Consultative meeting on Clinical Management of Rape (CMR) Services

Date: December 8, 2016

Time: 10 am – 1:00 pm

Venue: UNHCR, LEA Building, 1st Floor, Conference Room

I. Background

Since the outbreak of the Syrian armed conflict in March 2011, an estimated 11 million Syrians have fled their homes taking refuge in the neighboring countries or within Syria itself[1]. It is one of the largest exoduses in recent history resulting in an economic, social and political disaster. With no political solution in sight, the humanitarian actors are looking at ways to find solutions to respond to the growing needs of affected people. Lebanon, Turkey and Jordan have received the largest number of displaced people followed by Iraq and Egypt[2].

According to UNHCR, figures in Lebanon is the highest per capita host of refugees in the world, which has put a considerable strain on the already weak economy of the country. The number of registered Syrian Refugees in Lebanon is 1,033,513 as of June 2016 of which around 31% are females between 12 – 60 years of age[3]. Refugees have access to most basic services through public and private institutions, UN agencies, NGOs and INGOs

There is limited sharing of quantitative data in respect to violence against women and girls, but many ones reported having experienced violence. Women and children in Lebanon continue to be particularly at risk and disproportionately affected by gender based violence. According to available data, more than 70 per cent of the reported incidents in 2015 as well as the 1st quarter of 2016 were perpetrated by either an intimate partner, primary caregiver or other family member. Over the 1st quarter of 2016, the gender based violence information management system and assessments indicate that the most commonly reported types of violence continue to be physical domestic violence, sexual violence and forced marriage. Reported incidents of sexual exploitation have increased throughout 2015 and the 1st quarter of 2016. Although difficult to ascertain the patterns, given the sensitivities around these types of violations, refugee women are reporting increased concerns about being forced into survival sex to cover the basic needs of their families and to go about their day to day lives.[4]

Concerns also remain in regards to the provision of CMR services for Lebanese women.
Lebanese women suffer from social stigma when it comes to reporting on SGBV, as well as having limited access to services when they report on incident, and this has been observed even before the Syrian crisis. Moreover, the law on family violence was passed in April 2014 but hasn't been properly implemented yet. Furthermore, there is a lack of awareness related to the law amongst all populations, including Lebanese women and girls, as well as PRL, PRS, and refugee populations. Survivors are reluctant to report Sexual and Gender based violence (SGBV) or seek support due to the shame, fear and 'dishonor' to their families. Women risk further physical and sexual violence, including death, often from their own families, when reporting SGBV, a pattern that exists in many contexts.[5]

---

[1] Syria the story of conflict: BBC news. Is it the complete reference?
[2] http://data.unhcr.org/syrianrefugees/country.php?id=122 – UNHCR web portal
[3] http://data.unhcr.org/syrianrefugees/country.php?id=122 – UNHCR web portal
[4] SGBV quarter 1 dashboard- 2016, UNHCR web portal
[5] http://www.fmreview.org/detention/anani.html#sthash.gNa9SWf1.dpuf

Many national and international organizations have been working on reducing SGBV against women and girls, focusing on prevention and protection programmes using a holistic multi-sectoral approach incorporating a range of services such as legal services, information provision and awareness raising, medical and psychological health services, including clinical management for rape (CMR) survivors , etc. These services are decentralized and spread out throughout different regions and are provided by a variety of service providers, based on capacities, expertise and funds.

In regards to provision of medical services for the survivors of sexual violence, there were no specific protocols or standardized service providers who were trained on CMR before the onset of the Syrian crisis. Since then, a clear referral system have been established among providers to facilitate access to the beneficiaries and also up to 35 health facilities have been trained to provide standardized CMR services. Another example is the creation of Clinical Management of Rape (CMR) task force (TF) at national level to better coordinate the medical response needed for a sexual assault survivor. The TF through its advocacy and close collaboration with national and international entities, has been able to establish CMR centers across the country through capacity building initiatives and provision of Post-Emergency Prophylaxis (PEP) kits also known as the RH kit no 3. Also, it has been coordinated closely with the protection sector to enhance the referral mechanisms and ensure better privacy and confidentiality for the survivors seeking medical care. Despite the continuous evident need to provide holistic services for survivors of sexual assault, significant gaps in quality, geographical distribution service provision and type of beneficiaries (i.e. Syrian Vs host communities) remain present.

Given the above, CMR TF proposed to capitalize on its previous achievements and lessons learned, as well as on its close collaboration with SGBV TF, Health Working group (HWG) and the Ministry of Public Health (MoPH), and organize a national consultative meeting on CMR services that will be coordinated closely with the MoPH and will be inclusive of national stakeholders, UN agencies, NGOs, service providers and local experts.

II. Objectives

The objectives of the meetings were to:

- Brainstorm, discuss and agree on challenges and lessons learnt on the establishment and provision of CMR services for all survivors of sexual violence including Syrians, Lebanese, PRS/PRL and other nationalities.
- Discuss and agree on a road map for strengthening CMR services (identification of cases, diagnosis, treatment and referral) for Syrians and host communities.
- Establish a referral system from all PHC centers to CMR service delivery points.

III. Agenda

- Welcome, introduction & Agenda & Objective
- Presentation – Achievements related to CMR/GBV services
- Presentation – main findings and recommendations of CMR assessment
- Presentation – Challenges & way forward – summary of field level consultation meetings on CMR services
- **Coffee break**
- Group work - Action plan for strengthening of CMR services:
  - ✓ Geographical coverage
  - ✓ Technical: diagnosis (forensic doctor), confidentiality, fee for service for both Syrian and host communities
  - ✓ Logistical: drugs (availability & expiration), opening hours of center, availability of CMR focal point per service delivery points
  - ✓ Coordination/referral – coordination between CMR delivery points and SGBV focal points, updated information on CMR available services, etc.
  - ✓ Demand creation awareness
  - ✓ Monitoring of CMR services

IV. Meeting Notes

A. List of participants

Name	Organization	Title	Telephone	Email
Maria Frangieh	New Health Concept	Managing Director	03772334	mariafrangie@gmail.com
Dania Hajj Ali	Makhzoumi Foundation	Health Coordinator	03040861	d.hajj-ali@makhzomifoundation.org
Justine McGowan	IMC	Deputy Country Representative	76408417	jmcgowan@internationalmedicalcorps.org
Dr. Ibrahim Saleh	Medair	Health Manager	76890143	Health-manager-zah@medair.org
Gaia Pallecchi	Intersos	Protection Coordinator	71498400	Protection.coord.lebanon@intersos.org
Wafa Dakwar	MAP	Senior program officer	71674635	Wafa.dakwar@map.uk.org
Wissam Doudar	Seraphim Global	Emergency Health Specialist	70868020	wissamdo@gmail.com

Rima Makki	MSF Swiss	Mental Health Activity Manager	70463130	msfch-lebanon-mentalhealth@geneva.msf.org
Generieve Tam	MSF	Gynecologist	81681323	Geneviere_tam@yahoo.com
Amal Chamoun	MSF Belgium	Assistant Medical Coordinator	03968323	Msfocb-beirut-medcoassist@brussels.msf.org
Coiret Nurielle	MDM	Program Coordinator	70126158	Coord.progs.lebanon@medecinsdumonde.net
Aurelie Leroyer	MDM	GBV Program Officer		Aurelie.leroyer@medecinsdumonde.net
Dr. Vlad Chaddad	MDM	Medical Coordinator	70169513	medco.lebanon@medecinsdumonde.net
Mathilde Verstraete	UNHCR	IA Coordinator - SGBV		verstrae@unhcr.org
Mona Kiwan	UNHCR	Asstt. PH Coordinator	79160198	kiwan@unhcr.org
Diana Aoun	UNHCR			AOUND@unhcr.org
Pilar Pena	UNHCR	Asstt. PO CPB	70183361	PENABRIC@unhcr.org
Najeh El Sadek	UNRWA	Chief of Health	78881116	n.elsadek@unrwa.org
Loubna Batlouni	WHO	Public Health Officer	70127891	albatlouni@who.int
Nisrine Tawily	UNICEF	Child Protection Officer (GBV)	76774434	ntawily@unicef.org
Aline Potts	UNICEF	GBV Consultant	81623999	apotts@unicef.org
Dina Dib	UNFPA	GBV IMS Coordinator	79316688	dib@unfpa.org
Waleed Ikram	UNFPA	Program Specialist RH/HIV	79151823	ikram@unfpa.org

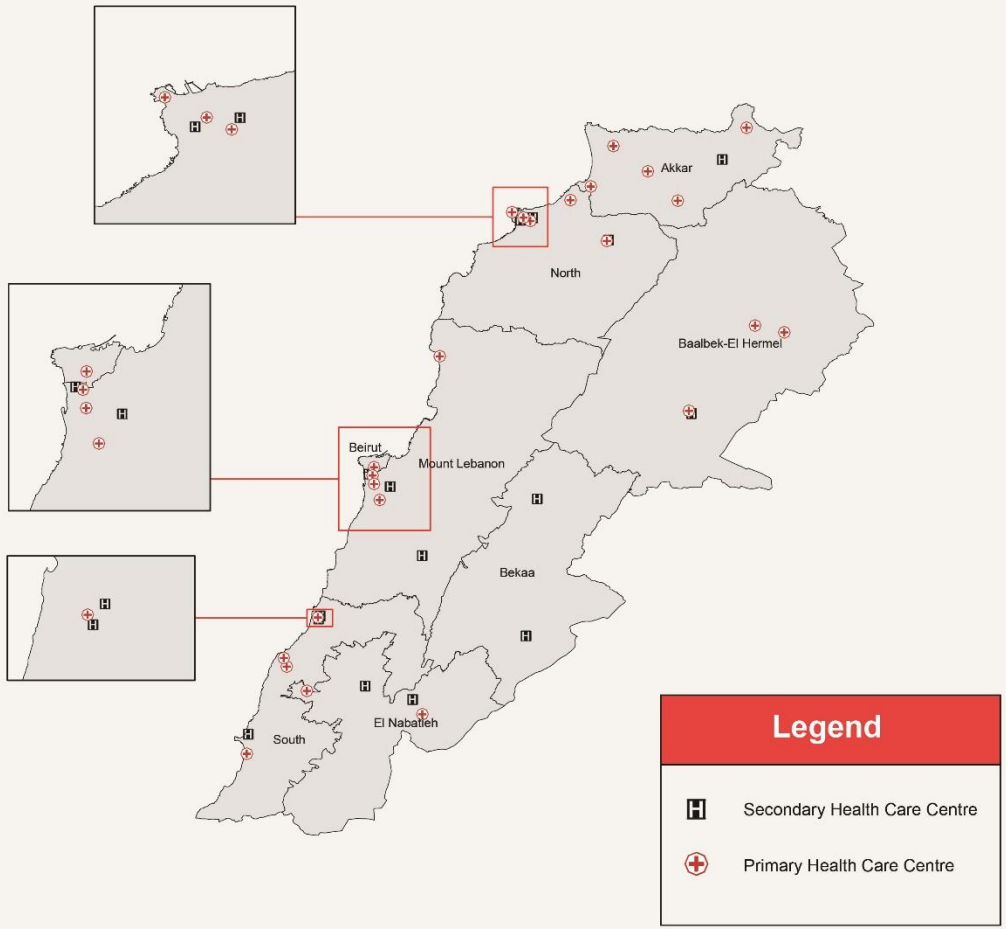
1. After the welcome and round of introductions the objectives and the agenda of the consultative meeting on Clinical Management of Rape (CMR) Services were presented by UNFPA on the behalf of CMR Task Force (TF).

B. Presentation – Achievements related to CMR/GBV services: On behalf of CMR and SGBV task forces, UNFPA presented the needs based on the GBV IMS data and achievements related to the CMR services since 2012 – 2013. The presentation included summary of the GBV IMS tool, its limitations and data for Q3 2016 highlighting the current SGBV trends. Moreover, the presentation included the back ground of CMR services, summary of the trainings carried out and the current list of CMR facilities updated as of November 2016. As per the list, following are the number of CMR trained health facilities per region;

- ✓ Akkar: 6 Centers - North: 8 Centers
- ✓ Beirut & Mount Lebanon: 8 Centers
- ✓ Bekaa: 2 Centers - Baalbek & El Hermel: 4 Centers
- ✓ El Nabatieh: 3 Centers - South: 8 Centers

The below map shows the geographical distribution of the CMR trained health facilities.

Health Facilities with CMR Services by governorate



This map has been produced by UNFPA based on maps and material provided by the Government of Lebanon for UNFPA's operational purposes. It does not constitute an official United Nations map. GIS & Mapping by UNFPA.
For more information about mapping; contact Hasan Shloun at shloun@unfpa.org
Data Source: MoPH,UNHCR,UNFPA, iNGOs and NGOs; contact Waleed Ikram at ikram@unfpa.org

Akkar

Machha Primary Health Care Centre
Makassed PHC in Wadi Khaled
HNDP Hospital
Tal Maayan Primary Health Care Centre
Fnaydek PHC
Iman PHC

Baalbek-El Hermel

Baalbeck Governmental Hospital
MSF PHC Clinic & Maternity Centre in Al Irshad
MSF PHC Clinic in Baalbek
Laboueh Municipality Center

Beirut & Mount Lebanon

Beirut Rafic Hariri Governmental Hospital
Makhzoumi PHC
Baabda Governmental Hospital
Byblos PHC
Al Mir Majid Irslan Primary Health Care Centre
MSF Women Health Clinic
MSF Chatila PHC Clinic "
MSF Borj Barajni PHC
Ain w Zein Hospital

Bekaa

Rachaya Governmental Hospital
Bekaa Hospital

El Nabatieh

Nabatieh Governmental Hospital
Marjaayoun Governmental Hospital
Amel Association

North

Tripoli Governmental Hospital
Mazloum Hospital
Sir Dinniye Hospital
Iman Clinic
Nahda Primary Health Care Centre
MSF Swiss PHC Tripoli
Makarem Al Akhlaq PHC
Iman PHC

South

Saida Governmental Hospital
MSF Swiss / Human Call Association
Sarafand PHC, Lebanese Welfare Association
MAP Ain El Helwe Women Health Centre
MAP Rashdieh Camp Health Centre
Hiram Hospital
Serepta Association
Ansar PHC

C. **Presentation – main findings and recommendations of CMR assessment:** Main findings and the recommendations of Health facility based CMR assessment were presented. UNFPA commissioned a consultant, Mr. Wissam Doudar to carry out a health facility based assessment of CMR services in Lebanon that was carried out during November & December 2016. The below provides summary of the presentation:

- ✓ The purpose of the assessment was to contribute towards the advocacy efforts to further improve CMR services across various facilities in Lebanon for both Lebanese and Syrian beneficiaries.
- ✓ The main findings of the semi-structured interviews conducted during the assessment included
  - 100% of CMR cases were referred through various NGOs – sometimes from a different governorate.
  - 27% of the facilities have received zero cases as per the assessment respondents. Could be also that the interviewed staff didn't receive any case.
  - 13% of the assessed facilities are not able to provide CMR services due to staff turnover and lack of having CMR trained staff or because of being understaffed.
  - 17% of the respondents didn't have access to PEP kit.
  - 27% of the respondents know about the SGBV referral pathway for accessing other protection related services
  - 14% of the respondents were medical doctors (1 gynecologist & 3 GPs)
  - 50% of the interviewed staff did not receive on the job coaching. 100% staff requested a CMR refresher.
  - 13% of the assessed facilities do not allow CMR trained staff to examine survivors and assign any physician or GYN for the physical.
  - Staff turnover was insignificant at most of the visited center, in contrary to what was expected.
  - 76% of the assessed facilities are open 24/7 and mentioned to be able to handle adult and child survivors both.
  - 86% of the staff trained on CMR are female

%	Findings
93	Asked to have refresher CMR training and periodic refreshers
93	Didn't know timing on when to use STI medication
20	Unfamiliar with PEP contents and use
76	Will ask survivors to come for follow up visits
62	Didn't know timing on when to use EC
62	No CMR case management plan
55	Don't refer to SGBV case manager

52	Don't have CMR referral pathway
51	No CMR team
51	Don't have back-up plan to train new staff
48	Don't have CMR trained staff in all working shifts
45	PEP is not inside exam room
41	No CMR educational material
41	Don't refer for psycho-social support
30	Didn't know timing on when to HIV medication,
28	Considered their health facility doesn't tackle CMR seriously
24	Don't know or don't have access to Forensic Doctor
24	Will not call ISF for whatever cases
21	Wrong order of physical examination
14	Didn't receive PEP kit, UNFPA Kit no. 3

D. **Presentation – Challenges & way forward – summary of field level consultation meetings on CMR services:** Aiming to improve and strengthen the provision of Clinical Management of Rape (CMR) services and considering all the issues faced at field level for survivors to access CMR services, the CMR task force organized field level consultations with health and SGBV coordinators in four geographical regions (South, North, Bekaa, Mt. Lebanon) and organizations involved in the provision and referral of CMR/other services for SGBV survivors to discuss strengths, challenges and opportunities. Main challenges and the recommendations were presented by UNFPA as following:

Challenges	**Recommendations**
Geographical Accessibility - Geographical coverage is related to access issues like distance to the facilities, checkpoints, and transportation costs. South: Saida/Jezzine/ Hasbaya / Zaharani North: Chekka, Batroun, Anfe, Qalamoun, Zgharta, Koura, Bcharre Akkar: Akkar El Atika, El Abboudiyeh, Halba, Wadi Khaled, and Kfartoun.	**Geographical accessibility** - Increase geographical access in the North - Increase geographical access especially in Hermel area. - Suggested facilities and organizations include Labwe PHC, Farhat hospital (in west Bekaa) and identifying a PHC in Hermel District preferably a PHC within the MoPH network - MSF

Baalbek-El Hermel: Hermel and surrounding locations	
Security - Police station in certain cases or case management agency serve as an entry points for rape cases. Police stations are not aware of referral pathways and how to access CMR services.	**Security** - Sensitization and capacity building of ISF on CMR cases identification and referral.
CMR Facilities infrastructure - Difficult procedures to access the CMR focal point that in some cases has led to breach in confidentiality (e.g. at the reception). - No backup system exist for CMR focal points. In Bekaa hospital, there are only two staff for CMR services. - No IEC materials available - Availability of medication & supplies • Not all trained centers have PEP kit • HIV testing not available in the kit and no follow up test after 6 month. - Hospitals are the only facilities providing 24/7 services (RHUH provides services after 6 pm)	**CMR Facilities infrastructure** - Sensitization and capacity building of health facility staff on ethical considerations while dealing with a survivor. - On call doctors and focal points/ back up system at the CMR facility level. - Availability of CMR trained staff at the health facility (during weekends and night shifts). - Improve survivor access to health facilities that provide case management package including CMR/MHPSS/diagnostic services. E-g PHCs providing universal health coverage.
Human resources - High staff turnover at PHC level. Labwe PHC – CMR trained staff doesn't work there anymore. - Inadequate technical skills to deal with child survivors (in particular boys) - Non-Medical staff (receptionist, health educator, etc.) not trained on CMR related identification and referrals of survivors. - In some cases, facility based follow up wasn't completed as part of CMR training. - In some cases, the focal point assigned for PEP kit is not the person trained. - Scarcity of forensic doctors in certain regions adds up to delay in management of the case.	**Human resources** - Addition management of child survivors in CMR training; Pediatrician should be part of the trainings. - Staff refresher trainings on ethical considerations to ensure privacy. - Expand CMR identification and referral trainings to SDCs also. The advantage of having SDCs trained on CMR is the presence of a social worker which can properly follow-up and refer. It would also increase access for Lebanese. The services at SDCs cost less as compared to PHCs.

Culture - Issues related to the perception of health staff when an SGBV case presents. Stigma exists which affects how the case is treated at the CMR facility. In some instances survivors felt that the health facility staff are providing these services this as favor. - Some doctors do not even report the case as a survivor of sexual violence specifically in the case of minors. - Doctors/pediatrician not always willing to interfere because of legal reporting and their own protection by law. - Refusal of admit & to deliver in case of pregnancy if father is unknown - Attitude of service providers need improvement; in many cases the survivor doesn't want to access facility close by.	**Culture** - Advocacy needed for protection of juvenile survivors. Under Law 422, juvenile court only responds to legal needs of a child survivor when the perpetrator is within the family. If the perpetrator is out of the family, the legality of the matter goes to criminal court whereby causing more protection risks for the child survivor. - Need to work on policy level with the Lebanese Order of Physicians (LOP), MoPH, Syndicate of hospitals) to improve protection rights of survivors. - Make health staff (doctors) should be accountable to report cases of child abuse.
Referral - Referral to secondary care resulting in confidentiality breach sometimes and slows down procedures to provide services - Referral system as such for MHPSS and other services from the facility providing CMR services does not exist. - Case management agencies do not have access to documents in the facility. - No functioning referral system (for instance from police to CM, or PHC to CM). - Self-referrals are not referred to any specialized services. In many instances cases are reported (i.e. children) not to the appropriate entity. - New trained PHC are not included in the referral pathways until they get evaluated by the SGBV TF. - Information on SGBV referral pathway is not updated and not shared at the facility level and circulated within the organization themselves.	**Referral** - Include CM agencies in coaching sessions - GBV actors to be involved in training and coaching as well as CP actors. - Channel safe communication inside hospitals - i.e. direct referrals from receptionists to doctors for survivors. - SGBV TF to share a standard checklist/criteria to assess facilities for inclusion in referral pathway instead of in person visits. - Need to strengthen the referrals by non-traditional actors. CMR related updates to be regularly circulated across different sectors. - Establish information sharing mechanism between GBV Case Management Agencies providing CMR trained facilities.

- Lack of awareness among case managers about trained and active CMR facilities. Case Managers and case management agencies rely on the SGBV referral pathway document; the list of CMR trained facilities is not reflected in the document and not regularly updated.	
Reporting - MoPH circular regarding mandatory reporting was shared with facilities as well as the HWG; however hospitals are not being compliant which needs the further attention by the MoPH. - No updates shared on CMR trained staff availability at the facility level (in case of absence or staff turnover). - Health WG and SGBV TF do not have the jurisdiction over public facilities (PHCs or hospital) to be able to follow up or report on the quality of services. - No system for tracking consumption and expiration of PEP kits. - The untrained doctors at a CMR facility do not know about the CMR management pathway inside the facility (who to refer, where to report etc.)	**Reporting** - Establish a reporting system to provide CMR facility based data – e.g. Monthly reports including # of cases referred to a case management agency, # of cases received PEP kit, # of CMR cases etc. - Advocate with MoPH for establishment of an M&E system, beneficiary feedback and complaint mechanism and reporting lines for CMR facilities to improve accountability and transparency. - Health and GBV actors implement facility based research to assess data sharing procedures within the CMR facilities. - Advocate with MoPH for reviewing ToRs of the field coordinators to also become the focal points to follow up on CMR issues and reporting to the MOPH and CMR Task force.
Community Awareness / Outreach - Survivors are reluctant to access CMR services because of the fear losing their privacy and protection of data. - Limited understanding by the community on the importance of available CMR services - Stigmatization of SGBV survivors among communities. - Cases do not present within the 72 hours window of CMR services.	**Community Awareness / Outreach** - All community based awareness raising sessions should include CMR key messages (including for men and boys) - Use mass and social media to reach out a wider population with messages related to CMR. - Advocate with SGBV agencies to do focused programming for men and boys.
Coordination/Communication	**Coordination/Communication**

- Many primary health care facilities and not aware of CMR services in their respective areas. - Gaps exist in coordination and information sharing across health and GBV partners/stakeholders. - No IEC materials shared regularly. - Case managers not always aware of the full process of CMR as well as the basic actions and messaging related to CMR. - Juvenile judges are not aware of availability of CMR centers.	- Disseminate updated information on CMR across SDCs and other safe spaces - Dissemination of CMR services and referral pathways IEC material to PHCs, SDCs, ISF as well as other sectors. - Improve coordination and sharing of information/materials between SGBV actors and medical facilities.
Cost - Transportation fees is one of the factors for survivors not accessing CMR services. - No coverage of fees for Lebanese and non-Lebanese (non-refugees – example Migrant workers). This includes the consultation cost of the physician and forensic doctor. - Unavailability of resources to provide comprehensive services at CMR facility increases the out of pocket cost of the beneficiary and poses threats to breach in confidentially. - The cost related to CMR services may vary from one health facility to another depending on the number of diagnostic tests requested. - If survivor does not go through emergency admission for secondary care, issues with fee coverage have been reported.	**Cost** - Advocate with the MoPH for cost coverage of CMR services for Lebanese survivors. - Advocate with UNHCR to simplify the processes of admission to secondary care for survivors.

E. Group work - Action points for CMR services strengthening: After the presentations and coffee break, participants were then divided in to three groups to discuss a set of action points based on the findings and recommendations of the CMR health facilities assessment and the field level consultations. Each group was requested to work on several CMR services related themes and the below points are representative of each group's suggested action points regarding CMR services strengthening.

Group 1:

1. ***Geographical Accessibility & Security***
    - ✓ Covering all geographical gaps by having CMR health trained facilities, including Arsal, Hermel (North Bekaa, Labwe, Hasbaya, Shabaa, and others).
    - ✓ Sensitize ISF front liners and non-medical staff on CMR.
    - ✓ Have communication channels between SGBV coordinators and focal points from MoJ, MoPH and MoI to be used any time needed.
    - ✓ Advocate activities in relation to survivors who may have problem regarding their legal residence permit in the country.

2. ***Infra-Structure & Human Resources***

    - ✓ Include HIV rapid test in PEP kit protocol. Also to train staff on Voluntary and Counseling Testing (VCT).
    - ✓ IEC material available and accessible to all CMR trained medical staff at health facilities.
    - ✓ CMR trained staff (at least one) available at every working shift, and on Saturday and Sunday.
    - ✓ SGBV CM agencies to be trained on CMR – minimum package – as part of GBV SOPs – GBV core concepts
    - ✓ Have regular CMR refreshers for SGBV front liners, social workers and CMR care givers, to make sure information is always there and ready in their minds
    - ✓ Motivate CMR focal points by nominating them to attend some related trainings and coordination meetings where applicable.
    - ✓ Maintain regular meetings between SGBV front liners and CMR care givers to make sure they know each other and share contact details to be used any time this will be needed.

Group 2:

3. ***Culture***
    - ✓ Include in the curriculum of Medical/ paramedical schools introduction on SGBV (attitude, skills, and ethics).
    - ✓ Ensure that Policies and procedures for SGBV and CMR are present in the health facilities and that staff are provided refresher sessions.
    - ✓ Ensure that the recruitment of SGBV frontline staff considers their experience and background in SGBV.
    - ✓ Raising awareness using mass communication, Media.
    - ✓ Managers of the health centers activated for CMR should have an ownership of the program and the ambiance of the health facility should be welcoming and not discriminating against the survivors.
    - ✓ Supervision of trained staff should occur regularly.

- ✓ Staff care for those providing treatment and management of CMR, Peer to peer support and exchange of experience and best practices.
- ✓ Institutionalize CMR in residency courses &Training of university hospitals

4. ***Referral:***
   - ✓ Assessment of Health facilities trained and active for CMR.
   - ✓ M&E to be done regularly.
   - ✓ MoPH to take the lead of the program in order to ensure its sustainability.
   - ✓ Advocate to have detection and safe referral of SGBV and CMR as an important feature and recommendation to be included in the health facility essential package.
   - ✓ Ensure that health facilities trained and active for CMR to be able to refer to other needed services e.g. for MHPSS.
   - ✓ Improve relationship between the SGBV focal persons/front line staff and the care providers.
   - ✓ Advocating and working to increasing the self-referral to health facilities noting that efforts should be put in place in order that the attitude in the health facilities to improve towards supporting the survivors.
   - ✓ Providing information sharing and awareness using culturally appropriate tools and to be appropriate as well to the level of the served community (e.g. using photos).
   - ✓ MoPH to enroll a training to the PHC staff on the identification and safe referral of survivors- important entry points like midwives, pediatrician, gynecologist/obstetrician to be considered.
   - ✓ Lebanese Order of Midwives to include SGBV in the midwifery curriculum in order to sensitize the latter on the screening and the latter to gain attitude that makes the survivor to be trustful and confident to talk

5. ***Reporting***
   - ✓ Establish a reporting system to provide CMR facility based data – e.g. Monthly reports including # of cases referred to a case management agency, # of cases received PEP kit, # of CMR cases etc.
   - ✓ Advocate with MoPH for establishment of an M&E system, beneficiary feedback and complaint mechanism and reporting lines for CMR facilities to improve accountability and transparency.
   - ✓ Health and GBV actors implement facility based research to assess data sharing procedures within the CMR facilities.
   - ✓ Advocate with MoPH for reviewing ToRs of the field coordinators to also become the focal points to follow up on CMR issues and reporting to the MOPH and CMR Task force.

Group 3:

6. ***Community awareness***
    - ✓ Develop a communications strategy & advocacy strategy – CMR TF & SGBV TF to work together
    - ✓ Develop more specific and culturally acceptable key messages – CMR TF & SGBV TF to work together.
    - ✓ Disseminate updated information on CMR available services across SDCs and other safe spaces
    - ✓ Develop a community-friendly poster for CMR, to be put at hospitals and PHCs, to show the phone number, or the extension number, of the CMR focal person at the CMR trained health facility.

7. ***Coordination/communication***
    - ✓ Dissemination of CMR services and referral pathways IEC material to PHCs, SDCs, ISF as well as other sectors.
    - ✓ Regularly circulate the forensic doctors' schedule shared by UNHCR with all CMR facilities and SGBV TF members.
    - ✓ Coordination and communication strengthened among SGBV front liners and CMR focal points within a given geographical area through a monthly platform – CMR to be as one of the agenda points in SGBV and HWG meetings at field level.

8. ***Cost***
    - ✓ Work on eligibility criteria to be proposed to MoPH for Lebanese survivors to be covered for CMR services related cost.
    - ✓ Lebanese order physician – Discuss the possibility of a circular by MoPH for the Lebanese Order of physicians for cost reduction or omission for CMR survivors.
    - ✓ Assess cost of service per beneficiary (Lebanese)/actual cost of service.
    - ✓ Secondary care through Nextcare – Meet UNHCR secondary health care services to discuss entry points, challenges and way forward.