Documentation of

Human Rights Violations against

Women Engaged in Sex for Money (WSM)

Soins Infirmiers et Developpement Communautaire

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" تمّ تطوير هذا المنشور بفضل دعم الشعب الأميركي من خلال الوكالة الأميركية للتنمية الدولية (USAID). إنّ محتويات هذه المنشورة هي مسؤولية الإستشاري، ولا تعكس بالضرورة وجهة نظر أو آراء الوكالة الأميركية للتنمية أو حكومة الولايات المتحدة".

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ABBREVIATIONS:

CSO	Civil Society Organization
FSW	Female Sex Worker
GARP	Global AIDS Response Progress
HIV	Human Immunodeficiency Virus
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NGO	Non-Governmental Organization
OHCHR	Office of the United Nations High Commissioner for Human Rights
PLHIV	People Living with Human Immunodeficiency Virus
SIDC	Soins Infirmiers et Developpement Communautaire
STI	Sexually Transmitted Infection
UK	United Kingdom
UKNSWP	United Kingdom Network of Sex Work Projects
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
US	United States
WHO	World Health Organization
WSM	Women who engage in Sex for Money

BACKGROUND:

The health and human rights model acknowledges the presence of adverse health consequences as a result of human rights violations. Such health consequences of brutal violations are especially evident among vulnerable populations (Johnston et al., 2009). Lesbian, gay, bisexual, transgender, and intersex individuals (LGBTI), children, minors, pregnant women, prisoners, refugees, people living with human immunodeficiency virus (PLHIV), drug users, and sex workers including both male sex workers (MSWs) and female sex workers (FSWs), are among the most vulnerable populations (Bittman & Couffignal, 2017). Vulnerable populations are deprived of developmental prospects due to their detrimental living situations and the varying cultural and socio-economical practices in their surrounding environments. These challenges prevent them from fulfilling their human rights and leading a contented life (Sastry & Gade, 2012).

The World Health Organization (WHO) defined the term sex workers as "all adults and young people (above the age of 18), including female, male, and transgender individuals who sell or exchange sexual services for money, goods or benefits (e.g., transport, shelter, food, and drugs) either regularly or occasionally" (WHO, 2012). Sex workers are considered among the most vulnerable populations because of several factors, including but not limited to; lacking the appropriate education, coming from a low socioeconomic status and being excluded from society (Vamdepitte J et al., 2006 & Scambler & Paoli, 2008). In addition, they confront multiple challenges and risks like having multiple sex partners, being alcohol and drug users, sharing injectable equipment, and not being able to negotiate with clients on consistent condom use; thus being at high risk of unwanted pregnancies, unsafe abortions, contracting human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs) (Campbell & Mzaidume, 2001; Jewkes *et al.*, 2013; Kerrigan et al., 2013; WHO, 2012; Scorgie et al., 2013 & Shannon et al., 2009).

In addition to the above-mentioned challenges and risks, sex workers face cultural stigma and discrimination as a result of aggressive societal norms that criminalize their existence and nourish their feeling of social exclusion, low self-esteem, worsening their psychological and physiological well-being (Aunon et al., 2015 & Scorgie et al., 2013) and exposes them to be the victims of violent acts and preventing them from accessing various services; particularly

healthcare and social services (Shannon et al., 2009). Therefore, sex workers can be often the direct victims of inequitable care and treatment within the healthcare and social systems (Shannon et al., 2009). As a result of recurrent experiences of stigmatization and discrimination in these settings, they may, despite their need, become reluctant to seek assistance from the health system (Shannon et al., 2009). This negatively inflicts on sex workers' overall health status particularly since it prevents them from acquiring needed health related information and services such as sexual health services, prevention and treatment of HIV and other STIs among others social related services and care such as financial and social support (Shannon et al., 2009).

While the difficult experiences that FSWs are subjected to have been investigated in many regions of the world, Lebanon is still lacking any documentation regarding the violations they are exposed to in society and while seeking services from healthcare and social centers. Therefore, in order to understand the experiences and violations these women face in society and within healthcare and social centers this study aimed to document cases of violations FSW (including transgenders) are exposed to. Ultimately discovering what is lacking in these institutions and suggesting recommendations for policy amendment can allow FSW to fulfill their human rights one day.

SEX WORK:

The term 'sex work' can refer to an extensive range of sex services, such as prostitution, stripping, table-dancing, porn acting or phone sex services (Kontula, 2008). It can also be defined as the provision of sexual services for money or its equivalent. Sex workers may be males, females, or transgendered, and the boundaries of sex work are indefinite, ranging from erotic demonstrations without physical contact with the client, through high risk unprotected sexual intercourse with several clients. Some individuals may occasionally and unscrupulously acquire money or gifts for a sexual courtesy without distinguishing themselves as sex workers, or they may be engaged full time in the provision of sex services (Harcourt & Donovan, 2004). Sex work has many faces with substantial differences between populations, it can differ in the way it is organized, its level of visibility, and its accompanied risks (Vandepitte et al., 2006).

Estimating the population size of sex workers in the different countries around the world is a very difficult to achieve. Sex workers are estimated to represent between 0.1% and 7.4% of

the general population in different regions and this might be an underestimated percentage, since sex workers are a hard-to-reach population group, depending on the country's legal view and the level of stigma towards sex workers (Vandepitte et al., 2006). Furthermore, the number of sex workers is subjected to change continually over time and by place, as sex workers move in and out of sex work based on their financial needs, they move from rural to urban settings based on the demand of sex work, follow seasonal laborers and tourists, or move through a country or in between countries to fulfill their needs (Vandepitte et al., 2006).

In Lebanon, there are many aspects that come into play when considering sex work in the country. Although the World Bank has classified Lebanon as an upper-middle income country, the political and regional instability has made the economic situation unstable. This, in addition to Lebanon's location and climate, which attract many tourists into the country, mark Lebanon as a good destination for sex workers to make quick money (UNAIDS, 2008). The UNAIDS (2016), has estimated the number of sex workers in Lebanon to be around 4220, from different nationalities and backgrounds. They are found in the most popular areas of Beirut on major roads, under bridges, and along the sea front in summertime. Moreover, there are sex workers that work specifically in night clubs and pubs under the profession of dancers or singers. These are considered the most common locations for sex workers to recruit their clienteles; however, their work is usually performed in their homes, hotels or rented apartments based on the clients' preference (UNAIDS, 2008).

THE DRIVERS FOR SEX WORK:

The entrance into sex work is driven by several motivating factors and causes that can be divided into two sets of dynamics: unconscious compulsive or psychoneurotic needs; and voluntary, more rational motivations (Benjamin and Masters, 1964). James and Meyerding (1976) distinguished three categories of encouraging factors: psychoanalytic motivations also referred to as conscious motivations, including economic reasons and working circumstances; and situational stimuli, which include early life experiences like abuse and neglect. Also, James (1978), claimed that the most prominent factors that drive individuals into sex work include; deprivation, physical or sexual abuse, affluence, or overindulgence. Additionally, Benjamin and Masters (1964) stressed that many factors contribute to a women's entrance into sex work, and divided them into: (1) predisposing factors: rudiments in her background; a broken home, parental promiscuity, or

tolerance of prostitution within one's environment; (2) attracting factors: those elements that attract one into prostitution, such as financial rewards, an easier life, a more interesting or exciting occupation, and the expectation of sexual gratification; and (3) precipitating factors: including economic pressures, enticement by a pimp or peers, and an opportunity (Silbert & Pines, 1982). Finally, homelessness and drug addiction have been identified as the two most significant factors which prompt engagement in on-street sex work and two of the main barriers to stabilizing the lives of sex workers (Spice, 2007).

For migrant sex workers, there are a wider range of factors which may result in their engagement in sex work. The inability to find work in their hosting countries is one reason why migrants have migrated and ended up working in the sex work industry (Scambler, 2007). Migrants engage in sex work to fund aspirations of social mobility, better living standards, educational aspirations and greater and more rewarding working conditions. In addition to earning money which they then send back to their home countries to support families, including their own children and other dependents. Migrants are often unable to find other forms of employment which are as financially rewarding as sex work due to language barriers, a lack of qualifications, a lack of rights to work and the lack of adequately paid jobs on offer (Agustin, 2006).

Currently most sex work serves as a strong and primary a source of income for sex workers, but also for dependent kin and associates including pimps, managers, and ancillary workers. Individual sex workers have very different levels of need ranging from survival, debt, drug dependency, coercion, and social connection, to desire for wealth and social mobility (Harcourt & Donovan, 2004). Factors such as the neurotic need to punish oneself, rebellion from family, the neurotic attachment to a pimp, alcohol and narcotics, mental deficiency, laziness, and psychological inadequacy are all possible reasons for the engagement in sex work (Balfour & Allen, 2014).

Legal Status of Sex Workers Around the World:

Many of the human rights challenges, vulnerabilities and barriers sex workers are subjected to, are due to criminalization and the obstructive laws, regulations and practices that are enforced in many countries. For instance, at least 39 countries partially or fully criminalize selling and/or buying sex whereas in many other countries, some aspect of sex work is criminalized or a general

criminal law is used to criminalize sex work (UNAIDS, 2017). Therefore, criminalization is the main state policy forced on commercial sex worldwide. The perspective behind criminalization stems from an abolitionist approach and is based on a strong ethical refusal of sex in exchange for money. All forms of sex work, whether it is selling, organizing, or buying are subjected to punitive measures under the criminalization laws. Governments vary in the ferocity of enforcing the anti-sodomy laws and policies based on a set of conditions that may relate to the sex workers' age, immigrant status, recruitment strategies, mandatory registration, health checks, geographical locations, and building regulations (Vanwesenbeeck, 2017).

Traditionally, in many countries including the US and the UK, selling and organizing sexual services are aggressively tracked down and prosecuted (Vanwesenbeeck, 2017). Additionally, all countries of Asia and the Pacific criminalize sex in exchange for money or its associated activities, except New Zealand and New South Wales (Australia). These countries follow strict punitive approaches that are impeded in national constitutions to deal with people who engage in sex for money (UNDP, 2012).

Legal Status of Sex Workers in Lebanon:

The Lebanese government criminalizes sex workers unless they have been proven to be victims of trafficking (Saghieh & Geagea, 2009). In fact, sections 526 and 527 of the Lebanese Penal Code states clearly that sex work is illegal in Lebanon and criminalizes people who engage in sex for money (Mohamed, 2015). Therefore, sex workers are considered to be practicing an explicit criminal offence; which subjects them to punitive laws threatening their well-being (Scorgie et al., 2013). According to a previous legal analysis of the current Lebanese laws around sex workers, there exist many loopholes that stigmatize and discriminates sex workers. Also, the law suggests severe punishments on sex workers that would make them silent against clients and pimps, and doesn't subject client/pimps to punishment unless the sex worker was a minor. Moreover, there is an unclear definition of whom is considered a victim of trafficking and exploitation and thus not all women are given the chance to be protected. Thus, the criminalization of sex in exchange for money exacerbates human rights violations and neglects all the efforts done by health promotion activists, confines access to health care services, deteriorates working conditions, encourages violence and harassment, and nurtures stigma and discrimination (Decker

et al., 2014; UNAIDS, 2012; Godwin, 2012; Startdust, 2014; Daniel, 2010; Harcourt et al., 2010; Kim, 2015; Abel, Fitzgerald, & Brunton, 2007; Abel, 2014; Donovan et al., 2010).

Furthermore, although Lebanon does not legally condemn transgender identities, transgender sex workers continue to suffer at the hands of Lebanese law enforcement through arrest and torture, using Article 534 of the Lebanese Penal Code; which states "Any sexual intercourse contrary to the order of nature is punished by imprisonment for up to one year", among morality laws as justification (Wright et al., n.d.). Consequently, sex workers are afraid to request services and have limited resources or options to challenge culprits, or pursue justice and legal reparation. This in turn restricts the possibilities that are available for them to revolt above their perilous circumstances (Mahfoud et al., 2010).

Social Stigma and Discrimination:

Sex workers are subjected to stigmatization, discrimination, prosecution, and harassment. They are often perceived as immoral individuals or as victims of unscrupulous traffickers who take advantage of the de-privileged living conditions of these individuals in most of the poor countries around the world (Wolffers & Van Beelen, 2003). The social stigma sex workers are subjected to, increases among the transgender population and those living with HIV (Mumtaz et al., 2011; Kaplan et al., 2015). Transgender individuals experience stigma and discrimination in all parts of life and rejection is common from both families and society at large. Secondary to such discrimination come difficulties in obtaining education, employment, and housing, which can lead to poverty, survival sex work, and mental health comorbidities. For transgender people, there is a significant risk to seeking healthcare, "coming out" to family or the community, and even simply to be oneself (Kaplan et al., 2015; Anderson, 2011; El Feki, 2013; Wright et al., n.d. & Saleh & Qubaia, 2015). Therefore, sex workers particularly transgender individuals are susceptible to inconveniences that threaten their safety at several levels and by all segments of the community (Kaplan et al., 2015). These circumstances influence all aspects of life and compel their capacities to dynamically grow and progress, and to even get through and remain alive (Kaplan et al., 2015).

Stigma at Healthcare setting:

Literature has revealed that sex workers are often stigmatized and discriminated against, ignored, and insulted in health and social care facilities, particularly in the public sector. Therefore,

it is confirmed that stigma is an essential barrier to health access for sex workers (Anderson, 2011; Lazarus et al., 2012; Scorgie et al., 2013; & Csete & Cohen, 2010; Cohan et al., 2006; Kurtz et al., 2005; Scambler and Paoli, 2008). Despite the fact that most service providers are trained on specific codes of conduct, they still fall into the trap of shadowing the social norms in their surroundings and tend to stigmatize and discriminate against sex workers. Even if some service providers sensitize with sex workers and plan to provide them with the adequate health and social services, they still fear being discriminated against by their fellow providers or from the community at large. This in addition to the deep criminalization of sex workers that is strictly engraved in the laws makes it exceptionally challenging for sex workers to realize their right to health (Csete & Cohen, 2010). Furthermore, the absence of institutional policies, practices and guidelines on how to deal with sex workers in healthcare and social services centers further exacerbates their situation, rendering access to healthcare or social centers by sex workers difficult and avoidable (Lazarus et al., 2012). This has fueled sex workers' vulnerability predisposing them to even more social exclusion, preventing them from seeking health or social services, consequently worsening their pre or existing health problems. All these factors have compromised the quality of life of sex workers, causing a detrimental breach of human rights (Csete & Cohen, 2010). It is important to mention that this situation is affecting also transgender. Enclosed by a culture governed by male and cisgender prerogative, a term use when someone's gender identity matches their biological sex at birth (El Feki, 2013), sex workers particularly transgender feminine persons are subjected to peculiar barriers; such as paucity of knowledgeable providers, lack of insurance coverage and stigma and discrimination when seeking healthcare services (Kaplan et al., 2016).

Violence Against Sex Workers

The World Health Organization (WHO) defines violence as "the deliberate use of physical power, threatened or actual, against oneself, another person, or against a group or community that results or has a high probability of resulting in injury, death, sexual or psychological harm, poor development, or deprivation of liberty" (WHO, 2013). Sex workers face varied forms of violence in the different parties; including clients, pimps, family members, and society in general. This helps legitimize inequality, disaffection and weakness among them, raising alarming questions regarding the human rights of this population (Mahfoud et al., 2010). Male, female and transgender

sex workers may face violence because of the stigma associated with sex work, which in most settings is criminalized, or due to discrimination based on gender, race, HIV status, drug use or other factors (UNAIDS, 2012). This may be physical, sexual and psychological violence, and may be perpetrated by national agents such as law enforcement officers, staff within closed settings such as health care and social centers, clients, families, intimate partners and other community members (Ditmore, 2013).

Violence was found to be one of the most important correlates of mental disorders. A history of abuse can possibly impede women's capacity of defending themselves against assaults. This may in turn encourage clients to behave abusively or may attract potentially abusive customers, therefore, a vicious circle between violence and ill mental health might be established (Romans, Potter, Martin, & Herbison, 2001). Hence, violence or fear of violence usually prevents sex workers from accessing harm reduction, HIV prevention, treatment and care, health and other social services as well as services aimed at preventing and responding to violence (UNDP, 2012). All these factors further drive sex workers to be the victims of even worse health risks, which include anxiety, stress, depression, rape, suicide attempts, and eventually death (Scorgie et al., 2013).

HIV Prevalence Among Sex Workers:

Since the beginning of the epidemic sex workers have experienced a heightened burden of HIV across settings, despite their higher levels of HIV protective behaviors. Unfairly, sex workers have often been framed as "vectors of disease" and "core transmitters" rather than workers and human beings with rights in terms of HIV prevention and beyond. While the relative burden of HIV varies per geographic and epidemic context, sex workers are often found to be at significantly increased vulnerability to HIV through biological, behavioral, and structural risks (WHO & UNAIDS, 2009). Despite the higher levels of HIV protective behaviors among sex workers, legal and policy environments and unsafe and non-enabling working conditions often place them at significantly higher risk for HIV infection (UNAIDS & WHO, 2011).

On average, sex workers are 10 times more likely to become infected with HIV than adults in the general population (UNAIDS, 2014). However, there are significant variations between regions and countries. In low- and middle-income countries, the average HIV prevalence among

sex workers is estimated to be approximately 12%, with an odds ratio for HIV infection of 13.5 compared to all women aged between 15 and 49 years old. In 110 countries with available data, the prevalence of HIV infection is almost 12 times higher among sex workers than for the population as a whole, with prevalence at least 50-fold higher in four countries. Even in very high prevalence countries, HIV prevalence among sex workers is much higher than among the general population. An analysis of 16 countries in sub-Saharan Africa in 2012 showed a pooled prevalence of more than 37% among sex workers. In Nigeria and Ghana, HIV prevalence among sex workers is 8-fold higher than for the rest of the population (UNAIDS, 2014). The GARPR (2013) estimated the prevalence of HIV among sex workers in Lebanon to be 1%.

By gaining a deeper understanding of the epidemiologic and broader policy and social context within which sex work is set one begins to quickly gain a sense of the complex backdrop for increased risk to HIV among sex workers. This backdrop includes the critical role of stigma, discrimination and violence faced by sex workers, as well as, the importance of community empowerment and mobilization among sex workers to address these regressive forces. In addition to other challenges and risks such as; high-risk sexual exposures through multiple numbers of sexual partners and high concurrency of these partners, high prevalence of bacterial sexually transmitted infections, intersection of injection drug use and sex work through increased parenteral exposures from shared injection equipment, sex with more HIV-positive partners, and low condom use (Baral et al., 2012).

MENTAL HEALTH OF SEX WORKERS

Women with pre-existing mental disorders might be more predisposed to get involved in sex work. But the ratio of lifetime prevalence rates and the 1-year prevalence rates rather indicate a reverse effect - the burden of sex work during the last year impacts on the women's mental health to an extent comparable to the rates developed during their whole lives (Rössler et al., 2010). This indicates how burdensome sex work might be. In addition to violence, the possible negative impact of selling sex for money could be described in three ways: first, the emotional implications for managing sex as work and sex as pleasure; second, the risks posed by the threat of 'being discovered' working as 'a prostitute'; and third, the potential failure of emotional management strategies. Some sex workers described how their form of work was emotionally

risky because the negative emotions generated by the commodification of their bodies affected their social identities and relationships.

Moreover, many sex workers might be often consumed by the constant worry whether anyone suspected or whether they would meet someone they knew at work. Having to hide everything connected with work (daily routine, money, clothing, equipment, condoms, etc.) from the private sphere, while at the same time avoiding revealing details about the home life at work, was a continual effort that required more time and energy than other occupational hazards. Finally, strong negative emotions that are not managed can have significant consequences especially in relation to mental health (Sanders, 2004). In fact, involvement in sex work has been linked to post-traumatic stress disorder (Farley, Baral, Kiremire, & Sezgin, 1998), depression (Chudakov, Ilan, Belmaker, & Cwikel, 2002), eating disorders (Cooney, 1990) and drug use (Surratt, Inciardi, Kurtz, & Kiley, 2004). Although no causal inferences can be made from these studies, they significantly indicate that for many women, sex work may directly or indirectly contribute to psychological distress.

RESPONDING TO THE PROBLEM:

As has been highlighted above, sex workers face high levels of exclusion and have a complex array of needs view their poor mental and physical health status, their addiction problems, their situation of homelessness, their debt, poverty, poor education and lack of social support from family or other social networks (Tonybee Hall, 2007; UKNSWP, 2008c; Bindel et al., 2012).

A key message to emerge from the literature stresses on the vulnerability and structural stigma that hinder FSWs from seeking their needs and fulfilling their human rights and the importance of holistic approaches to address all forms of exclusion sex workers are facing within the communities and from society. In order to achieve this two approaches should be considered from the human right and the public health dimension.

The International Human Rights instrument indicates that sex workers like all human beings, are eligible to full protection of their human rights (United Nations, 1948 & World Conference on Human Rights, 1993). These rights include; the right to non-discrimination and stigma, respect of person and privacy, freedom from random arrest, imprisonment, harsh and brutal

treatment, and the protection from violence and attainment of high standards healthcare and social services (UNAIDS & OHCHR, 2006).

As for the public health dimension that stresses on the violations sex workers are subjected to in society and healthcare and social centers should be placed at the center of debate. Therefore, in order to respond to the problem, interventions at the individual, social, and structural levels should be implemented to alleviate the vulnerability inflicted upon sex workers (Lazarus et al., 2012). Hence, the following principles are suggested, government officials from across the spectrum should summon greater levels of political will and commitment to address social marginalization, economic exclusion, and violence within broader governance. Mechanisms should be initiated, preferably in cooperation with human rights groups and civil society, to enhance the independent monitoring of human rights agreements; protect the rights of vulnerable populations; and punish violators. National policies that negatively affect sex workers' human rights and access to health services should be revised or eliminated. Law-enforcement authorities should implement policies that help stem harassment and abuse of sex workers by society and official bodies, all members of the police and other law-enforcement entities should receive regular training on issues related to HIV, drug use, and the legal and human rights of all individuals, especially sex workers and other vulnerable groups. Police should also be expected to refer sex workers to programs and shelters where they can receive appropriate assistance (UKNSWP, 2009).

Furthermore, health authorities should make HIV testing voluntary and confidential for all individuals, including sex workers and should also provide harm reduction services, including needle/syringe exchange, at all public health facilities. Healthcare and social service centers should maintain confidentiality and respect sex workers' privacy and human rights, be non-judgmental, inclusive, accessible and flexible, comprehensive, involve sex workers and build community capacity, recognize and adapt to the diversity of sex work settings, do no harm and not reinforce stigma (UKNSWP, 2009). Hence, health services should be made available, accessible and acceptable to all sex workers based on the ideologies of respect, openness, and the right to health (WHO, 2006). For this to be achieved, new policies and practices in healthcare and social centers that ensure the provision of comprehensive services equitable to all members of the community including sex workers should be developed. (Csete & Cohen, 2010; WHO, 2012; Lazarus et al., 2012; & Nyblade et al., 2009). These policies include; providing a full range of preventative and

curative services to sex workers, providing counseling service, including psychosocial and legal support along with integrating violence prevention counseling interventions. Establishing both a drop-in-center and an outreach program that can support sex workers at any time. Social centers should make sure to train and sensitize sex workers about sex work-related laws and their human rights through raising awareness and disseminating information or tips. They should also provide sex workers with soft skills training, especially negotiation and self-efficacy skills. Healthcare and social center staff should be trained on sex worker's human rights and the different laws and policies related to sex workers. Also, they should be provided with a documented protocol for referral to support services in the community. Moreover, staff should document violence faced by sex workers and map the locations of sex workers. Finally, there should be continuous effective and efficient evaluation of service programs in healthcare and social centers to ensure proper service provision (Kerrigan et al., 2013 & Sanders & Campbell, 2007).

The successful implementation of these principles rely not only on policymakers and service providers, but also on the ability of sex workers to advocate for their own rights. In order for this to happen more consistently, building the capacity of sex workers with the support of healthcare and social service providers will help them feel more comfortable and less fearful in general, they will be able to work together more closely and consistently to advocate for their rights. As much as anything else, this development could have the most positive effect on their own health and the health of those in their lives (UKNSWP, 2009).

RATIONAL:

This study seeks to build on SIDC's existing experience in working to promote, protect and advocate for the human rights of marginalized groups in Lebanon and with a specific focus on Vulnerable Women who are engaged in Sex for Money (WSM). This specific target group is marginalized in Lebanon with violations of their human rights because of the multiple challenges they face in society and in healthcare and social centers. In fact, WSM have shared their experiences with the Civil Society Organizations (CSOs) working with them about assaults at the detention centers or from service providers in health or social institutions; however, these CSOs do not have any form for documenting these violations and abuses, which increases the complexity of responding to the needs and rights of WSM. The documentation of such assaults and violations occurring at detention, healthcare and social centers are encouraged because of the absence of

specific guidelines on how to deal with WSM in their institutional policies and programs. Therefore, the main problem SIDC plan to tackle in this study is

"Stigma and discrimination against women engaged in sex for money from health and social services".

Based on the aforementioned analysis of the situation around WSM, the mentality of accepting those women as humans with rights is still missing. Even though working on amending the existing policies/laws at the dentition centers is of high priority and idealistic, it is currently far-fetched and considered as a long-term goal to advocate for since the present cultural, social and political climate is not ready yet for drastic changes in the law.

This issue is still ripe, with initial problems lying in awareness and perception of the community at large, service providers and the WSM themselves acknowledging their rights. As such, any effort to improve their acquisition of their rights should work on sensitizing the service providers, the WSM and ultimately the community before advocating for changes in the laws. These efforts should occur through frequent, constant, and consistent advocacy on a wide array of community segments across a long period of time in order to respond to these women's rights. As soon as the social/legal/political climate begins witnessing improvements, more concrete demands will be advocated for. These include law amendments at the level of the ministries and/or advocacy measures for integrating specific policies regarding WSM rights within the syndicates and orders of professionals providing services for WSM and ultimately a shift in the cultural practices against them.

LEBANESE CONTEXT*:*

Lebanon still lacking any documentation regarding the violations WSM are facing in society while seeking services from healthcare and social centers

METHODOLOGY*:*

To obtain an in-depth understanding of the personal experiences of WSM, a questionnaire was administered. Questionnaires allow the researcher to investigate the personal experiences of the participant (DiCicco-Bloom & Crabtree, 2006) using both closed and open-ended questions that help focus on the main topic of the study (Bryman, 2016 & DiCicco-Bloom & Crabtree, 2006).

The questionnaire *(Appendix I)* was developed in a way that ensures that there is minimal interaction between the researcher and the interviewee and has specific and non-warning questions allowing the interviewee to give clear, direct, and specific answers. The questionnaire included the following sections; social and demographic status, behavior and lifestyle, health and medical status, psychological health, violations and abuse in healthcare and social centers, social support services, and treatment and violations at detention centers. All questionnaires were administered in colloquial Arabic after obtaining the consent of the interviewees *(Appendix II)*. Following that, the closed ended questions of the interviews were statistically analyzed using SPSS software and the open ended questions were transcribed verbatim, coded and analyzed following the six steps of thematic analysis suggested by Braun & Clarke, (2006) including; familiarization, generation of initial codes, developing and reviewing main themes, and finally writing the results. The generated results of both the statistical and thematic analysis were reviewed by the researcher and the policy specialist, who identified potential changes/recommendations for long-term advocacy at the level of institutional policies within healthcare/social service centers.

In order to conduct the above, a coalition constituting 7 CSOs and institutions who work directly or indirectly with WSM was. Forming a coalition aimed at increasing the feeling of belonging and dedication to the cause and ensuring that the study's team is well equipped with the needed expertise and outreach to influence change in those institutions. Further, it also aimed at building the advocacy capacity of the coalition members by enhancing teamwork and collaboration to achieve a specific aim and increasing their competence to influence policy change. The CSOs that were chosen are in Beirut and Mount Lebanon where SIDC has a good visibility; particularly Nabaa, Sin el fil, Dora, and Burj Hammoud. These areas are well known for the presence of high risks groups; including migrant women and refugees who are at greater vulnerability of being involved in sex work, as well as include a large number of healthcare and social centers which provide services for these women. These healthcare and social centers have an established coordination committee from which the partners were chosen for their active involvement in the community.

Three documenting CSOs from the coalition members were given three days of training on active reporting and documentation of the violations against WSM. They were trained on the use of a standardized process for the conduction of the interviews, which aided in capturing the abuses

or violations of WSM in a way that can be analyzed based on specific themes including; abuser characteristics, type of abuse, the reason of abuse, and the potential follow up measures. Also, they were given educational sessions covering; sexual, reproductive, and mental health of WSM, legal rights of WSM, and the means of effective communication with WSM. These CSOs conducted the interviews with a convenient random sample of 50 adult WSM based on the inclusion criteria; being above the age of 18 years old, from any nationality residing in Lebanon, has more than one intimate partner, engages in sex for money or other benefits, has faced a violation or abuse in a healthcare or social services center, and could be a drug user, a migrant, or a member of the LGBTI community. The trained staff assessed the case socially using a social assessment form to ensure that the WSM meets the inclusion criteria, reported the violations by completing the questionnaire and then referred her internally or to another NGO according to her needs.

OBJECTIVES:

- To document 50 cases of abuse/violations WSM have been subjected to in healthcare/social centers and gain an in-depth understanding of the scope of these abuses
- To identify potential policy changes/ recommendation for long-term advocacy at the level of institutional policies in healthcare/social service centers

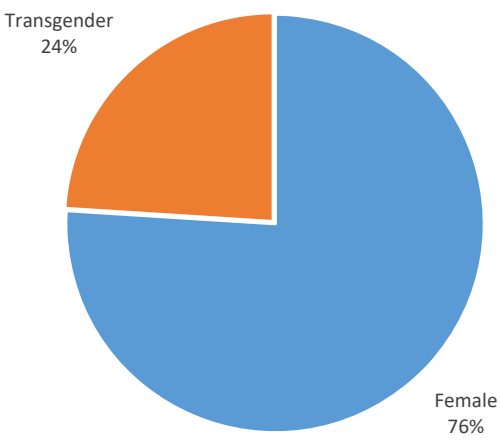
RESULTS:

SOCIODEMOGRAPHIC CHARACTERISTICS

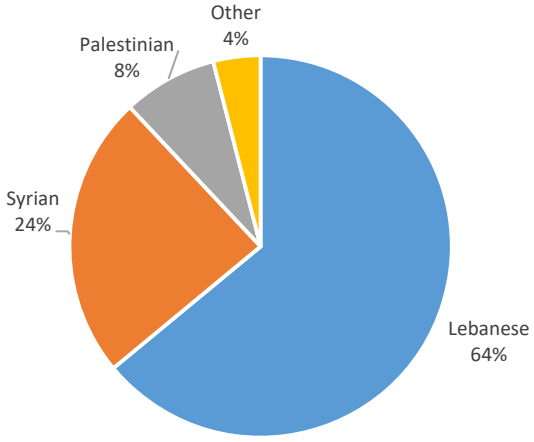
A total of 50 questionnaires were administered to women who experienced at least one type of violation while seeking services from social and/or healthcare centers either at the CSOs' premises which participated in the documentation (70%) or in prisons and detention centers (30%). The mean age of the participants was 37 ± 11 years, ranging between 20 and 63 years (Table).

The sample was mostly Lebanese (64%) and from Mount Lebanon Governorate (46). Half of the participants were separated or divorced at the time of the study followed by single (20%), married (14%), living with a partner (10%) and widowed women (6%). It is worth noting that one quarter of the participant are transgender women (24%) who have all undergone

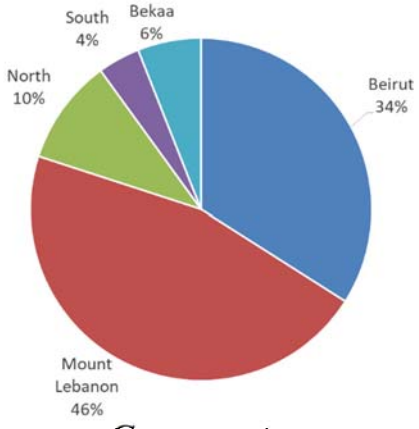
hormonal therapy with two of them having undergone a complete transformation surgery (intersexed-born with “ambiguous” genitalia or a combination of “male” and “female” body parts).



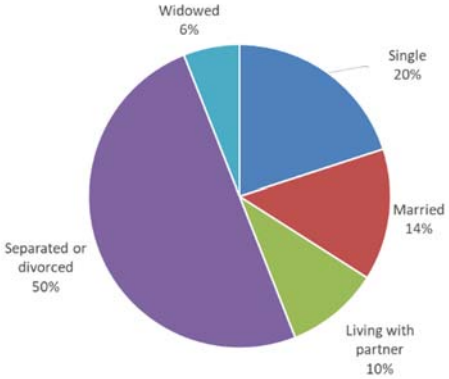
Gender



Nationality

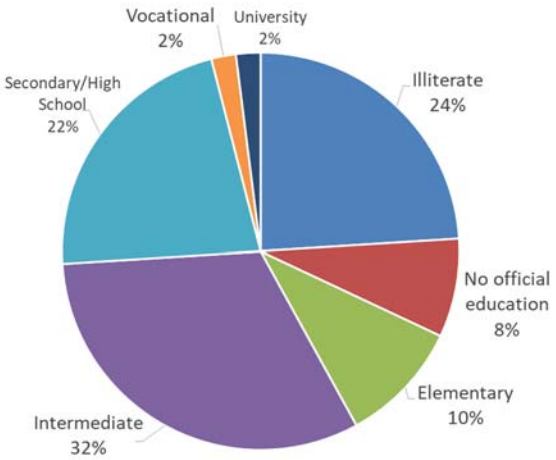


Governorate

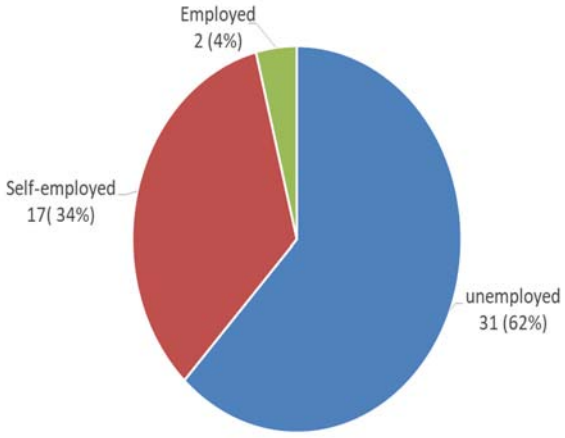


Marital Status

Most of the participant were raised in low socioeconomic status families, which resulted in either lack of education or drop out of school at a young age. For instance, around three quarters of the participating women haven't reached secondary school (74%). Moreover, regarding working status, the majority of the participants were un-employed (62%) compared to only 2 of the participants who have a full-time job in a private or public sector at the time of the study (4%). The remaining women are self-employed (34%) and currently clean houses or restaurants, sell flowers, work makeup artists or in home nursing.



Educational Level



Work Status

Only 16% of the participants had a fixed monthly salary from their job, with a mean monthly income ranging between 80,000 LBP and 750,000 LBP (380,000 ± 240,000 LBP).

History of the participants

At least half of the participants were either physically abused, by their parents or step-parents, during their childhood and teenage years or raped by one of the family members including their father, brother, or uncle. Three of them claimed that the rapist was under the influence of alcohol or drugs. In addition to that, because of their poor living conditions, seven of the

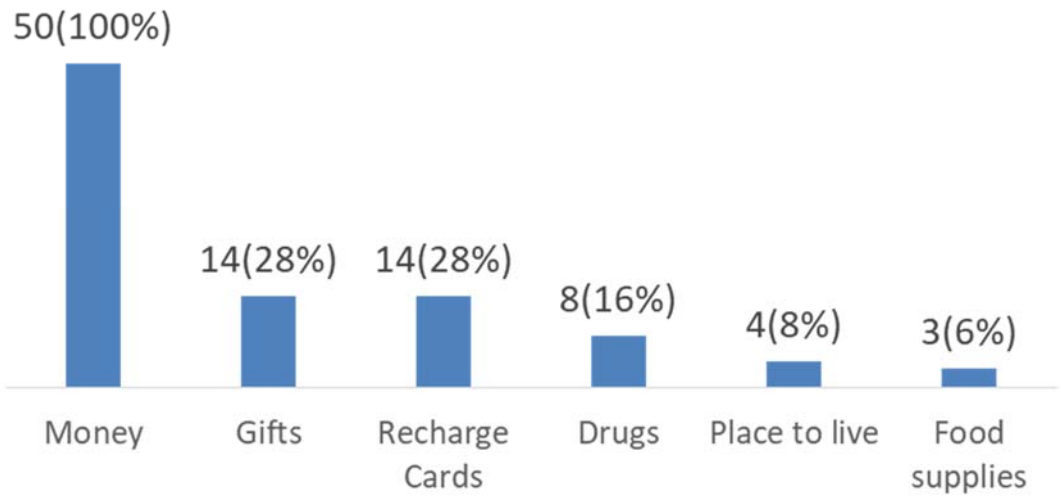
participants started working at a young age in restaurants, bars, or housecleaning, and eventually ended up being raped by the managers or house owners.

After several experiences of abuse at home, half of the participants succeeded in running away and found themselves caught in the trap of sex work; either because they met a group of people that sheltered them at first and then introduced them to the world of sex work, or because they became drug and alcohol addicts and needed easy money for continuous supply, or simply a friend facilitated their way into sex work. Furthermore, at least ten of the interviewees, who succeeded to run away from home, fell in love, got married, and after a while their husbands started abusing them and dragged them into sex work; mostly because of financial reasons. On the other hand, four of the participants were sold by their parents to a wealthier man, who abused them verbally, physically, and sexually.

The majority of the participants got pregnant during their journey in sex work and gave birth to children, who are not registered until today. This, in addition to, the feeling of neglect and abandonment have been driving factors for at least half of the women to continue sex work either to provide food and shelter for their children, or simply to feel that they are needed or wanted.

Sexual services

All the participating women offered sexual services during the last 6 months in exchange for money. However, some declared also receiving non-monetary items such as recharge cards (28%), gifts including garments, gadgets, cosmetics and jewelry (28%) or even drugs (16%). Few of the participants were offered a place to live (8%) or food (6%).



The monthly income from sexual services as well as the expenses, as indicated by the participating women, ranged between 80,000LBP - 6,000,000LBP. Despite the fact that 84% of the participants directly acquire the monetary or non-monetary fee in exchange for their sexual services, only around half of them reserve all the attained money or items for themselves (48%). Instead, 12% share what they have acquired with either their family or mediator or 10% share them with their partners.

Questions revolving the participants' living conditions were explored. The majority of the participants reported living in a rented house or room (80%) whereas the remaining women declared living with their parents or the mediator's house (12%). It is worth noting that two participants reported living in a small room made from tin by the Rawshe rocks in Beirut.

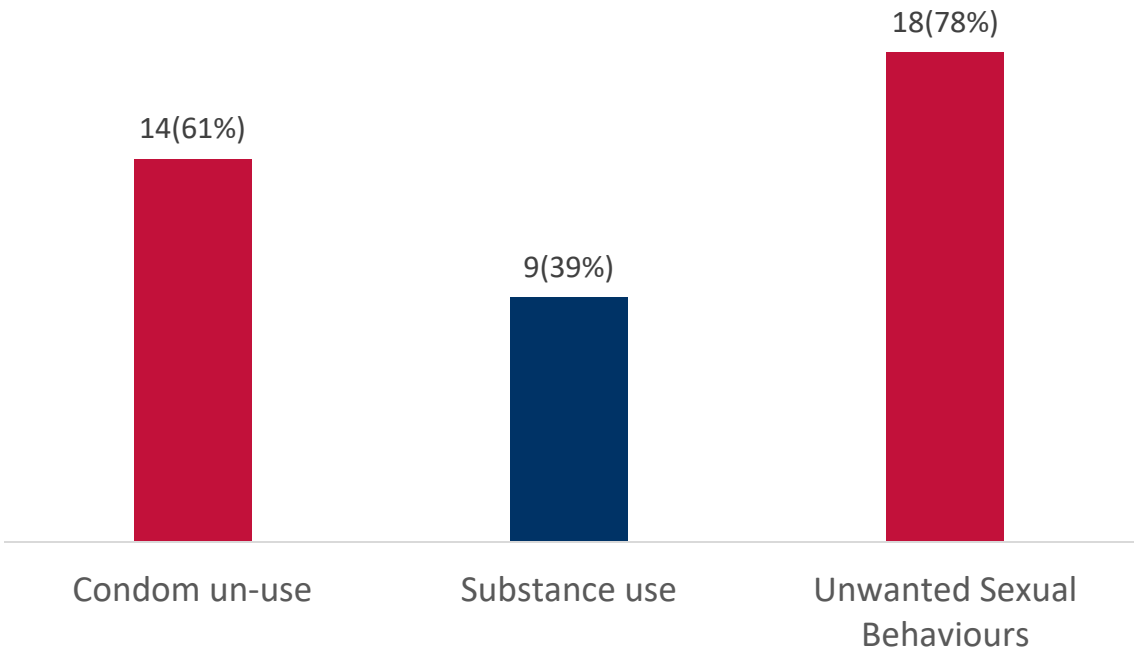
Further, results revealed that the majority of the participants (88%) are the main income supporters for themselves. Only 4% obtain some support their partners whereas the rest obtain help from their siblings or husbands (8%).

On the other hand, those who were dependent on the sex workers were explored. It is interesting to note that more than one third of the participants revealed supporting themselves only and 34% supporting their children. The rest indicated either supporting their parents (10%), partners (2%) and husbands (2%).

It is noteworthy to indicate that the mean age of the participants when they first began engaging in sex for money was 21± 7 years (range: 11-44 years). However, the majority of them 64 haven't received any kind of advice before being engaged in sexual relations (64%). The number of clients vary vastly between participants (Range: 1 client monthly to 4 clients daily)

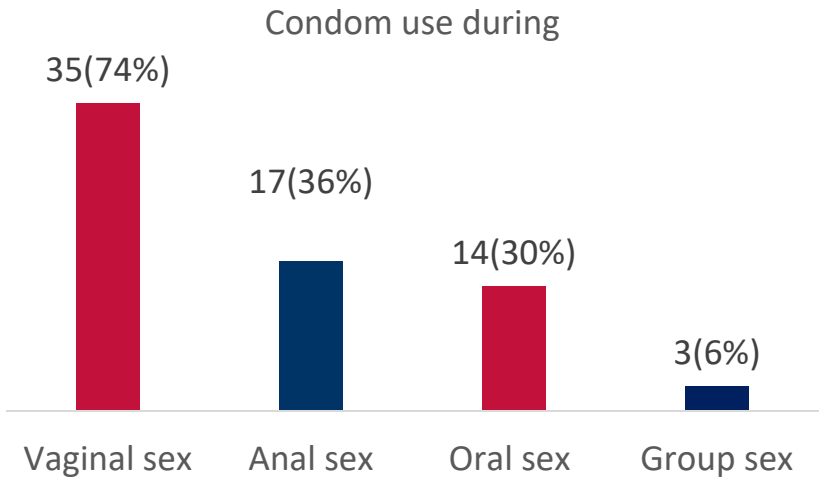
UNWANTED PRACTICES

Around half of the participants declared that the client oblige them on being engaged in unwanted practices during the sexual relations (46%). Such practices include but are not limited to unsolicited sexual advances (Group sex, anal sex, violence, slavery, lubricant non-use, ejaculation inside the mouth, etc.), waiving condom use (61%) in addition to substance use including alcohol, drugs and sedatives use (36%).

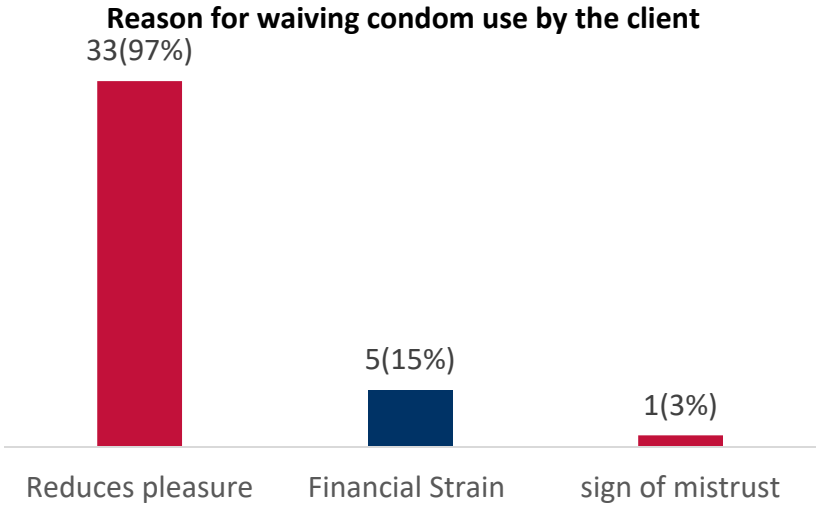


Condom Use

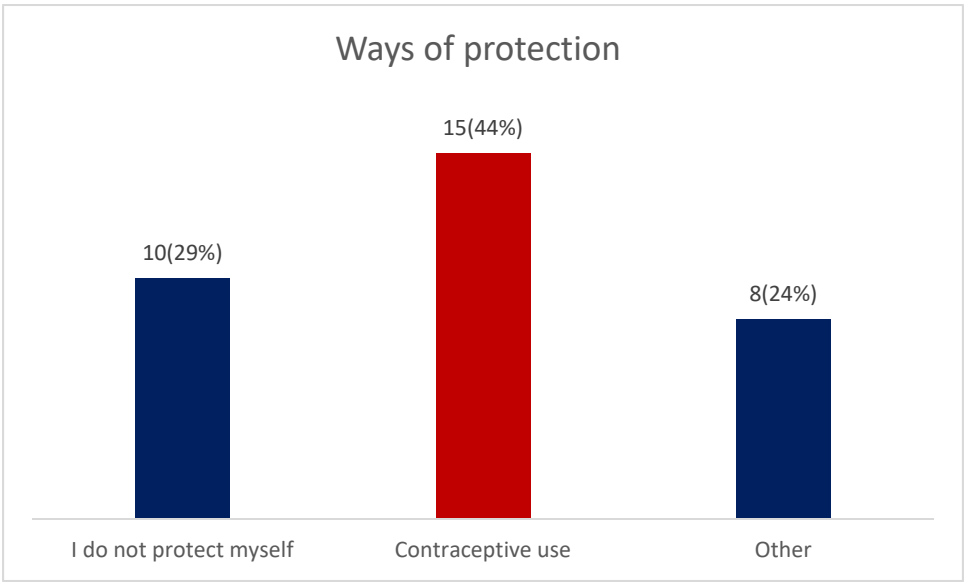
The present study found that only one third of the participants reported consistent condom use with clients (32%). Condom is mainly used during the following types of sexual intercourses: vaginal sex or penis-in-vagina intercourse (74%), anal sex or penis-in-butt intercourse (36%), oral sex or mouth to genital contact (30%) and group sex (6%).



Results demonstrated considerable contrast between factors influencing condom use by the clients. For instance, the vast majority of the participants declared that the main reason for waiving condom use by the clients is their belief that condom use reduces pleasure during sex (97%). Practical issues such as financial strain and limited access to condoms were also perceived as barriers to condom use (15%). It is worth noting that in two of the cases, condom use was avoided due to its negative symbolism as condoms were seen as suggestive of filth, disease, infidelity and mistrust (3%).



Regardless of the reason behind condom non-use, when asked about ways of protecting themselves during the sexual intercourse, half of the participants use contraceptives methods (contraceptive pills, loop, and condom) to prevent the risk of getting pregnant. It is worth noting that around one third of the participants claimed that they do nothing about it (29%). Other ways of protection, as indicated by the participating women, include routine check-up with the physician, washing the reproductive area after each sexual relation, avoiding open wounds and ejaculation outside the vagina (24%).



PHYSICAL HEALTH

Presence of disease and/or symptom(s)

Slightly more than half of the participants suffered from a disease and/or symptom(s) at the time of the study (52%). Results have depicted an array of diseases and symptoms from which the participants suffer from. For instance, more than half of the individuals suffer from various organ diseases including liver (15%), cardiovascular (15%), skin and kidney diseases (15%), lung diseases (11%), high blood cholesterol (15%), diabetes mellitus (7%) and hypertension (7%).

In addition, around 22% of the participants reported acquiring sexually transmitted infections (STIs). HIV and Chlamydia were among the notable STIs with 4 individuals living with HIV and 1 infected with chlamydia.

Among other diseases that 2 participants revealed include epilepsy and colon problems.

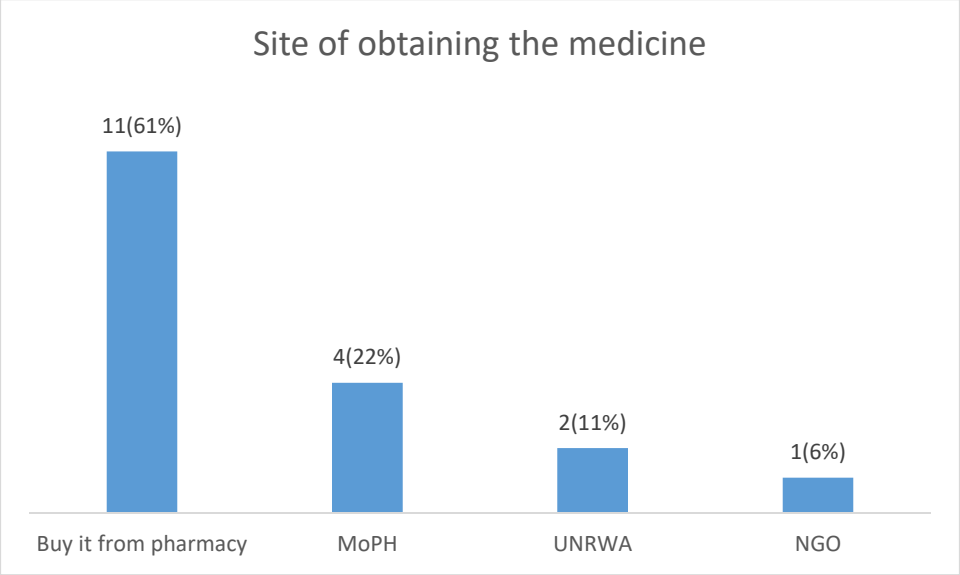
It is worth mentioning that in addition to the abovementioned diseases, participants used to experience palpitations (8%), anxiety (4%), back pain (8%), nasal pockets (4%) and inflammation of vocal tendons (4%).

Treatment

Interestingly, the majority of the participants who suffer from a disease and/or symptom(s) reported taking medications for treatment (70%). A number of medications were listed among which include those to treat the aforementioned diseases and symptoms. Treatment medications for HIV were the most used, and other medicines include those for mental illnesses and depression, thyroid disorders, hypertension, palpitations, and insulin.

The majority of those taking medications declared that they were prescribed by physicians (89%). Two of the participants stated taking their medications without prescription or after consulting the pharmacist (analgesics and antidepressants) (11%).

The pharmacy was the main vendor for purchasing medications (61%). The remaining sites for medication acquisition free of charge were from the Ministry of Public Health (MoPH) - Karantina (HIV treatment) (22%), UNRWA (11%) and NGO (6%).

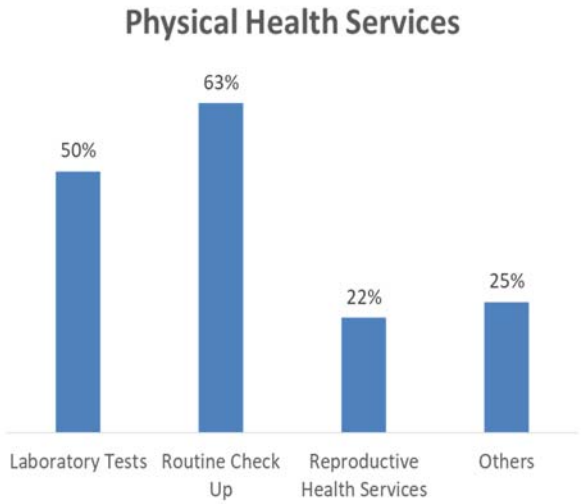


As for abiding by the prescribed medications, 20% of those taking medications do not comply with the recommended dose. The reasons for non-compliance are due to the lack of medication availability and forgetfulness to take their medication regularly.

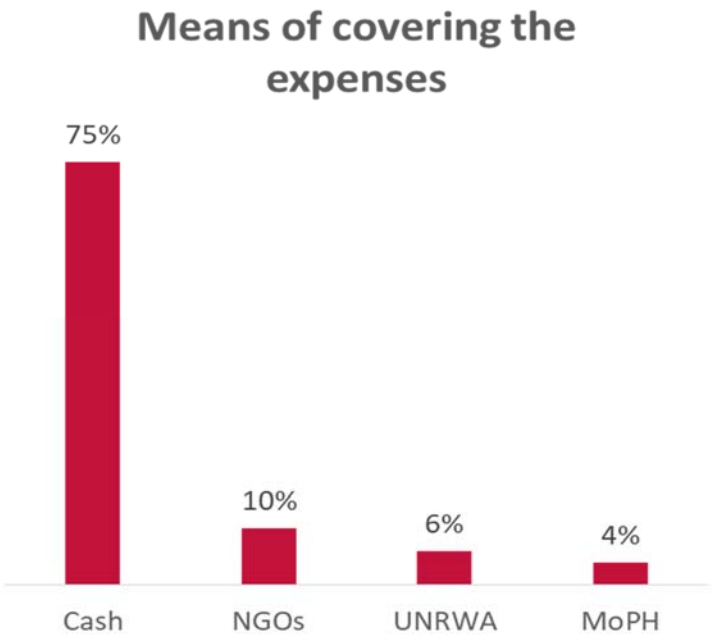
Visits to the Healthcare centers:

Results of this study depicted that more than one third of the participants have not visited a healthcare facility during the past 6 months (36%). Interestingly, visits for physical health examination is the most frequent only when the need arises (50%), otherwise it is once monthly (10%) or every few months (14%).

Despite varying number of visits for health and physical examinations, results revealed diverse services seeked by the participants at healthcare facilities. The majority of the participants disclosed performing routine check-ups (64%) and laboratory tests (59%). The remaining participants implied visiting to receive a physician to receive reproductive health services (22%).



Nonetheless, results show the means of covering the expenses of the participants' health and physical examination tests. It is worth noting that payment via cash was the most prominent mode to cover the needed services (75%).



Mental Health

The Mental Health and functioning of women engaged in sex for money participating in this study were examined. For instance, the vast majority of the participant perceived their mental health status as being weak (74%) or acceptable (20%) *(Table 1).*

Mental Health of participants	*Excellent*	*1 (2%)*
	Good	*2 (4%)*
	Acceptable	*10 (20%)*
	Weak	*37 (74%)*

Table1: Mental Health Status as perceived by the participants

Despite the poor self-reported mental well-being, the majority of the participants did not use to seek mental health services (66%) while 17 women addressed their symptoms and developed coping strategies by visiting a mental health specialist (psychologist/therapist) (34%).

Similar to the number of visits made to carry out health and physical examination tests, results show that those participants who seek mental health services only do so when needed (41%) with the remaining going once weekly (29%) or monthly (14%) *(Table 2).*

Frequency of visits to seek Mental Health Services	Weekly	4 (29%)
	Monthly	2 (14%)
	Twice monthly	3 (21%)
	Yearly	1 (7%)
	As needed	4 (14%)

Table 2: Frequency of visits to seek Mental Health Services

Moreover, when exploring the extent to which feelings related to poor mental health was experienced during the past 3 months, results revealed similar outcomes. For instance, the vast majority of the participants stating experiencing most of the time or always feelings of severe depression (94%), despair (%) and frustration (%). A relatively high percentage of the participants had thoughts of committing suicide (66%). Noteworthy, 22 out of the 50 participants tried attempting suicide at least once, but failed (44%) *(Table 3).*.

Feelings experienced during the		Always	Most of the times	Sometimes	Never

last 3 months	Severe Depression	14 (28%)	9 (18%)	19(38%)	8(16%)
	Despair	15 (30%)	11(22%)	15 (30%)	9(18%)
	Frustration	16(32%)	14(28%)	15(30%)	5(10%)
	Anger	11 (22%)	6(12%)	19(38%)	17(34%)

Table 3: Feelings experienced during the last 3 months

During the occurrence of such thoughts, the majority of the respondents reported never seeking the needed help (65%). The remaining women were either reaching out to NGOs for assistance and support (71%), a specialist (24%), friends (18%) with only two participant stating seeking parental advise (12%).

Social Services

Twenty one of the participants claimed never receiving any kind of social support services (42%). On the other hand, the remaining women used to attend counseling sessions with a social worker (93%) or receive in-kind assistance including food and c***hildren related services*** such as ***gifts*** and ***clothing*** (10%). The majority of the participants visit the centers on a weekly (31%) or monthly bases (31%) to seek the previously mentioned services. The frequency of visits to obtain social services by the participating women can be seen in table 4.

	Yes (%)		Yes (%)			
Receive Social Support Services	29 (58%)	***Counselling Sessions with a social worker***	27(93%)	**Frequency of visits**	Weekly	9 (31%)
					Monthly	9 (31%)
					Twice monthly	3 (10%)
					Every 3 months	3 (10%)
					Every 6 months	1 (3%)
		Receiving in-kind assistance	3 (10%)		As needed	4 (14%)

Table 4: Social Support Services

VIOLATIONS

SETTINGS OF THE VIOLATIONS

Participants in the study claimed that they were subjected to the different types of violations in multiple settings: health care setting (47 violations), detention centers (27 violations) and social setting (14 violations). It is important to note that most violations had occurred in the health care settings. The violations took place at detention centers (21 violations),hospitals (18 violations), dispensaries (15 violations), social and religious centers including ministries and NGOs (14 violations), private clinics (12 violations), police stations (5 violations), as well as), pharmacies (2 violations) (*refer to tables 5& 6*).

Violation setting	**#**
Healthcare setting	47 violations
Social setting	14 violations
Detention center	27 violations

Table 5: Violation setting

Place of violation	**#**
Detention Center	27
Hospital	18
Dispensary	15
Private Clinic	12
Social Center	12
NGO	2
Pharmacy	2

Table 6: Place of violation

REASONS OF VISIT TO THE DIFFERENT SETTINGS

Participants who had visited the different healthcare places with the intention of receiving services including abortion or child delivery, regular checkups and blood tests, treatment, and medication for back pain, loss of consciousness, flu, ear pain, pneumonia, restlessness, teeth pain, continuous headaches, and diabetes. While participants who were seeking social support claimed to request food, clothes, shelter, tuition fees, employment support, and a stipend. Others were being taken into custody for questioning and imprisonment (*refer to table 7*). In fact, 32 participants reported being imprisoned for reasons including sex work, drug trafficking, drug use, alcohol intoxication, not carrying their identification cards or being a she-male.

Reason of Visit	**#**
Imprisonment and/or detention	32
Physician consultation and treatment	25
Social Support	14
Abortion	8
Blood tests	8
Delivery	3
Medication purchasing	3

Table 7: Reason of visit

VIOLATOR/ABUSER'S PROFILE

Many participants were subjected to several types of violations by several parties and during several encounters. Many of the interviewees whose rights were violated in the health care setting claimed that the violation they were subjected to was perpetuated by physicians from different

domains particularly obstetrician-gynecologists, general medicine practitioners, dentists as well as nurses. Some participants reported being abused in several ways by police officers, guards, prison directors and investigators. Also, other interviewees stated that social workers, secretaries, and receptionists fell in the trap of stigma and discrimination and subjected them to being treated in an abusive way. The rest claimed that the violation came from pharmacists, religious leaders, and managers (*refer to table 8*).

Violator/Abuser	**#**
Nurse	17
Physician	16
Police officer	10
Receptionists and secretary	10
Healthcare staff	8
Investigators	6
Social Worker	5
Prison Manager	4
Pharmacist	3
Prison Guard	2
Religious Leader	1
Manager	1
Nun	1
Dentist	1

Table 8: Violators/Abusers

TYPES OF VIOLATIONS

Participants in the study indicated at least four types of violations: denial of care, humiliation or psychological abuse and blaming, physical, and sexual abuse (refer to table 9).

Type of Violation	#
Humiliation, psychological abuse or blaming	48
Sexual Abuse	17
Physical Abuse	11
Denial of care	10
Breach of confidentiality	2

Table 9: Types of violation

Denial of care

A few of the participants claimed that the service providers they had sought, refused to provide them with the needed services. They perceived that the denial of care was mainly due to the pre-determined stigma and discrimination towards sex workers.

> *I visited the Dr.'s private clinic and asked if it is possible to undergo abortion, he screamed in my face; "You are a bustard, I will report you to the police", and he kicked me out of his clinic. – 34 year old Lebanese female*

ذهبت الى طبيب وعرضت عليه إجراء عملية اجهاض لي؛ فما كان منه الا ان صرخ بوجهي واستعمل عبارات مثل :

أنت بنت حرام؛ بدي بلغ الدرك. وطردني من عيادته.- إمرأة لبنانية بعمر 34 سنة

One of the participants stated that she went to a social center for financial support, because her home was set on fire. When the receptionist knew that she engages in sex for money, she pushed her away.

I had lost all my belongings and had been sleeping on the streets for 3 days. I sought the help of a social center. Once the receptionist knew my occupation she told me in a mean way: "Currently, we don't have any available assistance". -50-year-old Palestinian Female

فقدت كل شيء، لم يبق اي شيء من ملابس او اوراق او فرش او ادوات، صار لي ٣ أيام نائمة على الطريق. ذهبت الى مركز اجتماعي حتى احصل على مساعدة مادية، أول ما عرفت موظفة الاستقبال عن نوع شغلي، قالت لي انه حالياً لا يوجد مساعدات بطريقة فيها لؤم. -إمرأة فلسطينية بعمر 50 سنة

Another participant spoke about a similar circumstance in which she visited the physician due to continuous back pain. The physician refused to provide her with care and treatment:

The Dr. mockingly, refused to examine me, he didn't order an X-ray or any tests. He even told me; "You are fine, you can go back to work."- 26- year-old Syrian female

الطبيب تعامل معي باستهزاء، رفض معاينتي، ولم يكتب لي اي صور أو تحاليل وقال لي ما بكي شيء فيكي ترجعي على الشغل. – إمرأة سورية بعمر 26 سنة

Humiliation or psychological abuse and blaming

Almost all of the interviewees coming from different backgrounds, age groups and nationalities reported that they had been subjected to humiliation, constant blaming, and verbal abuse by caregivers and service providers.

A participant related her experience during her visit to a social center in Beirut when she requested financial assistance:

I went to a religious center, I was welcomed by one of the staff members, she asked me about my name and the reason I wasn't wearing the veil (I used to wear the veil for a while), I told her that I removed the veil, and I know that this office helps all people. She replied: "Go check the color underneath your eyes, as if you are a drug addict. As long as

you took off the veil, you are definitely involved in an improper job."- 38-year-old Lebanese female

ذهبت الى مكتب ديني، عند دخولي استقبلتني احدى السيدات؛ سألتني عن اسمي ولماذا لست محجبة (وانا كنت محجبة لفترة محدودة) فأخبرتها انني شلحت الحجاب وانني اعرف ان المكتب يساعد كل الناس. فردّت المرأة: "روحي تطلعي تحت عيونك كيف اللون كأنك بتطعاطي؛ بعدين طالما كنت محجبة وشلحتي يعني صرتي تشتغلين شيء مش منيح" - إمرأة لبنانية بعمر ال 38 سنة

Another participant reported getting negative verbal messages from a nun at a religious institution for child protection. She said:

The nun told me I was wrong and a bad person, if I put my daughter at their organization I will have to abide by the laws of visit and communication. They will try to provide my daughter with a decent future. While I will be that emotionless mother that turns her back to her children and lives her life going out with men. She added that I have to accept the fact that I will be separated from my daughter. While I turned to leave her office, she said: "What is wrong with you, as if you are throwing a garbage bag, you turned your back and left." - 63-year-old Palestinian female

بدأت الراهبة تقول أنني خاطئة وزانية وانني اذا وضعت ابنتي عندهم يجب ان اتقيد بقوانين الزيارات والتواصل، وانهم يحاولون صنع مستقبل محترم. بينما انا تلك الام التي لا عاطفة لها التي تدير ظهرها لأطفالها وتعيش حياتها وتخرج من رجال، يجب ان اتقبل انفصال ابنتي عني. قالت لي الراهبة عندما خرجت من مكتبها " شو بكي متل الي عم بيكب كيس زبالة برمتي ضهرك وفليتي" .- إمرأة فلسطينية بعمر 63 سنة

Moreover, another participant expressed her devastation from the harsh comments and maltreatment that she had received at the different institutions she attends and seeks for help or support.

I was taken into custody under the accusation of prostitution and drug abuse, the police officers at the station humiliated me by talking to me in the masculine pronoun: "Where did your penis disappear, you did a transformation surgery? So now you can have sex from both sides?"- 27-year-old Lebanese transgender female

تم توقيفي بتهمة الدعارة والمخدرات، أذلني الدرك صاروا يحكوني بطريقة ذكر. "وين راح عضوك الذكري، عملت عملية صرت تمارس الجنس من قدام ومن ورا؟" - إمرأة متحولة جنسياً بعمر 27 سنة

One woman stated that her experience with dispensaries has been shameful and disgraceful.

> *I visited a dispensary near my house in an attempt to get rid of an unwanted pregnancy. While reviewing my file, the Dr. looked at me with disgust and said: "If you weren't a bitch, and if you weren't jumping from one man to another, this wouldn't have happened to you. You are a worthless person that has the guts to kill an innocent soul."- 21-year-old Lebanese female*

زرت مستوصف بالقرب من منزلي في محاولة للتخلص من الحمل غير مرغوب فيه. أثناء مراجعة ملفي، نظر الدكتور إلي في اشمئزاز وقال:" لو منك شرموطة ومن واحد لواحد ما صار فيكي هيك خراب بيوت من بعيد عليها تقتل طفل بريء."- إمرأة لبنانية بعمر 21 سنة

Furthermore, one of the participants stated being verbally assaulted by one of the staff members of a renowned international organization, accusing her of being a sex worker due to the fact that she is a trans-woman.

> *"Every once in a while I carry out blood tests, an international organization's staff didn't allow me and told me that I'm a she-male and go out with clients to have sex. They begin interrogating me and make me feel low. I didn't say anything but I feared going back again"- 25-year-old Lebanese Trans-woman*

Physical Abuse

Some of the participants (in 10 out of the 88 violations) reported having been subjected to physical abuse in police stations and detention centers mainly due to their status as women who engage in sex for money.

> *Irrespective of the different types of abuses I have been subjected to during my life, the most painful event that has left a mark in my life is being beaten until I became unconscious by a police officer only to confess that I am a sex worker - 39-year-old Lebanese female*

بغض النظر عن الإساءات المختلفة التي تعرضت لها خلال حياتي، فإن الحدث الأكثر المأ الذي ترك أثرًا في حياتي هو التعرض للضرب المبرح من قبل الدرك للاعتراف بأنني من جماعة الدعارة.- إمرأة لبنانية بعمر 39 سنة

Another participating woman also expressed her suffering during investigation with police officers at the gendarmerie.

> *I fell in the traps of police officers and was dragged into the police station. The police officers noticed that I was pregnant and asked about the father. After I refused to answer, two police officers started kicking me on my stomach until I miscarried the baby- 35-year-old Lebanese female*

لقد خدعتني وجرتني الشرطة الى المخفر. لاحظوا أنني حامل وسألوني عن الأب. بعد أن رفضت الإجابة، بدأ شرطيان في ركلي حتى أجهضت.- إمرأة لبنانية بعمر 35 سنة

Sexual Abuse

Several participants (17 out of the 88 violations) reported being sexually abused upon requesting a service. The majority of the cases who were subjected to sexual abuse were in private clinics of physicians (12 out of the 17 violations).

One of the participants explained more about the manipulation that she passed through.

> *When I went to the physician to undergo an abortion, I found out that the cost of the surgery is more than what I actually have. I didn't find anyone that can lend me the money, and I didn't want to delay the abortion. The Dr. asked for sex in return of abortion at the amount of money that was available with me, and this is what actually happened.- 40-year-old Lebanese female*

عندما توجهت الى الطبيب لإجراء عملية الاجهاض، وجدت ان المبلغ المطلوب أكبر بكثير من المبلغ المتوفر معي، لم أجد من استلف منه المال ولم أرد ان اتأخر في الحمل أكثر من ذلك، عرض علي الطبيب اقامة علاقة معي مقابل الاكتفاء بما لدي من مال، وهذا ما حدث.- إمرأة لبنانية بعمر 40 سنة

Furthermore, another participant claimed that she had been raped by a religious leader when seeking social support for her children. She clarified:

> *I arrived to the religious institution according to my appointment, they had an underground warehouse, the religious leader asked me to follow him so I can pick*

whatever I need from clothes and material for the house and my children. Once I finished picking the stuff I needed, he came closer and started touching me improperly and said: "I didn't ask you to fill in the application, I treated you in a special way and gave you what you needed quickly, others would have required more time to get what you got." - 37-year-old Lebanese female

وصلت الى الجمعية الدينية حسب الموعد، وكان لديهم مستودع تحت الارض، دعانيرجل دين الى النزول لاختيار ما احتاجه من البسة واغراض للمنزل والاطفال. عندما نزلت واخترت ما اريده، اقترب مني وبدأ يلامسني وهو يقول انه لم يطلب مني تقديم طلب للحصول على المساعدة بل عاملني بتميّز واعطاني الاغراض بشكل سريع بينما غيري سيأخذ الموضوع معه وقت أطول.

Sexual abuse was also perpetuated by two nurses in a dispensary in Beirut as reported by one of the interviewees.

I went to the dispensary for consultation with dermatological problems. The nurse took me into a private room, while another nurse followed her, she gave me a dose of anesthesia until my body was completely numb. I wasn't able to move, and I was raped by one of the nurses. - 31-year-old Palestinian Female

ذهبت للاستشارة عن مرض جلدي فقامت الممرضة بأخذي الى غرفة وكانت بصحبة ممرض وأعطتني حقنة وتخدر جسمي. لم أعد أستطيع التحرك فقام الممرض باغتصابي. – إمرأة فلسطينية بعمر ال 31 سنة

RESPONDING TO THE VIOLATION

Furthermore, it is worth mentioning that healthcare settings were among the highest places where incidents of violations occurred with a total of 47 violations followed by 27 violations at detention centers and 14 violations at social centers (refer to table 10).

Response to violation	**#**
Accepted the Violation	69
Refused the Violation	14
Reported the Violation	5

Accepted the Violation because of:	
Fear of embarrassment	8
No other choice	5
Fear of imprisonment	11
Useless	5
No one will listen	10
Didn't know who to report to	12
No need to report	2
Afraid of stigma & discrimination	12

Table 10: Responding to the violation

Interestingly, almost half of the participants (24 out of 50) experienced only one violation at one of the aforementioned settings throughout the past six months whereas 21 participants experienced 2 violations and only some (5 participants) experienced 3 violations in similar or different settings *(Table 11).*

Number of violations	**#**
One violation	22participants
Two violations	23 participants
Three violations	5 participants

Table 11: Number of violations

The questionnaires filled with the participants in this study led to the identification of three different ways the participants responded to the violations: refused the violation, reported the violation to higher bodies, and accepted the violation.

Refused the violation

Violations were refused several times by the participants (14 out of 88) whereby they faced the violator directly.

One participant explained:

> *I went to the Dr. for a regular checkup, he tried to sexually abuse me by touching me improperly. I refused and told him that I am here for a checkup in exchange of money and you have to stop what you are trying to do. – a* 44-year-old female with no identity

كنت عند الطبيب في عيادته لإجراء فحص نسائي، فقام بالتحرش بي وبملامستي. تصدّيت له وأخبرته أنني هنا للفحص مقابل دفعي المال وعليك أن توقف ما تفعله وهذا ما حدث. - امرأة مكتومة القيد بعمر 44 سنة

The above experience is very similar to that of another participant who was sexually abused by a general medicine physician after visiting for consultation of general fatigue and pneumonia, in one of the dispensaries in Lebanon.

> *He looked at me and said that he would like to have sex with me. I refused immediately and told him: "Not every bird can be eaten". I tried to get out of his office, but he grabbed my hand and pushed me back. I pushed him away and ran out of his office in a hurry. - 52-year-old Lebanese female*

نظر الي وقال لي انه يرغب بإقامة علاقة معي، رفضت رفضاً قاطعاً ، وقلت له "مش كل طير بيتاكل لحمه" حاولت الخروج من غرفة الفحص، الا انه امسك بيدي محاولاً ارجاعي الى طاولة الفحص، فنفضت يده بعيدا عني، وخرجت مسرعة.- إمرأة لبنانية بعمر 52 سنة

Reported the violation to higher bodies

Surprisingly, a small number of the interviewees were courageous enough to report the violation they were subjected to by the provider (5 out of 88) . They claimed that reporting wasn't easy to achieve, but was mandatory to prevent the reoccurrence of such disrespectful treatment in future encounters.

One of the participants expressed her irritation from the different abuses she has been exposed to when seeking care or support. She further explained that in one encounter at a dispensary, she was verbally abused and humiliated by the nurse because she asked for HIV testing. She stated:

> *I reported the abuse to the manager at the dispensary and told him: is this the right way to treat patients coming for blood tests, I will not return to this dispensary?" he immediately apologized*-24-year-old Syrian female

تقدمت بشكوى للمسؤول بالمستوصف وقلت له: "هيك بيتصرفوا مع الناس يلي جاي تعمل فحوصات عندكم انا ما بقى اجي. عندها اعتذر مني"-امرأة سورية بعمر 24 سنة.

Accepted the violation

The remaining majority of the participants accepted (69 out of 88) and didn't report the abuse they were subjected to for multiple reasons. At least six of the participants reported that they accepted the violation because they felt shameful, embarrassed and humiliated to report.

One of the participants related her experience with one of her physicians who accused her of getting pregnant outside of marriage. She stated:

> *I couldn't report, I felt embarrassed and humiliated to ask for help*- a 40-year-old Lebanese female

لم أستطع أن أبلغ، حسيت بالذل والحرج من طلب المساعدة-امرأة لبنانية بعمر 40 سنة

Few of the interviewees believed that they had no other choice than remaining quiet and accepting the violation; on the other hand, some were afraid of being taken into custody by the police, imprisoned, and punished under the accusation of sex work.

One participants went to a private physician to undergo abortion, she was raped, while her friend waited in the next room. She said:

> *I accepted, I had no other choice, I was new to Lebanon and didn't know how to act*- A 31-year-old Syrian female

قبلت ما كان عندي خيار ثاني بوقتها كنت جديدة على لبنان ما كنت بعرف اتصرف.

Another woman, who was living on the streets, decided to seek help from one of the ministries that handles social issues who refused to assist her and socially support her. She claimed:

> *I didn't report, I was afraid that the ministry refers me to the police and I will be taken into custody and punished for being a woman who engages in sex for money*- a 36-year-old Lebanese female
>
> *لم أبلغ خفت يحولني عند الدرك ويكلفوني بأعمال شاقة لأن بشتغل بالدعارة.*

A couple of them felt that reporting is useless and will not lead to any improvement in care provision, while others stated that no one will listen to their vulnerable voices or understand their needs.

For example, one of the participants explained that when the abuse took place she felt that she is unseen, no one understands the distress and suffering she is passing through. She further elaborated:

> *I didn't report, I find reporting useless no one understands or even listens. Reporting to anyone besides God is very humiliating*- a 50-year-old Palestinian female
>
> *لم أبلغ، ما في نافع من التبليغ، لا احد بيسمع ولا بيفهم. الشكوى لغير الله مذلة*- امرأة فلسطينية بعمر 50 سنة

Moreover, some of the participants claimed that they did not know who to report to in case of violations or abuses, there isn't a referral system that can help guide them in reporting.

One participant, who was subjected to physical abuse in jail refused to report:

> *I will not report, I don't even know who are the responsible bodies that I should report to. No one can help me when I am in a detention center*- a 21-year-old Syrian female
>
> *ما بلغت لا أعلم إلى أين اذهب وإلى من التجئ ما حدا في يساعدني وأنا بالحبس*- امرأة سورية بعمر 21 سنة

Additionally, only a couple of the interviewees felt that there is no need to report, they are used to such types of violations and find it normal to hear such discriminating and humiliating accusations in their daily life activities.

A woman who was dragged into a police station and was verbally, sexually, and physically abused felt that reporting wouldn't help her, instead would add to the burden of the issue. She reported:

I didn't feel the need to ask for help or report- a 19-year-old Lebanese female

لم أشعر بضرورة طلب المساعدة أو التبليغ- امرأة لبنانية بعمر 19 سنة

Finally, all the participants agreed that reporting might aggressively worsen the stigma and discrimination that they are exposed to in society, particularly in healthcare, social and detention centers.

DISCUSSION

Prior to elaborating on our findings, it is important to note that participants for this study were selected from three CSOs; therefore, the results of this study could not be generalized to all WSM in Lebanon; however, the information obtained exemplifies and highlights a number of key issues related to this vulnerable population.

The findings show that all participants in this study have experienced abuse from healthcare and social providers and from other members of society in a variety of contexts. Previous studies have suggested that negative experiences with health care and social providers related to sexual orientation and practice discourage sex workers to seek health care services (Mohamed, 2015). in order to Therefore, the development/revision of effective recommendations in terms of policies in the Healthcare and social services centers becomes vital and cannot be achieved without Thus, it engaging WSM in documenting the different types of violations.

This is consistent with previous findings that reveal being involved in sex work is an immediate barrier to health access. Therefore, there is a critical need for policy and societal shifts in views of sex work, in order to create conditions where women feel both safe to disclose their involvement in sex work to their support networks and able to access non-judgmental services. (Lazarus et al., 2013)

All the participants in this study indicated that they have had a prolonged history of abuse and neglect in their childhood and adolescent years. They have been excluded from society

particularly from their families and relatives. This has been the main driving factor for them to seek sex work in return of money to survive. This is similar to the findings of the study conducted in Tijuana, Mexico, were all participants reported to begin this line of work as a result of financial need after being isolated from their surroundings (Bucardo et al., 2002).

Furthermore, the study revealed that WSM in Lebanon are stigmatized and discriminated against because of their occupation. This stigmatization has been perpetuated by health and social workers, and by law enforcement individuals in healthcare, social, and detention centers, this raises an alarming question regarding the human rights of WSM. The analysis has also identified four types of violations and abuses that these women face in these centers; denial of care, humiliation, psychological abuse, and blaming, physical abuse, and sexual abuse. The majority of the cases are sexual abuses in private clinics in return for a service, which is against all professional conduct. In fact, these violations deny sex workers' claim to their individual human rights under current laws and frameworks (Okal, Cherisich, & Temmerman, 2011). Therefore, capacity building for healthcare and social workers and police officers is a must in order to train them on the correct means of dealing with vulnerable populations, particularly WSM. These findings have also been suggested by Kurtz et al., (2005), claiming that social service and health care staff members (including administrative, reception, and secretarial staff) would benefit from training designed to increase their sensitivity to the needs, fears, social disconnectedness, and secretiveness of sex workers.

Furthermore, the majority of the respondents agreed that they are afraid to report the violations they are subjected to in these centers because they want to avoid further stigmatization and discrimination, they are in need of the service they are seeking, and they wanted to avoid being taken into custody because of their occupations. Criminalization obstructs sex workers from reporting perpetrators of violence and seeking legal recourse after physical or sexual assault, which in turn serves to strengthen clients and police subjugation over them (Richter et al., 2013).

Finally, the women in this study shared a common characteristic of having a poor and deteriorated physical, psychological, and mental well-being because of the life struggles they have been subjected to. It has been documented that the isolation and violation that sex workers face in society increases their vulnerability, aids in the loss of their self-esteem and self-worth (Kurtz et al., 2005). Also, these characteristics were prevalent in a study by Scorgie et al., (2013), where

many sex workers' mental health problems and described suicide attempts, overdoses and self-harm were because of the abuses and daily struggles they face.

RECOMMENDATIONS

National efforts need to focus on improving the culture surrounding the provision of services to vulnerable women including women engaged in sex for money (WSM). Whether health and social services or legal and psychological support services, all need to be equitably provided and accessible with a rights based approach ensuring responsiveness, respect and independence while suppressing and eliminating stigma and discrimination.

In this respect, interventions have to be developed at several level starting with the two key affected parties in the services delivery namely the vulnerable women and the service providers. But this has to be supported by institutional as well community based cultural change that would provide responsive settings at the local level. These would in turn encourage vulnerable women to seek care and services at local social health institutions.

For the services to be comprehensive it will also depend on building the capacity of current and future human resources with careful understanding of the vulnerability and appropriate protocols and practices under in such circumstances. Furthermore, this would require coordinated and consorted efforts of referral to amenable support agencies and effective follow-up. To secure all these efforts, there is a need to actively engage health authorities and religious leaders to advocate for their legal, policy and community support for their protection of the safety and health of vulnerable women including WSM.

In this regard, it is recommended that effective interventions have to be enacted with appropriate policies and standardized practices that are tailored to the various providers at all levels *(Appendix III):*

1) **National Action and Support**
    a) Revise policies and laws that criminalize WSM
    b) Develop and implement policies that address social marginalization, economic exclusion, and violence

c) Enhance the independent monitoring of human rights agreements; protect the rights of vulnerable populations; and punish violators.
d) Revise/Enact policies that improve WSM' access to health services should be revised or eliminated.
e) Implement/monitor the component from the national strategy addressing mental health needs of vulnerable groups
f) To implement/monitor the component from the National AIDS Strategy addressing needs of vulnerable groups

2) Provision of Services to WSM

a) Providing a full range of inclusive, accessible, acceptable, flexible, and comprehensive social health services to WSM
b) Providing mental health and legal support services to WSM
c) Provide preventative, curative, and counseling services
d) Provide harm reduction services, including needle/syringe exchange
e) Provide violence prevention counseling interventions

3) Capacity Building of WSMs

a) Develop activities to raise WSM' knowledge of their rights in relation to sex work and violence, and their confidence to claim these rights.
b) Raising awareness about their vulnerability and appropriate care to their needs that are available and accessible in the community
c) Disseminating information or tips about safety to WSM
d) Providing training on soft skills (negotiation and self-efficacy)

4) Provision of Support to CSO staff

a) Provide the appropriate infrastructure to service delivery
b) Training staff on human rights of WSM, ensuring responsiveness, respect and confidentiality
c) Training staff on laws and policies related to WSM

d) Providing a documented protocol for referral to support services in the community
e) Providing a documented protocol for documenting violence or abuse faced by WSM

5) Community Action and Intervention

a) Building institutional accountability
b) Building a network of referral/support services in the community
c) Sensitization and awareness raising of the police force
    i) All members of the police and other law-enforcement entities should receive regular training on issues related to HIV, drug use, and the legal and human rights of all individuals, especially WSM and other vulnerable groups
    ii) Police officers should be trained on referring WSM to programs and shelters where they can receive appropriate assistance
d) Building partnership for advocacy

6) Surveillance, Monitoring and Evaluation

a) Mapping of WSM in the community
b) Mapping of services rendered to WSM
c) Maintaining confidential records
d) Evaluating service programs (effectiveness and efficiency)
e) Documenting violence faced by WSM and defending their human rights

SOCIAL JUSTICE AND ETHICAL CONSIDERATIONS

This study acknowledged key ethical principles according to the Belmont report. The autonomy of the participants was respected since consents were obtained before the initiation of the interviews. Also, confidentiality was maintained all through since the information disseminate didn't identify any of the participants. Although, recounting events regarding previous abuses may cause the respondents distress, the interviewer was a social worker and well trained on providing the respondent with comfort and psychological support in order to limit these risks and harms. Furthermore, a protocol for referral was established, once the participant was interviewed, she was

referred to a CSO based on her needs. This was achieved by establishing a committee that links the different CSOs together, adding to the benefits of this project and assuring the effective and efficient provision of services based on the needs of the participant. Also, one of the participating CSOs deal with the legal aspects of WSM; therefore, if any of the respondents' lives was in danger, she was referred to this organization for legal support. On the other hand, a general benefit on the long run is predicted through the amelioration of current challenges and abuses WSM face in healthcare, social, and detention centers using the recommended new adopted policies and practices that are tailored to protect the human rights of WSM.

Moreover, social justice and health equity are critical ethical issues in this study. WSM are considered among the most vulnerable populations, this project sought to ensure that the needs of this vulnerable group in terms of health and social services are met using high quality service provision guided by principles and written guidelines. Additionally, this project aimed to reduce social stigma and discrimination against WSM and other vulnerable populations, enhancing their accessibility to treatment and health services; hence, promoting equity and equality in the attainment of health and social services by all individuals.

APPENDICES:

APPENDIX I: QUESTIONNAIRE

القسم الأول			
I.	**أسئلة حول الوضع الاجتماعي والديموغرافي**		
الرَمز: (أول حرفين من اسم الجمعيّة المشاركة باللّغة الاجنبية يليها رقم الاستمارة)		**التاريخ:** -- / -- / ---- **(يوم/شهر/سنة)**	
1	**أين تمّت تعبئة الاستبيان؟**	1. داخل الجمعيّة 2. في السجن/مركز توقيف 3. منزل المستفيدة 4. غير ذلك، يرجى التّحديد:	
2	**كيف تمّ الوصول الى المستجوبة؟**	1. مستفيدة دائمة من خدمات المؤسسة 2. احالة من مؤسسة اخرى، يرجى تحديد اسم المؤسسة: 3. وصلت الى المؤسسة من أجل خدمة أخرى، يرجى تحديد نوع الخدمة: 4. احالة من مستفيدة أخرى في الجمعية	
3	**المحافظة (عنوان السكن)**	1. محافظة بيروت 2. محافظة جبل لبنان 3. محافظة الشمال 4. محافظة البقاع 5. محافظة النبطية 6. محافظة بعلبك الهرمل 7. محافظة عكار 8. محافظة الجنوب 9. محافظة كسروان جبيل	
4	**المنطقة/ المدينة/البلدة:**		
5	**تاريخ الميلاد/سنة الميلاد:**		
6	**الجنسية:**	1. لبنانية 2. غير لبنانية، يرجى التحديد:	
7	**اذا كانت المستجوبة من الجنسية غير اللّبنانية:**	**في أي سنة وصلت إلى لبنان؟**	
		هل أنت مسجلة مع:	1. لا ينطبق 2. الدولة 3. المفوضية -UNHCR 4. الاونروا 5. غير ذلك، يرجى التحديد:
		إذا كان الجواب "لا ينطبق"، لماذا لم يتم تسجيلك؟ (ضعي علامة على جميع الاختيارات التي تنطبق)	1. لم تعرف أنها تستطيع ذلك 2. لم تعرف كيف 3. لا تريد 4. غير مؤهلة للتّسجيل، يرجى التّوضيح:

			5. غير ذلك، يرجى التحديد:
		هل تحصلين على دعم من خارج لبنان؟	1. كلا 2. نعم، مساعدة مالية من: 3. نعم، مساعدة صحية من: 4. غير ذلك، يرجى التحديد:
8	**الجنس عند الولادة:**	1. أنثى 2. ذكر 3. غير ذلك، يرجى التحديد:	
9	**الهوية الجندريّة/ النوع الاجتماعي:**	1. أنثى 2. متحول	متحول: 1. خضعت لعلاج هرموني 2. خضعت لعملية جراحيّة، يرجى التحديد: 3. خضعت لكلاهما
10	**ما هي ميولك الجنسية؟**	1. ثنائية الجنس(Bisexual) 2. مثلية الجنس (Lesbian) 3. مغايرة الجنس (heterosexual) 4. غير ذلك، يرجى التحديد:	
11	**ما هو وضعك الاجتماعي الحالي؟**	1. عزباء 2. متزوجة 3. أعيش مع شريك من نفس الجنس 4. أعيش مع شريك من الجنس الاخر 5. منفصلة 6. مطلقة 7. أرملة 8. غير ذلك، يرجى التحديد:	
12	**المستوى التعليمي:**	1. لا أعرف القراءة والكتابة 2. أقرأ و أكتب، لا تحصيل علمي رسمي 3. ابتدائي 4. متوسط 5. ثانوي 6. مهني 7. جامعي 8. دراسات عليا 9. غير ذلك، يرجى التحديد:	
13	**الوضع المهني:**	1. ربة منزل 2. طالبة 3. متقاعدة 4. موظفة في القطاع العام/الخاص 5. صاحبة مصلحة أو مؤسسة خاصة 6. مهنة حرّة 7. عمل تطوعي بدون أجر 8. عاطلة عن العمل - لا أبحث عن عمل 9. عاطلة عن العمل - ولكن أبحث عن عمل 10. عاطلة عن العمل - غير قادرة على العمل، يرجى تحديد السبب 11. غير ذلك، يرجى التحديد:	
14	**هل لديك دخل يومي/ اسبوعي/ شهري ثابت؟**	1. كلا 2. نعم، لدي دخل يومي 3. نعم، لدي دخل أسبوعي 4. نعم، لدي دخل شهري	

15	**ما هو معدّل دخلك..**	**اليومي:** **الاسبوعي:** **الشهري:**
16	**هل قدمت خدمات جنسية بمقابل خلال الأشهر الستة الماضية؟**	1. كلا 2. نعم
17	**ماذا تتلقين مقابل القيام بالعلاقات الجنسية؟**	1. المال 2. الهدايا 3. كرت شحن للهاتف 4. مخدرات 5. مكان للسكن 1. غير ذلك، يرجى التحديد:
18	**هل تحصلين عليه مباشرة (وجود وسيط)؟**	1. كلا 1. نعم
19	**هل تحتفظين به كاملا ؟**	1. كلا 1. نعم
20	**اذا كان جوابك كلا، من يشاركك ما تتلقينه؟**	1. شريكي 2. زوجي 3. أحد أفراد أسرتي، يرجى التحديد: 4. أحد الاصدقاء 2. غير ذلك، يرجى التحديد:
21	**ما هو معدّل دخلك اليومي/الاسبوعي/الشهري اذا كنت تتلقين المال مقابل ممارسة الجنس ؟**	**اليومي:** **الاسبوعي:** **الشهري:**
22	**ما هو معدّل مصروفك..**	**اليومي:** **الاسبوعي:** **الشهري:**

23	**أين تسكنين؟**	1. بيت ملك 2. منزل الأهل 3. شقة مستأجرة 4. غرفة مستأجرة 5. عند صديق، قريب او شريك (لا أدفع تكاليف الاجار) 1. غير ذلك، يرجى التحديد:
24	**مع من تسكنين؟**	2. بمفردي 3. أهلي أو عائلتي، يرجى التحديد: 4. صديق/أصدقاء 5. شريكي 6. زوجي 7. غير ذلك، يرجى التحديد:
25	**ما هو عدد الاشخاص المقيمين معك؟**	
26	**كم غرفة يوجد في البيت ما عدا المطبخ، الحمام، الكراج، والشرفة**	
27	**من هو المعيل الأساسي لك؟**	1. نفسي 2. أهلي أو عائلتي (أولادي، أمّي، أبي، جدّي، جدّتي، أختي، أخي، الخ..)، **الرجاء التحديد:** 3. صديقي 4. شريكي 5. زوجي 6. غير ذلك، يرجى التحديد:
28	**هل يوجد من تعيليهم؟**	1. لا يوجد 2. نعم، أهلي أو عائلتي، حدّد (أولادي، أمّي، أبي، جدّي، جدّتي، أختي، أخي، الخ..)، يرجى تحديد العدد: 3. أولاد/بنات أخ/أخت، يرجى تحديد العدد: 4. شريكي 5. زوجي 6. غير ذلك، يرجى التحديد (مع العدد):
II.	**أسئلة حول السلوكيات وأسلوب الحياة**	
29	**قبل بداية علاقاتك الجنسية، هل كان هناك من قدم لك النصح حول كيفية ممارسة العلاقة الجنسية بشكل صحي وسليم**	1. كلا 2. نعم
30	**اذا كان جوابك نعم، الرجاء تحديد التالي:**	**من قدم لك النصح حول كيفية ممارسة العلاقة الجنسية بشكل صحي وسليم:** **متى تم تقديم النصح حول كيفية ممارسة العلاقة الجنسية بشكل صحي وسليم:** **أين تم تقديم النصح حول كيفية ممارسة العلاقة الجنسية بشكل صحي وسليم:**
31	**ما هو عدد الأشخاص الذين تمارسين الجنس معهم بمقابل (العدد اليومي-الاسبوعي أو الشهري)**	

32	**كم كان عمرك عندما بدأت بممارسة الجنس بمقابل؟**			
33	**من قام بتسهيل ممارستك الجنس بمقابل؟**	1. أنا، دون وجود مسهّل 2. شريكي 3. زوجي 4. أحد أفراد أسرتي، يرجى التحديد: 5. أحد الاصدقاء 6. غير ذلك، يرجى التحديد:		
34	**هل يقوم من تمارسين الجنس معه بالقيام ببعض الممارسات رغما عنك؟**	1. كلا 2. نعم		
35	**اذا كان الجواب نعم، الرجاء تحديد الممارسات التي يرغمك على القيام بها؟**	1. عدم استخدام الواقي الذكري أثناء العلاقة الجنسية 2. اجباري على تناول مواد معينة قبل /خلال اقامة العلاقة الجنسية 3. غير ذلك، يرجى التحديد:		
36	**بالنسبة لاستخدام "الزبون" للواقي الذكري**	الى أي مدى يستخدم الشخص الذي تمارسين الجنس معه الواقي أثناء العلاقة الجنسية (من أول العلاقة لآخرها)؟	1. أبدا 2. نادرا 3. أحيانا 4. دائما	
		في حال كان استخدام الواقي الذكري من قبل الزبون نادرا، أحيانا أو دائما، في أي علاقة جنسية يتم استخدامه ؟	1. لا ينطبق 2. أثناء العلاقة المهبلية 3. أثناء العلاقات الجماعية 4. أثناء العلاقة الشرجية 5. أثناء العلاقة الفموية 6. كل ما سبق	
		في حال عدم استخدام الواقي بصورة دائمة	**ما الذي يمنعه من استخدام الواقي الذكري؟**	1. مربك استخدامه 2. يضيع اللذة 3. حساسية 4. مسألة ثقة 5. غير ذلك، يرجى التحديد:
			كيف تحمين نفسك خلال القيام بالعلاقات الجنسية:	1. لا أحمي نفسي 2. حبوب منع الحمل 3. لولب 4. واقي نسائي 5. غير ذلك، يرجى التحديد:
37	**في حال يتم ارغامك على تناول مواد معينة <u>قبل /خلال اقامة علاقة جنسية</u>، حدّدي <u>نوع وكمية</u> تلك المواد المتناولة**	1. لا ينطبق 2. كحول 3. مخدرات 4. مواد مرخية للأعصاب 5. غير ذلك، يرجى التحديد:		

38	**هل تتناولين أو تستخدمين أي نوع من المواد النفسانية التأثير <u>في حياتك اليومية</u>؟**	1. كلا 2. نعم	
39	**اذا كان الجواب نعم، الرجاء تحديد نوع، كمية والسبب وراء استخدام المواد النفسانية التأثير ؟**	1. الكحول	النوع: الكمية اليومية: السبب: 1. لا ينطبق 2. فشة خلق 3. نوبة غضب 4. أحب الكحول 5. مسايرة الأصحاب 6. التخلص من الاكتئاب 7. رغما عني 8. لا أعرف 9. أسباب أخرى، الرجاء التحديد:
		1. المخدرات	النوع: الكمية اليومية: السبب: 1. لا ينطبق 2. فشة خلق 3. نوبة غضب 4. أحب المخدرات 5. مسايرة الأصحاب 6. التخلص من الاكتئاب 7. رغما عني 8. لا أعرف 9. أسباب أخرى، الرجاء التحديد:
40		1. الدواء المهدئ	الكمية اليومية: السبب: 1. لا ينطبق 2. فشة خلق 3. نوبة غضب 4. أحب الدواء 5. مسايرة الأصحاب 6. التخلص من الاكتئاب 7. رغما عني 8. لا أعرف 9. أسباب أخرى، الرجاء التحديد:

			من قام بوصف الدواء: 1. من طبيب 2. من صديق 3. من الأهل /الأقارب 4. من جمعية 5. غير ذلك، الرجاء التحديد:
			هل تلتزمين بالجرعة الموصوفة: 1. كلا، السبب: 2. نعم
41	**هل تدخنين السجائر؟**	1. كلا 2. نعم	
42	**ما هو عدد السجائر التي تدخنها ًيوميا**	1. أقل من علبة واحدة يومياً 2. من 1-2 علبة يوميا 3. من 3-5 علبة يوميا 4. أكثر من 5 علب يومياً 5. لا أدخن	
43	**هل تدخنين النرجيلة؟**	1. كلا 2. نعم	
44	**حددي عدد نفس النرجيلة التي تدخّنينها**	1. نفس أرجيلة واحد في اليوم 2. من 1-5 نفس أرجيلة واحد في اليوم 3. نفس أرجيلة واحد في الاسبوع 4. من 1-5 نفس أرجيلة واحد في الاسبوع 5. بين حين وآخر 6. لا أدخن	
45	**ما هو سبب التدخين نرجيلة / سجائر**	3. لا ينطبق (لا ادخن) 4. فشة خلق 5. نوبة غضب 6. أحب التدخين 7. مسايرة الأصحاب 8. التخلص من الاكتئاب 9. لا أعرف 10. أسباب أخرى، حدد:	
46	**هل لديك نشاطات اجتماعية**	1. كلا 2. نعم	

47	**اذا أجبت بنعم، الى أي مدى تقومين بالنشاطات الاجتماعية التالية:**	

	دائما	أحيانا	نادرا	أبدا
أقوم بزيارة عائلتي				
أقوم بزيارة أصدقاءي				
أنا عضو في مجموعة/ جمعية/ منظمة، وأشارك في نشاطاتها. حددّي المجموعة/ جمعية/ منظمة:				

48	**اذا كان جوابك كلا، ما السبب؟**	1. لا أحب الاختلاط مع الآخرين 2. غير ذلك، الرجاء التحديد:

III. أسئلة حول الوضع الصحي والمشورة الطبية

49	**هل تعانين من أمراض/عوارض معيّنة تستدعي اللّجوء لخدمات صحية، الرجاء تحديد**	1. مرض القلب / الشرايين 2. مرض في الكبد 3. التهاب كبد B (Hepatitis B) 4. التهاب كبد فيروسي (Hepatitis C) 5. أمراض الرئة 6. أمراض الكلية 7. فيروس نقص المناعة المكتسبة(HIV) 8. مرض السكري 9. مرض الضغط 10. داء الزهري 11. مرض السل 12. مرض بالعظم 13. مشاكل بالفم 14. فطريات 15. أمراض كوليسترول 16. سرطان... في الـ: 17. لا أعرف 18. أمراض أخرى، التحديد: 19. لا شيء مما سبق
50	**هل تتناولين أي نوع من الأدوية للأمراض/العوارض التي تعانين منها؟**	1. نعم، الرجاء التحديد: 2. لا
51	**اذا كان جوابك نعم..**	**من وصف لك الأدوية** 1. الطبيب 2. الصيدلي 3. أحد الجيران 4. فرد من أفراد العائلة، الرجاء التحديد: 5. أحد الأقارب، الرجاء التحديد: 6. غير ذلك، يرجى التحديد:

		من أين تحصلين على الأدوية؟	1. أشتريها من: 2. أحصل عليها مجانا من:
		هل تتبّعين جرعات الدواء الموصوفة	1. نعم 2. لا، الرجاء تحديد السبب:
52	**هل قمت بزيارة مرفق صحي خلال الستة أشهر الماضية؟** **المرفق الصحي قد يكون مستشفى، مركزا صحيا، جمعية، عيادة صحية، عيادة طبيب خاصة، مركز أمومة**	1. نعم، الرجاء التحديد: 2. لا	
53	**حدّدي عدد زياراتك للحصول على خدمات صحية جسدية**	1. مرة كل شهر 2. مرة كل 3 أشهر 3. مرة كل 6 أشهر 4. مرة في السنة 5. غير ذلك، حدد: 3. ولا مرة	
54	**ما هي الخدمات الصحية التي تقومين بزيارة المرفق الصحي للحصول عليها؟**	1. تحاليل مختبرية 2. فحوصات دورية 3. خدمات الصحة الانجابية 4. خدمات أخرى، يرجى التحديد:	
55	**كيف تغطين تكلفة الخدمات الصحية الجسدية التي تحصلين عليها؟**	1. مسجلة في الضمان الاجتماعي 2. لديّ التأمين 3. نقدا 4. وزارة الصحة 5. غير ذلك، يرجى التحديد:	
56	**هل تعرّضتي/ تتعرّضين لأي نوع من أنواع التعدّي/الاساءة/العنف/الاهانة /الانتهاك أثناء حصولك على الخدمات الصحية الجسدية**	1. كلا 2. نعم	
	إذا كانت الإجابة نعم، من فضلك صفي لنا الأحداث:	o **ما كان سبب زيارتك عند تعرضك للانتهاك؟**	

		o **المكان الذي حصل فيه الانتهاك:** 1. مركز صحّي 2. مركز اجتماعي 3. المستشفى 4. الصيدليّة 5. المركز الطبي في السجن 6. صيدلية السجن 7. مستوصف 8. عيادة خاصة 9. جمعيات دولية 10. غير ذلك، يرجى التحديد:
		o **تاريخ حصول الانتهاك:**
		o **من قبل من تعرّضت للانتهاك؟**

		o تفاصيل الانتهاك: (اعتداء جسدي، نفسي، جنسي، خرق الخصوصية، تقديم العلاج بطريقة مهينة، نقص بالتسهيلات المناسبة، اهمال وعدم خبرة في تقديم العناية، رفض مقدمي الخدمة توفير الخدمات، التعرض لتدابير صارمة، طلب دفع مبلغ إضافي أكثر من السعر الأساسي، الاجبار على القيام بأي تدبير طبي أو اختبار، الخ..)
		o **هل تعتقدين أنّ ممارستك الجنس مقابل المال هو السبب الذي من أجله تم التمييز ضدك؟** 1. نعم 2. لا

		o **كيف تصرفت عند تعرّضك للانتهاك؟** 1. لم أفعل شيء 2. تقدّمت بشكوى، لمن: 3. اتصلت بالشرطة 4. قمت بضرب الشخص الذي قام بفعل الانتهاك 5. غير ذلك، يرجى التحديد:	
		o **في حال عدم التصرف، ما الذي منعك؟** 1. لم أشعر بضرورة طلب المساعدة أو المشورة 2. الخوف من الوصمة والتمييز 3. لم أعلم أين أذهب أو لمن ألجأ 4. شعرت بالاحراج من طلب المساعدة 5. أخاف من أن تقوم الشرطة باحتجازي 6. أخاف أن لا يستمع الي أحد 7. بسبب تهديد من : 8. اسباب مادية 9. غير ذلك، يرجى التحديد:	
IV.	**أسئلة حول الصحة النفسية**		
57	**بصورة عامة، كيف تقيّمين حالتك الصحية النفسية:**	1. ممتـــازة 2. جيدة جدا 3. جيـــــدة 4. مقبولـــة 5. ضعيفـــة 6. لا اعرف	
58	**اذا أجبت ب "جيدة، مقبولة أو ضعيفة"، هل تحصلين على خدمات في <u>الصحة النفسية</u>** (مثال: استشارة مع مختص بالمشاكل النفسية)	1. نعم 2. لا	
59	**اذا كان جوابك نعم، الرجاء تحديد التالي:**	**نوع خدمات <u>الصحة النفسية</u>** التي تحصلين عليها	1. استشارة فردية مع مختص بالمشاكل النفسية 2. علاج جماعي 3. المعالجة بالتخليج الكهربائي (ECT) 4. غير ذلك، يرجى التحديد:
		عدد زياراتك للحصول على خدمات في <u>الصحة النفسية</u>	1. مرة كل شهر 2. مرة كل 3 أشهر 3. مرة كل 6 أشهر 4. مرة في السنة 5. غير ذلك، حدد: 6. ولا مرة

60	**خلال الـ ٣ الأشهر الماضية، الى أي مدى راودتك الافكار التالية:**	

	أبدا	أحيانا	غالبا	دائما
1. شعرت بكأبة حادة				
2. شعرت بيأس				
3. شعرت بإحباط				
4. شعرت بنوبات تعصيب				
5. فكرت بالانتحار				
6. حاولت الانتحار				

61	**في حال راودتك إحدى المشاعر /الأفكار المذكورة سابقاً، هل طلبت أية مساعدة؟**	1. لا ينطبق 2. نعم 3. لا
62	**في حال طلبت المساعدة، حدّدي ممن:**	1. لا ينطبق 2. من طبيب/ مختص 3. من صديق 4. من الأهل /الأقارب 5. من جمعية 6. غير ذلك، الرجاء التحديد: 7.
63	**في حال عدم طلب المساعدة، ما الذي منعك؟**	1. لا ينطبق 2. اسباب مادية 3. لم أشعر بضرورة طلب المساعدة أو المشورة 4. الخوف من الوصمة والتمييز 5. لم أعلم أين أذهب أو لمن ألجأ 6. شعرت بالاحراج من طلب المساعدة 7. لم أرغب بالفصاح عن كوني أمارس الجنس مقابل المال 8. غير ذلك، الرجاء التحديد:
64	**الى أي درجة تجدين نفسك تحظين باهتمام، دعم، ورعاية من:**	

	لا ينطبق	بشكل كبير	نوعا ما	أبدا
1. الأهل/ العائلة				
2. الشريك				
3. الزوج				
4. الأصدقاء				
5. جمعية				
6. غير ذلك، الرجاء التحديد:				

65	**هل تعرّضتي/ تتعرّضين لأي نوع من أنواع التعدّي/الاساءة/العنف/الاهانة /الانتهاك أثناء حصولك على الخدمات الصحية النفسية**	1. كلا 2. نعم
66	**إذا كانت الإجابة نعم، من فضلك صف لنا الأحداث:**	o ما كان سبب زيارتك عند تعرضك للانتهاك؟

		o **المكان الذي حصل فيه الانتهاك:** 1. مركز صحّي 2. مركز اجتماعي 3. المستشفى 4. الصيدليّة 5. المركز الطبي في السجن 6. صيدلية السجن 7. مستوصف 8. عيادة خاصة 9. جمعيات دولية 10. غير ذلك، يرجى التحديد 11. 12. 13. :
		o **تاريخ حصول الانتهاك:**
		o **من قبل من تعرّضت للانتهاك؟**

		o **تفاصيل الانتهاك:** (اعتداء جسدي، نفسي، جنسي، خرق الخصوصية، تقديم العلاج بطريقة مهينة، نقص بالتسهيلات المناسبة، اهمال وعدم خبرة في تقديم العناية، رفض مقدمي الخدمة توفير الخدمات، التعرض لتدابير صارمة، طلب دفع مبلغ إضافي أكثر من السعر الأساسي، الاجبار على القيام بأي تدبير طبي أو اختبار، الخ..)
		o **هل تعتقدين أن ممارستك الجنس مقابل المال هي السبب الذي من أجله تم التمييز ضدك؟** 1. نعم 2. لا
		o **كيف تصرفت عند تعرّضك للانتهاك؟** 1. لم أفعل شيء 2. تقدّمت بشكوى، لمن: 3. اتصلت بالشرطة 4. قمت بضرب الشخص الذي قام بفعل الانتهاك 5. غير ذلك، يرجى التحديد:

			o **في حال عدم التصرف، ما الذي منعك؟** 1. لم أشعر بضرورة طلب المساعدة أو المشورة 2. الخوف من الوصمة والتمييز 3. لم أعلم أين أذهب أو لمن ألجأ 4. شعرت بالاحراج من طلب المساعدة 5. أخاف من أن تقوم الشرطة باحتجازي 6. أخاف أن لا يستمع الي أحد 7. بسبب تهديد من: 8. اسباب مادية 9. غير ذلك، يرجى التحديد:
V.	**أسئلة حول خدمات الدعم الاجتماعية**		
67	**هل تحصلين على <u>خدمات دعم اجتماعية</u>؟**		1. نعم 2. لا
68	**اذا كان جوابك نعم، الرجاء تحديد التالي..**	**نوع الخدمات التي تحصلين عليها**	1. مشاركة في حوارات جماعية 2. استشارة مع عامل اجتماعي 3. خدمات أخرى، يرجى التحديد
		عدد زياراتك للحصول على خدمات الدعم الاجتماعية	1. مرة كل شهر 2. مرة كل 3 أشهر 3. مرة كل 6 أشهر 4. مرة في السنة 5. غير ذلك، الرجاء التحديد: 6. ولا مرة
69	**هل تعرّضتي/ تتعرّضين لأي نوع من أنواع التعدّي/الاساءة/العنف/الاهانة /الانتهاك أثناء حصولك على خدمات الدعم الاجتماعية؟**		1. نعم 2. لا
70	**اذا كان جوابك نعم، من فضلك صف لنا الأحداث:**		o ما كان سبب زيارتك عند تعرضك للانتهاك؟
			1. المكان الذي حصل فيه الانتهاك: 2. مركز اجتماعي 3. جمعية 4. مؤسسات تابعة للأمم المتحدة 5. غير ذلك، يرجى التحديد:

		o **تاريخ حصول الانتهاك:**
		o **من قبل من تعرّضت للانتهاك؟**
		o **تفاصيل الانتهاك: (اعتداء جسدي، نفسي، جنسي، خرق الخصوصية ، اهمال وعدم خبرة في تقديم العناية، رفض مقدمي الخدمة توفير الخدمات، التعرض لتدابير صارمة، طلب دفع مبلغ إضافي أكثر من السعر الأساسي ، الخ..)**
		o **هل تعتقدين أن ممارستك الجنس مقابل المال هي السبب الذي من أجله تم التمييز ضدك؟** 1. نعم 2. لا
		o **كيف تصرفت عند تعرّضك للانتهاك؟** 1. لم أفعل شيء 2. تقدّمت بشكوى، لمن: 3. اتصلت بالشرطة 4. غير ذلك، يرجى التحديد:
		o **في حال عدم التصرف، ما الذي منعك؟**

		1. أخاف من أن تقوم الشرطة باحتجازي 2. أخاف أن لا يستمع الي أحد 3. بسبب تهديد من الطرف الثاني 4. غير ذلك، يرجى التحديد:	
VI.	**أسئلة حول الاحتجاز**		
71	**هل سبق أن قامت الشرطة باحتجازك من قبل؟**	1. نعم 2. كلا	
72	**في حال كان جوابك نعم، الرجاء تحديد التالي:**	**عدد مرات الاحتجاز:**	
		أسباب الاحتجاز: 1. تعاطي المخدرات 2. الاتجار بالمخدرات 3. الدعارة 4. السرقة 5. القتل 6. سبب اخر، يرجى التحديد:	
		كيف تم القبض عليك؟:	
		صفي لنا الظروف في الحجز لدى الشرطة:	
		هل تعرّضت لأيّ انتهاك في السجن: 1. كلا 2. نعم	
		اذا كان جوابك نعم، الرجاء تحديد التالي:	o **تاريخ حصول الانتهاك:**

			o **من قبل من تعرّضت للانتهاك؟**
			o **تفاصيل الانتهاك: (اعتداء جسدي، نفسي، جنسي، الخ..)**
			o **هل تعتقدين أن ممارستك الجنس مقابل المال هي السبب الذي من أجله تم التمييز ضدك؟** 1. كلا 2. نعم
			o **كيف تصرفت عند تعرّضك للانتهاك؟** 1. لم أفعل شيء 2. تقدّمت بشكوى للمسؤول 3. قمت بضرب الشخص الذي قام بفعل الانتهاك 4. غير ذلك، يرجى التحديد:

			o **في حال عدم التصرف، ما الذي منعك؟** 1. لم أشعر بضرورة طلب المساعدة أو المشورة 2. الخوف من الوصمة والتمييز 3. لم أعلم أين أذهب أو لمن ألجأ 4. شعرت بالاحراج من طلب المساعدة 5. أخاف أن لا يستمع الي أحد 6. بسبب تهديد من: 7. اسباب مادية 8. غير ذلك، يرجى التحديد:

APPENDIX II: INFORMED CONSENT

استمارة الموافقة المستنيرة للمشاركة في مشروع تحت عنوان "دعم حقوق النساء اللّواتي يقمن بعلاقات جنسيّة مقابل المال"

المحقّق: جمعية العناية الصحيّة

هاتف: 01/482428

عنوان البريد الإلكتروني:nbadran@sidc-lebanon.org

مرحبا. أنا اسمي [اسم جامع البيانات]. أودّ أن أدعوك للمشاركة في مشروع تحت عنوان **"دعم حقوق النساء اللّواتي يقمن بعلاقات جنسيّة مقابل المال"**، والممتدّ لفترة عام. أطلق المشروع جمعيّة العناية الصحّيّة بالتعاون مع عدد من الجمعيّات المعنيّة، من خلال برنامج لبناء التحالفات للتقدّم والتّنمية والإستثمار المحلّي-"بلدي كاب - Baladi Cap" والممّول من قبل الوكالة الأمريكية للتّنمية الدوليّة USAID.

قبل أن نبدأ، أرغب بأخذ بعض الوقت لكي أشرح أسباب قيامي بدعوتك للمشاركة بهذه الدراسة وكيف سيتمّ الاستفادة من المعلومات التي تقدّمينها. يهدف المشروع إلى تعزيز السّياسات والإجراءات الخاصّة والحقّ بالحصول على الخدمات اللازمة في المرافق الصحيّة والإجتماعيّة دون أي تفرقة أو تمييز. يستهدف المشروع الفتيات والنساء من عمر 18 سنة وما فوق من الجنسيّة اللبنانيّة وغير اللبنانيّة والأكثر عرضة للعنف واستخدام المخدّرات وغيرها.

سوف يتمّ اجراء 50 استبيان مع نساء يمارسن الجنس مقابل المال بهدف توثيق حالات التّعدي بحقّهنّ خاصّة عند الحصول على خدمات من المرافق الصحيّة والاجتماعيّة. سيستمر الاستبيان **ساعة كحدٍ اقصى.** الملاحظات التي تقدّمينها هي في غاية الأهميّة لهذه الدراسة لأنّها سوف تساعد في تحقيق أهداف هذه الدراسة والتوصّل إلى توصيات مناسبة.

يرجى الإنتباه إلى أنّ مشاركتك هي طوعيّة في الكامل. لديك حقّ الانسحاب أو التوقّف عن المشاركة في أي وقت و من دون أيّة عقوبات. لو شعرت بعدم الرّاحة في أيّة لحظة، بامكاننا انهاء الاستبيان وبامكانك كذلك رفض الاجابة عن أسئلة معيّنة. يعود لك كامل الحريَة بالمشاركة أو لا في هذه الدراسة. إن قرّرت عدم المشاركة، فهذا لا ولن يؤثر على علاقتك بجمعيّة العناية الصحيّة .

سيتمّ التعامل مع جميع البيانات التي سوف يتمّ جمعها على أنها سريَة. لن يتم ذكر اسمك أو ذكر أيَة معلومات اخرى قد تدلّ على شخصك في نتائج البحث أو في اي تقرير أو دراسة علميّة. في حال تمّ استخدام او نشر المعلومات التي تدلي بها في اي تقرير او دراسة علميّة من أجل مناصرة حقوقكنّ، لن يتم الإشارة إلى شخصك. فإنّ المعلومات التي تقدّمينها سوف تكون جزءاً من معلومات يقدّمها الآخرون.

أودّ أن أقوم بتذكيرك بأنّه اذا ما رغبت، في أيّ وقت ولأيّ سبب من الأسباب، بعدم الإجابة على سؤال معيّن خلال الاستبيان، الرجاء طلب تخطّي هذا السؤال بالقول على سبيل المثال "أود تخطي هذا السؤال". إذا رغبت في أي وقت التّوقف عن المشاركة، من فضلك التّعبير عن ذلك. يمكننا أن نأخذ أيضا وقتا للاستراحة وأن نكمل في وقت لاحق او انهاء الاستبيان.

ليس هناك أيّة تأثيرات سلبيّة تُذكر حول اشتراكك في الاستبيان. لكن يجدر الاشارة الى أن تذكّر أحداث مؤلمة حصلت في وقت سابق قد تولد تأثيرات سلبية عندك.

سوف أعطيكي الان بعض الوقت للتّأكد من أنك قرأت وثيقة الموافقة وترغبين بالمشاركة. سوف أترك معك نسخة من هذه الوثيقة. إذا كانت لديك أيّة أسئلة، يمكنك طرحها الآن. أمّا إذا أصبحت لديك أسئلة أو مخاوف أو شكاوى حول الدّراسة في وقت لاحق، يمكنك التواصل مع المساعدة الاجتماعيّة في جمعية العناية الصحية، ماريا هليّل عبر البريد الإلكتروني m.helayel@sidc-lebanon.org أو رقم المكتب (428 482-01 مقسّم: 107) أو مع منسّقة البرامج، ناديا بدران، عبر البريد الإلكتروني: nbadran@sidc-lebanon.org أو رقم المكتب (428 482-01 مقسّم: 113) .

يمكنك الحصول على نتائج هذه الدراسة في:

جمعية العناية الصحيّة، سن الفيل، شارع يوسف كرم، بناية ضو، الطابق الأول.

مديرة جمعية العناية الصحيّة
العناية الصحية كارين نصار

منسّقة البرامج في جمعية
ناديا بدران

استمارة الموافقة المستنيرة :

أفيد بأنّ المساعدة الاجتماعية قامت بشرح طبيعة البحث وأهدافه ومجرياته، ولقد أجابتني على جميع الأسئلة التي تقدّمت بها بوضوح تام وتعهّدت لي بإعلامي عن أي تغيير يطرأ في موضوع هذا البحث. تبعا لذلك،

- ☐ أوافق طوعاً على المشاركة في هذه الدّراسة
- ☐ لا أوافق طوعاً على المشاركة في هذه الدّراسة

الإمضاء : .....

التاريخ والوقت: .....

السياسات والإجراءات

خدمات المرأة
على مستوى الرعاية الأولية

تم صياغة السياسات والاجراءات الواردة في هذا الكتيب من خلال حلقات تشاورية مع المراكز التي تعمل على رعاية المرأة واسرتها في منطقة برج حمود - سن الفيل. وتهدف الوثيقة إلى استكمال وتوسيع نطاق الممارسات القائمة في المراكز بهدف تحقيق الصحة والرفاهية الاجتماعية للنساء وأسرهن المقيمين في المنطقة.

تم تحضيرها	آذار 2018
بموافقة مجلس ادارة جمعية دار الأمل	حزيران 2018

التوقيع:

رقم السياسة	
نص السياسة	تقديم خدمات المشورة والدعم النفسي والانساني والقانوني
المستهدف من السياسة	المرشدة الاجتماعية - الطبيب/ة النفسي-المحامي/ة
تاريخ وضعها قيد التنفيذ	حزيران ٢٠١٨
تاريخ التحديث	لا ينطبق

1. **هدف السياسة**:
   - تقديم المشورة الفردية للزائرات
   - تعزيز الصحة النفسية للزائرات
   - تقديم الدعم الانساني للزائرات
   - توجيه الزائرات واحالتهن لذوي الاختصاص (النفسي والقانوني)
     متابعة الاحالات وتوثيق الالتزام بالارشادات
2. **المسؤوليات**:

على [المرشدة الاجتماعية]:

- إعداد النشرات والكتيبات والمطويات المختلفة التي تعني بالتوعية والارشاد
- اعداد لائحة بالشركاء (المعتمدة من لجنة التنسيق) مقدمي الخدمات النفسية أو القانونية وغيرها،
- التنسيق مع كافة العاملين – كل بحسب اختصاصه- بالمركز للقيام بالارشاد والمشورة الفردية لجميع الزائرات ونشرها كما تقتضيه الحاجة بين الزملاء في المركز
- الاشراف على تعليق الملصقات الخاصة بالارشاد والمشورة في ممرات المركز
- الاستماع الى الزائرة والتعرف على مشاكلها الانسانية والاجتماعية والقانونية (تعبئة استمارة مرقمة تتضمن كافة المعلومات الخاصة بالزائرة)
- إحالة الزائرة إلى الخدمات الصحية والاجتماعية المتوفرة في المركز
- احالة الزائرة الى الشركاء المتخصصين و/أو مقدمي الخدمات الأخرين للخدمة الضرورية
- تشجيع وتحفيز الزائرات على تلقي الخدمات الشاملة في المركز
- أداء واجباتها متجنبة الضرر للزائرات

3. **الاجراءات**:

- تعرّف المرشدة عن نفسها وعن مسماها الوظيفي ودورها والخدمات التي تقدمها كمرشدة اجتماعية والخدمات التي يقدمها المركز
- إبلاغ الزائرة بأن المركز والعاملين/ات فيه ومقدمي/ات الخدمات يلتزمون بالسرية المهنية وبعدم افشاء اية معلومة عن الزائرة الا بناء لطلبها او طلب الجهات القضائية

- تتأكد المرشدة من اسم الزائرة ورقم ملفها (اذا كان لديها ملف سابق) او فتح ملف جديد لها
- تسجل وقت حضور الزائرة
- الاستماع الى الزائرة بانتباه وتعبئة استمارة مرقمة المعتمدة من قبل المركز لتوثيق حالات العنف
- تعلم المرشدة الزائرة عن حقوقها القانونية عند الضرورة
- تسأل عن حاجتها ومبتغاها
- على المرشدة ان تكن على بينة من خلفية الزائرة بما في ذلك ثقافتها، ووضعها الاجتماعي والاقتصادي والنفسي
- توفير -الدعم الاجتماعي واحالتها لدى اخصائي/ة نفسي/ة عند الضرورة كما تقتضيه حالة الزائرة وبما يتناسب مع النظام الداخلي والقواعد السلوكية للمركز وضمان وقايتها واسرتها من المخاطر والاضرار الذي يستجيب لمخاوفها
- استشارة محامية و/او احالتها اليها
- بعد التحقق من حاجتها، تعطى الزائرة كتيبات الارشاد/التوجيه المناسبة
- تقوم المرشدة بتقديم المشورة او الدعم اللازم كما تقتضيه حالة الزائرة بما يتناسب مع النظام الداخلي والقواعد السلوكية للمركز وضمان وقايتها واسرتها من المخاطر والاضرار
- تقوم المرشدة باحترام خصوصية الزائرة وسريتها
- تقوم المرشدة بالاجابة عن اسئلتها بهدوء واحترام
- تقوم المرشدة بالتحقق من أن الزائرة قد فهمت الارشادات والتوجيهات
- تقوم المرشدة بالحصول على موافقة الزائرةللمضي قدما في ملفها أخذة بعين الاعتبارمصلحتها و راحتها وخصوصيتها
- تقوم المرشدة بالنصح والمشورة للقيام بالفحوصات اللازمة كما تقتضية حالتها
- في حال وجبت الاحالة، يتم التنسيق مع الجهات المناسبة (سياسة واجراءات الاحالة الداخلية والخارجية)
- تقوم المرشدة بتقديم المساعدات العينية كما تقتضيه الحاجة والارشادات اللازمة للسلوكيات السليمة والآمنة
- توثيق الزيارة والاجراءات المتخذة للتقييم والمتابعة
- الحفاظ على سرية المعلومات الخاصة بالزائرة والتشخيص والتحاليل والعلاج والسجلات الطبية إلا بموافقة الزائرة الخطية ومنع سوء استخدامها – فيما عدا ما تطلبه الجهات القضائية

رقم السياسة	
نص السياسة	تثقيف وتوعية الزائرات حول السلامة العامة
المستهدف من السياسة	
تاريخ وضعها قيد التنفيذ	حزيران ٢٠١٨
تاريخ التحديث	لا ينطبق

4. **هدف السياسة**:
   - تغيير المفاهيم أو المعتقدات أو السلوكيات الى الأفضل.
   - توجيه الأشخاص لاكتساب المعلومات الصحية وإتباع السلوك السليم.

5. **المسؤوليات**:

على [مسؤولة التثقيف والتوعية]:

- إعداد النشرات والكتيبات والمطويات المختلفة التي تعني بالجانب التوعوي والمتعلقة بالسلامة الصحية والنفسية والبدنية للزائرة
- التنسيق مع كافة أعضاء الفريق الصحي العاملين بالمركز للقيام بالتوعية الفردية لجميع الزائرات
- البحث عن المواضيع الصحية وكتابتها بطريقة سليمة وتوزيعها بأساليب علمية بعد مراجعتها والتنسيق مع ادارة المركز والمتخصصين/ات
- الاشراف على تعليق الملصقات الخاصة بالسلوكيات السليمة في ممرات المركز وخاصة ذات المرور المزدحم
- التعرف على المشاكل الصحية للزائرات وتوجيههن إلى المكان المناسب
- أداء واجباتها متجنبة الضرر للزائرات
- الإحالة إلى الخدمات الصحية والاجتماعية المتوفرة في المركز أو التنسيق مع القيمين على الاحالات الخارجية
- تشجيع وتحفيز الزائرات على تلقي الخدمات الشاملة في المركز
- التثقيف الصحي للمجموعات المستهدفة

6. **الاجراءات**:
   - تعرِّف المرشدة عن نفسها وعن مسماها الوظيفي ودورها والخدمات التي تقدمها كمرشدة اجتماعية والخدمات التي يقدمها المركز

- إبلاغ الزائرة بأن المركز والعاملين/ات فيه ومقدمي/ات الخدمات يلتزمون بالسرية المهنية وبعدم افشاء اية معلومة عن الزائرة الا بناء لطلبها او طلب الجهات القضائية
- تتأكد المرشدة من اسم الزائرة ورقم ملفها (اذا كان لديها ملف سابق)او فتح ملف جديد لها
- تسجل وقت حضور الزائرة
- تسأل عن حاجتها ومبتغاها
- بعد التحقق من حاجتها، تعطى التعليمات/الكتيبات التوعوية المناسبة
- تقوم المسؤولة بشرح السلوكيات السليمة وضمان وقايتها واسرتها من المخاطر والاضرار
- تقوم المسؤولة باحترام خصوصية الزائرة وسريتها
- تقوم المسؤولة بالاجابة عن اسئلتها بهدوء واحترام
- تقوم المسؤولة بالتحقق من أن الزائرة قد فهمت
- تقوم المسؤولة بالحصول على إذن للمضي قدما في تقديم الخدمة الصحية/و/او النفسية للزائرةأخذة بعين الاعتباراراحتها وخصوصيتها
- في حال وجبت الاحالة، يتم التنسيق مع الجهات المناسبة (سياسة واجراءات الاحالة الداخلية والخارجية)
- توثيق الزيارة والاجراءات المتخذة كنتيجة لهذه الزيارة للتقييم والمتابعة
- الحفاظ على سرية المعلومات الخاصة بالمريض والتشخيص والتحاليل والعلاج والسجلات الطبية إلا بموافقة الزائرة الخطية ومنع سوء استخدامها – فيما عدا ما تطلبه الجهات القضائية

رقم السياسة	
نص السياسة	تدريب العاملين على حقوق الإنسان ولا سيما النّساء اللواتي يقمن بعلاقات جنسية مقابل المال
المستهدف من السياسة	العاملين
تاريخ وضعها قيد التنفيذ	حزيران ٢٠١٨
تاريخ التحديث	لا ينطبق

7. **هدف السياسة**:
   - تعزيز الخدمات المقدمة
   - الاستجابة الى حاجات المستفيدات من دون وصم أو تميز

8. **المسؤوليات**:

على الادارة:

- التنسيق مع كافة العاملين بالمركز لمعرفة حاجاتهم المهنية للتعليم المستمر
- القيام بسلسلة اجتماعات دورية تثقيفية حول العمل مع النساء المعرضات للعنف/ النّساء اللواتي يقمن بعلاقات جنسية مقابل المال
  - الحقوق
  - السرية والخصوصية في المعاملة
  - تقديم النصح والمشورة
  - التواصل، الاصغاء والدعم النفسي
  - التوثيق، المراقبة والتقييم
- تقييم الجلسات واثرها على الخدمات والمستفيدات

9. **الاجراءات**:
   - على الفريق الطبي ومقدمي المشورة ان يكونوا على دراية بما يلي:
     - خدمات المشورة والاختبار والإحالة المتاحة داخل المركز.
     - اعتبارات خاصة فيما يتعلق بسرية العمل مع الفئات المستهدفة.
     - توفير الرعاية المناسبة بما يقتضيه عمر وثقافة و نضوج المستفيدة
     - تأثير فيروس نقص المناعة البشرية والامراض المنقولة جنسيا على الزائرات ومحيطهن العائلي والمهني.

- سيتلقى جميع موظفي المركز تدريبا ليشمل:
  - حقوق الانسان والحالات الانسانية فى المجتمع المحلي
  - التواصل والدعم النفسي
  - النصح والمشورة
  - الحفاظ على سرية المعلومات الخاصة
  - التدابير الوقائية وخطط الحد من المخاطر.
  - الموارد المجتمعية ومراكز الإحالة المناسبة.
  - انتقال والوقاية من الامراض المنقولة جنسيا
    - العلامات والأعراض المرتبطة بالامراض المنقولة جنسيا ، إيجابيات وسلبيات اختبارات الكشف وأنواع الاختبارات المتاحة.
    - القدرة على شرح الاختبارات السرية ودون الكشف عن الهوية
  - مكافحة العدوى في المركز لضمان السيطرة على انتشار الامراض المعدية.
  - التوثيق، المراقبة والتقييم

رقم السياسة	
نص السياسة	بناء شبكة من خدمات الإحالة / الدعم في المجتمع
المستهدف من السياسة	المنتدب الى لجنة التنسيق
تاريخ وضعها قيد التنفيذ	حزيران ٢٠١٨
تاريخ التحديث	لا ينطبق

10. **هدف السياسة**:

- بناء الجسور بين الخدمات المجتمعية.
- إقامة روابط مجتمعية مستدامة.
- توسيع نطاق الخدمات للنساء المعرضات للخطر من خلال الروابط والشبكات
- تمكين بيئة تحفز النساء المعرضات للعنف من الحصول على الخدمات دون تمييز

11. **المسؤوليات**:

على [لجنة التنسيق]:

- إنشاء فريق من ممثلي المراكز - اعضاء التحالف- لتأسيس شبكة تعاون واحالة على ان تضم على سبيل المثال لا الحصر:
  - مستشار قانوني
  - طبيب صحة نفسية
  - مختبرات/تصوير تشخيصي
  - مراكزعلاج فيزيائي
  - الخ
- وضع نظام داخلي للشبكة يحدد دورها، مدتها- عملها ، اهدافها، نشاطاتها.
- تقييم احتياجات المجتمع ونطاق عمل الشبكة
- وضع نظام لبدء الشراكات وتعزيزها

12. **الاجراءات**:

- القيام باجتماعات منتظمة للشبكة (شهريا ومن ثم فصليا وحسب الحاجة)
- اعداد لائحة بالمؤسسات الخدماتية ذات الصلة
- توقيع اتفاقيات تعاون مع هذه المؤسسات والمراكز وعقد اجتماعات دورية لتقييم العمل والخدمات المقدمة والنتائج والتحديات والدروس المستفادة(مرة كل ثلاثة اشهر)
- عقد سلسلة محاضرات لتعريف العاملين بنطاق عمل والية العلاقة مع الشبكة والشركاء فيها

- عقد دورات تدريبية للعاملين/ات الاجتماعيين/ان والنفسيين/ات حول الحقوق القانونية للزائرات ومواضيع قانونية اخرى تتعلق بمسألة العنف
- تحديد مسؤولين (٢) للاشراف والمتابعة
- تأمين جهة /مشرف لمرافقة السيدة الى المؤسسة الشريكة
- عقد اجتماعات دورية للجنة التاسيسية بهدف متابعة وتقييم عمل الشبكة
  - تقييم الاحتياجات والقدرات
  - مناقشة تجنيد الموارد وتخصيصها
  - تحسين جودة الخدمات
  - التواصل مع المستهدفات
  - المراقبة والرصد والتقييم
- عقد جلسات توعية/دورات تدريبية / طاولات مستدية مع الشركاء المحتملين (امن داخلي- امن عام- محامين- مستشفيات- قابلا قانونيات- رجال دين---)
- اعداد بروشور يتعلق بالشبكة
- تأمين خط ساخن لتلقي الشكاوي، والمقترحات والاتصالات من الزائرات

رقم السياسة	
نص السياسة	توثيق العنف الذي تواجهه النّساء وبالاخص اللواتي يقمن بعلاقات جنسية مقابل المال
المستهدف من السياسة	الطبيب أو الممرضة؟؟؟
تاريخ وضعها قيد التنفيذ	حزيران ٢٠١٨
تاريخ التحديث	لا ينطبق

13. **هدف السياسة**:

- تحسين توفيرالخدمات لضحايا الاعتداء الجنسي
- التركيز المنهجي على احتياجات ومخاوف ضحية الاعتداء الجنسي
- ضمان تقديم الخدمات الحساسة والمتعاطفة مع وضع المعتدى عليها
- توثيق الحالات للتخطيط والبرمجة

14. **المسؤوليات**:

على [؟؟؟]:

- إعداد النشرات والكتيبات والمطويات المختلفة التي تعنى بالعنف والاعتداء الجنسي
- اعداد لائحة بالشركاء (المعتمدة من لجنة التنسيق) مقدمي الخدمات النفسية أو القانونية وغيرها
- التعرف على المشاكل الصحية والانسانية للزائرات وتوجيههن إلى الجهات المختصة
- الإحالة إلى الخدمات الصحية والاجتماعية المتوفرة في المركز أو التنسيق مع القيمين على الاحالات الخارجية
- تشجيع وتحفيز الزائرات على تلقي الخدمات الشاملة في المركز
- أداء واجباتها متجنبة الضرر للزائرات

15. **الاجراءات**:

- تعرّف ? عن نفسها وعن مسماها الوظيفي ودورها والخدمات التي تقدمها ك? والخدمات التي يقدمها المركز
- إبلاغ الزائرة بأن المركز والعاملين/ات فيه ومقدمي/ات الخدمات يلتزمون بالسرية المهنية وبعدم افشاء اية معلومة عن الزائرة الا بناء لطلبها او طلب الجهات القضائية
- تتأكد ؟ من اسم الزائرة ورقم ملفها (اذا كان لديها ملف سابق)او فتح ملف جديد لها

- تسجل وقت حضور الزائرة
- ترافقها الى غرفة عناية لترعى خصوصيتها
- تتاكد من طبيعة الاعتداء
- تشرح إجراءات جمع الأدلة والحق في رفض إجراء فحص طبي (جزئي أو كامل).
- الحصول على موافقة مستنيرة من السيدة للحصول على الفحوصات المخبرية اللازمة.
- إجراء الفحص الطبي.
    - ضمان الاعتراف بجميع الإصابات ومعالجتها.
    - اختبار الحمل والأمراض المنقولة جنسيا عند الاقتضاء.
- تقديم معلومات بشأن خيارات العلاج ومنع الحمل والبدائل.
- ترتيب لمتابعة الرعاية الصحية لاختبار إضافي أو الرعاية حسب الحاجة.
- العمل بالتعاون مع المشرف القانوني لتوثيق المعلومات الأولية.
- توفير المواساة والدعم النفسي الذي يستجيب لمخاوفها
- توثيق الحالة (نموذج التوثيق)
- تقوم ??? بتقديم المشورة او الدعم اللازم كما تقتضيه حالة الزائرة بما يتناسب مع النظام الداخلي والقواعد السلوكية للمركز وضمان وقايتها واسرتها من المخاطر والاضرار
- تقوم ?? باحترام خصوصية الزائرة وسريتها
- تقوم ?? بالاجابة عن اسئلتها بهدوء واحترام
- تقوم ?? بالتحقق من أن الزائرة قد فهمت الارشادات والتوجيهات
- تقوم ?? بالحصول على إذن للمضي قدما أخذة بعين الاعتباراراحتها وخصوصيتها
- تقوم ?? بالنصح والمشورة للقيام بالفحوصات اللازمة كما تقتضية حالتها
- في حال وجبت الاحالة، يتم التنسيق مع الجهات المناسبة (سياسة واجراءات الاحالة الداخلية والخارجية)
- توثيق الزيارة والاجراءات المتخذة كنتيجة لهذه الزيارة للتقييم والمتابعة
- الحفاظ على سرية المعلومات الخاصة بالزائرة والتشخيص والتحاليل والعلاج والسجلات الطبية إلا بموافقة الزائرة ومنع سوء استخدامها – فيما عدا ما تطلبه الجهات القضائية

??? يرمز الى المسؤول عن هذه الخدمة وتوثيق هكذا حالات (الطبيب/ة و/أو الممرضة)

الاستماع والارشاد

الزائرة تتصل بالمركز او يتم احالتها اليه من قبل احدى الجمعيات/المراكز/الافراد

اول شخص من المفترض ان تقابله الزائرة هي المرشدة الاجتماعية التي تقوم بتعبئة استمارة لها وتقديم المعلومات والدعم الاجتماعي لها،وتسليمها المنشورات المتوفرة ، واحالتها الى:

- الخدمة النفسية
- الخدمة الصحية
- الخدمة القانونية

ملاحظات :

- يتوجب على المرشدة الاجتماعية المتابعة والتوثيق مع مقدمي الخدمات بحيث يتضمن ملفها كافة المعلومات والاجراءات المتعلقة بالزائرة.
- يمكن تحديد واجبات وحقوق مدوني الخدمات بموجب مدونة سلوك او بروتوكول تعاون، وكل ذلك لضمان حقوق الزائرة وتأمين حمايتها وسلامتها وضمان الالتزام بالسرية
- اعتماد استمارة موحدة من قبل جميع المراكز مما يضمن سهولة الاستحصال على الاحصاءات والمعلومات، وقياس النجاحات والتحديات والحاجات.
- المطبوعات : اصدار 3 كتيبات، قد تكون عبارة عن سؤال وجواب :

أ- قانونية (عنف اسري، اتجار، مكتومي القيد، اجهاض، اغتصاب/تحرش/سفاح قربى/ حضانة ونفقة/ الحقوق امام الضابطة العدلية)

ب- صحية(اجراء الفحوص- نقص المناعة-حبوب منع الحمل-----)

ت- نفسية واجتماعية : تتضمن معلومات عامة وما يمكن للزائرة اتخاذه من قرارات/افعال/ بمن تتصل... ما الخدمات التي يمكن تقديمها لها من قبل المركز... ارقام هاتف

- طباعة بوسترات وبروشرات تتضمن معلومات توعوية واضحة ومباشرة.
- يقتضي ابلاغ الضحية بالتزام المركز بالسرية وبعدم تقديم اية معلومات لاية جهة الا بناء لطلبها الخطي او بناء لطلب القضاء،

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