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Assessment of Clinical Management of Rape in Occupied Palestine

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Foreword

Sexual and gender-based violence, including rape, is a problem throughout the world, occurring in every society, country and region. In order to prevent and manage possible health consequences, rape survivors must have access to clinical care, including supportive counselling, as soon as possible after the incident.

Rape continues to be severely under-researched and under-attended to, across all service sectors including health. Rape victims/survivors continue to be confronted with exceptional socio-cultural and systems barriers; structural, procedural and attitudinal, that blocks their access to any type of services they may seek.

In order to develop effective response systems to gender based violence, a series of researches has been carried out in the last two years in Palestine, related to protection, health services, social and legal services provided to women survivors of violence.

This study is intended to shed light on the clinical services provided to women survivors of rape, where a high quality, gender-sensitive, timely and accessible health and legal response is needed.

We hope that the study will stimulate an enthusiastic discussion among policy makers on how to build the national capacity for better response to the issue of clinical management of rape based on the findings and the recommendations of this study.

Special thanks go to all health service providers and health institutions that responded and cooperated during this study either through individual interviews, discussion in focus groups or filling out the research form.

It is our honour to extend our thanks and gratitude to our International partner; UNFPA and the Government of Denmark for providing the financial and technical support to PMRS for the completion of this study.

Dr.Khadija Jarrar,
Director of Women's Health Program/PMRS

Executive Summary

Rape remains a taboo in Occupied Palestine and the region. Although distantly touched on in some studies within acceptable social and cultural wrapping and naming, it has never been addressed from the health services perspective. Rape victims/survivors still face exceptional socio-cultural structural, procedural and attitudinal and systems barriers, which block their access to any type of services available.

Hence, this pioneer study aims to investigate rape from the perspective of health service provision, focusing on the assessment of the availability of services for clinical management of rape (CMR) in the healthcare facilities in occupied West Bank including East Jerusalem and Gaza Strip.

This assessment utilizes a descriptive cross-sectional mixed-method approach to address CMR. The target population is at the micro level; thus, a purposive sample was selected from the health sector service providers operating at the primary and tertiary healthcare levels. At the macro policy and strategic levels, expert opinion was solicited through semi- structured interviews with selected stakeholders in the areas of healthcare, social services, women rights, justice system and donor agencies. In the quantitative part, two data collection instruments were used: a questionnaire targeting frontline staff at the primary and tertiary service provision where a total of 96 individuals participated and a health facility checklist whereby a total of 19 service facilities administered the checklist examining the facility readiness to provide survivors with CMR services. As for the qualitative part, stakeholder sampling was used to select a best-fit 22 informants and experts who were interviewed for the two regions of the West Bank including East Jerusalem and Gaza strip.

Frontline clinical staff including senior and junior doctors, nurses and midwives working in direct contact with the service users in the selected departments of the identified health facilities namely Emergency Department (ED) and Obstetrics and Gynaecology wards were targeted. Around 42% of the respondents were doctors, over half of whom were females. An equal number of 24 nurses and midwives, each, participated in the study. Overall, women constituted around three quarters (74%) of the study respondents.

One fifth (21%) come from government clinics compared to a little more than one tenth (12%) from the none-governmental organizations (NGOs). This means that more than the half (51%) come from government professional staff, which implies that responses are notably indicative of CMR survivors' situation in government health facilities. Additionally, data on CMR for East Jerusalemite girls and women hold the weight of 33% of the responses flow.

Study findings show that more than a quarter of the study participants (25 out of 96) reported having offered post-rape care to a rape survivor during the last year in the studied facilities This is bearing in mind that raped girls and women choose to go to private hospitals for CMR, when they can, to ensure secrecy and minimum social visibility for family reputation protection. However, slowly and gradually changes are being observed in some major hospitals such as the Ramallah Medical Complex and Beit Jala Government Hospital where rape victims show up on monthly bases for CMR and referred cases are handled with respect and confidentiality. This was reported and noted to be linked to tangible improvements in the quality of the CMR service on offer, especially in terms of staff attitudinal and competence development. None-universality of this progress was marked by interviewed key informants.

UNRWA was found to be running a unique community and family based model in addressing GBV making use of its health and psychosocial program with the exclusion of sexual violence including rape, referring victims to MOH hospitals right upon presentation.

No policy framework for CMR exists anywhere. Although the majority of the examined health facilities reported availability of written medical protocol on CMR, interviewed experts were expressively cognizant of the lack of a uniformed approach or SOP about sexual violence including CMR survivors in Palestine and asserted that clinicians handle rape cases at a very narrow scale.
Key informants repeatedly confirmed that virginity examination is still the most commonly sought rape-related service due to its tight connection to the concept of honour in the Palestinian society.

It was found that rape survivors were offered available CMR services in healthcare facilities existent across the two regions and different parts of Gaza Strip and West Bank including East Jerusalem. As noted in the interviews, rape survivors seek rape related services in facilities located outside the population catchment area of their place of residence to avoid encountering people-

including healthcare providers- who might know them to keep secrecy of the rape occurrence. Study participants from East Jerusalem (36%), sequentially followed by South West Bank (24%) and mid Gaza Strip (16%) reported highest numbers of CMR survivors in the health facilities where participants work.

Participants reported having provided the following CMR services: documentation of injuries and injury treatment, referral to other institutions, psychosocial support, pregnancy test (in case of delayed rape reporting) & contraceptives provision as applicable, evaluation for STIs, and basic forensic evidence collection. No other crucial CMR service components were mentioned by any of the participants such as post-exposure prophylaxis (PEP) of HIV, tetanus or hepatitis B preventive care.

Participants' knowledge about selected aspects of CMR was found pretty poor. Unfavourable responses mounted up to 54%- 66% and did not fall below 42% of the responses at best. Statements that addressed communication skills to deal with the rape victims, safe environment for providing the victim with rape-induced services, and objective documentation of examination results received the poorest responses.

Interviewed experts expressed their willingness and readiness to work on a full CMR package that will operate in parallel across intervention levels: policy, law, service infrastructure (clinical & physical), staff capacity building and community awareness and sensitization. Some particularly went beyond the service sectors and expressed genuine concern about absolute public ignorance of the importance and conditions for the acceptability of forensic evidence as a proof of rape occurrence in court, for example.

Data on providers' capacity building in CMR revealed a modest number of the attended training activities altogether standing at around 20% participation rate at best, with sporadic coverage of CMR subject areas and almost absolute neglect of some such as collection of basic forensic evidence. In addition, participants voiced concerns about the quality of the received training including the expertise and competence of some trainers and the constantly insufficient use of training guides or curriculum.

Informants reported with recognition the later UNODC work on sexual violence, including rape, with special emphasis on workforce capacity building in forensics being it in the formation of forensic medicine specialists or on-the-job training of nurses in basic forensic evidence collection or GBV SOP

development. Yet they also voiced concern over regional, infrastructural, perceptual and attitudinal, as well as operational impediments that hinder utilization of the recently made available resources and national assets in this crucial area.
Participants were asked about their CMR-related training needs. The majority (50% and above of the full sample) expressed their need for sound referral systems as part of the services provided, mainly with respect to referral process, mechanisms, pathways and follow-up. A smaller majority wished to receive training on collection of basic forensic evidence and risk assessment and treatment of STIs, without any significant differences between professions.

Analysis of providers' attitudes toward rape showed high acceptance of rape myths. This affects their response to the needs of rape survivors who seek healthcare services at the institutions where they work, and sheds light on this area as a training priority.

In connection, informants particularly noted the futility of the medical report rape victims receive based on the clinical examination and treatment they receive in CMR facilities, mainly because of attitudinal, competency, and safety challenges physicians experience when treating rape survivors. On the one hand, many male physicians are unable to empathize with a raped girl or woman. On the other hand, they are clinically incompetent and/or fear the revenge of the perpetrator when it comes to the medical report contents in the absence of any form of protection for medical doctors in specific, and all other health service providers in general.

Assessment covered CMR facilities' infrastructures, checking furniture, settings, basic and advanced supplies with a special focus on forensic evidence collection kit/supplies, drugs and administrative supplies.

As for furniture or setting, specific items as defined by international guides and protocols for standard practice of CMR (WHO and UNHCR, 2004) were observed. Out of the 19 facilities examined in the two regions of West Bank including Jerusalem and Gaza Strip, there was no single facility that fully met the standards as stated in the globally adopted CMR protocol. This is although some of them are among the minimum requirements for examination and treatment of a rape survivor by the said protocol. The most frequently missing items were magnifying Glass (Colposcopy), and weighing scale and height chart for children.

Most basic supplies were available in the majority of the examined facilities. However, alarming deficiency was registered for resuscitation equipment, which is missing in 7 locations while sanitary materials were found missing from 4. Since such equipment represents the minimum requirements for examination and treatment of rape survivors by WHO and UNHCR standards (2012), legitimate questions arise as to the extent of basic readiness of the studied and unstudied facilities by extension. Data on advanced supplies also show that the readiness level for forensic evidence collection in the studied facilities is currently poor and so calls for an upgrade of the studied facilities clinical infrastructure.

Around two thirds of the studied facilities were hospital settings. Findings showed that 62% of the facilities that responded to this question reported drugs "for treatment of STIs" to be unavailable. In addition, out of 16 responding institutions, 9 reported lack of emergency contraceptive pills (ECPs). Many drugs were also lacking with the exception of antibiotics for wound care and local anesthetic for suturing and pain relievers. Still, alternative treatments ae available to give to survivors.

While almost all items identified under administrative supplies are considered minimum requirements for examination and treatment of a raped survivor, their absence in a considerable number of the studied facilities suggests poor quality rape treatment in these facilities, when provided. Almost all identified items are documentation-related, which has legal and judiciary significance for the survivor if she chooses to file a court case against the perpetrator. Indeed, lack of proper documentation places the victim's human rights in real jeopardy on the hands of the duty bearers. This undermines the victim's human rights and access to help from duty bearers.

Based on these findings, the study concludes that in order to provide raped survivors with the full CMR service package the following areas of action are recommended: • Sensitize policy makers about the National Referral System for Women survivors of violence
• Develop uniformed CMR protocol
• Improve rape service delivery
• Strengthen the health workforce
• Strengthen infrastructure and availability of supplies
• Organize community education and awareness raising activities
• Strengthen evidence focusing on collection and use of data on rape and CMR, ensuring close monitoring and evaluation of the quality of these data.

الملخـص التنـفيذي

ما زال الحديث عن قضايا الاغتصاب من المحرمات في فلسطين المحتلة والمنطقة. ورغم تطرق بعض الدراسات لهذا الموضوع الشائك عن بُعد في إطار تغليفات ومسميات مقبولة اجتماعياً وثقافياً، إلا أن ذلك لم يحدث من منظور الخدمات الصحية الواجبة. وتظل ضحايا/الناجيات من الاغتصاب يواجهن حواجز اجتماعية- ثقافية ونظامية استثنائية؛ بنيوياً وإجرائياً ومواقفياً، تحول جميعها دون وصولهن إلى أي نوع من الخدمات التي قد يسعين اليها.

وبالتالي، فإن الغرض من هذه الدراسة الرائدة هو البحث في موضوع الاغتصاب من منظور تقديم الخدمات الصحية، وتحديداً تقدير مدى توفر خدمات الإدارة السريرية للاغتصاب في القطاع الصحي، وذلك باستهداف مرافق الرعاية الصحية في الضفة الغربية بما فيها القدس الشرقية وفي قطاع غزة.

يستخدم هذا البحث المنهج الوصفي ذا المقاربات المقطعية مختلطة الأسلوب في تناول موضوع الإدارة السريرية للاغتصاب. وعلى المستوى الدقيق من الفئة المستهدفة ، فقد تم اختيار العينة القصدية بشكل أساسي من القطاع الصحي وتحديدا من مقدمي الخدمات الذين يعملون على مستوىالرعاية الصحية الأولية والثانوية.

أما على المستويات السياساتية والاستراتيجية الكلية، فقد التمست الباحثة رأي الخبراء من خلال مقابلات فردية شبه منظمة مع أصحاب المصلحة المختارين من مجالات الرعاية الصحية، والخدمات الاجتماعية، وحقوق المرأة، ونظام العدالة، والجهات المانحة. وعلى الجانب الكمي، لجأت الدراسة إلى أداتين: الأولى شملت استبيان استهدف العاملين ضمن الخطوط الأمامية في الرعاية الأولية والثانوية وشاركت فيه عينة قوامها 96 شخصًا. أما الأداة الثانية فكانت عبارة عن قائمة رصد للمرفق الصحي حيث طُلب من 19 مرفق خدمات صحية تعبئة القائمة التي تدرس جاهزية المرفق لتزويد الناجيات بخدمات الإدارة السريرية للاغتصاب. وفي البحث النوعي، سحبت الباحثة عينة من أصحاب المصلحة، واختارت مجموعة من 22 خبيرا من بين الأكثر ملاءمة لإجراء المقابلة في كل من الضفة الغربية بما فيها القدس الشرقية وقطاع غزة.

وضمت العينة بشكل محدد الموظفين السريريين في الخطوط الأمامية لتقديم الخدمة من كبار الأطباء، والأطباء المبتدئين والممرضات والقابلات العاملات على اتصال مباشر بالمنتفعات/ين من الخدمات في الأقسام المختارة من المرافق الصحية المنتقاة، وهي: أقسام الطوارئ وأقسام النسائية والتوليد. واشتمل المجيبون على 42% من الأطباء، أكثر من نصفهم طبيبات، وشارك عدد متساوٍ من الممرضات والقابلات، ما بلغ عدده 24. وشكلت النساء المشاركات قرابة 74% من إجمالي عينة الدراسة.

وتأتي نسبة الخمس (21٪) من العيادات الحكومية مقارنة بأكثر قليلاً من العشر (12٪) من المنظمات غير الحكومية. وهذا يعني أن أكثر من نصف العينة (51٪) آتية من الموظفين الحكوميين المهنيين، ما يعني أن الاستجابات تشير بشكل ملحوظ إلى حالة الإدارة السريرية للناجيات من الاغتصاب في المرافق الصحية الحكومية.. هذا وشكلت البيانات الخاصة بالإدارة السريرية للناجيات من الاغتصاب في القدس الشرقية ما قيمته 33% من إجمالي الإجابات.

أظهرت نتائج الدراسة أن أكثر من ربع المشاركين في الدراسة (25 من أصل 96) قدموا رعايةما بعد الاغتصاب إلى إحدى الناجيات من الاغتصاب خلال العام الماضي في المرافق المدروسة. هذا مع الأخذ في الاعتبار أن الفتيات والنساء المغتصبات يملن إلى الذهاب إلى المستشفيات الخاصة لتلقي خدمات الادارة السريرية للاغتصاب، لكما أمكنهم ذلك؛ لضمان السرية والحد الأدنى من الملاحظة الاجتماعية لحماية سمعة العائلة. ومع ذلك، لوحظت تغييرات بطيئة وتدريجية في بعض المستشفيات الكبرى مثل مجمع رام الله الطبي ومستشفى بيت جالا الحكومي حيث اصبحت الضحايا تصل بشكل شهري وتتلقى خدمات الادارة السريرية للاغتصاب، ويتم التعامل مع القضايا المحالة باحترام وسرية تامة. وقد تم الإبلاغ عن هذا وأُشير إلى أنه يرتبط بالتحسينات الملموسة في جودة خدمة الادارة السريرية للاغتصاب المقدمة للناجيات خاصةً فيما يتعلق بتطورات جلية في مواقف وتوجهات وكفاءات مقدمي الخدمة، الا ان شمولية هذا التقدم في المرافق الحكومية الأخرى لم تتحقق بعد وفقا للخبراء الذين تمت مقابلتهم. وقد وجد أن الأونروا تدير نموذجًا فريدًا مبني على المجتمع المحلي والأسرة في معالجة العنف القائم على النوع مستخدمة برنامجها الصحي والنفسي الاجتماعي مع استبعاد العنف الجنسي بما في ذلك الاغتصاب وإحالة الضحايا إلى مستشفيات وزارة الصحة فور وصولها.

عموما، لا يتوفر إطار سياساتي للإدارة السريرية للاغتصاب في أي مكان. ورغم إفادة غالبية المرافق الصحية المفحوصة بتوفر بروتوكول طبي مكتوب حول الموضوع، إلا أن الخبراء الذين تمت مقابلتهم كانوا على دراية بعدم وجود نهج منتظم أو دليل اجراءات موحد حول العنف الجنسي بما في ذلك بشأن الناجيات من الاغتصاب، وأكدوا أن الأطباء يتعاملون مع حالات الاغتصاب على نطاق ضيق للغاية. كما وأكدوا ايضاً أن فحص العذرية لا يزال الخدمة الأكثر طلبا/شيوعاً المتعلقة بالاغتصاب بسبب ارتباطه اللصيق بمفهوم الشرف في المجتمع الفلسطيني.

وقد تبين أن الناجيات من الاغتصاب قد تلقين خدمات الادارة السريرية للاغتصاب في مرافق الرعاية الصحية الموجودة في المنطقتين والأجزاء المختلفة من قطاع غزة والضفة الغربية بما في ذلك القدس الشرقية. وكما ذكر في المقابلات، تسعى الناجيات من الاغتصاب إلى الحصول على خدمات متعلقة بالاغتصاب في منشآت تقع خارج مناطق سكناهن لتجنب مواجهة الأشخاص - بما في ذلك مقدمي الرعاية الصحية - الذين قد يعرفونهن للحفاظ على سرية حدوث الاغتصاب. وأفاد المشاركون في الدراسة من القدس الشرقية (36٪)، وتبعهم بشكل متتابع جنوب الضفة الغربية (24٪) ووسط قطاع غزة (16٪) بأعداد كبيرة من الادارة السريرية للاغتصاب في المرافق الصحية التي يعملون فيها.

وتحديدا، فقد أفاد المشاركون بأنهم قدموا الخدمات الآتية للناجيات من الاغتصاب: توثيق الإصابات ومعالجتها، والتحويل إلى مؤسسات أخرى، والدعم النفسي -الاجتماعي، واختبار الحمل (في حالة تأخر الإبلاغ عن الاغتصاب)، وتوفير وسائل منع الحمل حسب الاقتضاء، وتقييم الحالة بشأن الأمراض المنقولة جنسياً، وجمع الأدلة الجنائية الأساسية، فيما لم يأت أي من المشاركين على ذكر تقديمه لأي من مكونات خدمات الادارة السريرية للاغتصاب الأخرى مثل الوقاية ما بعد التعرض المحتمل لفيروس نقص المناعة البشرية والكزاز أو التهاب الكبد الوبائي "ب".

ومن ثم فقد تبين ضعف معرفة المشاركين بجوانب مختارة من الادارة السريرية للاغتصاب. وقد بلغت الردود غير المواتية، اي سلبية الدلالة، نسبة تتراوح بين ٪54 - ٪66 ولم تقلّ عن ٪42 من الردود في أحسن الأحوال. وظهرت أدنى نسبة في العبارات التي تناولت مهارات الاتصال للتعامل مع ضحايا الاغتصاب، والبيئة الآمنة لتوفير الخدمات المتأتية عن الاغتصاب للضحية، والتوثيق الموضوعي لنتائج الفحص.

وعبّر الخبراءالذين تمت مقابلتهم عن استعدادهم وجاهزيتهم للعمل على رزمة كاملة للإدارة السريرية للاغتصاب التي يجب أن يجري العمل عليها بالتوازي ضمن مستويات التدخل في مجالات السياسة، والقانون، والبنية التحتية للخدمات (السريرية والفيزيائية)، وبناء قدرات الموظفين، وخلق الحس والتوعية المجتمعية. فيما ذهب البعض لأبعد من القطاعات الخدمية بحد ذاتها بالإعراب عن قلق حقيقي إزاء الجهل العام المطلق بشأن أهمية وشروط قبول الأدلة الجنائية كدليل على حدوث الاغتصاب في المحكمة، على سبيل المثال.

وكشفت البيانات المتعلقة ببناء قدرات مقدمي الخدمات في مجال الادارة السريرية للاغتصاب عن عدد متواضع من أنشطة التدريب التي حضرها المشاركون، وهي تقف في حدود 20 بالمائة في أفضل الحالات، مع تغطية عشوائية لبعض المواضيع في مجال خدمات الادارة السريرية للاغتصاب، والإهمال التام تقريبا لبعضها الآخر من قبيل جمع الأدلة الجنائية الأساسية، على سبيل المثال. وبالإضافة إلى ذلك، فقد أعرب المشاركون عن قلقهم بشأن جودة التدريب الذي تلقوه، بما في ذلك خبرة وكفاءة بعض المدربين وعدم استخدام أدلة التدريب أو المناهج الدراسية في كافة التدريبات تقريبا.

وأشاد المشاركون في الدراسة بإنجاز مكتب الأمم المتحدة المعني بالمخدرات والجريمة (UNODC) بشأن العنف الجنسي بما في ذلك الاغتصاب، مع التركيز بصفة خاصة على بناء قدرات القوى العاملة في مجال الطب الشرعي سواء من خلال بناء كادر اختصاصيي الطب الشرعي أو التدريب أثناء العمل للممرضات في مجال جمع الأدلة الجنائية الأساسية أو في إطار انتاج دليل إجراءات العمل الموحد حول العنف المبني على النوع، ولفتوا الى وجوب البناء عليه. غير أنهم أيضا أعربوا أيضا عن قلقهم إزاء العوائق المناطقية والبنى التحتية والإدراكية وفي المواقف والعمليات التي تعرقل استخدام الموارد والاستفادة من الأصول الوطنية التي اصبحت متاحة مؤخرا في هذا المجال المهم.
سُئل المشاركون عن حاجتهم التدريبية في خدمات الادارة السريرية للناجيات من الاغتصاب. وكانت أعلى نسبة احتياج (50٪ وما فوق) في الجوانب المتعلقة بالتحويل وبالأخص فيما يتعلق بعملية التحويل بحد ذاتها والآليات المتبعة والمسارات والمتابعة. ويتبعها في ذلك موضوع جمع الأدلة الأساسية للطب الشرعي، وتقييم المخاطر وعلاج الأمراض المنقولة جنسياً دون أي فروق ذات دلالة بين المهن.

وقد عُنيت الدراسة في الكشف عن توجهات ومواقف مقدمي الخدمات الصحية من الاغتصاب، تحديداً في شكل قبول الأساطير الاجتماعية بشأنه. وقد أظهرت النتائج أن غالبية المشاركين في الدراسة لديهم نسبة قبول عالية لهذه الأساطير والمفاهيم النمطية حول الاغتصاب. وهذا يثير التساؤل حول شكل استجابة هؤلاء لاحتياجات الناجيات من الاغتصاب اللائي يسعين إلى الحصول على خدمات الرعاية الصحية في المؤسسات التي يعمل فيها المجيبون، كما انه يلقي الضوء على هذا المجال كأولوية في التدريب.

وفي جانب متصل، اشار عدد من الخبراءالذين تمت مقابلتهم بشكل خاص الى عدم جدوى التقرير الطبي الذي يتم اعطاؤه لضحايا الاغتصاب بناء على الفحص السريري والعلاج الذي يتلقونه في مرافق الخدمات الصحية. وقد ارجعوا ذلك الى تحديات تتعلق بالمواقف القائمة والكفاءة، وسلامة الأطباء المعالجين للناجيات من الاغتصاب، سيما وان العديد من الأطباء الذكور غير قادرين على التعاطف مع فتاة أو امرأة اغتصبت في المقام الأول. ليس هذا وحسب، بل إن كثيرا منهم يفتقرون إلى الكفاءة السريرية الكافية و/ أو يخشون انتقام الجاني منهم عندما يتعلق الأمر بمحتويات التقرير الطبي في ظل غياب كامل لأي شكل من أشكال الحماية لمقدمي الخدمة الطبية خاصة والصحية عامة.

وحول مدى جاهزية المرافق الصحية لتقديم خدمات الادارة السريرية للناجيات من الاغتصاب فقد ركزت الدراسة على فحص هذه المرافق خلال النظر في البنية التحتية المتاحة من حيث الأثاث أو الإعداد واللوازم الأساسية والمتقدمة مع التركيز على رزمة جمع الأدلة الجنائية ومستلزماتها، والأدوية، وأخيرا اللوازم الإدارية.

أما فيما يتعلق بالأثاث أو الإعداد، فقد رُصِدت بنود معينة على النحو المحدد في الأدلة والبروتوكولات الدولية بشأن الممارسة القياسية لخدمات الادارة السريرية للاغتصاب (منظمة الصحة العالمية ومفوضية الأمم المتحدة لشؤون اللاجئين، 2004). من بين المرافق الصحية التسع عشرة المفحوصة في منطقتي الضفة الغربية بما فيها القدس وقطاع غزة، لم يكن هناك مرفق واحد يلبي المعايير المطلوبة بشكل كامل وفق بروتوكول خدمات الادارة السريرية للاغتصاب المعتمدة عالمياً، هذا مع العلم ان بعض النواقص تقع ضمن الحد الأدنى من متطلبات فحص ومعاينة ومعالجة الناجي/ة من الاغتصاب حسب البروتوكول المذكور. واشتملت المعدات الناقصة على: الزجاجة المكبرة (التنظير المهبلي)، ومقياس الوزن للأفراد والرسم البياني المستخدم في قياس طول الأطفال.

وتتوفر معظم الإمدادات الأساسية في المرافق الصحية المفحوصة في الدراسة، ولكن القصور المسجل في معدات الإنعاش في 7 من هذه المرافق يدق ناقوس الخطر، وكذلك الأمر بالنسبة للنقص الحاد في المواد الصحية الخاصة بتنظيف الإصابات الجسدية في 4 من المرافق. ويذكر هنا أن هذه اللوازم تقع ضمن لحد الأدنى من متطلبات فحص الناجيات/ الناجين من الاغتصاب ومعالجتهن/هم حسب معايير منظمة الصحة العالمية، ومفوضية الأمم المتحدة لشؤون اللاجئين (WHO & UNHCR,2012) بهذا الخصوص. وهكذا تثير النتائج تساؤلات مشروعة حول جاهزية المرافق المدروسة وغير المدروسة لاستقبال الحالات، لا سيما وأن البيانات الخاصة بالإمدادات المتقدمة بينت ضعف بالغ في القدرة على جمع الأدلة الشرعية. وهذا يعني ضرورة ترقية البنية التحتية السريرية للمرافق الخدمية المعنية.

شكلت المستشفيات نحو ثلثي المرافق المدروسة.. وأظهرت النتائج أن 62 بالمائة من المرافق التي أجابت على السؤال تتوفر لديها الأدوية "لعلاج الأمراض المنقولة جنسيا"، كما أفادت 9 من أصل 16 مؤسسة بعدم توفر حبوب منع الحمل الطارئ. وافتقرت معظم المرافق المدروسة إلى جميع المواد الدوائية الأخرى، بخلاف المضادات الحيوية للعناية بالجروح والمخدر الموضوعي لقطبها ومسكنات الألم، وتلجأ هذه المرافق إلى تقديم علاجات بديلة للناجيات عند حضورهن لتلقي الخدمة.

تجدر الإشارة إلى أن البنود المذكورة تشكل الحد الأدنى من الإمدادات الإدارية المطلوبة لفحص ومعالجة الناجيات/ الناجين من الاغتصاب، وغيابها يعني تدني مستوى خدمات الاغتصاب المقدمة في هذه المرافق. وتكمن المشكلة في الخدمات ذات الصلة بالتوثيق لأهميتها القانونية والقضائية عند توجه الناجيات/ الناجين إلى تحريك دعوى قضائية ضد مرتكب الجرم، وهذا يعني المساس بحقوق الإنسان للضحية على يد الموكل إليهم واجب تقديم الخدمة في القطاع الصحي.

واستنادا إلى هذه النتائج، خلصت الدراسة إلى أنه من أجل ان يتوفر للناجيات/الناجين حزمة كاملة للإدارة السريرية للاغتصاب، يوصى بمجالات العمل والتدخلات الآتية:

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- تحسين خدمات الاغتصاب المقدمة.
- تعزيز القوى العاملة الصحية
- تعزيز البنية التحتية وتوافر الإمدادات
- خلق الحس والتوعية والتثقيف المجتمعي بشأن العنف الجنسي والاغتصاب
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This well-timed study appears as Palestine is witnessing unprecedented collaborative multi-sectoral national efforts and achievements with tangible political will and momentum to combat gender-based violence with utter dynamism and joint agency from all. In fact, it is this progressive climate that enabled us to embark upon researching the very sensitive taboo question of rape and address the right of rape survivors to services, understanding, compassion and support.

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Ayesha AlRifai
Principal Investigator

List of abbreviations

CMR:	Clinical Management of Rape
ECPs:	Emergency contraceptive pills
ED:	Emergency Department
HIV:	Human Immunodeficiency Virus
IAWG:	Inter-agency Working Group on Reproductive Health in Crises
MISP:	Minimum initial service package
MOH:	Ministry of Health
MOSD:	Ministry of Social Development
MOWA:	Ministry of Women Affairs.
NGOs:	None-governmental organizations.
NRSWSV:	National Referral System for Women Survivors of Violence
PCBS:	Palestinian Central Bureau of Statistics
PEP:	Post-exposure prophylaxis
PMRS:	Palestine Medical Relief Society
RH:	Reproductive Health
RMA:	Rape-myths acceptance
SOP:	Standard Operating Procedures
STIs:	Sexually transmitted infections
WHO:	World Health Organization
UNFPA:	United Nations Population Fund
UNHCR:	United Nations High Commissioner for Refugees
UNRWA:	United Nations for Relief and Works Agency.
UNODC:	United Nations Office on Drugs and Crime
VAW:	Violence against Women.

Introduction

World Health Organization (WHO) has recognized sexual violence as a major public health problem and a violation of human rights. Rape is one of the most severe forms of sexual violence that is defined as "physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape" (WHO, 2013). The vast majority of the severe forms of sexual violence take place at the home of either the victim/survivor or the perpetrator, which facilitates the full concealment and none-reporting of the event (UNODC, 2016).

Rape is also one of the most extreme expressions of the patriarchal drive toward masculine domination over the woman primarily perceived as the feminine body. Nevertheless, the victim can also be a man or a boy within a gendered relationship where that victim is the weaker party such as a male child, orphan, student, refugee or prisoner raped by an older family member, an inmate, a sustainer/caretaker or a teacher.

Although male rape is being reported more often than before, the majority of rape victims continue to be women (Suarez & Gadalla, 2010). International data indicate that male to male rape ranges between 5-10% of the total rapes annually (UNODC, 2016). This is compared with one in four women who may experience sexual violence by an intimate partner (WHO, 2013), and up to one-third of adolescent girls reporting their first sexual experience as being forced (UNICEF, 2014).

This all happens with perpetrators' awareness but disregard to the profound impact and damaging consequence such an atrocious experience has on the raped person's mental, emotional and physical wellbeing that leaves the victim with physical and emotional scars for life. As a matter of fact, the atrocity of the rape experience is one of the reasons why rape has always been and, sadly, continues to be used as one of the most vicious weapons in wars (Krug et al., 2002; WHO, 2013). Historically and ambivalently to date, man continues to use his sexuality the way he uses his gun to degrade, defeat, control, and possess the 'other', regardless of who he defines this 'other' to be (AlRifai, 2007), ironically starting with women and men of his own society and people, if and when desired, and ending with women and men of the farthest enemy in

the farthest spot of the planet. A well rounded understanding of gender-based sexual violence, including rape, acknowledges that women can also be the perpetrators in a sexual violence encounter when they are located in a power position in certain circumstances, despite rarity (UNODC, 2016).

In this study, raped girls and women are visualized and addressed as survivors and victims at the same time, because they are able to proceed with their lives despite all the agony and trauma of the rape experience. Yet, this does not negate the fact that they are victims of such crimes too. Therefore, the term victims and survivors is reciprocated with an emphasis on the empowerment of girls and women victims of sexual violence in a way that does not promote the concept of the dispossessed victims' will, eligibility, or efficacy.

Along the same line, this study observes that the detailed Standard Operating Procedures (SOP) Guide United Nations Office on Drugs and Crime (UNODC) developed on handling sexual violence and GBV recognizes that most individuals who are raped are girls and women compared with their male counterparts. However, except where the context dictates otherwise, use of male pronouns and gender neutral language and terms to refer to rape victims/ survivors characterize the guide. In some occasions gender insensitive terms were spotted such as in using "paternal" to imply "parental", for example. As informative as it is, subsequent prints of this reference document is deemed worthy of a careful gender examination for deliberate integration of gender sensitive language into the document that is meant to address a gender issue at the first place.

Background, Significance and Contexts

A key factor that shapes the outcome of rape is protection or the lack thereof. Numerous reports document that not only are rape victims/ survivors deprived of the protection they need and deserve but also they are harshly treated by their own families who get ostracized by society and ostracize the rape victim in turn. These families are faced with pressure and fear stemming from the norms that shame, stigmatize and blame the raped girls and women with humiliating allegations of seductive and improper wear and/or behaviours being responsible for the rapist "sexual desire provocation" and the occurring of sexual aggression against them (Al-Eryani et al., 2007; AlRifai 2007; Krug et

al., 2002; Sidawi, 2007). This is when many sources such as Coleman (2015) & UNODC (2016) for example, reiteratively emphasize that rape is not a crime of lust or eroticism. It is a crime of power, intimidation, and violence both emotional and physical.

Even worse, in some Arab states, laws prescribe that a rapist can evade punishment if he marries the victim (Haddad, 2017).
A World Bank report (2015) indicates that 37 countries around the world exempt rape perpetrators from prosecution if they are currently or subsequently married to the victim. Even when incest results in pregnancy, its termination by a clinically induced abortion is also illegal to date in the Palestinian penal code for example. Yet, under criminal legislation a blood relationship is a mitigating circumstance to reduce the penalty for the criminal act of a mother who kills her new-born child to avoid shame, the same applies to the crimes denominated as “honour killing”.

Criminal Codes of Iraq, Syria, Lebanon, Libya, Kuwait, Bahrain, Algeria, Tunisia and Palestine provide that if the offender of rape lawfully marries the victim, any action becomes void and any investigation or other procedure is discontinued. They further prescribe that if a sentence has already been inflicted for such action, it shall be revoked. A unique case is Saudi Arabia where there is no codified Penal Code and no clear definition of rape. Also, the criminal codes of Sudan and Mauritania have no definition of rape as a crime at all. Furthermore, although Egypt abolished this case in its criminal code, it is still widely practiced outside the court system. Morocco revoked the law in 2014 after a 16-year-old girl committed suicide when she was forced to marry her rapist. Recently, Jordan succeeded in nullifying the law in 2017 and took steps towards abolishing Article 308 and Lebanon's Parliamentary Committee for Administration and Justice announced a recommendation to repeal Article 522 of the country's penal code on the same subject (Haddad, 2017).

Women’s groups and human rights advocates in Palestine have worked hard to introduce fundamental changes to the criminal law to ensure women and girls are adequately protected from all forms of violence. The draft penal code, prepared by the national commission in 2010-2011, criminalizes sexual harassment (Article 465) and domestic violence (article 347); and creates new rules to protect women from violence, including rape and sexual assault (Article 461). The process has been suspended, however, following the internal political divide between the West Bank and Gaza (UNDP, 2012) and has not resumed yet.

Overall, effective laws are a source of oppression against women who report or disclose such crimes: they do not only support impunity of perpetrator, but also reward him with protection while the victim is deprived thereof, which leaves her vulnerable to killing under the pretext of "family honour" once the news is spread about her rape, especially in case of incest. As such, the law preserves wrongful social traditions negating the right of women and girls as full citizens and human-beings to live safely under the protection of the law and society.

The logic behind these laws is imbedded in the culture that promotes the "need to silence the occurrence of the rape, preserve female virginity, and treat the crime in private in order to safeguard family honour and reputation" (Shalhoub-Kevorkian, 1999). Such practice re-victimizes and weakens the victim since it prioritizes the protection of family reputation in the society over her agonies and needs. In Arab culture, a raped woman is no longer chaste or marriageable. Hence, marriage to her rapist is perceived as a solution to this problem and an exit from shame that would address the need of her family not to feel dishonoured or seek vengeance-honour crime, as often happens. Consequently, in this case the law "protects" the girls by forcing attackers to marry them. But what sort of protection? And how perpetual is GBV against the victims in the framework of this "protection"? And what form of protection is there for the victim when the rape happens in incest? These are all legitimate questions that this law has no observance for. Feminist and human right activists argue that such legal system legitimizes rape and rewards the wrongdoing of the rapist and, in fact, allows him to continue his violent act of raping the victim within marriage making her a perpetual victim of SGBV. Let alone that this law ignores any redress for the victim, which should be the aim of the law at the first place.

The legal framework of rape cases, together with sociocultural practices, including victim blaming, women's objectification and denial and trivialization of rape occurrence in such patriarchal societies – including in Palestine – draw the image and reality of rape and system's response there to, including as relates to service-seeking survivors.

Paradoxically, much of this depiction is akin to what was coined in 1970s in the West as the "rape culture" denoting a form of rape tolerance that was believed by many writers to be rooted in the "domination and objectification of women" with pornography as a key contributor because it is believed to lead

to patterns of oppression in the objectification of women, and reducing the female and male body to a commodity (Coleman, 2015).
Pervasiveness of rape myths in today's societies contribute toward the "culture of rape" by its function of "blame shifting" from perpetrators to victims. Despite this, no attention has been paid as to how rape prevention programs and policies can address this phenomenon, and there is no updated information on the demographic, attitudinal, or behavioural factors currently associated with rape myths. Suarez & Gadalla (2010) attempted to address this gap by examining the correlates of rape-myths acceptance (RMA) in published studies. A total of 37 studies were reviewed, and their results were combined using meta-analytic techniques. Overall, the findings indicated that men displayed a significantly higher endorsement of RMA than women. RMA was also strongly associated with hostile attitudes and behaviours toward women, thus supporting feminist premise that sexism perpetuates RMA. RMA was also found to be correlated with other "isms," such as racism, heterosexist, classism, and ageism. These findings suggest that rape prevention programs and policies must be broadened to incorporate strategies that also address other oppressive beliefs concurrent with RMA. Indeed, a renewed awareness of how RMA shapes societal perceptions of rape victims, including perceptions of service providers, could also reduce victims' re-victimization and enhance their coping mechanisms towards recovery.

Given all the compounded informal dimensions impacting rape, including the traditions, beliefs, values, attitudes, norms, and practices that are deeply embedded in culture, and which operate at systemic, community and the individual levels (Batliwala, 2013), the Palestinian healthcare system is logically expected to fall in alignment. In particular, scarcity of information about services available to rape victims/survivors anywhere in the health sector is well observed and acknowledged. Particularly, very little is known about clinical management of rape (CMR) service availability, quality, accessibility and acceptability. Even though some practical guides and theoretical documents have been produced and are around on GBV including rape since several years now, the actual implementation of the rape services part remains a conundrum. In particular, this study gives notice to the "Booklet Guide for Healthcare Providers: Mechanisms for dealing with women GBV survivors". The booklet was developed back in 2012 by the Women Health and Development Directorate- MOH with UNFPA funds, and comprised a special section on rape management. It was never put in effect despite the concrete guiding information it incorporated.

It is recognized, however, that the respective policy discourses associated with the production of these documents and projects through which they came into existence such as Takamol project for example, together with the national surveys data on the prevalence of GBV in Palestine, all served as mobilizing drivers that eventually brought to life the National Referral System for Women Survivors of Violence (NRSWSV) the Ministerial Cabinet issued in 2013 - a milestone in the policy and commitment of the Palestinian National Authority towards combating GBV within a multi-sectoral participatory approach.

This materialized subsequent to numerous incremental processes for GBV integration into successive including current policy documents namely the National Strategy to Combat VAW, Cross-Sectoral National Gender Strategy, National Health Strategy, and the National Strategic Plan for Reproductive and Sexual Health. Out of these four policy documents, nonetheless, rape per se, was mentioned only in two. In the National Strategy to Combat VAW 2011-2019, 29 appearances of the world "rape" was spotted compared to only 2 in the gender strategy, while it was not vividly stated anywhere in the two other health policy documents.

However, careful examination of the National Health Strategy 2017-2022 shows that attention to the question of GBV, in its broad sense, is well articulated in page 48 under objective 5 of the strategy being to "Enhance health governance, including effective management of the health sector, enforcement of laws and legislations, cross-sectoral coordination and integration among service providers". Namely paragraph c under the same objective reads as such:

"Implementing cross-sectoral strategies and interventions: The MOH cooperates with the MOSD and MOWA in the implementation of the National Referral System for Women Victims of Violence and the case surveillance system, in addition to MOH interventions aiming to reduce violence and gender-based violence (GBV) through awareness-raising and educational programs, and the establishment of women empowerment clinics in health directorates and different government hospitals".

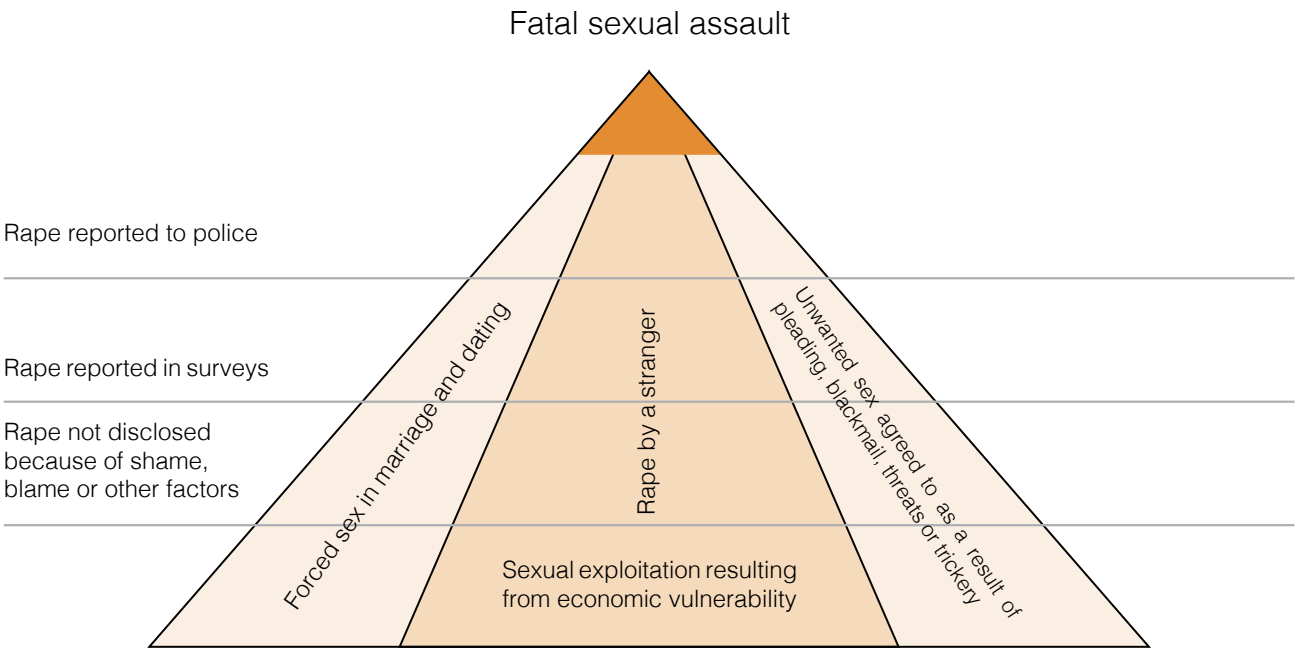
National Referral System for Women Survival of Violence (NRSWSV)
Article 18
Raped Girls and Women

When dealing with the raped women and girls the following must receive observance;
1. Priority must be given for working with the raped women in addressing their health status by assessing if there is pregnancy, injuries, or STDS. Then, medico-legal and forensic tests follow.
2. Raped women must be served by a team that includes different health specializations according to the case, along with social workers and forensic medicine specialists. Right upon the arrival of the raped woman, a social work specialist must be called in, either from the health facility itself, if available, or from a partner health institution.
3. An integrated service provision approach must be followed in a way whereby healthcare services and forensic examination are offered at the same time and place with deliberate avoidance of any repetition in; examination, testing, interview or assessment done to the raped woman.
4. Time of the victim's arrival at the health facility must be determined.
5. Written consent of the raped victim must be obtained in order for the medical team to conduct the assessment, examination and treatment.
6. Raped women must be treated with respect.

Drawing from this, the National Strategic Plan for Reproductive and Sexual Health 2018-2022 identified GBV as one of its main areas of achievement as well as challenges and future priorities, but here too rape is not mentioned anywhere in the strategy document. By implication then, CMR is not yet on the agenda of the identified priorities in the health sector. However, this will have to change at some point, to meet the requirements of Article 18, page 20, consigned to raped girls and women, under Chapter Three on the role of healthcare providers in GBV survivors' protection interventions, in the NRSWSV. The said Article holds the six provisions shown in the box above.

This demonstrates that GBV in general has long been on the Palestinian women, health and human rights agenda. However, the above-described socio-cultural and legal contexts along with the existing national data illustrate that most emphasis in GBV interventions focused primarily on physical violence and its consequences, much less so on sexual violence and much lesser on rape, with a considerable distance between each. This also corresponds with the global picture as well. Data on sexual violence typically come from police, clinical settings, nongovernmental organizations and survey research. According to Jewkes & Abrahams (2002), as illustrated in the figure below, the relationship between these sources and the global magnitude of the problem of sexual violence may be viewed as corresponding to an iceberg floating in the water. The small visible tip represents cases reported to police. A larger section may be elucidated through survey research and the work of NGOs. But beneath the surface remains a substantial unmeasured component of the problem.

Graph 1: Magnitude of the Problem of Sexual Violence



Source: Jewkes & Abrahams (2002). The epidemiology of rape and sexual coercion in South Africa: an overview. Social Science and Medicine, 55, 1233

Rape continues to be severely under-researched and under-attended to, across all service sectors including health, even if variably. Certainly, the health sector included. Rape victims/survivors continue to be confronted with exceptional socio-cultural and systems barriers; structural, procedural and attitudinal, that blocks their access to any type of services they may seek. Inter alia, this contributes to the little documentary and research evidence on the services available to raped survivors. Hence, this pioneer study investigates rape in particular, from the perspective of service provision, namely, availability of clinical management of rape survivors (CMR) in the health sector.

In parallel, for UNFPA & UN Women, Wadi (2017) conducted a review of health, justice and police and social essential services available for protection of women and girls' survivors of GBV. In this review, she noted that in 2014 alone, 25 women were killed under the pretext of "family honour". Alongside, referencing the WB GBV Sub-Cluster inputs for Protection Cluster HNO and HRP 2018, she too pointed out rape incidents as being extremely underreported, either due to masking the incidents under other forms of violence, or not reporting the incident altogether. Furthermore, across the three reviewed sectors, sexual violence including rape was always identified as an area of deficits, gaps, and poor preparedness on the side of service provision, whether in terms of infrastructure or staff training and attitudes or other aspects. Agreeably, this can't be thought of as a coincidental finding but rather an area worthy of further examination and scrutiny especially as regards to decision makers' priorities, strategic choices, and agenda setting, bearing in mind the particularly strong patriarchal dimension of this form of GBV at all levels of service sectors.

The purpose of this study is to detect the place of rape service in policies and strategies in Palestine and verify if and what components of clinical management of rape are in place and where in the Palestinian health sector in Palestine. This will be achieved by meeting the following objectives:

- To detect, describe and analyse the place of CMR in relevant strategies and other policy making reference documents and processes.
- To explore if and what services are available and offered to rape survivors and where.
- To reveal the current healthcare providers and planners' knowledge and attitudes towards the provision of CMR to survivors.
- To understand the policy makers and healthcare providers' willingness, acceptance and readiness to work on a full CMR package to survivors

In order to prevent and manage possible health consequences, rape survivors must have access to clinical care, including supportive counselling, as soon as possible after the incident. Since availability of CMR services" is essentially a composite indicator, it may be difficult to ascertain if a particular health facility provides CMR survivors with a "yes/no" response. For example, the facility may be out of antibiotics on the day of assessment. Or perhaps a private consultation area has been established, but not all the service providers are able or willing to utilize it. In this assessment, the assessor had to determine a system for identifying what does and what does not constitute available clinical services for rape survivors in order to detect if a given health facility indeed provides this service.

Clinical management of rape survivors involves the availability of trained staff and the following components: Supportive communication; history and examination; forensic evidence collection as relevant, compassionate and confidential treatment including: 1) emergency contraception, 2) treatment of STIs, 3) post-exposure prophylaxis (PEP) to prevent HIV transmission, 4) care of wounds and prevention of tetanus,5) prevention of hepatitis B, 5) referral to further services in the area of health, and 6) psychological and social care (IAWG, 2010).

The first attempt to address CMR as a distinct service pillar in the health sector vis-à-vis GBV work in Palestine was made five years ago by the UNFPA. But it was then confronted with substantial reservation and resistance from care providers and policy makers, mainly fearing the social taboos, the predominant pseudo-religious arguments and the hegemonic female sexual behavioural control element embedded into it. Therefore, it was only possible to address the issue within the framework of intervention guide that was prepared for health care providers working with GBV survivors. The guide however was not fully adopted and implemented in the service provision processes in health sector including its CMR component. This is evidenced in a study by the Ministry of Health (MoH) on the National Referral System for Women Survivors of Violence (AlRifai, 2017)

Minimum Initial Service Package (MISP) for reproductive health in crisis situations was the subsequent UNFPA attempt to introduce CMR as part and parcel of a specialized training with a substantial rape component particularly concerned with emergency services in humanitarian situations. MISP training was completed in the two regions of West Bank and Gaza more than two years ago. Beyond that, sexual violence was examined in a few Palestinian studies,

particularly for cases of incest, namely with respect to relevant laws (Nasir Barghouti, 2012), the so called "honour killing", and sexual abuse in child marriage and rape (AlRifai 2007; Shalhoub-Kevorkian, 1999). Nonetheless, CMR per se remains a virgin area of research in Palestine.

One donor agency officer summed it up as such:

"Rape is like a black box about which we know nothing. We do not know about the needs or available service. We do not know about the competence level of the service providers or the extent to which the services on offer are institutionalized including in plans or strategies. We don't know about the extent of rape services readiness and acceptance among the individual health care providers and institutions in their practice and service offers. And we don't know if we should start working on plans and protocols for providing CMR services".

Magnitude, Consequences and Impact of Rape

The crime of rape shrouded with silence in Palestine, engenders paucity of information on its nature, magnitude, consequences and impact, although the first survey data on domestic violence in general detected rape as one form of sexual violence the surveyed women reported having experienced. This was conducted as early as 1995 by Bisan Centre for Research and Development. Years later, the latest relevant reliable source on prevalence and magnitude is the 2011 Palestinian Central Bureau of Statistics (PCBS) National Survey on Violence. It reported that a total of 11.8% of the surveyed ever married women experienced marital sexual violence during the last 12 months prior to the survey, with more than the half reporting having experienced it three times or more during the said period. The survey also reported that 0.8% of the never-married women aged 18-64 years experienced sexual violence from a family member (PCBS, 2011). On the one hand, this latter figure does not conform in any way with the international literature on sexual violence against the non-married women, on the other, it points at the social taboo surrounding the disclosure of female sexuality related experiences beyond the marriage institution especially in the form of incest which if disclosed forms a prime violation of religious doctrine, rupture of social order and family cohesion in addition to an inherent legal liability dimension. As such the reported figure could strongly be argued to be an under-reporting on incest. This may also explain the reason why the survey did not go further into sexual violence categorizations, and so what percent of this is rape remains unknown.

Globally however, data on rape provide a clearer picture. For example, a national sexual violence survey the CDC conducted in 2011 in the USA found out that nearly 1 in 5 women (18.3%) and 1 in 71 men (1.4%) in the United States have been raped at some time in their lives, including completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration. In addition, more than half (51.1%) of female victims of rape reported being raped by an intimate partner and 40.8% by an acquaintance; for male victims, more than half (52.4%) reported being raped by an acquaintance and 15.1% by a stranger (Black et al., 2011).

Mohammed & Hashish (2015) conducted an evaluation on the magnitude of sexual violence (prevalence, scene, pattern, assailants, and contributing factors), and its impact on female sexual function in Egypt. A cross-sectional study involved 150 participants, who completed self-report questionnaires. Sexually active female participants fulfilled full history-taking and general examination. Sexual function was assessed by using the Female Sexual Function Index (FSFI). All participants were exposed to violence including; Verbal, Pornography, Sexual contact and Rape. Out of 46 sexually active participants, 33 had sexual dysfunction. The study found that as the severity of the violence increased, the desire, arousal, lubrication, orgasm and satisfaction significantly decreased.

Increasingly, research evidence shows that impact of rape on female sexuality and reproductive health is immensely harmful, immediate and long-term and of interrelated physical, psychological, biologic, and behavioural dimensions (Coleman, 2015; Weaver, 2009). Studies documented moderately high rates of genital injuries and moderate rates of sexually transmitted infections post-rape and significantly greater difficulties with aspects of reproductive/sexual functioning, including dyspareunia, endometriosis, menstrual irregularities, and chronic pelvic pain for raped compared with non-raped women. Raped women also were found to be engaged in significantly high-risk sexual behaviours. Posttraumatic stress disorder emerged as an important mediator of sexual victimization and sexual health (Weaver, 2009).

Assessments of the impact of the Syrian crisis indicate high levels of sexual and gender-based violence, with rape, assault, intimate partner violence (IPV) and survival sex appearing increasingly common. Survivors are reluctant to report SGBV or seek support due to the shame, fear and ‘dishonour’ to their families. Humanitarian agencies urgently need to work together to address this trend (Anani, 2013).

Analysis of cases of rape in Nigeria documented the clinical findings of rape and its outcomes in order to improve the quality of care the victims receive. Case notes of patients who presented with alleged rape at Joe University Teaching Hospital between January 2001 and December 2003 were retrieved and analysed. During the study period, 2,135 patients were seen in the Gynecology Emergency Unit. A total of 120 were for alleged rape, representing 5.6% of the total cases seen. However, only 105 case notes were available for analysis. Around 64% of the alleged rapes were in children, with the infantile age group (below 7 years) accounting for 26.7%. More than 36% of the victims had experienced some form of sexual exposure prior to the rape. A previous relationship with the rapist existed in 77.4% of the cases, and 46.6% of the rapes occurred in the victims' homes. Most cases delayed in presenting to hospital. Thirty-six percent of the cases did not have a human immunodeficiency virus screening test done. Candida albicans (13.3%) accounted for most of the infectious agents. Emergency contraception was administered to the victims when needed. The study concluded that women under 16 years of age (63.8%) were at an increased risk of being raped, possibly because they are defenceless and vulnerable. Three quarters of the assailants had some form of relationship with the victims, which may account for the delays in reporting (Daru et al., 2011). Along the same lines, RAINN (Rape, Abuse & Incest National Network), the largest anti-sexual assault organization in the United States, indicates that 44% of women raped are under the age of eighteen, too (Coleman, 2015).

Domenech del Rio and Garcia del Valle (2016), using a nationally representative sample of 10,171 women, investigated the consequences of intimate partner violence on health in Spain. The study examines the association between current and previous intimate partner violence and current health status. Current physical or sexual violence was found associated with the highest likelihood of reporting health outcomes, followed by current emotional or economic abuse. Current controlling behaviour increased the odds of reporting poor health whereas previous controlling behaviour has less effect on current health, the study reported. Controlling behaviour alone often was the first expression of mistreatment. If health professionals could identify violence at this early stage, long-term effects on women's health could be minimized, the study concluded.

Immediate and long-term mental health outcomes in adolescent female rape survivors was investigated to assess the prevalence and associated factors of emotional distress in a cohort of adolescent rape survivors in

Cape Town. Participants in this prospective longitudinal study were 31 adolescent female rape survivors recruited from a rape clinic in Cape Town and assessed within 2 weeks of the assault. Assessment measures included a socio-demographic questionnaire and initial screening with the Child and Adolescent Trauma Survey (CATS), the patient-rated Children's Depression Inventory (CDI), and the Multidimensional Anxiety Scale for Children (MASC). The CATS, CDI, and MASC were repeated at 1, 3, 6, 9, and 12 months' post enrolment. Psychiatric diagnoses were made with the clinician-administered Mini International Neuropsychiatric Interview–Child and Adolescent version (MINI-Kid). At baseline, on the MINI-Kid, a definitive diagnosis of major depressive episode was endorsed in 22.6% of the participants. Stress-related disorders were found in 12.9%, whereas 16.1% had anxiety disorders. There was no diminution of symptoms on self-reported psychopathology measures at follow-up assessment over the five follow-up time points, suggesting persistent psychopathology over a 1-year period despite repeated clinical assessments and supportive counselling. Symptoms of anxiety, depression, and posttraumatic stress disorder in this sample of adolescent female rape survivors were high at enrolment and found to be persistent, underlining the need for long-term support, screening, and evidence-based follow-up care (Oshodi et al., 2016).

Extant literature in Kenya indicates an alarming rate of sexually abused minors presenting to poorly equipped health facilities with untrained health providers for post rape care. National guidelines on management of sexual violence have been in existence since 2004; however, little is known on the impact of these guidelines on post rape care provision to minors. Therefore, the study aims to assess the knowledge, attitudes, and practices of health providers with regard to post rape care provision in a Kenyan District health facility. The study used a triangulation of different qualitative methods: review of 42 health records of minors seeking post rape care, 15 in-depth interviews, and informal conversations with health providers. Findings indicate that the Kenyan national guidelines on management of sexual violence were non-existent in the health facility. Consequently, health providers possessed limited knowledge on post rape care administration. The limited knowledge translated into poor collection and preservation of evidence, and inadequate psychosocial support, and clinical care. In addition, rape myth attitudes and religious beliefs contributed to survivor blaming and provider hesitance to perform legal abortion care. To facilitate provision of quality post rape care, policy makers and health institutions' managers need to avail protocols in line with evidence-based best practices to guide health providers in post rape care administration. The study

also concluded that there was a need for rigorous training and supervision of health professionals to ensure better service provision (Wangamati, Gele & Sundby, 2017).
The contribution of multiple types of violence to adult victimization in female survivors of childhood violence and abuse was investigated in a recent Norwegian study conducted by Flood Aakvaag and colleagues in 2017. The researchers interviewed 2,437 Norwegian women (response rate = 45.0%) about their experiences with violence. Logistic regression analyses were employed to estimate associations of multiple categories of childhood violence with adult victimization. Women exposed to childhood sexual abuse often experienced other childhood violence, and the total burden of violence was associated with adult rape and intimate partner violence. The researchers concluded that clinicians need to take into account the full spectrum of violence exposure.

In a study of rape victims' and supporters' experiences of barriers within the police and the health care system in Tanzania, grounded theory guided the analysis of 30 in-depth interviews with raped women and community members who had supported raped women in their contact with the police and health care services in Tanzania. The aim of the study was to understand and conceptualize the experiences of the informants by creating a theoretical model focusing on barriers, strategies, and responses during the help seeking process. The results illustrated a process of managing in the contemporary world characterized as walking a path of anger and humiliation. The study showed that the barriers are illustrated by painful experiences of realizing it's all about money, meeting unprofessionalism and irresponsibility, subjected to unreliable services, and by being caught in a messed-up system. Negotiating truths and knowing what to do captured the informants' coping strategies. The study indicated an urgent need for improvement in the formal procedures of handling rape cases, improved collaboration between the police and the health care system, as well as specific training for professionals to improve their communication and caring skills (Muganyizi et al., 2011)

To better understand barriers service providers may face when advocating for survivors, a study using grounded theory and qualitative, semi structured interviews was conducted of rape victim advocates (N= 25) working in rape crisis centres in a large metropolitan area. Broader societal attitudes framed and were reflected in institutional responses to victims and in barriers faced by advocates working with survivors. Organizational barriers noted by advocates related to resources, environmental factors, professionalization, and racism.

Staff burnout was a major barrier affecting advocates' ability to help survivors. Finally, the most salient direct service barrier was secondary victimization by criminal justice and medical or mental health systems (Ullman & Townsend, 2007)

Rape survivors who speak out about their assault experiences are often punished for doing so when they are subjected to negative reactions from support providers. These negative reactions may thereby serve a silencing function, leading some rape survivors to stop talking about their experiences to anyone at all. The current study sought to examine this worst case scenario. Focusing on the qualitative narratives of eight rape survivors who initially disclosed the assault but then stopped disclosing for a significant period of time, this study sought to provide an in-depth description of how negative reactions silenced these survivors. Three routes to silence were identified: 1) negative reactions from professionals led survivors to question whether future disclosures would be effective; 2) negative reactions from friends and family reinforced feelings of self-blame; and 3) negative reactions from either source reinforced uncertainty about whether their experiences qualified as rape (Ahrens, 2006).

One study examined the mediating and moderating impact of fear of victimization on the relationships between forcible and vicarious rape on depression and post-traumatic stress disorder (PTSD) among college women. Forcible and vicarious rape positively affected PTSD and depression symptomology, but fear did not mediate these relationships. Fear moderated the impact of forcible rape on PTSD, but was not a moderator for depression. Findings suggest that there may be “healthy” levels of fear in the aftermath of victimization where having too little fear may leave women unnecessarily vulnerable to victimization, while having too much fear may lead to social isolation and withdrawal (Spohn, Wright, & Peterson, 2017)

A regional audit was undertaken to evaluate current practice in the management of survivors of sexual assault seen in genitourinary medicine clinics in the North Thames. The majority of the survivors were women. Most were fast-tracked or seen in dedicated sexual assault clinics. Over 60% of staff had specific training in management of sexual assault. Core services provided included screening and treatment for sexually transmitted infections, emotional support, emergency contraception and hepatitis B vaccination. The sexual health needs of these survivors of sexual assault are being met by most clinics. The study suggested that the development and use of a standardized

care Porforma across the region may be a means to further improve the care provided (Obeyesekera et al., 2007)

Health Systems Response to Sexual Violence

A key component of MISP is the CMR survivors themselves. An evaluation was conducted to determine the status of MISP implementation for Syrian refugees in Jordan as part of a global evaluation of reproductive health in crises. In March 2013, applying a formative evaluation approach 11 key informant interviews, 13 health facility assessments, and focus group discussions (14 groups; 159 participants) were conducted in two Syrian refugee sites in Jordan, Zaatri Camp, and Irbid City, respectively.

A key finding revealed that lead health agencies addressed MISP by securing funding and supplies and establishing reproductive health focal points, services and coordination mechanisms. However, Irbid City was less likely to be included in coordination activities and health facilities reported challenges in human resources capacities. Access to CMR survivors was limited, and both women and service providers' knowledge of availability of these services was low. Activities to reduce the transmission of HIV and to prevent excess maternal and new-born morbidity and mortality were available, although some interventions needed strengthening. Some planning for comprehensive reproductive health services, including health indicator collection, was delayed. Contraceptives were available to meet demand. Syndromic treatment of sexually transmitted infections and antiretroviral for continuing users were not available. In general refugee women and adolescent girls perceived clinical services negatively and complained about the lack of basic necessities.
Seven key informants reported knowledge of measures to prevent sexual violence and treat survivors. However, these measures were insufficient and only one site had the human resources capacity and supplies to provide clinical care for rape survivors.

In Zaatri Camp, women expressed concerns about lacking or inadequate lighting and their fears of using the toilets at night. In Irbid City, women reported feeling unsafe sending their daughters to school on public buses. Women said that they were fearful of telling their families of sexual violence due to fears of honour killing, or being disowned by family. The women discussed what they perceived as more cases of domestic violence in the camp than what they observed while living in Syria. However, they were fearful of negative

consequences if they reported their personal violence experiences. The women voiced a desire mostly for psychosocial services, in addition to prevention and medical care but were unaware of service availability. Nearly all women across the groups in Irbid City agreed that they would not feel comfortable attending health services due to unperceived benefits of such health care and fear of family stigmatization. Additionally, all groups with young women said that they would not tell anyone if they experienced violence. Regarding incidents of sexual violence that are usually reported to UNHCR protection, the Moroccan Field Hospital did not receive any sexual violence survivors, although Mafraq Hospital received one. Treatment and forensic evidence collection was available at Prince Hamza or Mafraq hospitals but they did not have standard protocols. Jordan Health Aid Society clinic was the only facility visited that has a protocol to manage sexual violence survivors in the camp. In Irbid City, there was a formal referral protocol for sexual violence survivors from the health centres to the Family Protection Unit including a standard incident reporting form. Partners stated the MOH was developing a national protocol for clinical management of rape survivors.

The study revealed that prevention of sexual violence was not treated as a priority in humanitarian response. It also detected several challenges to handling CMR survivors due to lack of National CMR Survivor Protocol in addition to challenges related to the use of emergency contraception and post-exposure prophylaxis. The infrequency of survivors reporting for treatment is possibly related to: Syrian women's unawareness of the benefits and availability of health care; taboos around talking about sexual violence in the community; and an inadequate number of trained service providers/ delivery points. Women are unlikely to weigh the benefits of seeking services against their fears of vengeance and cannot make an informed choice about seeking care without knowledge on how medical care can prevent health consequences (Krause et al., 2015).

Compassionate and confidential treatment of rape survivors incorporates emergency contraception (EC) as one key measure of the care plan. New Mexico enacted a law in 2003 requiring that emergency departments (EDs) offer EC to survivors of sexual assault and that both doses be administered in the ED. Examining practices and knowledge of ED providers about EC in the setting of sexual assault Espey and colleagues (2009) visited hospitals in New Mexico from July 2005 to December 2005 and administered an 18-item questionnaire to three providers-a physician, a nurse, and a clerk-in the ED. The questionnaire included items related to characteristics of the hospital,

knowledge of providers about EC and the law, and ED practices relevant to EC for sexual assault survivors as well as for women who had consensual unprotected intercourse. Surveys were completed at 33 of 38 hospitals (87%). Overall, 52% of respondents reported that EC was routinely offered to sexual assault survivors, and 33% reported that both doses were administered in the ED. Forty-one percent of registered nurses, medical doctors, and clerks reported that EC was offered to sexual assault survivors who were minors regardless of age. Overall, 64% of respondents knew that EC may prevent pregnancy up to 72 hours after unprotected intercourse, and only 12% of respondents reported awareness of any requirements to offer EC to sexual assault survivors. Respondents reported that physicians in the ED more often routinely offered EC to sexual assault survivors (52%) than to women who requested it after consensual sex (20%).

First and for most, CMR survivors involves the availability of trained competent staff who is capable of providing a complementary set of the needed services to rape survivors (IAWG, 2010). Using a mixed-methods approach, Smith and colleagues (2013) employing a purposive sample of 106 healthcare providers before and 3 months after training conducted a survey to measure attitudes, knowledge, and confidence. In-depth interviews with 40 providers elaborated on survey findings. Medical record audits were conducted in 35 health facilities before and 3 months after the intervention to measure healthcare providers' practice. While negative attitudes, including blaming and disbelieving women who report sexual assault, did not significantly decrease among healthcare providers after training, respect for patient rights to self- determination and non-discrimination increased from 76% to 91% ($p < .01$) and 74% to 81% ($p < .05$) respectively. Healthcare providers' knowledge and confidence in clinical care for sexual assault survivors increased from 49% to 62% ($p < .001$) and 58% to 73% ($p < .001$) respectively following training. Provider practice improved following training as demonstrated by a documented increase in eligible survivors receiving emergency contraception from 50% to 82% ($p < .01$), HIV post-exposure prophylaxis from 42% to 92% ($p < .001$), and STI prophylaxis and treatment from 45% to 96% ($p < .01$). The study concluded that although beliefs about sexual assault are hard to change, training can improve healthcare providers' respect for patient rights and knowledge and confidence in direct patient care, resulting in more competent and compassionate clinical care for sexual assault survivors.

To determine whether a national training program on post-rape care in South Africa resulted in improvements in knowledge and confidence in health

professionals, and to distinguish baseline factors related to these changes in knowledge and confidence, Jina and others (2014) conducted a cross-sectional study and data were collected over four training sessions in 2008 using questionnaires and multiple choice question papers given to 152 health professionals. Information was collected on demographics, service provision, and previous training. The change in knowledge and confidence was calculated from baseline and post-training scores. Factors related to these changes in knowledge and confidence were tested through the development of two models. Health professionals showed significant increases in percentage knowledge (40% at baseline vs 51% post training; $P < 0.001$) and confidence (67% at baseline vs 80% after the training). In the final multivariate models, empathy was significantly associated with a change in knowledge (coeffcient1.2; 95% CI, 1.9 to 0.4; $P = 0.005$), while the facility level and baseline knowledge and confidence were significantly associated with change in confidence.

Along the same lines, an audit was conducted on the medical management of complainants of sexual assault in a public university hospital with a high referral of rape complainants. Retrospective study of rape complainants, based on medical records (n= 356) including women admitted at the emergency department between January 1, 2002 and December 31, 2007 was done. Most complainants were Caucasian (median age: 25 years, range: 15-79 years). About 82% of the assaults were committed by one assailant only, and almost two-thirds of the rapes were characterized by vaginal penetration. In 8% of the patients, no blood sample to screen for sexually transmitted disease had been taken and in 38% of the patients, no cervical smear for C. trachomatis had been done. Prophylactic antibiotics were provided to 40% of the patients. Eighty percent of the complainants who were not using contraception received an emergency contraceptive treatment. Respectively, 10%, 16% and 11% of the complainants were seen at a gynaecological, infectious diseases or psychological support follow-up visit. Only about 20% of the complainants received optimal care. Different steps were taken to improve the medical management, including a specific computerized checklist and involvement of a social nurse for the follow up. These steps aim at reducing psycho-affective and medical morbidity of rape complainants (Gilles, Van Loo, & Rozenberg, 2010).

To wrap up, the afore provided examination of research evidence presented this study with a foundational knowledge on the magnitude, consequences and impact of rape on the rape survivors' life experiences, and the socio-cultural and legal contexts that operate shaping and defining the manner by

which the health systems respond (or not) to the healthcare needs of rape victims and realize their right to health, protection and dignity.

Methodology

Design: This assessment utilizes a descriptive cross-sectional exploratory mixed-method approach to address CMR in West Bank including East Jerusalem and Gaza Strip in Palestine. Triangulation principle espoused utilization of several data sources, research techniques and data collection methods and tools to validate findings, pinpoint issues of interest and construct the most comprehensive and solid depiction of the assessment. This is in order to enable planners and policy makers at the Palestine Medical Relief Society (PMRS), interested donors, partners from other NGOs or the government of Palestine construct an insightful analysis of the situation of CMR, where to take it and what are the priorities to ensure service availability and access to rape survivors.

Target Population: In this assessment different complementary population groups from the West Bank including East Jerusalem and Gaza Strip were targeted. At the micro level, the sample was purposively chosen primarily from the health sector from service providers operating at the primary and tertiary healthcare levels. At the macro policy and strategic levels, expert opinion was solicited through semi structured interviews with selected stakeholders being senior service providers, managers, policy makers or planners in the areas of; healthcare, social services, women rights, justice system and donor agencies.

Sampling Methods: Purposive none-random sampling method was used in the quantitative part of the study where two data collection instruments were used. The first being a questionnaire targeting primary and tertiary service providers to explore their knowledge and attitudes about the question of rape and the survivors, as well as understand their role, if any, in the provision with CMR in their respective healthcare facilities. Meanwhile, the second instrument was a health facility checklist whereby the extent of facility readiness to provide survivors with CMR service was examined.
A total of 96 healthcare providers partook in the study by filling up the questionnaires, while 19 healthcare facilities agreed and completed the service facility checklist themselves.

As for the qualitative part, stakeholder sampling was found to be particularly useful in the context of this assessment. Best-fit 22 informants and experts were interviewed after being identified jointly by the researcher, director of women health program at PMRS and UNFPA gender officer.

Data Types & Sources

A) Desk review for relevant policy documents and State strategies, with particular reference to the National Health Strategy and the National Referral System for Women Survivors of Violence to examine if, where and how the issue of rape and namely CMR is addressed in these documents as an expression of State commitment to women right to relevant services. In addition, international and local previous studies conducted were looked into to construct the background and conceptual foundation of the assessment.

B) Primary data from direct sources:

1. **Quantitative data** was collected using a specially tailored and validated questionnaire targeting primary and tertiary service providers to explore their knowledge and attitudes about the question of rape and the survivors, as well as understand their role, if any, in the provision with CMR in their respective healthcare facilities. In addition, a health facility checklist whereby the extent of facility readiness to provide survivors with CMR service was also employed. The used checklist was developed and disseminated in a World Health Organization/United Nations High Commissioner for Refugees joint publication (2004). Thereafter, it was globally used for CMR service facility assessments.

In selecting the examined facilities, attention was paid to target facilities the researcher knows from before and is familiar with in various capacities. In addition, it was requested and assured that the checklist is administered by the senior/in-charge person with whom the researcher has an established rapport so that the accuracy of the given information is trusted and optimal.

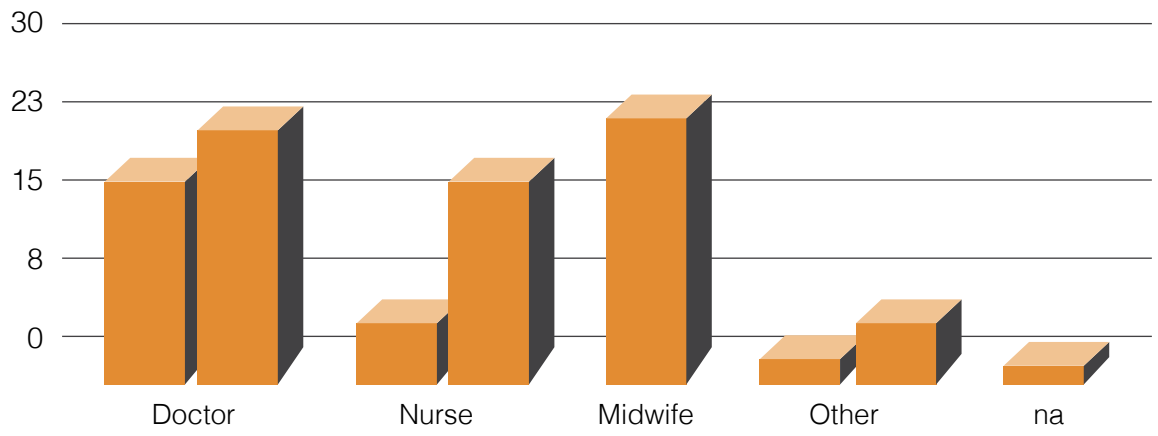
2. **Qualitative data** was collected from identified stakeholders located at the policy and leadership levels in their respective institution using semi structured interviews to obtain an insight about the place of CMR in their service provision processes, program planning, and strategy formulation and implementation.
c) Dissemination and Validation Workshop involving key internal and external stakeholders with the view of strengthening the quality of the collected data and validate it in addition to promoting stakeholder engagement. This took place after the completion of first draft of the report.

Data Analysis and Synthesis:

Two types of data were gathered in this assessment; quantitative and qualitative. Quantitative data obtained from the questionnaires and health facility checklists after being completed were entered into the computer using Excel program, coded, cleaned and statistically analysed using basic descriptive statistics. These were presented in tables and graphs and interpreted in a narrative manner. Analysis of qualitative textual data gathered in interview transcripts helped identify similarities and differences across several accounts. For interpretive content analysis, data were categorized into recurrent themes and topics that are relevant to answer the study questions. The reasoning logic was therefore a deductive one. It worked from the more general content, which were the transcripts and open ended questions and ended more specifically thru conclusions that were made from available observations. Throughout the process, qualitative analysis was integrated from the start with the other parts of the study, rather than being an afterthought.

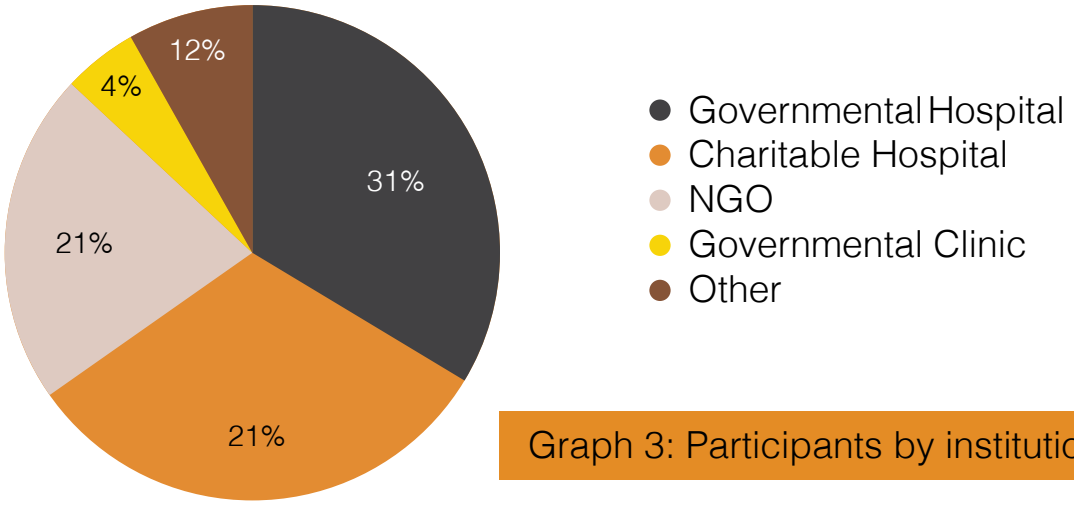
Study Results and Major Findings
Participants' background

These data were basically collected from frontline clinical staff being senior and junior doctors, nurses and midwives working in direct contact with the service users in the identified health facilities namely Emergency Department (ED) and Obstetrics and Gynaecology wards. Graph 2 below shows that around 42% of the respondents are doctors with a little more than the half being females. An equal number of 24 nurses and midwives, each, participated in the study. Few held clinical management posts such as quality coordinator, department head or director of nursing. Overall, women constituted around three quarters (74%) of the study respondents.



Graph 2: Participants by gender and profession

As can be seen in graph 3 below, more than two thirds work in hospital settings almost equally distributed between charitable (in Jerusalem) and government hospitals. One fifth (21%) come from government clinics compared to a little more than one tenth (12%) from the NGOs. This means that more than the half (51%) come from government professional staff which implies that responses are notably indicative of CMR survivors' situation in government health facilities. Additionally, data on CMR for East Jerusalemite girls and women holding the weight of 33% of the responses follow.



Graph 3: Participants by institution type

What rape services are made available, where and by whom?

Graph 4 below clearly shows that more than a quarter of the study participants (25 out of 96= 26%) reported having offered post-rape care to a rape survivor during the last year, even though the offered service was not defined as being CMR by the operational definition adopted in this study, yet responding to the healthcare needs of a raped girl or women in the targeted health facilities was the central idea here. Interestingly, by weight of professions in the study sample, midwives appear to be most involved or willing to disclose information about providing rape services to survivors followed by nurses and doctors, sequentially, despite the substantial women representation under the doctor ca tegory.

This draws attention to the strength (or not) of human rights base and orientation of the included professions practices, as well as to the liability surrounding rape within the legal context in effect in Palestine. While this value is not claimed to hold any statistical significance, yet it remains indicative and insightful for planning for CMR in Palestine.

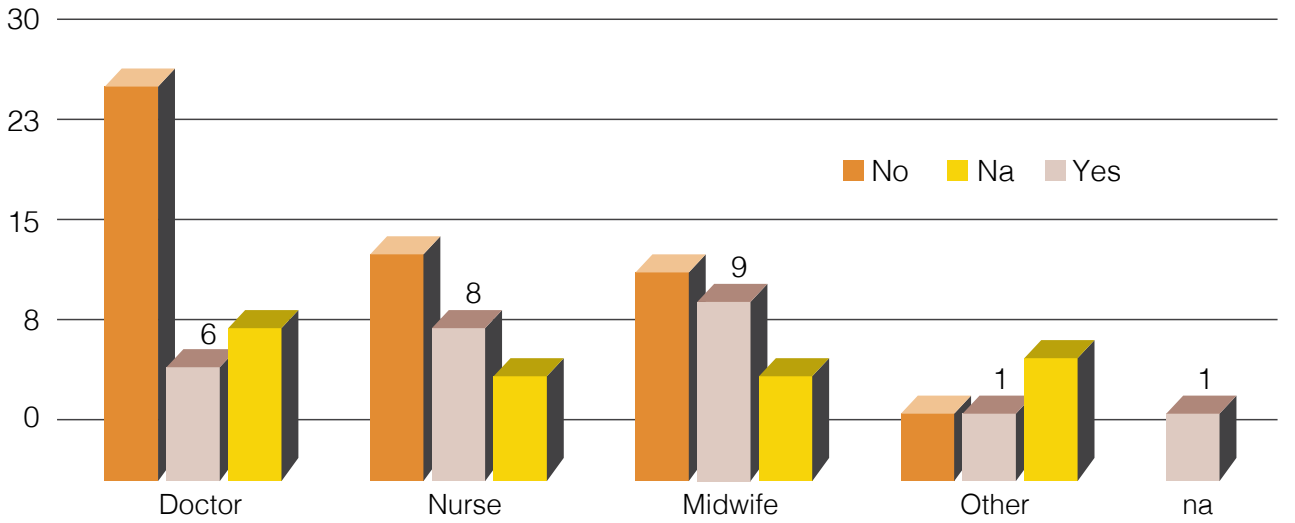
“Most reported cases of rape in Palestine occur within the family and happen during childhood. These cases become known only when the rape survivor gets severely harmed with bleeding, for example, and medical help is inevitable and urgent”, an interviewee from MOWA said. What’s worse is that most cases seek healthcare in private hospitals where all is secretively handled, but whose owners are not open to research engagements with outside parties. Rarely do rape survivors seek healthcare in a public hospital, or so is the conviction of some study informants. However, slowly and gradually a change is being seen in this regard in some major hospitals such as the Ramallah Medical Complex where an average of 1-2 rape victims show up every month for CMR including those coming from other governorates, it was reported. “What is encouraging for the raped victim and her family to come for the service is the absolute confidentiality, respect and compassionate non-judgmental treatment we ensure she gets. This extends to use of civil dress code by police accompanying her in any mobility she needs to do from and to the health facility so as to avoid her identification as a potential criminal by the public eye”, the same informant said. This finding aligns with Wadi’s (2017) where she stresses the discouraging effect of the location of the Family and Juvenile Protection Unit within the Palestinian Civil Police for GBV victims and the clear disadvantage this poses for privacy and confidentiality assurance.

Strict adherence to the described police civil dress code in the West Bank does not apply to Gaza, as confirmed by Gaza informants. Although some protection measures for the victim are taken yet she still gets identified by the public eye, which subjects her to all the consequential reputation and other forms of harm and stigmatization.

Beit Jala government hospital was particularly pointed out by a lead NGO informant to be distinctly receptive and cooperative about rape-resulting pregnancies when referral arrangement for a rape survivor is initiated. This contradicts the long standing rarity of rape survivors seeking healthcare in public hospitals, especially major ones. Conversely nevertheless, expert informants also reported some service facilities that are still lagging behind and uncooperative in handling rape survivors, attitudinally and competence wise.

UNRWA, the key health, education and social services provider to the Palestine refugee population has a well-developed community and family based GBV response plan operating across all refugee camps in the West Bank and Gaza Strip, with the involvement of community gatekeepers. Although UNRWA

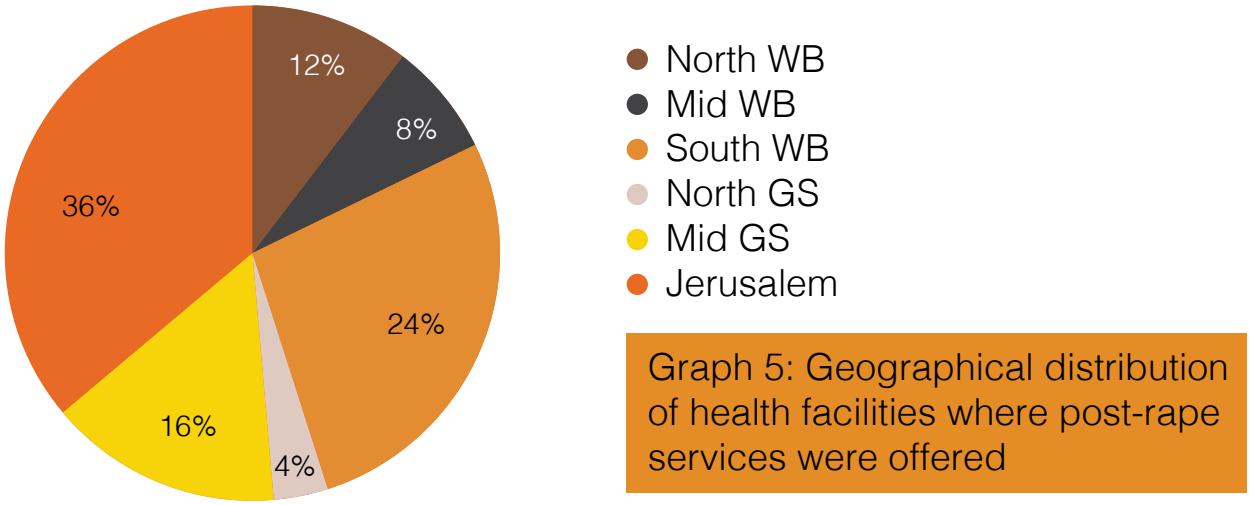
managed to identify and provide the needed psychosocial and health services to high numbers of GBV survivors through its community based protection networks and mental health program, yet this study found out that the Agency lacks appropriate response to sexual violence including rape survivors who are immediately referred to MOH hospitals. This signifies a serious gap in UNRWA's GBV protection plan with respect to sexual violence and rape in specific, given the fact that it falls within its mandate. The same finding was also reported by Wadi (2017) in her review of GBV services in the health sector.



Graph 4: Participants by profession offering post-rape care during the last year

No policy framework for CMR exists anywhere. However, the health facility checklist showed that written medical protocol on CMR is available in Arabic in 12 out of 19, while it was not in 7 of the studied facilities. However, it was not possible to see the reportedly existent protocols or examine their quality. In addition, this finding appears to be inconsistent with other findings in this study as well as with anecdotal observation about common practices in CMR. Therefore, it suggests that participants were probably referring to the MOH booklet guide for healthcare providers that delineates mechanisms for dealing with women GBV survivors including rape that was developed in 2012 jointly with health NOGs under Takamol project, or the National Referral System for Women Survivors of Violence (NRSWSV) and its article and items on rape survivors under the third chapter on health services, as individually interpreted by each institution for it does not include any operational or procedural details on CMR survivors.

In support of this understanding, the study has shown that there is a wide recognition among interviewed experts that there is no uniformed approach or SOP about sexual violence including CMR survivors in Palestine, but rather clinicians handle rape cases in a very narrow scale, especially given that only few raped victims seek medical assistance at the acute post rape phase. What happens is that clinicians find themselves having to handle later rape outcome mainly being extramarital pregnancy, most often for girls between the ages 14-17 years. One women health expert physician reported that throughout her more than 30 years long medical practice in a lead health NGO she only handled around 10 cases of rape. Currently in the same institution, she adds, each doctor handles an average of 1-2 rape cases yearly bringing the total annual average to 7-8 rape cases. She also confirmed that virginity examination is still the most commonly sought rape-related service due to its tight connection to the concept of honour in Palestinian society. This was also confirmed later by a forensic medicine specialist interviewed in this study.



Graph 5: Geographical distribution of health facilities where post-rape services were offered

Along the same lines, Graph 5 above shows that rape survivors were offered available CMR services in healthcare facilities existent across the two regions and different parts of Gaza Strip and West Bank including East Jerusalem. As noted in interviews, this does not necessarily mean that victims would be residents of the same area. On the contrary, they choose to seek rape related services in facilities located outside the population catchment area of their place of residence to avoid encountering people- including healthcare providers- who might know them to keep secrecy of the rape occurrence. Study participants from East Jerusalem (36%), sequentially followed by South West Bank (24%) and mid Gaza Strip (16%) reported highest numbers of CMR survivors in the health facilities where participants work. While the sampling bias could have largely contributed to this distribution, what matters here is that rape survives do seek and get offered the available services in the existing facilities, but nothing is known about the quality of the services they get.

Service providers' knowledge about CMR

When asked about the exact services they provided, by order of frequency from most to least frequent, all responses polled into; documentation of injuries and injury treatment, referral to other institutions, psychosocial support, pregnancy test (in case of delayed rape reporting) & contraceptives provision as applicable, evaluation for STIs, and limited forensic evidence collection. Evidently, other crucial CMR service components were not mentioned by any of the participants such as post-exposure prophylaxis (PEP) of HIV, tetanus or hepatitis B preventive care.

Table 1: Participants self- perceived CMR knowledge by selected aspects

#	Statement	Agree Strongly	Agree	Un Decided	Disagree	Strongly disagree	NA
1	I am confident that I understand the emotional needs of victims of rape.	10	41	19	20	1	5
2	I am confident that I have the necessary communication skills to work with rape survivors.	4	34	20	25	8	5
3	I know the minimum services that must be available for rape survivors.	3	47	14	22	5	5
4	I am sure I know how to refer rape survivors to appropriate services when needed.	5	38	13	30	6	4
5	I have the skills to find a safe environment to provide rape-induced healthcare to survivors.	6	22	22	33	8	5
6	I have a basic understanding of how to perform clinical and forensic examination needed to rape survivors.	5	38	13	30	6	4

#	Statement	Agree Strongly	Agree	Un Decided	Disagree	Strongly disagree	NA
7	I have basic understanding of how to do objective documentation of the examination results of a raped survivor.	3	31	21	28	9	4
8	I am capable of advising a raped woman about taking an emergency contraceptive and give her treatment if she wants to.	11	34	17	21	8	5
9	I am able to provide advice to rape victims on prophylactic treatment of STIs, including prevention of AIDS, and to provide appropriate guidance when they so desire.	8	42	13	21	8	4
10	Healthcare providers must rely on their own conclusions in shaping results.	18	33	14	18	8	5

Table 1 above displays quite dispersed responses about almost all addressed aspects of CMR. Unfavourable responses mounted up to 54%- 66% of the responses about statements that addressed; “possessing necessary communication skills to deal with the rape victims”, “find safe environment for providing the victim with rape-induced services”, and “objective documentation of examination results”. In addition, unfavourable responses to other statements did not fall below 42% of the responses, by statement at best. This means that the favourable responses are in an overall minority position. In a study sample of 96 persons only, the combined high weight of the “undecided”, “disagree” and “strongly disagree” responses to positively stated statements that address selected aspects of CMR survivors must be compelling to health planners and policy makers as to the need to invest in comprehensive workforce capacity development and strengthening in CMR, technically, operationally and strategically.

Interviewed experts expressed their willingness and readiness to work on a full CMR package that has to operate in parallel across intervention levels of; policy, law, service infrastructure (clinical & physical), staff capacity building and community awareness and sensitization.

Some particularly went beyond the service sectors expressing genuine concern over the absolute public ignorance about the importance and conditions for the acceptability of forensic evidence as a proof of rape occurrence in court, for example. One informant testified with a story about a woman who brought her six years old son after being raped by an adult male in the family, for examination and treatment, Initially, she had intended to take the perpetrator to court with the medical report, however changed her mind with so much bitterness when she learnt that she was supposed to bring the child right after she found out about the attack, for the forensic evidence to have legal value and effect. The same informant declared that, in fact, along the last six months the only rape victims she saw were three boys raped by men. These boys, too, were all brought late for forensic evidence collection. Delay to address rape occurrence is very common when it happens within the family because it presents it with multiple compounded threats to be accounted for in the decision making process about the rape occurrence, another expert confirmed.

Providers' capacity building in CMR

CMR involves the availability of trained staff as a prerequisite to appropriate and full service provision. Table 2 below shows the participants' attended training activities on CMR by identified components. Two key observations can be made about data in this table. First is the variations in the addressed subjects and frequency of participation in training activities by CMR components, indicating that no holistic approach to CMR is adopted and reflecting a sporadic fragmented manner in training as much as the actual service provision process itself as shown in table 1 above. Worth noting here is the poor attention paid to collection of basic forensic evidence despite its legal significance and recent introduction to the health and justice system in relation to rape cases in Palestine. Second is the overall modest number of the attended training activities altogether standing at around 20% participation rate at best. In addition, participants voiced concerns about the quality of the received training including the expertise and competence of some trainers and the lack of use of training guides or curriculum almost always.

Table 2: Participants' attended training activities on CMR by identified components

CMR service components	Doctor	Nurse	Midwife	Other	Total
Documentation of information about injuries	6	2	4	1	13
Collection of forensic evidence	2	2	4	0	8
Injury treatment	3	3	4	0	10
Risk assessment and treatment of STIs	4	3	2	1	10
Risk assessment of pregnancy and Provision with emergency contraceptives	6	3	4	1	14
Provision with psycho-social support and follow up	8	3	6	2	19

Out of the 19 examined healthcare facilities, 9 reported having rape-trained clinical staff. Of these, 5 facilities incorporate 24 hours on call into their work schedule. It is not clear however if the talk here is about the full CMR training package or about fragments only. Linking this finding with the participants' self- reported training suggests the later, nevertheless.

Informants interviewed in this study reported that the later United Nations Office on Drugs and Crime (UNODC) work addressed sexual violence including rape from the perspective of human security and social Justice. This was a landmark initiative that has unlocked the door for an open address of rape despite being a prime taboo in Palestinian society. Namely, implemented with the Institute of forensic medicine at the Ministry of Justice in the West Bank, this included three fundamental capacity building activities. First is the completion of a comprehensive capacity building program of four-year duration academic training of eight doctors as specialists in forensic medicine, by the year 2017 in Jordan. Second is the provision with a specialized on-the-job training on basic forensic evidence collection for twenty-three nurses over two-year duration. These nurses work at the MOH health facilities where GBV services are offered to survivors. International forensic medicine experts conducted this training. Third is the development of SOP manual on the response to GBV and sexual violence. In Gaza Strip, specialized training in forensic medicine was offered only to three female doctors who are already practicing specialists in the area of Obstetrics and Gynaecology. Under the Ministry of Health in

Gaza, the three trained doctors form a committee whose work is to provide the needed services, assessments, and reporting concerning GBV survivors who show up at any health service facility with any form of sexual violence including rape. This and other GBV related services provision was backed by the Norwegian Refugee Council and UNICEF produced SOP on the response to GBV combined with Child protection in the Gaza Strip under the global protection cluster- child protection, few years earlier informants from Gaza reported. Alongside, a recent SOP was developed for joint action on GBV including sexual violence and rape. This was lead by the Ministry of Women Affairs as the head of the National Team for the NRSWSV, with respective other government and NGO partners, with UNFPA funds, while an akin one in Gaza is underway. This was meant for a standardized national practice regarding all types of GBV in light of NRSWSV.

These significant efforts, however, are hindered by three impediments informants have identified. First is the lack of adequate infrastructure in terms of clinics and safe spaces fit for forensic medicine practice and evidence collection. This was seen to be stemming in the poor perception of what forensic medicine is really about and what it incorporates, and needs for its proper practice and efficient utilization. This is across the board within the healthcare system at MOH.
Second, is the prejudice and patriarchal mentality many care providers, predominantly doctors, continue to hold and exercise in handling women and girls, victims of sexual violence including rape. One strong manifestation of this is the healthcare providers and leaders' encouragement and at times defines of the idea of the victim's marriage to her rapist, for the sake of family reputation protection and minimization of possible post-rape repercussions, more so in Gaza than in the West Bank, nonetheless. Third is the obvious fragmentation of GBV related forensic services and lack of consistency of providers' place in the service provision system/s being Ministry of Justice for some (specialists) and MOH for others (nurses) in the West Bank and MOH for all in the Gaza Strip. Role ambiguity is experienced as a result with clear statements about the demoralizing influence this has for forensic service providers.

Participants were asked about elements of care they believe they need to be trained on and learn more about as regards to the provision with the complete service package of CMR survivors. Table 3 below shows that of the total, those who recognize their need for further training in various CMR components range between 32% (n=31)- 55% (n=53) individuals, with the highest (50% and above) being in referral related aspects of the care giving process mainly with

respect to referral process, mechanisms, pathways and follow up. Collection of basic forensic evidence and risk assessment and treatment of STIs follows, without any significant differences between professions.

Table 3: Participants by their recognized training need in CMR areas by components.

CMR service components	Doctor	Nurse	Midwife	Other	Total
Collection of documented information about injuries.	15	7	14	1	37
Collection of forensic evidence	20	9	11	1	41
Injury treatment	16	9	12	0	37
Risk assessment and treatment of STIs	17	8	14	1	40
Risk assessment of pregnancy and Provision with emergency contraceptives	15	4	10	2	31
Provision with psycho-social support, case referral and follow up.	23	11	13	2	49
Referral mechanisms and pathways.	22	11	17	3	53

Training on forensic evidence collection was called for by informants in Gaza and West Bank alike. One Gazan expert has expressed her interest in this specific CMR facet like this;
“Evidence needed to change the laws lies in our hands in the health sector. If we create and accumulate convincing evidence on rape and its harmful consequences we will be in a much better position to pressure and lobby for the legislative amendments we want”.

This might also be influenced by the previously mentioned investments made in this area, more comprehensively in the West Bank. The eight Palestinian doctors who became forensic medicine specialists and the twenty-three nurses who received the specialized forensic evidence collection training with the UNODC grants are a great asset for quality provision of CMR services to survivors, if effectively utilized. With appropriate support, they can serve

as a national resource hub for the government, in specific, but also to other actors as well, to create, shape and guide the practice of forensic medicine in Palestine. They must also be actively engaged in forming an in country pool of experts and trainers in CMR, as was uttered by one of them interviewed in this study.

Along the same lines, although consequences of rape were not addressed as per se in this assessment, respondents frequented their firm awareness of the connection between suicidal behaviours and rape. Some expressed concern over the missing point in the way suicidal attempts, especially those committed by adolescents and single women, are handled in emergencies in hospitals across the West Bank and Gaza. One GBV focal point from southern West Bank called for a policy intervention to integrate a more sexual violence integrated approach in clinical management of attempted suicide in the healthcare facilities.
This argument is well supported in literature where suicidal behaviour is cited as one of many consequences of sexual violence including rape. Research evidence shows that women who experience sexual assault in childhood or adulthood are more likely to attempt or commit suicide than other women. The experience of being raped or sexually assaulted, studies confirm, can lead to suicidal behaviour as early as adolescence. For example, in Ethiopia, 6% of raped schoolgirls reported having attempted suicide. A study of adolescents in Brazil found prior sexual abuse to be a leading factor predicting several health risk behaviours, including suicidal thoughts and attempts (Krug et al., 2002).

Rightly bringing in this facet of rape experience, respondents shed light on a serious system failure and addressed a critical gap in CMR in healthcare facilities that requires attendance and clinical redress immediately, including by staff capacity building and training.

Providers' attitudes about rape

Table 4: Participants acceptance of rape myths

#	Statement	Agree Strongly	Agree	Un Decided	Disagree	Strongly disagree	NA
1	It is easy for women and girls to lie about rape.	28	39	7	14	4	4
2	Some women are raped because they behave or dress in an inviting manner.	8	27	10	29	18	4
3	Some conditions make it acceptable for a man to force a woman into sex with him using physical force.	4	16	5	21	46	4
4	If the rape victim does not resist then it's not rape.	10	17	15	32	18	4
5	If the offender was drunk during the act then it is not considered rape.	1	1	8	32	49	5
6	It is possible to make sure that a girl is sexually assaulted by the way she behaves when you talk to her.	8	35	18	26	5	4
7	Rape is a sexual act.	16	30	14	24	7	5
8	Physical injury is the only result of rape that is related to health.	1	7	10	38	37	3

Literature confirms that myths about rape serve the purpose of "blame shifting" from the perpetrator to the victim (Crall and Goodfriend, 2016; Suarez and Gadalla, 2010) and perpetuate deeply rooted socio-cultural barriers to CMR service provision and hinders the protection of the rape victim. Unequivocally, the majority of the study participants possess a high acceptance rate of rape myths, as can be seen in table 4 above. This brings into question the manner by which they respond to the needs of rape survivors who seek healthcare

services at the institutions where they work. This is on the one hand. On the other hand, it also sheds light on this significant area as a priority training need for care providers being the duty bearers whose responsibility is to provide rape victims with socially accessible CMR through a compassionate address of their needs within the health care sector.

In connection, informants particularly noted the futility of the medical report rape victims get based on the clinical examination and treatment they receive in service facilities, mainly because of the existing attitudinal, competence, and safety challenges physicians experience in the case of rape survivors' treatment. Many male physicians are unable to empathize with a raped girl or woman at the first place, but then also are clinically incompetent and/or fear the revenge of the perpetrator when it comes to the medical report contents in the absence of any form of protection for service providers. One prominent female informant from Gaza with law background and practice stated it thus;

"What value is there in a medical report of a raped girl or women if all what it encompasses are only her complaints and the doctor's description of her injuries, without any diagnosis or clinical interpretations as to what could have caused them, avoiding to make any connection between them and the rape occurrence. Such report has zero value in the court. This way the doctor fails his duty to fulfil the victim's right to health and justice and facilitates impunity for the perpetrator",

Service facility readiness to provide CMR care

The health service facility readiness for CMR survivors was further investigated by looking into the available infrastructure in terms of furniture or setting, supplies both basic and advanced focusing here on the forensic evidence collection kit/supplies in the later, drugs, and lastly administrative supplies.

As for furniture or setting, specific items as defined by international guides and protocols for standard practice of CMR (WHO and UNHCR, 2004) were observed. Table 5 below shows that out of the 19 facilities examined in the two regions of West Bank including Jerusalem and Gaza Strip, there was no single facility that fully met the standards as stated in the globally adopted CMR protocol. This is although some of them are among the minimum requirements for examination and treatment of a rape survivor by the said protocol.

Table 5: Examined health care facilities by specific items of furniture & setting availability.

FURNITURE OR SETTING	Available	Not Available
Room (private, quiet, accessible, with a toilet)*	17	2
Examination Table*	18	1
Light (Preferably Fixed), A torch can frighten children	17	2
Access to Autoclave to sterilize equipment	17	2
Weighing scale and height chart for children	15	4
Magnifying Glass (Colposcopy)	9	9
Access to Laboratory facilities with a microscope and trained technician	17	1

* Items marked with an asterisk are the minimum requirements for examination and treatment of a rape survivor.

The most frequently missing items were magnifying Glass (Colposcopy), and weighing scale and height chart for children. Two facilities did not have a room that is private, quiet, accessible, and with a toilet, while one did not have an examination table, and these are two minimum requirements for examination and treatment of a rape survivor.

Table 6: Examined health care facilities by availability of basic supplies

For basic facility, i.e. where treatment is done and possibility of collection of evidence limited;	Available	Not Available
Speculum	19	0
Supplies for Universal Precautions (gloves, safe disposal boxes	19	0
Resuscitation equipment for anaphylactic reactions*	12	7
Sterile medical instruments for repair of tears, and suture materials*	18	1
Gown, cloth or sheet to cover the survivor during examination	18	1
Sanitary materials (pads or local cloths)*	12	4
Pregnancy tests	14	5

* Items marked with an asterisk are the minimum requirements for examination and treatment of a rape survivor.

Supplies were categorized into two; one concerning basic supplies in basic facilities and another on advanced supplies in advanced facilities. About the first, table 6 below clearly shows that in the majority of the examined facilities most supplies were available. However, the highest alarming number of the registered deficiencies was about resuscitation equipment found missing from 7 locations and sanitary materials found missing from 4. That both are minimum requirements for examination and treatment of rape survivors by WHO and UNHCR standards (2012) rings the bell as to the extent of basic readiness of the studied and unstudied facilities by extension.

Table 7: Examined health care facilities by availability of advanced supplies

ADVANCED SUPPLIES For Advanced Facilities where evidence may be collected, check for the forensic evidence collection kit including:	Available	Not Available
Comb for collecting foreign matter in pubic hair	0	15
Syringes/needles(butterfly for children/tubes for collecting blood	13	3
Glass Slides for preparing wet/and dry amounts of sperm specimens	5	10
Laboratory Containers for transporting swabs	7	9
Paper sheet for collecting debris as survivor undresses	3	13
Paper bags for collection of evidence*	5	11
Paper tape for sealing and labelling container bags*	7	9
Cotton tipped swabs/applicators/gauze compress for collecting samples.	12	4
Set of replacement clothes	7	9
Tape measure for measuring the size of bruises, lacerations, etc*.	9	9
Speculum (preferably plastic, disposable, only adult sizes)*	19	0
Universal precaution supplies (Gloves, box for safe disposal of contaminated and sharp materials)*	18	1
Resuscitation equipment*	8	9
Sterile Medical Instruments (kit) for repair of tears and suture materials*	12	6
Gown or cloth to cover the survivor during examination*	16	2
Sanitary supplies (Pads or local clothes)*	14	4
Pregnancy tests	14	4
Pregnancy calculator to determine the age of pregnancy	13	5

* Items marked with an asterisk are the minimum requirements for examination and treatment of a rape survivor.

Interpreting the figures in table 7 above, it was born in mind that the examined facilities are not necessarily meant to routinely conduct forensic evidence collection, but should this be needed they must be capable and prepared for providing appropriate CMR services to rape survivors in accordance with the international protocols and standards that must be put in place, one informant assertively stated. They also have the duty to contribute to making CMR an available and accessible service to rape victims in all areas across the two regions of West Bank and Gaza in Palestine, as per the provisions on the health sector in the NRSWSV.

Overall, data in table 7 show that the readiness level for forensic evidence collection in the studied facilities is currently poor. On the one hand, this calls for an upgrade of the studied facilities clinical infrastructure. On the other one, existing deficiencies could be interpreted as an indirect indication on the lack of technical competence of the existing staff far more than budgetary constraints as regards to filling the existing gaps, especially given the low expected costs of the missing items. This in turn speaks to the CMR training needs and priorities in future agenda setting in the area of CMR survivors, nationally.

Around two thirds of the studied facilities were hospital settings. Findings presented in table 8 below show that 62% of the facilities that responded to this question reported drugs “for treatment of STIs” to be unavailable. In addition, out of 16 responding institutions, 9 reported not having emergency contraceptive pills (ECPs). However, they have alternate treatments to give when survivors present, one key informed elucidated. She also voiced concern about the shift in programmatic focus from services to advocacy UNFPA made in the last two years, linking it to this specific study finding. With elaboration she proceeded saying that UNFPA used to provide the health NGOs through MOH with contraceptives including ECPs, but seized doing so based on the significant improvements in reproductive health indicators including contraceptives prevalence rates based on “mission accomplished” kind of thinking.
Given that MOH does not budget for contraceptives, a serious regress was witnessed with the unmet needs for family planning methods including emergency contraceptives standing at 11% in 2014 **reflecting a growing demand for contraception (Courbage, Abu Hamad & Zagha, 2016).** Thorough discussions on this matter among partners and UNFPA resulted in bringing family planning methods including ECPs back to UNFPA supported services to address the issue.

Except for; antibiotics for wound care, local anaesthetic for suturing, and pain relievers, all other drug items were found predominantly lacking in most studied facilities. The implication this has for CMR survivors are not insignificant and require immediate action on the side of the MOH as well as the aid agencies concerned with CMR.

Table 8: Examined health care facilities by availability of drugs

DRUG CATOGORIES	Available	Not Available
For treatment of STIs as per protocol*	6	10
For Post exposure prophylaxis (PEP) of HIV Transmission as per protocol	1	15
Emergency Contraceptive Pills (ECPs) and /or Copper bearing Intrauterine device (IUD) as per national protocol*	7	9
Tetanus Toxoid, tetanus immunoglobulin	2	13
Hepatitis B Vaccine	2	12
Pain relievers*	18	0
Anxiolytic (e.g. diazepam)	7	11
Sedative for children	5	13
Local anaesthetic for suturing*	12	6
Antibiotics for wound care*	17	1

* Items marked with an asterisk are the minimum requirements for examination and treatment of a rape survivor.

While almost all items identified under administrative supplies are considered minimum requirements for examination and treatment of a raped survivor, their absence from a considerable number of the studied facilities suggests poor quality rape treatment in these facilities, when provided.

Table 9: Examined health care facilities by availability of administrative supplies

ADMINISTRATIVE SUPPLIES	Available	Not Available
Medical charts with pictograms*	6	12
Forms for recording post rape care	2	14
Informed Consent*	2	15
Information pamphlets for post rape care*	3	12
Safe, locked space to store confidential records*	12	7

* Items marked with an asterisk are the minimum requirements for examination and treatment of a rape survivor.

As can be seen in table 9 above, almost all identified items are documentation-related which has legal and judiciary significance for the survivor if she chooses to file a court case against the perpetrator. Missing such core CMR components indicates that the healthcare providers as the duty bearers within the health sector fail to respect, protect or fulfil the victim's basic human right in this matter. This adds yet another significant training and capacity development building block for agenda setters in this area.

Conclusions and Recommendations

Discourse, agency and activism about all forms of GBV including sexual violence and rape, have been living and vibrant since many years in Palestine, as was read in various reports, draft laws, strategies and national surveys data reviewed in this study. Yet, subsumed always under the broader concept of GBV where almost all other forms, such as physical or emotional violence, are less threatening and less destabilizing to social norms and power structures, rape has systematically been hidden away and ignored in redress except for when severity, harm or loss are utter. Even then, interventions take the form of rescue remedies and so remained shallow in depth and limited in scope.

Incremental collective efforts of all actors persistently, aggressively and extensively pushed for the integration of GBV including rape in national polices, strategies and systems documents. This is until this effort reaped fruit with the issuance of the National Referral System for Women Survivors of Violence (NRSWSV), where Article 18 with its 6 provisions, is explicitly consigned to raped girls and women, under chapter three on the role of healthcare providers in GBV survivors' protection interventions. Prior to that, in the National Strategy to Combat VAW 2011-2019, 29 appearances of the world "rape" were spotted signifying its visibility and materialization in the selected policy interventions throughout the strategy. In conclusion then, these policy commitments of the Palestinian National Authority towards combating GBV including rape have become compelling for action, especially given the respective International Treaties to which it has become a signatory.

Sensitize policy makers about the National Referral System for Women survivors of violence

At the policy level, undoubtedly, all healthcare providers across the board must be fully familiarized and aware of the NRSWSV, with a special focus on chapter three on health care providers and Article 18 for those working on rape cases. Some service providers – depending on their jobs and duties – will need to develop a more profound understanding of its finest details. According to findings of this assessment, it can be confidently argued that this is not the case for the majority in the heath sector thus far. This must be well thought of if the NRSWSV is meant to take effect and truly protect women from all forms of GBV. National sensitization workshops, per sector, could initiate the correction here. Beyond policy, below are the more concrete service oriented recommendations;

Develop uniformed CMR protocol:

The assessment revealed a wide recognition among participants about the absence of a uniformed approach to CMR service provision in accordance with a protocol or SOP about sexual violence including CMR. Informants asserted that clinicians handle rape cases in a very individual and narrow scale, especially given that only few raped victims seek medical assistance at the acute post rape phase. It should be noted here that at least two different SOPs have been produced in the West Bank and a third one in Gaza, each by a different party, with a varying degree of practicality and technical details. In addition, no training has yet been done on any, although an intention to do so was communicated by UNODC in an interview conducted for the purpose of this assessment. It is strongly recommended to capitalize on the work already done and agreeably adopt one unified reference protocol for the two regions of the West Bank and Gaza, if possible, and put it into practice, including by conducting the needed training and capacity building sessions.

Improve rape service delivery

Participants used the term CMR loosely to mean any minor or major rape-related service/s a raped girl or woman receives at a healthcare setting. The number of participants who reported having offered post-rape care to a rape

survivor during the last year in the studied facilities is modest, and services they reported having offered do not include the full range of CMR service components. In addition, nothing is known about the quality of the service these victims got there.

On the positive side, this implies that factors that push victims away of health service institutions are declining, and that willingness to disclose information concerning rape occurrence and courage to seek medical help about it is budding. This conclusion is supported by the finding about the Ramallah Medical Complex where an average of 1-2 rape victims shows up every month for CMR services. Additionally, Beit Jala government hospital was particularly pointed out by a lead NGO informant to be distinctly receptive and cooperative about rape-resulting pregnancies when referral arrangement for a rape survivor is initiated.
This contradicts the long standing rarity of rape survivors seeking healthcare in public hospitals, especially major ones. It means that the public, girls and women in this case, are seeing and appreciating the supportive communication and the compassionate, confidential and dignified treatment the trained staffs are using in dealing with them. A change in perception, behaviour and culture on the side of service providers and recipients alike appears to be taking place here.

Conversely nevertheless, expert informants reported some service facilities that are still lagging behind and uncooperative in handling rape survivors, attitudinally and competence wise. Informants reported situations where a referred raped girl who was not received well by the receiving institution just fled without getting the service or returning to the sending institution whose confidence in which she's most probably lost. Others brought in the connection between suicidal attempts and rape. They expressed concern over the missing point in the way suicidal attempts especially those committed by adolescents and single women, are handled in emergencies in hospitals across the West Bank and Gaza. The same Informants, who included men, called for a policy intervention to integrate a more sexual violence integrated approach in clinical management of attempted suicide in the healthcare facilities. This all reflects inconsistent poor case management and lack of standardized practice in CMR. While this holds implications for the service; availability, accessibility, quality, and acceptability, it also marks the significance and value of investing in the health workforce strengthening within the existing structures.

Strengthen the health workforce

Service providers' knowledge about CMR in general was found rather poor. Unfavourable responses to knowledge questions came from up of 66% of the study participants in the questionnaire, for example. In addition, the most frequented training needs participants expressed were in the areas of; referral pathways, mechanisms, and follow up followed by collection of forensic evidence and risk assessment, which are all core CMR components.

Overall, variations in the frequency of participation in training activities by CMR components indicated that no holistic approach to CMR is adopted reflecting a selective fragmented manner in training as much as the actual service provision process itself. The low attention paid to collection of forensic medicine despite its legal significance and recent introduction to the health and justice system in relation to rape cases, was well observed. The modest number of the attended training activities altogether standing at around 20% participation rate at best was another observation here.

Literature confirms that myths about rape serve the purpose of "blame shifting" from the perpetrator to the victim, perpetuate deeply rooted socio-cultural barriers to CMR service provision and hinders the protection of the rape victim. The majority of the study participants demonstrated a high acceptance rate of rape myths. This brings into question the manner by which they respond to the needs of rape survivors who seek healthcare services at the institutions where they work, and sheds light on this significant area as a priority training need for care providers as the duty bearers by law, professional ethics and human rights principles.

This all indicates there is a serious need to invest heavily in a comprehensive plan for workforce capacity development and strengthening in CMR, technically, operationally and strategically. Specifically, capacity building of doctors as specialists in forensic medicine should be greatly invested in as a national human resource and asset, as TOTs for further health workforce development in this respect, as well as in awareness raising and community sensitization, as the expert authority voice in this, in order for them to contribute to eventual change in the public view about rape and use of CMR service for treatment and Justice realization for the victims, too.

Strengthen infrastructure and availability of supplies

The health service facility readiness for CMR survivors was examined by looking into the available infrastructure in terms of; furniture or setting, supplies both basic and advanced focusing on the forensic evidence collection kit/supplies in the later, drugs, and lastly administrative supplies. In all identified areas, there was no single facility that fully met the standards set in the globally adopted CMR protocol, and in most aspects the facility readiness ranged between poor and very poor according to these standards. This included items that are among the minimum requirements for examination and treatment of a rape survivor by the said protocol. This is when around two thirds of the examined facilities were hospital settings. It is true that the existing infrastructure could be argued to be much better than that in many other corresponding countries in the region. However, considering the huge investments donors have made in these facilities, and given that the reference point in this study is the set standards versus the existing comparable realities, this study calls for strengthening and upgrading the studied facilities clinical infrastructure and supplies. Alongside, existing deficiencies are suggestive of the lack of technical competence of the existing staff far more than budgetary constraints as regards to filling the existing gaps, especially given the low expected costs of most missing items. This in turn speaks to the CMR training needs and priorities in future agenda setting in the area of CMR survivors, nationally.

Community awareness raising and education

This is about the whole question of rape of the two sexes including incest. Particularly, forensic evidence is an area with huge information, service and public awareness gaps. Public ignorance about forensic evidence in rape (including of male children) exacerbates the raped person trauma and worsens consequences of rape, especially when proof is needed for court. Complete ignorance especially about the importance and conditions for forensic evidence acceptability in court indicates that public awareness about this matter is none existent. Doing so, investments should be made in the above mentioned workforce development of forensic medicine specialists. The power of use of media outlets should not be ignored here, side by side with face to face professional encounters as needed.

Strengthen evidence focusing on collection and use of data on rape and CMR, ensuring close monitoring and evaluation of the quality of these data.

Increasingly, triggered with the issuance of the NRSWSV perhaps, scarcity of information specifically about services available to rape victims/survivors anywhere in the health sector became pretty visible and the need to fill this information gap and create some evidence on the subject became more pressing than ever. This includes clinical management of rape (CMR) service availability, quality, accessibility and acceptability, let alone the need to study the raped person experience for the full image of reality. While this assessment represents only a small start for creating such evidence in Palestine, it confirms and strongly argues for more strategic work for creating more comprehensive evidence by systemic organized documentation of numerical and textual data on rape cases. It also suggests conducting further scientific research with the view of building a national database on CMR survivors from both sexes, in order to inform policy and guide progress more strategically.

In closure I say, in all interventions at every level, the bottom line is: The right of the raped girl, woman or person to protection, compassion, support and service is inalienable. The real shame is not that somebody gets raped. The real shame is that society rapes the victim over and over again, by denying her/him basic human rights, criminalizing her/him and protecting the real criminal with impunity instead.

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