GENDER DYNAMICS IN SOUTHERN SYRIA

AN ANALYSIS OF GENDER, PROTECTION, AND INCLUSIVE GOVERNANCE ISSUES IN SOUTHERN SYRIA

OCTOBER 2016

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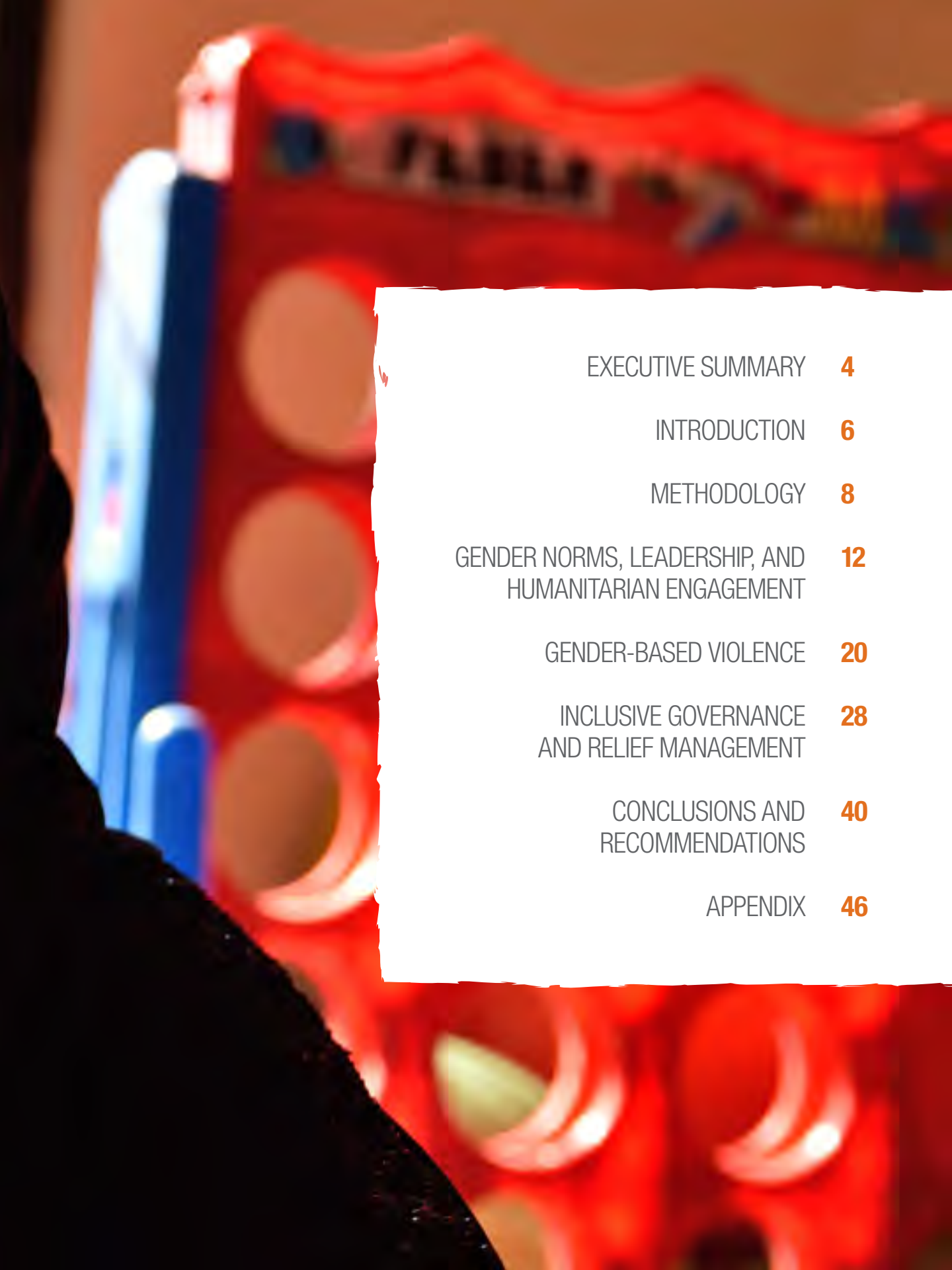

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EXECUTIVE SUMMARY

More than six years into the crisis in Syria, there are now nearly 13.5 million people in Syria in need of humanitarian assistance. As the humanitarian context continues to evolve, humanitarian actors strive to respond to these needs, with Syrian partners implementing the vast majority of programs despite challenges such as security, access, capacity, and information gaps. In southern Syria in particular, information about gender equality, protection, and the ways in which governance actors engage with and represent women and girls has been largely unavailable, and few comprehensive studies have been carried out. To address this, CARE International carried out a gender analysis in the southern Syria sub-districts of Jasim, Hrak, Nawa, Dara'a, Quneitra and Busra Esh-Sham in Dara'a and Quneitra governorates in the summer of 2016. The study focused on how women's agency is constructed, restrained, and/or enabled by social factors and the changing crisis context. It also captured men's perspectives on gender dynamics in times of crisis. This report consolidates the results of this gender analysis and recommendations are framed to support

humanitarian agencies provide less gender blind and more gender sensitive programming, effectively and systematically addressing deep-rooted societal attitudes toward gender equality, protection, and inclusive governance.

In southern Syria, the analysis indicates social norms related to de-facto access challenges, a largely untrained cadre of humanitarian workers, public-private divides, notions of formal leadership, and acceptable behaviour for women, men, girls, and boys often shape what kind of humanitarian activities are prioritised, who controls aid, and who benefits from it. Traditional social norms and gender dynamics in Syria have been compounded by the current crisis, resulting in wider gender gaps, increased risks for vulnerable groups, and major gaps in service provision and the ability to participate in civil society. In addition, the context has resulted in a near inability for women, men, boys, and girls to participate equally in governance or civil society, a sphere that women have traditionally engaged in amongst themselves.

Results from the analysis indicate that women and girls are adapting their traditional roles based on new needs for them and their families, however, social norms related to women's roles are not necessarily changing. Furthermore, women's ability to interact in the public sphere, including in both formal and informal governance structures, has been significantly reduced. Humanitarian programs must take this evolution and societal attitudes in this context into account to ensure approaches are realistic. Our analysis indicates that this must begin with both women's empowerment and men's engagement. The findings from this study confirm a need to improve gender mainstreaming in humanitarian programming and the report offers recommendations to do so. Local, contextual, household-based approaches to sensitive topics will build on existing leadership and also support establishing a platform for improving equitable engagement and service delivery.

INTRODUCTION

The purpose of this gender, protection and inclusive governance analysis was to fill knowledge gaps related to:

1. Gender dynamics: What is the nature of gender dynamics and social norms in relation to agency and autonomy, division of labor, access, control, decision making, mobility, information flows, and coping strategies?

2. Gender based violence (GBV): How do gender dynamics and gender norms affect survivors' coping strategies, especially related to gender based violence and trauma?

3. Inclusive governance: How do local gender dynamics affect governance and aid delivery?

The results of this assessment also show how traditional social norms within the current Syrian context have led to a gender blind humanitarian response in which women and girls are increasingly isolated. While there is an opportunity to promote women's leadership, men are by-and-large blind to the gendered nature of the war context and relief efforts. This current context puts women and girls in extreme risk often without actually alleviating even their most basic needs. The same can be said for persons with disabilities, the elderly and persons from other traditionally vulnerable groups.

This assessment report seeks to provide actionable recommendations for humanitarian programming that are grounded in local context and that involves traditionally vulnerable groups, as well as power holders, in meeting basic needs and addressing social inequalities at the same time.

METHODOLOGY

This assessment attempted to balance multiple, competing information needs from multiple actors in the Syria response with the need to inject gender and protection mainstreaming into humanitarian actions. It also attempted to balance the need to reach diverse beneficiary groups with the limits of a relatively rapid analysis. Finally, the methodology was designed with the understanding that enumerators with only an introductory exposure to research methods and gender equality concepts would be collecting data in an insecure environment.

The lead researcher undertook a literature review and rapid interviews with Syrian non-governmental (NGO) leaders and activists in the aid community in order to understand not only some of the key gender issues in southern Syria but also the operating context in which the assessment would be implemented.

The research team targeted rural and urban areas in Busra esh-Sham, Hrak, Jasim, Mzeireb, Nawa, and Quneitra in Daraa and Quneitra districts in southern Syria. The team identified these six communities based on safety and accessibility, the presence of key informants, the presence of internally displaced people (IDPs) and IDP camps, the ability to reach both urban and rural areas, and whether CARE's experience in these areas. The field enumerators included both male and female teams, with women collecting data from women and men collecting from men.

The team used three tools, daily clocks, key informant interviews and a quantitative survey.

1. Daily Clock: A daily clock activity was administered to separate focus groups of 3-5 IDP women and 3-5 IDP men, in an IDP camp in each of six communities. The tool followed the standard format and procedure for a daily clock. Participants were asked to describe their activities according to time units.

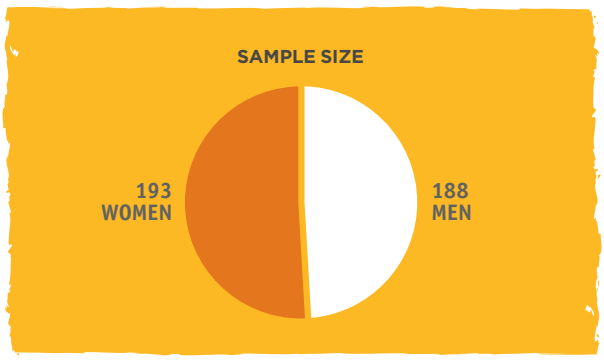
- Enumerator teams began with the daily clocks. They picked one IDP camp in each community, based on prior knowledge and experience in the locations.
- Enumerators asked for three to five female volunteers and three to five male volunteers from the camp to participate in the clock.

2. Quantitative Survey: A 52 question quantitative survey was designed to ask individual women and men standard gender analytic questions as well as questions on the governance situation and service delivery.

- The sample size for the quantitative survey was chosen based on the population figures for Quneitra and Dara'a provided by the 2015 – 2016 Humanitarian Needs Overview data set. The survey was administered to 193 women and 188 men. This included 141 IDP women and 88 IDP men and 83 women and 22 men who identified as single, widowed, divorced, or indicated that their spouse is elsewhere. 28% of female respondents were IDPs who were single, widowed or divorced, or whose husbands were elsewhere. In order to show how the multiple vulnerabilities of being unaccompanied, female and an IDP affect women in times of crisis, the tables and statistics used in this report show results for this 28% of female respondents as a separate subset of all women. When reading the tables in this report, the category "women" refers to all 193 women including unaccompanied female IDPs. The category "unaccompanied female IDPs" refers to only this 28% of women who are displaced and not accompanied by a male counterpart.
- Volunteers from the daily clock activity identified the first participants in the quantitative interviews. Following the initial interview by each enumerator team, sampling for the quantitative interviews was random (every fifth house) with some modification to ensure that enumerators reached a good balance of young and old, unaccompanied women, persons living with disabilities (PLWD), people from urban and rural areas, and IDPs and hosts.
- The survey was adapted to include two versions in an effort to enable women and men to talk through their individual experience. This strengthened the ability to compare and contrast women's and men's experiences.
- The survey tool was designed to ask specific questions depending on the situation of the respondent. For example, different questions related to shelter were asked to respondents living with host families or hosting IDPs versus persons living in other shelter conditions.
- Rather than reading out the answer choices, enumerators asked each question and listened to respondents' answers before choosing the "most similar" answer from amongst the list. In some cases, this meant that men were asked slightly different questions, and in others it means that the answer choices were different. In some cases, the most similar answer chosen did not always reflect the respondent's full response.

3. Key Informant Interviews: Qualitative semi-structured surveys were administered to four different types of key informants: local council leaders (all men); male and female health workers including doctors, nurses or clinicians; male and female community based organization (CBO) leaders; and women and men who were identified as community leaders.

- Enumerators administered tailored surveys for each key informant focus group, including at least 6 key informants per group. For example, local council key informants' responded to different questions than health key informants, who answered some more sensitive questions regarding gender-based violence, governance and protection. Thus when reading the analysis it is important to remember which key informant may be responding to the question.



The qualitative and quantitative tools were designed to triangulate one another. The quantitative tool included less sensitive questions while some of the key informant interviews probed on governance and GBV. This was done to attempt to mitigate safety issues and to couch the discussion of sensitive topics in group anonymity.

ENUMERATOR TRAINING

CARE formed six teams of enumerators comprised of one man and one woman each. The teams moved from one community to another and rotated taking the lead on different types of data collection with different respondents. The teams administered the quantitative survey by working simultaneously with female and male respondents. For qualitative data collection, the consultants joined into groups of two women and two men. This allowed women to travel in a safe and culturally acceptable way to reach female key informants, and it allowed for one person to carry out the interview and while one recorded answers.

The enumerators who participated in this exercise are CARE's field staff, engaged regularly for monitoring and data collection. They had little formal training in social science data collection and basic gender equality concepts before this assignment began. Accordingly, CARE administered a two day participatory training in Arabic using skype and covering basic gender equality concepts, concepts related to GBV and protection, and ethical and safety considerations in interviewing. The standard Inter Agency Standing Committee (IASC) definition of GBV was introduced during the training. The enumerators reviewed each tool in detail and discussed each with the research team in Amman to ensure a common understanding of the tools and methodology.

ETHICAL CONSIDERATIONS

To preserve anonymity and confidentiality, the names of key informants and other participants were not recorded, and no visuals were used to collect information. Location and sex of participant but not names, ages or other identifying features were taken for the quantitative survey. Open data kit (ODK) was used to record answers in Syria, and data was encrypted and stored in CARE's server. Only the location and number of participants was recorded for daily clocks. The location, number of participants and sex and type of informant was listed for key informant interviews.

Survey instruments were designed to be as rapid as possible so as to not expose enumerators or respondents to risk by engaging in lengthy surveys. CARE refrained from asking sensitive questions, for example, questions related to bias in aid delivery based on ethnic or religious divides. Enumerators discussed the notion of re-traumatising survivors during training, and to stop interviews should respondents show related signs. Iterative and rolling sampling was used to overcome general insecurity and safety issues.

DATA ANALYSIS AND INTERPRETATION

Data analysis and interpretation began with reflection sessions that enumerators held at the end of each round of qualitative data collection. Enumerators gathered to summarize key points and observations. The next steps were a collaborative effort between two gender advisors, one of whom is fluent in both Arabic and English, both long distance and in-situ in Amman. Quantitative data was analysed in English, downloaded from ODK and worked into tables as presented in this report. Qualitative data was analyzed in Arabic and sorted into matrices organized by type and location of respondent and coded by topic. The team then used a standard gender analytic framework to interpret data and trends.

The survey team worked closely together and with external and volunteer translators, striving to ensure that tools and results were translated accurately and in keeping with local context.

LIMITATIONS

Locations for the assessment were chosen by CARE's team, based on population data, access considerations, and the need to include a mix of rural and urban populations. Access limited the assessment to opposition held areas in southern Syria and thus results should not be seen as representative to populations in government controlled or in inaccessible locations.

The daily clock activity was carried out in IDP camps, chosen by the enumerators in the target assessment locations. The camps for the daily clock may not be fully representative, as persons there have likely been served by humanitarian actors. Furthermore, respondents for the daily clock were volunteers from the camps, and were likely more comfortable answering survey questions than persons who may be most vulnerable in these locations.

The goals of this assessment included gathering information on sensitive topics where currently there is a critical dearth in information for humanitarian programming. Sensitive topics require skilled handling on the part of qualitative interviewers. For this assessment, CARE asked remotely managed consultants with limited background in many of these topics to collect highly sensitive data. Due to this, data collection tools did not include a full range of gender analytic, governance or protection questions, nor did they touch on all gender issues in each humanitarian sector. The report does not do a thorough analysis of men's perspectives on gender based violence or look at the experiences of people living with disabilities, the elderly, or unaccompanied minors in detail.

Given the limitations of the assessment described above, some of the results of this analysis may contradict those of other sectoral assessments. Where this is the case, readers are encouraged to view different sources as complimentary and to use the broad gender trends described in this report as a basis for more detailed inquiry into specific situations.

GENDER NORMS, LEADERSHIP, AND HUMANITARIAN ENGAGEMENT

HOUSEHOLD HEADSHIP AND DECISION MAKING

Household headship and decision making patterns determine how aid is accessed and distributed at the household and individual level. They also determine the extent to which individuals are able to independently access and control the assets and services to cope throughout an emergency. In southern Syria, men dominate in household decision making, and both women and men firmly ascribe this role to men. Where women are de facto heads of household, particularly the case among IDPs, this is deemed to be necessary as an exigency of the crisis, and not the sign of a deep change in social norms.

HEAD OF HOUSEHOLD (SEE TABLE 1 ON PAGE 47)

WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
30%	66%	91%

The pattern of headship and decision making has shifted given the rising number of female-headed households. Although 91% of men claim to be household heads, 30% of women and 66% of unaccompanied female IDPs also claim this role for themselves. Prior to the conflict, 78% of men self-identified as the final decision makers in their household, compared to 7% of women.

Today, four times as many female respondents indicated they are now the household final decision maker. Furthermore, prior to the conflict, 75% of female respondents indicated that their spouse was in charge of assets.

Female key informants said that women were increasingly becoming heads of their household because men are absent, they have died, been wounded or joined armed factions. Where single or widowed women before the conflict would rely on brothers or fathers, to make decisions in the past, these men are no longer to be found.

HOUSEHOLD DECISION MAKERS (SEE TABLE 2 ON PAGE 47)

AFTER THE CONFLICT

THE NUMBER OF UNACCOMPANIED FEMALE IDPs INCREASED BY AN ADDITIONAL 625%

Even where men are present, women have more responsibilities because men's movement is constrained. Women from CBOs and self-help organizations explained that women who worked in agriculture, education or other sectors before the conflict are more likely to take on decision making now. Women who did not have work in the public sphere before the crisis still have little ability to make decisions or control access.

"He is the man. A man means the one who must be in charge in the family."

AS ONE WOMEN FROM THE DAILY CLOCK DISCUSSIONS STATED

Male key informants made the same observations, but most expressed resentment at the change. They often indicated they felt offended by the role reversal, but didn't feel that they had a choice for the sake of their own safety. A few were satisfied and saw that women are capable of decision making.

Both female and male key informants overwhelmingly agreed that men must live up to traditional notions of household headship, showing strength and decisive leadership, even in times of crisis and amidst their own trauma. The contrast between these results and those regarding women's increased participation in decision making shows that while the community accepts that some women may need to take on headship out of necessity; this is still ideally men's role.

While women are taking on household headship, they themselves may not feel qualified or satisfied in doing so. Throughout qualitative interviews, women repeatedly requested training and support to develop basic life skills linked to household headship. Although community sympathy is with women who head households, there are few deep social traditions or supports to women in this position.

Female key informants and daily clock participants described gender norms in household headship, decision making and control, explaining men are stronger and better decision makers, especially in the areas of education, work and how to deal with other community members. Women did not see themselves as qualified to take on household headship because they lack the experience or opportunity to practice decision making. Most male key informants agreed with these statements. While about 5% of men said that they and their wives engaged in consensual decision making, most men explained that they have the right to make decisions. Traditional gender norms in southern Syria lead people to perceive that men should behave as decisive leaders. In addition, respondents indicated that their communities associate men with being more responsible and rational and women as more emotional and in need of someone to protect them.

DIVISION OF LABOR

According to the respondents, women traditionally, and with few exceptions, stay inside the house and have domestic responsibilities. Men are active in public space and primary decision makers at home.

Women's domestic roles have become complicated by the current context. Women living in collective shelters, for example, clean and tidy, prepare supplies and food, maintain safe WASH conditions, protect and calm children during bombing, try to mitigate the damages caused by bombing and displacement, adapt the living space into a semblance of suitability, prepare sandbags, and provide primary first aid. In interviews, women expressed frustration because they must somehow do all of these things without basic services such as water or electricity.

Both male and female respondents indicated that even if men are at home more, they largely do not engage in any domestic activities, outside of occasionally amusing children.

Some women who worked outside the home before the conflict began have managed to retain their positions as civil servants, community service workers, teachers or nurses. Many female respondents from agricultural families continue to work in the fields. Some women who were not working outside their homes before the conflict have become more active, in income generating activities and in securing assistance. Respondents emphasized that looking for relief is women's main public labour, and that they do this on top of domestic activities.

Some male survey respondents noted that the conflict has restricted job opportunities and increased the chances of conscription or detention. Consequently, men often restrict their movements. Some male respondents who used to work in agriculture, no longer work in their fields. Respondents indicated that the community looks on men who are not working as victims of the war. They are sympathetic, and justify men's inactivity by classifying them as vulnerable.

Conversely, some male respondents also indicated that they have been able to find new ways of working in the public sphere. Some participate in informal community activities such as helping build IDP shelters or helping displaced families find homes. In this way, while men do restrict their movements, they also attempt to still engage as primary decision makers. As with gender dynamics in household headship, decision making and control, the attitudes around gender and the division of labor have not changed. Respondents indicate that both individual and community attitudes affirm women, men, boys, and girls in their respective, traditional roles.

LEADERSHIP AND MOBILITY

The division of labour described above, is reproduced in the public sphere, especially in relief management and access. Women were more likely than men to recognise that informal roles such as being pro-active in caring for the elderly and disabled in a shelter constitutes leadership as much as being an elected official. When asked about qualities of a strong leader, both male and female respondents indicated leaders should be brave and courageous, have a university degree, be a respected elder, and be well connected.

In qualitative interviews with CBO key informants, women said that the most important leadership traits that women can have is courage and a strong personality. Women should have self-confidence, a satisfactory level of education, and strong social relationships based on trust and respect.

Women also responded that female leaders must have the support of men.

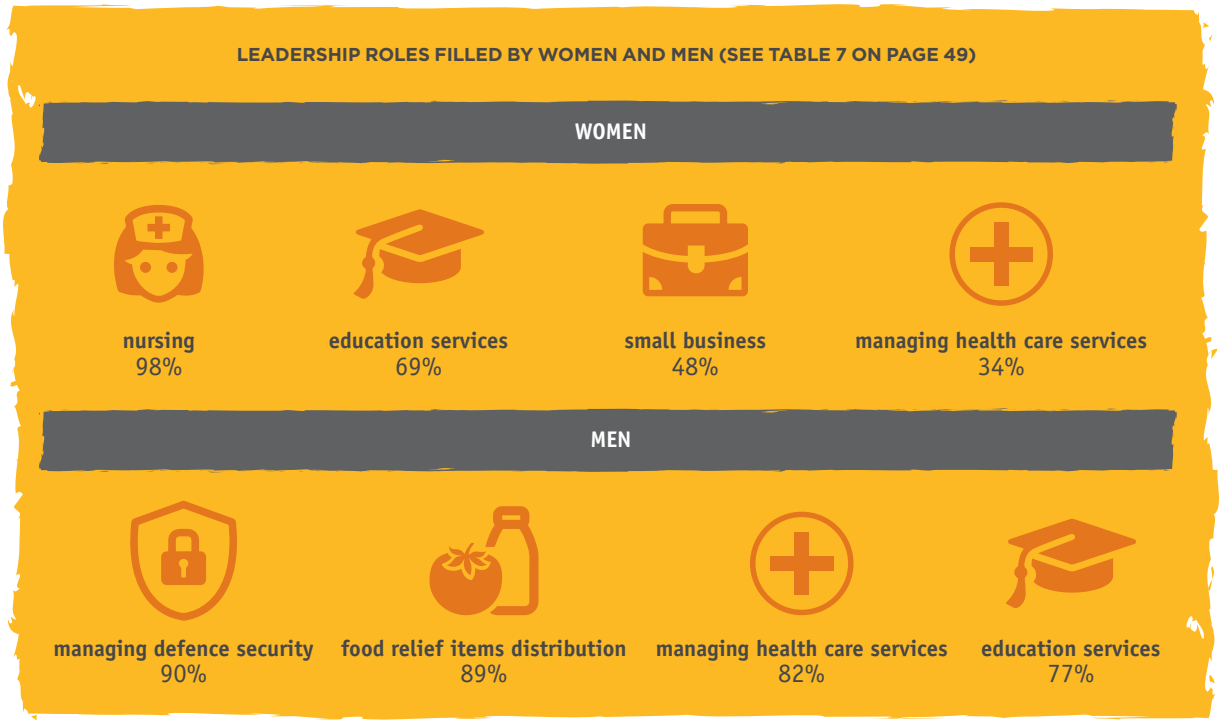
Women listed challenges to engaging in leadership, both formal and informal, and including: few opportunities for self-development, combatting trauma and depression, and lower levels of technical knowledge and life skills.

Male key informants discussed whether women could be leaders. For some men, women can be farmers, midwives, nurses or teachers. They can provide support to the distressed, take on sewing, or lead other women at the mosque. Some respondents discussed women's leadership qualities and the social challenges that women face in breaking into roles beyond the stereotype. Male respondents discussed that women who are able to get through male-dominated society and lead usually have a high level of education and self-confidence.

Men echoed women's statement that women leaders must be accepted and be seen to have the patronage not only of their own male relatives but also of male leaders.

By contrast, men only need to be respected, connected and well educated in order to move into leadership.

The above discussions, held with community leaders, contrasts slightly with what IDP respondents discussed during daily clocks. Among daily clock participants, the majority of women and men both believed that women are not capable of handling critical situations or discussing political issues because they are too weak, sensitive or emotional.



"There was a girl whose brother's leg was amputated during the war. She used to take care of him, and this gave her good medical experience. She started to work in the field hospital and treat injured people and sometimes she provided treatment to injured people on the front. Now she is giving first aid training at [a local association]."

NAWA FEMALE NGO LEADER

INVOLVEMENT IN PUBLIC ACTIVITIES BY WOMEN AND MEN BEFORE THE CONFLICT AND NOW (SEE TABLE 3 ON PAGE 47)

WOMEN	MEN
75% ↓ decrease in participating as executive member of religious group	57% ↓ decrease in participating as executive member of religious group
87% ↓ decrease in forming community action group	1% ↑ increase in forming community action group
98% ↓ decrease in belonging to a political party	97% ↓ decrease in belonging to a political party
75% ↓ decrease in attending public meetings	62% ↑ increase in attending public meetings

These attitudes were practically demonstrated when women and men were asked where they had observed women and men leading. The traditional division of labour repeats in the public sphere, and with communities in southern Syria relying more and more on humanitarian relief, the lack of the ability for women to engages in roles related to relief management or policy making prohibits women from having an equal voice in the way humanitarian aid is being administered. Furthermore, according to respondents, the gender gap in participation in key governance and public leadership activities has widened.

As the data in table 6 (page 49) shows, respondents indicated men to be 71% more likely to be involved relief management and distribution, 50% more likely to raise awareness about how these items are distributed, 55% more likely to form or lead groups to bring relief to the distressed and 30% more likely to lead IDP groups. In all of these cases, fewer than 12% of women said they are involved in these activities, indicating women's involvement in management or decision making related to relief activities is extremely limited.

Importantly, however, respondents noted that before the conflict, women were significantly more involved in political and community action, with 14% of women having been involved in local governance, 56% of having been a member of a political party, 13% having direct engagement with elected or appointed officials, and 27% attending public meetings. Although this creates a strong base of experience on which to support women's engagement in these areas, now only 1-2% of women engage in these kinds of activities.

MOBILITY FOR WOMEN AND GIRLS (SEE TABLE 8 ON PAGE 50)

REASONS TO GO OUT

look for work, go to jobs, school
74%

search for food
65%

visit friends neighbours or relatives
56%

social or religious activities
26%

bringing children to and from school
23%

supplying water
16%

This represents a serious decline in women's political participation and public life, and in a context where governance actors have tremendous influence over service provision and aid delivery, this is a major obstacle to ensuring equitable access to assistance for women and girls.

There are some exceptions to the above, and a number of female respondents identified non-traditional, informal forms of leadership as roles women often hold. Furthermore, women were more likely than men to discuss informal leadership, where many women were likely to identify female leaders.

Results from questions related to mobility confirm the gender dynamics described above and add nuance to discussions related to the conditions under which women and men restrict their mobility.

ISSUES THAT PREVENT WOMEN, GIRLS, MEN AND BOYS FROM GOING OUT IN PUBLIC (SEE TABLE 6 ON PAGE 49)

WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
79% aerial bombings	**81%** aerial bombings	**69%** aerial bombings
54% money for transport	**69%** money for transport	**86%** money for transport
47% no one to accompany	**64%** no one to accompany	**28%** no one to accompany

"A women as a leader is not accepted in our religion and our culture, but now everything is changing."

ONE FEMALE PARTICIPANT IN THE DAILY CLOCK EXERCISE

Notably for humanitarian programming, 59% more men are likely to move to manage relief activities, 35% more men move to participate on civic committees and 26% more men move to participate in NGO schemes. Men are over twice as likely to bring in a water supply and 30% more likely to go out of the house for reasons that build social capital. Further, men are 30% more likely to participate in CBO activities.

The insecurity due to conflict is a key reason both women and men to restrict movement. Aerial bombing and lack of the means or money for transport were the two highest reasons given by both women and men. In qualitative interviews, both women and men repeatedly noted that transport is a huge barrier to accessing services. Means of transport does not exist, it is prohibitively expensive, or it is not safe. Women said that "safety" means safety from bombing, shelling or crumbling buildings and also from GBV. Men are more likely than women to stay at home to avoid arrest (by 25%), kidnapping (by 14%), issues at roadblocks and checkpoints (by 11%) and harassment or intimidation by armed groups (by 6%).

Of particular note to the information above, while 20% of women said they were more likely to go out in the company of men, only 7% of men said that they went out more in order to protect women and girls.

This data shows the need for some nuance in discussions on mobility patterns in south Syria. While unaccompanied female IDPs are mobile for specific reasons, they are more likely than other women to face transport, accompaniment and other barriers. Although women in this category are equally mobile with men in certain areas, overall, men are still much more mobile in areas that are key to humanitarian response and to coping with the conflict, relief management and social capital. Furthermore, men are much more likely to define a number of ways that their movement is being restricted due to the current conflict environment.

“Inside the shelter a woman is the mother, the cook and the nurse.”

“The woman is the internal manager of the shelter”

QUOTES FROM MEN ON WOMEN’S ROLE IN SHELTER MANAGEMENT

GENDER-BASED VIOLENCE

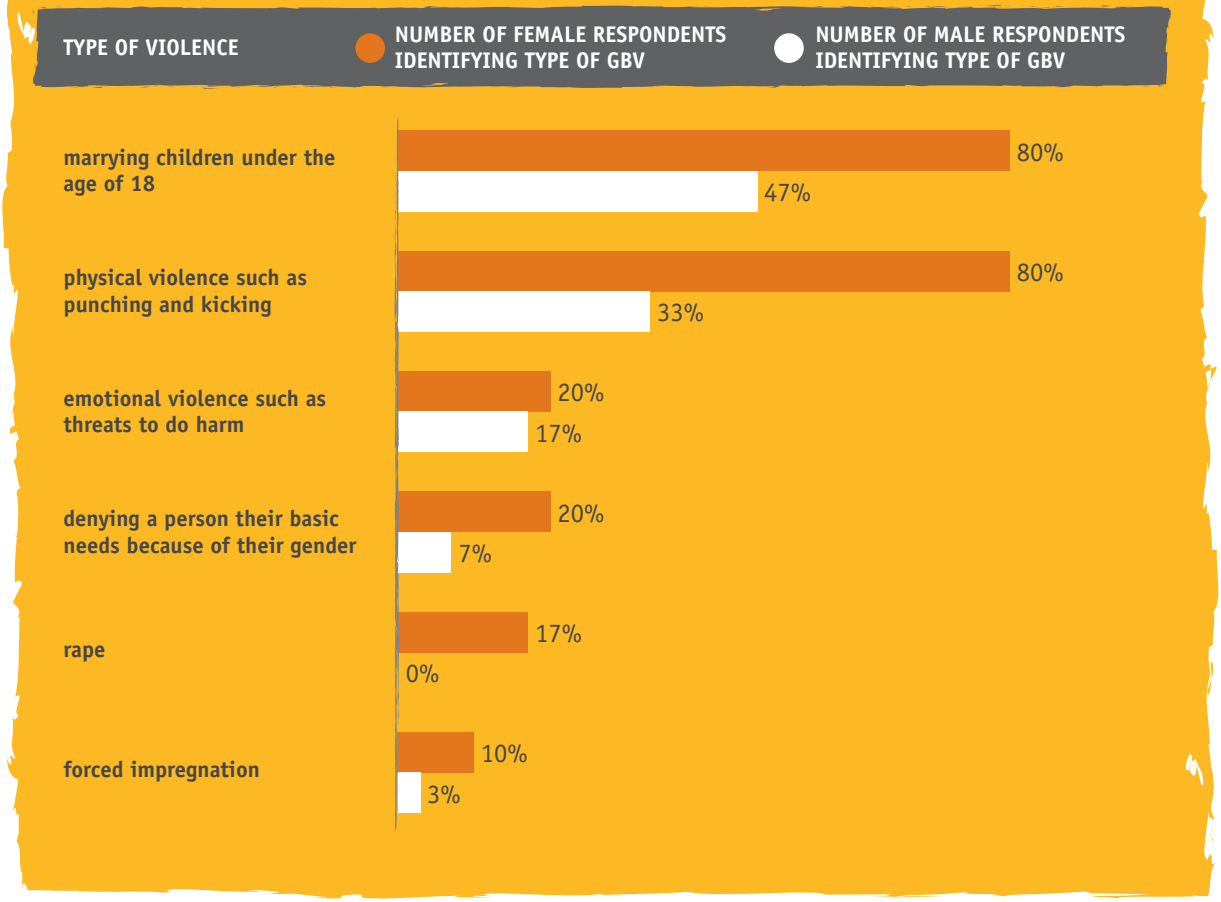
The bulk of information in this section comes from a set of open- and close-ended questions asked of 30 female and 30 male key informants. These questions attempted to explore survivors' experiences as well as individual, family and community response mechanisms. To the extent possible, interviewers attempted to discuss gender based violence as experienced by men with male respondents, but, as the discussion below shows, most male respondents discussed gender based violence assuming that survivors are all female. According to key informants, unaccompanied or single women, adolescent girls aged 15 – 19 are most at risk of GBV, whether they are married or not. While both women and men recognised GBV amongst unaccompanied or single women and girls, markedly fewer men were likely to recognise GBV amongst adolescent girls who are married.

Both women and men most frequently chose marrying children under the age of 18 and physical violence as common forms of GBV. Female key informants were more likely to choose more forms and to choose forms of sexual violence such as rape and forced impregnation. Women said that the prevalence of child early forced marriage (CEFM) was caused by poverty and a desire to protect a girls' honour. Female health workers also provided examples of a high level of general violence within the family as an environmental factor.

GBV (SEE TABLE 9 ON PAGE 50)

DEMOGRAPHIC CATEGORY	NUMBER OF FEMALE RESPONDENTS	NUMBER OF MALE RESPONDENTS
unaccompanied or single women		
newly married adolescent girls (aged 15 – 19)		
unaccompanied or single adolescent girls		
disabled women		
unaccompanied adolescent boys		
women who are married and living with their spouses		

WHAT FORMS OF GBV ARE MOST COMMON? (SEE TABLE 5 ON PAGE 48)



Male health professionals were more likely than their female counterparts to deny sexual violence or to redefine GBV in order to remove any sexual or gendered elements. One male health worker noted that awareness raising campaigns are needed because adolescent girls (and their families) do not understand the health, physical or psychological repercussions of GBV, specifically of early marriage.

Women were more likely than men to recognise that home is the greatest place of vulnerability or risk to GBV. Other areas were at checkpoints and roadblocks, randomly in public places, when receiving food aid or relief services. Women were also more likely than men to indicate that there are locations where GBV occurs, showing that moving about town, going to work and being newly arrived is more dangerous for women and girls than for men.

LOCATIONS LIKELY FOR GBV TO OCCUR (SEE TABLE 10 ON PAGE 51)

FEMALE RESPONDENTS INDICATING LOCATION	MALE RESPONDENTS INDICATING LOCATION
87% at home	**53%** at home
47% at checkpoints or road blocks	**53%** at checkpoints or road blocks
40% randomly on the street or in fields or abandoned buildings	**30%** randomly on the street or in fields or abandoned buildings

These prevalence findings, firstly, confirm prior studies (UNFPA, 2015; IRC, 2014) to show high rates of child early and forced marriage and gendered domestic abuse, and to show that being female, single, married and at home are the greatest risk factors for GBV. The forms of GBV mentioned here are a continuance of those seen before the crisis began, showing another way in which gender dynamics and inequalities from before the conflict continue during wartime. Findings also show women's greater recognition of the potential scope and depth of GBV.

SURVIVORS' RESPONSES TO THEIR EXPERIENCES

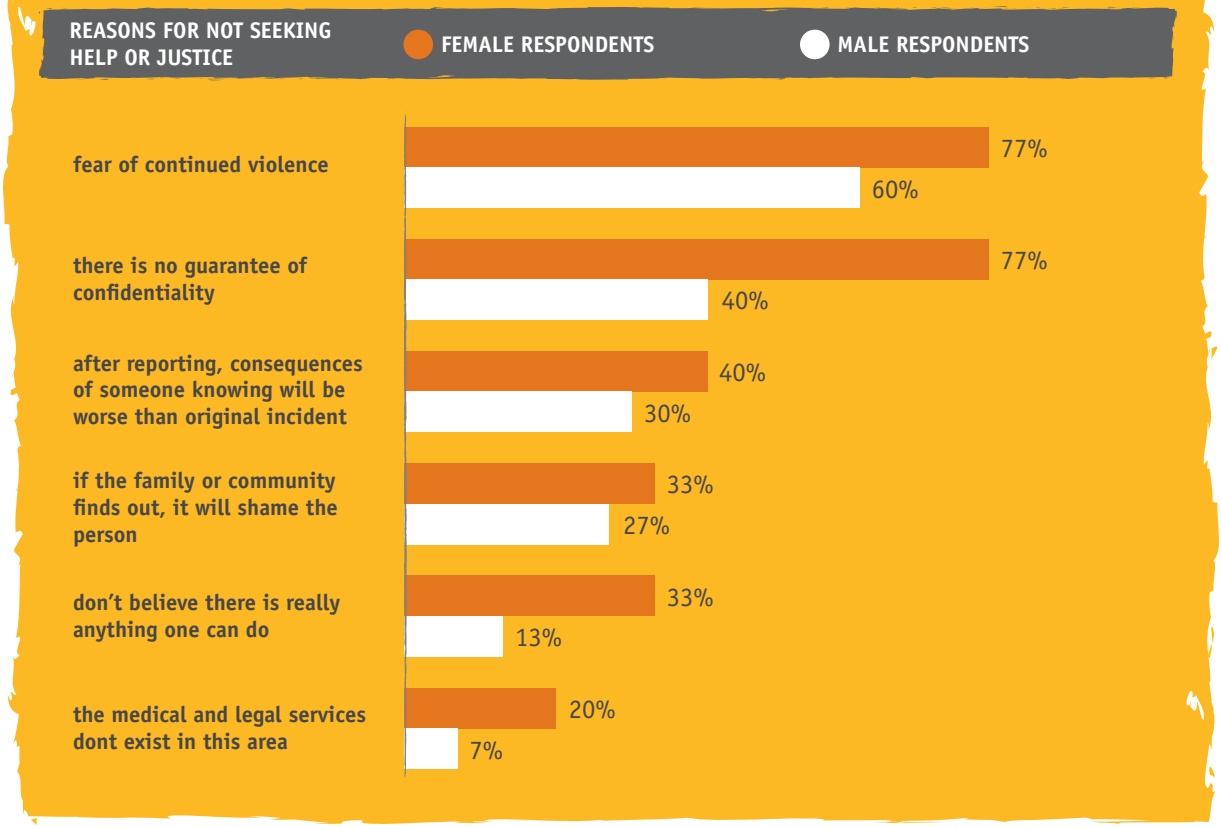
Both women and men said that both male and female survivors will base their actions on the nature of the GBV they have experienced. Overall they will keep the incident to themselves and only share or seek support with extreme reluctance. Women's descriptions of survivors' responses were much more nuanced than men's, and women were able to provide a range of scenarios. By contrast, men's expressions of women's responses were formulaic and linear and their discussion of their own responses was brief.

Women responded that women do not report GBV out of fear of loss of reputation, because there is no support, out of fear for their children's future, or fearing that the perpetrator will kill the survivor. Domestic, physical or emotional abuse was seen as too minor to speak up about. Women mentioned that women tell family members, usually a very close female within their natal family or a close member of the husband's family. A few (six) women mentioned going to the Shura council or the Shari'a court to get some sort of reparation for incidents. A small number of female respondents mentioned seeking psychosocial support, looking for material support from humanitarian organizations, seeking medical attention, or divorcing the perpetrator.

Men's answers are more formulaic and more likely to mention traditional courts. Most men mentioned that (female) survivors seek recourse through the family because there are no solutions outside the family. Men also explained that women and girls will keep silent to avoid shame. Four men mentioned going to Shari'a court or a religious leader.

In sharp contrast to the types of family and community responses discussed below, male and female quantitative survey respondents equally and overwhelmingly showed sympathy towards both female and male survivors. This contradiction between personal or individual attitudes and family and community actions provides a starting point for humanitarian organizations who are working on GBV in the south Syria context.

FACTORS THE PREVENT SEEKING JUSTICE FOR GBV (SEE TABLE 12 ON PAGE 51)



The responses to this question begin to show a pattern in which those who are closest to survivors, who should be their greatest allies, are also those who are most likely to turn on survivors in the name of "solving the problem." According to respondents, survivors perceive the family and community coping mechanisms available are not survivor-centered, so it is better to keep silent than to report any incidents.

GBV RESPONSE

Family, community and public mechanisms to address GBV are rarely survivor centered, or are too weak to provide survivors with appropriate care and justice. Family and community responses, even when considered positive by community members, frequently re-traumatize survivors and focus on managing family reputation. Health, justice and other public services are spread thinly, ineffective or in disarray. Community leaders such as religious leaders or teachers are seen as having a role to play in preventing GBV, but may not always advocate for survivor centered responses.

> *[A man] would tell the family only, and then try to get his rights back by himself... No, he will not seek any support, [because] we do not have any place or organization that provides any kind of support.*
>
> QUNEITRA, MALE HEALTH WORKER

Family Responses to GBV

In discussing family responses to GBV, key informants listed few positive coping strategies for supporting survivors or dealing with stigma.

Female respondents frequently mentioned that families will physically abuse the survivor, isolating them at home or even killing them. Survivors may be forced to marry either the perpetrator or another man. They said that family members may react negatively by repeating gossip, forcing the survivor to wear modest clothes, or excusing the perpetrator. Only one mentioned holding a perpetrator responsible, but by beating him, not by bringing him to court. Two mentioned more positive responses such as trying to regulate the issue in private and visiting the survivor with support.

> *An underage girl was forced to get married by her family. She refused because she wanted to get a university degree. She tried to get her grandfather to help her, but her father forced her to get married. She is now living a miserable life, being beaten by her husband.*
>
> QUNEITRA, MALE HEALTH WORKER

Male respondents indicated that family responses would depend on the type of abuse and the moral reputation of the survivor. Many indicated that stigma does not apply in cases of physical abuse as it does in cases of sexual abuse. They said physical abuse is considered a family matter and solved internally. Families may use forced marriage or move location in order to avoid stigma from sexual violence. A few men listed a positive family response of understanding and accepting the situation calmly and without blaming the survivor.

Community Responses to GBV

As with family responses, both female and male respondents noted that community responses are often harmful even when intending to be positive. The most frequent community response that they mentioned was negative gossip that focuses on the survivors' morals, dress and behavior, and on the ability of parents to exert control over children. Four respondents mentioned that the community will boycott the survivor and their family. One woman mentioned that the community will abuse the girl but will not bring the perpetrator to justice. Despite the above, women and men said that the community role was to de-escalate the situation and to help solve problems calmly. More men than women said that cases may be brought to a tribal or Shura council and the perpetrator may be forced to pay a fine. In a demonstration of just how loaded this issue is for women in south Syria, two female enumerators, based on their own observations as community members, broke with standard data collection protocols and exercised their voice by refusing to either ask questions about or record positive community coping mechanisms.

(Un)available Public Services

Respondents described public response services, such as health care, justice or psychosocial and livelihoods support, as either non-existent or not equipped to respond to GBV. Both women

Here is the way society deals with survivors of sexual violence. We remember an accident that happened two years ago where a 10 year old girl from a poor, displaced family in the town was raped by two boys aged 17 and 18. The girl was taken to the health center, where she had vaginal rejuvenation surgery and then went back home. The community leaders intervened and the problem was solved by [the boys' families] paying 700,000 Syrian pounds to the girls' father. Shortly after, the father slaughtered his daughter and buried her, which means that the boys did not get their punishment and the girl was a victim twice in this society.

QUNEITRA, MALE HEALTH WORKER

and men listed general health services (not specialised medical response) as the easiest service to access, with justice, safe spaces and economic means as increasingly more difficult to find. Psychosocial services were listed as non-existent.

Informants noted that there are no survivor services offered by the humanitarian community. Two men mentioned that women will not go to humanitarian organizations because they are not seen to be accessible or meaningful. The social norms explained above create a kind of cultural opposition to accessing public humanitarian services that is too strong for women and girls to overcome.

Community Leaders' Response to GBV

Community leaders such as Shura council members, imams or teachers play key roles in defining and dispensing justice and upholding a moral code, but their responses to GBV potentially put the survivor at risk or re-traumatize them. Shari'a court and Shura council members (mostly men) act as mediators and decision makers in cases of GBV. They may support reparations for survivors or access to services, but they may ignore survivors in favor of finding a solution, such as marrying the perpetrator or paying a fine, that preserves family reputation. A few men noted that the Shura council has the authority to stop community gossip, sanction perpetrators, support the survivor with counseling, and enforce fines paid to the survivor's family. Both women and men saw religious leaders as reinforcing people's morals and raising awareness about GBV. Teachers and school counselors have a role to play in teaching sexual and reproductive health as well as morally proper behavior.

Outside of this, both female and male key informants noted that community leaders were likely to either deny that GBV exists, not talk about it freely, or not offer very concrete solutions. Respondents implied that local councils have little authority to respond to GBV, but that security groups, the Free Syrian Army and other more militarized forces have more authority due to their control over the community.

Significantly, male CBO and community leader key informants unanimously denied the presence of GBV, citing religion, traditions and a desire to avoid incest as shields that prevent men from perpetrating violence. While men in this group were willing to admit that GBV would occur at the hands of the government, they struggled to face the idea that GBV occurs in private or non-militarised settings. Male health workers showed a wider variety of attitudes. For example, male health workers from Quneitra were fully ready to discuss men's, women's and children's experiences of GBV; to offer critical reflection on community responses; and to provide more pragmatic solutions.

Health key informants showed some awareness of the effects of negative coping strategies and a willingness to be involved in real solutions, but were able to suggest few realistic programming options to improve the current situation. Some female health workers noted a need to change the culture of the community and increase its consciousness. They suggested awareness raising courses about women's rights and early marriage, and programming that focuses on women's education, self-fulfillment and decision making. They also said that communicating with parents and providing psychosocial and material support were two ways to reduce stigma.

COPING AND AGENCY

Whether preventing and responding to GBV or providing targeted humanitarian assistance, humanitarian organizations have an opportunity to support women's and men's pre-existing agency, self-confidence and skills as part of a response. Accordingly, the survey identified the sources of strength that women and men currently rely on. Both female and male respondents primarily rely on close friends or family members for support in the crisis. Men tend to place greater reliance on outsiders such as religious and community leaders (at least 19% more than women) and NGOs (at least 10% more than women). At the same time, neither women nor men were as likely to rely on outside agencies as on their own families. Men are at least 30% more likely to take their frustrations out on other family members. According to respondents, men are 10% more likely than women to contact NGOs for services as a method of coping.

Women's and men's three key sources of agency are a belief in themselves and their capabilities, a need to do something for their children and skills or lessons learned from the past. Men are at least 13% more likely to believe in themselves.

At least 56% of men in the quantitative survey were confident they could take care of themselves and their dependents. Significantly for humanitarian organizations, 61% of women get their strength from skills or lessons that they learned in the past. This response suggests that appreciative methods of women's empowerment may be more effective than the critical consciousness methods that humanitarian organizations usually use.

A displaced girl moved to Jassim town. There, a man began to follow her and eventually sexually violated her. At this point, community leaders interfered to solve the problem. They agreed that the man should marry the girl.

JASSIM, FEMALE NGO LEADER

HOW DO YOU DEAL WITH PROBLEMS AND SUFFERING? (SEE TABLE 14 ON PAGE 52)

WOMEN	MEN
64% talk with close friend or family member of same sex	**63%** talk with close friend or family member of same sex
56% talk with close person of opposite sex (spouse, etc.)	**88%** talk with close person of opposite sex (spouse, etc.)

WHAT ARE YOUR SOURCES OF STRENGTH? (SEE TABLE 15 ON PAGE 52)

MOST COMMON AMONG MEN AND WOMEN

BELIEF IN SELF AND CAPABILITIES

DOING SOMETHING FOR CHILDREN

SKILLS OR LESSONS LEARNED FROM PAST

INCLUSIVE GOVERNANCE AND RELIEF MANAGEMENT

LOCAL COUNCILS

Leadership in local councils is not standardized and varies from one location to another. Local councils are largely formed via traditional methods of leadership group formation in which reputable male community leaders elect or appoint representatives from amongst themselves or from amongst the overall male population. Both male and female respondents indicated women largely do not play a substantial role in this process. This governance structure is critical for humanitarian organizations to understand, especially at the community level. Currently most humanitarian response, including the development of beneficiary lists and the location of IDP services, is closely coordinated with local councils.

Local council key informants confirmed that the mechanism used for selecting members varies by location. Quneitra and Mzreib local councils discussed a consensus process. Jasim local council members are elected. In Hrak, the Shura council chooses members. In Busra Esh Sham, local council members are appointed or recommended by officials. Key informants explained that the councils include representatives from each village in the area and between 12 and 35 members in total, depending on the size of the area. In daily clock and key informant sessions, neither women nor men expressed even an expectation that women would be involved in local council processes.

While informants noted some variation in the method of choosing local councils, criteria for membership was somewhat similar across assessment sites.

LOCAL COUNCIL MEMBER CHARACTERISTICS (SEE TABLE 16 ON PAGE 53)

MOST COMMON AMONG MEN AND WOMEN

REGISTERED AS SYRIAN NATIONAL

SOMEONE PEOPLE TRUST

GOOD REPUTATION

AS AN EXAMPLE OF AN INABILITY TO SEE DIFFERENT NEEDS FOR WOMEN, GIRLS, MEN AND BOYS EXCEPT ON STEREOTYPICAL LINES, ONE LOCAL COUNCIL LEADER SAID THAT

"Men's needs are fewer than women's needs because men have the ability to endure hard situations. They are stronger and used to hard work, and they don't have the private needs that women do."

Whereas information in previous sections showed that there was at least some scope for women's participation in formal governance before the conflict, with this highly masculinised system of forming local councils, this participation is significantly reduced.

Overall, informants implied that while local councils may have key influence in registration, beneficiary lists and some extremely basic services, their overall ability or capacity to provide a full range of services while upholding humanitarian principles or standards is extremely weak. This includes an ability to differentiate and design services that equally meet the needs of different beneficiary groups.

Furthermore, the services that local councils provide, or are perceived to be providing, vary greatly from area to area. Respondents indicated this includes providing food, especially bread and wheat, as their main service. They also provide some water,

electricity, schooling and agriculture services. They possess offices for census and statistics and academic affairs. Some local councils include an "armed faction" that provides security and protection for residents. In some areas, services are provided by both the government and the opposition. For example, the government still occasionally provides access to electricity, water, and education services in some places. In addition to service provision, local councils also noted that they are the coordinating link between the community and relief organizations.

Despite this critical role, local council key informants showed themselves substantively unable to distinguish the difference between women's, men's, girls', and boys' practical or strategic needs unless using traditional gender stereotypes. They said that women were more likely to need health care, especially maternal and reproductive health services and psychosocial support, because women are weaker and more easily traumatised. They said that widowed and single women need social services, and women without male providers need employment opportunities. They said that men's priorities are job opportunities and productive agricultural projects so that household heads can take care of their families properly.

Local council members said that they try to provide the elderly, PLWD or other vulnerable groups with support depending on what they have available. They mentioned doing home visits, sponsoring orphans, providing equipment to PLWD and providing milk for children.

Local councils did not mention conducting any needs assessments or attempting to talk to persons from vulnerable groups about their needs before deciding on services and the targeting of relief activities.

Key informants confirmed local council members' descriptions of the local council's role. They said that council priorities are to register community members, to deliver safe shelter, cash assistance and food aid, and to coordinate with the humanitarian community. Respondents mentioned local councils' involvement in providing shelter and health care; opening a center for persons with disabilities; running a school for orphans; clean roads and provide sanitation services; repair schools, water facilities and electricity networks; and provide water, sanitation and hygiene (WASH) services. The coverage and quality of these services varied from area to area in responses.

Other key informants noted that local council capacity to govern and to organize and structure basic services to meet community needs is limited. Local councils were discussed as not having appropriate and efficient advocates or administration. Both men and women mentioned local councils are largely unable to distinguish different needs for women, men, boys, and girls.

REGISTRATION

Both female and male survey respondents and key informants described the process for registering with local councils to get onto beneficiary lists as relatively easy regardless of sex, age or ability. Despite this, gender dynamics create gaps in the registration process through which women and other vulnerable groups fall. For example, women hold but do not necessarily control their identity papers. Sixty two percent of all women said they physically hold their identity papers in their hands. However, 97% of men said that they have the right to control when and how women use these papers.

With some variations from area to area, local council members largely agreed on the registration process.[1] When a group of IDPs comes to the outskirts of the area under the local council's control, a security committee or census bureau meet with the group of IDPs and registers them, noting information regarding their sex, age and ability. People with no official documents are either vouched for by someone in the community or are later able to register at the local council offices in the "security record" section by bringing witnesses with them. One local council mentioned that all residents are documented in a census committee, with information updated every three months via household visits.

Female community leaders said that either a person presents themselves to the local council with their papers or with people who can vouch for them. Official identity documents must be presented to the local council or to the service delivery organization in order to receive aid, especially food. Men said that registration was done either by local councils or by village delegates and they confirmed that papers are needed.

[1] The LAC in Nawa did not answer this question, so the material here is a composite of answers from the other five areas.

AS AN EXAMPLE OF THE TYPES OF ISSUES PEOPLE ARE FACING EITHER AT REGISTRATION (WITH LOCAL COUNCILS) OR WHEN TRYING TO ACCESS SERVICES FROM INTERNATIONAL NGOs

A divorced woman told me that while she was registering her name for distribution, she discovered that the relief representative was distributing packages to his relatives, but under her name.

NAWA FEMALE NGO LEADER

"There is no timetable for the work of organizations that distribute aid. If you are seen to have work such as being self-employed in agriculture or livestock, you will lose your right to get the help when it arrives."

MALE SURVEY RESPONDENT

I have heard of an incident involving a widow. A man went to a local association and requested relief packages on behalf of this lady. She doesn't know him, and she didn't know that he was using her name to get those packages for a year and a half without delivering anything to her.

NAWA FEMALE NGO LEADER

AS AN EXAMPLE OF THE ATTITUDE THAT MOTIVATES MEN OR FAMILIES TO SEND WOMEN TO SEEK RELIEF, ONE MAN SAID THAT

"women are weak persons, so everybody will support them when they ask for help or services."

Both women and men discussed the need for patronage if those without identities or protectors are to be registered. Key informants also said that if women do not have papers they can ask the mayor or influential people for a reference, but this assumes that women know influential local leaders. Informants provided examples of disrespect, discrimination or favoritism that women or other vulnerable groups face in the process of finding a patron and getting registered.

Men further noted that women are challenged by the distance to and layout of registration centers. The centers do not provide separate spaces for women and men, effectively barring women

from registering or coming to receive aid because mixed-sex spaces pose the risk of harassment (or even the risk of being tainted with the accusation of being harassed). Men also briefly cited corruption, favoritism and lack of justice displayed by service providers.

Thirty four percent of women, compared to 94% of men, said they were registered in their own name to receive aid from their local councils. When asked why women may not be registered in their own names, the majority said that they were already registered on their husbands' registration or on that of another male family member. A high number of women who are heading households may have husbands or male family members who hold their registration cards elsewhere.

Men registered under their wife's name indicated that they were trying to remain invisible from local authorities for a number of gendered safety reasons. In some cases, this is because they work in an area controlled by the government and live in an area controlled by the opposition. In others, they do not want to be con-

INFORMATION ABOUT RECEIVING AID (SEE TABLE 17 ON PAGE 53)

BOTH WOMEN AND MEN RECEIVE INFORMATION VIA WORD OF MOUTH FROM THE SAME SEX

WOMEN ARE MUCH LESS LIKELY TO RECEIVE INFORMATION DIRECTLY FROM THE LOCAL COUNCIL

WOMEN USE SOCIAL MEDIA A THIRD AS MUCH AS MEN

scripted or arrested or they had been conscripted or arrested at the time of registration. Four respondents said they had not registered for or received assistance because they are men, with the implication that assistance providers are biased towards women, who are perceived to be weaker and who get more community sympathy.

In the quantitative survey, women and men maintained that it is still easy to access key services, even if a person is not registered with the local council. However, twice as many women (46%) as men (24%) indicated that it was difficult to secure basic services.

Given their relative isolation, women are often less able than men to receive key information related to relief activities. Both women and men receive their information mainly through word of mouth, women are reliant on other women and on men for information, while men are 30% more likely than women to source their information directly from local councils.

16% more women than men said they were unable to get to the place where information was distributed. Six percent more women said that information is provided to another family member but not passed to them. Female IDPs find it hardest to access or buy airtime.

Engaging Vulnerable Populations

More than one third of male and female key informants mentioned that local councils are unable to cater to the specific needs of people in traditionally vulnerable groups. Men noted that persons with disabilities and elderly women have few opportunities to earn cash and often cannot access relief items or services. Women said that the only way that elderly people are able to access services is if they have children who can facilitate. They noted that elderly women had become a particular burden to or source of tension in their families. Further, both male and female respondents indicated that having a disability is a reason why some people cannot be registered with local councils. Some male and female respondents indicate that it is difficult for PLWD to get onto beneficiary lists if they are not registered, however response varied greatly depending on the type of respondent.

SERVICES THAT THE LOCAL COUNCIL PROVIDES (SEE TABLE 18 ON PAGE 54)

UNACCOMPANIED FEMALE IDPs	MEN
56% food aid	82% food aid
10% supplies other than food	49% supplies other than food

SERVICE DELIVERY

When asked about the services they have received from local councils, food, electricity and water, items other than food, and education services were most commonly cited by the survey respondents. Interestingly, 41% more men than women reported receiving electricity and water supply, 38% more men than women highlighted receiving supplies other than food, 19% more men than women specified receiving food aid, and 12% more men than women indicated benefiting from access to justice and legal services.

As detailed in previous sections, women who have connections to men are more able to access public spaces, goods and services through means that are officially sanctioned, formal

"Everyone in my family has a disability, and we haven't received any assistance or any information about it."

We often hear about problems between husbands and wives because of the presence of the old mother... and having to accommodate her heavy expenses, as they say, despite the tiny income... Old people need food and medicine...

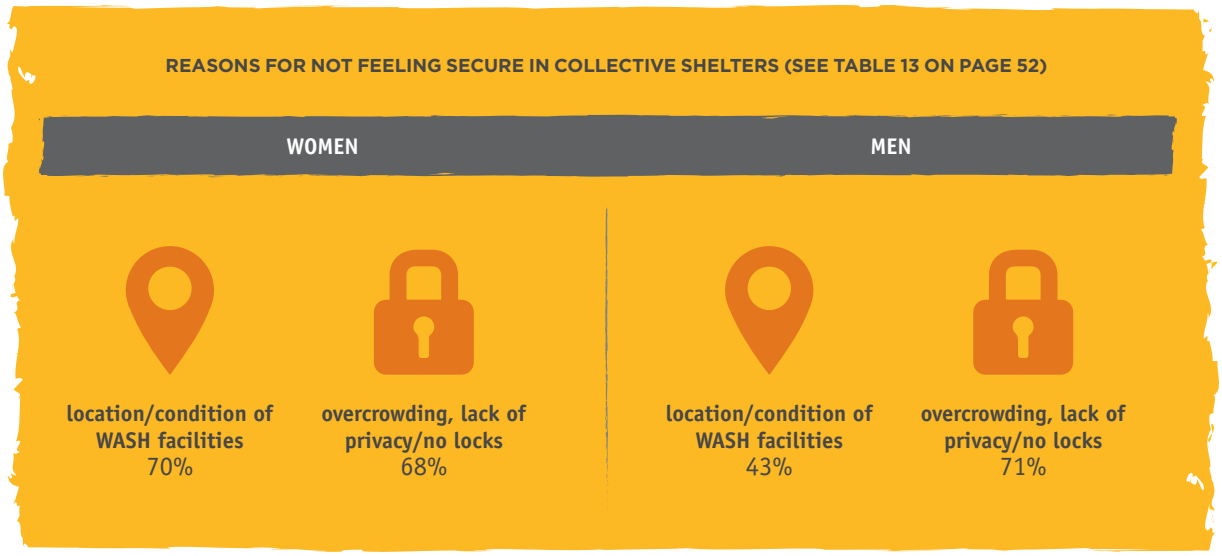
JASSIM, FEMALE NGO LEADER

or socially acceptable for women. Respondents consistently noted that the humanitarian community is offering the bulk of health services and non-food items (NFIs), and is the only body able to provide services on the basis of sex, age, ability or other vulnerability criteria.

When asked about services and assistance received from local civil society or humanitarian organizations, which typically work closely with or through the local councils, thirty percent fewer women than men reported that women could move about to participate in CBO activities. In qualitative interviews, both male and female respondents provided examples of corruption, favoritism and lack of justice displayed by humanitarian service providers. Some men noted that there are no set or organized times and places at which relief services are provided, so that hearing about available humanitarian activities is difficult. Men recounted a practice in which men send their wives or sisters to access aid from organizations on the assumption that CBOs, like local councils described above, will be more sympathetic to women. Women recounted a number of stories in which female household heads or women living with disabilities found their aid to be diverted either to their husbands or to CBO staff and their relatives. CBO informants mentioned that there are no mechanisms to ensure justice in distribution or aid delivery, although some conduct evaluations using simple questionnaires.

REASONS FOR NOT FEELING SECURE IN HOST ACCOMMODATION (SEE TABLE 11 ON PAGE 51)

WOMEN	MEN
78% overcrowding, lack of privacy	84% overcrowding, lack of privacy
20% fear for daughters safety	54% no good locks



Justice Systems

Both women and men equated justice with Shari'a court and Shura councils, not with a state justice system. Two respondents were somewhat positive about women's access to justice, but largely, women described the legal and justice system in all areas as "chaos." Women noted that this is affecting justice for reported violence, marriages, divorces, or any other type of civil legal need. In Quneitra women discussed a lack of authority to implement justice, and indicated that going to court would actually increase women's problems without providing them with real solutions. Even if courts exist, women rarely file complaints because of the community stigma associated with women going to court.

"There are no courts to confirm and approve the marriage agreement. There are a lot of bad consequences of this. Some sheiks write the marriage agreement and the LAC certifies what they have written."

QUOTES FROM MEN ON WOMEN'S ROLE IN SHELTER MANAGEMENT

Food Distributions

Local councils were discussed as providing food aid that is somewhat easy for vulnerable groups to access, but that for the most part is accessed and controlled by men. Seventy eight percent of women compared to 54% of men said that food was available. However, male respondents were twice as likely as women to indicate food aid was accessible (13% of female, 30% of male respondents) and controllable (8% female, 15% male respondents). Women listed challenges to accessing food such as distance to distribution centers, high transport costs and a fear of being harassed on the way to distribution centers.

Health Services

Key informants pointed out key gender gaps in health service delivery, some of which create general health risks for women and adolescent girls. No local council has a health committee established to support health care, and they rely on external assistance to provide services.

Respondents did not indicate that they knew about any mobile health services, but also indicated that health workers do make home visits. Female health informants carried out home visits to administer polio and other vaccines to children, care for the war wounded and follow-up after operations, all through home visits.

According to health key informants, reproductive health services, especially professional services and equipment to deal with complications, are not available in most areas. Most women rely on a limited number of midwives. In Quneitra, Nawa and Hrak health service providers are running workshops on reproductive health, and a few types of contraception are limitedly available. These services are reportedly not available in public clinics in Busra Esh Sham, Jasim and Dara'a, although private pharmacies may carry some contraception. Male health workers noted that there are no available forms of contraception, awareness raising workshops or similar sexual and reproductive health services for men and boys.

Key health care informants agreed that psychological care is not an option. There are no specialized services, so women rely on midwives or trusted individuals.

Repeatedly, all respondents indicated distance and transport as the largest issue in access to health care. Both male and female key informants confirmed that people are required to travel out of their own area to access health services, especially sexual and reproductive health services. Either there is no transport or the distance between home and the clinic is too great or transport is costly. Where private clinics exist, their prices are prohibitive.

Shelter and NFIs

Respondents represented a range of shelter conditions, urban and rural hosts, urban and rural IDPs, and IDPs in camps. In interviews, respondents discussed collective shelters such as government buildings, schools, mosques as well as independent collections of tents. Slightly more women (38%) than men (32%) feel insecure or very insecure as or with hosts. By contrast, 90% of women, and 60% of men ranked collective shelters as either insecure or very insecure.

Both men and women indicated overcrowding as the main reason for not feeling secure as or with hosts. Women also mentioned the inability to keep separate from men, fear for their

One night, a woman was ready to give birth. Her husband asked his neighbour to accompany him and his wife to the midwife, but they refused for fear of going out in their car at night. This delayed the man's ability to get his wife help on time. The man was forced to take his wife on a motorcycle, and on the way she gave birth. She lost the baby and her health has since deteriorated.

JASSIM, FEMALE HEALTH PROVIDER

I gave birth at home at night. We weren't able to know about the baby's situation even though our neighbourhood midwife helped with the birth. Finally after two days my husband took the baby to the doctor and he was diagnosed with oxygen deficiency and sever pneumonia.

QUNEITRA, FEMALE NGO LEADER

My sister was in labour at night. All of the neighbors refused to help her husband for security reasons. Knowing that there is no ambulance, myself and my mother were forced to help my sister at home.

QUNEITRA, FEMALE NGO LEADER

ONE HEALTH CARE WORKER SAID

"We get [medicine] from organizations. The local council did not provide any health services because there is no support from outside. The majority of health services come from NGOs."

daughters' safety, a lack of locks, and being amongst strangers. Men often discussed the lack of locks and lack of privacy.

In collective shelters, women indicated insecurity as being associated with the location of the WASH facilities. Men, on the other hand, listed first overcrowding and lack of privacy as well as the location or condition of WASH facilities.

Where collective shelters were opened or administered by local councils, female key informants noted that generally they are unlikely to take vulnerability and protection concerns into consideration. Men further explained that local councils do not have the ability to provide housing and shelter, and, if they do, they do not often take the specific needs of women and children into account.

FACTORS MAKING WASH FACILITIES UNSAFE (SEE TABLE 4 ON PAGE 48)

OVERCROWDING & OVERUSE WAS MOST COMMON

WOMEN WERE LESS CONCERNED ABOUT LOCKS & LIGHTS

WOMEN WERE MORE CONCERNED ABOUT DISTANCE AND DANGERS ALONG THE WAY TO THE FACILITIES

9% of women and 26% of men said NFIs were available to women. Women and men nearly equally said NFIs were accessible and 27% of women and 17% of men said that women can control NFIs.

Water, Sanitation, and Hygiene

Similar trends exist in water access and control as well as WASH safety. Six percent of women compared to 13% of men said water was controllable. Women and men indicated that water was available, and more women (41%) than men (28%) said it was accessible.[2] In qualitative interviews, women mentioned a critical lack of soap and water for hygiene needs related to menstruation and taking care of children.

Only 38% of female respondents indicated they do not have a problem accessing WASH facilities, toilets and showers. Of those who do, some respondents indicated they might use free spaces, go outdoors (men) or use the space between damaged buildings (women), when there is nowhere else available.

20% more women indicated that WASH facilities are currently unsafe, with women living in collective shelters noting the greatest concerns. Women and men listed overcrowding and overuse, lack of privacy and locks, and then distance as reasons for insecurity in collective shelters. Women are 15% more likely than men to mention distance and 11% more likely to mention dangers on the way, suggesting that this design element creates a risk for women and adolescent girls – again, particularly in collective centers.

In qualitative interviews, most female respondents said that if they are available and if they have enough money, women will buy feminine hygiene from local supermarkets and pharmacies. Unfortunately, these products are costly. While some supplies may be included in health kits from international relief organizations, for the most part they are not included or not included in sufficient amounts to meet women's and girls' needs.

Women also indicated there is often nowhere to dispose of used pads or hygiene items. This makes it difficult and embarrassing for women, so they must find a place to burn them instead. Adolescent girls are highly affected, feeling embarrassed with no privacy to take care of this business in the public bathrooms or outdoor areas that are available.

I have been told a story by a woman who was in a pharmacy. [She overheard] another woman asking the pharmacist for pills that delay the period. When the pharmacist asked her why she wanted to buy these pills, the woman answered that she is newly displaced. She lives in a school with no money to buy pads or old cloth to be used as pads, so she is trying to delay her period for two to three months. She knows what the effects of the pills will be on her body, but it's cheaper than buying pads.

NAWA, FEMALE NGO LEADER

[2] Based on the experiences of humanitarian actors in southern Syria, water is not perceived as a need because it is available through water trucks, but this is costly. While this explains the lower control and higher access and availability figures, it does not explain gender differences in access and availability.

CONCLUSIONS AND RECOM-MENDATIONS

This analysis has confirmed that gender inequalities and deeply rooted social norms existed before the conflict in Syria began, and have persisted, and in many cases worsened, over the past six years. In southern Syria, women are significantly less involved in public life and leadership roles than they were before the start of the conflict, and women's mobility has become severely restricted. However, many women, particularly those now heading a household, have had to take on greater, and often traditionally male responsibilities.

Public services and humanitarian assistance are now largely managed or directed through male-dominated local councils, even where the assistance is provided via Syrian civil society organizations. Some councils provide a broad range of services and a more equitable distribution of assistance. However, many do not, and their ways of working vary widely. Women currently have very limited opportunity to influence the councils, or by extension, to influence how and what services and aid are delivered to which populations. People with multiple vulnerabilities, such as being female, elderly, living with a disability or

internally displaced, seem most likely to be excluded from distributions and service provision, both by councils and by local humanitarian organizations.

Current response efforts are creating opportunities for exploitation and harm, and in many sectors, serious protection concerns persist and have not been considered, let alone addressed, by humanitarian actors. In addition, gender-based violence as an issue has been down-played within the humanitarian response in the south, but is a very real issue which requires more research and response.

Based on this analysis, which has a provided an improved understanding of the interplay between gender dynamics, protection and governance in southern Syria, a number of key recommendations for immediate action have emerged:

STRENGTHEN WOMEN'S INVOLVEMENT IN GOVERNANCE, SERVICE DELIVERY, AND THE DIRECTION OF HUMANITARIAN AID

Although women have traditionally been less involved than men in political life, governance, and community leadership, this survey has revealed that before the start of the conflict, up to 14% of women participated in local government and 27% engaged in public political meetings. Women and men also noted that female leaders certainly exist, and are typically well-educated, have a high level of confidence, and have the support of male family members and local leaders. Women also highlighted that they would be better able to take on leadership roles if they had more opportunities for self-development and support for dealing with trauma and depression. In light of this, CARE proposes the following actions:

1) With few women's representatives to local councils, communities should build on the tradition of women's engagement in civil society, like women's groups and women's CBOs, to find opportunities for key women to become champions for women's practical and strategic needs. Furthermore, humanitarian actors can work to further build or to re-establish community-based women's networks, organizations, groups.

2) Identify female leaders and women's/women-led organizations in the communities where humanitarian programs are implemented, and seek out their active involvement in program planning and delivery.

3) Provide training and personal development opportunities for women in areas required for them to take on new household and enhanced leadership roles. Trainings should be in a variety of topics such as household financing, life skills, leadership, and decision making. Provide a range of opportunities that either support women in their current roles or challenge the traditional division of labour.

4) Support the formation of women's advisory/relief committees to provide input to local councils and/or relief councils on subjects such as registration processes, the preparation of beneficiary lists, the planning of service provision and aid distribution, addressing community feedback, etc. The establishment of these committees must, however, be carefully couched in tradition and social norms.

5) Other women's community groups can also be established to provide support to women and to provide women opportunities to discuss their challenges, coping, and priorities.

6) Sensitize men, governance actors, local partners, and local communities to the importance of ensuring that governance and assistance listen to women's voices in order to be as effective as possible for everyone.

ENGAGE MEN ON GENDER ISSUES

The findings in this report show, first, the key roles that men play in private life and public governance. The findings show that men are under pressure to act in highly masculinised ways, even where these are not the most sustainable personal coping mechanisms or crisis response strategies. Finally, men hold a very broad range of knowledge and attitudes regarding gender issues. Given their decision making positions, this set of knowledge and attitudes directly affects how women, girls, men and boys access the goods and services they need to cope with this crisis. Based on these findings, CARE recommends that Humanitarian organizations use a range of informal mentorship or lead-by-example opportunities, community dialogues, and formal capacity building to begin the process of strengthening men's awareness and knowledge around gender issues. Consider engaging male IDPs and beneficiaries, male CBO or service delivery partners and informal opinion leaders as a first step.

WORK WITH SYRIAN PARTNER ORGANIZATIONS TO STRENGTHEN DO-NO-HARM AND GENDER EQUALITY AND PROTECTION MAINSTREAMING APPROACHES

While Syrian organizations operating in the south have an exceptional understanding of context and an extraordinary capacity to operate on the ground despite incredibly challenging circumstances, few of them have any background in humanitarian action or concepts such as do-no-harm or gender equality and protection mainstreaming. Men comprise the bulk of active decision makers in many organizations. It is therefore incumbent on established humanitarian organizations to support Syrian partners to develop in these areas in order to ensure a better, safer and more equitable humanitarian response in the South. Based on the lessons learned from this analysis, CARE therefore proposes the following actions:

1) Ensure that due diligence processes for the selection of partner organizations consider organizational capacity in the areas of gender equality and protection. Where gaps are identified, build relevant training and mentoring into project planning with the partner.

2) Using available technology and resources, provide all partners with an orientation on do-no-harm, gender, equality and protection. Using concrete examples from the local context, help male and female staff to understand why it is essential to consider these approaches, and how it can make their response efforts stronger.

3) Ensure trainings are delivered directly to male and female field staff, not just headquarters staff.

4) Build relevant requirements into partner grants and contracts, and ensure payment is contingent on achievement of these requirements. For example, ensure that beneficiary selection criteria, such as the inclusion of female-headed households, are listed in partners' program requirements.

5) Support partner organizations to recruit, retain and invest appropriately in female staff.

6) Women noted that traveling to and receiving humanitarian assistance increases the risk of GBV. Partners must ensure that basic gender equality and protection considerations are applied systematically. For example, female staff must be present at all program activities, and separate spaces and times should be established for distributions to women.

7) Partner with women/women's led organizations.

8) As part of the standard engagement process between Syrian partners and local councils at the outset of any project, require that councils accept basic processes to ensure that programs are fair and safe for everyone. These processes should include:

- Verification of beneficiary lists provided by councils
- Authorization for partners to assess additional households and include beneficiaries who do not appear on council lists
- Consultation with community members other than the councils to select distribution sites

9) Do not provide assistance in locations where councils will not allow these processes to take place.

10) Work with partners to identify risks and opportunities for exploitations and abuse in programs. Recognize that these things will occur, and make it clear to partners that they will not be blamed, but rather supported to address any issues which may arise so long as they are reported quickly and transparently.

11) Explore opportunities for the south Syria response as a whole to apply minimum protection/do-no-harm standards to programming. If all organizations refuse to provide assistance in a location where assistance is being mismanaged, it may be possible to effect change in that location.

SUPPORT FAIR AND TRANSPARENT REGISTRATION PROCESSES

Registration processes for newly arrived IDPs and most-vulnerable households are typically managed by local or relief councils. Unfortunately, power dynamics between councils and vulnerable people, along with documentation and patronage requirements, create considerable opportunities for exploitation and abuse. While humanitarian programs cannot control these processes, some steps may be taken to lessen the opportunities for sexual exploitation and abuse (SEA):

1) Support partners to assess and identify households which meet programmatic selection criteria, but which have not been included on council lists.

2) Accompany those households through the registration process. For example, ensure partner staff members, including a female staff member, are present when the identified household representative requests registration.

3) Consult with leaders from vulnerable segments of the population (women, the disabled) to generate their own lists of families most in need, and support partners to advocate with councils to register the households on those lists.

INVEST IN COMPLAINTS, FEEDBACK AND PREVENTION OF SEXUAL EXPLOITATION AND ABUSE (PSEA) MECHANISMS

The remote management aspect along with organizational confidentiality considerations in the south Syria response have limited efforts by many international NGOs to establish mechanisms which allow for direct reporting from beneficiaries or concerned individuals in the field. This adds a layer of difficulty when addressing the potentially negative effects of gender dynamics discussed in this report. Challenges in verifying and responding to potential complaints are considerable, and concerns around the creation of false expectations are legitimate. However, this does not excuse the humanitarian community from the need to listen directly to beneficiaries. Recommendations to strengthen program safety and accountability are therefore as follows:

1) Immediately establish complaints and feedback mechanisms that are accessible to and appropriate for women, girls and other vulnerable groups, and circulate contact information throughout targeted locations.

2) If mechanisms provide direct reporting to an INGO, ensure complaints and feedback are shared with partners.

3) Be honest with complainants that it may not be possible to verify or address their complaint.

4) Ensure that women and men receiving complaints have been trained in how to respond to complaints related to GBV, with a particular emphasis on confidentiality.

5) Complete mapping of service providers to identify whatever referral pathways may be available.

6) Work with women, women's organizations and relevant service providers to identify ways to support victims of GBV/SEA.

7) Humanitarian actors should work to establish standardized codes of conduct for employees and ensure all employees are trained on these topics.

ENHANCE PROTECTION, AND SPECIFICALLY GBV, PROGRAMMING

This analysis has revealed that women and girls live with the constant threat of GBV at home and in nearly every location they access. However, incidents are rarely reported. Domestic abuse is considered too minor to mention, and when it comes to reporting more serious cases of GBV, women fear that doing so may result in loss of reputation, a negative impact on their children, or death at the hands of the perpetrator. In addition, they feel that even if reported, there is nowhere to turn for meaningful support, despite the largely male-reported availability of a small number of justice mechanisms. In this difficult situation, potential recommendations are as follows:

1) Further research and exploration is needed to work with communities to identify safe, supportive and context-appropriate ways to assist survivors.

2) Protection and GBV-related programming must be expanded, but at an appropriate pace, allowing for the incremental training of staff in the field.

3) Confidentiality in a context where reporting GBV can be extremely dangerous must be reinforced as a corner-stone of all protection and GBV programming.

4) Expansion of basic psycho-social support activities can be a first step, and should include the provision of awareness-raising sessions on the topics below, which were requested by women themselves throughout this analysis:

- Women's rights
- Early marriage
- Women's education
- Self-fulfillment
- Decision making

5) Build the skills of female health professionals and midwives to provide medical and psychosocial services to GBV survivors, and to manage their own trauma. Train and remunerate women who are already in this role and recruit others as peer supports and community leaders who are able to provide house-to-house visits.

6) Initiate a GBV mapping exercise to identify where services are available or may be strategic to implement. Coordinate any GBV services closely with primary health care (PHC) services for safety and protection of survivors seeking services.

7) Build the capacity of local service providers to better serve the needs of women, related to sexual and reproductive health, mental health and psychosocial support, and GBV response.

SECTOR-SPECIFIC RECOMMENDATIONS:

Over the course of this analysis, many sector-specific lessons were learned, resulting in the following recommendations. Some of these are listed above, but have also been repeated below for ease of reference:

Basic Needs

1) Work closely with partners and local councils developing beneficiary lists to ensure inclusion of vulnerable groups including women, female headed households, the elderly, and persons with special needs.

2) Advocate for CBOs to support accompaniment for women to access relief as well as accompaniment to be formally registered with local councils.

3) Establish separate locations or times for relief distributions (food, NFIs), ensuring there is safe places for women and men to access relief supplies.

4) Revisit core kit contents, addressing specific needs of women and other vulnerable groups , including ensuring appropriate clothing in winter clothing kits, women-specific hygiene items in hygiene kits, items for the disabled/elderly, etc).

Shelter

1) Ensure that shelters have safe and private places for women and girls; adequate water, drainage and lighting; locks on doors; and shower and toilet facilities that meet IASC and Sphere standards.

2) Involve women, the elderly, PLWD and other vulnerable groups in all aspects of shelter and water and hygiene system design. Use related rapid participatory tools that focus on reproductive activities and capacity building techniques to do this.

3) Establish both female and male shelter or IDP camp safety committees. Use good practices in watch-and-ward, safety mapping and committee awareness raising and mobilization from other emergencies. Facilitate dialogues between the male and female committees and set up a liaising function amongst committee members, shelter managers, local council members and others to address safety issues.

4) Support community mobilization among both IDPs and host populations to discuss safety and dignity in host settings. Ensure there are channels for IDPs being hosted to communicate any challenges or concerns.

WASH

1) Prioritize (in budgets, discussions with donors and discussions with local councils) the water and sanitation activities that will allow women and adolescent girls to manage menstruation safely.

2) Hold participatory safety mapping exercises to identify safe and unsafe spaces. Use the technique of mapping separately with each sex, then coming together with women and men in a facilitated or mediated discussion. Use small groups of leaders to begin, depending on how sensitive this topic is.

3) Involve women in water user management committees and in the design of water and sanitation elements. Turn discreet aspects of monitoring and compliance over to women (again, such as an observation checklist used to confirm whether contractors have installed water elements in ways and with materials that benefit vulnerable groups).

4) Identify and cultivate relationships with gender-aware men who can act as champions for women's and girls' strategic and practical shelter and WASH needs.

5) Specifically address issues of over-crowding, privacy, safety, and distance to facilities in collective centers by scaling up water and sanitation activities in those locations to provide more latrines and bathing spaces. Ensure those facilities have locks and adequate measures for privacy.

Health

1) Secure funding for and implement any health programming that focuses on maternal and newborn health, emergency medical obstetric and neonatal care (EMOC), minimum initial service package (MISP) and GBV response.

2) Design sexual and reproductive health activities appropriate for men and boys as well as women and girls.

3) Advocate with local councils or other local opinion holders and policy makers, donors and power holders to prioritize health emergency response.

4) Build the skills of female health professionals and midwives to provide medical and psychosocial services to GBV survivors, and to manage their own trauma. Train and remunerate women who are already in this role and recruit others as peer supports and community leaders who are able to provide house-to-house visits.

5) Initiate a GBV mapping exercise to identify where services are available or may be strategic to implement. Coordinate any GBV services closely with PHC services for safety and protection of survivors seeking services.

6) Build the capacity of local service providers to better serve the needs of women, related to sexual and reproductive health, mental health and psychosocial support, and GBV response.

AREAS FOR FURTHER STUDY

Though this report details out the findings of an analysis of the implications of gender dynamics, protection, and inclusive governance on humanitarian programming, it is by no means comprehensive. From this initial assessment, some areas for further study have been identified:

1) Local governance structures: Little is yet documented on the ways local councils are elected or appointed, in what capacity they work and how this varies depending on the area, their interactions with governorate-level governance, and the ways they interact with local communities. A thorough study of local councils will help to inform how partners can more closely and effectively coordinate activities with them, how agencies can identify targets and modalities for training local councils on humanitarian topics, and what expectations of local councils beneficiaries and target communities should have.

2) Governance and resilience programming: The role of governance and governance actors in supporting and ensuring sustainability for longer-term resilience programming.

3) Justice systems: In the absence of a formal court, Shura courts have become the de-facto only option for pursuing any justice. Protection actors should gain an understanding of these courts, how they work, and what justice they can provide, to further humanitarian programming related to justice and protection of rights.

4) Women's organizations and community leadership: The identification of and engagement with local female leaders and women's/women-led organizations;

5) Complaints / Feedback Reporting / PSEA Mechanisms: Consulting with communities to better understand how to identify and address issues of exploitation and abuse at all levels in a way that is adequate and appropriate to the target populations.

For additional data or for questions regarding this report, please contact CARE at info@care.ca.

APPENDIX

CBO – Community based organization

EMONC – Emergency medical obstetric and neonatal care

GBV - Gender based violence

IASC – Inter-agency Standing Committee

IDP - Internally displaced person

INGO – International non-governmental organization

MISP – Minimum initial service package

NFI – Non-food items

NGO - Non-governmental

ODK – Open data kit

PHC – Primary health care

PLWD – Persons living with disability

PSEA – Prevention of sexual exploitation and abuse

SEA – Sexual exploitation and abuse

TABLE 1: HEAD OF HOUSEHOLD

IDENTIFIED HEAD OF HOUSEHOLD	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
me	30%	66%	91%
my husband	57%	14%	0%
another adult male	9%	14%	1%
another adult female	3%	0%	7%
son	1%	7%	0%

TABLE 2: HOUSEHOLD DECISION MAKERS

IDENTIFIED HOUSEHOLD DECISION MAKER	NOW			PRE-CONFLICT		
	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
me	23%	58%	84%	5%	8%	78%
my spouse	55%	7%	1%	78%	76%	0%
another adult male	16%	27%	9%	14%	12%	15%
another adult female	5%	8%	0%	2%	2%	0%

TABLE 3: RISK FOR GBV

DEMOGRAPHIC CATEGORY	NUMBER OF FEMALE RESPONDENTS	NUMBER OF MALE RESPONDENTS
unaccompanied or single women	14	15
newly married adolescent girls (aged 15 – 19)	14	8
unaccompanied or single adolescent girls	10	12
disabled women	8	1
unaccompanied adolescent boys	6	1
women who are married and living with their spouses	8	3

TABLE 4: LEADERSHIP ROLES FILLED BY WOMEN AND MEN

LEADERSHIP ROLE	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
nursing	98%	97%	55%
education services	69%	69%	77%
small business	48%	42%	57%
managing health care services	34%	29%	82%
judge / lawyer	20%	19%	18%
food relief items distribution	12%	14%	89%
registering citizens	5%	7%	68%
organizing self-help group	5%	2%	35%
managing defence security	2%	0%	90%
managing finances, fiscal planning	2%	0%	49%
implementing local council policies	3%	0%	46%

TABLE 5: WHAT FORMS OF GBV ARE MOST COMMON?

TYPE OF VIOLENCE[3]	NUMBER OF FEMALE RESPONDENTS IDENTIFYING TYPE OF GBV	NUMBER OF MALE RESPONDENTS IDENTIFYING TYPE OF GBV
marrying children under the age of 18	24	14
physical violence such as punching or kicking	24	10
emotional violence such as threats to do harm	6	5
denying a person their basic needs because of their gender	6	2
rape	5	0
sexual harassment	3	2
trafficking, sexual or other exploitation such as asking for sex in order to receive a basic right such as food	3	2
forced impregnation	3	1
husbands forcing their wives to have sex even if their wives have refused	2	2
using any of these forms of violence as a tactic of intimidation during war	2	4
honour killing	1	0

[3] Taken from IASC definition of GBV

TABLE 6: ISSUES THAT PREVENT WOMEN, GIRLS, MEN AND BOYS FROM GOING OUT IN PUBLIC

REASONS TO RESTRICT MOBILITY	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
aerial bombings	79%	81%	69%
no money for transport	54%	69%	86%
no one to accompany	47%	64%	28%
means of transport doesn't exist	44%	51%	77%
roadblocks and checkpoints not safe	17%	19%	38%
harassment and intimidation by armed groups	15%	17%	21%
fear of kidnapping	15%	15%	34%
Physical environment generally unsafe	12%	12%	39%
new rules limiting mobility	10%	10%	16%
fear of arrest	11%	8%	36%

TABLE 7: LOCATIONS LIKELY FOR GBV TO OCCUR

LOCATION	NUMBER OF FEMALE RESPONDENTS INDICATING LOCATION	NUMBER OF MALE RESPONDENTS INDICATING LOCATION
at home	26	16
at checkpoints or road blocks	14	16
randomly on the street or in fields or abandoned buildings	12	9
when receiving food or other relief aid (Standing in lines, going to offices)	9	7
required to go out around the town frequently in order to access health clinics, schools, services, food distribution, etc.	6	5
when newly arrived	5	1
at work	4	2
when attempting to report incidents or get justice from police or other security personnel	2	0
when doing things or going places in groups with women	2	1

TABLE 8: MOBILITY FOR WOMEN AND GIRLS

REASONS TO GO OUT	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
look for work, go to jobs, school	74%	98%	92%
search for food	65%	81%	78%
visit friends, neighbours or relatives	56%	73%	84%
participate in social activities or religious festivals	26%	31%	56%
accompany younger children to and from school	23%	31%	30%
supplying water	16%	25%	36%
participate in NGO or CBO schemes	9%	14%	35%
organize or manage community relief activities	4%	5%	63%
participate on civic committees	2%	3%	37%

TABLE 9: FACTORS THE PREVENT SEEKING JUSTICE FOR GBV

REASONS FOR NOT SEEKING HELP OR JUSTICE	NUMBER OF FEMALE RESPONDENTS	NUMBER OF MALE RESPONDENTS
fear of continued violence	23	18
there is no guarantee of confidentiality	23	12
the consequences of someone coming to know that the person has reported will be worse than the original incident	12	9
if the family or community finds out, it will shame the person	10	8
don't believe there is really anything anyone can do	10	4
the medical and legal services really don't exist in this area	6	2
the person one is supposed to report to could have been the original perpetrator	3	1
it is a long, expensive and time-consuming process to report a case of GBV and get justice; the person may not have the money, time, documents or information required.	3	4

TABLE 10: WHAT ARE YOUR SOURCES OF STRENGTH?

SOURCE OF STRENGTH	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
belief in self and capabilities	60%	69%	82%
need to do something for children	51%	63%	72%
skills or lessons learned from past	61%	61%	79%
encouragement of other family/ friend	26%	36%	65%
encouragement of spouse	49%	8%	64%
work	11%	7%	26%

TABLE 11: INFORMATION ABOUT RECEIVING AID

METHOD OF RECEIVING INFORMATION	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
word of mouth from men	59%	80%	84%
word of mouth from women	80%	78%	60%
local councils	42%	47%	72%
phone, SMS	11%	15%	9%
local hospital or clinic	4%	10%	0%
internet social media	9%	7%	30%

TABLE 12: SERVICES THAT THE LOCAL COUNCIL PROVIDES

TYPE OF SERVICE	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
food aid	63%	56%	82%
education and vocational training	25%	20%	21%
electricity and water supply	11%	10%	52%
supplies other than food	11%	10%	49%
general medical care	8%	5%	12%
justice and legal aid	2%	0%	14%
police and security	0%	0%	9%

TABLE 13: REASONS FOR NOT FEELING SECURE IN HOST ACCOMMODATION

REASONS FOR INSECURITY IN HOST ACCOMMODATIONS	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
overcrowding, lack of privacy	78%	79%	84%
no good locks	17%	29%	54%
fear for daughter's safety	20%	26%	12%
we're with many strangers	17%	24%	0%
everyone can see and hear our business	10%	18%	46%
landlord harassment	8%	9%	10%
lack of safety in WASH areas	0%	0%	7%

TABLE 14: REASONS FOR NOT FEELING SECURE IN COLLECTIVE SHELTERS

TYPE OF INSECURITY	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
location or condition of WASH facilities	70%	80%	43%
overcrowding, lack of privacy/no locks	68%	56%	71%
being elderly or disabled	43%	40%	37%
being from outside the community	21%	36%	23%
other people knowing about possession of relief items	11%	12%	14%

TABLE 15: FACTORS MAKING WASH FACILITIES UNSAFE

REASONS FOR INSECURITY	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
overcrowding and overuse	67%	69%	72%
lack of privacy, no locks	52%	59%	73%
distance	30%	39%	15%
no water or water is far	24%	34%	26%
no lights, dark, dingy, etc.	29%	22%	46%
dangers on the way	16%	17%	5%
water only running at certain time	22%	15%	27%

TABLE 16: HOW DO YOU DEAL WITH PROBLEMS AND SUFFERING?

METHOD OF COPING	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
talk with close friend or family member of same sex	64%	66%	63%
talk with close person of opposite sex (spouse, etc.)	56%	66%	88%
go to religious or community leader	21%	24%	43%
midwife	14%	19%	4%
seek help of health professional	18%	14%	20%
cry in a private space alone	19%	12%	10%
take frustrations out on family members	8%	3%	38%
contact NGO for services	5%	2%	15%

TABLE 17: LOCAL COUNCIL MEMBER CHARACTERISTICS

CHARACTERISTIC	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
registered as Syrian national	78%	88%	91%
someone people trust	85%	83%	93%
good reputation	86%	81%	97%
not militant	59%	53%	71%
hold bachelor's or higher degree	38%	37%	38%
male	28%	22%	37%

TABLE 18: INVOLVEMENT IN PUBLIC ACTIVITIES BY WOMEN AND MEN BEFORE THE CONFLICT AND NOW

TYPES OF PUBLIC ACTIVITIES	NOW			PRE-CONFLICT		
	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN	WOMEN	UNACCOMPANIED FEMALE IDPs	MEN
school meetings or teaching	88%	92%	83%	68%	64%	85%
leading at the mosque	41%	34%	74%	51%	37%	80%
raising awareness about and distributing relief	12%	17%	62%			
helping needy people	12%	14%	40%	30%	27%	40%
participating as executive member of religious group	5%	10%	11%	20%	17%	26%
managing how relief items are distributed	5%	3%	76%			
leading IDPs	2%	3%	32%			
voting	4%	2%	38%	95%	97%	95%
forming or leading groups to bring relief to distressed	4%	0%	59%			
forming community action group	3%	0%	24%	23%	19%	26%
being on the executive of local area council	2%	0%	30%	14%	19%	42%
belonging to a political party	1%	0%	2%	56%	58%	70%
meeting elected or appointed officials	2%	0%	22%	13%	14%	30%
attending public meetings	2%	2%	47%	27%	27%	29%