CARE Rapid Gender Analysis

COVID-19 and Beyond

Lebanon – May 2020

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Cover page photo: Al Inmaa Camp Refugee Camp, Bebnine Akkar

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Contents

Abbreviations

CIL	CARE International Lebanon
FGD	Focus Group Discussion
GoL	Government of Lebanon
(I)NGOs	International Non- Governmental Organizations
KII	Key Informant Interviews
LGBTIQ+	Lesbian – Gay – Bisexual – Transgender – Intersex- Queer - Plus
WHO	World Health Organization
MOPH	Ministry of Public Health
MOSA	Ministry of Social Affairs
PRS	Palestinian Refugees from Syria
PRL	Palestinian Refugees from Lebanon
LCRP	Lebanon Crisis Response Plan
VASyR	Vulnerability Assessment Syrian Refugees
SGBV	Sexual and gender-based violence

Executive Summary

On February 23rd, Lebanon reported its first COVID-19 positive case. On March 16th the Lebanese authorities responded in a promptly manner by declaring a state of general mobilization and encouraging citizens to observe physical distancing. At the same time the newly formed government adopted a series of measures including movement restriction, curfews, shop closure the temporary suspension of flights. The virus was identified on January 8, 2020 and has since spread to 210 countries, infecting more than 5.33 million people and caused fatalities all around the globe**.** As of June 16th, Lebanon counts 1,446 COVID-19 positive cases[1].

The Covid-19 pandemic in Lebanon is a crisis within a crisis. It occurred during a broader socio-economic meltdown that has shaken the country in recent months. In October 2019, Lebanese occupied the streets in various cities across the country demonstrating against corruption, unemployment and sectarianism in the country. Lebanon appears to have responded effectively to the pandemic so far, a number of major challenges await it. With little measures to mitigate the economic impact of the confinement and protesters pushing to return to the streets, the country is entering a challenging era with major impact on people's lives; refugees (about 1,5 million) and host communities. It is imperative that measures that address the different needs of women, men, children and youth with particular attention to underlying vulnerabilities of certain groups including displaced people, refugee populations and migrant workers should be adopted in a comprehensive and coordinated way.

The Rapid Gender Analysis (RGA) intends to highlight how COVID-19 in the context of the socioeconomic crisis impacts differently women, girls, boys and men and recommend measures to address and mitigate risks related to the protection and wellbeing of affected population. The RGA is looking into the following areas of interest:

- Gender roles and responsibilities
- Decision making, participation and leadership
- Health, mental health and SRHR
- Access to services and resources
- Safety and Protection
- Access to information and technology
- Capacities and coping mechanisms

Key findings

- Women experience additional burden as care givers while they have fewer opportunities to contribute financially in their households.
- COVID-19 affected everyone's access to livelihood opportunities, with women having less access and control over their income.
- Women, men and youth experience increased feelings of distress and anxiety as the economic situation worsens and people result into poverty.
- Access to services including health and SRHR has been affected particularly for women and girls who experienced additional movement restrictions and lack of income.
- Incidents of gender-based violence have increased with women and girls feeling less safe in the households and communities and access to specialised services being constrained.
- Risks of sexual exploitation and abuse increases as a result of more people being unable to meet their basic needs.
- Extremely vulnerable groups such as migrant and domestic workers have little protection while their needs exacerbate as a result of the crisis.
- Low participation of women and men in decision making mechanisms at community level with women being the less represented and involved.

[1] As of June 16th 2020 https://www.moph.gov.lb/maps/covid19.php

Key recommendations

The following recommendations are targeted toward humanitarian and development actors in Lebanon as well as the relevant government bodies and donors.

- All actors involved in the humanitarian and COViD-19 response should consistently collect and analyse sex, age, and disability disaggregated (SADD) data and utilize in tailored actions to address the COVID-19 pandemic.
- Priority should be given in effective engagement with communities in order to better understand their needs and priorities and enable their capacities to respond to emergencies through a community support system.
- Targeted intervention including in kind and voucher support to be made available to vulnerable groups including migrant and domestic workers with priority to those who are unable to cover their basic needs.
- NGO, civil society organization and authorities engaged in GBV service provision to scale up their response and ensure continuity of relevant services in line with precautionary measures and guidelines developed by the SGBV Task Force on GBV activities during the COVID-19 outbreak.
- Agencies responding to the pandemic should resume mental health and psychosocial support services for women, girls, boys and men including group and individual sessions in line with COVID-19 measures
- Economic empowerment and equal participation of women and men in the labour market should be prioritized through tailored interventions to address the needs of the current context efficiently and in a timely manner under the recovery phase.
- Donors should emphasize and prioritize gender responsive programming with an emphasis on do no harm approach and PSEA as a mandatory requirement for (I) NGOs and local partners.
- Advocacy efforts against the abusive kafala sponsorship system[2] should be reinforced with join messages from the humanitarian community, civil society, human rights advocates, UN bodies and donors ensuring protection of migrant and domestic workers rights under the labour law in safe, equal and dignified manner.

[2] "Under the Kafala system a migrant worker's immigration status is legally bound to an individual employer or sponsor (kafeel) for their contract period. The migrant worker cannot enter the country, transfer employment nor leave the country for any reason without first obtaining explicit written permission from the kafeel." …" The power that the Kafala system delegates to the sponsor over the migrant worker, has been likened to a contemporary form of slavery." ILO and the Migration Forum in Asia. Policy Brief No2.: Reform of the Kafala (Sponsorship) System https://www.ilo.org/dyn/migpractice/docs/132/PB2.pdf

Introduction

Background information and Humanitarian Context in COVID-19 crisis

Nine years into the Syrian crisis, Lebanon remains the country with the highest refugee population per capita, hosting as per (GoL) estimation of 1.5 million refugees living in informal settlements (ITS), in urban and rural areas. Based on the LCRP,3.2 million people - refugees and host community members - are in need of immediate support[3]. Gaps in the humanitarian response are exacerbated as a result of the economic situation and its repercussion on the stability of the country. At the same time, durable solutions for the refugee population remain uncertain with significant barriers to return, the lack of sustainable safety and security in Syria, housing, land and property issues, lack of access to services and livelihood opportunities.

Number of people who tested positive for COVID-19 numbers of reported cases: 1788 (56% Male; 44% Female)

Number of fatalities: 34

Number of people tested positive disaggregated by age group:

less than 10Y	8.25%
10-19Y	10.6%
20-29Y	24.68%
30-39Y	16.67%
40-49Y	13.86%
50-59Y	11.51%
60-69Y	7.33%
70-79Y	4.52%
80+Y	2.58%

Figure 1- Data as of July 2nd 2020, https://www.moph.gov.lb/maps/covid19.php

On the 2nd of September 2019, Lebanon declared a "state of economic emergency" as a result of the country's long-standing structural problems, including the crippling public debt. The country is suffering from accumulating economic problems which have led to a deep and wide-reaching social, political and economic crisis that led thousands of protestors to the streets on 17th October 2019. Protesters, who took to the streets as recently as April 2020, have demonstrated against the political climate in the country, the corruption, and the deteriorating quality of life including the hyperinflation, increase in commodity prices, the informal capital controls measures, scarcity of foreign currency, and high levels of unemployment and redundancy affecting mostly women and youth[4].

On February 23rd, Lebanon confirmed its first COVID-19 case. On the 16th of March, the Prime Minister declared a stage of general mobilization and called upon its citizens to observe a "self-imposed curfew" and instructed law enforcement bodies to ensure that citizens remained at home and exercised social distancing practices. The precautionary measures imposed by the GoL mitigate the spread of the virus has had a series of consequences on access to livelihoods opportunities and services and created challenges for a number of women and children for whom staying home is not the safest of options. In addition to this, human rights organizations report that local authorities in the North and Bekka had imposed movement restriction and curfews on refugee populations prior to the official announcements in a disproportionate and unjustified manner[5].

The impact of the worsening economic situation coupled with the COViD-19 crisis (health crisis within a compounded economic crisis) has effected all social standings, but especially the already poor and vulnerable households among the Lebanese and refugees' communities in the country. This has primarily impacted the living

[3] 51% are women and 54% children, add to the 1.5 million Lebanese whose vulnerabilities have been exacerbated by the crisis. The affected population also includes an estimated 27,700 Palestinian refugees from Syria and 180,000 Palestinian refugees from Lebanon. LCRP 2020, https://data2.unhcr.org/en/documents/download/74641

[4] The general unemployment rate is estimate at 11.4 percent, reaching as high as 23.3 percent for youth. https://www.executive-magazine.com/opinion/leaders/lebanon-faces-growing-unemployment

[5] https://www.hrw.org/news/2020/04/02/lebanon-refugees-risk-covid-19-response

condition of the vulnerable population: straining the lack of income opportunities, lower wages, worsening working conditions, limited access, and dysfunctional basic public services (health, social services, infrastructure, etc.). With a large portion of the population below the national upper poverty level (SYR 69%, LEB 28.6%, 65% PAL)[6] , it is foreseen that the current crisis will lead to a significant cohort of vulnerable households falling below the poverty line and potentially into a negative coping mechanism. People living in deprived areas rely mostly on public services, yet these people are most likely to only have access to lacklustre and poor-quality services.

The Rapid Gender Analysis objectives

The current report examines the impact of COVID-19 within the Lebanese context on the following key areas: gender roles and responsibilities, decision making and leadership, access to services and information, safety and protection, coping mechanisms, and capacities of affected populations. It aims to better understand the impact of the crisis through a gender lens and provide a meaningful recommendation to the relevant stakeholders including the authorities and the humanitarian and development community.

The Rapid Gender Analysis (RGA) for Lebanon has the following key objectives:

- To identify and analyze how COVID-19 outbreak has impacted differently women, girls, boys, and men considering the adverse effects of the economic crisis.
- To provide an analysis based on secondary data and available resources produced during and before the COVID-19 outbreak.
- To inform COVID-19 response and recovery interventions focusing on women's economic empowerment and participation, protection and SGBV, access to health (including mental health) and SRHR services.

This report is intended for policy makers, local and national authorities, civil society organizations, local and international NGOs, community members, donors, and the international community at large. It is organized around broad themes and areas of focus of particular importance to those whose programming advances gender equality and reduces gender inequalities. It seeks to deepen the current gender analysis available by encompassing learning from global gender data available for the COVID-19 public health emergency.

Methodology

Rapid Gender Analysis (RGA) for COVID-19 provides information about the different needs, risks, capacities and coping strategies of women, girls, boys, and men in the COVID-19 crisis in Lebanon. The current RGA has adapted progressively throughout the crisis: using a range of primary and secondary information to understand gender roles and relations and how they may change as a result of the COVID-19 outbreak as the country undergoes a major socio economic crisis. It provides programming and operational recommendations to meet the different needs of women, girls, boys, and men and to ensure we *'do no harm'* when planning and implementing interventions in response to the crisis. The RGA used the tools and approaches of Gender Analysis Frameworks[7] and adapted them to the rapidly changing context as well as the physical distance measures in line with the GoL decision on general mobilization.

[6] VASyR 2019,
[7] https://www.care.org.au/wp-content/uploads/2015/02/Good-Practices-Brief.pdf

The research has been undertaken in a period of three weeks, from the 5th to 20th of May 2020. CIL prioritised the use of secondary data reviews and complemented the research with low scale field data collection. In line with instructions to maintain social distancing and in order not to exhaust our resources and staffs engagement in the emergency response, CIL Research team conducted phone interviews and online surveys to collect data as well as a number of KII conducted in person post distribution of emergency aid in Akkar with refugee populations. Research methods included:

- **Secondary Data Review** (Reports and assessments are enlisted under Annex)
- **Key Informant Interviews** with 27 people (16 women and 11 men)
- **Household Phone Surveys** with 44 beneficiaries (37 women and 7 men)
- **Focus Group Discussions:** 6 FGDS with 23 participants, (16 women and 7 men)

A total of 94 people participated in the data collection 33.7% Lebanese and 66.3% Syrian Refugees (71.9% women and 28,1% men). Interviewees were identified through existing CIL program activities. Given CIL focus on women and girls programming the majority of interviewees are female. Out of the 68 people contacted to participate in the HH surveys, 9 people refused to participate, 9 people were unreachable and 6 surveys were not properly saved on the online tool.

The analysis was conducted by the CIL MEAL and with the Gender and Protection Coordinator with support of the CARE MENA Gender focal points.

Ethical considerations

When conducting this RGA for COVID-19, several practical, logistical and ethical considerations were taken into account. **A Do No Harm approach was taken and prioritised throughout the process**. This involved mitigating risks; as in direct risks, for staff and the community, associated with the novel virus, as well as ensuring that essential human, financial and logistical capacities were not diverted away from the immediate needs and direct response to COVID-19. Considerations included:

- **Secondary data was prioritized**. A significant proportion of data collection relied on the use of secondary data due to the following reasons: a) data on key aspects was readily available through assessments and reports prepared by other actors. There was a need however to triangulate and analyse the information which is reflected in this report. b) extensive data collection was not feasible due to the limitations mentioned below, highlighting issues around the restriction of movement and physical distancing which the team tried to mitigate though alternative measures.
- When any remote primary data collection or in-person field data collection was conducted, CIL ensured that precautionary measures were taken; **In person data collection**: a) compliance with CIL safety and security procedures; b) maintaining a physical distance (minimum of 1 meter) between the data collectors and interviewees; c) necessary equipment such as gloves and masks were made available for data collectors. Trainings and awareness raising sessions were provided to the data collectors and the beneficiaries who took part in the KII surveys. **Remote data collection:** a) the team of data collectors were outreach volunteers and CIL staff trained on them on protection, referrals, and facilitation skills; b) data collectors, were also trained on the use of the online tools.
- Data protection, confidentiality and the safety of respondents were considered at all stages. Data was collected **confidentiality** and **anonymously**. Data was collected in line with the principles of necessity and proportionality, and no names were registered to not be affiliated with the answers collected. Disclosure of protection incidents or incidents of SGBV was discouraged during the remote phone interviews and only specialized staff could engage these cases.

- Data was collected on a **voluntary basis**, CIL data collectors explained the purpose of the assessment, the duration and confidentiality and sought **informed consent** which was shared verbally and documented (through Kobo) before the phone survey and the in person interview (verbal consent was sought during the in person interviews to avoid any close contact or sharing of items such as pens).
- PSEA/GBV. All staff involved in the data collection process were trained on PSEA and safe identification and referrals. They were aware and ready to share **PSEA reporting mechanisms** and **SGBV referral pathways** including hotlines as needed.

Limitations

The assessment team dealt with several limitations. The out reaching of adolescent boys and girls was significantly challenging given that at times, they did not have equal access to a personal phone and/or they were not afforded the time to complete the questionnaire. For the households surveys, the team identified beneficiaries who were already familiar with the team, however, given that the vast majority of the program's beneficiaries were female, that resulted in a lower percentage of male participation in the survey. Due to the non-representative sampling size, it might not be advised to extrapolate generic conclusions on certain groups. The sampling size of such groups is: for pregnant and lactating mothers (3.91%), PWDs (women: 4,30%, men: 3,13%) and the elderly (6,97%). The findings of this report should be considered in conjunction with other reports and assessments which focus on the specific needs and vulnerabilities of PWDs and the elderly.

Demographic profile

Sex and age disaggregated data

Lebanon is a country of an estimated 6.8 million people[8] residing within a densely populated area of 10,400km^2. The country hosts the highest per capita refugee population – (estimated 30% of the population). According to the GoL, the country hosts 1.5 million Syrian refugees[9], 180,000 Palestinian refugees from Lebanon (PRL) and 27, 000 Palestinian Refugees from Syria (PRS). In addition to that, it is estimated that 250,000 migrants – most of them being women working as domestic helpers - are also residing in the country. It is worth mentioning that Lebanon is host to 18 officially acknowledged religious groups[10] and has a well-established sectarian system that has historically played a paramount role in the social, political and economic history of the country and influences many aspects of Lebanese wellbeing including aspects of gender equality and family law.

- Population Age Disaggregation for Lebanese: 0-14 years: 24.09%, 15-24 years: 16.42%, 25-54 years: 44.79%, 55-64 years: 7.91%, 65 years and over: 6.78%.
- Population Age Disaggregation for Syrians 0-4 years: 15.2%, 5-11 years: 25.2%, 12-17 years: 14.8%, 18-59 years: 42.1%, 60 years and over: 2.7%
- Average household size for Lebanese 4.3, for Syrians: 5
- Female headed households for Lebanese: 15%, for Syrians 20%
- Literacy Rates above 15 yrs. for Lebanese 93.9%, male 96%; female 91.8%[11]

[8] No Household Budget Survey (HBS) has been conducted by CAS since 2011/12 and the last national census was in 1932. However, estimated data is available here https://population.un.org/wpp/Graphs/1_Demographic%20Profiles/Lebanon.pdf
[9] This number includes 918,874 registered as refugees with UNHCR, along with 27,700 Palestinian refugees from Syria (PRS) and a pre-existing population of an estimated 180,000 Palestinian refugees from Lebanon (PRL), LCRP 2020.
[10] The **18 religious groups** are: Alawite, Armenian Catholic, Armenian Orthodox, Assyrian Church of the East, Chaldean Catholic, Coptic Orthodox, Druze, Greek Catholic, Greek Orthodox, Isma'ili, Jewish, Roman Catholic, Maronite, Protestant, Sunni, Shi'a, Syriac Catholic and Syriac Orthodox. Religious minorities exist and are often discriminated and marginalized https://reliefweb.int/sites/reliefweb.int/files/resources/mrg-briefing-religious-minorities-in-lebanon.pdf.

Findings and analysis

The impact of the COVID-19 outbreak in the context of the economic crisis has affected women and girls disproportionately as a result of their attributed roles in Lebanese society and the power dynamics that have played a significant role in decision making, access to livelihood opportunities, information services and resources. The assessment has focused on the following areas and looked into the effects of the crisis on women, girls, boys and men and in particular, groups faced with additional constraints such as refugees, displaced populations, people with disabilities, migrant and domestic workers.

Gender roles and responsibilities

Access and control of resources

Based on the HH surveys, 60% of responders agreed that men and women should share resources in households. However, 18.6% of interviews reported that men decide how resources will be allocated in the HH, compared to the 11.63% who reported that women were the ones making these decisions. FGD findings showed that more men in comparison to women control resources such as family income. The KIIs reported that even though spending is a topic of mutual concern among a husband and wife, the husband typically takes the final decision on how resources should be used. 57.14% of men and only 11.12% of women interviewed reported to have control of their income. 43% of men reported sharing their resources partially or fully. 63.89% of the women reported that this line of questioning was not applicable to them as they had no personal source of income and thus are dependent on their husband's income.

Our findings showed that the COVID-19 crisis has not changed the dynamic of who controls the household's resources, with 19.35% of women with a source of income are now reported to be sharing their full salary with their partner. Women and men have also reported that the harsh economic conditions have forced families to take hard decisions with women revaluating their priorities and neglecting some of their personal needs in order to give priorities to the family needs.. A positive change has been reported by the volunteers in Tripoli who stated that the harsh socioeconomic situation has encouraged women to engage in income generating activities (either home based or full time) potentially having a positive impact on their financial freedom and having a more significant say on how their households resources are spent and allocated.

"Women have started working to support themselves and their families by either sewing clothes, juice, or tailoring."

As demonstrated above and further triangulated using HH survey data and information collected during the FGDs, men typically possess ownership and control over resources with women gaining some space when they are able to generate their own income. This might affect the family dynamics which is something to be monitored closely as the situation evolves.

Division of (domestic) labour

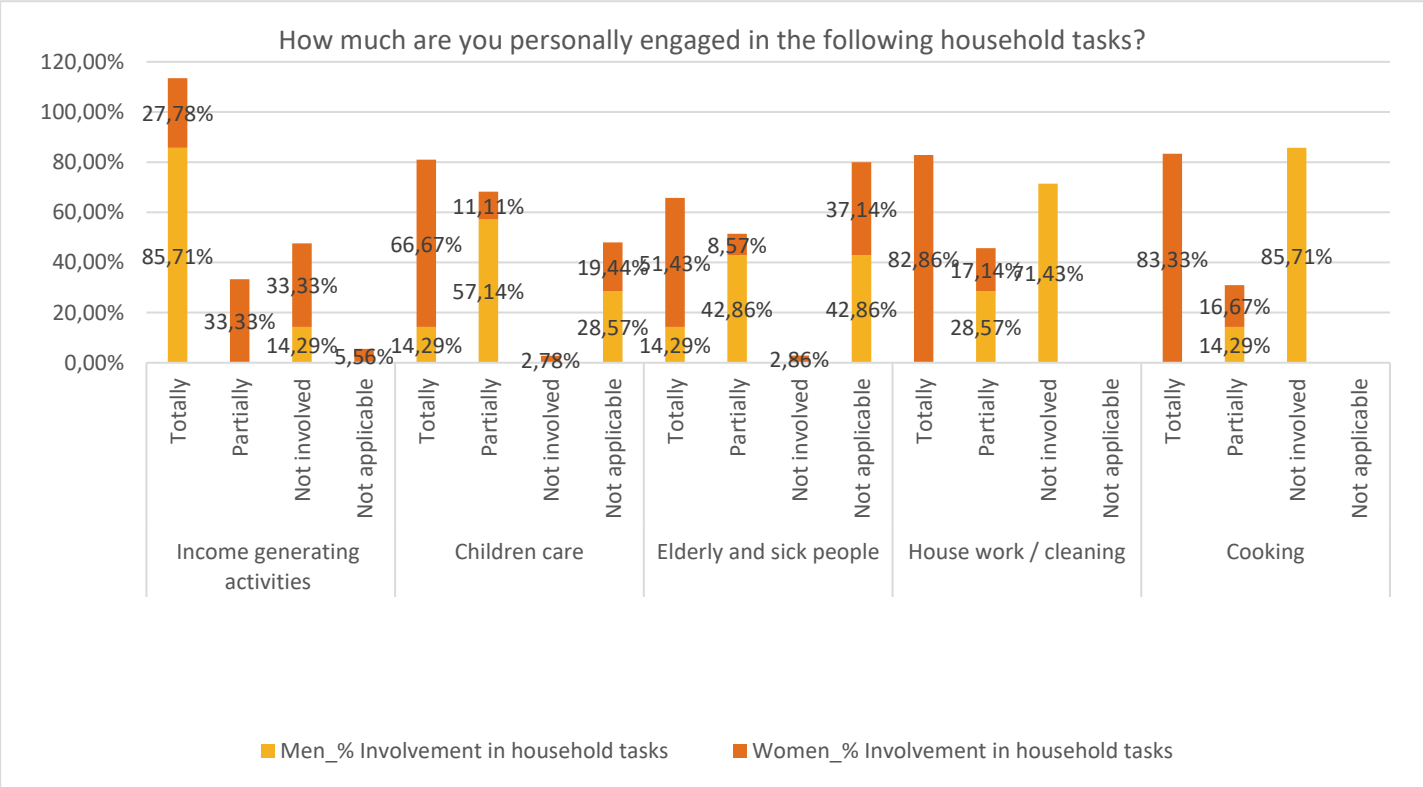
Lebanese, Syrian, and Palestinian families uphold clear division of roles and responsibilities, with women and adolescent girls performing households related tasks including childcare which increased in intensity during COViD-19. Women during COVID-19 were expected to carry out additional unpaid work including caring for the elderly, PWD and dependant family members. Women during KII reported that they felt overwhelmed because they had to take on additional responsibilities and extra hours to clean and cook for family members. The additional burden has led to physical and emotional distress for women, negatively affecting their wellbeing.

Although men spend more time in the household, it remains highly unlikely that they would engage and contribute to household chores such as cleaning, cooking, childcare and others.

During the FGD in Tripoli, women mentioned that having men present in the house was at times helpful because the husbands tended to support the women with home schooling and childcare. However, key informants (women and men) reported that men staying at home negatively affected the family dynamic and increased tensions in the household with reported incidents of abuse against women and children.

Statistics from the HH surveys show that men usually spend more time than women on wage earning tasks than household tasks, and the contrary for women. Reportedly, men spend an average of 85.71% of the time on income generating work and an average of 14% on household tasks, while women spend an average of 83,33% of their time on household activities and 27% of their time on income generation. While many reported that women's role in income generation has increased since the crisis with women trying to find innovative ways to generate income; tailoring, juice making etc, the level of increase in women's involvement in productive work remains low.

A further breakdown of the percentage of time of men's and women's involvement in various household tasks (options including "not applicable", "not involved", "partially involved" and "totally involved") is as follows:



Income and paid employment

Prior to COVID-19, statistics indicated that women's participation in the labor force represented 23.54% of the female economically active population[12] positioning Lebanon as one of the lowest countries in comparison to other middle-income countries within the region[13]. According to the 2019 figures only, 1 out of every 4 Lebanese

[12] https://www.theglobaleconomy.com/Lebanon/Female_labor_force_participation/
[13] https://beirut-today.com/2019/08/05/lebanon-should-womens-labor-force/

women was either engaged or actively looking for employment. The worsening economic situation and the strict movement measures has significantly affected the access to livelihood and income generating activities for both men and women. In the HH surveys, 33% of responders reported that the income of their HH had decreased by 50% since March 2020; 40.54% of women in comparison to 28.85% of men reported to have lost their jobs after the COVID-19 outbreak. The impact of the COVID-19 measures is significant for Syrian refugees[14] and those engaged in daily work and the informal sector, with the consequences affecting their capacity to meet their families' basic needs and cover rent and shelter expenses. During the FGD, women and men reported that women may have to resort to seeking for employment which may have a positive impact on their role in the household and community. Data shows that women and children have a prevalent role in the informal sector and risk being further exposed to mistreatment, exploitation, and abuse. Furthermore, boys and girls engaged in child labour are often forced to return to work in poor hygiene conditions, with no access to hand washing facilities or protective equipment. It was noted that men's inability to provide for their families and fulfill their roles as breadwinners has had negative repercussions on their mental health and perception of their gender roles. The KIIs showed that increased feelings of stress and uncertainty has affected people's mindset and are often guilty of venting their anger and frustration out on their family members i.e mostly women and children. This can be also verified through the results of the recent SGBV Task force Assessment where women reported to feeling less safe in their household's post COVID-19[15].

> ***"I had to find a job to support my family, this is the first time I work outside of the house and although I was hesitant this is a great opportunity for me to learn and do something useful for my community and myself. I do not earn a lot of money but what is more important is that I feel more empowered and confident."*** **CIL female Volunteer.**

Decision-making, participation, and leadership

Participation and Decision making

Within the household: No major changes in the decision-making authority of the household have been attributed to the COVID-19 outbreak. Decision making in the household, has been largely attributed to men[16],with women having limited decision-making authority on issues related to daily household tasks and childcare. After COVID-19, the findings of the KII showed that men spend more time in the house, and this allows them to control decision making including issues related to health care, which prior the health crisis, were mostly attributed to women. Before COVID-19, mothers were responsible for making decisions on expenses related to childcare Women reported reduced decision making authority as a result of men presence at home. . When women asked about their ability to make decisions about their sexual and reproductive health and family planning options, they shared that these decisions are often taken by their husbands or mothers. Women reported that sometimes they had to resort to contraceptive methods such as IUDs, bearing the high risk of infection. The impact of the novel coronavirus has hindered the men's ability to provide as the primer bread winner for their families, which in turn has adversely impacted the household dynamic and might impact in the long term the decision-making patterns.
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[14] 95% of working Syrians are engaged in the informal sector with no social or legal protection
[15] Lebanon: Inter-Agency- Impact of COVID-19 on the SGBV Situation in Lebanon, SGBV Task Force- May 2020, https://data2.unhcr.org/en/documents/download/76729
[16] Understanding Masculinities: Results from the International Men and Gender Equality Survey (IMAGES): https://promundoglobal.org/resources/understanding-masculinities-results-international-men-gender-equality-survey-images-middle-east-north-africa/#

At community level: The RGA respondents reported that since the COVID-19 outbreak, the local government is taking the decisions on behalf of the community on issues related to precautionary measures related to COViD-19. It is also reported that very little equitable participation from community members has been achieved; 84.72% of the participants reported that neither women nor men participate in decision making procedures at community level. Only 20.45% answered that they felt their voices were heard and that the decision-making process is inclusive of their needs and priorities. Female respondents of KIIs reported no participation in any groups or collective decision-making fora while both men and women acknowledged a higher level of men's engagement in community decisions when feasible. In some cases, informants mentioned a joint decision-making process, but most still reported that ultimately men were guiding the decisions that impact the wider community, particularly in camps that rely heavily on traditional unorthodox structures (such as the Shawish system[17]). During COVID-19, refugee women experienced more difficulty in leaving the house or the camp, KIIs reported that women and adolescent girls movement were restricted because of the following reasons: fear of being harassed, contracting the virus and being arrested. At the same time, as reported by both women and men in the FGD, women tend to participate more than men in grass root initiatives and volunteer on the community level by supporting elderly or extremely poor families who needed support establishing safety nets for their families and communities.

Political participation and leadership

Despite great advancements in recent decades, the presence of women in leadership roles in Lebanon is still lacking and even less present in rural communities, where opportunities for female representation in local authority structures are scarce. In 2019, Lebanon ranked 149th out of 153 countries in women political empowerment, scoring Lebanon as one of the lowest representations across the MENA region and the world with only 3% of the representatives in parliament being women. Given the low representation of women in public institutions and decision-making bodies, there is a risk that gender aspects of the COViD-19 response are not taken into consideration. On a positive development, the reformed government established on the 21st of January consists of five (5) women in key Ministerial Positions[18] indicating that women have managed to gain ground in the political sphere. Lebanon has a strong women rights movement actively engaged in advocating for reforms and promotion of gender equality.

Health, including Sexual and Reproductive Health and Rights (SRHR)

In Lebanon, women make up 79.52% of the nurses in the health care system. This puts female nurses at the forefront where they are the main care givers and therefore the most exposed to occupational health risk in the hospitals and make them suffer stigma and social isolation. It might also expose their families to a higher risk of infection.

Safe access to health care and services (including SRHR)

[17] Shawish is a local leader – member of the community – appointed to monitor and supervise the refugee settlements. The Shawish might have connections with the Lebanese authorities and often act as mediator between the local authorities and the families residing in the specific camp. The Shawish has significant powers although very little legitimacy by the community.
[18] https://www.arab-reform.net/publication/lebanese-women-and-the-politics-of-representation/

The recent outbreak has increased the burden on Lebanon's health systems, making barriers to accessing quality health services greater for both men and women[19]. Women and men who work in the informal sector experience additional constrains in accessing free healthcare services given that they do not benefit from any form of social protection and access to the public health care system. Women and men in remote areas and refugee populations largely rely on WHO and humanitarian organizations to access essential health care services which have also been affected by the outbreak[20]. Among refugee communities, KIIs shared that costs associated with access to health care was a major cause for concern. This is also verified by the recent results of the IRC, NRC, HI Assessment on access to healthcare[21] : *".the main reported barriers to accessing PHC were financial (40%) or linked to transportation (23.5%)"*. Women reported that access to health care services has been affected negatively. This is triangulated with information collected during FGDs where women shared additional constraints which hinder their access to SRHR services. Such constraints include movement restrictions, lack of financial resources, and fear of getting infected. The recent Plan International assessment indicates that 83% of the women interviewed mentioned fear of COVID-19 contraction followed by 35% reporting safety and security reasons[22].

'It is a bit hard for the women and girls to safely access services, especially SRHR services, because families prefer to use the money to buy basic necessities such as food instead of paying for transportation to access such services' Male Key Informant.

Women expressed concerns related to the access to family planning measures and specialized tests which are either unavailable because activities have been suspended or difficult to access due to the movement restrictions in PHC and to health actors' centers[23]. Already, 42.43% of the women responders reported that since COVID-19, they have no access to family planning solutions and SRHR services. 83% of those women reported that fear of COVID-19 transmission is a barrier for them accessing SRHR services, particularly in Akkar[24]. 35% of female caregivers (49% Syrian, 51% Lebanese) reported that pregnant women have no access to antenatal care, and 56% (69% Syrian, 31% Lebanese) reported that pregnant women have no access to vitamin supplements, with Syrian women having slightly less access, in particular in Baalbek-Hermel. Such a gap may have serious effects on pregnant women, leading to an increased risk of pregnancy complications.

Both men and female participants agreed that those who experience the highest risks are PWD and elderly who depend on other family members support to access assistance or require specialised aid.

Mental health and psychosocial support

Access to mental health services has been challenging due to limited awareness, mobility restrictions, and general constraints of available services in the country. In addition, social stigma and misconceptions about mental health have prevented women and men from seeking support and specialised assistance. As per the Global School survey, mental health issues are prevalent among youth and school children, at times resorting to substance abuse (tobacco and alcohol) as well as bullying and suicide ideation occurring especially between the ages of 13 to 17 years old[25]. NGO work has been essential in targeted support to women, children, and youth. However, since the beginning of COVID-19, mental health services provided through NGOs and civil society organizations had to scale down or change their support modalities to remote counseling and PSS activities. Feedback from the FGDs indicate that face to face interaction is more efficient

[19] https://www.hrw.org/news/2020/03/24/lebanon-covid-19-worsens-medical-supply-crisis
[20] https://www.synaps.network/post/lebanon-health-hospital-covid-coronavirus
[21] Worsening access to Healthcare in crisis hit Lebanon, May 2020, Paper by IRC, NRC, HI
[22] Plan international Lebanon COVID-19 Needs Assessment, April 2020
[23] Reported by CARE midwives upon consultation with beneficiaries
[24] Plan international ibid
[25] Global Health School Survey, WHO 2017 https://www.who.int/ncds/surveillance/gshs/lebanon/en/

and preferable. Participation in online/phone sessions is not always feasible when being at home because of other obligations such as taking care of the children and household.

It is worth mentioning that Lebanon has seen a steady increase in suicide and suicide attempts since 2016, with 2018 recording over 200 cases[26]. Given the stigma attached to mental health problems, the number of reported cases might not be representative of the actual incidents. However, this increase in number warrants the attention of the relevant organizations and authorities. According to ISF data, in the first quarter of 2019 the number of incidents exceeded the average of previous years. Although there are no conclusive findings in the Lebanese context, feelings of increased anxiety and induced stress attributed to environmental factors such as the economic situation might exacerbate risks related to mental health conditions. The SGBV impact assessment conducted in November 2019 reported high levels of stress among women and girls interviewed throughout the civil unrest[27]. More recently, CIL social workers reported an increased demand for psychosocial support for women under confinement who are unable to cope with the situation. The SGBV Impact Assessment also showed that only 3% of women accessed non SGBV mental health services. Feedback collected during FGD shows that restrictions on access to mental health services is related to stigma and misperception in the community, but mostly lack of resources to cover transportation cost which is also confirmed by other secondary resources finding lack of money as the primary reason for not accessing such services. KII reported that men's mental health has been significantly impacted because of unemployment. Men reported feeling "bored", "useless" and "depressed" when staying at home unable to provide for their families. Feelings of hopelessness in addition to the fact that they can no longer fully feel their

[26] https://blogs.lse.ac.uk/mec/2020/01/28/lebanons-economy-and-its-effect-on-mental-health/
[27] Lebanon: Inter- Agency – SGBV Task Force – Humanitarian Impact Assessment of Lebanon's Ongoing Social Unrest and Possible Economic Crisis on Women and Girls (December 2019) https://data2.unhcr.org/en/documents/download/72847

traditional roles as breadwinners and provide for their households contributes to increased stress with negative impact on their mental health and overall wellbeing[28].

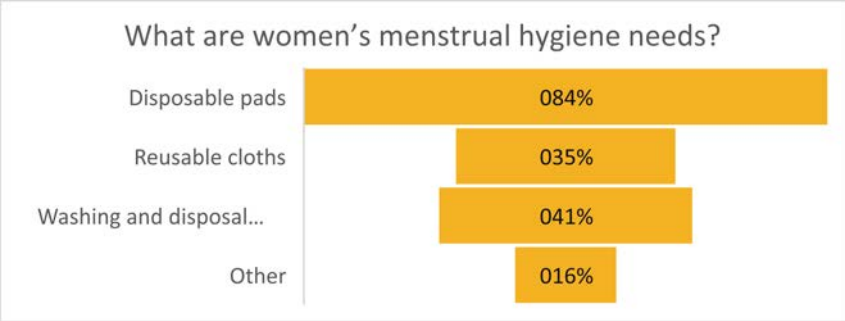
Access to services and resources

Public services in Lebanon including electricity, water, education and healthcare have always been of poor quality or interrupted especially in rural and remote areas. Certain groups experience additional difficulties accessing available services and as the economic situation deteriorates more and more people including women and girls experience additional constraints due to limited capacities, movement restrictions, lack of cash, fear of being

harassed (reported by women during FGD) and fears related to the spread of the virus. During the COVID-19 outbreak, access to services has been challenging to women, girl, boys and men as a result of the movement restriction, the loss of jobs and income as well as the services being limited and insufficient. Elderly and pregnant women are the ones mostly affected by the restriction as KII indicated. Furthermore, refugees who might have experience additional restrictions and curfews faced constraints with women and girls being unable or restricted to leave the camps in order to seek support. In certain areas women and girls' movement is further restricted by their families due to risks of harassment which makes access to services even more challenging. Access to hygiene items and in particular menstrual products has been consistently challenging especially for adolescent girls. In a recent assessment conducted by Plan, 35% of adolescent girls report not having physical access to local shops within walking distance to buy menstrual pads, and 66% do not have the financial means of securing

[28] December 2019 witnesses an increase in male suicide with three men committing suicide and one attempting suicide due to his dire financial situation. Understanding the Role of Women and Feminist Actors in Lebanon's 2019 Protests December 2019

these items, recording its highest levels in Akkar[29]. KII in Akkar reported that women would find alternative ways to cover their needs which often might put their health at risk.



Regarding education, 56.7% of the HH surveyed reported that both girls and boys attended school before the COVID-19 crisis, while 14.63% reported that neither boys nor girls attended school and 7.32% reported only boys attended school respectively. **From those who used to attend school, only 35.00% attend remote educational activities** with more girls attending remote learning than boys as reported during FGDs. This is confirmed by Plan Assessment findings, indicating that among the 46% of adolescents attending distant learning 58% are girls and 42% are boys. This might be because girls spend more time at home than boys and are more engaged to home-based activities during the lockdown.

Access to information and technology

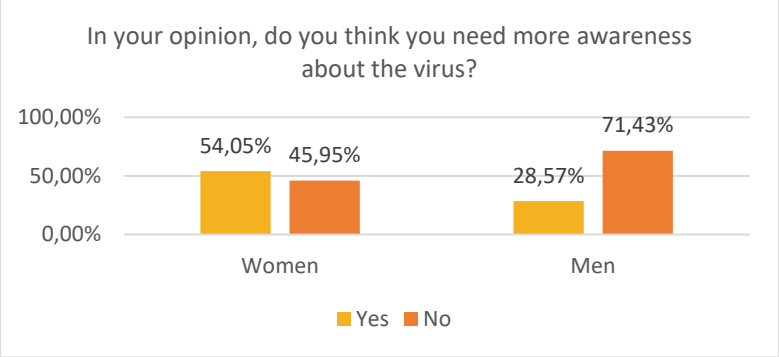
Access to information on COVID-19 varies with the vast majority of Lebanese and Syrians relying on TV news and social media. Awareness on COVID-19 also varies among different groups with Syrians reporting there is a need for additional information on physical distancing and prevention measures in the camps[30]. This is also confirmed by the HH results indicating that 51,72% of the Syrian participants reported there is a need for awareness on the virus. While a lot needs to be done in order for women and men to have safe access to accurate information in a timely manner, information should be disseminate in a way that allows for people with disabilities such as hearing or visual impairments to be able to access relevant information in an equitable manner.

As per the FGD findings, men rely mainly on TV news while women and adolescents' access online media for their information and receive information from NGOs and word of mouth. This confirmed by the results of the HH surveys with 71,43%% men comparing to 35,14% women considering TV as reliable source of information and 14,29% men comparing to 45,95% women find social media as the most reliable source of information. It is worth mentioning that women reported they also rely on other family members while 2,78% of women also reported they have no access to information.

It is worth mentioning that UNW report[31] estimates that only 1 out 3 women have regular access to a private phone. It is worth mentioning that based on a paper on access to technology published in 2017, only one third of the female interviewees reported having a phone in their possession. While percentage for adolescent girls are even lower with access to internet being at 55% and phone ownership at 17%[32]. Meanwhile, women and men acknowledged that there is a high risk for misinformation as well as cyber exploitation and abuse for

[29] Plan International Lebanon, ibid
[30] Oxfam paper on community discussions findings on COVID19.
[31] UN Women, "Unpacking Gendered Realities in Displacement - Lebanon," 2018.
[32] Research Paper, SGBV and use of technology in Lebanon, 2017

those groups using online resources and social media. As indicated in the below chart, more women (54,05%) believe there is a gap in awareness raising than men (28,57%).



During the FGDs, women reported that there are still gaps around information dissemination and more precisely information on the transmission of the virus as well information tailored to needs of pregnant and lactating mothers (breast feeding, protection of children and infants) is unavailable.

Safety and protection

Gender Based Violence

SGBV was already a challenge for Lebanese and refugee women and girls. Men and boys in Lebanon are also subject to violence and abuse however numbers remain low because of social stigma and lack of specialised service providers. Based on analysis of secondary resources including impact assessments, SGBV in Lebanon has increased during the COVID-19 outbreak as movement restrictions have trapped women and children in often unsafe environments. The lack of updated information on the availability of SGBV services, the lack of income (40,54% of women vs 28,57% men participating in HH surveys reported they have lost all their income), in addition to the movement restrictions create multiple barriers for survivors to have access to services and to seek refuge. Simultaneously, SGBV response and prevention services have been suspended or slow down while access to legal protection for survivors have been delayed due to the courts closure. Access to services is further restricted for survivors with unclear legal status, such as refugees and migrant workers. According to the information reported by SGBV actors, access to safe spaces has seen a decrease since the last quarter of 2019 due to movement restrictions and changes in priorities by women and girls in dire economic situations. A female beneficiary has shared with CIL that ***" .. this type of services are more and more important especially for women trapped in abusive environments but even then the priority is to bring food on the table".***

Gender-based violence

"Women find themselves locked down with their perpetrators. They are unable to reach out and seek support because of the confinement imposed by the government and at the same time they cannot report the incident or seek support remotely either because they have no means of communication (the phone has been deprived or they never had independent access to it) or because seeking support is not safe." GBV actors reported.

These findings are complemented by concerns raised during CIL FGD, with both male and female participants reporting that although domestic violence has always been a concern, as the economic situation deteriorates family disputes intensify and might lead to violence against the weakest members often women and children. Meanwhile, the SGBV Task force assessment[33] findings show an increase in violence in the household and

[33] Lebanon: Inter-Agency - Impact of COVID-19 on the SGBV Situation in Lebanon - SGBV Task Force - May 2020 https://data2.unhcr.org/en/documents/download/76729

the community (54%) with more prevalent types of violence being emotional abuse (79%) followed by physical violence and deprivation of resources (53%). According to GBVIMS data the rate of female survivors reached the highest (99%) in March 2020 while there was also a 5% increase of physical assault in March 2020 compared to January 2020, and a 3% increase of violence perpetrated by intimate partners or other family members in the first quarter of 2020 compared to the first quarter of 2019. These figures imply the increasing risks of domestic violence for women and girls.

Safety of extremely vulnerable groups

Migrant and Domestic workers: In Lebanon, there are over 250,000 migrant workers most of the them women from African and Asian countries whose rights are tight to kafala system with very little to no protection by labor law, thus putting them at risk of further exploitation and abuse with very little power to negotiate or hold their employers accountable. As the economic crisis - and more recently the health crisis - strikes domestic workers find themselves exposed to series of violations including losing their residency and being at risk of deportation[34]. A number of suicide attempts and other abuses reported to media over the last months indicate a high risk of abuse and exploitation by employers and very little access to services such as mental health support. ILO paper informs that since COVID-19, live-in women migrant domestic workers are subject to increased restrictions on their mobility with no day off and limited capacity to communicate with family and friends that negatively affects their mental health[35]. Human rights groups and civil society organizations, fear rising levels of violence, particularly for those in domestic work where women workers predominate. Domestic workers who are not protected by labour laws are excluded from national COVID-19 policy responses, such as wage subsidies, unemployment benefits or social security and social protection measures. Where access to COVID-19 testing or medical treatment is available, they may not come forward due to fear of detention or deportation, especially those in an irregular status or those whose residency permit has expired and did not manage to leave the country.

LGBTI+: LGBTI+ community in Lebanon has for years lived under suppression with their rights and freedoms being violated as a result of a conservative society and discriminated system. In Lebanon, same sex relationships are penalized and lead to imprisonment. At the same time, LGBTI+ people experience institutional discrimination[36] as well as harassment and abuse in their households, communities and the working environment.. Historically, in times of crisis, family and social network in Lebanon is of a paramount importance and a way for women and men to find protection and support. However, this has not been the case for LGBTI+ people, who are often rejected at home or forced to leave leading to marginalization form their communities. Before the COVID-19 crisis, LGBTI+ organizations and community centers in Lebanon served as a refuge for some people, who relied on their services, however, the economic crisis had already overwhelmed these organizations, and with the lockdown measures, these services have diminished dramatically. LGBT people who previously extended support to others in need, including by providing temporary accommodation can no longer offer the same levels of help due to the economic crisis and the necessity of physical distancing. After being rejected by the families and with less and less services available LGBTI+ people are exposed to risks which require dire attention from the humanitarian sector and the government.

Sexual Exploitation and Abuse

[34] https://www.amnesty.org/en/latest/campaigns/2019/04/lebanon-migrant-domestic-workers-their-house-is-our-prison/
[35] ILO Impact of COVID-19 on migrant workers and what employers can do about it, Lebanon April 2020 https://www.ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/publication/wcms_741604.pdf
[36] "The Lebanese NGO Legal Agenda has claimed that the majority of rights violations in Lebanon toward LGBT people are perpetrated by the state, rather than by citizens. They see it as part of the state's broader tendency to mistreat members of all marginalized communities." http://www.refugeelegalaidinformation.org/lebanon-lgbti-resources

CIL in partnership with Global Women's Institute have recently published the findings of a research on SEA in Lebanon[37]. Consultations with women and girls have shown that women and girls are exposed to sexual exploitation and abuse in their communities and when they access humanitarian aid. The research assessed the following sectors; cash assistance, food, shelter and wash and found that SEA is more prevalent to occur during the following instances; when women and girls register for potential assistance, while waiting for aid to be distributed (queues and distribution sites), when transferring aid back home as well as when aid workers and contractors conduct home visits for assessment or rehabilitation purposes. It has also been reported that single women and women head of families in particular are exposed to SEA by landlords under the threat of eviction. As described earlier the socioeconomic situation in the country exacerbated by the health crisis will result to more households being unable to cover their basic needs therefore dependency on humanitarian aid will increase exposing more people especially women and girls to unequal power dynamics and risks related to exploitation and abuse. FGD revealed, that in certain locations (Mount Lebanon, Beirut) men are often embarrassed to queue in order to wait for assistance this is why the females of the household will be the assigned to collect aid which might potential be a risk for their safety. Furthermore, as the situation deteriorates, more people especially those lacking social protection (refugees, LGBTI+, domestic workers etc) will be unable to cover their survival needs and will entirely depend on service providers, including private initiatives and charity organizations.

CARE International in Lebanon: Door to door distribution of food parcels in Chouf area. @Marwa Yehya

Capacity and coping mechanisms

Economic vulnerability in Lebanon is exacerbating with women, girls, boys and men being unable to meet their basic needs. World bank projections for 2020, suggest a sharp increase in poverty, with an anticipated 40% of the Lebanese population living below the poverty threshold (currently at $350/per month), and 20% facing extreme poverty[38]. Already in 2019, poverty for Syrian households increased with 73% of the registered population living below the Minimum Expenditure Basket[39]. It is estimated that 220,000 jobs from the private sector have been lost between October 2019 and January 2020 while since the onset of the health crisis …. Have either lost their jobs or their salaries have been decreased to 50%. as long as emergency measures continue, displacement-affected populations have minimal access to any livelihoods, which translates to loss of income, increasingly higher expenses and resort to negative coping strategies. Anecdotal evidence shows that more HH are unable to pay their rent and they are at risk of eviction while food insecurity increases among both refugee and host communities.

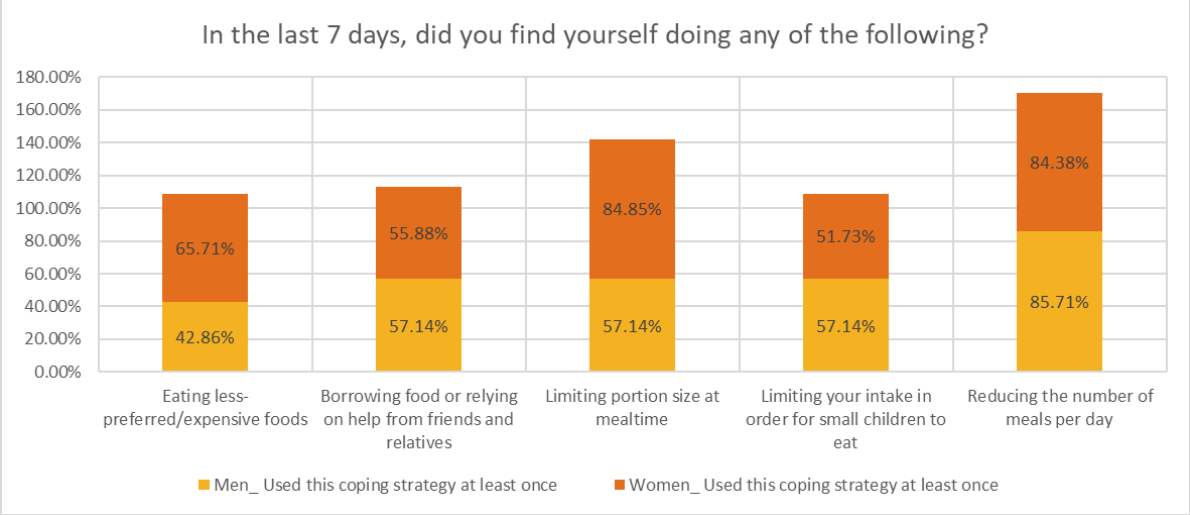
Social cohesion is at risk of being further strained because of potential competition for the work that is available and in the immediate aftermath of any easing of restrictions. At the same time, the regulatory

[37] Empowered Aid: transforming gender and power dynamics in the delivery of humanitarian aid, CARE, Global Women's Institute, Preliminary findings May 2020
[38] *World Bank, April 2020,* http://pubdocs.worldbank.org/en/525341554825472233/mpo-lbn.pdf
[39] At the governorate level, the highest concentration of economically vulnerable Syrian refugee households is found in Baalbek El Hermel (78%), followed by Bekaa (72%) and Akkar (71%). VASYR 2019

limitations on Syrians' access to formal work is likely to compound the challenge of adapting effective program responses to support people to resume or develop alternative livelihoods.

Meanwhile, Lebanon has seen an increase in child labour (2,6%) with boys being at higher risk of child labour than girls, 4.4% and 0.6%, except in agriculture, where Syrian refugee girls have the more significant share of full-time child workers[40]. Adolescent girls are at high risk or early marriage with VASyR 2019 indicates that 14% of Syrian girls aged between 14 and 17 years are married, compared to 1% of boys.[41]. KII expressed concerns about child marriage and the risk of girls being forced to marry at early age in order to alleviate financial burden of families struggling to cover their basic needs.

As shown in the graph both women and men adopt coping mechanisms related to food consumption in order to cope with the harsh economic situation. 65,7% of women comparing to 42,8% eat less preferred food, 84%,85% of women compared to 57,1% of men are limiting the position of food at mealtime while almost equally both men and women limit their intake in order for smaller children to eat (F: 51,73%, M: 57,14%).or reduce the number of meals (F: 84,38%, M: 85,71%). The table below summarizes the answers of KII on coping mechanism related to food consumption adopted by women and men.



Recommendations

The following recommendations are targeted toward humanitarian and development actors in Lebanon as well as the relevant government bodies and donors. This is not an exhaustive list of recommendations, and it serves to initiate a dialogue among humanitarian and development stakeholders while informing programming and future inventions.

Overarching recommendations

- **This Rapid Gender Analysis report should be updated and revised as the crisis unfolds and relief efforts continue.** Up-to-date gender analysis of the shifting gender dynamics within affected

[40] Save the Children. 2020. 'Child Labor in Lebanon: The Economic Crisis and the Compounding Impact of the COVID-19 Pandemic'. https://lebanon.savethechildren.net/sites/lebanon.savethechildren.net/files/library/Child%20Labour%20Policy%20Brief%20-%20Final%2008042020.pdf

[41] VASyR 2019

communities allows for more effective and appropriate programming and will ensure both humanitarian assistance and the preparedness, prevention and response to COVID-19, is tailored to the specific and different needs of women, men, boys and girls. It is recommended that organisations invest in gender analysis, coordinates, and shares information with key stakeholders and when appropriate with key community members. It is important that reports with key recommendation are shared widely (in English and Arabic) and that programming will be adapted to the changing needs.

- Humanitarian and development organizations as well as the GoL should collect gender and age disaggregated data on the impact of COVID-19. **All actors involved in the response should consistently collect and analyse sex, age, and disability disaggregated (SADD) data and utilize in tailored actions to address the COVID-19 pandemic.** While SADD data is considered a minimum standard in most humanitarian and development data collection, it is critical that response actors ensure all assessments and reports collect and utilize information that can help identify the differential impact of the virus on women, girls and boys and men of different ages and with or without disabilities, and thereby plan for appropriately tailored program interventions. Gendered and disability differences should be considered during the design, implementation and evaluation phase of each type of response.

Targeted recommendations

- **Community participation and engagement**: Priority should be given in effective engagement with women and men in order to better understand their needs and priorities and enable their capacities to respond to emergencies through a community support system. Emergency response often neglects to engage constructively and incorporate feedback of targeted population on distribution modalities and aid delivered. It is imperative to engage with communities (women, girls, boys and men) through regular dialogues with key community members (community activists, women and youth led organizations, CBOs, local authorities when relevant) and tailor the interventions in order to correspond to the priorities and utilize the capacities of the targeted population. Leverage the capacities of community groups, women and youth groups, to support two-way risk communication approaches in order to dispel myths and misinformation about COVID-19. Where feasible, engage them to support local surveillance systems and train them on how to respond in case of symptoms.

- **Information dissemination and awareness raising based on identified gaps:** It is key to better understand the different needs and wishes of women, girls, boys and men and develop tailored messaging based on identified gaps, interests and priorities of the targeted population. The content of the messaging should correspond to the interests and needs for information of each group. Means of communication should be inclusive of PWD and elderlies as well as other groups who might be illiterate or unable to understand information disseminated in Arabic. This is particularly relevant to migrant workers for whom little has been done until now in terms of key information messaging related to COVID-19, promotion and protection of key aspects including health.

- **Promotion of gender equality through the participation of women and men in decision making procedures in the household and the community:** based on contextualised understanding of the family and community dynamics and taking into consideration the diverse societal background of Lebanon, appropriate methods should be explored to promote gender equitable households and communities. Although a lot has been done to raise awareness and build women agency, interventions should now be targeted to men and boys, community and religious leaders and other key figures in the community who can play the “role model” in their communities. This should occur concurrently with initiatives that aim to enhance women’s agency beyond traditional stereotypes and challenge the impact of cultural gender norms and attitudes embedded in individuals and communities.

- **Advocate for gender balanced and inclusive decision-making bodies while engaging women and men including PWD and elderly in COVID-19 response**. Authorities should encourage equal representation and women leadership throughout Covid-19 preparedness and response at local and national level. This can be ensured using quotas and indicators to measure women participation including women with disabilities. The establishment (if not already available) of women committees and women led organizations could be an entry point to support women's engagement in decision making procedures. In addition, such interventions should focus on key community figures with influence in their communities.

- **Ensure safety of extremely vulnerable groups and life free of violence and discrimination adhering to right based approaches:** Targeted intervention including in kind and voucher support to be made available to vulnerable groups including migrant and domestic workers with priority to those who are unable to cover their basic needs. Information dissemination on access to services including legal assistance (free of charge) and access to safe shelters should be prioritised with a focus on outreach and information provision in a safe and accessible manner. In addition, employers; education and awareness on migrant workers' right should be encouraged and promoted and avenues to additional support should be made available.

- **Advocacy efforts against the abusive kafala sponsorship system should be reinforced with join messages from the humanitarian community, civil society, human rights advocates, UN bodies and donors ensuring protection of migrant and domestic workers rights under the labour law in safe, equal and dignified manner.**

- **Humanitarian organizations and UN agencies response should be inclusive to LGBTIQ+ people's needs and capacities in areas such as food, shelter, health (including mental health) and livelihood opportunities.** LGBTIQ+ people in Lebanon have already experienced structural marginalization prior to the economic and COVID-19 crises. It is imperative that organizations and UN agencies advocate for **right based approaches and non-discrimination** when it comes to access to essential services. Durable solutions including revision of current legislation and awareness at societal and structural level should be encouraged in order for LGBTIQ+ people to be able to live in a protective environment of equal opportunities.

- **NGO, civil society organization and authorities engaged in SGBV service provision to scale up their response and ensure continuity of relevant services in line with precautionary measures and guidelines developed by the SGBV Task Force GBV activities during the COVID-19 outbreak.** The national and local authorities should allow the provision of GBV services in line with the precautionary measures and facilitate access to remote and underserved locations through mobile teams and other modalities. Restriction of movements for women and girls at risk should be lifted in case of emergency in order for women to be able to safely access services. Relevant messaging including GBV hotline numbers should be made available to communities. NGOs to consider covering transportation fees and emergency cost for women survivors in need of life-saving saving services. National authorities with support from GBV actors and gender experts should ensure that GBV hotlines and awareness messaging is incorporated into the response. In addition, law enforcement actors including the ISF and the police municipality should ensure female staff is onboard and fully trained to responds to the increase calls for support in case of GBV including IPV and domestic violence.

- **Humanitarian organization and donors to ensure that gender is mainstreamed in emergency response interventions.** WASH, food security and health actors to closely coordinate with protection and GBV specialist in order to ensure that gendered needs are addressed throughout the design and implementation of the interventions in line with do no harm principle. Humanitarian actors and their

partners should proactively engage and incorporate GBV mitigation measures[42] when providing assistance in response to the health and economic crisis.

- **Health service providers and facilities (PHC) and NGOs should prioritize provision of sexual and reproductive health (SRH) services for women and girls in reproductive age in line with the menstrual hygiene management (MHM) materials, with emphasis on rural and underserved areas and in particular areas with high density of refugee population**. Women health needs are essential and seems to be overlooked during the outbreak with high number of women and girls not accessing services including family planning and hygiene materials due to increased cost or movement restrictions. This type of services should not become secondary to other health-related needs or priorities. Accommodations should be made for women and girls with disabilities.

- **Protection and in particular GBV services, including hotlines, referrals, case management and psychosocial response services for survivors, including cash support when appropriate and needed.** Considering the increase in intimate partner and domestic violence, emotional abuse, and other forms of GBV such as SEA, donors and service providers should prioritize GBV prevention and response activities with attention to adolescent girls and associated risks (early marriage) and increase allocation of funding to GBV services that are adapted for COVID-19 response modalities including mobile units and hotlines.

- **Agencies responding to the pandemic should resume mental health and psychosocial support services for women, girls, boys and men including group and individual sessions in line with COVID-19 measures.** Levels of psychosocial distress were prevalent prior to the COVID-19 pandemic and it is expected to be exacerbated due to the fear of infection as well as the socioeconomic impact of the health and economic crisis, leading to increased anxiety and stress and potentially tensions in the household. Gender and age appropriate services should be available to refugees and host communities as well as targeted interventions for caregivers, LGBTIQ+ communities and elderly people should be designed to address the specific needs of different groups and address issues of social isolation and hopelessness. Particular attention should be given to community based intervention that might be more efficient especially at times of physical distancing and challenges with movement restrictions.

- **Economic empowerment and equal participation in the labour market. Prioritization should be given to tailored interventions to address the priorities of the current context efficiently and in a timely manner under the recovery phase.** Particular attention should be given to the informal sector and to women and men who need support in order to safely resume their activities without putting themselves and others at risk of COVID-19. Relevant actors should explore digitalised options and ITC opportunities for women and youth, including building their capacities and skills.

- **Utilize existing capacities of Lebanese and non-Lebanese women and build on new value chains relevant to the context per area of implementation in a way that will allow them to financially contribute to their households and communities**. Support SMEs with small loans and cash transfers with an emphasis on building capacities and skills to ensure sustainability and self-reliance. Activities should be inclusive of women with disabilities and different age groups as well as other vulnerable groups (LGBTQI+ etc).

[42] IASC, Identifying and mitigating Gender Based Violence risks within the COVID-119 response https://gbvguidelines.org/wp/wp-content/uploads/2020/04/Interagency-GBV-risk-mitigation-and-Covid-tipsheet.pdf

- **Given the few livelihood opportunities available and until women and men are able to safely resume their activities, cash and voucher assistance should be considered and prioritized especially for extremely vulnerable cases and people with specific needs:** Unconditional cash either through or voucher modalities should be made available for vulnerable and extremely vulnerable household to meet their basic needs and reduce the risk of negative coping strategies. Ensure that comprehensive risk assessment are put in place in order to prevent and address constraints related to bank transfers. Establish mechanisms to monitor and mitigate against GBV risks associated to cash distribution for women including female headed households and women at risk.

- **Donors should emphasize and prioritize gender responsive programming with an emphasis on do no harm approach and PSEA as a mandatory requirement for (I) NGOs and local partners.** As the economic crisis deepen more and more local initiatives, private donors and other associations engage in distribution and community support. It is imperative that local organizations and community members are sensitized and aware of their rights and the available reporting mechanisms. This could happen through dissemination of key PSEA messages and sensitization of staff, frontlines including volunteers and available authorities. NGOs should ensure that any reporting procedures ensure confidentiality as well as access to GBV services. Attention should be given to groups who might are at higher risk such as domestic workers, LGBTIQ+, women and adolescent girls.

Annexes

Annex 1: Secondary Data Review

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CARE works with poor communities in developing countries to end extreme poverty and injustice.

Our long-term aid programs provide food, clean water,basic healthcare and education and create opportunities for people to build a better future for themselves.

We also deliver emergency aid to survivors of natural disasters and conflict, and help people rebuild their lives.

We have 70 years' experience in successfully fighting poverty, and last year we helped change the lives of 65 million people around the world.