



EAST AFRICAN COMMUNITY

**REPORT ON THE HIV – SEXUAL AND GENDER-BASED VIOLENCE
SYMPOSIUM
28th MARCH, 2013
Serena Hotel, Kigali, Rwanda**

**East African Community Secretariat,
Arusha, Tanzania
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TABLE OF CONTENTS

2.0	OPENING REMARKS AND PRESENTATIONS	4
2.1	Presentation on HIV and AIDS: EAC Regional Perspective	4
2.2	Presentation from Population councils	8
2.3	Overview of SGBV and HIV: Regional and international perspectives	9
3.0	STATUS OF SGBV AND HIV & AIDS INTERVENTIONS IN EAC PARTNER STATES	10
3.1	Uganda:	10
3.2	Kenya:	11
3.3	United republic of Tanzania	12
3.4	Republic of Burundi	14
3.5	Republic of Rwanda	14
4.0	NETWORK PARTNER PRESENTATIONS	15
4.1	Girls Empowerment Clubs 'Plus' Program - Swaziland by Nelisiwe Mtshali	15
4.2	Assessing the Feasibility of Improving Access to HIV PEP for SV Survivors	16
4.3	Thohoyandou Victim Empowerment Programme	17
4.4	Testing the Feasibility of Police Provision of EC in Malawi	18
4.5	Improving the collection, documentation, and utilization of medico-legal evidence -	18
4.6	is missing from the Table of Contents ('Screening for Intimate Partner Violence ...')	
5.0	KEY OBSERVATIONS, NETWORK RESOLUTIONS AND RECOMMENDATIONS	20
5.1	Key observations	20
5.2	Resolutions	20
5.3	Recommendations:	21
1.0	Introduction.	

The East African Community HIV and AIDS Unit in partnership with Population Council, Nairobi, and the Ministry of Health, the Republic of Rwanda organized the HIV- Sexual and Gender Based Violence (HIV-SGBV) 2013 Symposium with the theme “**Toward a Multi-sectoral and Comprehensive Response in East Africa**”. This was held during the 4th East African Health and Scientific conference.

1.1 Convening of the meeting

The one day symposium on HIV and Gender Based Violence was convened 27th by the EAC HIV and AIDS Unit with Support from Population Council, Kenya during the 4th EAC Annual Health and Scientific Conference held in Kigali Rwanda from 27th to 29th March 2013.

1.2 Meeting participants

The symposium was attended by over 30 delegates from the Population Council-led 'Africa Regional SGBV Network,' Ministry of Health and Ministry of Gender officials, and members of civil society organizations in Eastern and Southern Africa (see Annex 1 for details). The Africa Regional SGBV Network is made up of partners in East and Southern Africa that have been developing, implementing, and evaluating core elements of a comprehensive, multi-sectoral SGBV response model since 2006.

1.3 Objectives of the symposium

The symposium provided a forum for Africa Regional SGBV Network partners, academicians, Partner States' technical staff, policy makers and to interact, interrogate and discuss various thematic issues and challenges related to the implementation of SGBV interventions in the East and Southern Africa region.

Specifically, the objectives of the symposium were to:

- i) Provide a platform for Partner States' ministries responsible for Gender, practitioners and researchers from countries in Eastern and Southern Africa to share their experiences and lessons, on SGBV
- ii) Provide an avenue for implementing partners responding to SGBV across the Eastern and Southern African region to highlight interventions, opportunities, and challenges, specifically in regard to translating their research into policy,

- iii) Provide a platform for discussing the contribution of SGBV to the HIV and AIDS Epidemic in the region
- iv) Bring together Africa Regional SGBV Partners Network members to avail information, and network with regional bodies, governments, implementers, and development partners to explore opportunities for relationship-building, and
- v) Provide space for intellectual dialogue amongst the people of East and Southern Africa.

2.0 Opening remarks and presentations

The meeting was graced by the following key note speakers:

- Dr. Nduku Kilonzo, Liverpool VCT, Care and Treatment, Kenya
- Dr. Michael J. Katende, Principal HIV and AIDS Officer, EAC Secretariat
- Dr. Chi-Chi Undie, Associate, Population Council, Nairobi

In their remarks, all speakers noted timeliness of the symposium on SGBV and the need for heightened attention to SGBV for the following reasons:

- SGBV has an impact on HIV and AIDS and vice versa.
- SGBV is more prevalent than HIV in the region and there is need to address SGBV if we are to succeed in controlling HIV/AIDS
- There are many social and cultural barriers that prevent SGBV victims from seeking care and support.
- National guidelines for managing SGBV are not sufficient to effectively provide the victim with the quality care and support they need.
- Effective programming addressing key issues affecting victims needs to be informed by proper research and not the wish of programmers / donors. The need for disaggregated SGBV data by age was stressed here.
- Poor documentation is a challenge in the justice system with poor evidence collection and protection, most of the time denying the victims justice.

2.1 Presentation on HIV and AIDS: EAC Regional Perspective

An overview of the EAC regional HIV and AIDS programme was provided by Dr. Michael Katende, of EAC Secretariat. This presentation outlined the mandate of

the EAC HIV and AIDS Unit, objectives of the EAC HIV and AIDS strategic plan 2012 – 2014, strategic areas of focus, HIV and AIDS situation in the region, and some keys issues to addressed.

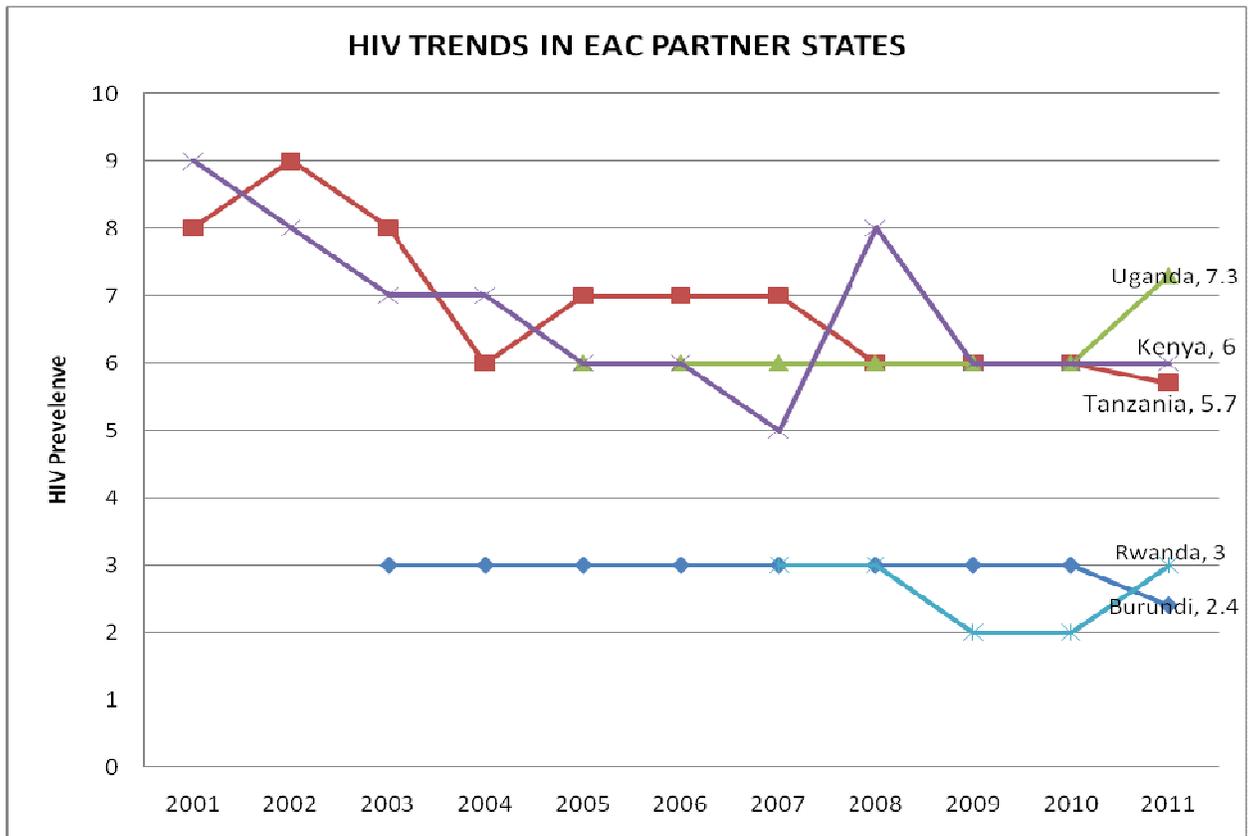
He informed the meeting that the EAC HIV and AIDS programme was supported by Sweden and Norwegian Governments through the Swedish International Development Agency (Sida) and Government of Ireland. Technical support to the programme was supported by UNAIDS, WHO and other partners.

The presentation further outlined the EAC's regional HIV and AIDS programme as a critical enabler to achieving commitments in Africa **Common Position Targets at the HLM New York 2012.**

The presentation proceeded to outline the mandate of the EAC regional HIV and AIDS programme as that of

- ✓ Co-coordinating HIV and AIDS initiatives at regional level
- ✓ Policy design and development, specifically relating to HIV and AIDS
- ✓ Research on specific areas of regional impact
- ✓ Resource mobilization for HIV and AIDS interventions
- ✓ Monitoring and evaluation aspects
- ✓ Facilitating effective HIV and AIDS networking through the design and sharing of operational frameworks and guidelines and exchange of best practices

Dr. Katende noted that some progress had been made in having many patients on ARV treatment, and the HIV prevalence in the region was on the decline in all countries in the region except some few where a slight increase in the rates had been noted (see *figure 1 below*).



Source: EAC Secretariat Facts and Figures – 2011.

He observed that there was risk of losing out earlier gains we had made in fighting HIV /AIDS if programming was business as usual. Still many patients are who should be on life saving treatment were not on HAART, e.g. only 53% for Uganda, and 55% for Burundi, etc and Paediatric uptake of ART is still very low, at 23% for Uganda.

The challenges facing HIV and AIDS programmes in the region were articulated and include:

- i) Dwindling financial resources for supporting HIV and AIDS programmes at Global, regional and national level. There is no clear long term sustainable funding for HIV programmes.
- ii) Competing priorities at global, regional and National level due the epidemiological transition (NCDs, Communicable diseases)

- iii) Challenging policy and legal environment in the region make it difficult to have meaningful interventions focusing on groups that are contributing to the HIV epidemic in the region e.g. key populations
- iv) Limited sharing of research findings, best practices, and slow implementation of recommendations by the region.
- v) Still experience supply chain management challenges leading to shortages in supply of key commodities, drugs and supplies for the effective implementation of the HIV and AIDS care and treatment programmes

He concluded his presentation with the following recommendations;

- i) Diversify funding sources for Health, HIV and AIDS in the EAC Partner States to include sustainable locally generated resources
- ii) Integrate HIV and AIDS interventions into other programmes for ease of funding e.g. Environment/ HIV and AIDS/ Reproductive health
- iii) All Partner States and development partners should provide a mandatory budget in their programmes / projects, of 5 to 10% of the total budget to cater for research.
- iv) Partner States' relevant ministries should put in place mechanisms for monitoring the implementation of key recommendations from fora such as this one. For detailed presentation see **Annex II**.

2.2 Presentation from Population Council

Dr. Chi-Chi Undie from Population Council Kenya welcomed participants to the symposium and praised the EAC and Rwanda's Ministry of Health for their efforts to address HIV and AIDS and SGBV as interconnected issues. She highlighted the lethal relationship between HIV and SGBV, pointing out the prevalence rates for each in various countries in the region (see Table below).

Country	Data Source	Women (15-49) reporting ever experiencing sexual violence	HIV prevalence (15-49)		
			Female	Male	Total
Burundi	DHS 2010	---	1.7%	1%	1.4%
Kenya	DHS 2008-09	21%	8%	4.3	6.3
Rwanda	DHS 2010	22%	4%	2%	3%
Tanzania	DHS 2010, Tanzania HIV/AIDS & Malaria Indicator Survey 2007-08	20%	6.6%	4.6%	5.7%
Uganda	DHS 2006, Uganda AIDS Indicator Survey 2011	39%	8.2%	6.1%	7.3%

She asserted although SGBV is a multi-faceted, multi-sectoral issue, until recently, little was known about how to effectively address it in a multi-sectoral manner. The Africa Regional SGBV Network emerged in response to this need. She summarized some key lessons learned by this Network through its work in the region over the last six years, namely:

- a. Most survivors of sexual violence seeking services are children below the age of 18.
- b. There are many cultural, community-level barriers that undermine care-seeking on the part of survivors of violence.
- c. National guidelines around the care of SGBV survivors are essential, but it takes a wide range of committed partners within and outside the government to ensure that guidelines are actually implemented.
- d. A variety of approaches can be used to provide quality, comprehensive care to survivors. One-stop centers for SGBV are ideal, but the reality is that few countries will have the capacity to set up enough of them. The Network's research has shown that we can make use of what we do have to provide comprehensive care, even if it is not all done under one roof.
- e. Functional linkages between police and health services are key because, in several countries in the region, survivors often report to the police first, and may not go anywhere else after that.

- f. Capacity-building of providers (doctors, nurses, police officers, counselors, social workers, etc.) is critical in order for providers to offer quality services.

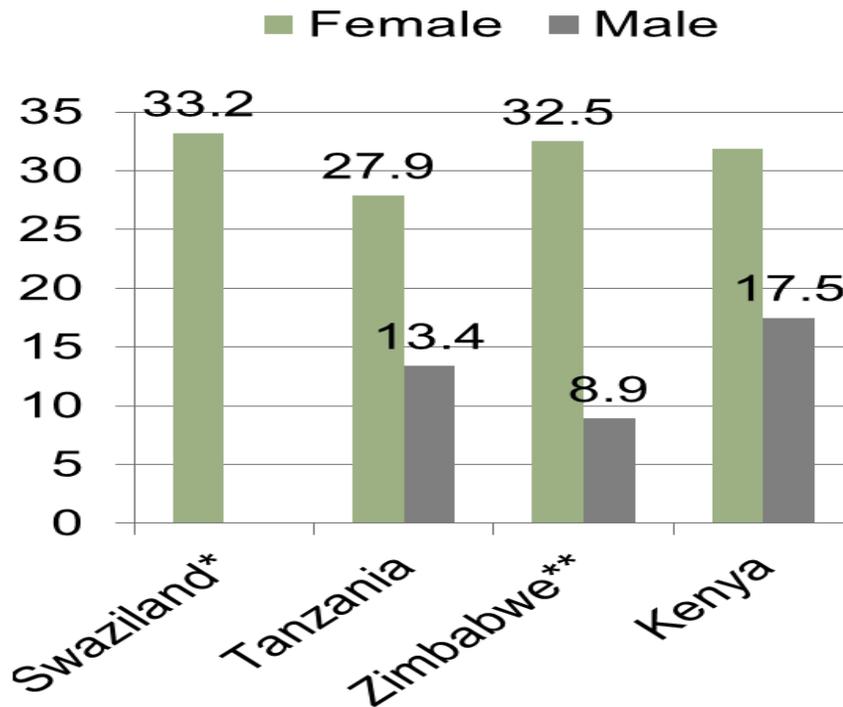
She concluded by encouraging participants to use the Symposium as a forum for drawing inspiration, and for cross-country sharing and lesson-learning.

2.3 Overview of SGBV and HIV: Regional and international perspectives

An overview of SGBV and HIV, regional and international perspectives was provided by Dr. Nduku Kilonzo, Liverpool VCT, Care and Treatment, Kenya.

She outlined the impact of SGBV on HIV and the need for immediate action based on the existing body of evidence, because SGBV and HIV are linked. She informed the meeting that Sexual Violence is prevalent in the region as is shown in figure 2 below.

**Prevalence of SV prior to Age 18 – Females & Males 13–24yrs
Swaziland (2007), Tanzania (2009), Zimbabwe (2011), Kenya (2012)**



Source: Drawn from the GBV/HIV workshop, July 2012 - Maternowska (UNICEF data)

She however noted that GBV programming and services are few, limited in scope with disjointed or non existing multi-sector response with limited funding from Government & partners.

She further informed the symposium participants that lessons & opportunities learnt from implementing HIV programmes should be used to implement interventions focusing on GBV. We need to have Consistent, sustained and synergized advocacy; good Monitoring and Evaluation (M&E) with common indicators and national data systems. She also underscored the importance of investing in research investment as an essential ingredient for local solutions, policy reforms and scale up. For detailed presentation see **Annex IV**.

3.0 Status of SGBV and HIV & AIDS interventions in EAC Partner States

All countries from East Africa made presentations at the symposium.

Key issues noted per country:

3.1 Uganda:

All interventions are guided by three key policy documents which provide a framework for SGBV and HIV priorities and interventions. These are:

- i) The National Development Plan (2010– 2015), the Health Sector Strategic Plans I & II (2000/'01–2009/10)
- ii) The Health Sector Strategic and Investment Plan (2010-2015)
- iii) The National Health Policy II (2010/2019)

Interventions

- The country developed materials in 2007 and has completed updating of them I 2012;
- Capacity building for the service providers
- Strengthening collaborations/ networks
- Under the coordination of Ministry of Gender (MGLSD), the ministry is providing integrated services under three thematic area Prevention, advocacy and

service delivery. they are conducting advocacy campaigns and providing SGBV services

- Services are promotive, preventive, curative and rehabilitation. For detailed presentation see **Annex VI**.

3.2 Kenya:

- A third of young women in Kenyan have experienced physical violence since the age 15 [KDHS 2008/09].
- 29% women reported experiencing sexual violence [KDHS 2008/09]
- 51% of women visiting antenatal clinics in Nairobi reported having been victims of violence; 65% from their husbands and 22% from strangers
- Both state and non-state actors are involved in prevention efforts and response to SGBV. The actors are Healthcare providers, Law enforcers/security, Legal/justice actors, Community, Advocates and Donors
- Although significant progress has been made in addressing gender issues in the country, there is still no gender parity in Kenya.
- Kenya's Vision 2030 acknowledges that cases of GBV are increasing and lays out strategies to reduce GI and vulnerabilities
- Interventions include Legislation and Services are available and offered to those affected by SGBV.
 - The Sexual Offences Act, 2006 in place
 - The Children Act (2000) provides for the protection of child sexual violence survivors and criminalizes FGM.
 - Other Acts and Bills on property rights, family, domestic violence
 - Taskforce on review of laws relating to women

Challenges

- In spite of the existing frameworks gender inequalities persist
- Both women and men justify violence to an extent; no clarity as to what is acceptable/unacceptable – Difficult to prioritize in development agenda
- Weak coordination.
- Insufficient awareness and information on the rights of women – inaction and silence
- Meager resources allocation
- Weak relationships between the main actors

Moving forward Kenya recommends;

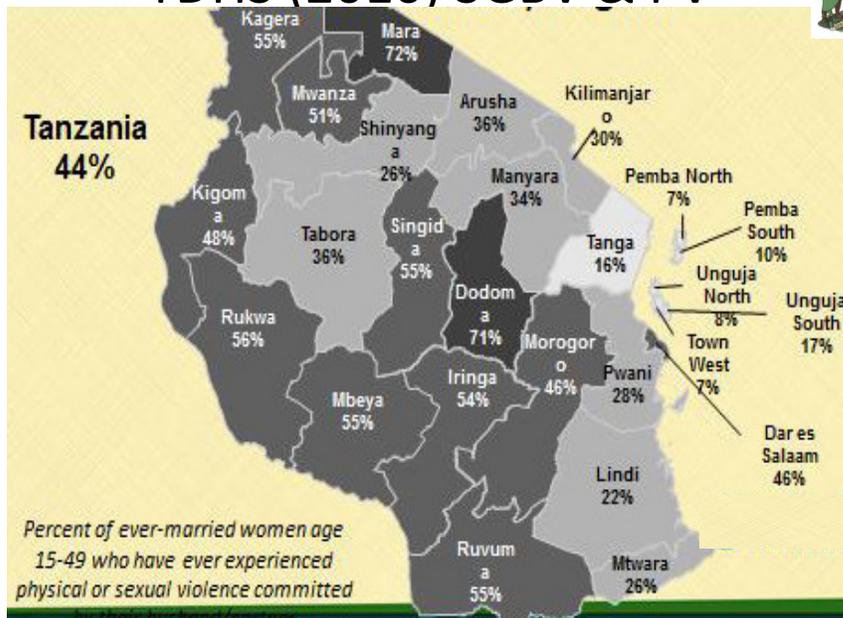
- i) Sustained advocacy to demystify SGBV, and to have resource allocated for implementation SGBV interventions;
- ii) Sensitization of decision-makers and community
- iii) Proper documentation, monitoring
- iv) Enhance Prevention strategies while providing care for survivors
- v) Strengthen male engagement as partners and champions
- vi) Conduct Audit and review of harmful and gender-blind clauses in policies/laws

For detailed presentation see **Annex VII**.

3.3 United republic of Tanzania

Dr. Grace Mallya made a presentation on the status in Tanzania mainland and noted that the vice was prevalent. She noted that there was a correlation between prevalence of SGBV and HIV prevalence.

TDHS (2010) SGBV & PV



Programme achievements

- i) National Strategy for Gender Development (2002) to promote gender equality and equity for women.
- ii) In 1998, The Sexual Offences Special Provision Act 1998 (SOSPA)

- iii) National Plan of Action to Prevent and Eradicate Violence against Women and Children (2001–2015)
- iv) Establishment of gender desks in ministry departments and Police gender and children desk in 394 police stations
- v) The National HIV and AIDS Policy and Health Policy provide a framework for the delivery of HIV and AIDS services to all in need, including GBV survivors.
- vi) National Policy and Management Guidelines for the health sector prevention and response to GBV – 2011
- vii) National Training Package for HCWs & SWOs

Challenges noted include:

- i) Poor coordination of the response
- ii) Inadequate resources for implementation
- iii) poor male involvement
- iv) Poorly developed referrals and linkages

Zanzibar

The presentation was made by Ms. Khadija Mohamed, who also noted that the problem of SGBV was prevalent in Zanzibar too.

Zanzibar had one stop centers that were providing all services to the victims mainly in the hospitals and health centres.

Achievements:

- i) Various services are provided to survivors of GBV/VAC under one setting and in a coordinated manner.
- ii) Proper documentation of the GBV/VAC cases and enhanced follow up of the cases.
- iii) Community awareness has encouraged reporting of GBV/VAC incidents.
- iv) Trained Health care service providers on management of GBV/VAC survivors.
- v) Strengthened collaboration among multiple sectors handling the GBV/VAC survivors

Challenge

- i) Lacks of permanent health care providers and supporting staff specifically for the centre
- ii) Incomplete of Most or insufficient medical evidence presented in the courts of law due to lack of skills or negligence among health care workers and police in forensic evidence collection.
- iii) Inadequate rehabilitation services for the GBV/VAC survivors due to lack of permanent social worker for counseling and a psychologist for psychosocial therapy.

For detailed presentation see **Annex VIII**.

3.4 Republic of Burundi

Dr. Damien Mpagaritse presented on behalf of Burundi and noted that SGBV is a complex problem that concerns many sectors : health, Security, human rights, justice, education. Its a common problem but under reported at all levelss due to many factors including stigma ,shame, being afraid of multiples and various consequences on oneself,her/his family,her/his community.

It has also been noted that SGBV is part of crimes such as theft committed during the night or night.

He further informed the meeting that there are two vulnerable groups namely :

- i) the Women and girls, mainly Unaccompanied women and girl, widows ; Un-married mothers ; sexworkers ; Refugies and internally displaced people ; prisonners ;people with handicap (physical/mental)
- ii) Chidren unacompanie, small girls alone, chidren at school, adolescents and chidren placed in family

Aggressors are majorly men, who have administrative ,social or moral authority over the victims. Among the aggressor, 8.96 % are people known to the victim (friends), 15% are family members and in rares cases employers , students, tutors , pastors, doctors etc.

The main actors providing SGBV interventions are mainly the Civil Society organizations, supported by Ministries of health, Human right and Gender, Police and Justice, Home affairs and International NGOs.

- Interventions that have been implemented include :
 - Mobilization of community leaders for the fight against SGBV (mass communication, radio, mobile cinema)
 - Setting up multidisciplinary provincial networks (police, health, justice, Humann rights, NGO, etc.)
 - Capacity building for actors implied in taking care of victims
 - Availing medical kits for care of victims

For detailed presentation see **Annex IX**.

3.5 Republic of Rwanda

- Rwanda has a National GVB law which treats any sexual relations with a child, as rape.
- Law n° 27/2001 on child protection
- The country has a national Coordination mechanism which has many Ministries involved, e.g. Health Gender and Justice; the national police; parliament, human rights commission and the civil society.
- The Government of Rwanda has a comprehensive package of services offered which includes?
 - Psychosocial support and counseling
 - HIV testing and Post-exposure prophylaxis
 - STI screening and treatment
 - Emergency contraceptive
 - Anti tetanus vaccine
 - Other complementary exams
 - Collecting the forensic evidence
 - Referral system between clinical and police services or other services needed

Challenges

- i) Lack of appropriate infrastructure (quiet space) for counseling and consultation of GBV survivors
- ii) Survivors come late after 48 hours
- iii) Weak collaboration on reporting teenage pregnancies

For detailed presentation see **Annex X**.

4.0 Africa Regional SGBV Network Partner Presentations

Members of the Africa Regional SGBV Network were present at the meeting. The presentations covered:

4.1 Girls Empowerment Clubs 'Plus' Program - Swaziland by Nelisiwe Mtshali

- This intervention was implemented in two schools among 95 girls out of 200 students that were targeted, with support from Population Council (SIDA and NORAD).
- The project support the development of the country's first ever National Multisectoral Guidelines for Management of Sexual Violence Cases as phase one and testing the feasibility and effectiveness of a comprehensive SGBV prevention project for in-school girls in Swaziland as the second phase.
- The overall project goal was to help prevent SGBV and increase reporting among in-school girls by using school-based girls empowerment clubs to build girls' social assets, following the Population Council's 'Safe Spaces' approach.

- The project was expected to:
 - i) Expanded and pilot tested Safe Spaces curriculum adapted for GEC-Plus'
 - ii) Establishment of a cohort of trained mentors to lead GEC Plus (adolescent girls between 18 – 25 years)
 - iii) Improved knowledge and attitudes about the causes and consequences of SGBV
 - iv) Increased social assets (i.e. friends, social networks) among GEC-Plus participants
 - v) Increased reporting of SGBV cases among GEC-Plus participants
 - vi) Feasibility of implementing GEC-PLUS in Swaziland established through SWAGAA's existing school-based programs and in new sites

Generally, the project was ongoing and had registered some successes. There was improvement in general knowledge on SGBV issues among the girls in the project.

- The project offers evidence to:
 - i) Improve response and strengthened reporting at national level.
 - ii) Support Advocacy for the enactment of the Sexual Offences and Domestic Violence Bill,
 - iii) Lobby government to take ownership and expand the program to all schools.
 - iv) Advocate for the review of guidance teachers job descriptions

For detailed presentation see **Annex XI**.

4.2 Assessing the Feasibility of Improving Access to HIV PEP for SV Survivors

- Assessing the feasibility of improving access to HIV PEP for SV survivors through Zambian Police Services was premised on the fact that Police is the first contact for SGBV and hence to the need to sensitize the police on SGBV.
- The project was supported by Population Council, Norad, Sweden and Government of Zambia.
- The project had 4 aims namely:
 - i) Understand and describe current services and challenges increase awareness and engagement of the community
 - ii) Introduce and monitor Sexual Violence Unit (SVU) provision of PEP and hospital referral
 - iii) Introduce and monitor VSU provision of PEP and UTH referrals
 - iv) Assess quality and consistency and coordination of Sexual Violence services
- The project observed:

- i) Fragmentation and weak coordination of services.
- ii) The ZP form 32 reporting form was instead a barrier to access to PEP. Forms were not available at the health facility so the victims had to travel to the police post to access the form, and had to make copies. This was expensive and breached confidentiality.
- iii) Human resources gaps exist. The health workers (senior doctors) who attend to SGBV victims were very busy with many competing priorities. Despite Sexual Violence laws and guidelines, only senior doctors attend to SV cases. There are 24 senior doctors in OBGY. Officers trained to handle SV cases are often assigned to other police duties and are not available when needed.
- iv) Weak infrastructure that is Insensitive to SV Trauma and lack of privacy;
- v) Lack of transportation,
- vi) Cases on Sexual Violence are lost in a sea of other (non-SV) medical and police cases
- vii) One Stop Center closed weekends, evenings, and holidays. SV communication skills in OPD lacking

For detailed presentation see **Annex XII**.

4.3 Thohoyandou Victim Empowerment Programme By Fiona Nicholson The Zero-tolerance Village Alliance (2010-2012):

- The mission of this programme is to “generate an attitude of ZERO TOLERANCE towards all forms of sexual assault, domestic violence, child abuse and HIV and AIDS stigmatization in the Thulamela Municipality (Vhembe District).
- The programme is supported by the royal Government of Sweden, Norad, Population Council and the Department of Social Affairs, republic of SA.
- This intervention brought together the traditional and cultural leaders, police, District hospitals and clinics (42) and the district administration in fighting SGBV Child abuse, and HIV and AIDS.
- The project through the Community Policing Forum and SAPS establish a “Victim Empowerment Committee (VEC). These established a 24-7 one stop trauma clinics” in partnership with DoH, SAPS, and local businesses. This was later transformed into the **Thohoyandou Victim Empowerment Trust** which implements the programme.
 - i) To enable behavioural change by building empowered and supportive environments in which all residents feel secure enough to speak out and exercise their rights
 - ii) Provide intensive, participatory workshops across four thematic areas of focus: SGBV, domestic violence, child abuse, and HIV/AIDS

iii) To revive the spirit of “ubuntu” (solidarity) by enabling communities to adopt the eradication of violence and stigma as a common goal. The programme was able: to reach 3732 participants directly by ZTVA workshops; Increase knowledge across key thematic areas of focus (n = 1180 surveyed); Register initial increase in victims who reported SGBV or child abuse and ultimate decline in reporting of SGBV in pilot villages. For detailed presentation see **Annex XIII**

4.4 Testing the Feasibility of Police Provision of EC in Malawi: Charles Gawani, Malawi Human Rights Resource Center

- To determine the feasibility of trained police officers as first points of contacts for Sexual Assault Survivors to safely and effectively Provide EC as a way of broadening Access.
- Supported by Norad, SIDS and Population council
- The study supported Capacity building of officers in EC provision, documentation; Analysis of statistical and qualitative data; Review of VSU and statistics conducted Key informant interviews with stakeholders. The also conducted lobby meetings with high ranking police officers & MoH official,
- The observations as the study was implemented are:
 - i) Effective screening of SA survivors by police officers to determine eligibility for EC
 - ii) Improved collaboration between police & Hospital
 - iii) Knowledge sharing with development partners: UNFPA & UNICEF
 - iv) Introduction of SA logbooks in Police – VSUs and
 - v) MoH approved to let Police provide EC to SA survivors
- Challenges noted include:
 - i) Trained police officers assigned to other duties
 - ii) Competitive engagement of trained police officers by other partners-cultivating allowance culture
 - iii) Protracted process to obtain ethical approval from MoH-Research Committee

For detailed presentation see **Annex XIV**

4.5 Improving the collection, documentation, and utilization of medico-legal evidence - Kenya: Carol Ajema & Wanjiru Mukoma, Liverpool VCT,

- This study was conducted in two districts in Kenya, targeting police and health care workers, for a period of two years, from 2012 to 2012.. The study involved review of records-baseline & end line; assembling a rape kit; and Training Police and health providers on use of existing national protocols.

- It was a joint collaboration between Ministry of Health division of RH and the government chemist, Office of Directorate of Public Prosecution; and the police department.
- The aim of the study was to generate evidence on documentation for survivors of SV reporting at health facilities and police.
- Study Observed that:
 - 67%(n=501) of survivors were under 18years, 331 survivors attended to at intervention site and 170 comparison site
 - Survivors at the intervention site were three times more likely to have the Kenya police (P3) form filled in for them both at the health facility and police station
 - PRC forms were not filled in for all survivors
 - Incomplete forms- names, age, gender, examining health provider information?
 - Only 17% of P3 forms at the facilities were signed
 - There was improvement in evidence collection

Conclusion

- There was good uptake of the Rape kit, introduction of the rape kit resulted in faster evidence collection and onward transmission.
- The rape kit reduced the number of reference documents required to complete the PRC form
- The rape kit can easily and effectively be used to improve evidence collection and documentation in poor resource settings - can be scaled up

Overall increase in use of and better completion of the medico-legal forms (PRC & P3).
For detailed presentation see **Annex XV**.

4.6 Screening for intimate partner violence in public health care settings in Kenya: Margaret Mak'anyengo,

- This Project was implemented through a collaborative effort between Kenyatta National Hospital and Population Council. The intervention involved screening clients for intimate partner violence in the ANC, Youth Centre, and HIV Comprehensive Care Clinic, and referring IPV-positive clients for comprehensive care at an on-site GBV clinic.
- The project has 3 Objectives namely:

- i) To assess the acceptability and feasibility of routine screening for IPV in Kenyan public health care settings
 - ii) To test the utility of a screening tool for IPV identification, referral, and response
 - iii) To share lessons learned under an IPV screening program in a developing country setting and describe the 'how-to' of screening in such contexts
- The study enrolled 121 participants.

Screening for IPV in public health care settings in the East African region was found to be acceptable and doable. However, the who, where, when, what, which, and how questions must be addressed and used to inform proper intervention planning. For detailed presentation see **Annex XVI**

5.0 Key Observations, Resolutions and Recommendations

5.1 Key observations

- Sexual and Gender based Violence is recognized as one of a factor in the spread of HIV.
- Under the coordination of relevant ministries in the EAC Partner States, all countries are providing integrated services / interventions for victims of Sexual Gender Based Violence under three thematic areas: Prevention, advocacy and service delivery.
- Generally most interventions in the EAC Partner States are provided by NGO projects and programmes; governments have allocated limited resources for these interventions.
- There is lack of appropriate infrastructure (quiet space) for counseling and consultation of GBV survivors.
- There are many social and cultural barriers that prevent SGBV victims from seeking care and support.
- There are innovative ways of fostering a multi-sectoral response to SGBV in the region without necessarily providing all services in one location.
- Use of innovative ways to address SGBV can contribute to better reporting among the victims, and thereby enhance access to services.

5.2 Resolutions

The meeting participants resolved to:

- i) Continue Advocating at for a framework for a multi-sectoral response to SGBV in the region
- ii) Provide sustained advocacy for resources allocation for SGBV at Partner/ Member States lever and regional levels
- iii) Advocate for mainstreaming SGBV across sectors
- iv) Audit and review of harmful, gender-blind clauses in policies and laws
- v) Engage and involve men in the prevention of, response to, SGBV (including SGBV against males)
- vi) Continue building the Capacity of range of providers (health, police, justice, social services, education, etc.) to address the needs of child survivors of SGBV

5.3 Recommendations:

The meeting participants recommended to the EAC to:

- i) Strengthen the EAC's Gender Department (resources, capacity, technical support, etc.)
- ii) Espousal of a multi-sectoral approach that highlights the role and voices of other sectors in addition to the health sector
- iii) Strengthening networking systems to boost linkages among sectors
- iv) Develop Strategies for political advocacy to galvanize political commitments and to priorities SGBV in the region
- v) Support investment in research: The EAC Research Commission should include SGBV on the research agenda
- vi) Integration of SGBV prevention and response mechanisms into existing national plans, with indicators for tracking progress
- vii) Standardize way of sharing lessons learnt /best practices from Africa Regional SGBV Network partners
- viii) Harmonize tools for SGBV management across the region
- ix) Integrated SGBV guidelines into health facilities
- x) Integration of long term intervention plans to measure intervention strategies
- xi) Interventions targeting children :
 - a. At primary school level, with a focus on changing social norms for prevention
 - b. Curricular-based interventions, involving inclusion of SGBV content

- xii) In-depth analysis of root causes of SGBV in the region, incorporating a women's rights and gender equality perspective.
- xiii) Strengthen community-owned resources to prevent and respond to SGBV