

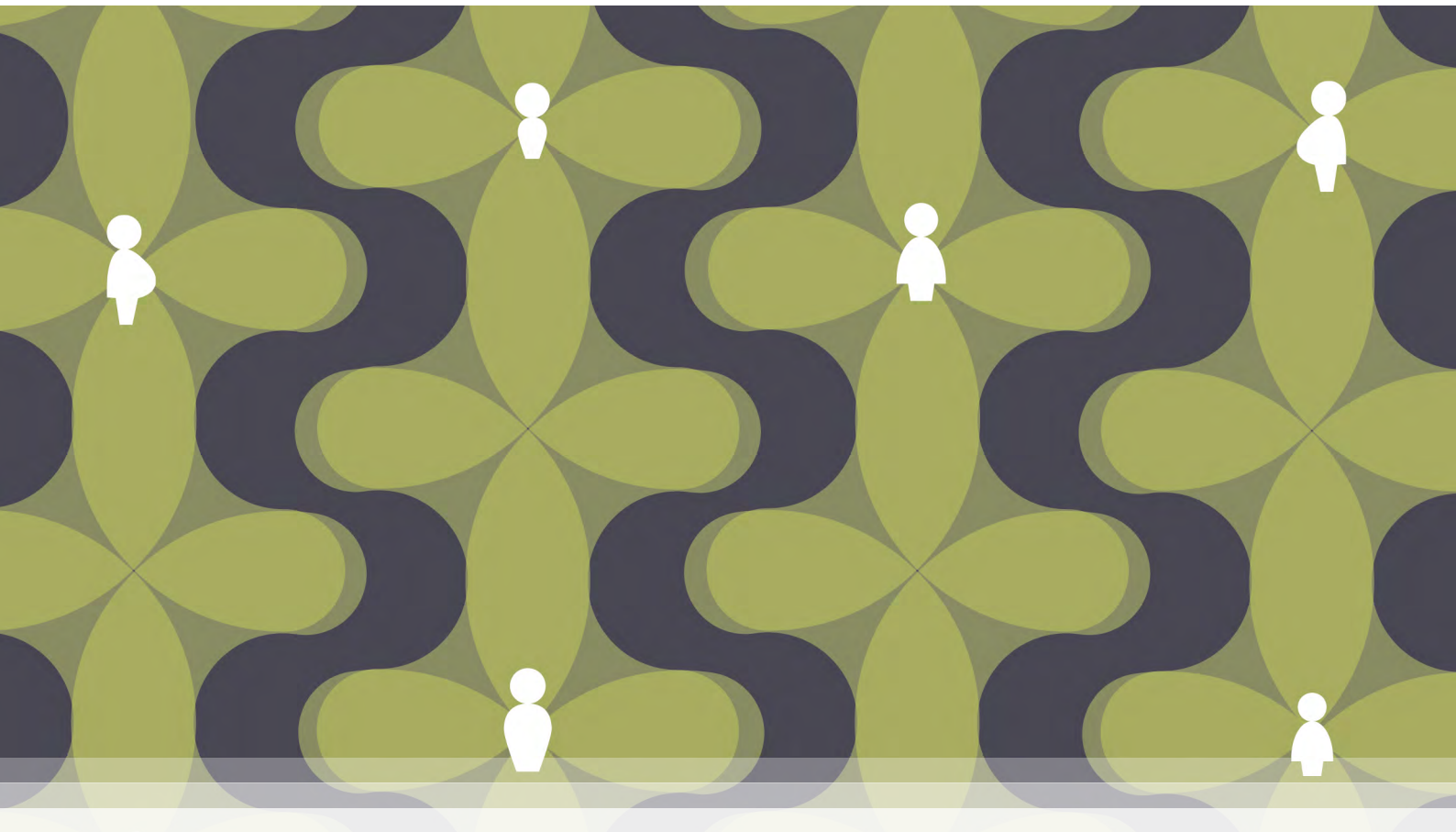
HPG report

Sex, health and rights in displacement and humanitarian response

Crises upon crises in Lebanon and beyond

Megan Daigle, Alexandra Spencer, Jasmin Lilian Diab, Bechara Samneh and Aida Afandi

October 2023



In memory of Dr Olfat Mahmoud, General Director of the Palestinian Women's Humanitarian Organisation – a committed feminist humanitarian, and an untiring champion of Palestinian women and girls.



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How to cite: Daigle, M., Spencer, A., Diab, J.L., et al. (2023) *Sex, health and rights in displacement and humanitarian response: crises upon crises*. London: ODI (www.odi.org/en/publications/sex-health-and-rights-in-displacement-and-humanitarian-response-crises-upon-crises-in-Lebanon-and-beyond).

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Graphic: Jessica Rennoldson/HPG

Acknowledgements

The authors would like to thank Tam Feters (Ipas), Charbel Maydaa (MOSAIC), Sanni Bundgaard (International Rescue Committee) and Fouad M. Fouad (American University Beirut), Oliver Lough and Wendy Fenton for their expert feedback on earlier drafts of this paper. This paper would also not exist without very capable support from Marika de Faramond, Sara Hussain, Jessica Rennoldson and Kate Oliver. We are also grateful to Emma Jones, Anna Panagiotou, Rhiannon Davies and Eleanor Snowden (The Cynefin Company) and Susan Bartels (Queen's University, Canada) for their indispensable support in research design and analysis. The project steering group, whose members are too numerous to name, provided helpful input at every stage.

Our greatest thanks go to the anonymous participants in our survey who entrusted us with their own very personal experiences in the hopes of improving services and treatment for all.

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Acronyms

AAAQ	Availability, Accessibility, Acceptability, Quality
Covid-19	Coronavirus disease caused by the SARS-CoV-2 virus
GBV	gender-based violence
HPG	Humanitarian Policy Group
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
HIV	human immunodeficiency virus
IUD	intrauterine device
LGBTQIA+	lesbian, gay, bisexual, trans, queer/questioning, intersex and asexual plus
MoPH	Ministry of Public Health (Lebanon)
MoSA	Ministry of Social Affairs (Lebanon)
MSF	Médecins Sans Frontières
NGO	non-governmental organisation
NSSF	National Social Security Fund (Lebanon)
PHC	primary health centre
PWHO	Palestinian Women's Humanitarian Organization
SDC	social development centre
SOGIESC	sexual orientation, gender identity/expression and sex characteristics
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
UN	United Nations
UNFPA	UN Population Fund
UNHCR	UN Refugee Agency
UNOCHA	UN Office for the Coordination of Humanitarian Assistance
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East

Executive summary

Lebanon hosts the highest number of refugees per capita of any country in the world (UNHCR, 2023). Key among their pressing needs is services for sexual and reproductive health and rights (SRHR). These are often more acute at times of (and following) crisis when fertility rates tend to rise and gender-based violence (GBV) increases. There are also everyday, non-crisis-specific needs that must be addressed: contraception, testing and treatment for sexual and reproductive illnesses, comprehensive pregnancy care, menstrual health, education and information.

SRHR is often seen as lower priority than other areas of humanitarian response – for example, food and protection (Crago, 2019). Extant SRHR programming typically focuses on maternal health and interventions related to GBV for heterosexual, cisgender women of reproductive age (Heidari et al., 2019: 344). In so doing, it fails to address the breadth of SRHR needs and does little to recognise the differing experiences and needs of marginalised groups, including those with diverse sexual orientations, gender identities/expressions and sex characteristics (SOGIESC), people with disabilities, older people or sex workers.

Therefore, this project – using Lebanon as a case study – sets out to provide evidence of unmet needs for SRHR services in protracted crisis settings and their impacts, addressing persistent misconceptions about the criticality and need for such services.

This project has entailed primary research with crisis-affected populations in Lebanon carried out via a collaborative partnership between the Humanitarian Policy Group (HPG), the Palestinian Women’s Humanitarian Organization (PWHO) and academic researchers from Lebanese American University’s Institute for Migration Studies. This was a mixed qualitative/quantitative study using non-probability sampling to capture multifaceted, cross-sectoral data and engage in participatory analysis with respondents.

Lebanon’s compounding crises complicate SRHR provision

Lebanon is facing ongoing economic and political crises, amid waves of displacement and increasingly stark structural inequalities. The country’s crisis-affected population includes approximately 2 million Syrian and Palestinian refugees, as well as migrants from other settings and other marginalised groups, including Lebanese people affected by poverty and the 2020 explosion in Beirut’s port. Due to structural barriers excluding them from Lebanon’s social infrastructure, refugees and vulnerable Lebanese people must rely on local and international humanitarian organisations and United Nations (UN) agencies for services, including healthcare.

The two main operational UN agencies in Lebanon are the UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and the UN Refugee Agency (UNHCR). UNRWA has a humanitarian and development mandate, specifically to Palestinian refugees, whereas UNHCR has a humanitarian

mandate to provide protection to refugees. Both UNRWA and UNHCR struggle with limited funding pots and strained operational freedom, much of which has been imposed on them by donor governments. This strained and overlapping architecture has resulted in the shrinking of programming in many cases, as well as an inability to cater to emerging needs, including in primary and secondary healthcare.

Multiple institutional barriers to SRHR access create gaps in coverage, inclusivity and health outcomes

Refugees in Lebanon are limited in their entitlement to particular types and modes of care due to their precarious legal status. This was exacerbated in 2015 when the government effectively halted Syrian refugees' ability to register and gain residence permits.

UNHCR and UNRWA lead a bifurcated, complicated response, creating confusion for those seeking humanitarian assistance. SRHR services are limited, raising cost barriers and delays even for urgent needs. Such a system is also arguably unprincipled, as it offers different levels of care according to legal status and nationality rather than need. This confusion is still more significant for those within binational families or marriages, who may be turned away from both existing architectures.

In terms of accessing information regarding health, 55% of respondents favoured doctors and medical experts as the preferred sources of trusted information on their SRHR needs. However, in practice they tended to use more informal channels rather than formal medical settings, which points to barriers in accessing inclusive and helpful information through medical channels.

Social and cultural barriers to SRHR care impact marginalised groups the hardest

Participants consistently cited three intertwined layers of stigma: contextual sensitivities around sex and intimacy; discrimination against marginalised groups; and racism against displaced groups.

Social norms around sex and intimacy restrict the ability of people to speak openly about SRHR concerns, even to medical professionals, in Lebanon's crisis-affected communities. As a result, little value is given to discussing or understanding routine SRHR healthcare, and respondents reported feelings of 'suffering' because of the lack of information about their sexual health. Medical professionals are also affected by such norms and may avoid discussing certain topics with patients, or may refuse patient requests. Aspects of privacy, confidentiality, safe spaces and non-judgemental care are all detrimentally affected when providers lack appropriate training, information and sensitisation on SRHR.

Respondents experienced discrimination by the host population and in particular by healthcare providers on the basis of diverse and intersecting forms of marginalisation, including their gender or gender identity, their sexuality, their racialisation or ethnicity, or their disability.

Groups living with multiple forms of marginalisation are often unseen or even erased due to the normative categories used. For example, lesbian women are often forgotten in programming that targets women and people with diverse SOGIESC alike. If someone is perceived to be, or can pass as, heterosexual or cisgender, they can more easily access care, and of a better quality. People with negative experiences when receiving healthcare were more likely to feel that perceptions guided their experience of healthcare more than any efforts at equal or need-based treatment.

Racism, xenophobia and anti-refugee sentiment all impacted access to inclusive and comprehensive SRHR. Palestinians and Syrians were more likely (compared with Lebanese respondents) to cite changes in people as the single factor that would improve SRHR services, highlighting the prevalence of negative attitudes towards refugees among providers. Racism can be seen in relation to fertility, which has long been considered a ‘problem’ to be managed in humanitarian settings, based on assumptions that ‘crisis-affected people should not, or could not, possibly want to have (more) children’ (Daigle and Spencer, 2022: 6).

There are ways to improve SRHR provision for crisis-affected people

Broadly, participants report turning to services and referral pathways provided by humanitarian actors when they had already encountered barriers in other settings. Notably, when asked about the visibility of humanitarian response, Palestinians rated it as more visible than Lebanese or Syrian respondents, likely stemming from UNRWA’s provision of primary care for them. Over half of respondents (52%) who reported visiting humanitarian agencies for healthcare describe their experience as negative or very negative. However, those with negative experiences also tended to find humanitarian agencies less visible, while those with positive experiences found them more visible. This correlation indicates an important role for humanitarian agencies in relation to expanding access, even as it also shows the improvements needed to humanitarian services and referral pathways.

Many of the positive experiences reported were marked by empathy and non-judgement on the part of service providers. Narratives classed as positive by participants also reveal that many of these experiences involved accessing care via non-governmental organisations (NGOs) that specialised in SRHR service provision and operated through an explicit lens of reproductive justice, although they often lack the capacity and resources to provide services at scale.

Both formal and informal advocacy emerged as key facilitators in opening up pathways to services and referrals to welcoming providers. Informal advocacy harnesses the role of communities, social circles and informal networks in facilitating access to care and helping individuals to navigate complex pathways.

Implications for crisis-affected people

Respondents see a clear role for humanitarian actors in the delivery of SRHR services.

The emotional and psychosocial dimensions of SRHR care and their effects on wider wellbeing feature more strongly in negative experiences than they do in positive ones. Recent research suggests that integrating SRHR services and referral pathways into other services, including GBV prevention/mitigation or mental health, that emphasise a more holistic notion of wellbeing could increase uptake of all the services involved. Respondents felt a limited sense of agency in relation to their SRHR, which is critical for a sense of wider wellbeing.

Gaps in SRHR can lead to exposure to harms and protection risks, including violations of bodily autonomy and obstetric violence. While SRHR has not been conventionally understood as a protection concern in humanitarian circles, it should be, and further research is needed to examine it as such. Using a protection lens highlights why it is so problematic to adopt a narrow, ‘needs-based’ approach that treats SRHR as a question of health alone, ignoring the ‘rights’ component of SRHR.

There is a strong potential role for peers, families, communities and other networks in improving access to and even delivering SRHR. Such de-medicalised modes of delivery make SRHR more accessible, more dignified and resistant to the pathologisation of normal bodies, sexualities and reproduction that can come with treatment in formal medical spaces (Assis and Larrea, 2020). There is a clear need for more evidence and contextualised national guidelines around the SRHR self-care initiatives that are patient-led, accessible and create demand, especially amid limited resources. At the community level, there is already a significant role played by place-based, grassroots organisations serving marginalised groups in crisis settings.

This also relates to gaining information on SRHR: respondents preferred seeking information from professionals, but given the obstacles outlined, they were actually approaching peer support networks (friends, family members, spouses and informal community groups) instead. **There are clear gaps in the quality and quantity of information available to people trying to access SRHR care, especially for those with negative experiences of SRHR access, among whom marginalised groups are heavily represented.**

The resonance of these findings in settings beyond Lebanon is clear, as more and more evidence emerges of unmet needs and serious harms related to gaps and failures in SRHR in places like Ukraine (Center for Reproductive Rights et al., 2023). Going forward, additional research is needed to better understand and account for the complexity of SRHR needs and gaps in provision. There is also space for replication of this study in additional crisis settings to further evidence unmet needs and establish the context-specific dimensions of SRHR needs and challenges.

1 Introduction

Lebanon hosts the highest number of refugees per capita of any country in the world (UNHCR, 2023), with a diverse and growing population of crisis-affected people caught between reluctant and struggling state institutions and an overstretched humanitarian response. Key among their pressing needs is services to meet their needs in SRHR.¹ Fertility rates tend to rise during and after crises of all kinds, due in large part to gaps in services and unmet needs that can prove life-threatening, as well as to increases in various types of GBV including early marriage, intimate partner violence and crisis-related sexual violence, all of which have been observed among Syrian refugees, who form the largest displaced population in Lebanon (Bartels et al., 2016; Balinska et al., 2019; Amiri et al., 2020; Abdel Khalik and Naji, 2021; Al Akash and Chalmiers, 2021: 297). Homophobia and transphobia, and other harms that result in critical SRHR needs, also tend to rise in crisis settings (Myrntinen and Daigle, 2017).

These concerns sit alongside ordinary, everyday needs for things like contraception, testing and treatment for sexual and reproductive illnesses, pregnancy care, safe abortion care, and education and information – needs that do not simply go away during a crisis. In 2015, for example, the United Nations Population Fund (UNFPA) estimated that – both inside Syria and in displacement – nearly half a million Syrian women were pregnant and that 70,000 would give birth in unsafe circumstances without further assistance (UNFPA, 2015). They also experience barriers relating to restrictions on their autonomy, mobility and distance, access to information and cost (Amiri et al., 2020: 17).

Against that backdrop, gaps in SRHR should be understood not only as a signal of critical but unmet needs, but also as protection concerns and lessons for wider humanitarian response and coordination across thematic silos. Nonetheless, health in general – and SRHR in particular – is all too often deprioritised by humanitarians in favour of food, protection and other areas that are deemed more ‘critical’ to response (Crago, 2019). Most policy and programmatic efforts are tailored narrowly towards maternal health and GBV-related interventions for heterosexual, cisgender women of reproductive age (Heidari et al., 2019: 344). Little research has examined the needs of, opportunities for or challenges facing marginalised groups, including those with diverse sexual orientations, gender identities/expressions and sex characteristics (SOGIESC), people with disabilities, older people or sex workers. In particular, there has been extremely limited research on contraception, particularly emergency and long-acting contraception; abortion, in both legally restrictive and permissive settings; or providing information on or a conducive environment for healthy sexualities, relationships and consent, particularly for young adolescents,² people with diverse SOGIESC, people with disabilities and Indigenous women (Chynoweth, 2015; DeJong et al., 2017; Women Deliver, 2020; Rich and Jacobi, 2021).

1 In this paper, we use ‘SRHR’ to refer to the provision of sexual and reproductive health services, as well as the related sexual and reproductive rights, as a holistic agenda in humanitarian response. We prefer ‘SRHR’ to ‘SRH’ precisely because it emphasises the centrality of rights rather than health alone, but when citing published research, we use whichever terminology appears in the original.

2 DeJong et al. (2017: 23) note that young adolescents (10–14 years) have been largely overlooked despite being ‘dramatically’ affected by displacement to Lebanon.

In long-term crises, the increasing risks of pregnancy complications, sexually transmitted infections (STIs) and GBV, combined with a lack of appropriate and accessible care and the disruption of families, networks and communities, mean that the ability to live a healthy sexuality and exercise bodily autonomy are more important than ever. Uptake of SRHR services is also troublingly low in many crisis settings, hindered by reproductive health's positioning as a lightning rod for cultural, religious and political sensitivities, which then engenders negative attitudes among health providers, agencies and donors (Chynoweth, 2015: 10–12; Cherri et al., 2017). Importantly, very little work has been done to situate SRHR as a matter of protection and rights, consent, bodily autonomy, agency or reproductive justice in humanitarian crisis and response (Women Deliver, 2020: 11; UNFPA, 2021; Daigle and Spencer, 2022).

The Sphere Standards currently integrate the priority activities laid out in the Minimum Initial Service Package (MISP), which is a set of coordinated priority activities designed to mitigate adverse outcomes in SRHR in acute crises, most recently updated in 2018 and detailed in the *Inter-Agency Field Manual on Reproductive Health* (IAWG, 2018).³ This, however, includes little on assessing or confronting the multiple and overlapping structural barriers to accessing SRHR, its place within a wider notion of wellbeing in crises, or on understanding the experiences of particular groups of people in attempting to found relationships and families, access SRHR services, and exercise their rights. At the same time, the humanitarian focus on 'immediate needs' in the wake of crisis has tended to result in a narrow approach to gender – that is, one focused largely on protection, and especially on responding to and/or preventing GBV (Daigle, 2022).

Sexuality, sexual health and sexual wellbeing therefore form a point of intersection between critical needs, not just for health but educational, legal and social services on one hand, and social or cultural needs for belonging, security, affection, leisure and family on the other hand – needs which do not diminish and may even increase in crisis settings (Lough et al., 2023).

1.1 Overview of project

This project sets out to provide evidence of unmet needs for SRHR services in protracted crisis settings and their impacts, addressing persistent misconceptions about the criticality and need for such services, with Lebanon as an illustrative case study. The research establishes both the scope and scale of health-related needs, as well as access barriers encountered by diverse crisis-affected people, demonstrating first that the current approach is inadequate, and second that the existence of services is not itself sufficient to ensure access amid complex social, economic, institutional and other barriers.

Building on an initial paper positing reproductive justice as a conceptual framework for SRHR in humanitarian response (Daigle and Spencer, 2022), this project has entailed primary research with crisis-affected populations in Lebanon carried out via a collaborative partnership between the Humanitarian Policy Group (HPG), the Palestinian Women's Humanitarian Organization (PWHO) and academic

³ While previous iterations of the Sphere Standards have explicitly committed to the MISP, the 2018 version does not, possibly due to the politics around this most recent revision.

researchers from Lebanese American University's Institute for Migration Studies. PWHO is a grassroots non-governmental organisation (NGO) with a strong track record of working to meet humanitarian needs in health, protection, education, shelter and livelihoods with a variety of funders and partners.

The study examines how people living in protracted crisis settings understand and pursue healthy sexualities and relationships through the lens of SRHR, including enablers and barriers that shape their experiences, with a particular focus on marginalised groups – women and girls, people with diverse SOGIESC, women and girls with disabilities, and youth. The findings of the research were then used to explore how humanitarian response can better support gender-responsive and -inclusive SRHR and wellbeing in crisis settings, with recommendations for international humanitarian agencies and national-level actors in Lebanon.

Lebanon was selected as an illustrative case due to the protracted and complex nature of crisis response there, and also as an example of a middle-income setting where existing healthcare infrastructure is understood to be comparatively strong (Abdel Khalik and Naji, 2021). As discussed in Chapter 2 below, however, this status is complicated by the country's ongoing political and economic crisis, outbound migration affecting the healthcare system, and growing dependence on international humanitarian funding for health service delivery, making the ramifications for humanitarian response all the more timely and relevant.

1.2 Research design, methodology and sampling

The research team carried out a collaborative design process, developing shared objectives, research questions and data collection tools. This was a mixed qualitative/quantitative study using non-probability sampling to capture multifaceted, cross-sectoral data and engage in interactive analysis with participants. Participants were recruited through the existing service user groups managed by PWHO and MOSAIC, a rights-focused organisation serving people with diverse SOGIESC in Lebanon, as this was deemed by the research team to be the best way to build trust into the process so that participants felt comfortable and protected in speaking about sensitive topics. It also helped ensure that participants had access to follow-on support to meet their immediate needs for SRHR services, other humanitarian assistance or psychosocial support as required, all of which was offered in the process.

Using the SenseMaker® software produced by Cynefin Company (formerly Cognitive Edge) on tablets, participants were invited to share a personal experience or story of their choosing that related to their efforts to access SRHR services and the obstacles they face. Respondents then participated in interpreting, analysing and assigning meaning by responding to prompts that situate their story in relation to a variety of concerns, actors and structures, allowing researchers to draw out continuities and divergences across the pool of stories (see Box 1).

The methodology was anonymous, open-ended and participant-led, to centre participants' privacy and allow them to articulate their own priorities and perspectives on health, wellbeing, bodily autonomy, fertility, sex and relationships. Rather than pre-determining definitions or priorities, the project

aimed to begin from respondents' own contextual and cultural frameworks, leaving ample space for sensitivities and diversity across geographical settings, political and cultural contexts, demographics and experiences of marginalisation. The majority of participants completed the survey in person with a researcher on hand to assist with using the platform for all in-person data collection (173 participants), while a smaller number completed it independently using their own devices (99 participants).

Data collection took place between January and April 2023 in Akkar, Beirut, Bourj al-Barajneh, Shatila and Tripoli. In total, 272 stories were collected, encompassing a diversity of genders and gender identities, sexual orientations, ages and nationalities (see Figure 2). The vast majority completed their surveys in Arabic, which were then translated and validated by the research team. Throughout this paper, when stories are directly referenced, people are identified using the categorisations they chose for themselves in terms of their gender, nationality, sexual orientation and displacement status.

Box 1 Understanding triads

Triads are a unique SenseMaker® analysis tool that allow respondents to add meaning to the stories they share. In each triad, respondents assess the influence and importance of three interrelated factors – mapped onto a triangle – with regard to their narrative (Figure 1).

For example, participants could be asked to categorise how they spent their time yesterday, placing their response ('stone') on a triad with points labelled 'sleeping', 'leisure' and 'working' in the location that best represents their experience. Most participants would likely indicate a combination of all three elements, tending towards whichever type of activity occupied more of their time. Extremes are also possible; for example, if someone spent the entire previous day sleeping, then they would place their stone closest to that point.

Figure 1 Example of a triad: how respondents spent their time

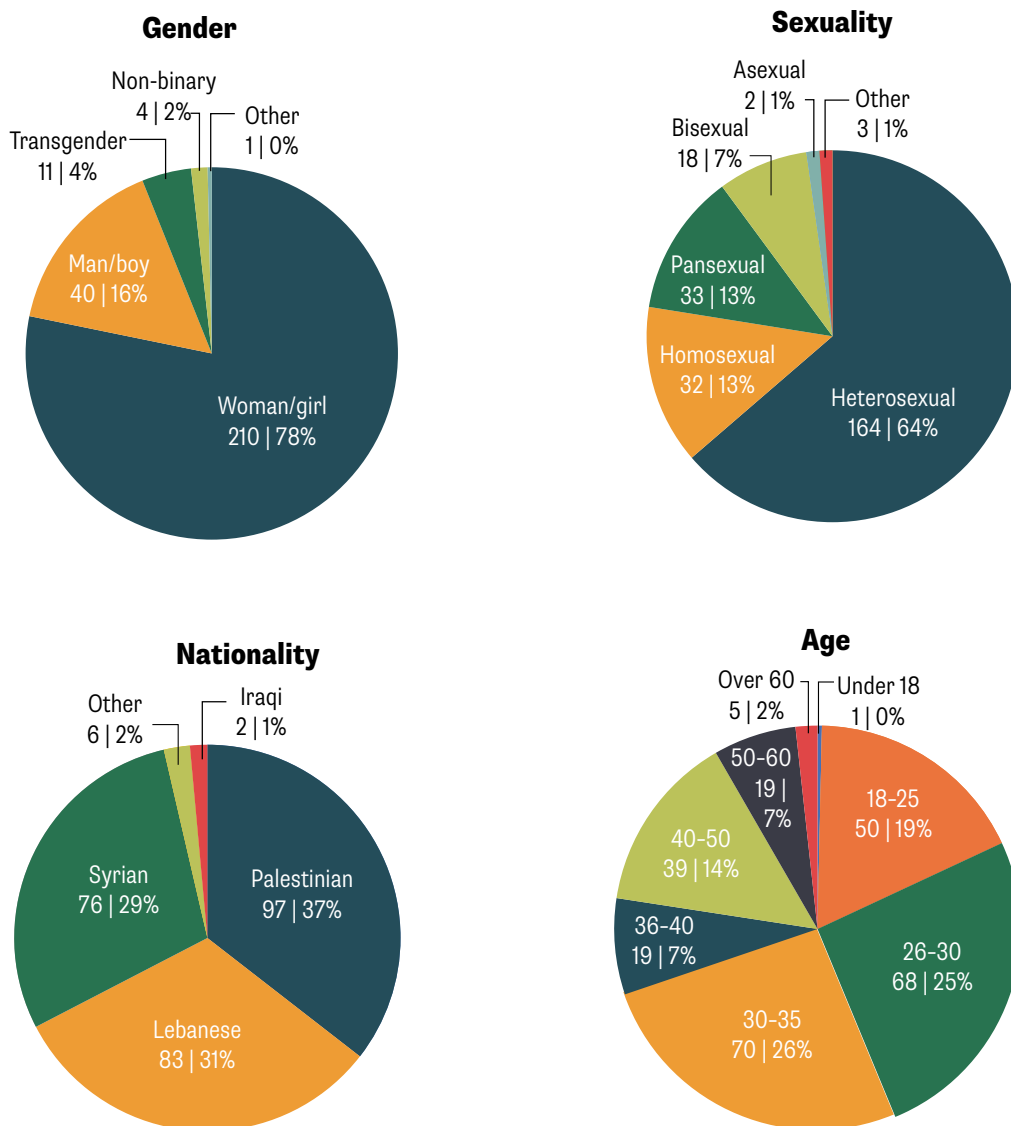
Similarly, **dyads** ask participants to position their response on a sliding scale between two points. For example, participants could be asked whether the amount of information provided to them in a given situation was sufficient, placing their response on a scale extending from ‘not enough’ to ‘excessive and overwhelming’.

In all cases, the options are intended to be value-neutral so as to avoid influencing the potential range of responses.

Additionally, this paper uses both percentages and absolute values to describe the survey results, where possible. The data collected from the triads are reported in percentages only, due to the way in which they are presented in the SenseMaker® software. To present these figures in absolute values would bring in inaccuracies due to (carried-through) rounding errors.

Source: Cynefin Company, 2019

Figure 2 Demographic data on study participants



Note: Some of the age categories overlap e.g. ‘26-30’ and ‘30-35’, due to an error in the data collection survey. It is possible that 30-year-old respondents feature in both groups, for example.

1.3 Scope and limitations of research

Given that this research broaches topics that participants find sensitive for cultural, religious and political reasons, the findings are based on what they felt comfortable sharing and thus may not necessarily or entirely represent their actual realities. This, along with the use of non-probability sampling, means that findings are indicative rather than statistically representative of the population group. Nonetheless, the research team is confident that the quantitative trends observed are clear enough to support the conclusions drawn and backed up by the qualitative data achieved in the survey, as well as by secondary literature and inputs from peer review.

Like all research of this kind, the findings presented here are also necessarily a snapshot of social relations at a given moment in time. The worsening economic crisis in Lebanon means that access to services for all of the groups surveyed can only have waned further. Moreover, Lebanese authorities have recently begun to summarily detain and deport Syrians, using raids and checkpoints in Syrian communities, and exposing them to risks of detention, conscription and other harms on their return to Syria (Amnesty International, 2023; HRW, 2023a; Sewell and Chehayeb, 2023). This means that the barriers facing Syrians in particular in attending medical appointments and services for SRHR care have increased (MSF, 2023), alongside a significant deterioration in their wider safety, stability and wellbeing in Lebanon, since the completion of the data collection for this project.

See Chapter 2 for more on these issues as they affect the target populations for this research.

2 Multiple and overlapping crises in Lebanon

Lebanon is confronting evolving and multifaceted crises that are only serving to exacerbate structural vulnerabilities and cause backslide on issues of social inclusion and economic justice, especially for already marginalised groups. The country's economic struggles are proving disastrous for Lebanese people and converging with the ongoing Syrian displacement crisis and other structural inequalities. The massive explosion in Beirut's main port in August 2020 has only deepened the crisis facing Lebanese and migrant populations alike.

2.1 Waves of displacement

Lebanon hosts an estimated 1.5 million refugees fleeing Syria's civil war, which includes those unregistered with the UN Refugee Agency (UNHCR), as well as 479,000 Palestinian refugees, who have been displaced in multiple waves since the 1948 Palestine War⁴ (UNHCR, 2022a; UNRWA, 2023). Most Palestinians live in camps or gatherings.⁵ Lebanon additionally hosts around 50,000 Iraqi refugees and more than 12,000 refugees of other nationalities, such as Sudanese (Kidderbos and Finberg, 2007; UNHCR, 2022b). It is also home to 250,000 migrant domestic workers from African and Asian countries, whose experiences of legal marginalisation and frequent rights violations further demonstrate the blurred categories and experiences of exclusion that characterise migration in Lebanon.⁶

Presently, according to the European Commission, 80% of Lebanese live in poverty and 90% of Syrian refugees cannot cover their basic needs (European Commission, 2023). According to a 2022 UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) survey, 93% of Palestinian refugee households are poor (UNRWA, 2022). Prior to the economic crisis, the percentage of refugees living in poverty was certainly significant, but perceivably lower. For Syrian refugees who entered Lebanon in 2011, for instance, and who lived in the country between 2011 and 2018, the poverty rate was 60–70%

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- 4 The 1948 Palestine War was fought in the territory of what had been British-ruled Mandatory Palestine. In Israel, this war is known as the War of Independence, while in the Occupied Palestinian Territories and elsewhere in the region, it is known as a core element of the Nakba – the mass displacement and dispossession of Palestinians – and the first war of the Israeli–Palestinian conflict.
 - 5 Gatherings refer to the settlements created by Palestinian refugees who fled formal camps during periods of war and conflict. Examples include Jal al Baher, al Meya w Meya or Sabra. People chose to remain in these settlements rather than return to camps following the conflict.
 - 6 The recruitment of a migrant domestic worker in Lebanon is carried out under the Kafala system, a sponsorship system that ultimately grants private citizens and companies almost complete control over migrant domestic workers' employment, immigration status and their access to services. The ambiguity of the Kafala system in Lebanon has resulted in migrant domestic workers enduring legal challenges and violations to their basic human rights (see Brochmann, 1993; Amnesty International, 2019).

(UN News, 2015). The proportion of Palestinian refugees living in poverty prior to the crisis additionally stood at 65%, according to a 2015 UNRWA and American University of Beirut (AUB) survey (Suleiman, 2020).

Very little research has broached the experiences and needs of marginalised groups in the context of these waves of displacement, but what research does exist shows compounding discriminations that transcend crises themselves, stemming from pre-existing stigma and marginalisation that are exacerbated by displacement, conflict and socioeconomic instability. For example, displaced people with diverse SOGIESC struggle to access housing and face homo-, bi- and transphobic harassment and violence in Lebanon, and may even confront discrimination within Lebanon's diverse SOGIESC community (Myrntinen and Daigle, 2017; Maydaa et al., 2020).

2.2 Economic and political crisis in Lebanon

Lebanon continues to grapple with what the World Bank has deemed one of the worst socioeconomic crises since the mid-nineteenth century (World Bank, 2021). At the time of writing, the country also remains at the centre of a political vacuum since October 2022, unable to elect a president and to shift beyond a caretaker government (Harb, 2022). Amid this intersectional and layered crisis, Lebanon's population (host, migrants and refugees) continue to struggle to meet their basic needs, secure their livelihoods, and obtain access to basic health and social services. Moreover, competition over scarce resources and employment opportunities remains an ongoing challenge, and public institutions and services – primarily in the areas of health and protection – continue to deteriorate.

The explosion in Beirut's port in August 2020, at a time when the aforementioned crises had already taken root, led to a more immediate emergency (BBC, 2020). More than 300,000 people were made homeless, over 6,500 people were injured and 220 lost their lives as a result, with fatalities continuing to rise in the succeeding year from injuries sustained during the blast (ibid.). To date, justice and accountability for the explosion have yet to be achieved, with little or no compensation for the loss of loved ones, livelihoods, and people affected by physical and psychological injuries (Fakih, 2021). The explosion, coupled with the largely 'mismanaged' Covid-19 pandemic response,⁷ has placed unimaginable strains on the country's already ill-equipped medical and healthcare resources (Bizri et al., 2021).

2.3 Lebanese state institutions and health systems

Lebanon remains a non-signatory state to the 1951 Refugee Convention and its 1967 Protocol, and it continues to resort to ad hoc agreements with UNHCR for its operations in the country amid different

⁷ The Lebanese government has been widely criticised for failing to enact a cohesive and inclusive strategy for the containment of Covid-19 and the roll-out of vaccinations, resulting in a fragmented and contradictory approach and leading to a high death toll (El Murr, 2021).

refugee influxes (Janmyr, 2017). The Lebanese Labour Law also continues to exclude refugees and vulnerable migrant categories from formal employment, a matter that has made their access to basic services and their survival in the country a constant struggle.

This strategic indifference on the part of the Lebanese government, as well as its isolation of these groups from broader forms of protection, has rendered these refugee and migrant groups dependent on local and international humanitarian organisations and UN agencies. Where refugees and migrants are included in government responses, this is largely externally funded by other governments, international NGOs or UN agencies, given that a unified government framework and policy remain absent from this space. The humanitarian sector in Lebanon has thus carried the brunt of responding to crisis-affected individuals, whether they be refugees, migrants or the host community. These gaps in coverage were exacerbated by the onset of Lebanon's economic crisis, and even more so by the Beirut blast.

The aforementioned intersectional and layered crises have given rise to a health sector split across the mainstream health system (run by and for Lebanese residents) and the humanitarian health response system, which has evolved in a patchwork way, primarily to serve the needs of multiple waves of refugees (Fouad et al., 2022). This has yielded an institutional divide between development and humanitarian priorities at the national level, and more specifically a persistent policy of strategic indifference when it comes to healthcare provision – ultimately, one of designating responsibility for refugee needs primarily to humanitarian actors (ibid.). Lebanon's deteriorating economic situation has placed unprecedented pressure on the country's public primary healthcare centres (PHCs) as Lebanese citizens continue to resort to them amid increased costs of private healthcare (WHO, 2022a).

The country's Ministry of Public Health (MoPH) has longstanding challenges ranging from shortages in technical support, human resources, regulatory and oversight functions, third-party financing, and direct service delivery (Gjertsson, 2021). Its ability to harmonise the sector is undermined by unclear mandates and responsibilities across different ministries. For instance, the Ministry of Social Affairs (MoSA) operates its own social development centres (SDCs), and NGOs and humanitarian actors have been known to coordinate with MoSA at this level rather than with MoPH – particularly when it comes to health support for vulnerable refugees and displaced groups (ibid.).

Healthcare services across the country are dominated by the private sector on the one hand. It is estimated that the private sector accounts for 85% of the healthcare system in Lebanon, which limits healthcare to those who can pay (Sullivan, 2022; Fouad et al., 2022). On the other hand, there are the humanitarian organisations that are combatting this reality (Mezher, 2023). The humanitarian health response system is not without its challenges, largely because it has evolved in a very ad hoc manner in response to the succession of crises impacting Lebanon across the years. There are persistent challenges to coordination, as the duplication of services, over-servicing certain areas and groups, and a lack of a centralised approach continue to build a fragmented response (see Section 3.2 below). Shifts in donor priorities and the emergence of new crises also impact humanitarian organisations' and UN agencies' funding and ability to serve the most vulnerable factions of the community.

The financing system for health in Lebanon has taken a major hit: as a result of the impact of the economic crisis on the healthcare system writ large, in early 2022 it was reported as being on the ‘brink of collapse’ (Azhari et al., 2022). Medical professionals emigrated, private hospitals closed departments, public health centres faced increased need, and the MoPH’s budget has shrunk from \$300 million to just \$20 million, due to the depreciation of the Lebanese currency by more than 90%.

Out-of-pocket payments have come to constitute a major funding source (Mezher, 2023). Around 42% of the Lebanese population do not have health coverage, and have relied heavily on services funded by the MoPH despite the deterioration in their quality (Soubra et al., 2021; Fleifel and Abi Farraj, 2022). Refugee and migrant groups have also become increasingly reliant on out-of-pocket spending, particularly for specialised secondary and tertiary care. For refugees and migrants, service provision varies depending on nationality. Despite the fact that an informal service-provider system has evolved to respond to growing needs of Syrian refugees in particular, there remain major concerns around the quality of SRHR services provided, discrimination within this space, and the overall lack of supervision at the level of PHCs and SDCs.

Taken together, these factors have contributed to a description of Lebanon’s health system as exclusionary and discriminatory, one that lacks an inclusive and intersectional approach which would cater to the community in all its diversity. This has proven particularly problematic for refugees; individuals from the lesbian, gay, bisexual, trans, queer/questioning, intersex and asexual plus (LGBTQIA+) community; young women; older people; and people with disabilities (Fouad et al., 2022).

2.4 International humanitarian response

The humanitarian provision and coordination of the response add an additional layer of complication for refugees in trying to access SRHR care. The humanitarian architecture in Lebanon recognises the specific mandates of both UNRWA and UNHCR. UNRWA has both a humanitarian and development mandate to provide assistance and protection to refugees from Palestine, and thus supports the Palestinian community in Lebanon and acts as their primary healthcare provider. UNHCR, on the other hand, holds a humanitarian mandate to provide protection to refugees (except those supported by UNRWA in its fields of operation, which includes Lebanon) and so supports the refugee population originating from Syria, Iraq, Sudan and other countries.

Both UNRWA and UNHCR struggle with limited funding pots and strained operational freedom, much of which have been imposed on them by donor governments. This has resulted in the shrinking of programming in many cases, as well as an inability to cater to emerging needs. For UNRWA, an important blow to its operations began in 2011, with the influx of Palestinian refugees from Syria (for which the UN agency requested an additional \$277 million), as well as the termination of United States (US) funding under the Trump administration (Beaumont and Holmes, 2018; UNRWA, 2018). Throughout the years, UNHCR has also warned against budget cuts, insisting that they would threaten humanitarian support for Syrian refugees in Lebanon (UNHCR, 2017). Emerging refugee crises have additionally strained the UN

agency's resources – particularly the refugee crisis in Ukraine, as well as Sudan more recently – reflecting a wider pattern in the humanitarian sector: 2022 saw the largest humanitarian funding gap ever with unmet requirements totalling \$22.1 billion (Development Initiatives, 2023).

Along with funding struggles, a notable lack of coordination among different international agencies and architectures has created parallel healthcare systems (alongside the Lebanese health sector) that service other populations. These parallel systems retain an international humanitarian focus on the 'basic needs' of crisis-affected people, even as Lebanon's crisis setting stretches into decades and even generations, prioritising short-term planning and interventions.

Thus, as we will discuss below in Section 3.2, while SRHR has been designated as a priority in Lebanon by the Global Protection Cluster's GBV Area of Responsibility (GBV AoR, 2023), significant challenges plague the response's ability to provide accessible, sustainable and comprehensive services in terms of both financing and coordination.

2.5 Legal environment for SRHR

While there remain communities and regions within the country that are characterised by cultural and religious conservatism, Lebanon has also frequently been painted as comparatively socially progressive compared to other countries in the region. That said, people in Lebanon still face legal challenges when trying to access SRHR care, in particular abortion. Lebanon's penal code (articles 539–546) has banned abortion since 1943. Presidential Decree no. 13187 in 1969 established an exception in order to save a pregnant person's life, which requires the consent of the attending physician and two others (UNDP et al., 2018). There have been no attempts to expand circumstances for access since then (Fathallah, 2019). Participants in this research noted that abortion services remain available through a variety of channels – including private-sector clinics and irregular or illicit providers – to those who can afford to pay, especially in more metropolitan areas of the country. This assertion is confirmed by the (admittedly limited) existing research. ⁸ Fathallah (2019: 22) writes that 'Lebanon's criminalization of abortion is not an insurmountable obstacle for women who want to safely terminate their pregnancy under medical supervision'. The upfront cost of an illicit abortion is around \$500, and the penalty for those prosecuted for illicit abortion (both patient and medical professionals) is six months to three years in prison. Both medical and surgical abortions are more difficult to access outside cities, especially in more conservative rural/remote areas like the Bekaa Valley, where an estimated one-third of Syrian refugees lived as of 2022 (Bouscaren, 2022). Criminalisation puts the burden not only on patients, but also on health workers who might otherwise be supportive, forcing them to refuse services to patients in need or to forge records (Arawi and Nassar, 2011).

The operational environment for humanitarian SRHR provision in Lebanon is therefore complex, with overlapping institutional architectures and cultural, social and legal restrictions that must be

⁸ In the past, the availability of clandestine abortion had made Lebanon a destination for abortion travel (Williams, 2014).

navigated. Globally, SRHR in crises also sits within a precarious political and economic landscape where underfunding is ‘pervasive’ (Tanyag, 2018: 655), but – due to SRHR often being subsumed under headings of gender, protection or health rather than recorded independently – Countdown 2030 (2020: 3) notes that ‘there is neither reliable nor consistent knowledge on the extent of the funding gap’. The short-termism of humanitarian funding models and a lack of coordination with longer-term actors are detrimental to both the sufficiency and quality of available funding (see Tanyag, 2018; Daigle and Spencer, 2022).⁹ Nonetheless, as will be discussed in Chapter 3, it is also clear that humanitarians are already playing (and will continue to play) a pivotal role in shoring up access to SRHR for crisis-affected people in Lebanon, whether through direct provision of services to crisis-affected groups or through referral pathways, information and funding.

9 Until recently, a large proportion of funding for SRHR across organisations had also been coming from a single anonymous private philanthropic foundation, which had brought about a sea change and facilitated much of the progress of the last 30 years. This donor is no longer funding services in crisis settings, leaving a major vacuum.

3 Institutional and economic barriers to SRHR for crisis-affected people

This chapter explores the institutional barriers to access for crisis-affected people that are found along pathways for SRHR care, including primary care, referral pathways and specialist services. These barriers are legislative, economic, political and humanitarian system-related barriers, and they emerged from the experiences reported by participants in this research. This mapping of barriers highlights the persistent obstacles and gaps in provision within the humanitarian response and, in doing so, is suggestive of how a more equitable system might look.

3.1 Legal status of displaced people

The legal status of refugees in Lebanon significantly complicates access to comprehensive SRHR for those of Syrian or Palestinian nationality and other refugees, both in proscribing their entitlement to particular types and modes of care and in marking them as outsiders in cultural terms. Since 2015, the Lebanese government has restricted admission to the country to those who have valid identity documents and whose purpose in visiting appears on an approved list that does not include seeking refuge (UNHCR, n.d.a).¹⁰ This, combined with the cost of applying for residence permits and the need for sponsorship, means that legal residency rates are now reportedly at an all-time low, with just 17% of displaced Syrians, 49% of Palestinian refugees from Syria and 20% of refugees from other nationalities holding legal residency (UNOCHA, 2023). Also in 2015, the government of Lebanon halted the registration of refugees from Syria with UNHCR.

Without legal status, many Syrians are unable to move freely throughout the country, and have increased difficulty in accessing healthcare, attending appointments, receiving education or obtaining formal work. These problems have only increased since the granting of residency was effectively halted and registrations ceased in 2015. Lebanon has also begun sporadically deporting Syrians, with the most recent wave of such actions beginning in 2023.

The legal status of Palestinians in Lebanon depends primarily on their period of arrival. Those that arrived in 1948 and their descendants tend to hold the most rights, since they are registered with UNRWA and the Lebanese Directorate of Political Affairs and Refugees, which confirms their legal residency (Asylos, 2023). The legal status of those arriving in the 1960s or 1970s, sometimes with UNRWA registration from other countries in the region, is more precarious because they tend to lack registration with Lebanese authorities. Lastly, in 2013 the government imposed entry restrictions

¹⁰ To enter Lebanon legally, Syrians must have a Lebanese sponsor, own real estate in Lebanon, or intend to undertake tourism, business, study, transit, medical treatment, or visa application at a foreign embassy in Lebanon (Frangieh, 2015). Syrian youth may stay on the basis of their parents' residency in Lebanon but must seek their own permission to stay from the age of 15 (El Daoi, 2017).

on Palestinian refugees from Syria and their stay was conditional upon obtaining a residence permit. Those already registered with UNRWA in Syria have access to UNRWA schools, health clinics and other services (ibid.).

Overall, refugees in Lebanon face restrictions on their rights and this creates barriers for inclusive and comprehensive SRHR in at least two ways. Firstly, refugees are restricted from accessing certain government-funded healthcare facilities and so options for care are more limited. As one Syrian woman stated:

As a citizen, I would not only have more access, my whole life would be different. I would have health rights and health education. [Married, aged 26–30, refugee, heterosexual.]

Secondly, by restricting refugees' access to work (at least in the formal sector), people are unable to afford private healthcare options, which are getting more expensive in the current economic crisis:

We are not able to work to pay for our medical expenses, which are very expensive now, and UNHCR does not cover us like they should. [Syrian woman, aged 40–50, refugee, heterosexual.]

Citizens have more options at least [...] even if we had the money, as Syrians we would be discriminated against. It is clear that there is much less funding with the UN and NGOs, and also clear that SDCs run by governments are broke. [Unmarried Syrian man, aged 26–30, refugee, homosexual.]

Respondents indicated a prevailing sense of helplessness among the refugee population in particular, as they face significant barriers to care, let alone quality care, as a result of their legal status. As discussed in Section 4.2 below, this distinction based on nationality is also intertwined with racism, xenophobia and anti-refugee sentiment, which has been exacerbated by the perception of pressure on services and resources since the start of Lebanon's economic crisis.

3.2 Humanitarian provision and coordination

While the bifurcated response led by UNHCR and UNRWA (described in Section 2.4) may seem logical to those that designed it, in practice it creates confusion for those seeking humanitarian assistance who find it both opaque and discriminatory:

We are confused by UNRWA and UNHCR to this day. [Married Syrian woman, aged 50–60, refugee, heterosexual.]

NGOs only help you if you are the target of their programming. They don't care if it's an emergency. [Unmarried Palestinian woman, aged 30–35, double displaced, bisexual.]

Such a system is also arguably unprincipled, as it offers different levels of care according to legal status and nationality rather than need. This confusion is still more significant for those within binational families or marriages, who may be turned away from both architectures.

Resource constraints for humanitarian agencies were recognised by participants as exerting a downward pressure on their ability to access SRHR care, a reality that is only likely to worsen given UNRWA's deepening financial crisis (UN News, 2023). Affected people are already noticing competition among agencies over remaining resources:

We are isolated from access to all public services – especially in the areas of health. When we are permitted access, this is through the humanitarian organisations/NGOs and the UN. And even then, there is a huge competition over resources. [Married Syrian woman, aged 30–35, refugee, heterosexual.]

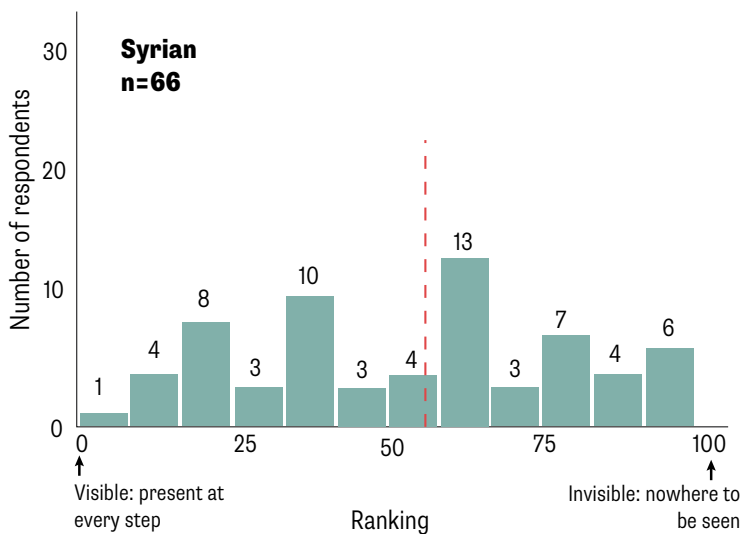
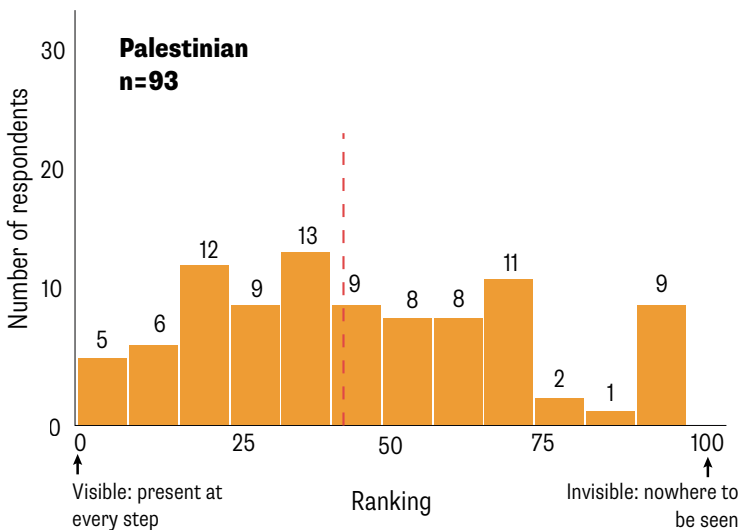
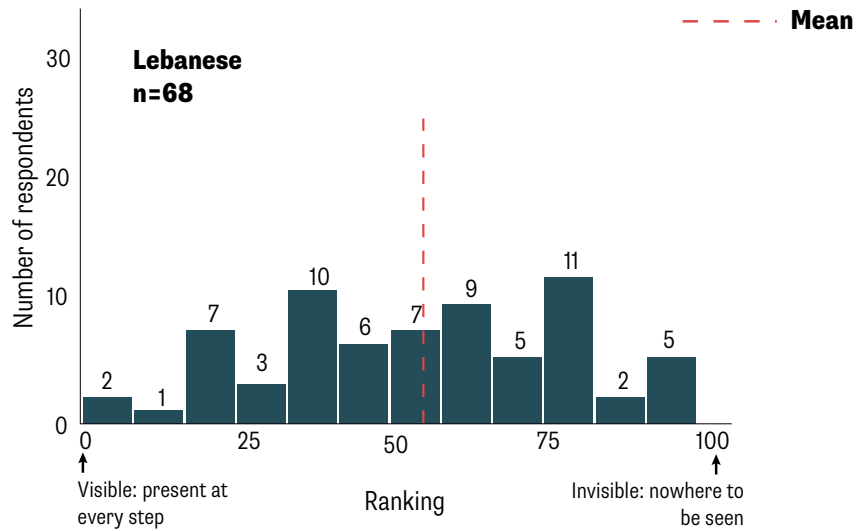
This point was also made in the quantitative data: when asked about the visibility of humanitarian agencies on a scale of 'visible: present at every step' to 'invisible: nowhere to be seen', respondents were fairly neutral. Notably, Palestinians rated the humanitarian response as more visible than Lebanese or Syrian respondents (see Figure 3), likely stemming from UNRWA's provision of primary care for them and the camp-based services that have been established (see Section 5.1).

Nonetheless, there is seemingly little faith in the formal humanitarian response to provide care for SRHR concerns – as well as little faith in the humanitarian response more broadly.

There is no system — the humanitarian sector does what it wants, the government does what it wants. It is a system where you fend for yourself. This is why the information you receive depends on where you are, social constraints, cultural barriers, etc. [Unmarried Syrian man, aged 26–30, refugee, homosexual.]

Figure 3 Visibility of humanitarian actors in SRHR provision, by nationality

Thinking of sexual and reproductive health and care, humanitarian agencies are...



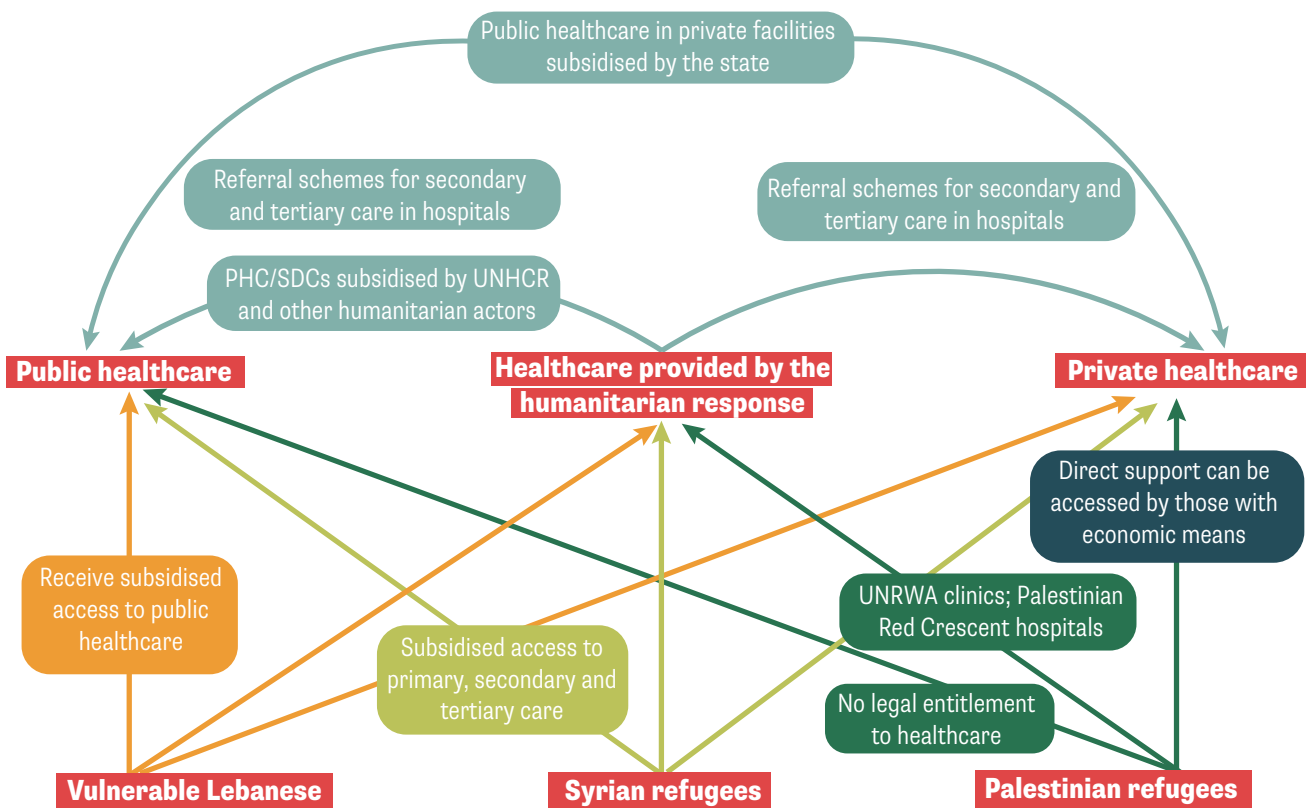
3.3 A blurred and under-resourced healthcare system

In general, and especially for those lacking the resources to pay upfront, accessing healthcare in Lebanon has been described as ‘subject to multiple layers of politics, economy, sectarian interests and political interests [...] [and] remains independent of any form of meritocratic or inclusive practices’ (Diab and Fouad, 2020). The economic situation in Lebanon has only degraded the opportunities for quality care for crisis-affected people. Understanding how these structural factors interplay with individuals’ experiences is critical to understanding the gravity and impact of the gaps through which entire communities of people can fall, and the subsequent impacts on health, wellbeing and quality of life.

Building on the discussion of Lebanon’s healthcare system in Section 2.3, the following section explores how participants have experienced and navigated healthcare spaces in the Lebanese context.

Figure 4 outlines the types of facilities available and who can access them. Uninsured Lebanese people, including those living below the poverty line and affected by overlapping domestic crises, can access primary care through PHCs but must pay fees for secondary and tertiary care.

Figure 4 Mapping of health facilities in Lebanon



Note: PHC, primary healthcare centre; SDC, social development centre; UNHCA, United Nations Refugee Agency; UNRWA, United Nations Relief and Works Agency for Palestine Refugees in the Near East

Refugees from Syria and elsewhere are entitled to access PHCs, where they can obtain a range of primary care services, including limited obstetric and paediatric services, as well as contraceptive care including intrauterine devices (IUDs) and contraceptive pills. However, many Syrian women report being unaware that they can get these items for free or at minimal cost, or they note shortages in availability and therefore resort to paying for them in private pharmacies (Cherri et al., 2017; Kabakian-Khasholian et al., 2017). Unregistered refugees only receive SRHR-related health services from UNHCR for antenatal and paediatric care, or through private Lebanese health facilities, paying fees similar to uninsured Lebanese citizens (Karaki et al., 2021).

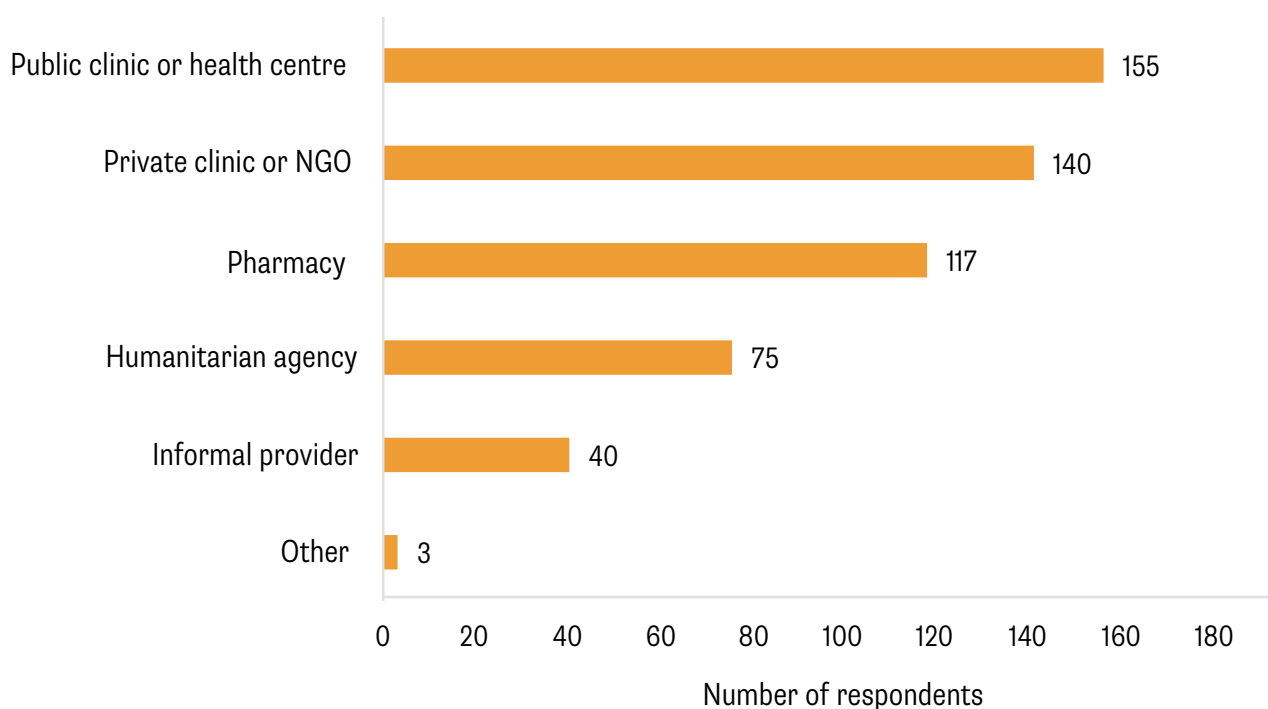
Secondary and tertiary care for Syrian and other refugees, regardless of whether they are registered with UNHCR, is managed through a network of public and private hospitals across the country (GoL and UN, 2019). SRHR concerns are prioritised through this referral system, offering subsidised care for obstetric and life-threatening conditions (covering 75% of total fees); this proportion rises in certain cases relevant to SRHR, such as where infants are in need of neonatal care (90% coverage) and in cases of GBV, particularly with rape survivors (100% coverage) (ibid.; see also Balinska et al., 2019).

However, the situation is different for Palestinian refugees who are ineligible for state social services, including healthcare, and so rely almost entirely on the humanitarian response or private actors for assistance (UNRWA, n.d.). These clinics are located in the Palestinian camps or gatherings. Secondary and tertiary healthcare for Palestinians is provided through an arrangement with the Palestine Red Crescent Society hospitals or through a reimbursement scheme with other private providers.

Respondents to this research stated that they seek care from public clinics or health centres most often (155 respondents; 59% of respondents) (see Figure 5).¹¹

In terms of accessing information regarding health, 55% of respondents (of a total of 262 people) favoured doctors and medical experts as the preferred sources of trusted SRHR information on their SRHR needs; however, in practice they tended to use more informal channels rather than formal medical settings. Three of the most selected answers were: family members (136 respondents; 52% of respondents), friends and peers (88 respondents; 34%), and spouse/partner (82 respondents; 31%).

¹¹ Respondents were able to select all health facilities that applied, so total figures in this section exceed the 272 respondents of the survey. Percentages are calculated against the n figure for each question, in this case 264 respondents provided answers to the question on entry points to healthcare.

Figure 5 Entry points to healthcare

Note: n=264; eight respondents chose to leave this question blank.

3.3.1 Public clinics or health centres

The public healthcare system in Lebanon includes two key facilities where people can access primary healthcare. The MoPH supports the nationwide PHC network, offering a relatively comprehensive range of primary services related to acute illness, chronic disease, maternal and child health, mental health, diagnostic services and dental care (UNHCR, n.d.b; WHO, 2022a). In terms of SRHR care, antenatal, postnatal and contraceptive care constitute a significant proportion of services provided to displaced Syrian women at the primary level (GoL and UN, 2019). In many cases, these centres are managed and financed by international humanitarian response, with the MoPH stating 68% of centres belong to NGOs and benefit from international funding (MoPH, n.d.). As a result, the distinction between public and private healthcare is more blurred in Lebanon than in other contexts.

Dispensaries make up a large proportion of other primary healthcare facilities. These include NGO clinics and SDCs, which are social and basic healthcare facilities affiliated with the MoSA in Lebanon (GoL and UN, 2019). They, too, are supported by the humanitarian response,¹² although typically provide more limited support to patients (ibid.). These services are available to the Lebanese community as

¹² For example, see the QUDRA 2 programme, a jointly funded project by the European Union, Germany (BMZ) and Spain (AECID) to rehabilitate six SDCs in Lebanon as part of their resilience programming for people displaced by the Syrian and Iraqi crises (Expertise France, 2021).

well as displaced Syrians, whether they are registered with UNHCR or not. Refugees and asylum seekers can access subsidised care at PHCs and SDCs supported by UNHCR, to reduce the out-of-pocket expenditures of these groups given their economic vulnerability (UNHCR, n.d.b). ‘Vulnerable Lebanese’ people – mostly defined as those living below the poverty line – can also access subsidised care at these UNHCR-supported clinics to address critical health needs and reduce the risk of tension between the refugee and host community (GoL and UN, 2019).

Of the respondents who visited public clinics or health centres, 38% (59 respondents) reported having negative or very negative experiences.¹³ In their narrative stories, too, participants shared dissatisfaction regarding their treatment at public health facilities:

As a nursing student, I have done my community nursing training in a PHC. I could see the gaps whether in cleanliness, dealing with patients, or quality or accuracy in care. [Unmarried Palestinian woman, aged 18–25, double displaced, heterosexual.]

The care that was provided by the public clinic was not adequate, so the patient ended up receiving bad health services. [Unmarried Lebanese woman, aged 18–25, heterosexual.]

Also [it’s] clear that SDCs run by the government are broke. [Unmarried Syrian man, aged 26–30, refugee, homosexual.]

There were also multiple stories from participants, particularly Palestinians, referring to the discrimination they faced when trying to access care from SDCs. These feelings are likely in part because Palestinians are ineligible to access the majority of public health centres, unless they are financially supported by UNRWA:

We felt that [other providers] were much more helpful and less discriminatory than SDCs or local hospitals. [Unmarried Palestinian woman, aged 18–25, double displaced, homosexual.]

I seek these services when and where they are available. Sometimes through an NGO, and sometimes at local SDCs when they are open – in the case of SDCs though, you know that as a Palestinian woman, there are certainly challenges. There is a lot of discrimination. [Unmarried Palestinian woman, aged 30–35, double displaced, bisexual.]

3.3.2 Private clinics and NGOs

In recent decades, the private health care system in Lebanon has seen rapid growth as the government has relied more heavily on it. In 1970, just 10% of the MoPH budget was spent on the care of patients in private facilities, but by the late 1990s, this figure had grown to 80% (Diab and Fouad, 2020). This created a hybrid model for public healthcare, where the National Social Security Fund (NSSF) provides

13 Respondents could select multiple health facilities.

subsidised care of up to 90% of a patient's treatment in a private facility for members of the scheme (and their dependents),¹⁴ again blurring the distinction between public and private healthcare (Ismail, 2023). This is now proving to be unsustainable, as payments to the private sector continue to use an old exchange rate (\$1 = 1,500 Lebanese pounds), despite inflationary increases to the Lebanese pound of approximately 90 times. As a result, NSSF payments are deemed to be 'nearly useless' (ibid.) to meet the financial requirements of private healthcare and people are seeking alternative options, accessing treatment less often or not attending formal health providers at all.

Two-fifths of respondents who visit private clinics and private NGOs for SRHR concerns also report negative or very negative experiences of care. This figure is complicated by the diversity of clinics and centres that fall under this category – for example, respondents' stories indicated much more positive experiences relating to certain providers, which were described as more welcoming and as providing less discriminatory care. A notable example is Marsa, a sexual health centre in Beirut that was particularly well reviewed by participants:

They listened to us about questions we had about our periods, about our SRH. It was generally a positive experience with NGOs and Marsa specifically. [Unmarried Palestinian woman, aged 18–25, double displaced, homosexual.]

However, in general I would share personal experiences from me or women I know, depending on what the friend was going through, put them in touch with a doctor I trust, or send them to an SRHR-focused NGO like Marsa. [Unmarried Lebanese woman, aged 26–30, heterosexual.]

While these are trusted facilities to access support, their popularity and the dearth of services elsewhere meant that some respondents noticed capacity gaps, particularly in terms of seeing patients in a timely manner:

I was worried that I had contracted an STI and I wanted to get immediate care and check-ups. I went to Marsa to get an appointment – unfortunately the closest appointment was not less than 3 weeks in time, which was a long time to wait to get tested. I ended up having to go to a hospital to get my tests done and paying from my own money because I did not want my condition to worsen. [Unmarried Lebanese man, aged 30–35, homosexual.]

By their nature as private institutions, cost is often a barrier (even where sliding scales exist) and makes care exclusive to those who cannot afford it:

[I can't access] the care that I want because of how expensive it is in the private healthcare sector. [Unmarried Palestinian woman, aged 18–25, double displaced, heterosexual.]

14 The NSSF is a mandatory insurance that covers formal employees and their dependents (including partners, children and parents over 60 years old), while employed in the formal labour market (The Centre for Social Sciences Research & Action, 2023).

This same respondent suggested she would try to keep accessing private healthcare but recognised that she may need to have a more limited number of visits and follow-up care as a result. In line with this, transport to and from a facility also plays into the cost implications for respondents, and those in more remote areas of the country in particular may not have the funds to access care.

3.3.3 International humanitarian actors

Humanitarian actors play a significant role in supporting healthcare in Lebanon. As previously mentioned, UNHCR and other humanitarian agencies (such as Médecins Sans Frontières (MSF)) and NGOs in Lebanon support the public health system to improve access to primary healthcare for affected communities. And, as noted above, Palestinians are ineligible for state social services such as healthcare and are thus dependent on UNRWA for primary care and the Palestine Red Crescent Society for secondary and tertiary referrals and care:¹⁵

I suffered from a benign mass in the breast, and I was examined by a gynaecologist in a clinic affiliated with a charitable organisation after examinations and pictures showing the need to remove it, and I underwent a lumpectomy in a hospital affiliated with the Red Crescent at a lower cost. [Unmarried Palestinian woman, aged 26–30, stateless, pansexual.]

Over half of respondents (52%) visiting humanitarian agencies describe their experience as negative or very negative. However, those with negative experiences also tended to find humanitarian agencies less visible, while those with positive experiences found them more visible. So while it would likely be over-optimistic to position humanitarian actors as facilitators of quality care, this correlation does indicate an important role for humanitarian agencies in providing services and referral pathways to people already confronting barriers elsewhere.

While the presence and value of healthcare provision from international humanitarian actors was well noted in the sample, perennial constraints of the system featured heavily in people's critique:

I was refused care at an SDC multiple times. I do not have much of a story to tell, I largely resort to UNHCR and their partner for support at the moment. My experience with them is not the best though. There is long waiting time, many delays, and the services are very limited. [Unmarried Syrian woman, aged 26–30, refugee, homosexual.]

As refugees it is very difficult for us in urgent situations. UN process could take days, and no hospital would let us in if we don't have the money. [Partnered Syrian woman, aged 26–30, refugee, bisexual.]

I have one bad experience to be honest with healthcare centres and hospital when it comes to women's health. I was pregnant at the time, and suddenly I started bleeding. I went to the hospital,

15 Users of these private providers must be conscious about the hospitals they attend since not all facilities are covered by the reimbursement scheme (Palestinian Refugee Portal, 2022).

but they wouldn't even let me in if I could not cover the costs [...] UNHCR wasn't responding at the time, and I did not have the money to pay [...] I was just bleeding at the doorsteps of the hospital. [Partnered Syrian woman, aged 30–35, refugee, bisexual.]

3.4 Poverty and economic barriers

Lebanon's economic crisis is exacerbating existing inequalities, further reducing people's ability to afford healthcare and entrenching the role of socioeconomic privilege in SRHR access. People are being forced to seek alternative options for care, attend services less regularly or not seek treatment at all.

Generally, things have become more expensive than before – what used to be an affordable doctor's visit is today almost a quarter – if not more – of your salary. Now, instead of seeing a doctor first, I try to go to the pharmacy first to see if it's possible to avoid having to pay the excessive fee prices they take for a check-up these days. [Married Lebanese woman, aged over 60, heterosexual.]

If the economic crisis continues, then we have to save more and visit healthcare services less. [Married Lebanese woman, over 60, heterosexual.]

I used to be able to have more regular check-ups and screenings when needed, but now with the economic crisis, everything is in USD [United States dollars] and you need to pay it. If you don't have money in USD, meaning if your salary is still in Lebanese pounds, then you cannot afford anything anymore [...] so we can't go like before. A single doctor's appointment can cost up to half of a salary if not more. [Married Lebanese man, aged over 60, heterosexual.]

The available pathways to SRHR services and information in Lebanon for crisis-affected people are characterised by multiple institutional and economic barriers, which create gaps in coverage, inclusivity and health outcomes. Confusion around which groups of people are entitled to which types of care leads to refusals, discrimination and delays. Timeliness and continuity of care are severely lacking, which is especially troubling for concerns including (but not limited) to HIV-related care, pregnancy, contraception and safe abortion care.

These institutional barriers are necessarily tightly intertwined with the social and cultural barriers detailed in the following chapter, where participants reported on the instrumentalisation of institutional processes and coverage in the service of social exclusion.

4 Social and cultural barriers to inclusive and comprehensive SRHR

This chapter explores the significant and overlapping social and cultural barriers faced by participants seeking quality services for SRHR. It particularly focuses on the experiences of women and girls; people with diverse SOGIESC; youth and older people; displaced people; and those of Syrian and Palestinian origin.¹⁶ Gaining an understanding of these experiences is important to inform a more inclusive and gender-responsive approach, and to understand the relationship between availability and uptake of services.¹⁷

Most notably, the research found three intertwined layers of stigma:¹⁸ participants consistently cited contextual sensitivities around sex and intimacy, discrimination against marginalised groups and racism against displaced groups. While these layers cannot be neatly separated, understanding how they function separately and together is important for highlighting their impacts on affected people.

4.1 Sensitivities and taboos around sex and intimacy

As in many other settings, social norms around sex and intimacy restrict the ability of people to speak openly about SRHR concerns, even to medical professionals, in Lebanon's crisis-affected communities. Everyday topics like menstruation or regular gynaecological or sexual health check-ups are laden with taboos, and sexual education is not included in the national curriculum (Porter, 2017; O'Regan, 2019).¹⁹ Restrictive norms around sexuality vary by location (and particularly whether it is an urban or rural location), levels of education and other factors. But this prevailing silence around sex is still so pervasive that 'don't silence sexual health' has become the tagline for efforts – implemented by the American University of Beirut Medical Centre – to normalise seeking medical advice for SRHR concerns (see AUBMC, n.d.; O'Regan, 2019).

Participants in this research widely recognised that SRHR was not talked about in wider society and even the household, particularly among women.

No one talks about [it] [...] simply [...] we are not informed or given limited information about our bodies – especially as women. [Unmarried Palestinian woman, aged 30–35, double displaced from Syria, bisexual.]

16 While the research recruited participants with disabilities, their stories and survey responses were not sufficient to achieve reliable findings about their particular needs, experiences or barriers faced.

17 For more on the distinction between gender-responsive and gender-transformative approaches, see Daigle (2022).

18 Stigma refers to the co-occurrence of 'labelling, stereotyping, separation, status loss, and discrimination [...] in a power situation that allows the components of stigma to unfold' (Link and Phelan, 2001: 367).

19 Sex education featured briefly on the curriculum in 1995 but was removed five years later following criticism from religious groups and parents in Lebanon.

However, by the nature of our closed societies, talking about these issues is a ‘disgrace’. [Syrian, aged 50–60, refugee, heterosexual.]

We are all rejected entirely or silenced when we ask for information [...] this is the general feeling and sentiments around such issues, especially our periods and our hygiene. [Unmarried Syrian woman, aged 18–25, refugee, bisexual.]

It is increasingly difficult to have discussions about this in our communities. We struggle with discussing these issues with our family even. [Married Syrian woman, aged 30–35, refugee, heterosexual.]

As a result, little value is given to discussing or understanding routine SRHR healthcare, and it is clear to see how and why this silence would prevail even in times of concern as well. The taboo nature has left respondents reporting feelings of ‘suffering’ because of the lack of information about their sexual health:

In our community [...] it is about talking about it. We are not informed about anything growing up. We discover these issues for ourselves and many times we suffer for years. [Married Syrian woman, aged 50–60, refugee, heterosexual.]

Ultimately these social norms represent a key barrier to accessing care for individuals with SRHR concerns. As a result, participants in this research referenced feelings of shyness and embarrassment when considering or attempting to access SRHR services.

I’m shy about my period [...] I am embarrassed to seek out this information. It is a private matter, and I am not accustomed to seeking this information out. No one tells you about this in our community. Even when I do access this information, I am shy. I do it very discreetly. [Married Syrian woman, aged 26–30, refugee, heterosexual.]

As this example shows, even when people feel able to seek out care, the barrier persists in their interactions with medical professionals. Another respondent reported that, upon visiting the health facility:

I was mostly quiet, I did not cooperate as much as I should have [done]. [Married Syrian woman, aged 26–30, refugee, heterosexual.]

While some of this sensitivity in the presence of medical professionals comes from the person seeking care themselves and their socialisation into restrictive and highly gendered norms, medical professionals are also affected by such norms and may avoid discussing topics such as sex or menstruation with patients, or may refuse patient requests due to a lack of confidence in SRHR topics or on the basis of their own personal, social, cultural or even religious frameworks. Aspects of privacy, confidentiality, safe spaces and non-judgemental care are all detrimentally affected when providers lack appropriate training, information and sensitisation on SRHR concerns, needs and services.

Such silences affect all patients having concerns or seeking care relating to SRHR, but its effect is heightened when queries relate to premarital sex or non-heterosexual relationships or sexual practices:

We do not talk about it and are not encouraged to talk about it. This will always be a barrier. As women, especially women who identify as part of the LGBT community, we feel isolated, and as though we cannot discuss our bodies or our feelings in general. [Unmarried Palestinian woman, aged 18–25, double displaced, homosexual.]

Particularly in more conservative settings, including rural and religious communities, medical professional may also fear offending patients by discussing taboo topics. Undoing some of the internalised taboo around sex and intimacy is critical for improving acceptance and uptake of SRHR services in Lebanon.

4.2 Stigma and discrimination in SRHR provision

Stigmatisation of certain marginalised identity groups featured significantly across this research. Stigma and discrimination are recognised as fundamental causes of health inequalities because they influence health outcomes, limit access to health resources and are found to be related to health inequalities regardless of the time or space (Bohren et al., 2022). They are also amplified in combination with the sensitivities around sex and intimacy described above.

Respondents experienced discrimination on the basis of diverse and intersecting forms of marginalisation, including their gender or gender identity, their sexuality, their racialisation or ethnicity, or their disability. Discrimination was felt more strongly by those respondents experiencing intersecting marginalisations, where multiple axes of oppression interact to produce effects that are both compounded and sometimes distinctive.

While we have disaggregated the groups below for the sake of analysis, they are all overlapping rather than discrete. Groups living with multiple forms of marginalisation – for example, lesbian women, who are often forgotten in programming that targets women and people with diverse SOGIESC alike – are often unseen or even erased in the deployment of categories such as these. Each of the headings below also entails a wide diversity of needs and intersectional experiences, which are dependent both on context and other intersecting identities, and thus should not be understood as monolithic.

We are a bigoted, racist, sexist and homophobic society. This makes accessing everything, especially when it comes to sexual health and hygiene, a nightmare. People that are supposedly experts and professionals are the ones bigoted. [Unmarried Syrian man, aged 26–30, refugee, homosexual.]

I don't seek healthcare because the experience is discriminatory. As a queer refugee, you can only imagine the levels of discrimination we face. [Unmarried Palestinian man, aged 30–35, refugee, homosexual.]

The role of others’ perceptions is also critical in how people are treated when they try to access SRHR care. Whether or not individuals are visible as being members of a stigmatised group – or, conversely, are able to pass as straight, cisgender or Lebanese, for example – has a major impact on their ability to receive care, or care of a better quality. This is relevant across the groups examined here but particularly for people with diverse SOGIESC, whose gender presentation may or may not match with socially prescribed expectations.

Broadly, when asked how people were treated when accessing SRHR-related healthcare, 38% of participants said that they were treated only according to how they were perceived rather than according to their need or equally to all other patients. This trend becomes more pronounced when focusing on people with negative or very negative experiences, where 56% of respondents thought that they were treated only according to how they were perceived (see Figure 6).

Figure 6 Survey respondents with ‘negative’ or ‘very negative’ experiences on how people were treated when accessing SRHR care



This indicates that those with negative experiences felt they were discriminated against when they used healthcare facilities. For comparison, the majority of those with positive experiences (51%) felt that everyone was treated the same, and that perceptions played a much more limited role in their experience. (For more on positive experiences, see Chapter 5.) The following sections will explore the dimensions of this discrimination in more detail.

4.2.1 Restrictive gendered norms and their impact on women and girls

Participants who identified as women and girls represent an interesting demographic in the sample, because they are the most likely to have a very positive or positive experiences (35% of respondents), compared to men and boys (15% positive) and transgender or non-binary participants (13% positive).²⁰ This is likely closely related to their status as the intended targets of most SRHR programming, especially in humanitarian crisis settings, which tends to be dominated by maternal and neonatal care, as well as particular forms of GBV. On the whole, their experiences appear to be closely tied to the type of service they are trying to access, and it is therefore likely unsurprising to find a link between more positive experiences and those using pregnancy and maternity care services, even though this too remains an area for improvement and where coverage has been described as ‘suboptimal’ (Balinska et al., 2019: 6).

Conversely, where women and girls do report experiencing discrimination and feeling the effects of stigmatisation, the most negative experiences surface in relation to accessing stigmatised forms of care, such as abortion or tubal ligation:

A friend of mine who is newly married and is not planning to have children, got pregnant and she went for an appointment to get consultation before aborting. She mentioned to me that the only thing that she received at the clinic was discrimination (and was labelled as she doesn’t deserve to be a mother) rather than education, support, and advice. [Unmarried Lebanese woman, aged 18–25, heterosexual.]

My friend once wanted to undergo tubal ligation. She was treated in a very bad way after knowing what she wants to do due to the taboos that exist in our culture. [Unmarried Lebanese woman, aged 18–25, internally displaced, heterosexual.]

These examples show how gendered norms around motherhood, sexuality and reproductive autonomy present themselves in health facilities and act as a barrier to receiving the comprehensive SRHR that women seeking the support require. Women are also likely to face social stigma beyond medical settings, as well as personal doubts and contradictory pressures in their reproductive decision-making. This is a result of religious, cultural or other norms around such services coming into contact with the instability of their displacement experience, as previous research has found (Cherri et al., 2017; Kabakian-Khasholian et al., 2017).

These experiences are further entrenched by legal restrictions on abortion in particular. As elaborated on in Chapter 2, while abortion services can be obtained, this access is a question of privilege, bringing added costs, requiring social capital and networks, and exposing patients to abuse. One participant shared the story of a friend, who:

thought herself to be pregnant and accordingly she underwent curettage [abortion] at the doctor’s clinic. However, the surprise was that she was not pregnant and that the doctor knew that but

20 This figure is skewed slightly by the small number of non-binary participants (n=4), who had a positive experience (n=2). None of the participants identifying as transgender reported a positive experience.

decided not to tell the woman and do the curettage instead for the sake of gaining money. [Married Palestinian woman, aged 26–30, refugee, heterosexual.]

The persistence of stigma around abortion and SRHR concerns more broadly only serve to worsen conditions for women and girls, and especially marginalised groups, since those in power are able to capitalise on the fear and social anxiety of being unmarried and pregnant or seeking an abortion, for their own financial gain. Fathallah (2019: 22) also writes that ‘most physicians who offer abortion services act as moral gatekeepers, often condemning the woman and preserving certain social norms rather than advocating for women’s bodily autonomy and free choice’. Experiences such as these only fuel mistrust in the system and contribute to wider barriers to comprehensive care.

While our own sample did not surface specific data or stories relating to accessing contraceptive care outside marriage, social sanctions against premarital sex are strong, in Lebanon broadly as well as among the Syrian and Palestinian communities surveyed (Fathallah, 2019; Bouscaren, 2022). A study conducted with unmarried, sexually active women in Lebanon, for example, found an urgent need for accessible, non-stigmatising and inclusive services for women’s sexual health to ‘promote safer sexual practices and effective decision making with regards to contraception and condom-use’ (Abu Zaki et al., 2021: 1).

4.2.2 Discrimination against people with diverse SOGIESC

Stigma and discrimination also feature significantly in the experiences of people with diverse SOGIESC when they try to access SRHR care. A significant proportion of the sample for the research were from this community, representing a diversity in both gender identities and sexual orientations, with 35% of respondents (88 respondents) identifying as homosexual, bisexual, pansexual, asexual or another preferred term. Six percent of respondents (15 respondents) identified themselves as transgender or non-binary. There are, of course, overlaps in these groups and the survey allowed for multiple identifications to accommodate complexity and diversity of experiences in this sphere of life.

Here again, Lebanon’s legally restrictive environment shapes experiences for people with diverse SOGIESC, as well as for LGBTQIA+ organisations and movements. The penal code still prohibits ‘sexual intercourse against nature’ and ‘disguising as a woman’, effectively criminalising same-sex relations and some gender identities (HRW, 2023b). Whilst recent jurisprudence has established consensual sex as ‘not unlawful’, arrests are still possible and the law is occasionally enforced (HRW, 2022). Further to this, Lebanese security forces and the interior ministry have increasingly restricted the space for events relating to LGBTQIA+ people, including banning peaceful gatherings in 2022 (ibid.).

Gender identity emerges as especially important, with those identifying as transgender reporting no positive stories regarding their SRHR care. This highlights the extent to which stigma and discrimination likely play a part in the care they receive. One participant, a trans man, reported that he has been:

harassed, assaulted and taken advantage of on multiple occasions by healthcare providers and professionals. [Unmarried Syrian/Lebanese man, aged 26–30, transgender and bisexual.]

As noted, the role of visibility and the ability to ‘pass’ impacts whether and the degree to which people experience stigmatisation. Thus, in practice, how one is perceived by others is as important as self-identification in terms of experiences of marginalisation in health spaces and beyond:

As an LGBTQI+ person in Lebanon who is also a refugee, you can imagine the double discrimination. It is honestly too much. I feel like I am someone ‘presenting’ in the sense that you can tell I am queer, and that has made everything from a simply [sic] blood test, to a check-up a nightmare [...] I am unable to even go to the local clinic for contraception. [Unmarried Syrian man, aged 26–30, refugee, homosexual.]

People who identified as homosexual, bisexual, pansexual or asexual had a more pronounced response to the question on how they were treated, with 46% indicating they were only treated according to how they were perceived (as opposed to 33% of heterosexual respondents). This suggests that the stigmatisation of sexuality contributes strongly towards the experience of discrimination in SRHR care.

Notably, homosexual men felt this more acutely than lesbian women (55% to 39% of respondents), suggesting that lesbian women had more opportunities to ‘pass’ and so may experience less pointed discrimination in medical facilities. Across the board, however, there was a belief among participants with diverse SOGIESC that identifying oneself as such would restrict access to care:

I can’t get any services as a Syrian gay refugee. [Unmarried Syrian man, aged 30–35, refugee, homosexual.]

Provider attitudes toward people with diverse SOGIESC, shaped by cultural and social norms of homophobia, biphobia and transphobia, continue to represent significant barriers to inclusive and comprehensive SRHR. This is further enabled and entrenched by the threat of criminalisation maintained by Lebanese penal code provisions, and results in profound barriers to accessing appropriate health care and information. This finding is supported by data from Assi et al., stating that only 19% of 2,238 men surveyed who had sex with men received sexual health education from reliable sources, putting them at risk of inconsistent condom use and potential HIV infection (2019: 1).

Given how very little data is available on people with diverse SOGIESC (Myrtilinen and Daigle, 2017; Assi et al., 2019; Maydaa et al., 2020) – not to mention the varied groups that fall under that umbrella and their divergent needs and experiences – these findings are all the more striking and urgent.

4.2.3 Racism and anti-refugee sentiment

As noted, Lebanon hosts the largest number of refugees in the world per capita and per square kilometre (UNHCR, 2023). The displaced population in Lebanon is made up predominantly of Syrians, but there are also significant communities of Palestinians, Iraqis and Sudanese people. The presence of these refugees in the midst of Lebanon’s worst socioeconomic crisis for decades (see section 2.2)

has given rise to the perception of strain on healthcare and other services, which has forged negative narratives around refugees ‘taking up’ space, resources or services that would otherwise be available to Lebanese citizens. (See Box 2 for a particular manifestation of racism and anti-refugee sentiment.)

Respondents reported marked experiences of racism and xenophobia as a result:

Not only am I Palestinian, I am Palestinian from Syria so there is double discrimination. [Unmarried Palestinian man, aged 26–30, double displaced, homosexual.]

I am a trans man, and I am also Syrian/Lebanese. Everywhere I go is a challenge. [Unmarried Syrian/Lebanese man, aged 26–30, transgender and bisexual.]

Box 2 Fertility and racism

Fertility has long been considered a ‘problem’ to be managed in humanitarian settings, based on assumptions that ‘crisis-affected people should not, or could not, possibly want to have (more) children’ (Daigle and Spencer, 2022: 6; see also Chalmiers, 2021; Holloway et al., 2022). Life, of course, is much more complex than those assumptions, and research shows that crisis or displacement are not the disruptors to fertility or family aspirations that people assume them to be (Johnson-Hanks, 2005; Maternowska, 2006; Greil and McQuillan, 2010; Fordyce, 2012; Singer, 2018; Sieverding et al., 2019, all quoted in Chalmiers, 2021). Other research describes humiliation and judgement experienced by Syrian refugees in clinical spaces relating to their perceived fitness as parents (Kabakian-Khasholian et al., 2017) and pressure from health professionals who ‘comment on their fertility’ (Cherri et al., 2017: 7).

Syrian and Palestinian women participants speak of feeling shamed for seeking fertility-related care to become pregnant:

I don’t want to share details, but it was humiliating. I had a very negative experience. They are so discriminatory towards us. As a Palestinian/Syrian woman you are made to feel like you cannot be pregnant because you are essentially ‘making more’ refugees. [Married Syrian/Palestinian woman, aged 36–40, double displaced, bisexual.]

This sample offered a limited number of stories that actively referred to experiences of racism related to fertility. While they are not statistically significant within the sample, they emerged organically rather than in response to specific questions from researchers, which is suggestive of a wider trend that merits investigation in the future.

This discrimination permeates beyond the general population and becomes a feature of the care people receive. It was fairly well recognised across the sample that, as refugees, people have much more limited access to services:

There is a lot of discrimination. They make me wait, and sometimes let Lebanese people in before me even when it is my turn. [Unmarried Palestinian woman, aged 30–35, double displaced, bisexual.]

Lebanese people already have barriers and this is their own country. People and the government do not want us here, and this of course, feeds into how we receive services. If there is no NGO in our area, we are essentially cut off. [Married Syrian woman, aged 30–35, refugee, heterosexual.]

Everything we struggle from is because we are refugees. We are isolated from the health system, from accessing information, and from real solutions to our problem. We are meant to feel unwanted and like we have no future. [Unmarried Syrian woman, aged 18–25, refugee, bisexual.]

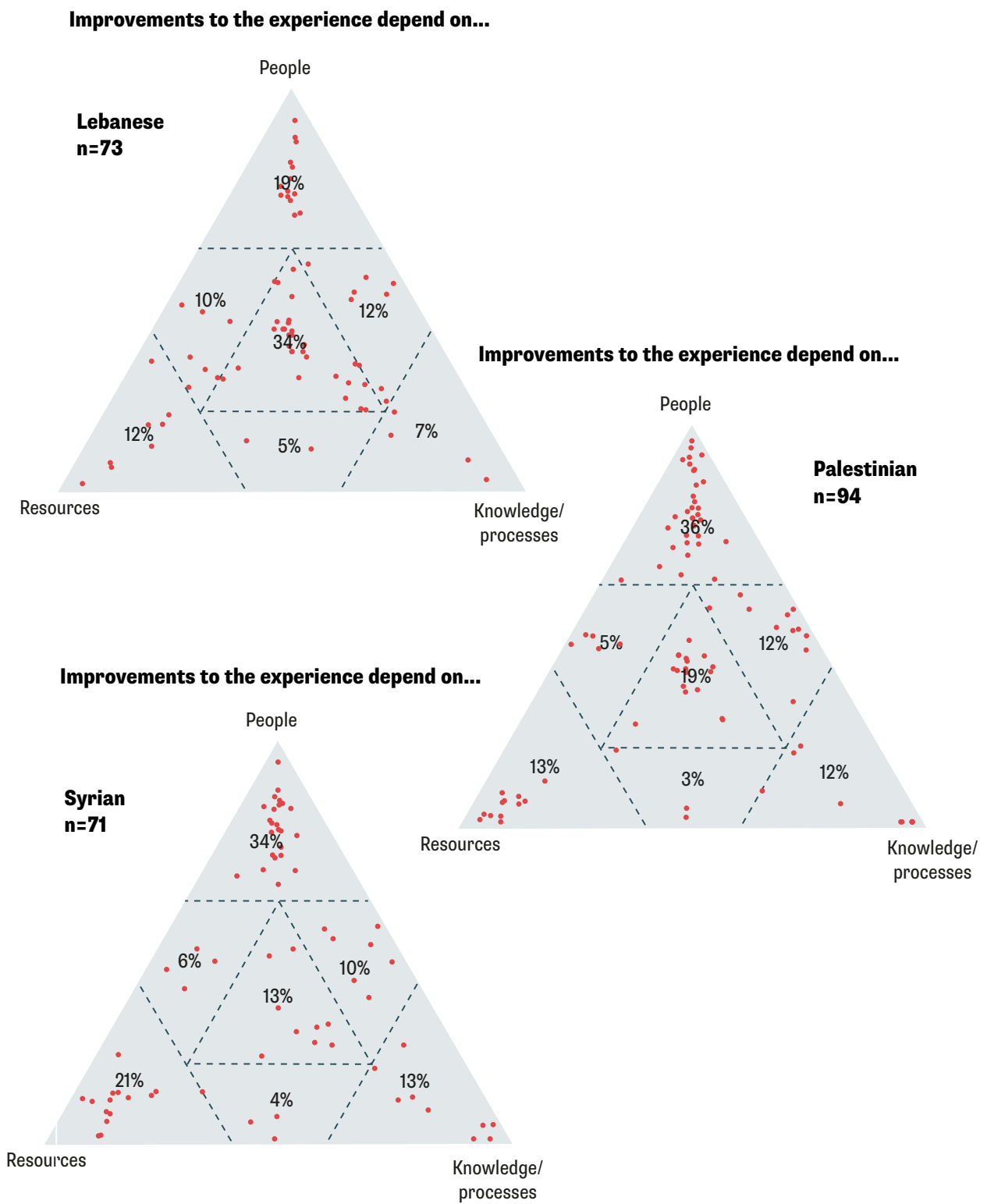
Even Lebanese participants in this study recognise the barrier that racism and xenophobia play in inclusive and comprehensive SRHR. While at their own obstetrics and gynaecology check-up, negative provider attitudes were noticed by a Lebanese woman who said:

The nurses there and the physician were not treating all the people the same. They were discriminating according to the nationality and literacy level. One pregnant Syrian woman who is aged between 16 and 18 was humiliated while being cared for. [Unmarried Lebanese woman, aged 18–25, heterosexual.]

The presence of such negative provider attitudes towards refugees likely explains why, when asked what would be needed to improve their experience, Palestinians and Syrians indicated that better SRHR services depend on changes in people alone (see Figure 7), representing 36% and 34% of respondents respectively. In comparison, just 19% of Lebanese respondents thought changes within people would improve SRHR services. This finding is supported by existing research pointing to humiliation and a lack of dignity in treatment as barriers to SRHR care for Syrian women in Lebanon (Kabakian-Khasholian et al., 2017; Endler et al., 2020).

The discriminatory social and cultural norms described here around gender, sexuality, racialisation and poverty complicated access to SRHR across the diverse sample collected for this study. In many cases, these norms are legitimised and strengthened by legal frameworks that criminalise and further stigmatise particular groups, activities and identities. Together with the institutional barriers discussed in Chapter 3, and given the key role of humanitarians in providing and facilitating SRHR and wider health services in the response, they are suggestive of the need for much greater engagement by humanitarians in order to ensure effective SRHR services are available and accessible, especially to the most marginalised, in line with the principle of impartiality.

Figure 7 Survey respondents on how SRHR experiences could be improved, by nationality



5 Enablers of more inclusive and comprehensive SRHR

While barriers and challenges are the dominant themes in our dataset, as discussed above, much can be learned from examining the stories that participants classed as positive, in terms of understanding how barriers were overcome or what made their experiences more humane, effective or supportive. The conditions and pathways that make them possible may hold solutions for wider change within the system.

In total, 83 respondents (32% of respondents) described their experiences as ‘positive’ or ‘very positive’. Of this group, a large number indicated that their experience pertained to maternal, neonatal and child health (see Figure 8). On the other hand, those with ‘negative’ or ‘very negative’ experiences were much more evenly dispersed across health concerns and services. Those reporting positive experiences also disproportionately identified themselves as married, heterosexual women. Notably, Palestinians were more heavily represented among the positive stories, with 38 versus 22 Lebanese and 21 Syrians (see Figure 9). As discussed elsewhere, this may relate to the presence of UNRWA as a dedicated (if limited) architecture serving the needs of Palestinians.

5.1 Provision and referral by humanitarian actors

Broadly, participants report turning to services and referral pathways provided by humanitarian actors when they had already encountered barriers in other settings. Interestingly, those who shared positive experiences tended to find humanitarian agencies more visible in the course of their navigation of SRHR spaces, whereas those reporting negative experiences found them less visible, suggesting that humanitarian actors have acted as useful conduits amid multiple barriers and restrictions:

My sister and I both attempted to seek our support from local NGOs and the humanitarian space in general. We were much more welcome there. We felt that they were much more helpful and less discriminatory than SDCs or local hospitals. [Unmarried Palestinian woman, aged 18–25, double displaced, homosexual.]

As a Syrian woman, I have been rejected support from local hospitals. Even when I wanted to pay. My successes in the areas of attaining this type of care has been with informal providers, NGOs and other local humanitarian networks. I have a Palestinian husband, who receives some aid from UNRWA, but this does not extend to me and my children because for a while we received UNHCR support. The system is messy and we have had unfortunate incidents in general – especially when I have SRHR questions. [Married Syrian woman, aged 50–60, refugee, heterosexual.]

Figure 8 Survey respondents on their experiences in receiving different types of SRHR care

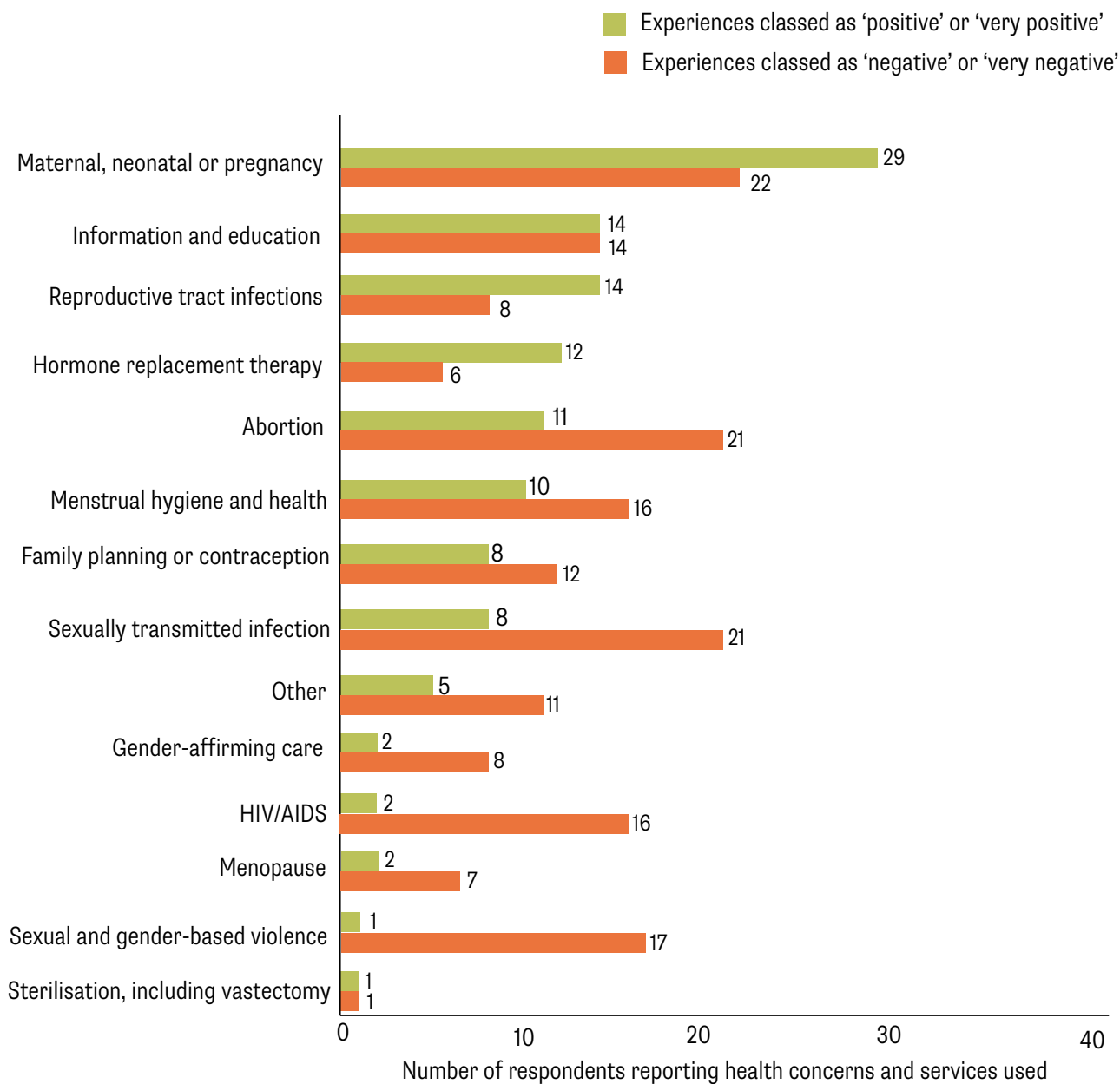
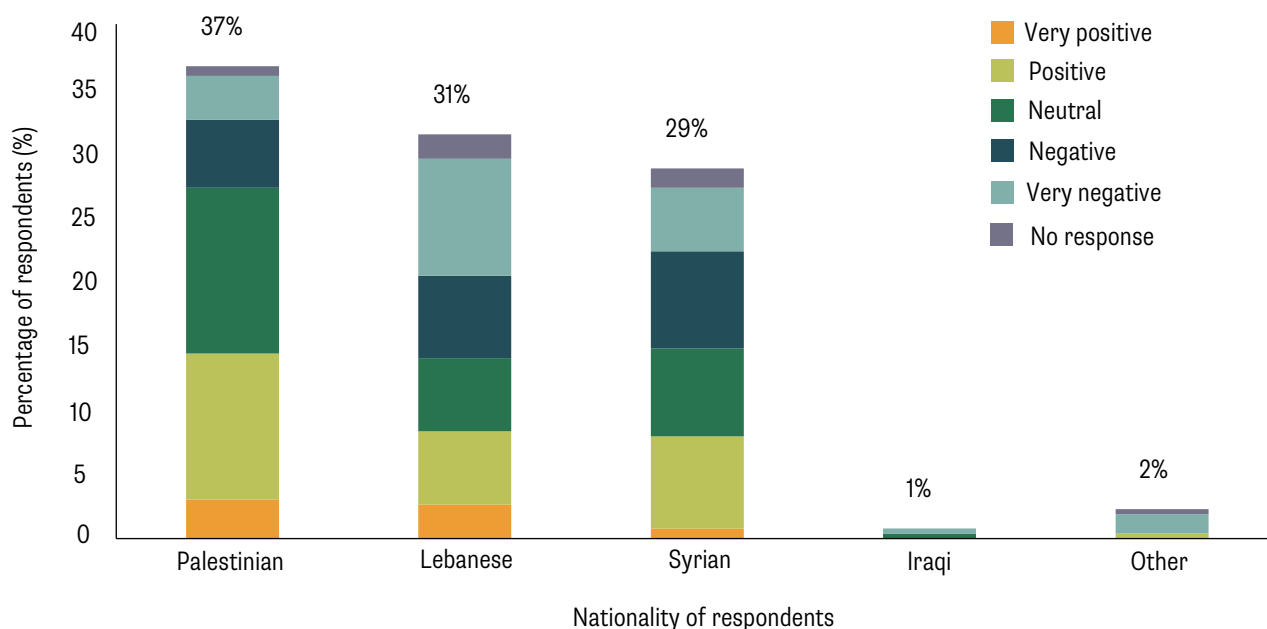


Figure 9 Survey respondents on how they classified their experience, by nationality

Along similar lines, when asked who should hear their story, 149 respondents (62% of respondents) chose humanitarians – second only to peers (167 respondents, or 70%) and above healthcare providers, which was selected by 137 respondents (57%).²¹ This may well speak to the important role of international humanitarian response in funding and filling gaps in the healthcare system in Lebanon, as well as declining confidence in that system on the part of users. Regardless, it is clear that respondents see a need for engagement by humanitarian agencies in facilitating as well as directly providing information, services and referrals.

Importantly, Lebanese and Syrian respondents find humanitarian agencies less visible than Palestinians do, which once again indicates the important role played by UNRWA for that community as a statutory provider of health services:

I'm a refugee, I seek this service in the camp, so we are all treated equally. In the camp help is even [sic] provided to others, no matter their nationality. [Unmarried Palestinian woman with a disability, aged 30–35, refugee.]

²¹ Respondents were able to select stakeholders that applied, so total figures in this section exceed the 272 respondents of the survey. Percentages are calculated against the n figure for each question, in this case 240 respondents provided answers to the question on who should hear their story.

With the issues of coordination and funding that are facing UNRWA in mind, whether this visibility and facilitation of care for Palestinians can be maintained is an open question. But the wider provision and increased number of referral pathways offered by humanitarian actors have proven effective amid multiple and overlapping barriers.

5.2 Non-judgemental and empathetic care

The flip side of the stigma and discrimination described in Chapter 4, much of which is enacted and perpetuated by service providers and other actors encountered along pathways to access, is empathetic and non-judgemental treatment of patients and would-be patients. The experiences where respondents felt that they were treated with warmth, kindness and understanding stand out from the overall sample:

One of my acquaintances underwent a small operation, as there were cysts on the ovaries. It was a good experience, as the doctor treated us well and was kind, even as she greeted us and explained the details to us. [...] It was hope. [Unmarried Lebanese woman, aged 18–25, heterosexual.]

Narratives classed as positive by participants also reveal that many of these experiences involved accessing care via NGOs that specialised in SRHR service provision and operated through an explicit lens of reproductive justice.

I once experienced heavy menstrual cycles and had to go to the hospital to get checked. In the hospital I was not treated well so I decided to never seek help regarding such topics. However, I once went with my friend to an NGO that cares for the women and their sexual health and since then I became aware of the presence of some NGOs that really support women and offer good care. [Unmarried Palestinian woman, aged 18–25, heterosexual.]

Importantly, however, several stories noted that such NGOs often lack the capacity and resources to provide services on the scale that is needed by their communities (see also sub-section 3.3.2).

Notably, respondents with ‘very positive’ and ‘positive’ experiences thought they were treated according to an immediate need, as opposed to norms or expectations (see Figure 10). This is a stark difference to those reporting ‘very negative’ or ‘negative’ experiences, where only 20% of respondents thought they were treated according to need and many more reported being treated in keeping with other’s expectations or established norms. Similarly, when asked how their experiences accessing SRHR had affected their body, mind and social relationships, participants who categorised their stories as ‘negative’ or ‘very negative’ tended to indicate a combination of all three elements, whereas those who described their experiences as ‘positive’ or ‘very positive’ skewed strongly towards the body alone (see Figure 11). This finding may seem intuitive to those with knowledge of SRHR: positive experiences may be encountered as a straightforward matter of seeking and successfully obtaining appropriate

care for a physical health need, while negative experiences entail the kinds of discriminatory practices and barriers described in Chapter 4 above, resulting in impacts on respondents’ sense of self, ability to exercise their bodily autonomy and sexualities, and even their mental health.

It is notable here that those with positive experiences seemed to value empathy comparatively less, suggesting that what was lacking for people with negative experiences was empathy to cope with a difficult experience – whether that negativity stems from a health problem itself or the experience of accessing care for it – whereas what was present for positive experiences was simply treatment that met their needs. It is also indicative of how empathetic and non-judgemental care could help to mitigate the impact of negative health experiences.

Figure 10 Survey respondents with ‘very positive’ experiences on the factors that influenced their treatment

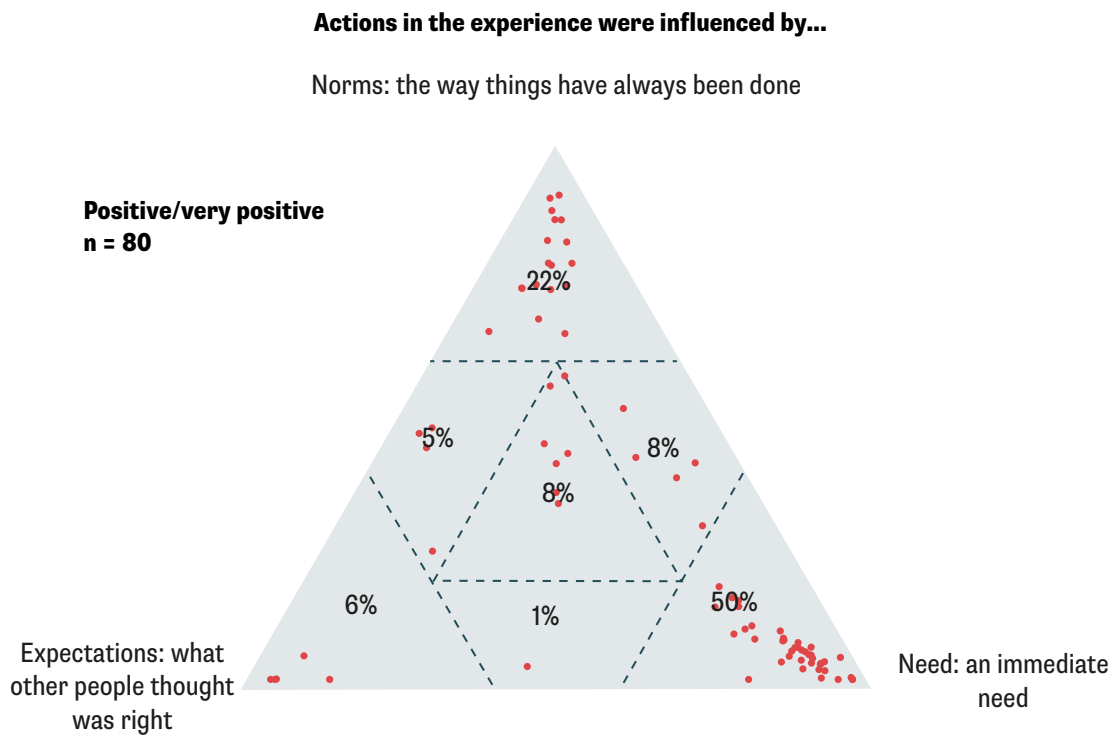


Figure 11 Survey respondents on how their experiences affected their body, mind and social relationships



5.3 Formal and informal advocacy

Finally, the role of advocacy of all kinds – whether formal (through rights-focused organisations serving marginalised communities) or informal (through family, friends and social circles) – emerged as a key facilitator in opening up pathways to services and referrals to welcoming providers. Sometimes this is as simple as sharing knowledge and experience with others facing similar challenges, or using personal contacts and resources to facilitate access:

I did once have a herpes scare, as I might have been exposed to it from a sexual partner who might have been exposed to it. I confided in a co-worker, who had a friend who was a gynaecologist, she shared the doctor’s contact details, I messaged her and the doctor told me what tests to take, which I took at a private lab, then my friend who was also a doctor read my results and told me that I thankfully had not contracted herpes. [Unmarried Lebanese woman, aged 26–30, heterosexual.]

The same participant continued, articulating a dynamic that is very familiar to SRHR advocates and providers:

In general I would share personal experiences from me or women I know, depending on what the friend was going through, put them in touch with a doctor I trust, or send them to an SRHR-focused NGO like Marsa. If they're seeking abortion, which is illegal, I have friends who know doctors they trust. As women, we create networks of friends we can share our struggles with, and each person comes with their own stories, and experiences, where they have encountered medical professionals that they have built trust with, and respectively share contacts amongst each other. [Unmarried Lebanese woman, aged 26–30, heterosexual.]

The role of communities, social circles and informal networks in facilitating access to care and helping individuals to navigate complex pathways should not be underestimated, particularly in a sector like SRHR that is subject to intense stigmatisation, regulation and restriction in Lebanon and around the world. Given the barriers to accessible and accurate information, these connections are an important – if not always reliable – conduit around the other barriers that people face. Nonetheless, these connections and the ability to engage in self-efficacy and advocacy are themselves a function of social capital and privilege relative to systems of exclusion, reliant on education levels, socioeconomic status and other factors.

The positive stories shared in the course of this study are admittedly limited, but they highlight the need for consideration of SRHR needs, challenges and opportunities to extend beyond health spaces. In particular, findings on the actual and potential role of international and local humanitarian agencies are suggestive of possibilities for more coordinated, integrated and joined-up ways of working on SRHR in particular.

6 Implications for crisis-affected people

The mapping of barriers and enablers above demonstrates clearly that the health needs of diverse crisis-affected people in the field of SRHR are not being met, with overwhelming reports of bureaucratic, economic and prejudicial barriers to comprehensive (or indeed basic) SRHR services. While these problems are also reported by the wider population in Lebanon, the status of our research participants as refugees, stateless or internally displaced persons clearly complicates their experiences.

Given the gaps in provision by other actors, whether due to lack of resourcing, institutional resistance or other factors, it is notable that respondents see a clear role for humanitarian actors in the delivery of SRHR services. As noted above, when asked who should hear their story, 149 participants (62% of respondents) indicated humanitarian agencies, second only to ‘my peers/people like me’ and above healthcare providers. This, along with the themes emerging from the stories themselves, indicates that confidence in state and private healthcare provision is low and the need for further support that extends beyond health spaces alone is critical. It also likely recognises the outsized role already played by humanitarian actors and thus their importance as conduits to care for crisis-affected people.

These problems are further exacerbated for those who experience additional forms of social marginalisation. This includes women and girls, and especially those who are unmarried and sexually active, or those seeking stigmatised care; people with diverse SOGIESC, especially gay men and trans women; and women with disabilities. The deleterious impact on the health of crisis-affected people in all their diversity forms the subject of this chapter, along with the undeniable effects on their mental health and wider wellbeing, which cannot be fully understood without reference to rights, bodily autonomy, and sexual and reproductive justice – elements that have not been meaningfully prioritised in humanitarian settings to date (see Box 3).

Box 3 Rights and reproductive justice

Meeting SRHR-related needs in crisis settings is entwined with upholding multiple recognised human rights – most notably, the rights to life, to live free from torture, to health, to privacy and to education, as well as prohibitions on discrimination. Nonetheless, few studies in crisis settings reference the language or substance of rights in relation to SRHR, including an individual’s right to choose if, when and with whom to be in a relationship and have sex, as well as reproductive rights related to contraception, childbearing and abortion (Tirado et al., 2020). This approach increasingly diverges from that of other sectors like public health, development and human rights that are active on this issue. There, SRH (i.e. sexual and reproductive health) has expanded to SRHR following the 1994 International Conference on Population and Development. Since then, the framework of reproductive justice has emerged, emphasising the structural conditions that shape choice for diverse groups, as well as the complex ways that people’s choices are regularly curtailed and repressed (Daigle and Spencer, 2022).

Rights-based humanitarian action has grown in the last 20 years, with many international NGOs and agencies labelling their work rights-based, but most only on paper as the implementation of needs-based approaches remains the norm – and especially in health. This is often for reasons related to maintaining access to crisis-affected people and conforming to humanitarian principles of neutrality and impartiality. It bears noting, however, that this is far from a universal interpretation of the principles and comes with considerable risks and trade-offs. Framing SRHR – especially its more controversial components – as ‘needs’ can be a powerful and strategic choice, but it does not negate the rights dimensions of SRHR. Delineating which needs are most pressing and should be met is itself a question of rights, particularly with an eye to avoiding paternalism, colonialism and the very real risk of obstetric violence (see section 6.2 for more on obstetric violence). A framing of ‘needs’ imbues SRHR with a sense of urgency and apolitical moral imperative, but the ‘rights’ perspective is critically important for ensuring that bodily autonomy and choice are never lost.

Without a rights lens, humanitarian responders risk: (1) an incomplete understanding of the health and protection risks faced by crisis-affected people related to their SRHR, and therefore a limited ability to address those risks; (2) the creation of new risks arising from a poor understanding of power relations not only between patients and their families, partners and communities but also between patients and medical professionals and/or humanitarian responders themselves; and (3) further excluding already marginalised groups, where their marginalisation stems at least in part from being denied or unable to realise their SRHR relative to the wider population.ⁱ

i For more on this relationship between compounding marginalisation and rights, see Barbelet and Wake (2020).

6.1 Support for wider wellbeing and agency

A key overarching finding from this research is that the emotional and psychosocial dimensions of SRHR care and their effects on wider wellbeing feature more strongly in negative experiences than they do in positive ones.²² For example, as discussed in Section 5.2, respondents reporting negative experiences and barriers like the ones described above were more likely to report impacts on their mind, body and social relationships, while positive experiences affect the body alone. Participants spoke therefore not just of ill health but of social dislocation and feeling depressed, marginalised and isolated, often as a result of their inability to access care as well as the discriminations they faced along the way:

So as a Syrian person you generally feel unwanted. This is the difference. You feel like there is no ‘value’ to helping you. [Unmarried Syrian man, aged 26–30, refugee, homosexual.]

22 For more on the concept of wellbeing and the various ways it can be understood in the context of humanitarian crisis and response, see Lough et al. (2023).

I also feel like I cannot ask questions or ask for more, you know? I feel like we need to take what they give us because it's free. It's an uncomfortable situation to be in, but nonetheless, it is all we can receive. [Unmarried Syrian man, aged 26–30, refugee, homosexual.]

Everything we struggle with is because we are refugees. We are isolated from the health system, from accessing information, and from real solutions to our problem. We are meant to feel unwanted and like we have no future. [Unmarried Syrian woman, aged 18–25, refugee, bisexual.]

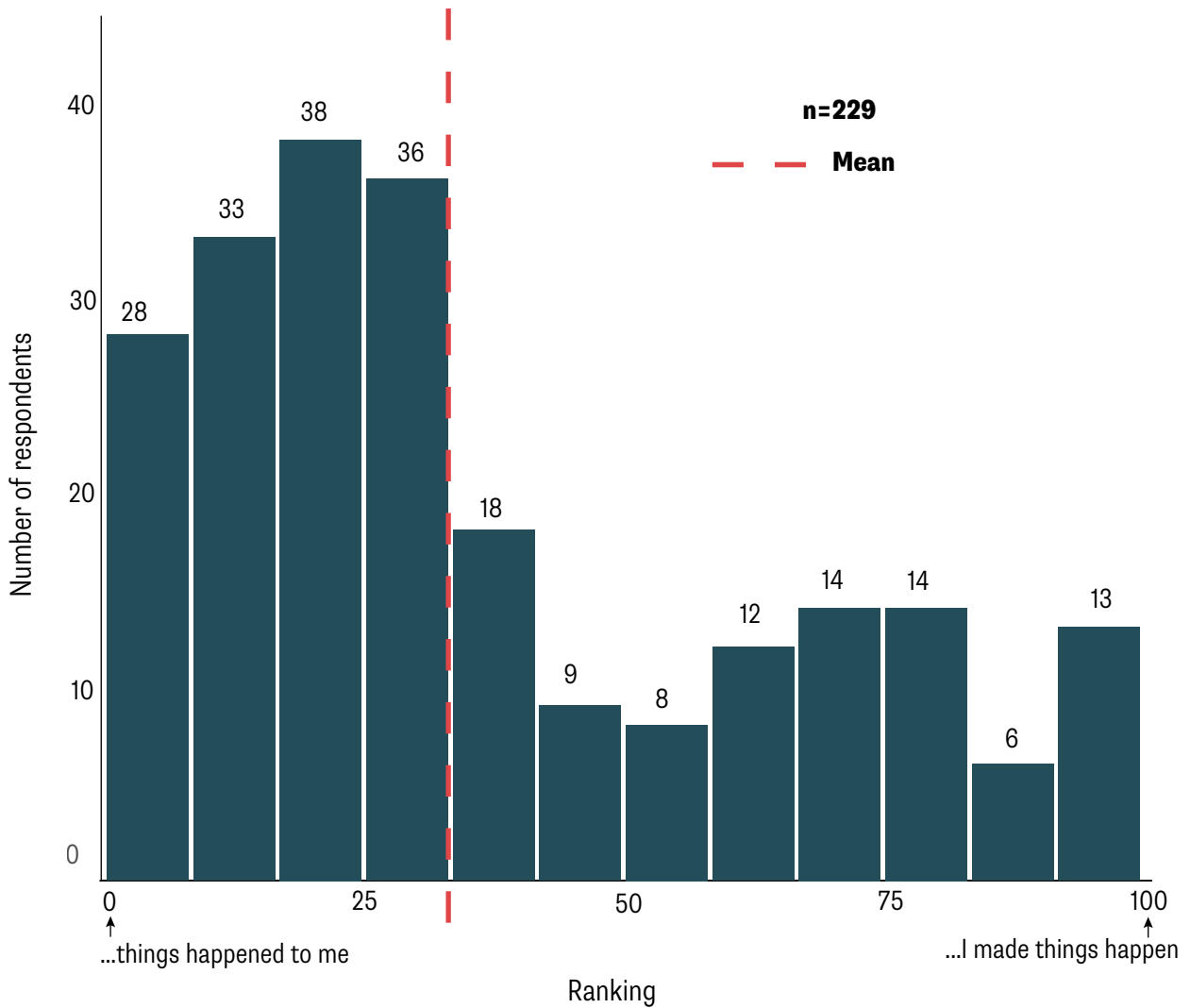
The prominence of such stories within the sample is indicative of the weight of negative experiences on respondents' wider wellbeing. Such impacts on wellbeing are inherently deserving of attention from relevant healthcare and humanitarian actors, but they can also create knock-on effects on health and SRHR specifically, having been shown to interfere with responsive caregiving by parents to their children, increase the risk of pregnancy complications, and correlate to inconsistent contraceptive use (Harper et al. 2020; Daelmans et al., 2021).²³ Recent research suggests that integrating SRHR services and referral pathways into other services, including GBV prevention/mitigation or mental health, to emphasise a more holistic notion of wellbeing could increase uptake of all the services involved.²⁴

Relatedly, respondents reported feeling forced into a passive role in their efforts to seek SRHR care, rather than being supported to take control of the healthcare services and systems available to them. For example, when asked to locate their experience on a sliding scale between 'In my story, things happened to me' and 'In my story, I made things happen', responses pulled strongly towards the former, expressing low levels of agency, self-efficacy and bodily autonomy (see Figure 12).

23 We refer here to wellbeing as a holistic concept, rather than mental health as a medical or psychiatric discipline. Some existing research has found higher rates of mental ill health have been observed in crisis settings – including depression, anxiety, post-traumatic stress disorder, bipolar disorder, and schizophrenia – at 22.1%, or one in five people, compared to a global prevalence of one in 14 (Vos et al., 2017 and Charlson et al., 2019 in Daelmans et al., 2021: 172). It is important, however, to apply idioms of mental health rooted in the Global North with caution in crisis settings in the Global South, especially relating to depression and post-traumatic stress disorder, as these can serve to individualise collective, interpersonal or social traumatic experiences and contribute to the medicalisation of crisis-relating human suffering (Carpi and Diana, 2020).

24 See Harper et al. (2020) for an example of integrating SRHR services and pathways with mental health and psychosocial support services.

Figure 12 Participants expressed low levels of agency



This finding is confirmed by numerous others where participants weighed the relative presence of empathy and compassion, access to information and care, and feelings of empowerment and choice. Participants tended to report a very low sense of empowerment and agency, even when they indicated a positive outcome from their experience. Agency is critical for a sense of wider wellbeing, in the sense of being able to act on the world and make choices rather than simply being carried along by it (Sen, 1993; Jackson, 2011).

When this finding was disaggregated across the different nationalities present in the sample, the result indicated a low perception of agency for all groups, but Syrian and Lebanese respondents indicated even less agency and empowerment than Palestinians. This may be linked to the presence of UNRWA as an architecture serving Palestinians specifically – see further discussion of this in section 2.3 and Chapter 3.

6.2 Recognising gaps in SRHR as protection risks

A lack of autonomy and agency in care-seeking and decision-making has an impact on wellbeing, as noted above, but it also is concerning because it raises the possibility of exposure to harms, including violations of bodily autonomy and obstetric violence, in the course of crisis-affected people's efforts to have their SRHR-related needs met. *Obstetric violence* refers to harms perpetrated by institutions, or indeed by medical professionals and humanitarian responders themselves, and may take the form of denial of services, persuasion or pressure to take up certain services or decisions, or overriding of patient consent (Sen et al., 2018). These harms often come under the pretence of medical professionals ostensibly knowing better than their patients.

Marginalised groups who are deemed, either implicitly or explicitly, to be 'undesirable reproducers' – people with disabilities, particular ethnic groups, people with diverse SOGIESC, or refugees and displaced people, for example – may be particularly vulnerable to reproductive harms such as these (Chadwick and Mavuso, 2021; Chalmiers, 2021). This is another acutely intersecting set of risks, which sees groups like refugees with disabilities facing especially complex and persistent denials of their bodily autonomy and agency.

Most research on obstetric violence to date²⁵ has not applied to crisis settings, so this is clearly an area for further research and understanding (see Box 2 in section 4.2). Learning and training on risks and ways to reduce, eliminate or mitigate them would help humanitarians and SRHR providers to better identify, detect and respond to reproductive and obstetric violence, as well as establishing protocols to avoid perpetrating it themselves.

This means that, while SRHR has not been conventionally understood as a protection concern in humanitarian circles, it should be. The 'rights' component of SRHR has not been meaningfully implemented in humanitarian settings to date; in fact, it is often actively resisted by humanitarians who see sexual or reproductive rights as political and therefore antithetical to principled humanitarian response, or as beyond the time-limited scope of humanitarian action and thus the purview of development actors. Together with the impacts on wider wellbeing discussed above, using a protection lens highlights why it is so problematic to adopt a narrow, 'needs-based' approach that treats SRHR as a question of health alone. Conversely, a reproductive justice lens (see Box 3 above) reveals the critical importance of rights, protection, and the structural conditions that shape crisis-affected people's ability to make choices, achieve positive outcomes, avoid undue harms and traumas, and pursue healthy sexualities and relationships.

The debate between needs-based or rights-based approaches in wider humanitarian response has ebbed and flowed since the early 2000s (Borgrevink and Sandvik, 2022: 287) but, amid shrinking funding pots and other pressures, more limited needs-based frameworks have lately resurged.

25 See, for example, a recent special issue of *Sexual and Reproductive Health Matters* on disrespect and abuse in maternal care (Sen et al., 2018).

When it comes to SRHR, which has long been heavily politicised and has experienced additional global backlash in recent years, a focus on needs is often read as helpfully avoiding divisive questions around premarital sex, abortion and other issues deemed culturally or politically controversial. It is also an attractive logic in a context of scarce resources to achieve truly comprehensive, holistic care (Samuels and Daigle, 2021; Tanyag, 2021). However, needs and rights are not so easily disentangled: the delineation of needs is itself a question of rights, agency and bodily autonomy – of whose needs are to be met, how, and under what circumstances (Petchesky, 2000: 21; Daigle and Spencer, 2022).

Engaging protection actors in designing and delivering SRHR pathways from a perspective of rights is a question of fulfilling the rights of crisis-affected people to appropriate care for their health and wellbeing, but also a recognition of the additional needs – for both health and protection – that are generated when rights are neglected, or even violated by the very people charged with providing care.

6.3 Community, peer and self-led care models

The findings from this study indicate a strong potential role for peers, families, communities and other networks in improving access to and even delivering SRHR, particularly amid barriers related to provider attitudes and discrimination, which obstruct marginalised people in particular from accessing the care they need. This is part of a broader move towards de-medicalised modes of delivery that make SRHR more accessible, more dignified and resistant to the pathologisation of normal bodies, sexualities and reproduction that can come with treatment in formal medical spaces (Assis and Larrea, 2020). De-medicalised approaches are also key to recognising and mitigating the trauma that individuals, especially from marginalised groups like people with diverse SOGIESC and people with disabilities, have experienced in medical spaces.

When asked who should hear their story, the largest number of survey respondents (167 respondents; 70%) selected ‘my peers/people like me’, demonstrating a desire for understanding that was also reflected elsewhere in the findings. This suggests that relational interventions at community level to support understanding and reduction of stigma around particular identity groups or SRHR services could be useful innovations, especially those spearheaded by civil society organisations led by the same marginalised populations that they seek to serve – including women, LGBTQIA+ people, and women with disabilities – and which are known to be effective on issues such as GBV (Imkaan, 2019). Such ‘by and for’ organisations are best placed to understand the intersecting and complex needs of marginalised groups, often operating with an ethos of solidarity-building, collectivity and ‘power with’ that engenders agency and allows marginalised people to define their own priorities going forward.²⁶

²⁶ Broadly, ‘power with’ refers to a group’s ability to take collective action towards shared goals, fostering a sense of agency and collaboration. It is commonly contrasted with and proposed as an alternative to ‘power over’, which denotes an asymmetrical and coercive relationship where one individual or group exerts influence over another (Pansardi and Bindi, 2021).

Aside from increasing accessibility and uptake of needed services, there is also real potential in such peer-to-peer models to mitigate the negative impacts that arise from isolation and discrimination reported by respondents, both in and out of clinical spaces.

Our findings on the need and appetite for peer and community support also flag the role already played by rights-focused civil society organisations in providing spaces for information-sharing as well as advocacy for bodily autonomy, rights and inclusion for marginalised groups outside of explicitly medical spaces. Previous HPG research has shown that place-based, grassroots organisations serving marginalised groups in crisis settings are agile, effective, and possess embedded knowledge of the realities of the communities they serve that international actors cannot replicate (Njeri and Daigle, 2022).

In Lebanon, such entities include PWHO, MOSAIC, Helem and FE-MALE, among others. Some of these organisations already carry out direct advocacy and provide referral pathways related to inclusive and accessible SRHR care.

Previous research in other settings suggests that approaches based on a more holistic notion of wellbeing, with attention to mental health as well as SRHR, can increase uptake of services (Harper et al., 2020). These interventions should entail community components such as peer support groups and drop-in centres; strong peer educational components focused on problem-solving, self-regulation, contraception and STI prevention; assertiveness and communication skills related to condom use and consent; GBV mitigation; and non-medical community workers and champions. These last two groups of people are critical for delivering services outside of traditional clinical spaces, which may be exclusive or the sites of previous traumatic experiences for marginalised patients (ibid.; Stephens and Lassa, 2020).

The survey also suggests real potential for self-care and other community-led, de-medicalised approaches to SRHR as possible means of circumventing institutional and attitudinal barriers encountered in formal healthcare spaces and pathways. Self-care interventions have also emerged in existing research on SRHR as an area for innovation in the humanitarian sector, especially for expanding contraception access, postpartum care, self-managed abortion care using the medication misoprostol, and self-testing for STIs including HIV (Jayaweera et al., 2021; Popple et al., 2021; Dawson et al., 2022). The World Health Organization (WHO) issued updated guidelines for self-care in 2022 (WHO, 2022b).

To date, studies on self-care have rarely touched on humanitarian actors or service delivery, or the particular barriers, implementation challenges or supply-chain issues that characterise humanitarian SRHR, making this a key area for research with as-yet unknown programmatic implications that will vary based on diverse factors (Tran et al., 2021; Dawson et al., 2022).

Notably, and particularly in crisis settings, self-care methods of various kinds likely already exist (Tran et al., 2021: 2):

Individuals living in humanitarian or fragile settings may increasingly resort to SRH self-care, as crises may accelerate the inequities in access to healthcare providers and services. A more deliberate application of self-care that recognizes underlying inequities and seeks to mitigate, rather than exploit them, could be particularly appropriate for increasing health coverage.

The findings discussed in Chapter 5 confirm that our participants also responded to barriers related to cost or discrimination by finding creative but sometimes risky solutions, including purchasing tests or medications outside formal medical channels, accessing illicit and/or private sector abortion services, and consulting with medical professionals informally through their own familial or social networks.

There is a clear need for more evidence and contextualised national guidelines around the SRHR self-care initiatives that are patient-led, accessible and create demand, especially amid limited resources. To date, however, the kind of programmatic models and guidance that are needed for decision-makers to allocate resources and practitioners to implement interventions safely are lacking, especially in crisis settings with highly disrupted health systems.

It bears noting here that, while self-care interventions can be conducive to agency and self-efficacy, greater uptake of services and improved health outcomes, they should never displace provision by humanitarian actors and government institutions where they are feasible. These entities have an ethical and statutory duty to provide accessible and appropriate SRHR services, and this responsibility must not be devolved to individuals under the guise of self-care except under the most extreme access or coverage restrictions.

6.4 Provider attitudes and healthcare avoidance

Chapters 3 and 4 examine intersectional barriers encountered by our research participants in their attempts to access SRHR care, many of which related to aspects of their identities that were stigmatised in the context of cultural, social, religious and other norms and stark inequalities. The role of attitudes of service providers and fears of judgemental or undignified treatment is a key cross-cutting theme here and poses obstacles to potential users (see also Endler et al., 2020). This is particularly the case for those experiencing intersecting oppressions, such as people with diverse SOGIESC, women and girls with disabilities or living in poverty, and refugees and other displaced populations.

Across a variety of contexts, crisis-affected people underline the importance of non-judgemental and dignified treatment from providers as a key factor in facilitating greater uptake of SRHR services. They also cite distrust of providers and negative attitudes towards them from service providers as exerting downward pressure on their willingness to seek out care, particularly for those with disabilities (Tanabe, 2015; Casey et al., 2020; Rivallas-García et al., 2021; Hossain and Dawson, 2022). Amiri et al. (2020: 18) reviewed interventions for Syrian refugees in Jordan, finding that service providers' own poor knowledge of SRHR and negative attitudes towards particular patients constitute 'important impediments that require immediate attention'. These barriers include refusing to provide emergency contraception to unmarried women and survivors of sexual violence, leading to increases in unsafe

abortion. Tanabe et al. (2015) and Casey et al. (2020) note how, even in settings where antenatal, contraceptive, HIV-related and other services were available, youth and people with disabilities were discouraged from using them or belittled in their attempts.

Among our own sample, perhaps the most troubling finding that emerged was a recurring indication that participants would not seek SRHR care again through formal channels as a result of the discrimination they had experienced. When asked how their experience would shape their future engagement with SRHR services and providers, the responses were striking in their directness and resignation:

I don't think I will ever seek help. At least, not from a professional. [Married Syrian woman, aged 30–35, refugee, heterosexual.]

I don't think I will seek out care unless I absolutely have to! [Lebanese woman, 30–35, heterosexual.]

Unfortunately, I will keep avoiding professional help when I need it because the community is still the same. [Married Syrian woman, aged 30–35, refugee, heterosexual.]

There are not too many options for us already. And when we do get help, people are not supportive or helpful. So the future is not looking like an option for me either. [Unmarried Palestinian man, aged 26–30, double displaced, homosexual.]

This finding should be of concern to healthcare providers, humanitarian responders and rights advocates alike, and merits attention in the future design and delivery of SRHR services to crisis-affected populations.

The available systematic reviews do not always distinguish between service providers from pre-existing health systems versus humanitarian responders; nonetheless, negative provider attitudes are a risk to all forms of SRHR provision and should form part of coordination, training, preparedness planning and monitoring. SRHR training is insufficient across the board, and this holds true for training relating to service provider attitudes, values clarification, confidentiality and compassion, and knowledge of and confidence working on SRHR-related topics (see, for example, Smith et al., 2013; Amiri et al., 2020). When providers are advised and supported to provide non-judgemental and quality services, they can build trust with patients, especially youth, and counsel them on their sexual health needs. Ipas offers an open-source toolkit for values clarification for addressing provider attitudes (Turner and Page, 2008).

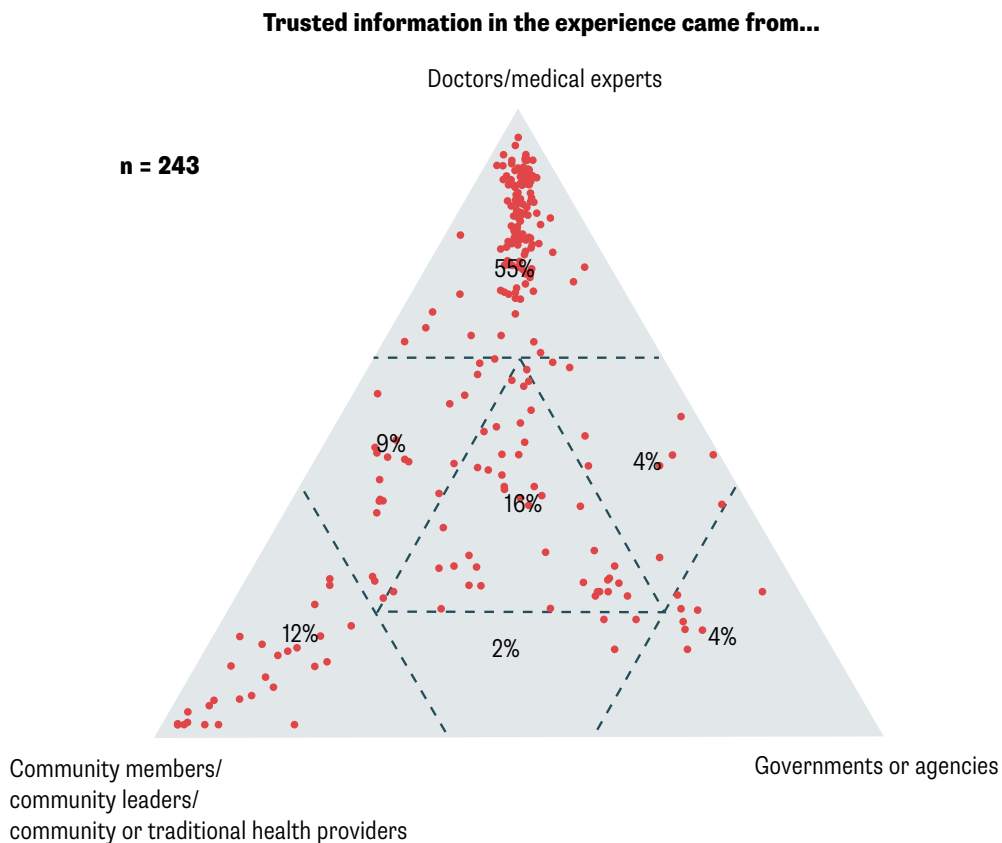
6.5 Gaps in information, awareness and education

On the whole, the findings show that people generally know that trusted information should come from reliable sources, but – importantly – they still are often unable to get it from those sources in

practice.²⁷ As noted in Chapter 3, respondents recognised the importance of doctors and medical experts in accessing trusted information on their SRHR needs, with 55% of respondents suggesting trusted information only came from doctors and medical experts (see Figure 13). This might be readily interpreted as a positive finding, particularly given the sensitive nature of the information and the complex and restrictive social norms around such issues.

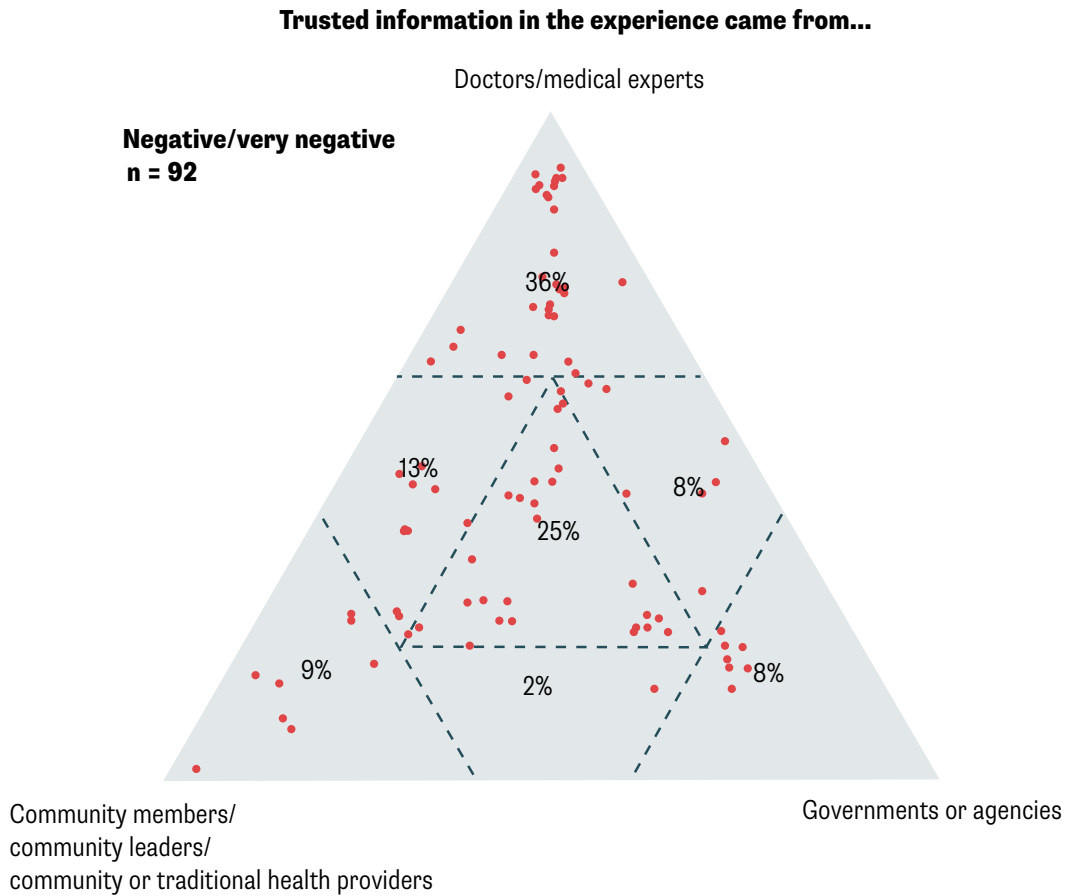
However, further examination of this and other data from the survey reveals two key caveats: first, for those who classed their experiences as negative, this figure drops to 36% of respondents (see Figure 14). Similarly, the same group reported the quantity of information they received as severely deficient, as well as lacking in empathy and compassion. Conversely, those with positive experiences strongly believed that trusted information came from doctors and medical experts (76% of respondents) and broadly found that information sufficient, practical and instructive.

Figure 13 Survey respondents on the sources of trusted information in their SRHR care



27 Contra our findings, Cherri et al. (2017) found that Syrian women in Lebanon relied on doctors as the main trusted source for information, with other sources of information being community health workers, pharmacies, family, friends and neighbours.

Figure 14 Survey respondents who had negative experiences on the sources of trusted information in their SRHR care



Secondly, when asked where respondents actually get information regarding their SRHR, despite their strong preference for information from medical professionals, the majority of the 262 respondents referenced seeking it instead from peer support networks (friends, family members, spouses and informal community groups). By contrast, private clinics, NGOs, public clinics or health centres were indicated as sources of information by just 32% of respondents (83 respondents), and international humanitarian agencies was selected by just 26% of respondents (67 respondents). This demonstrates that, while participants know where reliable and rigorous information about their SRHR should be found, they are unable to access it through those channels, likely due to the barriers already enumerated here.

Taken together, this data shows clear gaps in the quality and quantity of information available to people trying to access SRHR care, especially for those with negative experiences of SRHR access, among whom marginalised groups are heavily represented. Ultimately, doctors and medical professionals, those who are supposed to provide care on SRHR concerns, are poorly respected in terms of the information they provide and act as a barrier to better SRHR outcomes.

So, in all honesty, I know very little about this, and don't know who to trust. I try to do what other people in my community do. I resort to friends and family for advice. But I mean, what you don't

know scares you. I am scared that the professionals will not take social and cultural sensitivities into account. [Married Syrian woman, aged 30–35, refugee, heterosexual.]

Health literacy and access to information have been identified as key elements of increasing uptake of existing SRHR services, including among Syrian refugees: ‘According to one study in 2015, only 64% of households of registered Syrian refugees [in Jordan] knew that refugees had subsidized access to government primary health centers’ (Amiri et al., 2020: 15). Research in other crisis settings has also emphasised the importance of school- and community-based awareness campaigns and education around SRHR for increasing demand and uptake of services. Involving adults is key to influencing behaviours among youth and ensuring acceptability (Singh et al., 2018; Jennings, 2019; Bako et al., 2020: 28; Desrosiers et al., 2020). In conservative regions like the Bekaa Valley in Lebanon, consulting and building trust with communities and their leaders before introducing new SRHR services can help to increase acceptability and optimise utilisation.

A central contention of this study has been to evidence the unmet needs for SRHR in Lebanon; equally important, however, is to demonstrate that the existence of services is not sufficient on its own to ensure access.

Barriers to services are too rarely understood or addressed in humanitarian action, especially for marginalised groups, a fact that has been observed with regard to wider inclusion efforts beyond SRHR, despite the existence of rights-based frameworks for monitoring and analysing obstacles to services like the Availability, Accessibility, Acceptability, Quality (AAAQ) framework, which needs strengthening but nonetheless represents an opportunity (Lough et al., 2022).²⁸

Gaps in knowledge among crisis-affected people about those existing services and their entitlement to access them are also a clear impediment to uptake of services. Further engagement with awareness-raising and comprehensive sexuality education, particularly embedding these into existing approaches, interventions and services, will be key to combatting the spread of misinformation that may hinder the use of SRHR services.

From the data presented above, it is clear that pressing needs relating to SRHR are not being met for diverse crisis-affected populations in Lebanon, with far-reaching deleterious implications for health outcomes as well as mental health, social inclusion and wider wellbeing. Services that recognise the complexity and criticality of a holistic approach to SRHR are badly needed to build pathways to access that are conducive to outcomes far beyond health indicators and metrics. Amid the economic crisis in Lebanon and declining budgets for both UNRWA and UNHCR’s response in Lebanon, it is also imperative that such pathways are appropriately resourced.

²⁸ The AAAQ framework is outlined under the General Comment No. 14 on the Right to the Highest Attainable Standard of Health (OHCHR, 2000).

7 Conclusion

SRHR represents a critical need for crisis-affected people in Lebanon, bringing together evident health needs with sexual and reproductive rights, agency and bodily autonomy. While the impact on health outcomes at the individual and macro levels are clear and pressing, efforts to limit the agenda to health alone risk generating additional needs and harms. This has important ramifications for affected groups, and especially those experiencing multiple forms of marginalisation, that should be of immediate concern to humanitarian responders. It also creates further demands on limited humanitarian capacity for health, protection and other forms of support.

It is therefore imperative that humanitarians come to understand and reframe SRHR gaps as protection concerns with a direct impact on areas including (but not limited to) obstetric violence, intimate partner violence and domestic violence, and sexual violence; resilience, economic participation and livelihoods; political voice and participation; and wider wellbeing. This research has suggested some key ways to expand accessibility and inclusivity, including incorporating a reproductive lens that centres rights, bodily autonomy and enabling structural environments. De-medicalised approaches centred on community-level advocacy and service delivery, supported self-care models and holistic approaches are also promising.

Perhaps most pressing are the findings around especially stigmatised types of care and marginalised groups of people – most notably, in this case, people with diverse SOGIESC, who are strongly represented in the sample. Where, to date, many humanitarian agencies have cited safety concerns as brakes on their engagement with such groups, or even on generating understanding of their needs, this research demonstrates the potential of engaging sensitively, appropriately and consultatively through the medium of place-based organisations rooted in the communities they serve.

The resonance of these findings in settings beyond Lebanon and even the Middle East and North Africa region is also clear, as more and more evidence emerges of unmet needs and serious harms related to gaps and failures in SRHR in places like Ukraine (Center for Reproductive Rights et al., 2023). Going forward, additional research is needed to better understand and account for the complexity of SRHR needs and gaps in provision, especially relating to people of all genders with disabilities, particularly women and girls; people with diverse SOGIESC, including granular research on the diversity of groups that fall under that umbrella; barriers, enablers and availability of fertility care; and abortion in crisis settings. There is also space for replication of this study in additional crisis settings to further evidence unmet needs and establish the context-specific dimensions of SRHR needs and challenges.

7.1 Recommendations

7.1.1 International and national humanitarian actors

The following recommendations are aimed at national and international humanitarian agencies working in Lebanon with internally displaced, refugee or stateless populations and those affected by Lebanon's economic crisis and the 2020 Beirut explosion.

- **Adopt a reproductive justice lens that centres sexual and reproductive rights, bodily autonomy and agency in SRHR for all in crisis settings.** An approach grounded in reproductive justice offers the potential for better health outcomes, including for marginalised and harder-to-reach groups. It can also give rise to a greater sense of bodily autonomy that helps to reduce violence, grow confidence, and increase participation and leadership in inclusive humanitarian action (Daigle and Spencer, 2022).
- **Prioritise education and dissemination of accurate and appropriate information.** This should include:
 - conducting regular training for all healthcare workers, service providers, staff and volunteers on best practices, accessibility, gendered norms, cultural sensitivities, and combatting sexism, racism and homo-, bi- and transphobia;
 - making attitude transformation training mandatory for all service providers to address negative provider attitudes as a barrier to access;
 - working with service provision organisations to develop and deploy technological tools like mobile apps, phone lines, WhatsApp and other social media channels to disseminate education and information to crisis-affected and marginalised groups.
- **In all instances, prioritise enabling and empowering crisis-affected individuals in their healthcare decision-making.** Make sensitisation training on and prioritisation of patient autonomy core to humanitarian SRHR funding and service provision.
- **Urgently support the advancement of SRHR self-care**, in line with the Call to Action for Sexual and Reproductive Health Self-Care in Humanitarian and Fragile Settings produced by the Self-Care Trailblazer Group and the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) Self-Care Task Team.
- **Pursue cross-sectoral and cross-nexus ways of working** to better support continuity of care in SRHR and collaboration with actors working on protection, rights and social norm change. Coordinate with state health systems.
- **Adopt WHO's working definition and related policies on sexual health**, emphasising that everyone has the right to safe and pleasurable sexual experience (WHO, n.d).
- **Pursue integrated approaches across humanitarian response, especially with protection actors.** Key issues like GBV, menstrual health, mental health, stigma and restrictive social norms require integrated and cross-sectoral approaches. Examine the potential of wellbeing and other holistic approaches that break services out of silos and enable outreach beyond the usual spaces. Embed SRHR information and messaging into existing service delivery and pathways.

- **Consult meaningfully with crisis-affected people and place-based organisations in the design, implementation and evaluation of SRHR interventions.** This should include adolescents (especially girls), women, people with disabilities, people with diverse SOGIESC, older people, and displaced people, as well as organisations representing and led by these groups. Build sustainable systems for participation in decision-making and invest in gender-responsive and, where appropriate, locally-led gender-transformative approaches to improve agency and leadership around SRHR services and needs. Invest in appropriate and anonymous feedback mechanisms so that crisis-affected people can report back on the services and treatment they receive.
- **Collaborate with and support rights-focused ‘by and for’ organisations that represent the needs and priorities of marginalised groups.** These include PWHO, MOSAIC, Helem, FE-MALE and others that serve women and girls, people with diverse SOGIESC, people with disabilities, displaced people and refugees, and other marginalised groups.
- **Invest in evidence, programme evaluations and disaggregated data that is routinely collected and used.** This should include:
 - conducting rigorous evaluations of existing programmes to examine both process and short-, medium- and long-term impacts on adolescents and other vulnerable groups, and to establish any causal links between interventions and outcomes;
 - adding specific modules to routine data collection systems (e.g. a health management information system) and ad hoc surveys e.g. Demographic and Health Surveys and Living Standards Measurement Surveys, similar to an approach being piloted with UNICEF’s Multiple Indicator Cluster Surveys;
 - incorporating provider attitudes monitoring into regular monitoring, evaluation and quality control.
- **Be much more intentional about analysing and acting on barriers to realising SRHR in crisis contexts,** including by deploying and working to strengthen and improve tools like the AAAQ framework.
- **Invest in and collaborate with local specialist service providers, including civil society organisations like Marsa and Lebanese Family Planning Association, to design and deliver SRHR services,** in recognition of the fact that good-quality relief services can be a catalyst for better quality local services.

7.1.2 Lebanese state institutions

The following recommendations are aimed at Lebanese state institutions, healthcare infrastructure and civil society actors with the aim of supporting better health outcomes for internally displaced people, stateless people and refugees, as well as those affected by Lebanon's economic crisis and the 2020 Beirut explosion.

- **Ensure that national policies related to SRHR are in alignment with international standards and practices.**
 - Integrate SRHR into national strategies and programmes on health, protection, human rights and humanitarian response, as required by Target 3.7 (sexual and reproductive health) of the Sustainable Development Goals (SDGs).
 - Adopt WHO's working definition and related policies on sexual health, emphasising that everyone has the right to safe and pleasurable sexual experience (WHO, n.d).
 - Adopt and promote the WHO guidelines on SRHR self-care (WHO, 2019).
 - Commit to providing non-discriminatory care for refugees in alignment with SDGs 3 (ensure healthy lives and wellbeing), 5 (achieve gender equality and empower women) and 10 (reduce inequality).
- **Pursue joined-up and cross-sectoral ways of working** to better support continuity of care in SRHR and collaboration with actors working on protection, gender justice, social inclusion, rights and social norm change.
- **Prioritise community-driven approaches in collaboration with 'by and for' organisations representing marginalised groups**, including women and girls, people with diverse SOGIESC, people with disabilities, and displaced people and refugees. These include PWHO, MOSAIC, Helem, FE-MALE and others. Ensure that crisis-affected communities and marginalised groups play an active role in shaping, implementing, and reviewing interventions that affect them.
- **Strengthen healthcare infrastructure and coverage, particularly in areas with high concentrations of internally displaced people, stateless people and refugees.**
 - Ensure all policies and practices are inclusive and do not discriminate based on race, gender or status.
 - Establish a joint mechanism with public, private and humanitarian service providers for monitoring and evaluation of SRHR interventions across Lebanon, allowing for a standardised approach and benchmarking.
 - In collaboration with 'by and for' organisations, run national awareness campaigns on the importance of SRHR, targeting both the affected communities and the general public.

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