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Review Article

Acute Management of Rape Survivors in Lebanon: Overview and Challenges

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ABSTRACT

The management of survivors of rape in the Lebanese healthcare setting remains ambiguous. National initiatives have been established to train first-line responders to provide adequate care for these survivors; however, management often remains suboptimal. This article explores current practices and challenges faced in the management of survivors of rape and proposes recommendations for the advancement of care in this setting.

Key words: Middle-East, Arab, women, sexual violence, sexual assault, SANE

INTRODUCTION

In Lebanon, 18% of reported cases of gender-based violence involve incidents of sexual violence, of which 8% are rape.[1] Rape is an act of violence that usually involves some form of sexual penetration carried out without a person's consent.[2] While physical force is stereotypically used, rape may also be carried out by abuse of authority or coercion. There are several subtypes of rape, including acquaintance rape, date rape, statutory rape, and marital rape.[3] Common to all is the lack of consent.

Rape survivors may suffer from medical and psychosocial consequences that include HIV infection, unwanted pregnancy, post-traumatic stress disorder, depression, anxiety, isolation and shame, all of which increase the risk of suicide among survivors.[4-7] Optimal management of rape cases minimizes the physical, emotional and social adverse effects of the assault.[8-11] As there is still no international consensus on the optimal acute care for rape victims, each country may adopt a set of standardized evidence-based recommendations adapted to its own contextual reality.[12] In the United States, for example, the Sexual Assault Nursing Examiner (SANE) training was developed by first-line respondents in the 1970's and acted as a milestone in the management of survivors of rape.[8]

In many countries, the medico-legal processes and services available to rape survivors remain flawed in many ways, with minimal standards of effective care yet to be achieved.[13] Recognizing this gap, several nations such as Canada, Iceland, Finland and Norway have created specialized centers that cater to the needs of rape victims using unified protocols for the systematic collection of forensic evidence and the appropriate clinical treatment of survivors.[8,14] On the international humanitarian front, the UNFPA has developed a Clinal Management of Rape protocol, in collaboration with the World Health Organization (WHO) and United Nations High Commission for Refugees (UNHCR), providing major guidance for the management of survivors, particularly in low-resource settings and among displaced populations.[15]

In Lebanon, there are no clear national protocols to delineate a standard clinical approach to survivors of rape. Rape management training is, at best, inconsistent, limited or absent in undergraduate and postgraduate medical education; and none of the 18 nursing programs offers a course in forensic nursing, further highlighting the lack of expertise in the field.[16] This paper elucidates challenges to the acute management of survivors of rape in Lebanon and the current efforts taking place to meet those challenges and provides some recommendations to

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improve the care for survivors.

BARRIERS TO THE USE OF MEDICO-LEGAL SERVICES BY SURVIVORS OF RAPE

The quality and availability of clinical care for survivors of rape is tightly linked to the social and legal context in which such care is embedded. It is hence important to consider first the barriers that survivors may face in seeking medico-legal services.

Victim-blaming attitudes, which are pervasive in Lebanese society, constitute the first obstacle that prevents survivors of rape from seeking healthcare and from reporting cases to authorities.[17-18] Three major constructs distort the local perception of what qualifies as rape: the limitation of rape only to acts of physical coercion, the notion that rape is mostly an assault from a perpetrator previously unknown to the victim ("stranger rape"), and that marital rape is limited to "arranged" marriages.[17] These beliefs lead to increased stigma and disregard to many cases that qualify as rape under international law.[17-18]

The Lebanese Penal Code closely reflects the predominant societal understanding of rape, benefiting perpetrators over victims. It restricts the definition of rape to an act of "forced sexual intercourse with someone who is not one's wife by violence or threat" (article 503), which explicitly excludes marital rape, mental or social coercion, and acts against male individuals. In addition, article 522 allowed perpetrators to go free if they married their victims and was only abolished in 2017.[19] While a law was recently passed criminalizing sexual harassment in December 2020 and acts as a major milestone in the securement of women's rights and protection, it is vaguely phrased and prone to misinterpretation.[20]

It is crucial that the legal framework around rape is modified to optimize access to criminal justice as well as positive judiciary outcomes, while protecting the confidentiality and autonomy of rape survivors. A narrow definition of what constitutes "rape" excluded up to 40% of sexual assaults in the United States over a 20-year period[21], and rape legislation reforms have been shown to increase rape reporting worldwide.[13,22] This highlights the importance of legislative reforms in improving the utilization of medico-legal services. Recommendations published by the activist KAFA organization and the International Commission of Jurists, which propose a broader and more systematic legal framework in the penalization of gender-based violence and sexual assault against women, can be used to revise the current legislation.[23-24] Also, given the widespread misbeliefs around rape and the subsequent need for preventative efforts to curb the burden of rape in Lebanon, the adoption of laws and policies that tackle rape as a public health problem rather than a mere crime would best be suited to address the various dimensions of rape and sexual violence.[25]

Additional barriers include misinformation among front-line healthcare workers, such as the belief that reporting of rape cases is mandatory. While the law does not mandate reporting of cases of rape detected in healthcare settings, and the Medical Code of Ethics only obligates reporting of cases of rape on minors, healthcare workers inconsistently report cases involving adults irrespective of the victim's consent. These are complicated matters, particularly where the rapist is not a total stranger, but one who is related to the victim. This greatly deters rape survivors from presenting for medical care. It is hence essential to renew efforts to raise awareness among first-line respondents and the public around the autonomy and confidentiality of rape survivors and their right to seek medical care without choosing to press charges.

BARRIERS TO REPORTING BY FRONTLINE PRACTITIONERS

In a context where forensic doctors hold the "exclusive legal right to present forensic evidence to criminal court," front-line practitioners will continue to defer the forensic exam to the forensic doctors. This deferral trend is compounded by the time commitments of court hearings and depositions that will follow reporting by frontline doctors. Unless this is accounted for, practitioners will continue to be reluctant to take on this role even with the right training. The legal framework also would need to be adjusted to authorize and protect front-line providers for this to be an effective, sustainable practice.

CURRENT PRACTICES IN THE ACUTE MANAGEMENT OF RAPE SURVIVORS

National guidelines for the medical care and

medicolegal management of rape survivors are lacking and are currently physician-dependent. First-line responders were reported to have difficulties identifying cases of rape survivors, who often present with vague and nonspecific complaints. The frequency of cases of rape detected at a secondary care center in North-Lebanon increased following adequate training of the emergency staff, based on interviews with emergency medical staff at the center. Facility-level training and implementation of protocols have also been shown to significantly improve the management of rape survivors, further underlining the need to scale up efforts.[11] Nevertheless, the absence of a comprehensive framework beyond the hospital may undermine the impact of such training, as healthcare providers would remain incapable of counseling patients about their options with regards to reporting, financial coverage, and subsidized long-term follow-up. It is hence important that the Ministry of Public Health (MoPH) adopts and disseminates unified medical, legal, social, and psychological guidelines at first-line points of care. Such guidelines would then be implemented at the hospital level and would allow for a proactive training of staff at any health center. A complementary updated list or map of all centers that provide accessible and affordable psycho-social follow up would also be helpful for referral and follow-up of survivors.

Physicians authorized to investigate forensic cases under Lebanese laws, hereafter referred to as "forensic physicians," can be called to the ED in case a victim decides to press charges. In Lebanon, there is currently no published evidence or standards to demonstrate consistency in the forensic training of these forensic physicians or that any of them has received proper medicolegal rape examination and management. Yet, they retain the exclusive legal right to present forensic evidence to criminal court. Forensic physicians physically examine the patient and document all findings for a potential court order. They may also collect specimens for DNA testing, which could be compared to a growing database of DNA collected from individuals arrested in recent years. However, due to the lack of proper facilities for storage, a rape survivor may not access or secure the proper retrieval of forensic evidence for future prosecution if deferred at the present time.

The number of court-appointed forensic physicians remains insufficient. Those doctors are most often primary health care practitioners (e.g., family medicine physicians, obstetricians, gynecologists or general practitioners) who have obtained a diploma or certificate in any forensic-related venue. Due to the lack of a clear and all-encompassing legal definition of rape, and insufficient training, many of these physicians limit their exam to the hymen, disregarding other physical exam findings pointing to assault. Understandably, there is concern among healthcare providers and activists that an "intact" hymen could have acted as grounds for the acquittal of rape, even when an assault has actually taken place with the intention to rape.

Low preparedness of first-line responders, corruption, and lack of competence have been noted to lead to suboptimal treatment of sexual and nonsexual assault cases in the judiciary system worldwide.[13,26] Bridging these gaps is essential to the improvement of the management of rape survivors. These challenges can be met through the introduction of formal training around forensic examination in medical and nursing schools. With formal training, health care practitioners may be allowed to collect and present evidence in court, slowly decreasing reliance on government-appointed forensic physicians, and minimizing associated costs, discomfort, and waiting times.

It is also important that police officers, who may be called to the hospital, approach rape survivors in an attentive and compassionate manner, all while presenting them with the options available to them and prioritizing their health and well-being. An NGO-led training program has been carried out once in a police station in Beirut, with the goal to improve the knowledge and practices of police officers regarding rape, but this first attempt was neither evaluated nor scaled up. To optimize the comfort and well-being of survivors at the first point of interaction with the legal system, multi-disciplinary standardized training sessions, must be provided to law enforcers addressing the approach to rape survivors. Continuity and sustainability of training efforts could be improved through a "training-of-trainers" approach, whereby an officer would be trained to train other personnel at each police station.

INITIATIVES TO IMPROVE THE MANAGEMENT OF SURVIVORS OF RAPE

In order to improve rape management in

Lebanon, the MoPH has partnered with a number of local and international NGOs such as the International Medical Corps, International Rescue Committee, and the local ABAAD organization, in addition to an on-going collaboration with the UNFPA and UNICEF. This taskforce mostly coordinates trainings on the Clinical Management of Rape (CMR) protocol in different health facilities including MoPH-certified primary health centers as well as governmental and private hospitals across all Lebanese districts. Facilities with large-enough healthcare teams and with the highest patient load were prioritized to receive the training first and to be provided with post-exposure prophylaxis (PEP) kits by the UNFPA.

The CMR protocol was developed by the WHO to address healthcare needs of refugees and internally displaced persons.[15] Physicians and nurses are trained to identify rape cases, offer medical management including the use of PEP kits for STI and HIV prevention, and call appropriate responders in case victims wish to press charges. Staff are also trained to refer their patients for free long-term medical and psychiatric follow-up at a number of health centers.

Unfortunately, the management of rape survivors, even in centers which have received the training, often remains suboptimal. While CMR training has been delivered to 43 facilities since 2013, only 19 facilities continue to make use of the training protocols and PEP kits, according to key stakeholders at the MoPH responsible for the oversight of primary health centers when interviewed by the authors. The efficacy of the training is hindered by staff turnover within medical facilities and the absence of follow up to guarantee its proper implementation. The lack of commitment from health center directors, trained provider retention and the absence of a clear database of available referral centers for long-term follow-up undermine this initiative as well. In addition, the fact that PEP kits are only available for a fee to non-Syrians constitutes a financial barrier for many survivors. The limited number of facilities with trained staff also restricts access to CMR services.

One way to mitigate these challenges would be through the implementation of a similar "training-of-trainers" approach, whereby a healthcare worker would be trained to train other personnel at each facility. This person would also follow-up on staff familiarity with the CMR protocol, use and availability of PEP kits, and would act as a liaison between the CMR taskforce and the hospital.

CONCLUSION AND SUMMARY OF RECOMMENDATIONS

Optimal management of rape cases minimizes the adverse physical, emotional and social adverse effects of the assault and clinical management is incomplete without integrated psycho-social, forensic and legal care.[11] Therefore, it is imperative to have a clear legal and medical framework at the national level that survivors of rape feel comfortable utilizing, as well as guidance to ensure comprehensive multi-disciplinary management at points of care.

International and local NGOs, in collaboration with the MoPH, have played a significant role in advancing the clinical care of rape survivors in Lebanon, particularly in humanitarian settings. Unfortunately, management remains inadequate and inconsistent across hospitals. High-level recommendations to improve the acute management of rape survivors in Lebanese healthcare settings include:

1. Adoption by the MoPH of unified medical, legal, social, and psychological guidelines at first-line points of care, using the WHO-developed CMR protocol as a template.
2. Reforming the legal framework regulating the definition and approach to sexual assaults in Lebanon to (a) delineate a universal, encompassing definition of rape, and (b) define and facilitate the process of reporting for front-line healthcare providers.
3. Using community messaging to reshape the societal construct around sexual violence and rape, and thus increase the willingness of survivors to seek care
4. Increasing awareness among first responders and the public around the autonomy and confidentiality of rape survivors and their right to seek medical care without choosing to press charges.
5. Generalizing mandatory CMR training to all frontline health practitioners, possibly by adding it to hospital accreditation and re-accreditation criteria. Implementation of this training would then become independent from the networking

capacity of the center and turn-over rate of its personnel. This also will require governmental support and financial resources to cover the initial provision and maintenance costs of training and certification, as well as any extra healthcare costs this may impose such as the reporting practitioners' time-commitment to participate in depositions and court hearings.

6. Introducing formal training around forensic examination in medical and nursing schools and ensuring that forensic doctors have received the proper training on all aspects of rape, to provide the best possible protection to survivors. While the benefit of such training will remain limited if appointed forensic physicians are the exclusive legally authorized individuals to report on cases of rape, efforts to decentralize medicolegal authority and responsibility will be potentiated when front-line healthcare providers are trained to support proper rape management protocols.
7. Securing the proper ethical and professional delivery of forensic evaluations and legal proceedings. This will include provision that limit any corrupt practices throughout the whole management of these cases.
8. Training law enforcement authorities to attend to rape-suspected survivors in an empathic and competent manner.
9. Adoption of a "training-of-trainers" approach, whereby a staff member is trained to train other personnel at a given facility to optimize continuity and sustainability of training efforts for both healthcare workers and law enforcers.

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