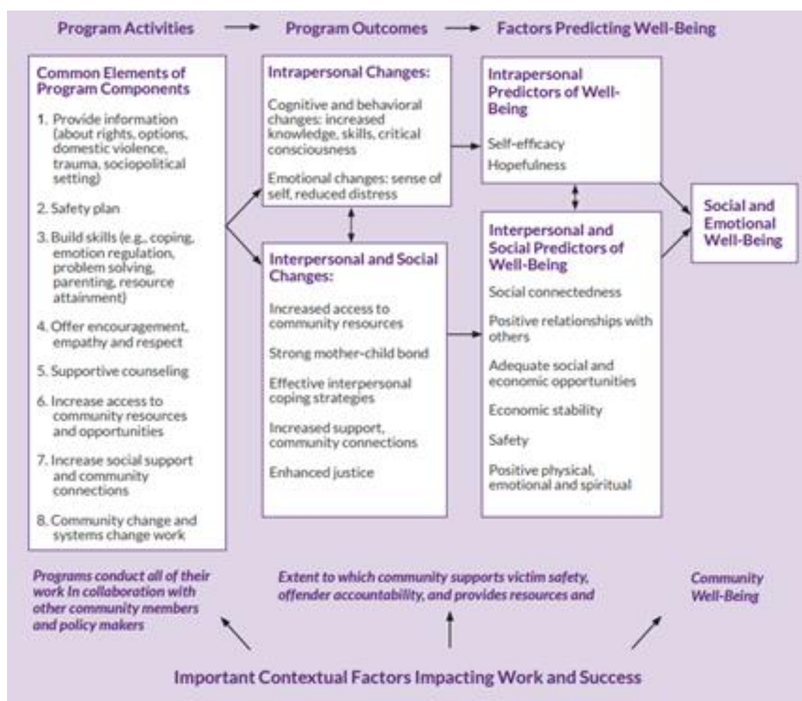


Figure 5. Theory of Change Underlying How Domestic Violence Program Activities Impact Adult and Child Survivors' Well-Being

III. RESULTS

Findings from this evaluation are divided into the following three sections: (A) an evaluation of the IRC Lebanon GBV mobile service delivery approach's ability to meet the safety and support needs of refugee women and girls; (B) an evaluation of the IRC Lebanon mobile service delivery approach's ability to meet international standards around GBV service delivery and; (C) an exploration of the sustainability of the IRC Lebanon's approach.

A. Ability of Mobile GBV Services to Meet the Safety and Support Needs of Syrian Refugee Women and Girls

Syrian refugee women and girls in Lebanon experienced:

- **Social and financial marginalization**
- **Loss of social networks**
- **Dynamics which favored men's power over women and girls**
- **Gender-based violence**
- **Limited access to essential services**
- **Distress**
- **Reduced sense of self**

Experiences of Refugee Women and Girls

Social and Interpersonal Context

Social and Financial Marginalization

The humanitarian crisis and relocation to Lebanon cost many Syrian families the social and financial comfort they had once experienced in Syria. With the loss of their homes, many participants also lost money, resources, and status. Husbands, fathers, brothers and sometimes even women themselves had held stable jobs in Syria but were often unable to comfortably support their families in their new country. A number of women and girls recounted the experience of downward mobility that accompanied their resettlement in Lebanon.

> ***Me, in Syria, I was a queen. I was a queen. I was… thank God, I had a big house, and thank God, we had a lot of money. But even if everything is gone, the house is gone, God is not gone. What can I do? There are people who have a… I go there, I clean the floor from the dirt, I sell the dirt, and I bring bread and my husband's medicine. What more can I do? (Adult, Participant, 48 years)***

Participants' experience of financial marginalization was both directly and indirectly tied to their status as outsiders in Lebanese communities. Not only were many Syrians unable to obtain work in Lebanon due to their legal status, but some felt they were also being economically exploited by their Lebanese host communities. As one young woman described, "Syrians… we feel that it is very difficult to live here. Everything is expensive; everyone sells with different prices and everyone tries to rip off and especially rip off the Syrians as much as possible" (Adult, Non-participant, 18 years). Although Lebanese public schools theoretically have open access for Syrian refugee children, a number of barriers including language[69], competing economic priorities, distance, and registration restrictions prevented some adolescents from attending. High rent, increased prices for common goods, power dynamics between landlords and tenants, and the economic and opportunity gulf between the Syrians and Lebanese created divisions between refugees and their host communities. For example, one girl described being forced to forgo her education in order to help support her family and the resulting resentment she felt for the "easier" lives of Lebanese girls:

> ***I go home [from work] tired, and I start to contemplate and to think: we used to live in grace in our country… I look at the Lebanese and I think… to be honest, I think: they're going to school, and they have the prettiest clothes, and they live in the best houses…. And on the other side, we're working so hard. (Adolescent, Participant, 15 years).***

The economic divisions between Syrians and Lebanese were further exacerbated by social and cultural divisions which often manifested as stigma against the refugee community. A few women and girls discussed how this stigma resulted in physical violence between the two communities. However, participants more often characterized the manifestation of this stigma as being laughed at, "talked badly about", or judged by Lebanese. When asked about the concerns of Syrian refugee

[69] While Arabic is spoken colloquially, the language of instruction in Lebanese schools is often French, which many Syrians do not speak.

women and girls, one woman relayed a common sentiment, "The concerns of people speaking about her… about being Syrians and refugees. If you buy pajamas for your kid, they say: 'Look at the refugees, they are getting clothes. Refugees and doing a good meal.' Like this, they speak a lot." (Adult, Focal Point, Age Unknown)

Loss of Social Networks

Another common impact of relocation for Syrian refugees was the loss of social networks and related support and resources. Separated from family, friends and a familiar way of life, many women and girls struggled to create social connections in their new environment. As one woman explained, "I stay home and I don't go out. We do not go out very often because I do not have relatives here, I feel sad" (Adult, Participant, 18 years).

Though some women and girls had small support networks of, primarily Syrian, friends, relatives and neighbors in their new communities, these individuals often struggled with the same financial and social challenges. As a result, a number of participants described rarely being able to rely on these people for material support during difficult financial times and often being hesitant to discuss problems with them, for fear of burdening them with additional emotional stress:

> ***I have some relatives, I have some relatives, but it's not… to each their own problems… I mean I don't like to bother people. There's me and my children. I don't like to bother people even if I was faced with these… circumstances, each one has their family, and the cost of living is high now, so I can't just bother people. (Adult, Participant, 30 years)***

Gendered Power Dynamics and Experiences of GBV

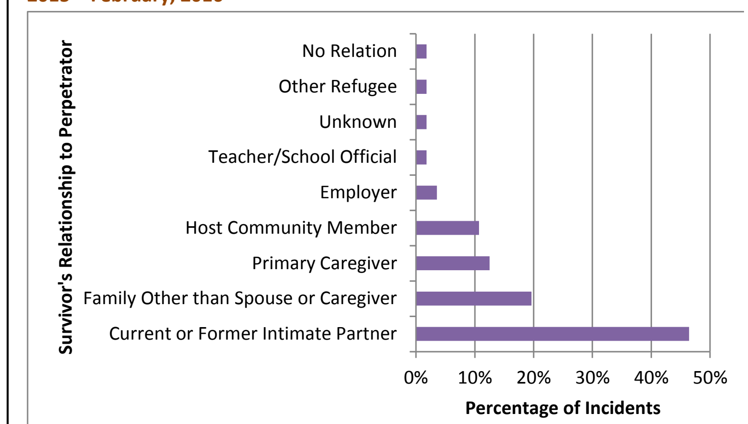
Women and girls' social isolation was further compounded by gender norms which limited their mobility and decision-making power in the household. Participants commonly described needing to obtain permission from the men in their families in order leave their homes. For adolescents, this was usually a father; for adult women, it was most often a husband. This permission could be challenging to obtain due to the perceived security threat outside of the home and cultural expectations around mobility of females. For example, traditional gender norms in a number of communities dictated that the home was a woman's domain and primary responsibility. Leaving the home, for some, was perceived as inappropriate or undignified and could be met with social sanctions:

> ***Participant: You feel that [women and girls] are under pressures. They really do not have support from the brother, husband or father. The woman doesn't own herself. She does not own herself... they are very... They are under pressure…***
> ***Interviewer: Is the pressure from society or because of the situation?***
> ***Participant: From society, a lot... like if a woman goes outside her house… If someone goes out of her home, people gossip about her. Women were scared. They had a lot of panic. (Adult, Participant, 25 years)***

The context of crisis, in some cases, further exacerbated these traditional beliefs. In some families and communities, the situation outside was perceived as unsafe and further justified keeping women and girls in the home. Though many participants described their communities as safe for women and girls, others named a variety of GBV risks, some of which were closely tied to their status as Syrian refugees. Most common among these was harassment. Participants reported being harassed by groups of men on the street, service providers, and even in schools. IRC staff noted that Syrian women and girls were also at risk for other forms of non-partner sexual and physical violence such as rape and physical assault. These risks were most pronounced for women and girls living in insecure

housing contexts such as shelters and ITS where lack of street lighting, the absence of locks on bathroom and tent doors, and communal bathrooms situated outside of the home could put women and girls at additional risk for assault. In ITS, women and girls were further subject to the power of the *shawish*, or the head of the settlement, who in some cases restricted females' movement and/or forced them into underpaid labor.

Figure 6. Survivors' reported relationship to perpetrators by incident, February, 2015 – February, 2016



Most of the GBV risks that women and girls faced, however, were inside of the home. IRC staff noted that intimate partner violence, domestic violence, and early and forced marriage were all concerns among the Syrian refugee community living in Wadi Khaled. Among the IRC mobile services case management clients, current or former intimate partners (46%) were by the far the most common perpetrators of GBV, followed by non-spouse or caregiver family members (20%), primary caregivers (13%), and host community members (11%) (Figure 6).

Limited Access to Essential Services

Within this context, there was a desperate need for essential GBV services.[70] However, in Wadi Khaled, access to these services was limited by social and structural barriers including availability, cost, quality, discrimination, and cultural taboos.

In a number of communities, particularly those on the border, there were no services present. When asked about services in her area, one participant explained, "There are no health centers here, no doctors or even a pharmacy…there are no services here, no social centers or anything. There are no centers at all" (Adult, Participant, 27 years). The distance and cost of transportation required to reach a needed service could be prohibitive, with security checkpoints further limiting access after sunset. Several women and girls joked that the distance to the nearest clinic was so far that a person would likely die before reaching a doctor. "There is a hospital but it is far… So by the time I get there, I will be in the grave [laughs]" (Adolescent, Participant, 14 years).

Local and international non-governmental organizations (NGOs) were primary providers of legal, financial, food and, in some communities, medical services for refugees in Wadi Khaled. However, these services were sometimes delayed, inaccessible to non-registered refugees, or disrupted by security concerns. One adolescent girl described her experience with a United Nations center as follows:

> ***They are very slow…for instance my house needs renovation... I applied 7 months ago or even more that it needs renovation. Its floor is made from gravel… I applied for this and spoke to them and to the organization and so…They have not visited us yet" (Adolescent, Participant, 14 years).***

[70] UN Joint Programme on Essential Services for Women and Girls Subject to Violence (2015). Essential Services Package for Women and Girls Subject to Violence." Module 1: Overview and Introduction." http://www2.unwomen.org/~/media/headquarters/attachments/sections/library/publications/2015/module-1-overview.pdf?v=1&d=20151207T184700

For refugees without UNHCR registration, both obtaining and traveling to services posed problems. Refugees sometimes encountered challenges crossing Lebanese army checkpoints and there were a number of services that UNHCR and partner NGOs only provided to registered refugees. Participants also noted that in communities bordering Syria, NGO services were sometimes disrupted, or might never be initiated, because of the security situation. One woman recalled an NGO that stopped sending ambulances to her area: "They were too afraid to come here; they could die before they reach us" (Adult, Focal Point, 25 years).

While some participants noted services that were provided at a discount to refugees, others lamented the high costs. One woman described her experience trying to seek medical care for her daughter with few financial resources:

> ***Participant: I hope God won't make anyone need a doctor… because I swear only God can help you. I took my daughter who has the disease in her heart. I took her to make a scan for her in Tripoli hospital… The scan was for 153,000 LL (USD $101). With transport expenses and other expenses it became 200,000 LL (USD $132).***
> ***Interviewer: Can anybody help you here?***
> ***Participant: No, not at all... It is hell... I am even deleted from the UN list. I do not get any help at all. No help at all. You feel that you totally hate life. Yesterday I needed a medicine for my daughter, she has this disease. I sat outside and started crying. I don't... I cannot… I cannot do any single thing to help her. What to do to help? We do not have money at home. (Adult, Non-Participant, 22 years)***

When services were available and affordable, access might still be limited by the quality of services or discriminatory attitudes of service providers. Adolescent interviewees were particularly skeptical of the primary care provided through free clinics. As one girl explained, "Here, if you do not go to a specialized doctor, you will not get well or get healed. A while ago, I went to the normal doctor, the one for free, I did not get any results." Participants and IRC staff also described the discrimination Syrian refugees faced at the hands of Lebanese service providers. When asked to describe the service at her closest clinic, one woman replied: "Not very good. It is all about their attitude. They act snobbish with you because you are Syrian. I tried to fight giving birth as much as possible. I gave birth in the car so I did not have to go to the hospital" (Adult, Participant, 40 years).

For mental health services, in particular, cultural taboos could limit access. When asked whom they could turn to for support if they felt sad or distraught, almost no participants raised the possibility of visiting a therapist or psychologist, with one woman noting, "They don't dare do it, talk [to a psychologist]… they prefer to talk to a friend. They don't have the idea of talking to a psychologist. You know, the village mentality is different … they feel it's a bit weird" (Adult, Non-participant, 18 years).

Intrapersonal Context

Experience of Distress

The experience of living through war in Syria combined with the challenging social, economic, and interpersonal context in Lebanon took a toll on Syrian women's and girls' emotional health. Many participants described living with constant feelings of sorrow, anxiety, and stress. One woman noted the connection between her anxiety and her history living through crisis in her home country: "Being scared came with us from Syria. It was not born here. It came from Syria… What happened to us…

We are scared from our shadow. If the window is open, we close it, we are scared" (Adult, Participant, 35 years).

This experience of distress interfered with women's and girls' family lives as well as their ability to form connections and leverage resources in their new communities. It catalyzed fights between participants and their family members and, in some cases, abuse of children. One woman explained, "You know, we're living in times of war and bad circumstances, and any little thing pisses you off. Whenever I am pissed off, I would hit [my child]" (Adult, Participant, 33 years). Depression and anxiety could be so overwhelming for women and girls that these feelings alone could keep them in the house. One young woman described why she never attended the IRC's activities, "At that time, I was sick, bored, not comfortable and depressed and we had some problems at home. My parents encouraged me to go but I did not feel like going out of the house" (Adult, Non-participant, 18 years).

Reduced Sense of Self

In an environment where women and girls' lives had been overturned by conflict and resettlement and their power and agency was limited by social, economic, and emotional dynamics, many experienced a reduced sense of self. Participants described this experience in different ways. Some noted feeling like an outsider, others described the loss of dignity and confidence, and some women and girls reported feeling like they had lost a sense of purpose. One woman described the feeling of "otherness" and self-loathing that she experienced living as a Syrian in Lebanon and how it affected her ability to forge social connections:

> ***I do not like to get out of the house or mix with people. After we left Syria, I felt that I have emotional problems. I do not like to go out and share with anyone. I feel that this environment is not ours. You feel that people in Syria are different. You feel that your life here became boring. It is like… you hate yourself. (Adult, Non-Participant, 22 years)***

When asked about the challenges facing female refugees, another participant described the loss of dignity, self-respect, and comfort that accompanied the downward mobility many refugees experienced as a result of resettlement:

> ***They want to be living in their own houses with dignity, not having to pay rent, not having to work or ask for help. You were in your own house with a job, and now you have to pay rent, to ask for help, and some of them even ask for help but no one helps them. These are the biggest worries. That we had to leave our houses and all our efforts so suddenly. In addition to those who have lost people [to the war], God forbid, like a brother, a child, a husband. Or seeing your house destroyed in front of your eyes. No matter how happy one gets here, it will not be the same as being in your home. (Adult, Participant, 30 years)***

Some participants further connected the idleness and isolation they felt due to lost social and economic opportunities to a lost sense of purpose. One woman explained how it felt to lose the economic opportunity she was afforded in her home country:

> ***When I was in Syria I used to work. So when I came here, I didn't have anything to do, I was sitting at home, and I'm not the type of women who like to sit at home, you know? I like to work and I like to have something that makes me feel that I am doing something.***
> ***(Adult, Participant, 32 years)***

Benefits of Participation in IRC's Mobile Service Delivery Approach

Improved Social and Interpersonal Wellbeing

The mobile service delivery approach contributed to participants' improved social and interpersonal wellbeing by increasing their social connectedness and social support, improving their relationships with family members, and breaking down barriers between Syrians and Lebanese.

The mobile services contributed to improved social and interpersonal wellbeing of Syrian refugee women and girls by:

- **Broadening Syrian women and girls' social networks and building social cohesion**
- **Increasing their access to support in the form of social relationships and the emotional support they provided as well as advice, information, and some resources**
- **Improving Syrian women and girls' communication skills and coping mechanisms, thereby ameliorating family relations**
- **Breaking down barriers between Syrians and Lebanese and combatting stigma against refugees**

Increased Social Connectedness

IRC's mobile service delivery approach in Lebanon broadened women and girls' social networks within their communities, reducing the number of neighbors who were strangers and expanding their circles of trust. Although the quality of relationships formed through the services varied by participant and community, at a minimum, most participants described a feeling of social cohesion that emerged from their participation in the mobile services. An adult woman observed:

> ***We became one group. So when you would talk to your neighbor and she would express her worries and concerns, you'd know what's bothering her and you'd become closer to her. This is the most important thing - we started to communicate with each other. It's true we're neighbors, but we weren't always together. (Adult, Participant, 24 years)***

In some cases, the relationships established through the mobile services developed into close, trusting friendships. One girl described a close confidant she met through the activities as follows, "Our relationship developed. We became more than friends. We became sisters. For instance, if I have troubles with my mom or dad, I tell her. Everything that happens between me and my parents… I tell her" (Adolescent, Participant, 14 years). Later in the interview, she compared the nature of friendships she developed through the mobile services program to those she met made through school adding: "I trust the girls from the [WPE] activities more [than my friends as school] because I met them and I know them well. But at school, you cannot trust everyone" (Adolescent, Participant, 14 years).

Increased Social Support

The social connections with neighbors and IRC staff fostered through the mobile service delivery approach provided women and girls with emotional, informational, and in some cases, material support that improved their overall quality of life.

Program participants unanimously described the safe spaces that were part of the mobile approach as a place where they could go to lift their moods. Through participation in the PSS activities, women and girls knew that they could be listened too, receive sympathy, and even laugh with other women and girls in their communities. When asked why she attended the activities, one woman summarized a common sentiment,

> ***I want to have fun and change my mood… and I have stuff in my heart that I want to speak out… Even only I am coming for fun and laughs, I am able to speak my heart out… [The Lebanese] think we are stupid to go: 'Look how silly she is, where she is going, where she is hanging out!' It is the opposite; when we meet together, we feel relaxed and psychologically better. (Adult, Participant, 35 years).***

IRC staff played a crucial role in both providing emotional support to participants and creating a safe and supportive environment for women to interact. All participants described the IRC activities as a place where women and girls spoke comfortably with one another and offered support in a cheerful and relaxed environment. One adolescent girl noted that she most enjoyed the emotional support groups because: "[The Adolescent Girls Assistant] gave us a lot of emotional support. After I sat with her, I changed without realizing it… I felt that I changed" (Adolescent, Participant, 18 years).

For GBV survivors, the case management services were a particularly important component of the emotional support provided by the program. Several participants described feeling, at first, apprehensive about the trustworthiness of the caseworker and her ability to provide useful support. They described cultural taboos around case management, doubts about the intentions of Lebanese case workers, and the low perceived ranking of counseling and emotional support in their hierarchy of needs as reasons that they often began case management through the mobile services with skepticism. However, most participants found that the caseworkers quickly gained their trust and provided services that helped them reduce stress and conflict in their daily lives. One woman detailed a common experience among case management clients:

> ***Participant: I was not expecting anything or that she will help me. I said that I will try but I will not get any benefits and I will not feel better. And after I spoke to her, it is true that I did not get material benefits but she gave me many information and services…but for me, because I spoke about private things to someone that I trusted quickly made me feel a bit better.***
> ***Interviewer: Good… when you spoke to her for the first time, what were you feeling?***
> ***Participant: I was scared…because I was afraid that I trusted the wrong person… maybe she will tell someone and then my family will know and I will be into a lot of troubles. Yes, I was very stressed and scared. (Adult, Participant, Age Unknown)***

Beyond emotional support, the mobile services were also a place where women and girls could obtain advice, information, and connections to resources. Most often, informational support came from IRC staff in the form of referrals and information provided through PSS activities. One woman observed: "You don't know many things in life, but you discover them. We used to learn new subjects. It is true I am educated, but I did not used to know everything; I learnt much information from them" (Adult, Participant, 18 years). The services were also a forum through which participants provided each other with advice on accessing services and improving family relationships. One woman who had to leave sessions early due to domestic responsibilities relied on those who attended to fill her in on what she had missed:

> ***I ask the women who attend: "What did you do today? What did you speak about? What was your session about?" For instance, I missed the breast-feeding session. One session about raising kids happened, about nursing the child. My friends who attended explained to me about it. (Adult, Participant, 35 years)***

Although provision of physical resources, such as money and food, was not a focus of the services, IRC staff did provide childcare during activities and gave program participants snacks and dignity kits

including items like hijabs and soap. In extreme situations, IRC also had an emergency fund available to provide transportation and fees for urgent medical services for GBV survivors and women and girls at risk. Though women and girls had limited resources to share, a few also recalled situations where fellow participants assisted them with childcare, food, and informal loans.

Improved family relations

A number of participants noted that their relationships with family members including children, parents, siblings, and husbands improved as a result of attending the mobile services. These changes were most often attributed to PSS sessions in which participants critically considered their own communication styles, discussed the effects of violence in the home, and learned stress management and coping techniques. Some participants described changing their behavior as a result of these sessions and, in doing so, creating more peaceful home environments. For example, adult and adolescent mothers reported that, as a result of the knowledge and skills they learned through the mobile services, they communicated better with their children, interacted with them more frequently, and used less physical violence to discipline them. One woman observed:

> ***I used to yell at [my children]. I yelled at them when they did wrong: "Why did you do this? Why did you behave like this? I just cleaned the house; the one that finishes eating should clean now!" My behavior with them changed. I started speaking with them quietly. "This is wrong. This is dirty. We should not do this. Let's go wash, let's go to the bathroom." Like this. The situation improved a bit from before. When the person is under pressure, she acts like this, but you learn that it should not happen. Raising kids. At first, we were like this, but we changed a bit. We used to use a bit of violence because it worked with the kid- don't do this. (Adult, Participant, 35 years)***

A number of adolescents applied similar lessons to their relationships with parents and siblings. After one girl learned how her own behavior was situated within the context of adolescence as a stage of development, she critically evaluated her interactions with her family members and changed her behavior towards them:

> ***I used to yell, scream and fight a lot. Once we had a session… She told us that when a girl is at this age, she always feels uncomfortable. She feels annoyed and concerned with anything. Since then, I started thinking, why should I be like these girls? Why should I yell at my mom and hit my brother? And like this. I became a bit better with them. (Adolescent, Participant, 14 years)***

Participants were less vocal about their relationships with spouses; however, a few women described using stress management techniques they learned through the mobile services to improve communication and reduce conflict with their husbands. One woman explained,

> ***Even my husband told me: "You changed a lot." I used to get angry. Now, sometimes, when I feel I really want to get angry… now actually, my situation is angering. But usually, when I feel I'm getting angry, when I feel I really want to get angry, I go and pray. Yes, like this, it goes away. (Adult, Participant, 48 years)***

Breaking down barriers between Syrians and Lebanese

Although less common across interviews, a few participants noted the impact that the mobile services had on breaking down barriers between Syrians and Lebanese. The mobile team and RRT staff were entirely Lebanese and activities in all communities were open to participants of both nationalities. Although the proportions of Syrian and Lebanese attendees varied greatly across sites,

this mixing of nationalities, in some cases, had the effect of dispelling stereotypes and creating stronger bonds between Syrian and Lebanese women.

Some participants described, at first, being hesitant to trust the Lebanese staff members but over time grew to respect and even love them, noting that the staff treated them as equals despite their being foreigners and refugees. One woman noted the symbolic importance of staff sitting on the ground with them during activities:

> ***It's more comfortable like we were doing, all of us sitting on the floor, us [Syrians] and them [the Lebanese staff]. Not like, pardon me, but maybe some people wouldn't sit with us, but they did, it was as though we were one family. We were very comfortable. (Adult, Participant, 30 years)***

A few participants further described bonds that were created between Lebanese and Syrian participants as a result of their participation in the activities. One focal point recalled of the activities,

> ***We met women to whom we didn't dare say hello even if we used to see her maybe once a month - whether Syrian or Lebanese. When the project started the situation was that the Syrians and the Lebanese were separated… at a time when my neighbor is Lebanese and I'm Syrian, but when we meet here [in the activity], we don't feel this difference. Before we would be scared of each other and feel a barrier between us, but after we met here [in the activity], we stopped feeling that barrier, you know? We were the same. There might be some differences in the way we think and some things, but we stopped feeling the barrier between each other. The barrier was broken when… we sat down and talked and laughed and joked, we felt that, that… we are all part of one village.***
> ***(Adult, Focal Point, 32 years)***

Improved Individual Wellbeing of Women and Girls

The mobile services contributed to improved wellbeing at the individual level by:

- **Providing Syrian women and girls with an opportunity to have fun and engage in stress-relief**
- **Increasing their knowledge of safety-promoting strategies, healthy coping techniques, effective communication skills, and management of their own health and that of their families**
- **Helping Syrian women and girls regain a sense of self and purpose and bolstering self-worth**

The GBV mobile services also contributed to participants' improved individual wellbeing through reduced distress, increased knowledge and skills, and a strengthened sense of self.

Reduced Distress

Almost all participants reported that reduced distress was a primary benefit of the mobile services. Participants overwhelmingly described the activities as a place women and girls could go to laugh, enjoy themselves, and relieve the stress of daily life, if only temporarily. As one woman noted,

> ***There was a nice… atmosphere. For example, this one is withdrawn; this one has lost her husband; this one has her husband disappeared, every one of us is withdrawn, closed to everyone, then you come here, you have fun, you vent a little bit. You have the whole world on your shoulders, then you come here and there's some chatting, and a nice gathering. (Adult, Participant, 33 years)***

Reductions in distress were not only felt internally by participants, but in some cases, observed by family, friends, and other participants as well. One woman described the effects of the program on a girl in her household, "We have a girl who lives with us in the same house that did not used to go

out. Because of these activities you feel that she became more relaxed. She changed her mood and spoke to other girls. She is having fun and taking small breaks" (Adult, Non-participant, 24 years).

Increased Knowledge and Skills

The approach also increased the knowledge and skills of participants in a variety of areas including safety-promoting strategies, coping strategies and stress management, communication, and health.

Both women and adolescent girls described information they learned through the mobile service delivery approach that helped them to protect themselves. Through discussion, safety mapping, and interactive role plays, participants were prompted to consider ways in which they could promote their own safety. As one girl described, "We learned things… like how to avoid… how to avoid someone… she [the IRC staff member] told us: 'If a guy flirted with you, who do you tell?" (Adolescent, Participant, 14 years). The same participant went on to explain,

> ***We had two girls with us who told us that the boys used to annoy them. They used to be scared of the complex where we used to live because it was full of boys and also they were scared of the road. So [the IRC staff member] told them: "Why do not you go from the other road?" and things like this. She used to ask them about the available roads. "Is there another road to use?" … and draw them. The area here… we used to draw it and discuss which road are we afraid of. For example, I am afraid of this road, so I put a red dot on it. I am scared of this shop, I put a red dot. I am afraid of this entrance, I put a red dot. (Adolescent, Participant, 14 years)***

Adolescent girls, in particular, described feeling safer as a result of participating in the exercises implemented as part of the *My Safety, My Wellbeing* curriculum. Another girl noted, "The advice they gave us in the activities made me feel safer….I used to be scared of going out of the house, now it's normal for me; I'm not scared anymore. And I used to be scared of going out to the shop, now I'm not" (Adolescent, Participant, 16 years).

Participants also discussed the value of the coping strategies they learned through the mobile services. One adolescent girl recalled: "We used to act also… and play… and learn to accept gain and loss. Learn what to do when you are angry. How to hide your pain...how to be sad..." (Adolescent, Participant, 17 years). One woman described how IRC staff encouraged her to deal with anger towards her son or husband in a more productive way than smoking a water pipe or simply walking out of the house. A number of adolescent girls also noted that their strategies for responding to stress and obstacles had changed thanks to their participation in the services: "I learned it is healthy and good to have someone to listen to my problems if I am bothered or sad" (Adolescent, Participant, 16 years).

Women's and girls' communication skills also improved as a result of participating in the mobile service delivery approach. In particular, participants described learning how to communicate in a healthy way with children, husbands, and other family members. One participant noted:

> ***My son was going through a very difficult age. He would cry from anything. His attitude is very difficult to deal with. He's seven. I learned how to treat him. I learned how to punish him. Punishments that are not done through beating, but through dialogue and understanding. I used to beat him. I learned that it doesn't work. We learned a lot of similar stuff. I changed the way, and slowly, he learned how to respond to me. (Adult, Participant, 33 years)***

Another girl commented, "Well when I am sitting with my husband discussing, I can hear the voice of [IRC Staff] in my head [*laughs*]… She told me that there should be respect between me and my husband. Every time when I want to raise my voice, I remember what she said" (Adult, Participant, 23 years).

Participants particularly valued the health-related information they learned through the services. Most popular among these were breastfeeding, menstruation, and first aid. As a result of participating in the mobile service delivery approach, participants noted they had an improved understanding of the importance of breastmilk for the health of infants as well as specific breastfeeding techniques. They also discussed self-care during menstruation and the myths related to menstruation that IRC staff dispelled. For example, one woman stated:

> ***There are things that I didn't know that they [IRC] taught us. Many things. For example, [pause] the period. They tell you: you shouldn't shower during you period. I used to be unconvinced by this. There was my doctor, my doctor in Qusseir, who told me: "Don't shower at the beginning of your period." … Turns out it's not true. Although it was the doctor who was telling me that. The doctor! What is wrong is actually to shower either in very hot water or in very cold water. There are many things like this… that you benefit from. Now I was doing this intuitively, turns out I was right [laughs]. (Adult, Participant, 33 years)***

Additionally, some participants described first aid, including wound care, treating illness and fever, and use of medication as a life-saving skill that could benefit their entire families.

Strengthened Sense of Self

Through strengthened social connections, reduced distress, and increased knowledge and skills, participants described regaining a sense of self that had often been lost during the conflict and displacement. A number of women and girls reported that the services enhanced their self-efficacy and provided them with a sense of purpose amidst otherwise disempowering circumstances.

Both women and girls described feeling more empowered and confident as a result of taking part in the mobile services. When asked about the services' impact on their lives, they noted that they "became bolder", their personalities "grew stronger", they began walking in the streets with pride, and that they became more confident in expressing their own opinions. As one adolescent stated, "In the beginning, I avoided conversations. Now, in any conversation that is going on, I participate confidently" (Adult, Participant, 35 years).

In particular, the services empowered women and girls to critically consider and challenge the inequitable gender norms and expectations that they experienced as part of their daily lives. For example, as part of Arab Women Speak Out, adult participants recalled discussing the socially constructed nature of gender roles. In My Safety, My Wellbeing, adolescents practiced strategies for responding to street harassment or a proposition of early marriage. As a result of participating in these sessions, some participants described changing both the way they thought about and responded to gendered power dynamics. As one woman described,

> ***It's a man's world here, and everything is forbidden to the woman. [IRC] taught us that even if it won't be heard, a woman must voice her opinion about anything and such, as in… asserting your presence in the house. Last time in the session, they were discussing these things, they used to give this often, so they asked for example, should the woman give her opinion about the meal that will be cooked? Some of them said yes, she should, some others said no, she doesn't give her opinion [laughs] and we started***

talking, like this. Another minor thing that a woman must give her opinion about is the children's wardrobe and things like this. So yes, she should give her opinion. We all know that some of the women here, even in these simple things she doesn't giver her opinion. So, time after time, you give your opinion and your word becomes listened to, maybe [laughs]. So a woman should give her opinion and shouldn't be silent about it. (Adult, Participant, 30 years)

A few participants noted that the mobile services made them feel proud to be Syrian and even gave them the confidence to challenge stigma they experienced based on their nationality.

We shouldn't let them laugh at us [all laugh]. So, us Syrians… They would tell us "you Syrians" over everything, that we do this and should learn that. We would tell them that it doesn't matter that we're Syrian, we're proud to be Syrian. (Adult, Participant, 30 years)

A number of participants described how the mobile services gave them a sense of purpose, normalcy, and value in circumstances which could feel monotonous and meaningless at times. As a focal point observed, "So this time that we spend, we schedule it in our lives, like a job, so it is part of our schedule to meet and have fun and laugh so much" (Adult, Focal Point, 25 years). By empowering women and girls and providing them with a sense of routine and normalcy that they had lost during displacement, the mobile services made participants feel valued. When asked how she thought the mobile services helped refugee women and girls, a different focal point speculated:

Maybe because they felt that they were important and someone was thinking about them. Before, they felt that no one cared about them. But when the program started becoming more about how the woman should be outspoken, they started feeling important and they learned a little more information. (Adult, Focal Point, 25 years)

B. Mobile Services' Ability to Meet International Standards around GBV Service Delivery

The mobile services met international standards for GBV service delivery to various degrees:

- **Engaging community members was a key ingredient in the program's success or failure to thrive within any given community; the loss of or failure to gain community buy-in and trust could be fatal for the GBV mobile services.**
- **Identifying a safe space in which to conduct activities was one of the mobile services teams' first priorities upon entering a site and was also one of the biggest challenges, particularly when activities took place in tents.**
- **The services highlighted the needs, desires, and consent of GBV survivor as the most important feature of counseling, referrals, and safety planning; Syrian refugee women and girls appreciated Lebanese staff who treated them as equals.**
- **The mobile service delivery model posed unique challenges to maintaining client confidentiality, and staff took precautions and creative steps to help ensure clients' confidentiality.**
- **By design, the model overcame many of the barriers refugees faced to obtaining services. Phone-based case management and the 24-hour hotline greatly increased the accessibility of case management services. However, poor health, disability, caretaking responsibilities, and gendered expectations around mobility remained barriers to attendance.**

International Standard: Community Engagement

Community engagement was integrated throughout the mobile service delivery approach and was a key ingredient in the program's success or failure to thrive within any given community. Upon first entering a community, mobile services staff met with community leaders to gain buy-in for the program and introduced themselves to male and female community members through tea and coffee sessions and door-to-door outreach. Both at the start of the program and throughout implementation, the program conducted community mobilization

activities including community and health service mapping, focus group discussions, safety planning, and safety audits. Community members chose program activities from a menu of options based on their own needs and interests and activities were scheduled to accommodate participants' work, school, and housework obligations.

A few features of the mobile service delivery approach facilitated staff's ability to quickly gain the trust and buy-in of community members. For example, staff noted that because the services were uniquely situated in locations where women and girls were already comfortable, they were able to build trust more quickly than the traditional static GBV centers. Additionally, face-to-face communication through the focal points and male community mobilizer, who were Wadi Khaled residents, helped the teams to efficiently garner support from refugees, including men, in the communities they served.

Conversely, the loss of or failure to gain community buy-in and trust could be fatal for the GBV mobile services. In some communities, staff were unable to initiate mobile services activities because community leaders, fathers and husbands, or Syrian refugee women themselves did not support program implementation. Even after staff initiated services, community support was necessary to keep the program running smoothly. Staff recalled a couple of incidents in which community leaders withdrew participants' access to safe spaces, halting or delaying implementation of program activities. The loss of community trust at any point during the implementation period could severely disrupt the program and even compromise the safety of staff and participants. The fragility of the trust developed between IRC's mobile services and community members is discussed further in the following section. However, one incident, in particular, was recalled by multiple staff in which rumors spread by a former staff member resulted in threats to IRC staff and even riots leading to the cancelation of activities and services in certain communities for two weeks.

Although advocacy was a relatively small component of the mobile service delivery approach's work in communities, staff noted a growing interest in building communities' ability to effectively advocate for themselves and the needs of GBV survivors. In one scenario, for example, staff recalled adolescent girls organizing to petition their community leadership for transportation to school.

International Standard: Safe Spaces

Safe spaces within communities are the bedrock upon which the mobile services are built. Implementation of the approach requires a physical space where program participants feel comfortable and know that they can receive safe, compassionate, and confidential assistance. As such, identifying a safe space in which to conduct activities was one of the mobile teams' and RRT's first priorities upon entering a site. It was also, according to staff, one of the biggest challenges.

Of the six safe spaces observed, the following minimum standards were met:

- **6 could be physically closed-off to non-participants**
- **3 had a bathroom easily accessible**
- **3 had a private room for case management**
- **6 case management spaces had doors**
- **4 case management spaces had furniture**

While staff noted that the appropriateness of the type of space varied by site, certain structures tended to work better than others. The ideal safe spaces were usually public buildings that all women and girls had access to (e.g., municipal halls). They were generally more private, strategically located in the center of town, had a number of different rooms for conducting PSS sessions and case

management, and could easily be closed-off to non-participants. Tents, on the other hand, could pose a number of challenges. Due to their thin walls, it was generally easy to see and hear the activity from both outside and inside the tent. When asked what she would change about the safe space in her community, one adolescent explained, "If I could, I would put a barrier in the middle of the tent so we can speak alone and no one will see us or hear us" (Adolescent, Participant, Age Unknown). There was no lockable door to keep non-participants out of the space, nor were there separate rooms in which to divide adolescent and adult activities or conduct case management. Additionally, tents were particularly vulnerable to extreme weather, including flooding, heat, and cold.

In some cases, the mobile teams secured private homes or tents as safe spaces while continuing to seek a public location for participants to meet. In some situations, these spaces worked well. However, in others, participants described feeling uncomfortable in the space. One woman described the difference between meeting in a private home versus a public space.

> ***It's not that I didn't like the house itself, but the housewife there was always checking that nothing was getting ruined in the house. Like if someone is stepping in with dirty shoes and such. But… when you're in that situation, you're exposed to that. For example if someone enters with a child… sometimes he's eating biscuits … it just wasn't working! The housewife had prepared a room with carpet in case we want to sit on the floor to make crafts. But here [in the new space] it's better! Here you don't worry about the housewife, whatever happens inside is not a problem... nobody's going to say anything about someone ruining something. And people are more comfortable like this. (Adult, Participant, 33 years)***

Among women and girls who completed the case management satisfaction survey,

- **90% felt comfortable in the safe space**
- **90% felt very satisfied with the privacy of the safe space**

Community dynamics could also create barriers to obtaining or maintaining a safe space. While securing a space rent-free was critical to ensuring its continued accessibility to women and girls, IRC staff often struggled to obtain a space for activities at no cost. In these low-resource contexts, residents were rarely willing to provide a space or even land for no payment and in situations where they did, sometimes demanded something in return (e.g., that IRC hire a relative). Although many of the spaces were "public", community leaders still exercised enormous power over their use. Staff described situations in which community leaders blocked access to safe spaces or decided part-way through program implementation that the activities could no longer be implemented there. This could result from a conflict over the space (e.g., land feud) or community perceptions of IRC's activities. For example, in one community, IRC met with women and girls in the hall of a mosque. Some male community members became angry that women were entering the mosque while menstruating and removing their veils during the activities. As a result, IRC had to leave both the mosque and community for a period of time. IRC worked through this and similar issues using a strategy of building community acceptance for activities including engaging community leaders, municipalities, and individual members of the community. Approaches to address blockages vary from situation to situation but have involved community meetings, identifying new safe spaces that were accepting of the activities, and targeted outreach.

Ensuring the privacy of participants was a consistent problem across safe spaces. Participants could easily observe what women and girls met privately with the caseworkers. Additionally, staff had little control over the environment outside of the structures. As a result, men and boys could gather

around the meeting space and observe who partook in services. In one ITS, the *shawish,* a perpetrator of GBV, would stand outside the tent observing activities. In this context, staff had to be creative to ensure clients' confidentiality (see below section on "Confidentiality").

Despite these challenges, the majority of participants reported feeling comfortable in the structures chosen as safe spaces and IRC staff managed to create spaces where women and girls felt cared for and respected.

International Standard: Safe Referrals

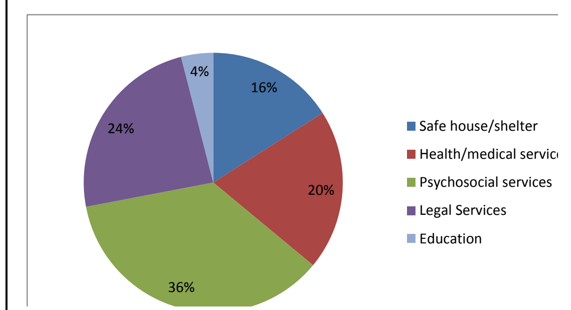


Figure 7. GBV survivor referrals conducted by IRC caseworkers, February, 2015- February, 2016

IRC's GBV mobile services conducted referrals for community members and GBV survivors through PSS and community mobilization activities as well as case management services. Caseworkers conducted a total of twenty-five referrals for survivors between February 2015 and February 2016 to psychosocial services (36%), legal services (24%), medical services (20%), safe houses/shelters (16%), and education services (4%) (Figure 7).

For community members, IRC staff provided an information sheet, updated monthly, that consisted of names and contact information for local service providers. For the majority of GBV survivor referrals, mobile service caseworkers completed a referral form which was submitted to the case management officer who then sent the form to the appropriate local service provider. Caseworkers then followed up with the survivor after a short time (usually a few days) to see if she had accessed the services. For more urgent cases, the case management officer followed form submission with a phone call. In the case of a medical emergency such as clinical management of rape survivors, which must be handled immediately, the caseworker could accompany the survivor to the service and provide transportation if desired by the client.

Almost all program beneficiaries reported receiving the referral information sheet from IRC as well as an oral description of each of the services. As one woman described,

> ***IRC once distributed for us a paper related to everything. Related to UNHCR, IRC, DRC [Danish Refugee Council]… It has everything, even health centers numbers were there. They said these are for you so you do not get lost. They even visited the houses and gave for each single house a paper… in the paper they gave, they explained what each number is and how it can be helpful. "If you face this problem you can call this number. If you get sick you can go to this center. If they won't receive you, you can go to this one." (Adult, Participant, 25 years)***

However, accessing these services was a challenge. By design, the program conducts activities in communities where few or no other services are available. Distance, checkpoints, gendered expectations around mobility, and transportation costs could, therefore, pose prohibitive barriers. One woman, who was referred to an NGO by the mobile services program explained, "Should I go to register with them? I will have to pay for transport costs. I eat with this cost. With 100,000 Lebanese Pounds I prefer to eat." (Adult, Participant, 35 years) The cost of medical services could be particularly challenging for Lebanese survivors, who are sometimes required to pay NGOs for

services that Syrians receive for free. Coordination with and between services providers could also pose a barrier to safe referrals. Service providers were often delayed in assisting survivors and were not always responsive to refugees' request for assistance, leaving clients to rely on IRC staff for follow-up and coordination.

Despite these challenges, staff and participants shared a number of successes related to referrals. For example, the mobile services established a special budget to cover costs related to emergency referrals, which helped a number of participants receive life-saving care. One participant recalled the mobile services helping her cover the costs of a complicated childbirth,

> ***[IRC] brought me money. I went that night to the hospital in ambulance… The second day, they visited me to give me the money so I can pay for the hospital. They visited me at home and they saw that I already gave birth. They told me: "Thank God for your safety". (Adult, Participant, 23 years)***

Among women and girls who completed the case management satisfaction survey,

- **100% reported the caseworker provided some information about another service in the community**
- **97% received a hard-copy list of services and contact information**
- **6% reported that the caseworker accompanied them to visit another service**

Additionally, in one scenario where women and girls in a shelter were being relocated, the flexibility of the approach allowed the RRT to provide services to them immediately prior to their relocation, including linkages to providers, such as a local IRC community center, in their new community.

International Standard: Survivor-centered Approach

The safety and agency of survivors was central to the IRC's approach to mobile service delivery. Each caseworker described the program's strong focus on informed consent when working with GBV survivors and highlighted the needs and desires of the survivor as the most important feature of counseling, referrals, and safety planning. This approach was validated by case management clients who, overall, described the mobile services as helpful and respectful. When asked if she felt respected by the caseworker, an adolescent girl gave a typical response,

> ***Very much and she never forced me to do anything that I did not want to do. She respected me very much in the way she dealt with me… She listens to my opinion and, for example, she takes a lot of care while taking notes." (Adolescent girl, Participant, Age Unknown)***

Among women and girls who completed the case management satisfaction survey:

- **81% felt "very satisfied" with the information provided by the caseworker, 16% were "a little bit satisfied, and 3% were "neutral".**
- **90% felt they were able to choose what services to pursue amongst those available.**
- **6% of respondents felt pressured by the caseworker to do something they did not want to do.**

The IRC consciously sought to hire staff who they perceived as open-minded and non-judgmental. These qualities were valued by program participants, who noted that the Lebanese staff treated them as equals despite their status as Syrian refugees. Although some participants were, at first, hesitant to trust the staff, almost all grew to trust them over time. Describing her experience with the IRC caseworker, one woman explained,

> **Participant: She respected us. You don't feel like she's an employee here but that she's one of us.**
> **Interviewer: Really?**

Participant: Yes, she would make us feel like she is one of us. We didn't feel like she was a stranger at all. (Adult, Participant, 33 years)

In an area where relations between Lebanese and Syrians were strained, identifying the right staff members could be challenging. Tensions between Syrian refugees and the Lebanese host communities over access to employment, services, and resources in some cases fostered discriminatory attitudes towards Syrians, such as the belief among some Lebanese that Syrian women were responsible for the violence that they experienced. As a result, a number of the mobile team and RRT staff were hired from outside of Akkar district.

International Standard: Confidentiality

The mobile service delivery approach posed unique challenges to maintaining client confidentiality. The physical location of safe spaces was, by design, often central in the community. While this increased the accessibility of the mobile services, it also meant that onlookers could easily observe who attended activities. Additionally, unlike static centers created for GBV programming, mobile service safe spaces were not designed with GBV services in mind. Some safe spaces (e.g., tents) had thin walls and doors without locks, making the space vulnerable to interruptions and community members listening-in on activities. Spatial features such as adjacent rooms for case management and back doors for discreet referrals were rarely present, making it easy for fellow participants to see which women and girls met with the caseworker or left the location for a referral.

This challenging context required that mobile service staff implement creative strategies for maintaining client confidentiality. To protect case management clients, IRC staff were intentionally vague about the nature of the service and limited case management sessions to approximately thirty minutes to avoid raising suspicions. They also periodically interviewed random program participants for feedback on IRC's activities so that when a survivor met with the caseworker to receive GBV case management services, other participants would assume they were discussing the activities. When accompanying a client to a referral, the caseworker secretly met the survivor at a different place in the community, like a school or on the roadside, instead of leaving together from the safe space. In tents, in particular, activities were often limited to less sensitive activities (e.g., handicrafts) and a community mobilizer or other staff member would "stand guard," distracting curious community members from listening-in. Last, when a one-on-one meeting would surely compromise confidentiality, case management was conducted over the phone.

To enhance the security of clients' information, caseworkers input their data directly into a tablet that transmitted the information into a database. Paper files, such as action plans, were dropped at the local static GBV center at least once per week where they were stored in locked cabinets.

Despite the many challenges to maintaining confidentiality in the mobile service setting, participants were, overall, pleased with the confidentiality of services and trusted the information they shared would remain private. As one woman described,

Participant: When I am speaking with [the caseworker] she listens to me, nobody knows later the things I tell. She never told anyone. When we spoke on the phone, she asks to speak to me in a very respectful way. She uses a very respectful language, very nicely and quietly with me.
Interviewer: Are you sure that she will not reveal the details of your discussion together to anyone?

> **Participant: After I met her and got to know her, yes... In the beginning as I told you, I doubted that anyone will tell her their problems. I did not take the idea in consideration. But after I met her, I trusted her a lot… One girl told me: "Are you sharing your family problems with her?" I told her: "Could be". She was making fun. I told her that I honestly trust [the caseworker]. She said: "I will never ever tell [caseworker] anything." I told her it is not a rule. When you know her well and know the real her you will tell her... I bet you that you will speak to her someday. (Adult, Participant, 18 years)**

Another explained,

> ***Girls who attend here encourage other girls, "Instead of telling me your problem you can tell [the IRC staff] anything. They will help you... They will not tell anything. Don't worry. Nobody from your parents or family will know". (Adult, Participant, 25 years)***

International Standard: Accessibility of Services

The mobile service delivery approach was initiated in order to increase the availability and accessibility of GBV response and mitigation services for Syrian refugee women and girls. By design, the approach overcame many of the barriers refugees faced to obtaining essential services. The proximity of safe spaces helped to overcome transportation costs, problems posed by check-points, and the expectation that women and girls would not travel far from home. The flexible timing of activities ensured that services were not provided during school or work hours. And the provision of free childcare during mobile service activities meant that women did not need to choose between their responsibility to care for children and attending the services. Additionally, the approach's process for introducing services in a staggered manner from least sensitive (e.g., coffee/tea sessions and recreational activities like knitting) to most sensitive (e.g., case management) helped to overcome initial fear or skepticism from the community and decreased the risk women and girls might face attending services.

The staff and volunteers who implemented the approach were also crucial to increasing accessibility of services. For example, the male community mobilizer played an important role reaching out to men in the community- sometimes even one-on-one- to ensure buy-in from husbands and fathers who might otherwise restrict women and girls' participation in the services. The Syrian refugee focal point played a key role in identifying Syrian refugees in the community, encouraging them to participate in the mobile services, and, when needed, liaising between community members and IRC staff.

Accessibility of case management services varied based on how long the mobile services had been in a community and the nature of the community in which the mobile services were operating. Mobile services staff were cautious when introducing case management services to a new community, often taking a nuanced approach to timing and description depending on the local culture and participant characteristics. In some sites, staff introduced case management to mobile service participants after just a few visits. This was particularly true among RRT sites, where mobile services were present for a shorter period of time. In other sites, the process took much longer or might not happen at all. For example, in sites where there was no safe space identified, case management was never formally introduced. To protect the confidentiality of clients and avoid stigmatizing the service, staff rarely mentioned GBV before participants entered a confidential one-on-one session.

Staff noted that phone-based case management and the program's 24-hour hotline had greatly increased the accessibility of case management services. Through the hotline, case management was available to all survivors living in Wadi Khaled, even if the mobile services had not visited their communities. By conducting case management over the phone, survivors who could not attend the services or engage in face-to-face case management were able to work with the caseworker.

Despite the many aspects of the mobile service delivery approach that facilitated its availability and accessibility to refugee women and girls, there remained some barriers to attendance. For some women, poor health, disability and caretaking responsibilities for young children and sick or elderly family members were persistent barriers to attendance, despite the proximity and convenient timing of services. Within more conservative families and communities, gendered expectations around mobility and the perceived threat of "empowering women" through support activities were sometimes too entrenched to be overcome by the mobile service delivery approach. One focal point described this challenge,

> ***First, the most important thing about the program is that it is a gathering of women. A gathering. Now there are men here in the area, be it Syrian or Lebanese, of course, it's not about Syrian or Lebanese, there are many men who don't accept the idea; they don't accept the idea saying "you want to teach the women to face the men", from that perspective, you're making them stronger facing their men, and this is an inconvenience for these men. For them, the woman should be in the house, the woman is here, no getting out of the house... There are a lot of people who gave me a difficult time with this issue, and I had to deal with a lot of talk, a lot. (Adult, Focal Point, 32 years)***

A few participants described the fact that Lebanese participated in the activities as a barrier to Syrians attending. The same focal point went on to explain,

> ***Some people liked this and some people didn't. Some people weren't comfortable with joining this society, they were afraid. They were worried that if they became part of this society quarrels might break out, and they felt that the barrier was real between the Syrians and the Lebanese, because the society is unknown to them. You know how people adjust or not to a new environment? So some people were able to adjust to this new environment and others were not able to do so.***
> ***(Adult, Focal Point, 32 years)***

Last, in some cases, women and girls did not perceive the activities as useful, instead privileging livelihoods activities or those that promised food, goods, and other material assistance over psychosocial support.

C. Sustainability of Services

Lasting Impacts of the GBV Mobile Services

While enhanced knowledge and skills were lasting impacts of the GBV mobile service delivery program, the social and interpersonal wellbeing and reduced distress that participants experienced as a result of program activities often faded after the services had left their communities. According to participants, relationships developed through the mobile services tended to be confined to the space and time of the activities, with participants rarely convening on their own after the mobile services ceased. Some participants noted that this was due to limitations on the friendships they made through the services.

The difference is that you do not become directly close to them. You cannot do this with all people. Before we used to go to the activities and meet each other there. We all knew each other but now there are no activities. Each woman stays at her home. We sit this half an hour now only. Can I get to know a woman in half an hour? No. It is not like doing activities and sit. (Adult, Participant, 50 years)

Another woman tied it to the continuing stigma she faced in her community and her reluctance to leave her home to visit the other program participants,

Interviewer: Okay. So you never saw or visited these women again?
Participant: Very rarely, to be honest. To go out like this… it's rare.
Interviewer: Why?
Participant: I don't know. To be honest… Because over here…. To be honest… you still feel that the area is not yours, you're not amongst your neighbors, to be able to come and go… even if… you still feel like a foreigner. Even if… for example you stay for two or three years, they make you feel… it's yourself, you make yourself feel that you're a foreigner. (Adult, Participant, 30 years)

A few participants, however, did note that women continued to meet with each other after IRC left their communities. One focal point said that although the women never met as a group after the services closed-out in their community, they did keep in touch with close friends developed through the services on a one-on-one basis:

Now the people who are close to you, you remain in contact, you can't leave them. The person who is a bit further, you need to wait for an occasion to visit her, or for her to visit you, unless we run into each other by coincidence. But for us to start talking again, laughing again, meeting again, no, I think now each woman is busy with her family and children, and her normal life. She forgot. (Adult, Focal Point, 32 years)

In at least one community, program participants continued to meet as a group after the mobile services had left, largely due to the initiative of their focal point, who described their meet-ups as follows:

After they finished, I met with 8 women…and we discuss what we learnt. We did it as a morning. I did not pressure the municipality a lot. We did it once at the municipality….We did it once at my house. Then we did it once at each of the 8 woman's house…We did a bit of women support. (Adult, Focal Point, 30 years)

When the mobile services departed some participants' communities, so did the mental relief and sense of purpose provided by the activities. A number of participants described a return to the social and emotional "status quo". When asked how her life had changed since the mobile services left, one participant replied, "I'm starting to feel uneasy more often. There are no more Mondays to take my mind off things. I used to plan that on Mondays, I'll go, I'll see my friend … take a nice lesson, that's how I used to think. Yes, now it's no more like this" (Adult, Participant, 48 years). Other participants described feeling as though a sense of idleness and isolation had returned to their lives:

Interviewer: Why did you feel upset [when IRC left]?
Participant: Because I used to go out a bit, change my mood, meet new people, see people… now my life is only at home. You always see the same people that you know… your parents and neighbors. (Adult, Participant, 27 years)

At close-out:
- **81% of sites had a focal point**
- **19% of focal points had received training from IRC on GBV core principles and safe referrals**

The young ladies they used to have something to enjoy and a reason to leave the house, they did not have to stay home all the time. Of course they wouldn't tell people that they are going in and out of the house regularly, but they had an excuse, a reason to do so. But now that the program ended, you feel that… we wish we could go back to it and gather once again like before, laugh and joke again, forget again, and at the same time benefit from it. (Adult, Focal Point, 32 years)

Role of the Focal Point in Sustainability

IRC staff viewed the focal points as playing a potentially important role in sustainability of the mobile services after they had left a community. For example, the focal points could refer survivors to the IRC caseworker, conduct community mobilization activities, and continue organizing women for informal PSS sessions. However, in general, the focal points interviewed saw their primary job duty as outreach to and communication with Syrian refugees when the mobile services were active and, overwhelmingly, did not perceive themselves as having any specific responsibilities related to the mobile services after IRC had closed out activities in their communities.

IV. CONCLUSIONS AND LESSONS LEARNED

The safety and support needs of refugee women and girls in Wadi Khaled, Lebanon were acute. At the interpersonal level, they experienced social and financial marginalization, loss of social networks, inequitable gender power dynamics, and GBV. At the individual level, they experienced emotional distress and a reduced sense of self. Findings from this assessment suggest that by providing free, flexible service delivery in women's own communities, the GBV mobile service delivery approach developed by the IRC in Lebanon overcame many barriers that limited women's and girls' access to essential services, providing them with GBV response and mitigation care that improved their social and individual wellbeing.

Despite the challenging context within which the GBV mobile service delivery approach operated, our study found that it was a survivor-centered approach and met most international standards to guarantee safety and quality of GBV service delivery including community engagement, assurance of confidentiality, and for the most part, accessibility of services. Identification of safe spaces and provision of referrals were two of the approach's primary challenges.

A number of key features of the mobile service delivery approach facilitated its ability to effectively and ethically provide services to women and girl refugees embedded in host communities. These included:

- *The flexibility and adaptability of the approach:* The most important advantage of the mobile service delivery approach is its flexibility and adaptability. Different from static approaches to GBV services, the mobile approach can mold to fit the unique needs of a community by providing services on the days and times that work best for women and girls and having communities choose the activities that best meet their needs and interests.
- *Identification of appropriate safe spaces for service delivery:* This evaluation found that, despite challenges identifying safe spaces, locating the appropriate place for mobile service activities was a key element in facilitating the program's success in communities. The ideal safe spaces were usually public buildings that all women and girls had access to (e.g., municipal halls). They were generally more private, strategically located in the center of town, had a number of different rooms for conducting PSS sessions and case management,

and could easily be closed-off to non-participants. However, the evaluation also determined that in high risk communities where a safe space often does not exist, the approach needs to adopt strategies that allow for flexibility (e.g., setting aside funds to improve the safety or confidentiality of a space or conducting PSS activities in a private home but case management over the phone).

- *Employment of highly qualified staff:* Highly qualified, non-judgmental staff are critical for the mobile service delivery approach to be successful. Mobile GBV service delivery requires staff who can quickly build community trust, effectively assess community readiness for activities, and think creatively to protect clients' confidentiality. In addition to the core positions central to the approach (caseworker, community mobilizer, adolescent girls assistant), this evaluation found that the male community mobilizer and community Focal Point played key roles in garnering community support and participation in the activities.
- *Staggered delivery of services:* The approach's process for introducing services in a staggered manner from least sensitive (e.g., coffee/tea sessions) to most sensitive (e.g., case management) was crucial in helping communities overcome initial fear or skepticism about the activities and decreasing the risk women and girls might face by attending the services.
- *Flexible approach to case management:* The mobile service delivery context requires a flexible approach to case management. Although face-to-face case management is preferred, this assessment determined that, in a context where many women had access to mobile phones, phone-based case management was a critical component of the work because it protected client's confidentiality and increased the reach and accessibility of case management services. Additionally, a flexible fund for case management referrals was important to ensuring the accessibility of emergency medical services for survivors.

V. LIMITATIONS

This evaluation had important limitations which should be taken into account when considering the results. First, participation in in-depth interviews was limited to a small number of refugee women and girls situated within a specific context. Although we did purposively sample from different service delivery sites to attain variation in geography, living situation of refugees, and type of mobile team that delivered the services to the community, the sample size—only six communities—is too small to allow us to say that our conclusions are generalizable across all the mobile service delivery sites. And although the evaluation aimed to generate theory about the impacts of the GBV mobile services that is generalizable beyond Syrian refugees in Akkar district, it is impossible to fully disentangle study findings from the effects of location. Second, for safety and logistical reasons, participants were recruited by IRC staff. It is possible that staff purposely selected participants who they knew had positive experiences with the program, biasing study findings about the effects of program participation. Third, to avoid potentially re-traumatizing survivors and to protect the relationship of trust they had developed with IRC staff, interviewers did not explicitly probe participants' own experiences with gender-based violence and how the mobile service delivery approach impacted this experience. In some cases, these experiences were discussed during interviews but were not consistently addressed across participants. Last, the interviewers for this study were Lebanese women. Although interviewers were paired with Syrian research assistants to increase participant comfort, given the divisions between the Lebanese and Syrian communities, it is possible that participants were hesitant to openly share their experiences with the interviewers.

VI. RECOMMENDATIONS

Despite the potential limitations of this evaluation, findings suggest that the IRC's GBV mobile service delivery in Lebanon is a promising approach for accessing hard-to-reach populations of women and girls, and in particular refugees, with GBV response and mitigation services. Below are recommendations for practitioners, donors, policymakers, and advocates that may enhance dissemination and future implementation of the GBV mobile service delivery approach in Lebanon and globally.

Practitioners should:

1. ***Engage community leaders, service providers, and affected populations early and often***: In order for mobile service delivery programs to be successful, it is important to engage relevant stakeholders early on to build trust, establish credibility, garner buy-in, understand the community's needs, and negotiate access and support. After a program is established, it is critical to continually consult with these key stakeholders to ensure ongoing support and commitment to the integrity and success of the program, especially for the operation of safe spaces. In this regard, practitioners might find it helpful to negotiate an MOU with community leaders that outlines roles and responsibilities for the program as well as terms of use for the establishment and uninterrupted operation of safe spaces.

2. ***Set the foundation for a replicable program model***: In order for the GBV mobile services approach to be effectively disseminated and replicated in other settings, it is important to have a clearly articulated theory of change that outlines the pathways through which the program impacts the wellbeing of women and girl refugees. This will allow practitioners to develop consensus around how the approach is expected to work and for program evaluators to target key anticipated outputs and outcomes for measurement and evaluation.

3. ***Identify core program elements and phase them in as trust is built***: Identify the core programmatic elements of the mobile service delivery approach that contribute to its ability to improve the wellbeing of refugee women and girls. Ensuring that these core elements are implemented in a phased approach in every community, while also allowing women and girls to choose some sessions of greatest interest to them, will ensure that the approach responds to community variation while still affecting the targeted program outcomes.

4. ***Remain flexible and adaptable to changing circumstances:*** As with any program, there will be challenges that may require deviations from the program approach. Anticipating these challenges in advance will mitigate any interruptions in service. For example, when designing a mobile service delivery program, consider establishing an emergency case management fund within the budget to allow staff to quickly access funding to help participants pay for emergency medical services. Similarly, when confidential case management services cannot be undertaken in a safe space, consider adapting the case management approach to provide private and confidential services over the phone.

5. ***Expand the approach to integrate additional service providers and activities over time:*** By design, the GBV mobile services target communities with few other quality services available. This makes referrals, a key component of case management, particularly challenging. However, looking forward, there may be opportunities to integrate other types

of services into the mobile service delivery approach. For example, the approach could place a medical provider with the mobile teams to provide on-the-spot assistance for survivors or give medical information to program participants. In addition, coordinating with other existing programs, such as livelihoods training, would allow participants the opportunity to gain marketable skills and to earn a certificate.

6. ***Build the capacity of local community members to foster sustainable outcomes:*** Findings from this evaluation suggest that many of the social and emotional impacts of the approach may not be sustained after the services leave a community. Expanding the role of the focal point so that she is more heavily involved in program implementation and referrals may help to create impacts that can be sustained after the services are gone. Additionally, creating greater ownership of mobile service activities among refugees throughout the implementation period may eventually allow for handover of certain activities (e.g., Emotional Support Groups, safety mapping) to program participants. Likewise, building in an advocacy component to help the community understand how the program benefits the women and girls in their families and communities may aid in increasing their support for female family members' participation as well as addressing harmful gender norms that inhibit women's and girls' access to services.

7. ***Conduct rigorous evaluation and testing of mobile approaches to GBV service delivery:*** Mobile approaches to GBV service delivery in humanitarian settings are relatively new. Although this evaluation showed promising results, additional research needs to be conducted to understand when mobile approaches are and are not appropriate in diverse settings, what the core elements are that contribute to the approach's ability to improve the wellbeing of women and girls, and what guidance on best practices is necessary to ensure the approach meets international standards for GBV service delivery. It would further be important to explore the ways in which static centers and mobile approaches can and should complement one another as a way to ensure the highest quality and most readily available services.

Donors and policymakers should:

1. ***Support more innovative and flexible mobile approaches to reach the hard-to-reach:*** As the landscape of humanitarian response shifts from a camp-based to an urban- and ITS-based response, it is important that donors and policymakers also consider complementary modes of delivering lifesaving GBV services. While static services will remain essential and should continue to receive dedicated financial and technical assistance, funding should also be directed to innovative and flexible mobile approaches where static services are unavailable. Allowing implementing partners to experiment with different approaches and test theories of when and where alternative models work, can have far-reaching consequences for influencing the entire humanitarian response.

2. ***Scale up proven programs with longer-term investments to encourage sustainability:*** As evidenced by this evaluation, mobile service delivery has the potential to increase the wellbeing of refugee women and girls, yet the short-lived nature of funding may mean these benefits fade over time. Those programs that are proven effective should be scaled up to reach more communities and for longer periods of time to ensure positive outcomes have the time to become embedded in the fabric of the communities reached as well as within the individual participants' lives. Additionally, service providers should focus on sustainability of

programming, transferring skills, knowledge, and motivation to local communities so that activities may be sustained after the mobile services leave.

3. ***Leverage influence with other donors and policymakers to support mobile service delivery in tandem with static services:*** Many donors fund both bilateral and multilateral programs. These donors can and should use their influence to advocate for other donors, UN agencies, and host governments to prioritize funding for mobile service delivery. In addition, donors and UN agencies should support host governments in building up their own capacity, including social protection and safety net systems, in order to provide safe, accessible, comprehensive care for survivors of violence both within refugee and displaced communities as well as within host communities.

4. ***Ensure funding utilized in mobile service delivery supports holistic services that prioritize the safety and confidentiality of women and girls seeking services:*** Donors and policymakers must ensure that all programs they support are implemented in a way that prioritizes the safety of survivors of violence. Poorly designed GBV programming can put survivors at increased risk for experiencing violence. Programming must protect the confidentiality of survivors' information and respect survivors' unconditional access to services regardless of a woman's choice to seek justice. Donors should hold implementing partners accountable to maintaining these standards, making funding conditional upon adherence to WHO and industry standards as well as the IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Actions.

Advocates and other non-GBV actors should:

1. ***Raise awareness of the availability of mobile services in the communities in which they operate:*** While mobile service teams lay the groundwork for engaging and obtaining buy-in from communities, other stakeholders also have important roles to play in building support for services. For example, advocates, service providers, other humanitarian actors and community mobilizers are well-positioned to reach out to community members to raise awareness of the availability of services, refer women and girls to services as needed, and foster conversations about the importance of the program and its benefits to individual participants as well as to the wider community.

2. ***Mobilize local community leaders and members to advocate for social norms change:*** In order to address the root causes of violence, it is critical that a strong advocacy component is incorporated into the mobile service delivery platform. This should encompass community-wide action to address harmful gender norms that perpetuate violence, including gender inequality, early and forced marriage, restrictions on women's movements and education, etc. Advocacy can help identify and support community-based solutions for addressing GBV; facilitate cohesion between refugees and host populations; and ensure communities understand the importance of risk identification and mitigation, safety planning, and engaging men and boys in behavioral change.

3. ***Advocate for changes in policies and laws that inhibit women's and girls' access to services:*** In addition to working with communities, advocates and other humanitarian actors have a role to play in influencing policies and laws that impact the program. For example, a host country may have in place restrictions related to registration and documentation, education, and employment of displaced persons, as well as discriminatory laws that require mandatory

reporting of GBV and/or onerous referral requirements for accessing health care. It is important to understand what policy and legal barriers may exist to implementing a mobile service delivery approach, and consider whether these barriers can be reasonably addressed without causing harm to the program approach or its participants.