WORKSHOP REPORT ON MEDICO-LEGAL RESPONSES TO SEXUAL VIOLENCE

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THEME:
Strengthening The Medico-Legal Response To Sexual Violence Through Multi Disciplinary Collaboration Among Organizations And Partners In Eastern, Central And Southern Africa.

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The organizing committee headed by Carolyne Ajema (LVCT) and Liz Dartnall (SVRI) with guidance from Dr. Nduku Kilonzo, Director-LVCT and Prof. Rachel Jewkes, Secretary-SVRI/Director-Gender and Health Research Unit, Medical Research Council, shaped the convening, and ensured that the convening met all the set international benchmarks.

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A very big thank you goes to the participants – your meaningful participation, inputs and hard work have ensured that the meeting was a great success.
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Finally, to the rapporteurs, thank you for having captured the discussions made during the convening.
Acronyms:

AIDS  Acquired Immune Deficiency Syndrome
ARV   Anti Retroviral
CBO   Community Based Organization
CLICK Centre for Legal Information & Communication in Kenya
COVAW Coalition on Violence Against Women
DHS   Demographic and Health Survey
DNA   Deoxyribonucleic Acid
DPP   Department of Public Prosecution
DRH   Division of Reproductive Health
EC    Emergency Contraceptive
FGM   Female Genital Mutilation
GBV   Gender Based Violence
GVRC  Gender Violence Rescue Centre
HIV   Human Immunodeficiency Virus
HIV/AIDS Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
IJM   International Justice Mission
KZN   Kwa Zulu Natal
LVCT  Liverpool VCT, Care & Treatment
ML    Medico Legal
MoH   Ministry of Health
MRC   Medical Research Council
NGO   Non-Governmental Organization
OCPD  Officer Commanding a Division
PTSD  Post Traumatic Stress Disorder
PV    Physical Violence
SGBV  Sexual Gender Based Violence
STIs  Sexually Transmitted Infections
SV    Sexual Violence
SVRI  Sexual Violence Research Initiative
UNFPA United Population Fund
UNHCR United Nations Commission of Human Rights
UON   University of Nairobi
WHO   World Health Organization
1. Introduction

Sexual violence (SV) is a profound human rights violation and public health problem. Patriarchy, anti-woman attitudes and rape myths fuel this epidemic and the treatment of survivors by the health, justice and police services. Criminal justice and health systems globally often are unable or unwilling to effectively respond to survivors’ legal and emotional needs. A Sexual Violence Research Initiative (SVRI) review on the uses and impacts of medico-legal evidence in cases of sexual assault of adolescents and adults found that survivors frequently chose not to report their assaults or were filtered out of criminal justice systems, resulting in low charge filing and conviction rates.¹

Appropriate management of survivors requires a standardized clinical evaluation, an effective interface with law enforcement for the handling of forensic evidence, and coordination for delivering of evidentiary requirements between a range of partners. The SVRI review highlights the striking lack of information and evaluative studies from which to assess the impact of medico-legal evidence on sexual assault cases. In Africa, there have been myriad responses to SV in legislation and health sector policy. There is little focus on medico-legal linkages that are critical for comprehensive delivery of service to the survivor and for justice to prevail.

In response to these gaps, and to ensure facilitation of evidence based programming, this regional convening was organised by Liverpool VCT Care & Treatment (LVCT) and Sexual Violence Research Initiative (SVRI). By using the findings of the SVRI desk review and sharing regional experiences and models this workshop aims to strengthen the way in which the health and criminal justice systems intersect and respond to sexual violence.

LVCT is a Kenyan HIV/AIDS NGO which utilises its research results and technical expertise to inform HIV/AIDS policy formulation and strengthen delivery of quality assured HIV Counselling and Testing, Care & Treatment services with special focus on vulnerable groups (survivors of sexual violence, youth, men who have sex with men, sex workers and people with disabilities).

The Sexual Violence Research Initiative (SVRI) is an initiative of the Global Forum for Health Research hosted by the Medical Research Council, South Africa whose aim is to promote research

¹ Download this review online at: [http://www.svri.org/medico.pdf](http://www.svri.org/medico.pdf).
on sexual violence and generate empirical data that ensures sexual violence is recognised as a priority public health issue.

The 4-day convening was officially opened on 2nd June 2008 by Dr. Hezron Nyangito, the Permanent Secretary, Ministry of Medical Services on behalf of the Minister for Medical Services, the Hon. Prof. Anyang' Nyong'o and was attended by 54 participants drawn from 10 countries at the Safari Park Hotel, Nairobi.

Participants at the four-day convening deliberated on issues pertaining to SV and concomitant factors. Case studies were presented with representatives outlining the nature and extent, interventions, partnerships, gaps, challenges and the way forward, with presentations on best practices which, if strengthened, could be adapted by other countries within the region. Evening sessions were also held for participants focussing on writing papers for publication, public health approach to sexual violence and on designing research studies.

The common thread running through the meeting was that due to the cross-cutting nature of SV, responses to SV needed to be multi-sectoral, multi-disciplinary and undertaken comprehensively in order to strengthen prevention, care and support for survivors through the justice system, social mobilization for effective sanctions against SV and health sector responses.

The convening was officially closed on 6th June by the Hon. Amina Abdalla, a nominated Member of Parliament in Kenya.

2. Official Opening Session:

2.1. Opening Remarks and Welcoming of Participants

By Dr. Nduku Kilonzo, Director, LVCT

An opening dinner was held for the participants. In her welcoming remarks, the Director outlined the mandate of LVCT which she explained was a Kenyan non-governmental not-for-profit organization that provides technical assistance and, which partnered with various Government agencies such as National AIDS Control Council, Ministries of Medical Services and that of Public Health, to scale up quality assured HIV care and treatment services and programmes.
Dr. Nduku said some of the LVCT programmes focus on special needs groups: survivors of sexual violence, the hearing impaired, men who have sex with men (MSM), youth and sex workers.

The Director said the convening was a collaborative effort of LVCT and the Sexual Violence Research Initiative (SVRI). She welcomed the convening delegates

2.2. Overview of Convening

Three key note addresses on the convening were then delivered by representatives from LVCT, SVRI and the William and Flora Hewlett foundation.

Speech by Dr. Nduku Kilonzo, Director, LVCT

Dr. Nduku explained that the convening was being held against the backdrop of numerous and diverse responses to legislation, service delivery, health and social services for survivors of sexual violence.

The Director said that these commitments had catapulted concerns about SV onto the regional and international arena and provided a forum conducive for strengthening advocacy for recognition of SV as a public health priority with HIV and AIDS signifying the need for a re-emphasis for engaging the call to action on sexual violence.

Dr. Nduku noted that the Ministries of Health and the Criminal Justice systems of many African countries primarily focused on prevention of sexual violence through legislation, enhancing awareness, advocacy, provision of post-sexual violence health care services, legal representation and rehabilitation.

She said despite the enhanced commitment to addressing and responding to sexual violence and HIV/AIDS in parts of Sub-Saharan Africa, there were key gaps due to the lack of a coordinated and multi-sectoral approach for survivors of SV – continuum of care, protection, awareness creation, advocacy, issues of legal representation, social support, counselling for trauma and medication, clinical services, HIV protection and prevention of pregnancy.

She noted that there were also gaps in legislation and its enforcement, in technical and human health care capacity to provide the required services and in the ability for strengthened coordination for a comprehensive response between medical and legal/justice sectors.
The Director said it was incumbent upon governments and implementing partners to strengthen multi-sectoral collaborative approaches to addressing sexual violence in order to intensify efforts towards prevention, care, rehabilitation for survivors through the justice system and social mobilization to enforce sanctions and health care responses.

Dr. Nduku said Sub-Saharan Africa had abundant opportunities for the development of cross-cutting, cross-coordinated research strategies and operational frameworks.

The Director said the convening had brought together participants comprising researchers, policy makers, medical and legal practitioners from countries in Sub-Saharan Africa contributing to medico-legal responses to sexual violence.

**Speech by Prof. Rachel Jewkes:**

*Secretary, SVRI*

Prof. Jewkes noted that sexual violence has gained increasing recognition internationally as both a public health problem and a violation of human rights. She highlighted the detrimental effect sexual violence has on women’s health and lives, both immediately and many years after the assault, and noted that despite its significance, sexual violence has not received adequate attention from researchers, policy makers and programme designers.

Prof Jewkes informed participants that the Sexual Violence Research Initiative (SVRI) is a project of the Global Forum for Health Research, hosted by the Medical Research Council (MRC), South Africa, and that it was established to fill this gap. A basic premise of the SVRI is that research can play a critical role in raising the public profile and understanding of sexual violence at global, regional and national levels and help to define most appropriate responses. To that end, the SVRI is building a network of researchers, policy makers, activists and donors that aim to ensure that the many dimensions of sexual violence are addressed from the perspective of different disciplines and cultural outlooks.

She also celebrated the recent announcement by the UN Security Council announcement recognising sexual violence as a threat to global security. Prof. Jewkes said health services have a
major role to play in building responses to SV and in mitigating the devastating effects of SV. She added that SV was massively neglected in health sectors in all countries the world over.

The SVRI Secretary commended Africa for being the first global region to put together a meeting such as the one presently being convened in Nairobi, to develop models which can be emulated by other global regions.

She expressed the hope that this meeting would result in new, innovative and regionally relevant plans and strategies for strengthening services and responses to survivors of SV.

Speech by Nicole Gray:
Programme Officer, William and Flora Hewlett Foundation

Ms. Gray said the William and Flora Hewlett Foundation was founded in the 1960s and has since been working towards formulating universally acceptable programmes and services in reproductive and sexual health. She said the convening created an opportunity for sharing and exchanging challenges and experiences in order to advance appropriate responses to SV in Africa.

2.3. Official Opening of Convening

The opening ceremony was graced by Hon. Njoki Ndung’u, former nominated Member of Parliament and Dr. Hezron Nyangito, Permanent Secretary, Ministry of Medical Services, Kenya.

Hon. Njoki Ndung’u:
Director, Centre for Legal Information & Communication in Kenya (CLICK)

Hon. Njoki Ndung’u, the driver behind a private members Bill which culminated in the Sexual Offences Act, 2006 said the beginning of the conference was significant in that it marked two days after the second anniversary of the Sexual Offences Act which was enacted on 31st May 2006. Hon. Ndung’u stressed the need for relevant agencies to scale up training on the provisions of the Act to facilitate its effective operationalisation.

Hon. Ndung’u then invited the guest speaker, Dr. Hezron Nyangito, the Permanent Secretary, Ministry of Medical Services, Kenya.
Dr. Hezron Nyangito
Permanent Secretary, Ministry of Medical Services, Kenya.

In his official remarks on behalf of Prof. Anyang’ Nyong’o, the Minister of Medical Services, Dr. Hezron Nyangito, his Permanent Secretary highlighted that sexual violence is a profound human rights violation and a public health concern. He also acknowledged that management of survivors following sexual violence requires a standardized clinical evaluation, an effective interface with law enforcement for the handling of evidence collected and multi-Sectoral collaboration.

The PS commended the organizers for convening a regional meeting with a focus on strengthening the medico-legal response to sexual violence through multi-disciplinary collaboration among organizations and partners in East, Central and Southern Africa. He then declared the convening officially open.

3. DAY 1

Session Moderator: Nduku Kilonzo, Director LVCT

3.1. Welcome and Workshop Objectives

By Dr. Nduku Kilonzo, Director, LVCT

Outlining the aim of the convening, the Director reiterated that it was essential for efforts geared towards addressing issues related to sexual violence be undertaken in a concomitant manner by multi-disciplinary teams working together.

Dr. Kilonzo said that there was need to identify opportunities for research and assess the knowledge gaps and creativity in terms of service delivery and the interventions. She explained that the convening would provide data on the current status of responses to SV on the continent while at the same time focusing on experiences and lessons learnt.

She explained that the convening would also look into means of strengthening approaches and strategies to ensure more coherence in the service sector. The aim and objectives of the convening are as follows:
3.1.1. Aim of convening

The aim of the convening is to strengthen the medico-legal responses following sexual violence through multi-disciplinary collaboration among organizations and partners in Eastern, Central and Southern Africa.

3.1.2. Objectives

a. To share findings of the SVRI desk review, highlight regional innovation, share experiences, research findings and lessons learned in integrating medical and legal services in response to sexual violence.

b. Identify gaps and opportunities in research, policy and service delivery.

c. Examine alternative measures for enhancing justice for victims of sexual violence.

d. Provide a platform to promote the creation of regional research networks, and advocacy programmes on strengthening medico-legal responses to sexual violence.

3.2. Overview of Research on Sexual Violence in the Region

By: Dr. Jessie Mbwambo, Specialist Psychiatrist & Senior Researcher, Muhimbili Medical School & National Hospital, Dar es Salaam, Tanzania

Dr. Mbwambo defined sexual violence from a broader perspective to cover all acts that are in principle sexual violence notably physical force, coercion, physical harm, date rape, attempted rape and sexual assault.

She presented the forms of SV that countries tended to shy away from in their documentation of SV cases, namely rape within marriage and date rape. Unwanted sexual advances or sexual harassment in return for favours (touching or fondling) were also mentioned, along with cultural rites and practices such as child marriage, forced cohabitation through kidnapping as was practiced among the Tanzanian Maasai all of which were forms of SV. Other culturally sanctioned violations of women’s integrity which constitute SV include Female Genital Mutilation (FGM) and virginity checks.

Dr Mbwambo singled out forced trafficking as a serious problem within the region, and attributed the large percentage of cases that went undisclosed to the belief that a woman’s dignity within the community was based on sexual purity.
She noted there were statistical discrepancies in evidence gained from SV research in her country, citing this was an indication that there was need to devise creative ways to gather data on these issues.

Dr. Mbwambo decried the secondary violation meted out at the first points of contact with services, and recommended the need for appropriate training for service providers, therapeutic interventions and coping mechanisms to address the problem.

She highlighted the need to critically examine the impact of the level of SV on women and to develop strategies to minimise the associated harms. She said research indicated that suicide was higher among women who had experienced SV due to depressive manifestations.

Dr. Mbwambo identified the community, societal and relationship factors that exacerbated SV, and said the continent should not remain silent but seek concerted action to address the menace.

She expressed hoped that the convening, that enables medical and legal practitioners to speak the same language, will be a good starting point for forging a partnership to better respond to survivors of sexual violence and ultimately prevent it.

### 3.3. Legislation for Sexual Violence in Africa: Preparing and Delivering Evidentiary Requirements

**Hon. Njoki Ndung’u, Director, CLICK**

Hon. Ndung’u outlined the purposes of the Sexual Offences Act (SOA) as being to re-define the crime of rape to include introduction of minimum sentences for offenders, revision of the age of consent, offences by persons in positions of authority (i.e. care givers, teachers, and police), deliberate infection of HIV/AIDS, gang rape and drug rape.

The aim of the Act was to introduce comprehensive law reform with regard to rape and sexual assault and to introduce stiffer penalties for offenders. Hon. Ndung’u said that previously laws related to rape and other forms of sexual violence were scattered across four different legislations, making it difficult to capture the magnitude of the problem and mete out appropriate penalties.

She recounted her experiences and efforts to lobby for support from religious organizations, Parliament and media and regretted the lack of engagement of the Judiciary in the lobbying
process. Hon. Ndung’u told participants that the SOA was the first gender-related Act to be passed in Parliament since independence.

The CLICK Director said she was confronted with numerous challenges, notably the expensive nature of the process, misconceptions of certain sections to the extent that they had to be removed from the Bill for example ‘castration’ – even though chemical castration was being practiced elsewhere, holding of the Bill up to ridicule and lack of resource commitment leading to the need to source funds from private sector.

Nationwide demonstrations by women activists and other human rights lobby groups, served to exacerbate the problems of Bill acceptance among parliamentarians, she explained. In subsequent lobbying efforts, Hon. Ndung’u said, she had to re-strategise negotiation tactics to prevent them from being perceived as posing a threat to male sexual control.

On best practices in evidentiary requirements in Africa, she noted that provisions on sexual assault in Kenya were advanced and covered privacy and protection of the victim – no automatic withdrawal of case, either as a result of coercion or agreement to receive compensation from the perpetrator - except with express authority from Attorney-General; in-camera proceedings; restrictions on publishing identity of victim or their family, with penalties for media spelt out; use of an intermediary to give evidence for and on behalf of the victim in the event that the said victim is unable to give evidence in court; and use of a rape shield where court must determine whether the character and history of the victim can be brought to court as evidence.

The Act provides for a mechanism for implementation in Sections 46 & 47, where a national policy framework for implementation is provided for and the government specified as the implementer of the Act. In South Africa and Namibia there is a proposal to establish a Division on Sexual Offences.

On care and support, the CLICK Director stated that courts must rely on circumstantial evidence such as medical reports and with the lack of a forensic lab, preservation of evidence becomes difficult. She recommended the need for guidelines to establish the relationship between hospitals (medical), the police and prosecution (criminal justice system) said the famous Kenyan ‘P3’ form was not adequate and that a more comprehensive form would replace it, which was yet to be gazetted. Another best practice outlined was the permission to terminate pregnancy resultant from rape as was done in South Africa. Provision of emergency
contraception to SV victims in police stations in Zambia was also cited as an example worth emulating by other countries.

With regard to HIV/AIDS criminalization of deliberate infection, there is a legal provision of sampling of suspect, for HIV/AIDS. Provision of PEP and ARVs where necessary as well as care and treatment of both victim and perpetrator are given.

Key indicators for effective implication include a National Policy Framework to secure acceptable uniform treatment of sexual-related offences, allocation of more funding by Parliament to address prevention, care, treatment and rehabilitation of victims of SV. Another indicator is a common curriculum for training medical sector and criminal justice system.

She said it was regrettable that despite the close relationship between SV and domestic violence most African countries legislated more on SV than domestic violence, with the exception of five countries, thus the urgent need for more legislation, policy and guidelines on domestic violence. For matters pertaining to SV to be adequately and appropriately addressed, Hon. Ndung’u said there should be a coordinating mechanism to bring together the Judiciary, Police, medical practitioners and Attorney General’s office.

### 3.4. SIDA/PEPFAR Project: An Overview of Lessons Learned on SGBV in Africa

*By Dr. Jill Keesbury, Associate, Population Council, Nairobi, Kenya.*

Dr. Keesbury outlined the preliminary lessons derived from a project undertaken with 17 partners drawn from 9 countries in East, Central, South and West Africa aimed at strengthening comprehensive services for survivors of sexual violence. She said it was essential to document lessons learned in order to have a rich body of knowledge to strengthen programmes throughout the region.

The project began with a literature review on SGBV in Africa, which focused on key thematic areas, which included medical management, community engagement and psychosocial care. She gave three intersections, which constituted the framework of comprehensive care as being medical (management at first point of contact with the survivor), justice (forensic evidence collection & creation of chain of evidence that can be used during prosecution) and community (psychological counselling & new and strengthened community-based prevention strategies that
were relevant & appropriate). This framework is outlined in the booklet “SGBV in Africa: Key Issues for Programming,” intended as a resource for programmers.

Dr. Keesbury discussed the lessons learned on SGBV in Africa. From examples drawn from partner activities in Zambia, Kenya, Malawi and South Africa it was clear that standardized, multi-sectoral frameworks, guidelines and protocols were essential to ensure comprehensive care.

Another vital lesson was that special needs of child survivors were under-addressed in police, medical, legal and long-term care settings. It was noted that over ½ of the survivors in Zambia ranged between 10 and 14 years old, and that there was most likely a discrepancy between reported cases and actual assaults across the continent. Programmes should therefore focus on the needs of child survivors especially as pertains to evidence collection and interviewing techniques used.

The need to enable access and utilization of the full range of medical and medico-legal services remains a core challenge of SGBV programmes. Most victims seek police protection more than they do health care yet medical evidence is essential for prosecution. In Africa access to medical services and specialised facilities is limited. To overcome barriers to seeking medical care, some countries in Africa are testing different approaches to overcoming these barriers; notable are one-stop shops for post-rape care (ESOG, TCCs) and linking rural health centres and police stations as is the case in Zambia.

The need to enhance training and capacity of service providers to increase the quality of care and improve provider attitudes is critical. In response, special emphasis has been placed on developing materials and structures which can be spread nationally and taken up across national borders.

Specialised police unit or Victim Support Units are vital in strengthening medico-legal responses. Success stories were cited from Zambia, Malawi and South Africa.

From these experiences various models emerge for medico-legal responses, the Population Council Associate said. Clear protocols and reporting forms that outline linkages between police and health workers with regard to referrals between facilities and forensic evidence collection procedures and community and civil society engagement in policy and programme levels should be developed.
She identified various medical, legal and social gaps in responses to SGBV in Africa. For example, should national guidelines still include DNA testing as a potential resource even when it is not available? There was also the need to establish the interface between formal and traditional courts.

To forge ahead, the SGBV network will enable technical exchanges and information-sharing between network members and identify and document emerging best practices. In addition, there is need for the SGBV network partners to engage in policy dialogues to promote evidence-based interventions.

**3.5. Sexual Violence: Societal factors, women’s responses, health consequences and interventions: The need for multi-level responses**

*By Prof. Jill Astbury, Co Chair, Coordinating Group, SVRI.*

Prof. Astbury explained that the findings were based on a desk review on women’s responses to sexual violence and the appropriateness and effectiveness of sexual violence services to in meeting the needs as survivors. The review examines the societal factors that influence rates of sexual violence, women’s immediate and long-term responses to such violence, including a range of health-related harm, and the interventions and treatment developed to respond to the needs of survivors of sexual violence and reduce its prevalence.

She said there were no rape free societies, but there were marked variations in prevalence rates and types of sexual violence between countries suggesting that social factors were important and that high rates of sexual violence were not inevitable. For the perpetrator and the society he represents, sexual violence serves multiple functions including its being used as a socially sanctioned strategy to punish women.

The findings indicate that sexual violence is maintained through socio-cultural beliefs about what constitutes rape and what elements reduce the likelihood of women defining forced sex as rape, rape myths which result in victim blaming and social stigmatization of victims and various cultural and religious beliefs that perpetuate rape prone societies.
The research presents the wide range of negative social reactions, which include victim-blaming reactions, which have the effect of attributing the crime against the victim back to the victim and displacing the responsibility for the crime from the perpetrator to the victim.

Hostile victim-blaming responses are common, according to the research findings, and exacerbate the harm already experienced by the victim. A cross-cultural study testing the levels of acceptance in the belief that a healthy woman can fight off rape found 20% of US students endorsing the belief as compared with 45%, 50% and 56% in Turkey, India and Malaysia respectively.

Research indicates that the highest rates of sexual violence were reported in relation to rape by intimate partners including husbands. The immediate and medium to long term responses by women survivors of rape are also brought out in the study including, the physical, psychological and behavioural consequences.

The positive responses and coping mechanisms were identified that result in improved psychological and other outcomes for victims, including living in a society that has a cultural and legal definition of sexual coercion.

Formal and informal sources of support, which reduce the risk of post-traumatic stress disorder, are enumerated in the study findings.

The primary prevention programmes which have been developed and implemented in the US are documented as are the mental health and criminal justice system interventions.

The research recommendations included the need to respond better to the needs of sexual violence survivors and to conduct research from the perspective of survivors and to develop models of intervention and practice that are effective, acceptable and affordable in diverse cultural settings.

3.6. Country Specific Group Discussions

_Moderator – Prof. Jill Astbury, Research Professor, Victoria University_

These sessions were carried out in the afternoons and participants were required to _discuss the extent to which services in the different countries meet survivors mental health needs; what research has been done, and what are the current research priorities_
Country presentations highlighted that survivors of sexual violence receive very minimal or no psychological support. Various factors were attributed to this, namely:

**At Community Level:**
The reactions to SV are usually mixed, with blaming the survivor being a very common response. Due to the perceived shame of the event the rape is often kept secret, particularly if the perpetrator is related to the family. In some cases, a familial/community based responses to SV may include the survivor being forced to marry their perpetrator. More supportive responses to the victim / survivor were reported for child sexual abuse.

**At Police/Hospital/Judiciary:**
Most service providers are not adequately trained and/or supported in dealing with SV and the mental needs of survivors are unmet. However, where interventions have been put in place service providers appear to manage the survivors in a sensitive way.

**Key Gaps:**
Key gaps identified by participants in meeting the mental health needs of sexual violence survivors include:

- human resource at all the levels-medical and legal sectors,
- lack of trained service providers and training programmes, with service providers lacking the skills, confidence and support to provide quality services to survivors of sexual violence,
- lack of support services e.g. transport to escort survivors to the hospital and follow-ups, laboratory services and facilities for forensic examination,
- existing guidelines/policies to govern and support delivery of medico-legal services to survivors that include reference to mental health services,
- lack of all levels of services to refer survivors of sexual violence including places of safety (particularly in the case of children); NGOs not available in all places to give legal aid to survivors, psychological services, and survivor focused treatment options
- limited referrals between traditional and formal systems,

In conclusion psycho-social support to survivors is limited and this is a particularly under-researched area
Research Priorities:
Participants identified the following as areas for research on mental health responses to sexual violence:

- Do support groups assist in reducing mental health outcomes of survivors?
- Comparing cost-effectiveness of support groups versus individual cognitive intervention in reducing mental health outcomes of survivors
- Assessing the extent of government interventions in responding to mental health needs of survivors.

4. DAY 2

4.1. Key Note Presentations

Moderator: Liz Dartnall

Presentations were made by speakers drawn from different countries on the responses made to addresses sexual violence from a medical and legal perspective. Focus was also placed on addressing sexual violence as a public health concern.

- Public Health Approach to Sexual Violence is Preventable not Inevitable.
  Ruxana Jina
- The role of medical evidence within the existing legal frameworks
  Emily Rogena
- Overview- Desk Review on Medico-Legal Services
  Rachel Jewkes
- Research to understand integrated medico-legal responses
  Rachel Jewkes
- Using Research to improve services nationally- developing strategies
  Rachel Jewkes

All these presentations can be obtained from: http://www.svri.org/medicoworkshop.htm
4.2. Emergent concerns arising from these presentations:

Intersections between health and justice sectors:
Participants highlighted the need to establish mechanisms through which the legal and medical sectors can engage more efficiently. The long period of time taken before processing cases of SV by the courts was seen as a major barrier to doctors giving evidence in court. If a trial goes on for a long time the doctors can be transferred to another facility and may no longer be available to give the evidence in court. In many countries health care providers do not feel adequately trained on how to present evidence in court, and that there was a need to provide service providers with such training.

Forensic Examination:
Participants reported that health care providers were not adequately trained on how to undertake a forensic examination and the handling of sexual violence cases. The importance of strengthening health care providers to undertake forensic examinations and properly document injury for presentation in court was highlighted as a priority. A need for sharing of, adapting and rolling out of existing training programmes was identified.

Use of DNA:
There was discussion around the need for DNA evidence to progress legal cases. Some of the descriptive studies presented in the SVRI desk review noted that medico-legal evidence appeared to be of minimal importance to the courts and was not always necessary for a case to progress. There is a need for ongoing research focussed on medico-legal evidence in relation to sexual assault.

5. DAY 3

5.1. Presentation on Best Practices

Moderator, Rachel Jewkes Secretary, Sexual Violence Research Initiative (SVRI)

The following presentations were made from various countries to highlight the different approaches in place to respond to sexual violence from a programmatic perspective:
1. Describing the standards for ‘custody-of-evidence’ chain for PRC services in Kenya
   By: Carol Ajema, LVCT, Kenya

2. The Copper belt Model of Integrated Care for Survivors of Rape & Defilement
   By: Mary Zama/Jill Keesbury-Population Council, Zambia

3. Experience in handling cases of Sexual Assault with focus on the existing Legislation & Medical Management
   By: Gilbert Ongoyo, CRADLE, Kenya

4. Innovative Responses to the Management of Sexual Violence in a Public Setting
   By: Mohau Makhosane, Gauteng Department of Health, South Africa

5. Post Rape Care Services- Public Health Model
   By: Hadley Muchela, LVCT & Dr. Margaret Meme, Division of Reproductive Health

6. Presentation on Medico Legal Response to Sexual Violence with Focus on the police Service and Judiciary System and Health Sector
   By: Patricia Njawili, Malawi Police Service, Malawi

7. Training of Sexual Assault Health Care Providers – National Curriculum Development
   By: Ruxana Jina, Medical Research Council, South Africa

8. Best practices in physical evidence collection
   By: John K Mungai, Government Chemist, Kenya

9. Sexual Violence Research Initiative
   By: Liz Dartnall, SVRI Programme Officer

These presentations can be downloaded from the SVRI website
(http://www.svri.org/medicoworkshop.htm)

5.2. Emergent issues from the above presentations:

Where do survivors seek help?

Groups estimated that more than 50% of survivors seek help from health facilities, where as a comparatively smaller percentage report to the police. Some survivors (families) do not seek services and instead prefer to be compensated by the perpetrator. Participants therefore felt that there was need to have the following in place:

- Having one stop centres to reduce the disparities in the delivery of medico-legal services in the different countries and within the region;
- Setting up of special courts would also address some of the challenges faced with delayed mention of cases.
Attitude change of service providers, as this continues to pose a challenge

Evidence in Court:
It was established during the plenary session that:

- Documentation is widely used in the absence of DNA by the criminal justice system
- The doctor’s testimony was found to be the most compelling evidence.
- The need to ensure accurate reporting of the medical examination carried out by the doctors was highlighted.

Justice
Participants outlined specific examples of when the prosecution may face difficulties interpreting medical evidence in court. Details of which are to follow:

- In cases where the examining doctor is not available to present the evidence in court or sends a representative, leading to questions on the quality of submissions made by the one clinician on behalf of the other.
- Slow nature of the criminal justice systems compounded by the lack of trust in the system resulting in case withdrawal before completion, or the community members accessing to alternative forms of justice.

Need for Multi-sectoral approaches
Multi-sectoral collaboration can lead to an increase in access/uptake of post rape care services and ultimately inform the judgements made by the courts. There is need to establish mechanisms that bring the different stakeholders together, and to strengthen the referral links between the medical and legal sectors. Service delivery can only be strengthened through collaboration between the health care workers, police and the courts. At the moment each of these players is working independent of the others.

Children:
There needs to be a special focus on child survivors as, presently, most of the service providers feel that they do not have the skills to deal with children and on mentioning the cases in court, the children are forced to “re-live” the ordeal, with instances of other magistrates the child related cases be heard in open courts, which may result in re-victimising and re-traumatising the survivor.
5.3. Development of Country Group Plans

Moderator: Rachel Jewkes

5 country teams were formed, namely: Kenya ; Uganda ; Tanzania ; South Africa ; Ethiopia ; Somalia ; Sudan and Zambia ; Malawi. Participants from DRC, Rwanda, Australia, USA were required to join any of the 5 teams.

The participants were required to come up with country plans on the following aspects:

- **Partnerships:**
  - Government
  - Research
  - Services (health; law; police)
  - NGO / Activisms

- **Research:** What is the one study that will make the most difference to developing policies etc.?

- **Policy:** Law? Health policy? Clinical Management Guidelines?

- **Training:** what training is there on sexual assault / rape for doctors, nurses, police etc

- What are the barriers to developing improved sexual assault care?

The following emerged from the presentations:

**Existing partnerships:**

There is need for the following sectors to work together:

- Government Ministries: Ministry of Health, Gender, Children, Youth Development, Education, Home affairs, Justice & Constitutional Affairs, Local Government, Finance, etc

- Commissions: Law Reform, Human Rights

- Research institutions including universities

- Service providers: Medical and legal

- Civil society organisations: NGOs, CBOs

**Existing policies and guidelines:**

Participants indicated that despite having policies in existence, there were gaps which lead to challenges in their implementation.
• Gender policies but not targeted to SGBV
• Health policy has limited mention of SGBV issues.
• There are no national guidelines in especially in conflict areas but services exist.
• Need to have standardised guidelines
• Minimal physical and mental health services exist for survivors of SV in the public health sector

Training:
In relation to training, participants identified the following gaps:
• Training in SGBV to police and medical practitioners’ needs to be harmonised, since these trainings are offered by NGOs and development partners.
• The duration of the existing trainings programmes is not standardised.
• Lack of national training curricular on SGBV
• The topics addressed currently are sectoral dependent, hence weakening linkages between the different sectors.
• Not all key stakeholders are part of these trainings, especially those drawn from the wider/general community.

Starting Point:
Where countries need to start from:
• Define the SGBV situation that is country specific
• Develop SGBV policies/laws
• Establish multi-sectoral collaborations to ensure ownership and ease of policy implementation by governments and stakeholders
• Carry out monitoring and evaluation of exiting SGBV programmes.
6. DAY 4

6.1. Closing Session

Moderator: Dr. Nduku Kilonzo, Director, Liverpool VCT, Care & Treatment.

The closing ceremony was graced by Hon. Amina Abdalla, a nominated member of the Kenyan parliament.

6.1.1. Way forward

By Dr. Nduku Kilonzo, Director, Liverpool VCT, Care & Treatment

The LVCT Director noted her appreciation to participants for the fruitful discussions which had culminated in country plans and the way forward. The LVCT Director said it was essential to strengthen documentation processes on best practices and lessons learnt in order to facilitate the sharing of successes and challenges in the variegated approaches to SV. Dr. Kilonzo said her organisation; NACC and the Division of Reproductive Health would be hosting a conference in Nairobi in September this year, where 300 delegates from East, Central and South Africa will convene to deliberate on strengthening linkages between reproductive health and HIV/AIDS with a special emphasis on sexual violence. The conference, which is scheduled to be held from 29th September to 1st October would post success stories on the website and provide a platform to strengthen country plans.

6.1.2. Official Closing of Convening

By: Hon. Amina Abdalla, Nominated Member of Parliament, Kenya.

Programmes that adapt a multi-disciplinary approach will go a long way in ensuring that evidence generated through research studies on sexual violence informs service delivery and national policies, according to Hon. Amina Abdalla a nominated MP.

Speaking at the close of the Medico-Legal Convening, Hon. Abdalla
urged participants to ensure that their respective governments remained committed to providing the legislative framework for sexual violence, generating evidence to influence programming on SV, providing an enabling environment to scale up services for the management of survivors of SV and fostering community participation in primary, secondary and tertiary prevention of SV.

The nominated MP expressed the hope that the country plans drawn up by participants at the convening, would be applied in strengthening linkages for responding to sexual violence in legislation and health sectors.

Commending LVCT and SVRI for organizing what she termed as the ‘important forum for strategic engagement of key actors’, Hon. Abdalla said that it was only through a comprehensive coordinated approach by Government, NGOs, legislative, health and private sector that the myriad responses to SV could have the desired impact.
Appendix I: Programme

2008 MEDICO-LEGAL CONVENING IN RESPONSE TO SEXUAL VIOLENCE
3rd June- 6th June, 2008, Safari Park Hotel, Nairobi, Kenya

DAY ONE, TUESDAY 3RD JUNE, 2008

Moderator: Nduku Kilonzo

9.00- 9.30 am: Welcome and Workshop Objectives
Nduku Kilonzo

9.30-10.00 am: Overview of Research on Sexual Violence in the Region
Jessie Mbwambo

10.00-10.30 am: Legislation for Sexual violence in Africa and considerations
For preparing and delivering evidentiary requirements
Hon. Njoki Ndung'u

10.30-10.45 am Tea Break

10.45-11.45 am: Overview of women’s responses: desk review and implications
For programmes, policies, services and research
Jill Astbury

11.45-12.15 pm: SIDA/PEPFAR Project: Lessons learnt
Jill Keesbury

12.15-13.00 pm: Country Specific Group Discussions:
1) To what extent do services in your country meet survivors’ needs?
2) What research has been done what are the current priorities?
Jill Keesbury

13.00-14.00 pm Lunch Break

14.00- 14.30 pm: Group Discussions cont.

14.30-17.30 pm: Group Presentations and Plenary Discussions
Jill Astbury

DAY TWO, WEDNESDAY 4TH JUNE, 2008

Moderator: Liz Dartnall

9.00-9.30 am: Public Health Approach to Sexual Violence
Ruxana Jina
9.30-10.00 am:  The role of medical evidence within the existing legal frameworks  
Emily Rogena

10.00-10.30 am: Overview- Desk Review on Medico-Legal Services  
Rachel Jewkes

10.30-10.45 am  Tea Break

10.45- 11.45 am: Research to understand integrated medico-legal responses  
Rachel Jewkes

11.45-12.15 pm: Using Research to improve services nationally- developing Strategies  
Rachel Jewkes

12.15-13.00 pm: Country Specific Group Discussions:  
Where are we now in terms of policies? Services models, training?  
Jill Astbury

13.00-14.00 pm  Lunch Break

14.00- 14.30 pm: Group Discussions contd.

14.30- 17.30 pm: Group Presentations and Plenary Discussions  
Rachel Jewkes

DAY 3, THURSDAY 5TH JUNE, 2008

Moderator: Rachel Jewkes

9.00- 9.30 am: Describing the Standards for ‘Custody-of –Evidence’ Chain for PRC services in Kenya  
Carol Ajema

9.30- 10.00 am: The Copper belt Model of Integrated Care for Survivors of Rape & Defilement  
Mary Zama/Jill Keesbury

10.00- 10.30 am: CRADLE: Experience in handling cases of Sexual Assault with focus on the existing Legislation & Medical Management  
Hon. Millie Odhiambo

10.30-10.45 am  Tea Break

10.45-11.15 am: Innovative Responses to the Management of Sexual Violence In a Public Setting  
Mohau Makbasane

11.15- 11.45 am: Post Rape Care Services- Public Health Model  
Hadley Muchela/ Dr. Meme
11.45-12.15 pm: Presentation on Medico Legal Response to Sexual Violence with Focus on the police Service and Judiciary System and Health Sector
Patricia Njawili

12.15-13.00 pm: Training of Sexual Assault Health Care Providers – National Curriculum Development
Ruxana Jina

13.00-14.00 pm  Lunch Break

14.00-14.30 pm: Sexual Violence Research Initiative
Liz Dartnall

14.30-17.30 pm: Development of Country Group plans
Rachel Jewkes

DAY 4, FRIDAY 6TH JUNE, 2008

Moderator: Nduku Kilonzo

9.00-10.30 am: Presentations: Country Plans:
Jill Astbury

10.30-10.45 am  Tea Break

10.45-11.45 am: Presentations and Consensus Building
Rachel Jewkes

11.45-12.00 pm: Way Forward
Nduku Kilonzo

12.00-1.00 pm: Closing ceremony
Hon. Amina Abdalla
## Appendix II: List of Participants

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<tr>
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<td>52</td>
<td>Ruxana Jina</td>
<td>MRC</td>
<td>South Africa</td>
<td><a href="mailto:ruxana.jina@gmail.com">ruxana.jina@gmail.com</a></td>
</tr>
<tr>
<td>53</td>
<td>Trepshord Kasale</td>
<td>Police</td>
<td>Zambia</td>
<td><a href="mailto:kaselet@yahoo.co.uk">kaselet@yahoo.co.uk</a></td>
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