



REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

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National Strategy
to Institutionalize Clinical
Management of Rape
Programming Within
Public Health Facilities
in Lebanon
2020-2021

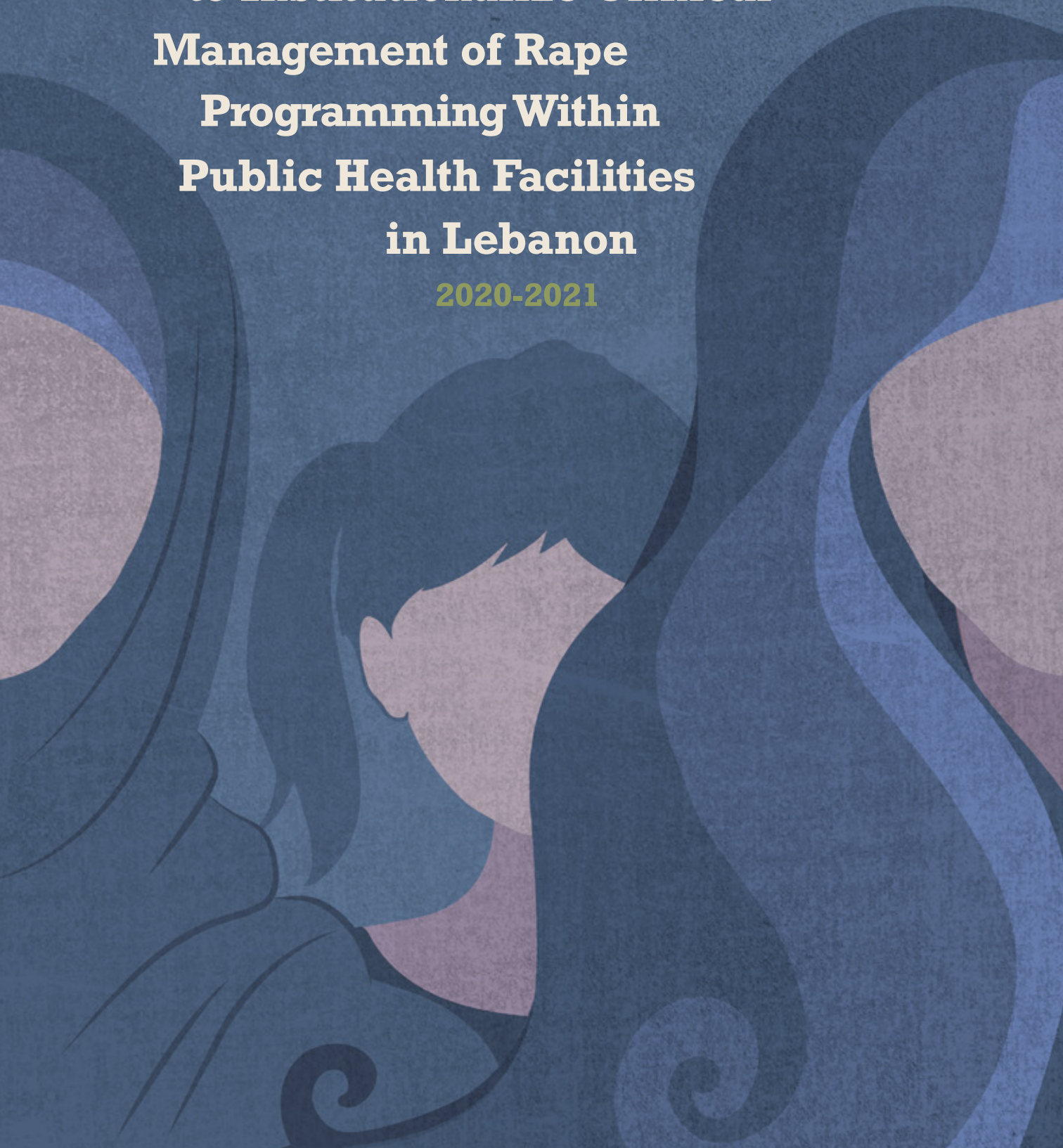


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Foreword

by the director of PHC & Social Health Department

Sexual assault including rape constitutes a major public health problem that has its impact on individuals at multiple levels encompassing physical, psychological and social; It's a problem throughout the world, occurring in every society and of course in Lebanon. Women and girls are particularly at risk of this violation of their human rights, especially during an emergency situation.

Identifying and supporting survivors of rape and sexual assault might be particularly challenging, considering inherited gender and social norms that work against survivors; the under-reporting due to stigmatization and blames, mobility restriction, economic dependency, and the notion of seeing "rape and sexual assault issues "as a private matter".

Prior to the Syria crisis, clinical management of rape (CMR) was not a service offered to survivors of sexual violence/rape in private and public medical facilities in Lebanon nor were there any specific protocols or skilled service providers who were trained on provision of CMR medical services for adult and child survivors of sexual violence.

Over the past 9 years, the Ministry of Public health (MoPH) in collaboration with the CMR Task Force (TF) and the Sexual and Gender based Violence (SGBV) TF have been working to put in place systems to respond to survivors of rape and sexual assault through making CMR services available in more than 43 Primary Health Care (PHC) Centers and public hospitals. Furthermore, due to a joint advocacy effort by MoPH PHC department and the CMRTF members, in 2015, a circular on mandatory reporting of sexual violence for adult survivors was amended by MoPH in order to comply with international standards for a survivor-centered approach.

Despite achievements, significant challenges remained ...this has necessitated a work under the leadership of MoPH in partnership with UNICEF / UNFPA and the CMR TF on drafting the CMR strategy. This strategy looked into the lessons learned throughout the roll out of CMR services during the past 9 years, and into successful examples

of provision of CMR services in other countries. Furthermore, it will ensure the availability of currently absent CMR national accountability frameworks. It will allow institutionalizing CMR services within MoPH health services network pertinent to international standards, while creating linkages with other concerned public and private entities including key ministries such as the Ministry of Social Affairs, Ministry of Justice, Ministry of Interior and Municipalities, Ministry of Education and Higher Education, and the civil society organizations that has a fundamental role in awareness and referral.

With the purpose of creating concrete national and local ownership, the development of this strategy sought to ensure that broad participatory approaches used at all stages. Extensive consultation with different stakeholders was ensured at all stages including line ministries, Orders and Syndicates i.e. Lebanese Order of Nurses, Lebanese Order of Midwives, Social Workers Syndicate and Lebanese Society of Obstetrics and Gynecologists, in addition to non-governmental organizations namely GBV service providers.

This strategy took into account the most recent technical information on the various aspects of care for people who have been raped, and made sure that the voices, needs and priorities of women and girls are properly heard and mainstreamed throughout this document. The next step is the development of the CMR action plan as well as a communication strategy to ensure operationalization and advocacy around the CMR strategy.

Randa Hamadeh

Director of PHC & Social Health Department,
UHC 2030 National Coordinator .

Acknowledgement

The Clinical Management of Rape (CMR) strategy has benefited from the valuable input of many persons. To thank, in particular, key informants of different governmental, non-governmental and international organizations as well as local experts and professionals for sharing their insights and experiences. Their input was instrumental.

A great acknowledgement is addressed to the Ministry of Public Health (MoPH) Dr. Randa Hamadeh (Director of PHC & Social Health Department, UHC 2030 National Coordinator), and Ms. Wafaa Kanaan (PHC Chief Central coordinator) who were " Champions " for women's rights in Lebanon and they supported and proactively engaged in every phase of the strategy development.

Recognition is also extended to concerned staff at UNICEF and UNFPA in Lebanon for their valuable guidance, contribution, and support throughout the process , along with the CMR task Force members for their substantial contribution and support .

The gratitude is also extended to women and girls who have shared their experience and perceptions and gave us the guidance to make this strategy "survivor's centered".

Hoping this strategy will pave the road to adequately advancing protection of "at risk" and "survivors" of rape in Lebanon with the aim of ultimately improving the quality of services and the wellbeing of the survivors.

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Acronyms

CEDAW	Convention of the Elimination of all Forms of Discrimination Against Women	MISP	Minimum Initial Service Package
CMR	Clinical Management of Rape	MOI	Ministry of Information
CMR TF	Clinical Management of Rape Task Force	MOIM	Ministry of Interior and Municipalities
COVID-19	Corona Virus Disease-19/Novel Corona Virus-19	MOJ	Ministry of Justice
DOPS	Direction d'Orientation Pédagogique et Scolaire/ Orientation and Counselling Department	MOPH	Ministry of Public Health
DRC	Danish Refugee Council	MOSA	Ministry of Social Affairs
GBV IMS	Gender-Based Violence Information Management System	MOU	Memorandum of Understanding
HIV	Human immunodeficiency virus	NAP	National AIDs Control Program
IASC	Inter-Agency Standing Committee	NGOs	Non-Governmental Organizations
IAWG	Inter-agency Working Group	PEP kits	Post-Exposure Prophylaxis Treatment kits
ICC	International Criminal Court	PTSD	Post-traumatic stress disorder
IEC	Information, Education, and Communication	RH	Reproductive Health
IMC	International Medical Corps	SDCs	Social Development Centers
IPV	Intimate Partner Violence	SDGs	Sustainable Development Goals
IRC	International Rescue Committee	GBV	Gender-based violence
ISF	Internal Security Forces	GBV TF	Sexual & Gender-based Violence Task Force
LCRP	Lebanon Crisis Response Plan	SOPs	Standard Operating Procedures
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex	STIs	Sexually Transmitted Infections
LRC	Lebanese Red Cross	UNDP	United Nations Development Program
LSOG	Lebanese Society for Obstetrics and Gynecologists	UNFPA	United Nations Population Fund
MEHE	Ministry of Education and Higher Education	UNHCR	United Nations High Commissioner for Refugees
MHPSS	Mental Health and Psychosocial Support	UNICEF	United Nations Children's Fund
		UNRWA	United Nations Relief and Works Agency
		ESCWA	United Nations Economic and Social Commission for Western Asia
		VAW	Violence against women
		WHO	World Health Organization
		WGSSs	Women and Girls' Safe Spaces

Part 1

I. Key Concepts Definition

II. Background Information

III. The Lebanese Context

A. Scope of the GBV Problem

B. GBV Risk Contributing Factors

C. CMR Current Situation: Gaps, Challenges and Opportunities

1. Legal and Policy Frameworks

2. Supply of CMR Services

3. Demand for CMR Services

D. Facilitating Factors



Key Concepts Definition

Clinical Management of Rape: The specific, urgent medical care that is directly related to the type of violence that rape survivors have experienced; whether they have experienced rape by a partner or by someone else. The clinical care provided to rape survivors includes the following: (1) First-line support: listening, inquiring about needs and concerns, and validating the survivor; (2) Obtaining informed consent and preparing the survivor; (3) Taking the history; (4) Performing the physical and genital examinations; (5) Providing treatment; (6) Enhancing safety and referring for additional support; (7) Assessing mental health and providing psychosocial support; and (8) Providing follow-up care (World Health Organization (WHO), United Nations Population Fund (UNFPA) and United Nations High Commissioner for Refugees (UNHCR), 2020).

Gender-Based Violence: An umbrella term for violence directed toward or disproportionately affecting someone because of their actual or perceived gender identity. The term 'gender-based violence' is primarily used to underscore the fact that structural, gender-based power differentials around the world place women and girls at risk for multiple forms of violence. This includes acts that inflict physical, sexual, and emotional harm or suffering, threats of such acts, coercion, and other deprivations of liberty, whether occurring in public or in private life. While women and girls suffer disproportionately from GBV, men and boys can also be targeted (UN, 2017).

Human Rights: Universal legal guarantees protecting individuals and groups against actions and omissions that interfere with fundamental freedoms, entitlements and human dignity. They are inherent to all human beings and are founded on respect for the dignity and worth of each person. Human rights are expressed, promoted and guaranteed by law, specifically through national laws, bilateral, regional and international treaties, norms and standards, customary international law, general principles of law and other sources of international law (UN, 2017).

Intimate partner violence (IPV): When women suffer from ongoing or past violence and abuse by an intimate partner or ex-partner including a spouse or boyfriend. The types of violence include physical violence, emotional/psychological abuse, controlling behaviors, and sexual violence (WHO, UNFPA and UNHCR, 2020).

Rape: According to the International Criminal Court (ICC), the elements of rape consist of the following (ICC, 2013, p.5):

- "The perpetrator invaded the body of a person by conduct resulting in penetration, however slight, of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body.
- The invasion was committed by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention,

psychological oppression, or abuse of power, against such person or another person, or by taking advantage of a coercive environment or the invasion was committed against a person incapable of giving genuine consent”.

Sexual Assault: Sexual activity with another person who does not consent. It is a violation of bodily integrity and sexual autonomy and is broader than narrower conceptions of “rape”, especially because (a) it may be committed by other means than force or violence, and (b) it does not necessarily entail penetration (UN, 2017).

Sexual Violence: Acts of a sexual nature against one or more persons or that cause such person or persons to engage in an act of a sexual nature by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, or by taking advantage of a coercive environment or such person’s or persons’ incapacity to give genuine consent. Forms of sexual violence include rape, attempted rape, forced prostitution, sexual exploitation and abuse, trafficking for the purpose of sexual exploitation, child pornography, child prostitution, sexual slavery, forced marriage, forced pregnancy, forced public nudity, forced virginity testing, etc. (UN, 2017).

II. Background Information

Addressing gender-based violence (GBV) in all its forms, especially rape, has always been a priority in regular as well as conflict and humanitarian settings, due to its life-threatening consequences on individuals and its immediate impact on the survivors’ sexual, physical and psychosocial well-being (IAWG, 2017; IASC, 2015). Besides its impact at the individual level, evidence also shows that GBV has impacts at the community level in terms of increased health care, legal, and security costs (IAWG, 2017; WHO, 1997).

Acting against GBV, including rape and intimate partner violence (IPV), is primarily the responsibility of the State in addition to all concerned non-state actors. These actors should be aware of the risks of GBV and should act in a collective manner to ensure a comprehensive and sustainable response against all forms of violence (IASC, 2013).

The health sector provides a unique opportunity during service provision to identify those subjected to violence and provide them with appropriate clinical and psychological care, link them with support services beyond health and contribute to preventing future harm. Furthermore, health care providers offer the first, most trusted form of professional contact, as those experiencing violence are most likely to go to the health facilities for care related to the violence they are undergoing or have undergone (WHO, 2017).

Additionally, the role of the health sector includes documenting the magnitude of the problem, integrating health education and health promotion messages to sensitize communities on the consequences of sexual violence (SV), its prevention, and the need to seek timely and appropriate care for those affected.

It is essential that SV and IPV response entails the provision of quality care that is survivor/child centered, gender-sensitive, respects confidentiality, provided in safe rooms for evaluations and checkups, and ensures timely referral of survivors to receive other needed services, such as case management, psychosocial support, legal support and livelihood opportunities, among others.

III. The Lebanese Context

A. Scope of the GBV Problem

Sexual and gender-based violence (SGBV) is one of the main protection concerns affecting at risk vulnerable groups from the Lebanese host community, displaced populations, migrant workers and persons that identify as LGBTQI. According to the data collected through the Gender-Based Violence Information Management System (GBVIMS)^[1] for 2020, **98 per cent** of GBV incidents reported to GBV case management service providers involved women and girls. This indicates that women and girls continue to be disproportionately affected, with grave consequences to health, security, psychosocial and socio-economic well-being. Men and boys are also affected, with male survivors constituting 2 per cent (2020) of all cases reported (one third of which are under 18 years of age). Out of all the reported GBV incidents in 2020, 11 per cent involved children and 1 per cent of survivors have some form of disability¹.

Disclosing incidents of GBV is particularly challenging, considering inherited traditional gender and social norms that work against survivors of GBV. Incidents of GBV continue to go under-reported due to stigmatization, mobility restriction, difficulty in accessing communication means due to sharing of phones with several family members, and economic dependency.

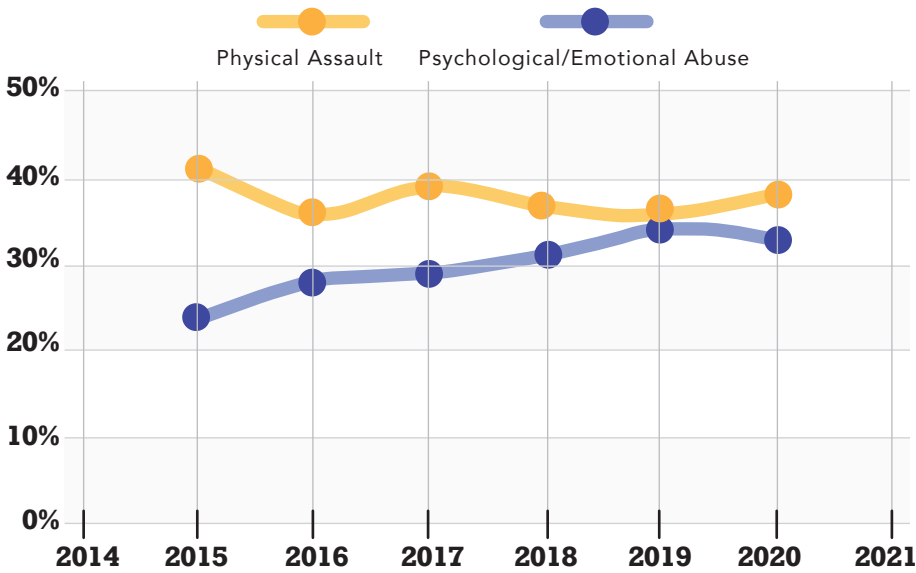


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1. "This data is only from reported cases, and does not represent the total incidence or prevalence of GBV in Lebanon. These statistical trends are generated exclusively by GBV service providers who use the GBVIMS for data collection in the implementation of GBV response activities across Lebanon and with the informed consent of survivors. Thirteen organizations contributed to the trends. This data should not be used for direct follow-up with survivors or organizations for additional case follow-up. This information is confidential and must not be shared outside your organization/ agency or used for any other purpose that what was agreed with the GBVIMS Steering Committee. Should you like to use this data or access more information on GBVIMS, please contact the inter-agency GBVIMS Coordinator (dib@unfpa.org) and/or the GBV Task Force Coordinator (talentino@unfpa.org). Failure to comply with the above will result in revoking future information sharing."

Furthermore, data from the GBVIMS indicates that the most reported type of incidents in 2020 were physical assault (38% in 2020) and psychological/emotional abuse (33% in 2020). These two types of GBV incidents are linked to incidents of intimate partner violence and domestic violence. Data from the GBVIMS also indicates a 3 per cent increase in 2020 (80%) compared to 2019 (77%) of incidents taking place at the survivor’s and perpetrator’s home.

Figure 1 | Incidents of Physical Assault and Psychological/Emotional Abuse 2015 -2020



Sexual violence including rape and sexual assault was also one of the predominantly reported GBV issues affecting adults and children during the last six years (2015 till 2020). According to GBVIMS (2021):

- 5.3 per cent** of the reported cases during the last six years were rape cases, and almost **12 per cent** were cases of sexual assault
- 82 per cent** of survivors of sexual violence were adults, and **8 per cent** of survivors were children
- 93.6 per cent** of survivors were females

Only information on reported incidents is recorded and shared with the informed consent of survivors. Accordingly, the GBV data produced by the GBVIMS does not represent a comprehensive overview of GBV incidents in Lebanon, but it exclusively represents incidents reported to 11 out of 14 service providers across the country using the GBVIMS system. It is important to highlight that GBV incidents remain underreported for several potential factors. These include socio-cultural issues such as fear, shame, and stigma experienced by survivors, as well as the limited availability of services. Other factors leading to underreporting include lack of awareness, inherited gender and social norms such as threat by family members including honor killing or being obliged to marry the perpetrator, and fear of Internal Security Forces (ISF) (Doudar, 2017; UNFPA, 2016).

B. GBV Risk Contributing Factors

Several factors contribute to increasing the risk of GBV in Lebanon, especially among women and girls, including, but not limited to: (1) attitudes, beliefs, norms and structures that promote and/or accept gender-based discrimination and unequal power; (2) overcrowded and poor living conditions; (3) socio-economic vulnerability; (4) limited access to basic support and social services, social safety net, and livelihood opportunities, especially amongst the displaced population and vulnerable Lebanese; (5) separation from families; (6) limited institutional capacities; and (7) lack of accountability among relevant actors which hinders the prevention and protection of women and children from violence, in particular (UNICEF, 2020; UNFPA, 2018; UNICEF Child Protection strategy note, 2016).

The presence of over a million Syrian refugees in Lebanon is another contributing factor to note within this context. Lebanon currently hosts the highest per capita concentration of refugees worldwide (UNFPA, 2018; UNHCR, 2018). GBV, including rape, was identified as one of the major protection risks affecting both the refugee and the host communities in Lebanon; women and girls being the most affected (UNDP, 2017). Rape was also considered an important public health and social issue to be addressed even prior to the Syrian crisis but was not visible due to prevailing contextual social and cultural norms previously noted (Wehbi, 2003; Abdul Husn, 1994).

C. CMR Current Situation: Gaps, Challenges and Opportunities

The following section provides an overview of the current CMR situation, reflecting the main existing gaps, challenges, and opportunities under three main areas: (1) Legal and Policy Frameworks; (2) Supply of CMR Services; and (3) Demand for CMR services.

1. Legal and Policy Frameworks

The UNFPA 2016 assessment highlights bottlenecks associated with facilitating access of rape survivors to quality services. These particularly

relate to: (1) an absence of a legal framework that provides protection for rape² survivors; and (2) the limited availability of laws, policies and guidelines for safeguarding the protection concerns of GBV survivors (safety, confidentiality, respect, non-discrimination, and others).

The existing bottlenecks make legal systems in Lebanon poorly accessible to, and utilized by all GBV survivors. According to GBVIMS data in 2020, **40 per cent** of survivors declined accepting referrals to legal assistance services when offered during the context of GBV case management services. Survivors and GBV actors face significant challenges in pursuing legal services because of fear of retaliation from families or perpetrators, according to in-depth interviews conducted while developing the CMR strategy. The engagement of GBV actors within the current judicial system is somehow limited; and, access to justice has been identified as a major gap to survivors. In fact, women face legal barriers including “laws that fail to fully criminalize certain violations of women’s rights; and inadequate or absent definitions of the relevant crimes, such as rape and marital rape, sexual assault, and sexual harassment, and unjust laws” (UN Women, UNFPA, National Commission for Lebanese Women (NCLW) and WHO, 2020; Barakat, 2018). For example, “according to the Lebanese Penal Code, rape is a criminal offense punishable by at least 5 years of imprisonment. With regards to exemption from punishment, article 522, (of the Lebanese Penal Code) which is applicable to all offenses, described in the articles from 503 until 521 and which exempts the offender from punishment if he/she marries the victim, was repealed in 2017. However, the exemption was retained in articles 505 and 518 (of the Lebanese



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2. **Rape** as reflected in the Lebanese Legislations: (No clear and particular definition of Rape is identified from the conducted desk review; however, the following could be noted): Rape is a criminal offense punishable by at least 5 years' imprisonment. This definition explicitly excludes forced sex in marriage. In the Lebanese penal code, Rape is reflected as follows under different related articles:

• **Article 503:**

A person who forces sex upon someone who is not his spouse, by means of violence and threat is sentenced to five years of hard labor at least. The sentence shall not be less than seven years if the victim is under fifteen years of age.

• **Article 504:**

Is sentenced to forced labor a person who has sex with a person who is not his spouse and who cannot resist because of a physical or mental deficiency or because of means of deception used against this person.

• **Article 505:**

A person who has sex with a minor who is under the age of fifteen (regardless of consent) shall be sentenced to temporary forced labor. The sentence shall not be less than five years if the victim is under twelve years of age.

A person who has sex with a minor above fifteen years of age and under eighteen years of age shall be sentenced to two months to two years imprisonment.

• **Article 506**

A sexual act committed against a minor between fifteen years and eighteen years of age by one of his/her parents, whether legal or illegal, or one of his/her in-laws, and any person who has a legal or effective act on him/her or any of the servants of those people, shall be sentenced to temporary hard labor.

Penal Code), whereby intimate partner rape remains unpunishable” (Ministry of Social Affairs (MoSA) Strategic Plan on the Protection of Women and Children – 2020-2026, p.19). Also, the Lebanese Penal code “fails to identify other forms of sexual violence such as sexual assault and abuse. In fact, it does not clearly define sexual assault as a violation of physical safety and sexual independence” (UNFPA, UN Women, and UNDP, 2018, p.24). However, it should be noted that in December 2020, the Lebanese Parliament has endorsed law number 205 criminalizing sexual harassment, especially in the workplace. As per the law, perpetrators can be sentenced from **6 months up to four years** in prison and fined up to **50 times** the value of the minimum wage, depending on the case. In addition, the law offers protection to both the victims and any witnesses who testify against the accused. It also aims to create a specialized fund at MoSA tasked with offering support and rehabilitation to victims and raising awareness about sexual harassment, and explicitly gives victims the right to seek compensation (Lebanese official gazette, 2020). Additionally, the Lebanese parliament also expanded the scope of law 293, which has been in force since 2014, and penalizes domestic violence. The law was amended in 2020 to strengthen protection against domestic violence for women survivors of violence and their children. Also, the amendment of this law includes penalizing economic and psychological violence, but it did not add any penalizations for marital rape and IPV (Lebanese official gazette, 2020). This law has been in force since 2014; however, it has been criticized for defining domestic violence too narrowly and failing to specifically criminalize marital rape.



As per the law, perpetrators can be sentenced from **6 months up to four years** in prison and fined up to **50 times** the value of the minimum wage, depending on the case

With regards to laws addressing acts of rape and sexual exploitation and abuse against children, the Lebanese penal code does not go into the different categorization of sexual exploitation and abuse acts, but rather uses generic terms (articles 507 to 510), and it does not specify exactly the kinds of indecent acts that a child could be exposed to³.

In addition to the above, circulars and memos have been issued by the Ministry of Public Health (MoPH) (circular number 1240/1 related

³. Illegal acts against children are mentioned in the Lebanese Penal Code as follows:

- Illegal Act No. 1: Sexual relationship with a child (Article 505);
- Illegal Act No. 2: Forcing a person, through violence or threat, to endure or do an indecent act (Article 507);
- Illegal Act No. 3: Committing an indecent act to a person by tricking him or taking advantage of his/her physical or mental illness (Article 508);
- Illegal Act No. 4: Committing an indecent act to a child (Article 509);
- Illegal Act No. 5: A civil servant who seduces the spouse of a prisoner or detainee or a person who is under his/her supervision or authority, or seduces a relative to these (Article 509);
- Illegal Act No. 6: Deflowering a girl after promising to marry her (Article 518);
- Illegal Act No. 7: Touching or caressing a minor, whether male or female, in an indecent way or against his/her will (Article 519); and
- Illegal Act No. 8: Offering an indecent act to a minor below 15 years old, or addressing him/her with indecent talk (Article 520)

to memo number 58 of 2015) and the ISF (no. 339/204 of 2017), concerning mandatory reporting⁴ of sexual assault victims. These highlight the need to maintain confidentiality in cases of rape or sexual assault and obtaining the consent of adult victims about the option of reporting to legal authorities (MoPH, 2015a; ISF & ABAAD, 2017). Yet, not all concerned actors are properly abiding to the mandatory reporting requirements necessitating survivors' consent to be able to report. Furthermore, there is a lack of legislation concerning the practice of forensic nursing in Lebanon. Nurses are considered to be the main primary health professionals receiving rape survivors in health centers, in view of the extremely limited number, or absence of female forensic doctors in Lebanon, as revealed through the fact findings interviews conducted with concerned stakeholders while developing this strategy.

Abortion is prohibited by Articles 539–546 of the Penal Code, including for women who have been raped. According to UNDP (2018), this law does not provide for gender equality, nor is it in line with international human rights standards and the recommendations of the UN Committee on the Elimination of Violence against Women. Moreover, the Law on Protection of Women and Other Family Members from Domestic Violence did not include any item explicitly addressing how to settle conflicts that may emerge between civil courts rulings on domestic violence and religious personal status courts judgments. The non-criminalization of marital rape, is one example (UNFPA, UN Women, and UNDP, 2018).

In relation to certain marginalized groups in Lebanon, such as LGBTQI+ community, at high risk of rape and sexual abuse, there is a lack in “specific laws that protect these marginalized groups from hate crimes or gender-based violence or discrimination. In addition, specific legal protection or acknowledgment of transgender women and men does not exist” (UNFPA, UN Women, and UNDP, 2018, p.29). Moreover, according to UNDP (2018), “uncertainty regarding the legal status of same-sex sexual conduct under the Penal Code contributes to the vulnerability to violence of Lesbian, Gay, Bisexual, and Transgender people. Article 534 of the Penal Code criminalizes “unnatural sexual intercourse” with up to one year in prison. This article is not commonly enforced but has been used by police in the past to charge Lesbian women as well as Gay men. Physical torture, psychological humiliation, and anal examinations have also been recorded.” (p.29).

4. A modification of the law 288 (22/2/1994)- Medical Laws

- Article 7 point 13: medical doctors have to report discovered cases of sexual assault and rape to legal authorities upon the written approval of the victim.
- Article 7 point 14: medical doctors have to report all discovered cases of sexual assault and rape in minors to the legal authorities
- Article 26 states that reporting any conditions that put the life of a minor at risk, is not considered a breach of confidentiality of the code of ethics of a work/job.
- Articles 399 & 400 of the Lebanese Penal Code: any employee has to inform legal authorities when discovering any criminal act during his/her duty otherwise he/she will be penalized. This applies only to conditions not related to the need of a filed complaint by the victim.

In addition, women's and survivors' access to justice is also impeded by obstacles in the administration of access to justice. This relates to: (1) absence of effective gender-sensitive investigations; (2) lack of coherent and effective prosecutions; (3) lack of adequate competences and resources; (4) discriminatory policies, practices, and gender stereotypes on the part of justice sector actors; (5) slow litigation processes and biased justice system; and (6) high fees associated with legal processes (UN Women, UNFPA, NCLW and WHO, 2020; Barakat, 2018).

Furthermore, in the event of Coronavirus Disease (COVID-19) pandemic, court closures have compounded the mentioned challenges, though some judges are using remote listening techniques to issue protection orders for women at risk of, and surviving gender-based violence (NCLW - Gender Alert in COVID, 2020).

To develop evidence-based legal services, there is a need to effectively engage with the different legal systems to gain an improved understanding of the systems and any barriers to access to justice. The proper engagement of forensic physicians, lawyers, general prosecutors and judges, is thus of utmost importance to ensure proper access to justice.

2. Supply of CMR Services

a. Progress over time

Prior to 2012, medical care for survivors of SV and IPV was not included as part of the services provided within the various public and private health facilities in Lebanon nor were there any specific or standardized protocols and service providers trained on CMR and IPV services.

In 2013, to address existing gaps, the CMR Taskforce (CMR TF)⁵ was established in coordination of the Ministry of Public Health (MoPH) and UNFPA in order to coordinate and advocate efforts at national level for increased access to quality and "empathetic" medical response for adult and child survivors in selected health facilities.

Since its establishment, the CMR TF served as a forum to discuss challenges, gaps, solutions, as well as knowledge and good practices regarding CMR and IPV; and it has coordinated its efforts with various health and protection sector agencies such as the GBV Taskforce⁶ and the Child Protection Working Group⁷.

⁵ The CMR TF is led by UNFPA and MOPH (PHC department) and is comprised of UN agencies such as UNICEF, UNHCR and WHO, and national and international NGOs such as: IRC, IMC, MSF, ICRC, Red Cross Movement, Seraphim, ABAAD,

⁶ The GBV TF is led by UNHCR/ UNFPA, co-led by MoSA and is comprised of UN agencies such as UNICEF, UN Women, and national and international NGOs such as: IRC, DRC, Intersos, KAFA, ABAAD, RDFL, and Makhzoumi.

⁷ The Child Protection working group is led by UNICEF, co-led MoSA and is comprised of UN agencies and national and international NGOs, such as Save the Children, TDH, Himaya, Movement Social.

Over the last nine years, there was significant engagement from MoPH (mainly the Primary Health Care - PHC department) on the work being done on CMR in the country. In 2015, the MoPH issued a circular on non-mandatory reporting of sexual violence for women accessing health facilities⁸ (as detailed above), and the PHC department has appointed a dedicated Focal Point (the PHC Chief Central Coordinator) who is co-leading the CMR TF; however, there was little to no involvement from other departments in the Ministry on this service and no involvement of MoPH field coordinators in monitoring the CMR and IPV services provided at the field level⁹.

To ensure availability of, and accessibility to CMR services to all GBV survivors of vulnerable cohorts (Lebanese, Syrian, and Palestinian), **43 health facilities** (public and private hospitals as well as primary healthcare (PHC) centers) were selected by the CMR and the GBV TFs in consultation with MoPH as CMR service providers. Since 2012, these facilities have received and still receive Post-Exposure Prophylaxis treatment (PEP) kits, also known as Reproductive Health (RH) kit no3, from UNFPA. The PEP kit contains treatments to prevent human immunodeficiency virus (HIV), sexually transmitted infections (STIs), and unwanted pregnancies. Availability of PEP drugs in the facilities has been challenging because there is no system in place to track the expiration date and consumption. Replenishment of PEP kits was done on regular basis by GBV actors contracted by UNFPA. However, rigorous monitoring of consumption is lacking as there was no consensus among actors about the reporting mechanism (confidentiality was a major concern in this regard); also, there is a lack of jurisdiction over health facilities to enforce reporting. As of 2019, the MoPH is in charge of replenishment of PEP kit /drug in the CMR facilities and yet CMR clinics are not always responsive in replenishing expired drugs.

Formal trainings on CMR, targeting the 43 selected facilities, started in 2012, by UNFPA, as part of the training on the Minimum Initial Service Package (MISP). The practitioners in the 43 facilities have been trained based on the International Rescue Committee (IRC) Clinical Care for Sexual Assault Survivors multimedia training tool and the WHO CMR survivors' protocols¹⁰ and MISP. The main actors involved in conducting the CMR trainings were UNICEF, UNFPA, ABAAD, IRC, International Medical Corps (IMC), and Médecins Sans Frontières (MSF). The trainings were provided in a condensed manner, consisting of 3 days of training: 2 days on CMR and 1 day on GBV (Doudar, 2017; UNFPA, 2016). Later in 2014, the aforementioned CMR trainings were institutionalized and were followed by CMR sensitizing sessions,



43 health facilities
(public and private hospitals as well as primary healthcare (PHC) centers) were selected by the CMR and the GBV TFs in consultation with MoPH as CMR service providers.

⁸. MoPH circular 58 / 2015.

⁹. Key informant interviews conducted during the preparation of the strategy.

¹⁰. WHO & United Nations High Commissioner for Refugees (UNHCR). (2004). Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons

as well as some coaching and refresher sessions, in some of the selected facilities, done by ABAAD and IMC. However, there was no accreditation for these trainings by the relevant authorities. Revision of the CMR chapter of the RH Sustainable Development Goals (SDGs) has been conducted in 2020 with significant updates on IPV, Mental Health and Psychosocial Support (MHPSS) and provision of first line response by health care providers. In 2016, a chapter on CMR was also included in the Reproductive Health Services Delivery Guidelines developed by UNFPA and MoPH.

As of 2018, there have been selection of 19 prioritized CMR facilities out of the 43 initially selected across the country. The selection of these facilities accounted mostly for their geographic location and being open 24 hours per day, seven days per week. As of 2019, replenishment of PEP kits was done only for the CMR prioritized facilities (with a few exceptions in 2020 due to COVID-19).

In relation to monitoring CMR service provision, members of the CMR TF, with the support of the GBV TF, were officially requested to conduct ad-hoc field visits to the medical facilities providing CMR services. Non-governmental organization (NGO) staff¹¹ accompany a survivor to receive treatment or whenever they receive a complaint from a survivor about the care received, or through dedicated monitoring visits; however, the conducted monitoring visits are reported to not be systematic nor regular in timing.

Furthermore, it was observed during the preparation of the CMR strategy, that effective oversight and assurance of a large number of CMR facilities (43 then 19 CMR facilities across the country) has been, and will continue to be, challenging for the CMR TF, and later on for MoPH.

Another issue of concern was that the roll out of CMR and IPV services in the country was not preceded nor followed by finalization of an accountability framework for CMR service delivery consisting of a legal / official binding documents that hold health facilities accountable for availability and delivery of CMR services in alignment with the minimum global standards.

Making CMR and IPV services available in 43 facilities over recent years might have enhanced the access of GBV survivors to this service by making it closer to them; however, several challenges remained despite all invested efforts undertaken by the MoPH, concerned health facilities, UN agencies, and national and international NGOs. These challenges are noted at the policy, health facility, and individual levels, as described throughout this section of the strategy.

Several assessments have been conducted for CMR services, including the IRC (2012) assessment and the UNFPA (2016) noted previously.

¹¹. It was mainly GBV service providers including IRC, ABAAD, DRC, INTERSOS and IMC.

Findings of these assessments and additional observations throughout the preparation of the CMR strategy showed that quality CMR services are still inadequate in Lebanon due to:

- (1) the lack of standardized training for the health staff;
- (2) attitudes and behavior of frontline health workers towards GBV survivors that remain judgmental due to sustained traditional gender roles and social norms;
- (3) high turnover of staff in health facilities which entails a persistent need for ongoing awareness, and capacity building efforts to ensure incoming staff have the required knowledge and skills to replace those leaving;
- (4) restricted opening hours of some PHC centers which represents an additional barrier for women and girls to access the CMR services;
- (5) lack of accountability framework for provision of CMR services in the health facilities, which sometimes resulted in lack of concerned staff and management for ownership of these services. This has been reflected in denying service access to some survivors; and poor investment in increasing their knowledge and skills after attending the initial CMR training in view of their overload, accompanied by insufficient regular training programs;
- (6) lack of “systematized / regular monitoring of the provision and quality of services” of such a large number of CMR facilities (43 prior to the prioritized 19) spread throughout the country. This was reflected by a difference in the quality of service delivery from a health facility to another; and
- (7) lack of information about existing CMR services.

Furthermore, a need prevails for the establishment of clear referral pathways for survivors: internally within the MoPH, between PHC centers and public hospitals, and externally with concerned service providers and other Ministries. This includes the MoSA for case management and the Ministry of Interior (MoI)/ISF for timely collection of forensic evidence in case the survivor is willing to file a complaint against the perpetrator, or there is a need for a referral to a shelter. This is besides the need to create and formalize linkages between CMR and existing national Standard Operating Procedures (SOPs) and Policies (such as the MoSA National Child Protection (CP) and the draft GBV SOPs; and the Ministry of Education and Higher Education (MEHE) CP Policy)¹².

Compounding the above, a complete integration of CMR services within the national health care system, namely the existing MoPH health services network, is needed to ensure a harmonized and qualitative response for the survivors of sexual violence across Lebanon.

All the barriers and challenges mentioned above might have hindered a proper access of survivors to CMR services, over the last nine years, even though it is “available” and “very close to them”.

¹². The Child Protection SOPs developed by MoSA, UNICEF and USJ in 2015; MEHE Policy for protection of Children in the schools developed by MEHE/UNICEF in 2018.

To address some of these challenges, as previously noted, 19 CMR facilities were prioritized by the CMRTF actors and MoPH for the referrals in 2018/2019 and 2020; however, this has not solved the issue of quality service, and many incidences of anecdotal information about survivors being turned away from a health facility due to the gender / sexual identity or nationality have been noted, as well as the fact that service providers are still not satisfied with the quality of CMR services being provided in these 19 selected facilities.

b. CMR Integrated Response

● Health and Case Management Care

Healthcare and GBV concerned actors are investing efforts to ensure the provision of a comprehensive set of CMR services that meet international standards of care.

In addition to the above stated efforts invested to provide proper CMR services, it is important to highlight the proper management of the risk associated with HIV as a result of rape and as part of a proper CMR response. In this regard, and as a step towards reducing stigma and discrimination associated with people living with HIV/AIDS, the National AIDS Control Program (NAP), established by MoPH, opened a center for the distribution of HIV/AIDS medications at Karantina, Beirut. The NAP dispensary team also follows up with concerned drug companies to ensure sustainability and continuous availability of treatment for people living with HIV/AIDS. Antiretroviral treatment (ARV) is also provided by MoPH, free of charge, through NAP. Moreover, voluntary counseling and testing (VCT) is part of NAP's activities, whereby the NAP team trains health care workers and nurses from various NGOs, health centers and clinics on VCT service delivery. NAP services and related activities are done with the support of UN agencies including WHO and UNICEF. The services are confidential, free, voluntary and anonymous. The services are located within specific NGOs; where high-risk individuals can communicate with a qualified professional to acquire the needed services. Information and brochures about HIV/AIDS and STIs, HIV testing (pre and post-test counselling), and referrals to health care and social services are also ensured as part of the provided services (where required) (MoPH, 2021).

National efforts invested in case management also aim to ensure that survivors have access to a comprehensive set of needed CMR and IPV services. Recently, there have been improvements in the provision of case management services due to trainings that took place after the onset of the Syrian crisis, as well as after the finalization of the GBV case management SOPs developed by the SGBV TF in Lebanon. Also, NGOs which are part of the Lebanon Crisis Response Plan (LCRP) coordination mechanism made training on GBV case management for case workers compulsory. This is particularly the case for non-state actors. MoSA social workers are also trained on to the National SOPs for the Protection of Juveniles in Lebanon¹³, including case management for cases of sexual

¹³. The National SOPs for the Protection of Juveniles in Lebanon developed by MoSA , UNICEF and USJ in 2015.

assault. Moreover, there is a number of Women and Girls' Safe Spaces (WGSS)¹⁴ operated by local and international NGOs¹⁵ and funded by UN agencies across the country where women and girls can have access to age / culturally appropriate GBV prevention and response services. These services include: (1) awareness and information sessions to increase beneficiaries' knowledge on available protection and social services, and critical issues (including GBV, health and education services); (2) case management with referral to specialized services (legal, mental health, safety and CMR); and (3) psychosocial support (PSS) activities, including recreational, focused and non-focused PSS activities and life skills sessions.

Despite the noted achievements, the provision of case management is still facing some social and cultural barriers that limit survivors' ability to access service centers. Another barrier is the reliance on international funds to provide case management training and WGSS services. Further, almost no MoPH health facilities provide any case management services. However, recently, through an initiative led by UNFPA, a number of MoPH PHC centers are starting to sensitize their health care providers on GBV and sexual and reproductive (SRH) services integration.

Within the same context, currently, there are very few community-based protection mechanisms in place, and there are a limited number of safe shelters for protection of survivors at imminent risk available for survivors in rural and urban areas. The current existing safe shelters include those established by local and international NGOs such as ABAAD, Caritas, Mariam and Marta and Bon Pasteur. These shelters target women and children in particular, and are accessible to persons with physical disabilities, among other marginalized groups.

A limited capacity for receiving new survivors at safe shelters was conveyed recently. It has been reported that "several women's shelters across Lebanon are at full capacity and have reported that they can no longer be able to host new survivors. In addition, some shelters are unwilling to accept hosting survivors of violence due to fear of COVID-19 contagion" (WHO, UN Women, UNFPA and NCLW, 2020, p.3). However, some organizations, like Caritas, have extended the capacity of their shelters.

● Quality of Care

To ensure quality of CMR care, investing in continuous education and engagement in capacity development initiatives is needed. The content of the trainings mentioned above, focused on soft as well as hard skills. These include the methods and skills of identifying and managing cases of SV and IPV using internationally adopted curricula

14. Some of the WGSSs are located in SDCs.

15. For example: KAFA / ABAAD/ The Lebanese Council to Resist Violence Against Women, RDFL, IRC, INTESOS, DRC, CARE, among others have Women and Girls Safe Spaces across the country.

and tools. Training modules also included topics which relate to GBV as a public health social issue; how to receive and deal with survivors of sexual assault; the roles of the medical and administrative staff members; the Lebanese laws related to patient rights and child protection; direct medical service provision to survivors of sexual assault; the administering of PEP kits; and forensic evidence collection. Health care providers at the PHC level also received a training covering reproductive health service delivery guidelines and which included a module on CMR.

As previously noted, medical and other health care providers might not be sufficiently trained in the provision of CMR services¹⁶. Also, there is no consistency across organizations on the type and length of training received; and a lack of proper follow up of trainees after receiving CMR training.

Besides targeting CMR and IPV services frontline health care providers, such as nurses, midwives and doctors/physicians, capacity building efforts need to also target forensic physicians since they are the only party in Lebanon who can legally sign a medical certificate which is used as evidence in court, if the survivor chose to report to police or need a medical certificate (Inter-Agency SOPs for GBV Prevention and Response in Lebanon, 2014).

Some of the hospitals and/or health centers providing CMR services lack confidential and private spaces at the health facilities where examination, counselling and treatment of survivors occurs. In addition, some of these facilities are not adequately equipped with the needed supplies and equipment.

Also, despite being targeted by the CMR including GBV trainings since 2013, the police/ISF do not prioritize adequately GBV/Rape cases and are not well-informed about GBV/Rape-specific laws, as well as related guiding principles as highlighted by key actors in the sector.

● Cost of Care

CMR medication including essential and chronic drugs, RH drugs including contraceptives, vaccine, and PEP kits are currently subsidized

¹⁶. Note on timeliness of Health Services for survivors (Inter-Agency Coordination Lebanon, 2014, p.32-33):

Within 72 hours after incident: PEP kit, Emergency Contraception, Vaginal examination, Hepatitis B vaccine, STI testing and treating + tetanus shot + general examination

Within 120 hours after incident: Emergency Contraception, Vaginal examination, Hepatitis B vaccine, STI testing and treating + tetanus shot + general examination.

Within 2 weeks after incident: Vaginal examination, Hepatitis B vaccine, STI testing and treating + tetanus shot + general examination.

Within 5 weeks after incident: Hepatitis B vaccine, STI testing and treating + tetanus shot + general examination

After 5 weeks: STI testing and treating + tetanus shot + general examination

by UNFPA and other UN agencies, and not by the MoPH in Lebanon. This raises concerns about the sustainability of the provision of these medications, should UNFPA support end¹⁷.

Regarding the cost of CMR services, UNICEF and UNHCR cover related fees for registered Syrians, whilst UNRWA and UNICEF cover related costs for Palestine refugees. Lebanese survivors are covered by UNICEF through its GBV case management partners, but not all survivors of rape go through UNICEF-supported GBV case management services; and although responding to a lifesaving need, this approach is not sustainable on the long run.

It is also important to note that survivors directly accessing a CMR clinic might not be informed about the available coverage; and, accordingly, may not benefit from existing support, while survivors referred/ accompanied by case workers would benefit from the subsidization of services.

3. Demand for CMR Services

Demand for CMR services is influenced by many factors. Besides what has been mentioned in the sections above, a recent study conducted by the American University of Beirut (AUB), UNICEF and MoPH (2020) explored additional barriers for adolescent girls' access to primary health care including CMR services in Lebanon. These include: (1) the lack of awareness and information about available health services in Lebanon, including specialized services such as CMR services, and (2) the belief that PHC services are of lower quality compared to those offered by private health centers. Moreover, the study reported other gaps related to CMR services, in particular, which include, but are not limited to: (1) fear at the individual level resulting from, among other things, lack of information about services and fear of family members' reactions; as well as fear of stigma associated with seeking health services, whether on sexual and reproductive health (SRH), mental health, or disclosing and seeking support for harassment; and (2) poor decision-making associated with a proper management of any case as a result of overarching and governing social norms around gender roles and expectations (AUB, UNICEF and MoPH, 2020)¹⁸.

Accordingly, survivors are frequently reluctant to seek CMR services because of stigma, and fear of retaliation by their families and/or the perpetrators. Moreover, preserving the family's reputation and avoiding scandal are reasons why some families avoid reporting sexual violence incidents. Fear that authorities might get involved in the case and the lack of awareness and community acceptance are other reasons which contribute to non-disclosing incidents of sexual violence against children (MoSA Strategic Plan on the Protection of Women and Children, 2020 - 2026).

17. The unit cost of the PEP kit is currently estimated at 1,200 U.S. Dollars

D. Facilitating Factors

The main facilitating factors enabling the development and implementation of the proposed strategy include:

- The leading role of the MoPH PHC department, and its dedicated human resources for supporting processes allowing for the development of this strategy and ensuring proper engagement of, and coordination among all concerned.
- Technical expertise provided by the CMR TF different members under the leadership of UNFPA and MoPH and its substantial role in monitoring the quality of the CMR services.
- Expressed interest of private and public entities including NGOs, INGOS, GBV TF, professional groups, and UN agencies to support the implementation of the proposed strategy.
- Expressed interest and willingness of concerned public entities, NGOs, INGOs, civil society organizations (CSOs), and UN agencies to advocate for the amendment and/or repeal of related laws and articles.
- Expressed commitment of health care providers in general and CMR service providers, in particular to activate and upgrade their engagement in the provision of CMR and IPV services to be aligned with international standards and properly respond to existing needs.

18. To access the full research brief : <http://uni.cf/395FZTA>

Part 2

National Strategy for the Clinical Management of Sexual Violence/Rape

- A. The need for a National CMR strategy
- B. CMR Strategy Vision, Mission, and Goal
- C. Guiding Principles
- D. Approaches
- E. General Assumptions
- F. Key Actors



A. The need for a National CMR strategy

In view of the absence of CMR national accountability frameworks, in December 2016, a review of the practices for CMR Strategies and Guidelines conducted by the CMR TF identified concrete action points to develop a national strategy to institutionalize CMR and IPV services within MoPH health services network as per international standards; while outlining linkages with other ministries including the MoSA Ministry of Justice (MoJ), Ministry of Interior and Municipalities (MoIM), and MEHE.

The MoPH, in partnership with UNICEF and UNFPA, has taken the leadership in developing this strategy in close coordination with the CMR TF led by UNFPA and MoPH.

The strategy development extended from July 2019 until May 2021 and consisted of undertaking the following main activities:

- 1. Conducting a comprehensive desk review:** Reviewing and mapping national strategies, frameworks, initiatives, and stakeholders supporting CMR and IPV response; as well as regional or global strategies, frameworks, and initiatives that could inform or support these efforts. This included an assessment of the existing interventions and monitoring tools, including laws and circulars aimed at providing services to survivors of sexual assault to understand what is being done, what works, and what can go to scale including the mechanisms and strategies needed to do so.
- 2. Developing an evidence-based framework:** The framework was developed at the first stage through a desk review and was later updated and upgraded through the collection of evidence-based data and information, using a participatory, bottom-up approach. The framework served as a guide for the development of the national CMR strategy. The key elements of this framework included the following main areas: (1) the national and international legal frameworks; (2) local and international SOPs, guidelines and protocols; (3) concerned governmental bodies, task forces, working groups and national and international NGOs and UN agencies which contribute to the CMR and IPV response in Lebanon; (4) relevant capacity building initiatives, and CMR and IPV awareness material developed locally; (5) CMR challenges and gaps; and (6) available opportunities for the prevention of and ensuring a proper response to SV and IPV in Lebanon.
- 3. Conducting national and field consultations:**
 - National and field consultations were conducted through key informant interviews with key stakeholders and representatives from all concerned public, private, professional, and academic sectors.
 - Health facility assessments were conducted with 10 health facilities providing CMR services. This assessed the availability

and appropriateness of CMR-IPV services, facility readiness and infrastructure, availability of supplies and equipment, and health care providers reported know-how on survivor-centered quality care and IPV care.

- Developing an understanding about at-risk women and girls related needs and their perceptions about existing services through feedback from interviewed key informants and service providers, as well as based on the recent study conducted by AUB, UNICEF and MoPH (2020) on barriers of adolescent girls' access to health including CMR services in Lebanon. Face to face meetings with at risk women and girls were not possible due to the COVID-19 pandemic national lockdown and restrictions, and the sensitivity of the issue to be tackled remotely.

4. **Undertaking a gap analysis:** This aimed at examining at the following main determinants: (1) Enabling environment (laws and policies – management and coordination, including information management; (2) Supply (availability and management of essential commodities such as PEP kits); and (3) Demand (financial access, timing and continuity of use; social and cultural beliefs; among others).

The most recent guide, developed by WHO, UNFPA and UNHCR (2020), "Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings", was used as the technical framework to develop the CMR strategy.

B. CMR Strategy Vision, Mission, and Goal

Vision

All persons with different gender profile, including persons at risk, persons with disabilities and marginalized groups, living in Lebanon, will have the opportunity to live in a society free from violence (including IPV), abuse, exploitation, and neglect, while properly responding to their survivor-centered health care needs associated with sexual assault and abuse (rape).

Mission

To ensure the development of a sustainable health system that guarantees the provision and accessibility of: high-quality, survivor-centered, preventive and curative management of rape services, through an evidence-based, multidisciplinary, and cost-effective approach, while emphasizing community outreach and involvement, continuum of care, human rights, and cultural relevance.

Goal

To guide, strengthen, and contribute to sustaining the CMR and IPV response in Lebanon for individual survivors of sexual assault, including girls, boys, women, men, persons with disabilities, and other high risk and marginalized groups, and for communities affected by humanitarian crises, while respecting the technical guiding principles, delivering quality care, and ensuring a survivor-centered approach.

C. Guiding Principles

The development of the CMR strategy has been guided by the below listed principles:

Non-Discrimination and Impartiality: To ensure non-discrimination and impartiality in all interactions with survivors and in all CMR and IPV service provision. To provide inclusive services without discrimination based on age, sex, gender, religion, ethnicity, wealth, language, nationality, status, political opinion, or culture. All actors shall be impartial.

Safety and Security: To ensure the safety of the survivor, child and family at all times. In all cases, to make sure that the survivor is not put at risk of further harm by the assaulter. To also maintain awareness of safety and security of people who are helping the survivor, such as family, friends, health workers, and others.

Confidentiality: To respect the confidentiality of the survivor, child and their family at all times. If the survivor gives his/her informed consent, to share only relevant information with others for the purpose of helping the survivor, such as referring for services. All written information about survivors must be maintained in secure, locked files. All identifying personal information (name, address, etc.) will be withdrawn in the reporting, compilation and sharing of data. To encourage other community members and humanitarian actors to respect the confidentiality of the survivor to limit increasing the stigma of the survivor and discourage other survivors from seeking help in future. With children survivors, to make sure they understand the need to share the information with their trusted caregivers or other appointed legal guardian while ensuring the best interest of the child, safety and security are given due consideration.

Informed Consent: To ensure receiving informed consent (or assent for a child) from the survivor, or legal guardian, or general prosecutor if working with a minor, prior to any CMR response service or sharing of information. If the survivor cannot read or write, an informed consent statement will be read to the survivor and a verbal consent will be obtained or a thumb print. The survivor should have the option to provide limited consent, whereby they can choose which information is released and which is kept confidential. Children must be consulted and given all the information needed to make an informed decision using child-friendly techniques that encourage them to express themselves. The evolving capacity of the child or adolescent will determine the appropriate information to give based on their age, seeking informed assent as appropriate, while respecting their autonomy and wishes and offering appropriate choices during their medical care.

Respect: To offer information about available CMR and IPV support services and respect the choice of the survivor concerning which services s/he wishes to access. To maintain a non-judgmental attitude and behavior. To ensure that children are participating in the decision-making process of CMR and IPV services they can access, and are involved in all decision-

making processes regarding referral and access to CMR services.

Do No Harm: To ensure that risks are not greater than the benefits to the survivor when documenting, reporting, monitoring or providing services to a survivor.

Best Interest of the Child: To give priority to the best interest of the child in all cases concerning a child survivor. To adopt and apply all mentioned guiding principles to children, including their right to participate in decisions that will affect them. A child should be listened to and his/her concerns should be taken seriously. If a decision is taken on behalf of the child, the best interests of the child shall be the paramount guide and the appropriate procedures shall be followed while providing CMR and IPV services.

Self-determination: To guarantee the right of the survivor to make one's own decisions including: sexual and reproductive decisions; right to refuse medical procedures and/or take legal action; and right to choose the course of action.

Right to highest attainable standard of health: To ensure the right of the survivor to health-care including mental health services of good quality, that are available, accessible and acceptable.

Right to Information: To guarantee the right of the survivor to know what information has been collected about one's health and to have access to this information, including medical records.

D. Approaches

The CMR strategy is based on five main comprehensive and integrated approaches:

The human rights approach is based on the Human Rights Charter, the Convention on the Rights of the Child, The Convention of the Elimination of all Forms of Discrimination Against Women (CEDAW), and sustainable development goals, among others. This approach seeks to analyze and address the root causes of discrimination and inequality to ensure that everyone, regardless of their gender, age, disabilities, ethnicity or religion (among other factors), has the right to live with freedom and dignity, safe from violence, exploitation and abuse, in accordance with principles of human rights law.

The survivor centered approach highlights the prioritization of the survivor's rights, needs and wishes when designing and developing GBV-related responses and programming. It is also based on the proper engagement of at-risk groups and CMR survivors at every stage of the process, starting from identifying risks to mitigating those risks and finding solution.

The systemic approach is a multi-levelled approach that is based on the interaction of elements associated with individuals, their families, their local communities, and their relationships with society as a whole. It is

also positioned around existing related laws and legislations.

The **community-based approach** is based on actively engaging affected populations as partners in developing strategies related to their protection and the provision of needed support and care.

The **multisectoral approach** is based on coordination among different concerned stakeholders and actors including governmental, non-governmental, and other public and private entities as well as the intra coordination within each of these entities.

E. General Assumptions

The main pre-conditions and main assumptions for a successful roll out of the CMR strategy include:

- The MoPH leadership on the strategy assumed by the PHC department with the support of the Hospitals Department at the MoPH
- Proper allocation of the needed resources including financial resources to implement the strategy
- Socio-Political stability
- Proper alignment of CMR strategy with other strategies for women and children in Lebanon; as well as other related national health and protection strategies
- Proper coordination and collaboration among concerned key actors
- Endorsement and support of all concerned stakeholders

F. Key Actors

The PHC department at the MoPH is responsible for implementing the CMR strategy in coordination with relevant ministries and public entities. These include: (1) MoSA; (2) MoJ; (3) MoIM; (4) MEHE; (5) NCLW; (6) Lebanese Orders of Physicians, Nursing, and Midwives; (7) Lebanese Society for Obstetrics and Gynecology (LSOG); and (6) concerned others.

The implementation of the CMR strategy will be also done in partnership with; (1) CMR TF and other concerned TFs; (2) civil society organizations; (3) international organizations; (4) UN agencies; (5) the private sector; (6) professional entities; and (7) others.

Part 3

Strategic Areas

A. Strategic Area 1: Access to Justice and Rule of Law

B. Strategic Area 2: Cross-Sectoral Communication, Collaboration and Coordination

C. Strategic Area 3: Access to an Integrated Comprehensive Response

D. Strategic Area 4: Quality of Care Assurance

E. Strategic Area 5: Primary Protection

F. Strategic Area 6: Evidence-based Data and Knowledge Generation, Improvement, and Management



The CMR Strategy revolves around six Key Strategic areas to be addressed, as detailed below. These priority areas are not classified by order of priorities to be tackled. They have each the same weight of importance for contributing to the implementation of an effective CMR strategy.

The proposed Key Strategic Areas highlight the different elements that need to be ensured and work in synergy to guarantee availability of, and accessibility to quality care CMR services. The noted elements are:

1. **Existence of an Enabling Environment:** to be ensured through appropriate laws, policies, regulations, guidance, coordination, and sufficient resources allocation.
2. **Proper Supply of Quality Services:** to be ensured through well-defined services and adequate capacities.
3. **Sustained Demand for, and Utilization of Services:** to be ensured through supportive social norms and effective promotion, prevention, and response actions.
4. **Data Availability for Decision Making:** to be ensured through high quality evidence-based data.

When these elements are made available and concerned actors work together, a system that is better able to address the needs of rape-IPV survivors will be created.

A. Strategic Area 1	Access to Justice and Rule of Law
B. Strategic Area 2	Cross-Sectoral Communication, Collaboration and Coordination
C. Strategic Area 3	Access to an Integrated Comprehensive Response
D. Strategic Area 4	Quality of Care Assurance
E. Strategic Area 5	Primary Protection
F. Strategic Area 6	Evidence-based Data and Knowledge Generation, Improvement, and Management

A. Strategic Area 1

Access to Justice and Rule of Law

Goal: Promoting the Adoption of Laws and Policies Leading to Access to Justice and Rule of Law

According to the Inter-Agency Standing Committee (IASC) GBV Guidelines (2015), protection responsibilities related to GBV include advocating for the rights of survivors of SV and compelling countries to comply with international and national standards, laws, and policies that promote protection against SV including rape. Accordingly, all GBV and health actors should be aware and apply the international and national legal frameworks that relate specifically to SV, including rape and IPV. They should also be aware of the international standards, regional and national laws, policies, declarations and programs of action relevant to their setting.

The collection and documentation of medico-legal evidence is an intersection of the medical and legal processes, and appropriate implementation requires a range of multisectoral actors involved in the prevention and response to sexual violence. These actors include those involved with the provision of services associated with: health and social services, forensic medicine, forensic laboratory services, police/ investigation, and the legal system involving lawyers and judges (WHO, UNODC and UN action against Sexual Violence in Conflict, 2015).

Strategic Objectives

1. Support law-reform initiatives to promote adoption of laws and policies that conform to international standards and protect people at risk of sexual violence including rape-IPV, and in situations where there may be concerns with facing retribution by perpetrators if SV has been reported, and stigmatization or rejection by community or family would be faced.
2. Support the development and adoption of policies and guidelines associated with; (1) development and endorsement of the CMR Pathways; (2) development/ adaptation of national CMR guidelines; (3) ensuring the coverage of the CMR services cost through inclusion of some or all CMR procedures in the MISP or the Universal health Coverage Package; (4) guidance on mandatory reporting, including cases of children and adolescent girls; and (5) enabling nurses/midwives to collect forensic evidence based on a structured training.
3. Support the compliance of core ethical principles of the medico-legal process by individuals, agencies and organizations that are involved. These include: respect, confidentiality, physical and emotional wellbeing, non-discrimination, and informed consent.
4. Support the development of a "chain of evidence" process consisting of obtaining, processing and conveying evidence through accountable tracking mechanisms from the community to the health facility to police (including legal and security aspects).
5. Strengthen the capacity of service providers on examination of survivors, forensic evidence collection, storage, analysis, proper documentation and ethical storage of this information.

Key Strategic Interventions

a. Laws Reform

The MoPH PHC department with the support of the MoPH Legal Department will be responsible for coordinating with: The MoIM; MoJ including its Forensic Medicine Department (FMD); Beirut and Tripoli Bar associations; and the NCLW, to audit relevant national laws and related policies and practices and assess areas for possible reform. They will also advocate with concerned key actors for ensuring a substantive and procedural law reform mainly with concerned Parliament Committees including the Mother and Child, Human Rights, Justice, and Administration committees and civil society actors. This will occur in addition to advocating to ensuring the Signature and Ratification of relevant International Conventions and proper adoption of Rights clauses in the Lebanese Constitution by all concerned.

Particular laws and legal frameworks to be reviewed and also requesting the issuance and/or activation of related implementation decrees relate to: (1) definition of rape including marital rape; (2) mandatory reporting (adults and children); (3) definition of sexual assault; and (4) rights for access to safe abortion.

The MoPH PHC department, with the support of the MoPH Legal Department, will also be responsible to coordinate with the MOJ for the issuance of the needed circulars allowing properly trained nurses and midwives to collect “timely” forensic evidence that can be acknowledged by forensic doctors in the selected facilities.

This will be coupled with advocacy efforts to be ensured by MoPH, UNICEF, and UNFPA, with the Orders of Nurses and Midwives, for the development of an advanced training on collection of forensic evidence targeting nurses and midwives in the selected CMR facilities.

b. Policies Development and Adoption

The MoPH PHC department, with the support of the MoPH Legal Department, will also be responsible for coordinating with concerned actors to ensure the needed technical assistance and support to develop national policies and mechanisms relating to: (1) development and endorsement of the CMR Pathways - including definition of roles and responsibilities of medical and paramedical staff; (2) development/adaptation of national guidelines such as endorsement of the CMR Protocol; (3) ensuring the coverage of the CMR services cost through inclusion of some or all CMR procedures in the MISP or the Universal health Coverage Package; (4) guidance on mandatory reporting; (5) development of a “chain of evidence” process consisting of obtaining, processing, and conveying evidence through accountable tracking mechanisms from the community to the health facility to police; and (6) integration of CMR services requirements in the accreditation system of the hospitals and PHC centers (refer to Section C, below).

The MoPH PHC department, with the support of the MoPH Legal Department, will also work with the MoJ - FMD and concerned others to review, develop and/or establish national policies and mechanisms associated with the specification of the following:

- Mandatory versus optional reporting of rape incidence
- Medical practitioners (nurses, doctors, midwives, etc.) that should be legally empowered to conduct the medical examination, sign police forms, and give medical evidence in court; all, in compliance with core ethical principles of the medico-legal process
- Type of evidence allowed/used in court for adult and child rape cases that can be collected by medical staff (blood, urine, clothing, hair, fibers, DNA)

- Type of forensic evidence possible to collect in the country (e.g., DNA, acid phosphatase)
- Necessary procedures/protocols/documentation for collecting, storing, and transporting evidence samples
- Forms/documentation required and admissible in court
- Security requirements, if any, to be ensured for persons collecting or handling forensic evidence
- Safety and security requirements for survivor if he/she decides to have a legal case
- Capacity of the facility to store forensic evidence for a period of time if the survivor is unsure whether or not to proceed with a criminal case
- Fees should survivors be charged for forensic services, laboratory tests, or necessary forms; and mechanisms to cover these fees
- Party that facilitates the transport cost of service provider or expert witness to court

The MoPH PHC department, with the support of the MoPH Legal Department, will also coordinate with the ISF MoIM to ensure the availability of well-trained female officers in different areas in Lebanon to fulfill the role of focal points/ persons in interviewing rape survivors in police stations or any health facility. The training will also include GBV guiding principles and survivor-centered approach.

The MoPH PHC department will also collaborate with MoSA - Child Protection Department and MoJ to review and establish proper Child Judicial Pathways Referrals to properly reflect CMR related considerations and to better define and activate the role of Judicial Social Workers.

To achieve the above, a memorandum of understanding (MOU) between the MoPH and concerned ministries and other public entities will be signed.

c. CMR Services Cost Coverage

The MoPH PHC Department will advocate with all concerned to ensure the consistent availability of funds allowing for the subsidization of PEP kits and other essential medications, currently ensured by UNFPA and other funding entities.

Within this context, the MoPH PHC Department will consider means allowing transitioning from reliance on external funding to looking into the ministry budget to fund CMR services. Linking CMR services provision to MISP or Universal Health Coverage are options to consider.

The MoPH PHC Department, with the support of the Hospitals Department, will advocate with all concerned towards ensuring a 100 per cent coverage of CMR services within the selected CMR hospitals and subsidization of services within the selected CMR PHC centers.

B. Strategic Area 2

Cross-Sectoral Communication, Collaboration and Coordination

Goal: Driving Communication, Collaboration, and Coordination and Reducing Fragmentation

The multi-sectoral nature of comprehensive SV/CMR services requires that a range of Ministries are included in program planning and implementation. These include the MoPH, MoJ, MoSA, MoIM, and MEHE, among others. Other stakeholders including the NCLW, CSOs, NGOs, and INGOs, and UN agencies, are also involved.

The extent of collaboration among all concerned actors is yet to be clarified. Survivors of SV/rape face fragmented experiences while moving between the health, social care, and criminal justice systems, as well as difficulties in navigating the requested services. Thus, there is a significant need to establish a joined-up approach to the commissioning and provision of services if we are to provide at risk population and survivors with the right support at the right time. Without this collaboration, there is a risk of limiting access to support services and curative provision which will harm the recovery of survivors.

Collaboration and a reduction in fragmentation should reinforce the delivery of all priorities set out within this strategy, and in particular, should form part of the quality standards for a proper SV/rape response.

Strategic Objectives

1. Establish national-level multi-sectoral working groups to guide the implementation of CMR strategic objectives
2. Develop coordination and referral frameworks/pathways at the national, governorate and "Intra" (within entities) level

at the following three different levels: (1) among concerned ministries; (2) with the CMR TF members; and (3) at the regional/governorate level.

It will also work closely with relevant bodies and joint initiatives focused on CMR Health care services and GBV/SV to leverage partnerships, link to and inform joint advocacy, avoid duplication, and create linkages in planning and implementation.

Key Strategic Interventions

The MoPH PHC Department will establish itself as the first point of contact for coordination guidance on CMR. It will seek to engage and partner with concerned governmental entities as well as local organizations. It will also facilitate their active participation in coordination. Accordingly, the MoPH PHC Department will lead coordination

Accordingly, the MoPH PHC Department will support the development of a national coordination mechanism among national entities targeting at risk groups including vulnerable men, women, boys and girls, people with disabilities, marginalized groups, persons in social and welfare

institutions, among others. These national entities include: (1) MoPH with its different departments related to Mother and Child Health, Mental Health, Hospitals Affairs; (2) MoSA with its different departments related to Women, Children, Persons with Disabilities, Family Affairs, and Social Welfare and Specialized institutions; (3) MEHE/ Direction d'Orientation Pédagogique et Scolaire/ Orientation and Counselling Department (DOPS); (4) MoIM/ISF; and others.

The MoPH PHC Department will be also responsible to ensure the alignment of the CMR strategy with all other developed national strategies, plans, and related existing initiatives. These include the following, among others:

- MoPH Health Strategic Plan (2016-2020) (MoPH, 2017)
- MoPH Mental Health Strategy (2015-2020) (MoPH, 2015)
- MoSA Strategic Plan on the Protection of Women and Children (2020-2026) (MoSA/ UNICEF, 2020)
- The Policy of the MEHE for the Protection of Students in the School Environment (MEHE, 2018)
- NCLW Strategic plan (2011-2021) (NCLW and UNFPA, 2011) and National Action Plan (NAP) on UN Security

Council Resolution 1325 on Women, Peace and Security (2019)

- National Strategy for Violence against women (VAW) (2019-2029) (OMSWA, UNFPA and ESCWA, 2019)
- The “Social and Behavioral Change Communications Plan to Prevent Violence against Children and Women, Child Marriage, and Child Labor” – “Qudwa” (MoSA/ UNICEF, 2020)
- ISF 1325 and 1745 Hotlines
- The yearly GBV TF led by UNHCR and UNFPA workplan
- The yearly Case management TF (CMTF) co-led by Save the Children and IRC workplan

The MoPH PHC Department will also ask all organizations that commission or deliver CMR related services to sign up to a new governance framework that explicitly outlines the outcomes that they are expected to achieve and how they will report those outcomes. This will be done through coordination with the established CMR TF which includes representation from key actors (representatives of CMR/IPV facilities, health, CP, and GBV actors). Multi-sectoral working groups at governorate level will be formed to guide and support the implementation of CMR strategic objectives.

C. Strategic Area 3

Access to an Integrated Comprehensive Response

Goal: Ensuring the availability of, and accessibility to CMR services within primary health care centers and hospitals in the different regions in Lebanon

Survivors of rape frequently find it difficult to navigate a fragmented and disorganized array of services at times when they need them most. They also experience difficulties in knowing which services to access to get the support that they need, and inconsistencies in the quality of care that they receive once they do access services. Accordingly, to properly address the needs of rape survivors, there is a substantial need to provide comprehensive SV including IPV care that meets the range of medical, legal, and psychosocial needs of the survivor, from the first point of contact through the final stages of recovery and reintegration. This mainly includes: (1) comprehensive medical management by health care providers; (2) short and long-term psychosocial support; and (3) legal assistance to help the survivor access justice and shelter, if needed. Many of the needed services need to be provided as soon as possible and no later than 72 hours following the assault (Refer to Footnote 16). This also includes the provision of PEP, Emergency Contraception (EC) pills (within 120 hours for EC), and forensic evidence collection for those who consent.

Comprehensive care requires a multi-faceted, multi-sectoral response that involves a multitude of stakeholders, service providers, and the community at large. While health facilities can strengthen their services without referring to any other stakeholders, clinical management of SV/rape is most effective when it is positioned within this multi-sectoral response with an effective coordination and information-sharing among all concerned. Also, comprehensive SV/rape services can be provided at all levels of the public health care system, from local public health centers and clinics to national referral hospitals. The level of SV services that can be provided at a given facility will vary depending on the capacity and resources of the facility. National health policy and legal considerations also play a role at this level.

Comprehensive SV/rape care is preferable to be provided in one location that includes representatives from all the sectors, which is referred to as a "one-stop center". The "one-stop centers" can be co-located inside or on the grounds of existing hospitals or public health centers.

In most instances, even in "one-stop" settings, providing comprehensive care to SV/Rape survivors will necessitate one or more referrals to other service providers located outside the CMR health facility. These providers can be: (1) any government and public entity mainly the social development centers (SDCs) affiliated to MoSA where GBV and CP case management services are provided; (2) NGOs including community-based organizations (CBOs) that provide case management or other specialized services; (3) professionals and entities who provide direct services to SV/rape survivors and their

families; or (4) referrals to legal or safety/security (shelter and Police) services. Ensuring strong referral linkages to, and from these providers is a substantial element to ensure a comprehensive SV, including CMR, services.

Several factors influence the strength of referral linkages in a given community. These include: (1) proximity of services to one another – available and affordable transportation to improve accessibility; (2) knowledge and attitudes of service providers; (3) levels of awareness of services in the community; (4) use of standardized referral systems; (4) active collaboration and coordination between stakeholders; and (5) presence of the needed decrees and/or MoUs, that institutionalize the collaborations between the different concerned stakeholders.

Strategic Objectives

1. Select and provide support to 10 CMR/IPV facilities (5 Hospitals and 5 Satellite PHCs) to provide CMR services within the different governorates.

These will include one hospital and a satellite PHC in each of the following clusters of regions, while ensuring the availability of a CMR entity, particularly in the remote areas of Akkar, Bekaa, and South Lebanon:

- North Lebanon and Akkar
 - Baalbeck, Hermel, and the Bekaa
 - Nabatieh and South Lebanon
 - Beirut
 - Mount Lebanon
2. Establish a collaboration and coordination mechanism between PHC Department and Hospital department at the MoPH on CMR-IPV services provision
 3. Establish quality CMR/IPV services requirements within the selected CMR-IPV entities
 4. Establish a functional CMR Referral Pathway
 - a. Activate the adoption of the GBV including CMR Referral Pathway and SOPs developed by MoSA with the support of ABAAD in 2018
 - b. Add services on the existing online inter-agency referral pathway through UNHCR platforms
 - c. Set directives to develop a formal referral directory and protocol for out-referrals and within the CMR-IPV

- health facilities (NGOs, PHC centers, and Hospitals)
 - d. Develop directives to track use of referral services (health services, legal support, shelters, etc.)
5. Monitor the quality of services provided at the selected facilities
 6. Institutionalize collaboration and coordination mechanisms and the referral pathways between MoPH and other public and private entities through signature of MoU and establishment of clear referral pathways between these entities (Refer also to Strategic Area 2)

Key Strategic Interventions

The MoPH PHC Department will work with the CMR TF and concerned key actors to establish criteria to select CMR-IPV facilities. The selection of these CMR-IPV facilities will be based on the set selection criteria and health facility capacity assessment using adapted international standards.

The MoPH PHC Department will aim to introduce CMR-IPV requested services standards within the PHC centers and hospitals using currently adopted accreditation systems in close collaboration with concerned entities and departments within the MoPH.

The MoPH PHC Department will be responsible for providing support to the selected CMR-IPV facilities. It will coordinate with UNFPA to develop the

training material for the health care providers at the hospitals and the PHC centers, and will train them to be able to provide the comprehensive package of needed services, such as provision of first line response, identification of IPV, CMR for adults, children and adolescent survivors, referral, importance of follow up care for survivors, among others.

The support to be provided at the level PHC centers and hospitals will be as follows:

a. Primary Health Care Centers

The MoPH PHC Department will provide support to the selected PHC centers to provide core CMR-IPV services. Besides the provision of core services, the selected PHCs will also be supported to play a role in providing more accessible follow-up services. These can include: (1) monitoring and support for PEP adherence; (2) monitoring and treatment of STIs; (3) repeat doses of Hepatitis B vaccine; (4) follow-up HIV testing; and (5) emotional/psychosocial support.

The MoPH PHC Department will also support the PHC centers to establish an active referral network to ensure that all elements of comprehensive care are provided.

b. Hospitals

The MoPH PHC Department will work with the MoPH Hospital Department to establish a system of collaboration between them on CMR-IPV services provision in public hospitals in Lebanon.

It will be also responsible for coordinating with the MoPH Hospital department to ensure: (1) the provision of 24-hour emergency CMR-IPV services; (2) treatment for injuries resulting from rape; and (3) laboratory services. The selected hospitals will also be equipped to provide specialized services for HIV/AIDS, including antiretroviral therapy (ART) as part of the PEP kit.

Within each of the selected hospitals and depending on the particularities of each facility, the MoPH PHC Department, in coordination with MoPH Hospital Department, will ensure the provision of proper guidance on whether confidential CMR-IPV services can be provided in the emergency room or integrated in other departments including pediatric clinics or departments.

In addition to the above, the “Chief Central Coordinator at the PHC Department” will be assigned as a focal person to ensure the following: (1) establishment of systems of collaboration and coordination within the different concerned departments at the MoPH including the hospitals, Mental Health, and Mother and Child Health departments; and (2) the introduction of CMR and IPV requested services standards within the PHC centers and hospitals accreditation requirements adopted by the MoPH.

Also, an assigned focal person within the PHC department will be the resource person to the selected CMR facilities and concerned others.

The MoPH PHC Department will assign focal points/persons at the field level who will be in charge of monitoring CMR services provision (PHC center coordinators in the field).

The MoPH PHC Department will be responsible for coordinating with MoSA to ensure the activation and proper adoption of CMR-IPV Referral Pathway for CP and GBV cases. Accordingly, a MOU will be signed for the development and activation of a referral system between MoPH and MoSA.

The MoPH PHC Department will also take charge of supporting the development of directives to CMR facilities on: (1) how to conduct participatory community mapping

of all referral points; (2) developing a formal referral directory and protocol for inter and intra referrals; (3) developing a flow diagram of the system of care that includes internal patient flow/pathway and external referrals; and (4) tracking uptake of referral services. This will be coupled with the specification of communication approaches and processes between the CMR facilities and concerned ministries including MoJ, MEHE, and MoIM.

The MoPH PHC Department will be also responsible for developing a phasing out plan for the 19 CMR facilities currently providing CMR services and not included in the 10 CMR facilities that are to be selected. The phasing out plan will extend over a 1-year timeframe whereby the 19 previously selected CMR facilities will be trained on provision of first line response and referring survivors to the 10 facilities to be selected.

D. Strategic Area 4

Quality of Care Assurance

Goal: Improving CMR Quality of Care

The delivery of good quality and consistent care to survivors of SV including rape is vital to their capacity to recover and rebuild their lives. However, significant variation in the quality of service is experienced by survivors when trying to access support.

To improve the quality of CMR and IPV care and ensure adequate implementation of the CMR protocols and procedures, it is necessary to have multisectoral service providers. While health care providers are the main target group for the CMR and IPV training, other staff in the selected healthcare facility contributing to the delivery services should be sensitized. These include reception officers, program managers, counselors, security officer, paralegals, staff collecting forensic evidence, and others.

Such training is best provided by a multi-disciplinary training team (CMR experts and/or a multidisciplinary team already trained on CMR (Training of Trainers (TOT)) with updated knowledge based on the WHO, UNFPA and UNHCR 2020 guideline. This team includes: (1) medical specialists, such as gynecologists, pediatricians and forensic doctors who can provide detailed instruction on clinical care issues; (2) psychologists or GBV and CP expert counselors who can provide an additional dimension to discussions on first line response, psychosocial care and mental health complications as a result of trauma; (3) police and legal sector representatives including judges and general prosecutors who are best-positioned to speak about relevant laws and the uses of evidence in prosecution in alignment with GBV guiding principles and survivor-centered approaches.

The training needs to address issues associated with GBV and its concepts, gender norms, negative prejudice, value clarification, and communication skills. It also needs to be sensitive to the particularities of children survivors and LGBTIQ+ community, among other at-risk population groups. Finally, the training should be aligned with the WHO, UNFPA, and UNHCR guideline issued in 2020 (Clinical management of rape and intimate partner violence survivors. Developing protocols for use in humanitarian settings).

Strategic Objectives

1. Set a regulatory framework with clear operational plans to regulate CMR-IPV training undertaken by concerned entities
2. Develop a unified CMR-IPV capacity building program targeting selected CMR care providers

Key Strategic Interventions

UNFPA, in collaboration with the MoPH PHC Department, and with the support of UNICEF will be responsible for establishing an operational framework to regulate CMR-IPV capacity development targeting concerned service providers.

Training packages will be tailored as per the target groups.¹⁹

Accordingly, UNFPA in collaboration with the MoPH PHC Department, will collaborate and coordinate with the following entities to include CMR-IPV adopted guidelines and training within their programs and capacity building initiatives, through the following actions:

1. MoSA:

- a. To contribute to the promotion of the adoption of the national GBV SOPs and referral pathways developed by MoSA in collaboration with ABAAD or develop a new referral pathway.
- b. To include CMR-IPV guidelines and related tools in the CP SOPs.²⁰
- c. To revise the Terms of Reference (TOR) of MoSA Social Workers appointed within the context of UNFPA and UNICEF and other concerned donors supported projects to include CP / GBV case management.
- d. To sensitize the MoSA CP social workers in charge of CP case management and SDC social workers on CMR-IPV as well as GBV Case Management.
- e. To sensitize service providers of MoSA-contracted organizations on availability of CMR services.

2. MEHE and Lebanese University:

- a. To introduce CMR-IPV in the training modules and protocols adopted by MEHE's Orientation and Counselling Department (DOPS) targeting health counselors, psychosocial counselors, and public schools' teachers as well

- as in vocational training programs.
- b. To introduce a CMR-IPV academic module in medical, nursing, midwifery, and social work programs at the Lebanese University.
- c. To advocate for the introduction of a CMR-IPV academic module in similar programs within concerned private academic institutions.
- d. To sensitize the paramedical staff working on inclusive education programs in 30 MEHE pilot schools on CMR.
- e. To integrate CMR in the action plan of the CP policy currently under development with UNICEF.

3. MoJ:

- a. To include Gender, GBV, and CMR-IPV training in the e-curricula on "Justice for Children" developed in collaboration with UNICEF.
- b. To train forensic doctors; judges; juvenile judges; general prosecutors; and judicial social workers on gender, GBV and its concepts, medico-legal interlinkages for care of survivors, and protection file management including investigation in Police Stations and court sessions.

4. MoIM:

- a. To train ISF on CMR-IPV, as well as communication with survivors.

5. Lebanese Red Cross (LRC):

- a. To train the LRC staff and paramedics on CMR and survivors handling.

6. Concerned Orders and Syndicates

- including: physicians; the Lebanese Society for Obstetrics and Gynecologists

¹⁹. Trainings will target: PHC centers coordinators; Lebanese Society for Obstetrics and Gynecology (LSOG) in charge doctors; the staff in CMR facilities, ISF staff, MoSA social workers, sensitization of pharmacists, counselors in DOPS, etc.

²⁰. MoSA, UNICEF and University of Saint Joseph Lebanese School for Social Work. (2015). Standard Operating Procedures for the Protection of Juveniles in Lebanon (Operational toolkit). Retrieved from <http://www.socialserviceworkforce.org/system/files/resource/files/SOP%20for%20Juvenile%20Protection%20in%20Lebanon.pdf>

(LSOG); nurses; social workers; midwives; and the Bar Association:

- a. To introduce CMR-IPV training in their Continuous Education Programs.

7. UNICEF:

- a. To coordinate the activation of the CMR application²¹ with the 10 selected CMR facilities.²²
- b. To introduce CMR in the Lawyers Manual developed by UNICEF.

8. INGOs/NGOs (IRC/IMC/ABAAD, in close coordination with UNFPA as the

lead entity responsible of CMR-IPV Capacity Building):

- a. To contribute to the restructuring of their competency-based training and develop a unified TOT program.

Long-term Key Strategic Interventions

To work with MEHE and concerned orders and academic institutions/universities to include within their curricula: (1) forensic nursing (at Graduate Level); and (2) forensic medicine.

²¹. Previously developed by UNICEF and ABAAD.

²². The CMR application is an offline downloadable application available to staff in the already trained facilities that will summarize in a user-friendly manner the key steps to provide CMR treatment to all survivors, regardless of their sex, age, nationality. The application also provides tips on soft skills, such as listening tips when dealing with young children, and supports users to comply with a survivor centered approach (following guidelines and national legislation on mandatory reporting of sexual violence to the authorities according to the age of the survivor), and to know where and how to refer survivors for other services available in their area (based on the GBV referral pathways developed by the GBV sector)

E. Strategic Area 5

Primary Protection

Goal: Strengthening the Approach to Prevention through Behavioral and Social Change

Preventing sexual violence including rape from ever occurring should be vital. The responsibility to prevent SV and rape also includes a responsibility to protect and safeguard those who are mostly vulnerable and those who are placed in the care of others. Safeguarding is an effective way to protect children, young persons, marginalized groups, and vulnerable adults against any form of harm, abuse, and neglect.

Also, for survivors of previous incidents, reducing the risk of future re-victimization is crucial to their recovery, healing, and ensuring their safety. Early identification of any form of sexual assault and abuse is therefore fundamental to any health outcome and social well-being.

This can be achieved through programs that aim to address gender inequality, women's empowerment and respecting human rights. Also, through increasing public awareness, influencing behaviors and attitudes, and inducing social change, as well as through the adoption of proper prevention and protection measures.

Strategic Objective

1. Develop a national SV, including IPV, public awareness and communication strategy centered around Social and Behavioral Change
2. Develop a national prevention and safeguarding plan aimed at vulnerable and marginalized groups

Key Strategic Interventions

The CMR TF, with the engagement of the GBV TF and Health TF, in close coordination with MoPH PHC Department, will be responsible for ensuring the development of a public awareness and communication strategy and prevention and safeguarding plan with related mechanisms associated with SV including rape. This will be done in close coordination with concerned ministries primarily the MoSA, MEHE, MoJ, and MoIM; as well as with other concerned key

national actors including the NCLW.

The noted communication strategy and safeguarding plan will focus on social and behavioral change and will be aligned with all other national strategies mentioned under Strategic Area 2 above.

Accordingly, the CMR TF will be responsible for providing the needed guidance and support to:

- a. Establish a national framework and mechanism allowing to align preventive awareness actions undertaken by concerned ministries and other key actors.
- b. Develop frameworks that explicitly describe what safeguarding means for the population at risk and survivors of sexual assault and abuse/violence including rape and IPV, define responsibilities, and clarify what is expected of providers of services.
- c. Establish a national guidance

mechanism allowing strengthened linkages between the CMR health facilities and local communities to increase awareness about timely utilization of services. According to WHO, UNFPA and UNHCR (2020), “it is important to reach out to community members, once services are established, so that they understand what kinds of services are available for survivors and how they can access them or help others to do so” (p. 7).

Besides at risk and survivor women and girls, awareness should primarily target frontline health care providers with emphasis on pharmacists. These are considered to be among the first refuge entities for rape survivors seeking

CMR services (AUB, UNICEF, and MoPH, 2020). Other groups to target to ensure proper prevention include midwives, nurses, family doctors, gynecologists, local leaders, school counselors, and the community at large.

Information, education, and communication (IEC) material will be developed to induce basic social and behavior change using participatory and community-based approaches. These can include posters, pamphlets, videos, storytelling, games, social media platforms and/or any other written/audio/visual materials useful for conveying information and reinforcing messages tackling harmful gender norms hindering access to CMR-IPV services.

F. Strategic Area 6

Evidence-based Data and Knowledge Generation, Improvement, and Management

Goal: Generating Evidence-based Data and Developing CMR Reporting and Monitoring Frameworks and Systems

The collection of data on SV including rape is valuable from a range of perspectives. Timely and accurate context-specific data, which includes information about the nature of the setting, conflict stage, and perpetrator, can vastly improve decision making, allowing development of relevant policies and programs.

The existence of evidence-based data and comprehensive data collection and monitoring systems can also further facilitate the effective evaluation of CMR-IPV interventions in different social and cultural contexts.

Strategic Objective

1. Support the generation of evidence-based data aligned with global best practices related to collection, storage, and utilization of data
2. Facilitate the development of reporting and monitoring system(s) and mechanisms at the national and community levels

Key Strategic Interventions

The MoPH PHC Department will partner with academic institutions, think-tanks, and other concerned entities to identify gaps, further strengthen the evidence-based generation and disseminate research outcomes in order to promote innovative approaches for SV and IPV prevention and response efforts. The focus will be on practical advice that can be applied in the field on areas of emerging importance and identified gaps.

In particular, the MoPH PHC Department, in collaboration with academic and research entities, among others, will be responsible for coordinating with key SV

and IPV actors to develop data mapping techniques and intelligence sharing systems for scale and experiences of SV including rape to ensure a proper reporting. This is important to better understand the scope and magnitude of the problem at different stages and in different contexts.

It will also ensure the proper management of the generated data and information. This will be achieved through supporting the adoption of systematized and collaborative processes of collecting, processing, analyzing, storing, sharing and using data and information safely and ethically to allow evidence-based and quality SV/rape coordination, and timely and relevant response.

The MoPH PHC Department will also coordinate and collaborate with the GBVIMS to review the data points of the system while aiming at guaranteeing the inclusion of all survivors of SV including rape and IPV, with gender sensitivity and recognition of diversity assured. It is also suggested, while retaining a focus on

women and girls in GBV/Rape reporting, to also focus on men, boys, persons with disabilities and LGBTIQ+ communities more broadly.

For case and services monitoring, the MoPH PHC Department will coordinate and collaborate with MoSA to revise their monitoring tools, adopted with their contracted institutions, including social welfare institutions and SDCs, to include assessment indicators associated with SV and rape.

Furthermore, the MoPH PHC Department will be responsible for developing service monitoring and accountability frameworks and related implementation procedures within the selected CMR-IPV facilities including PHC centers and hospitals.

CMR services monitoring in selected PHC centers and hospitals, within this context,

will occur on a periodic as well as yearly basis, as follows:

- Periodic PHC CMR services monitoring will be assumed by the trained PHC centers coordinators.
- Periodic (on a 6-monthly basis) hospital CMR services monitoring will be assumed by trained assessors from at least two of the following multisectoral teams: healthcare provider, social worker/counsellor/psychologist, Police, facility manager, or GBV service supervisor (Jhpiego, Center for Disease Control and Prevention (CDC), WHO and President's Emergency Plan for AIDS Relief (PEPFAR), 2018).
- Yearly CMR services monitoring and evaluation within all selected CMR entities will be assumed by the Order of Physicians/LSOG. It will aim to provide related recommendation to upgrade and scale these services.

Part 4

I. CMR Strategy Scaling and Management

II. CMR Strategy Monitoring, Evaluation, and Accountability

III. CMR Services Costs

IV. CMR Strategy Budgeting

V. Risks and Risks Management



I. CMR Strategy Scaling and Management

The MoPH PHC Department will assume the overall coordination and management responsibility of the CMR-IPV strategy.

The MoPH PHC Department, in collaboration and coordination with the CMR TF, will guide the proper implementation of this strategy and ensure the provision of the needed support and guidance to the CMR selected facilities. The nature of support to be provided will revolve around ensuring: (1) review and amendment of regulatory frameworks; (2) stakeholder coordination; (3) provision of capacity building/training to concerned staff; (4) provision of quality confidential CMR services; (5) awareness and outreach; (6) evidence-based data and information generation; and (7) monitoring and evaluation over time.

The MoPH PHC Department will be also responsible for ensuring the establishment of frameworks allowing continuous assessment of the existing needs for CMR-IPV, and performance and extent of coverage of the initially selected CMR entities. This will allow decision-making on scaling over time of the CMR-IPV services based on needs and existence of proper services.

In particular and under the leadership of the MoPH PHC Department, the responsibility of the coordination and management of the different strategy key priority areas is suggested to be as follows:

- The management of the awareness component of the strategy will be steered by CMR TF.
- The management of the CMR-IPV services provision component of the strategy will be steered by MoPH PHC Department.
- The management of the capacity building component of the strategy will be steered by UNFPA in collaboration with UNICEF and with the support of the LSOG.
- The management of the justice/laws component of the strategy will be steered by the MoPH Legal Department.
- The management of the coordination and data generation and management components of the strategy will be steered by MoPH PHC Department.

II. CMR Strategy Monitoring, Evaluation, and Accountability

The MoPH PHC Department will commit to creating and aligning measurable activities against the strategic objectives outlined in this strategy. These activities will form the basis of a three-year work-plan (to be developed), which will include relevant indicators, assigned responsibilities, and timeframe.

On an annual basis, the MoPH PHC Department will conduct an internal interim review of the CMR-IPV strategy work plan, looking at progress

against indicators. At this time, the MoPH PHC Department will also assess the continuous relevance and feasibility of planned activities and, if necessary, amend the proceeding year's work plan to reflect both achievements and changes in circumstances or context.

After measuring the achievements of the work plan against output level indicators, at the end of the strategy and its work plan period, the MoPH PHC Department will commission an outcome level evaluation of the strategic plan, assessing progress towards the strategic objectives and their contribution to the overall CMR strategy mission, vision, and goal.

III. CMR Services Costs

The cost of establishing or strengthening CMR-IPV services at an existing health facility differs according to: (1) the setting; (2) extent of capacity building/training required; (3) supplies, equipment and services available within the facility; (4) infrastructure to provide audio visual privacy; and (5) availability of CMR-IPV protocol. In addition, costs to be considered include: (i) one-time start-up costs; and (ii) recurrent costs that relate to operational costs of the facility and provision of medical care. Accordingly, to ensure the sustainability of CMR-IPV services within the facility, recurrent costs should be assumed by the facility and incorporated within its yearly budget.

The start-up period for the provision of CMR services might extend over a long period of time before the full range of services is available within a facility. Based on reported experiences, this period might range from two months to two years.

Standard start-up costs include:

- Any needed remodeling of facilities to provide CMR services meeting the minimum standards
- Creating a child/adolescent friendly space
- Adaptation of tools, clinical protocols, and referral pathways
- Training of health providers and other concerned staff
- Technical assistance (planning, adaptation of protocols and tools, quality assurance)
- Equipment and supplies for basic sexual and reproductive health services (if not already available)
- Lockable cabinets for files and evidence
- Administrative forms including medical forms, history and examination forms, consent forms, chain of custody forms, etc.
- Staff time to set up proper linkages and referral systems with police, judiciary, forensic medical doctors, psychosocial services, and other support services needed
- Possible creation or upgrading of laboratory facilities for collection/ storage and analysis of biological and forensic evidence

- Initial community awareness and outreach activities development and production of user-friendly IEC materials
- Development of monitoring and evaluation system and instruments

Standard recurrent costs include:

- Fixed operational costs of the CMR services provided by the facility including staff time
- Supplies, medications, laboratory tests, additional staff (these costs may increase over time with increased uptake of services)
- Continuing training and mentoring/coaching of health and other concerned CMR-IPV personnel
- Debriefing support (care for carers)
- Production and dissemination of Social and Behavioral Change plans and IEC materials
- Ongoing awareness-raising and behavior-change activities
- Periodic self-assessment and action planning
- Stakeholder meetings and coordination
- Continuous monitoring of CMR-IPV provided services

IV. CMR Strategy Budgeting

Developing budget estimates for the implementation of the strategy was not possible within the current volatile economic and political situation in Lebanon.

The MoPH PHC Department with the CMR TF will advocate and lobby with concerned UN agencies, local and international non-governmental and non-government organizations to pledge funds to implement the different Key Strategic Interventions noted under the different Strategic Areas of the strategy.

V. Risks and Risks Management

The CMR Strategy builds on different contextual, situational and institutional planning assumptions. It includes different realistic scenarios based on the information deduced from the extensive consultations conducted with almost all concerned key actors. Unexpected developments can change the direction of the strategy or key priority areas of intervention.

Risks are to be considered at every stage of implementation of the strategy and can be of strategic, operational, and/or financial nature. Specific foreseen risks include, but are not limited to, the following:

- The impact of COVID-19 on the health sector
- The current economic crisis at the national level; and the possible budget cuts for a number of ministries

- ◉ Changing political dynamics
- ◉ Employment constraints within the public sector persist
- ◉ Increasing or decreasing numbers of refugees in Lebanon
- ◉ Changing nature and type of partnerships

Managing risks is essential for a successful CMR strategy. This will occur based on the adoption of a continuous risk assessment process during the strategy implementation. Accordingly, occurring risks will be addressed and mitigated through:

- ◉ Taking immediate actions that reduce their likelihood and/or resulting impact
- ◉ Adapting the operational plans to avoid or limit these risks

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