

**African Regional
Training Programme For
Care And Support Of
Sexual Assault Survivors**

Training Report

2 - 13 February
2009

Premier Hotel
Pretoria, South
Africa



FORD FOUNDATION



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Responding to Rape: A global project

Rape is a profound public health problem and human rights violation. There are no rape free societies. The impact of rape on survivors' physical and mental health and role in society is often substantial and long-lasting. Good quality holistic care for rape victims can play a critical role in recovery, and in supporting the transition from rape victim to survivor. Despite its pervasiveness, in most countries, services for rape victims have been neglected. Health services struggle to effectively meet the psycho-social and physical needs of survivors; policy is often lacking, services are poorly developed and health workers untrained. The police and justice systems struggle to deliver justice, whilst communication and cooperation between these sectors is limited.

Through seed funding from the Ford Foundation, and additional the support from CDC/PEPFAR, Global Forum for Health Research and the Medical Research Council South Africa, the SVRI is supporting processes within countries to develop health sector responses to rape survivors, both immediately after rape and in the longer term, and to promote an appropriate and effective interface between the health, police and justice sectors. The project has been launched in Africa.

The project builds on four components: partnership, training, policy, and research. The first phase of this multi-year programme of support has been to promote the development of working partnerships among policy makers, service providers and trainers, and women's advocates within countries. Through SVRI networks and partnerships, seven multi-disciplinary teams have been established in Rwanda, Zimbabwe, Zambia, Uganda, Malawi, Kenya, and Nigeria. Team members represent the health, justice and policing sectors from their countries. These teams are the core drivers of change at country level for developing and strengthening multi-sectoral responses to sexual violence.

Training forms a core part of the second phase of this project. Skills and knowledge of the country teams have been enriched through a multi-sectoral Regional Training Programme for Care and Support of Sexual Assault Survivors. The SVRI is also providing technical support and guidance for in-country processes to develop policy, models of care and inter-sectoral working, and training for health professionals, where appropriate supported by research. This process will be supported over several years.

This report provides details of the second phase of this project, the multi-disciplinary training programme for providers on the care and support of rape survivors. The first part of the report details the training aim, participant selection; training faculty, length and pre-course activities. Section two provides information on the training curriculum and content, while section three outlines the contexts and plans of the participating countries regarding sexual violence and strengthening service provision. The final section of the report highlights key lessons learnt and post course reflections.

SECTION 1: TRAINING PREPARATION

The course and training has opened various doors for improvement [both] on a short time and long term basis (Course participant, February 2009)

I am very honoured to be part of the course, I was enlightened on many issues and hope to apply all or many to my institution. (Course participant, February 2009)

The overall aim of the training programme was to shift how health services respond to survivors of sexual violence, both immediately after sexual assault and in the longer term, where high quality health services can exercise a critical role in reducing all sexual violence health related harms. This training was organised so that project partners were given an opportunity to discuss and debate good practice and to think through disjunctions between policy and the organisation of services in their own settings. It was also see it as a time where partners could reflect on what is needed at a country level in terms of research, policy and adaptation of the curriculum.

Who Participated?



Multidisciplinary teams drawn from the following 7 African countries: Kenya, Malawi, Rwanda, Uganda, Zimbabwe, Zambia and Nigeria. Teams constituted professionals from health (medical doctors and professional nurses), police and legal sectors (Table 1). Some teams had the total compliment of sectors attending while others only had health sector representatives. Project partners (PEPFAR/CDC and Population Council) also sent representatives to the course, both as observers and participants.

Table 1: Participants by country and sector

Country	Sector				Total
	Health	Police	Legal	NGOs	
Kenya	1	0	2	1	4
Malawi	2	2	1	1	6
Nigeria	3	0	1	0	4
Rwanda	3	0	0	0	3
Uganda	4	0	0	0	4
Zambia	4	1	0	0	5
Zimbabwe	3	1	1	0	5
South Africa ¹	1	0	0	0	1
Resource Persons	0	0	0	6	6
Total	21	4	5	8	38

Selection Process and Criteria

The diversification of participants from the various departments of health, judicial and police will definitely provide a major improvement on quality of service provided to sexual violence victims. (Training participant, February 2009)

A targeted call for applications to participate in this training was sent out to country partners identified through a training workshop held in Kenya, 2008. Country teams were asked to submit one application per country; applications from individuals were not accepted. Country submissions included a short motivation (no longer than one page) on how the training would support their current work on strengthening sexual assault services, and how they would take the training forward post the workshop. Applications were also required to outline country based multi-disciplinary teams (4/5 per country) who they wanted to attend the training. Teams had to include a minimum of two health sector representatives; one justice sector representative and one police representative.

Course Selection Criteria

Sector	Criteria
Health	<ul style="list-style-type: none"> a medical doctor or forensic nurse; actively managing survivors of rape/sexual assault in the public health sector; providing training on the management of rape/sexual assault for health care providers; involved in policy development at a senior level of government within the health sector.
Justice	<ul style="list-style-type: none"> should either be a prosecutor / district attorney (i.e. somebody working for a government agency); somebody who trains prosecutors.
Police	<ul style="list-style-type: none"> senior member of the police service manages family/child portfolio or a similar portfolio within country actively involved in the investigation of rape, or incest cases

Teams were asked to provide recent CVs [the names, designation, place of work and contact details] for members of the multidisciplinary team that they wanted to attend with the understanding that countries should submit a multidisciplinary team that is technically able and professionally empowered to adapt and promote the curriculum at country level, and to develop and / or strengthen post rape services, policy and legislation.

With few exceptions, only those submissions that successfully met these requirements were invited to attend the training.

¹The SVRI was responsible for coordinating teams coming from Nigeria, Malawi, Uganda, Zambia, and Zimbabwe; whilst the Population Council organized the Kenya and Rwanda country teams. In country logistical support was provided by CDC/PEPFAR. One health sector representative from the South African National Defense Force also attended, as a request from project partners.

Faculty

This course was really extremely resourceful for either health professionals or legal professionals. All facilitators master the content and have facilitation skills. (Course participant, February 2009)

The training programme was delivered by the Medical Research Council, South Africa, and faculty included a multi-disciplinary team of experts in the field of medico-legal responses to sexual violence. The team also included the following professionals from various sectors outside the MRC: legal (Adv Brandon Lawrence – National Prosecuting Authority), police (Senior Supt Anneke Pienaar – South African Police Service), forensic laboratory (Supt Anton Lucassen – Forensic Science Laboratory, SAPS) and the NGO sector (Lisa Vetten – Tshwaranang Legal Advocacy Centre). The team also included Dr Neil McKerrow – Specialist Paediatrician and Nicola Christofides – School of Public Health, University of Witwatersrand, Johannesburg.

Training Length and Pre-Course Activities

The training programme involved an 11 day course for doctors and a 6 day course for participants coming from justice and police sectors. In order to ensure active participation and engagement at this training programme participants were asked to prepare presentations on the context of sexual violence in their countries including research, health and criminal justice services, legal framework, policies and practices. Where available, participants were also requested to bring to the course copies of country specific standardised medico-legal forms usually completed by the medical examiner; policies related to rape and sexual violence, statutes and other relevant documentation/information.

SECTION 2: TRAINING METHODOLOGY AND CONTENT

It was a perfect blend of knowledge, skills, teaching ability, story telling and experience. (Course participant on training curriculum, February 2009)

The training programme is based on the South African national curriculum “Caring for survivors of sexual assault and rape: A training programme for health care providers in South Africa”. The curriculum builds on over a decade of initiatives undertaken across South Africa at policy, training, research and service levels to improve sexual assault care. The training emphasizes a holistic approach to care and the central importance of meeting the basic health care needs of survivors in mitigating potential harms of sexual assault by providing treatment to prevent pregnancy and sexually transmitted infections being acquired from the assault, and to support and assist in navigating its emotional impact. It also highlights the valuable role in collecting evidence to assist the process of securing justice for sexual assault survivors.

A number of adaptations were made to the curriculum to make it appropriate for different disciplines, geographical and socio-cultural settings. Adaptations included: country presentations on the context of sexual violence focusing specifically on research, health and criminal justice services, legal framework, policies and practices, along with review and discussion on country specific standardised medico-legal forms; policies related to rape and sexual violence, statutes and other relevant documentation/information and site visits.

The training methodology for this course drew on adult education principles: critical reflection, small group work, case studies, role plays and videos. The aim of this methodology was to build skills and empower participants to think through clinical and legal problems rather than just imparting knowledge. The course modules included:

Module 1: The social context of sexual assault

The first module provided a thorough introduction to the epidemiological and social context of rape in Africa. This module deepened participants' understanding of survivors' responses after rape and presented materials that very graphically demonstrate how difficult it is for survivors to pursue legal cases related to rape, the personal costs of pursuing cases and the substantial barriers that survivors face. Participants' norms and attitudes related to gender were challenged and personal double standards were also reflected upon by exploring of the idea of sexual rights.

Module 2: Talking with survivors

The focus of the second module was to deepen the capacity of participants to empathise with survivors in order to be competent in the provision of sexual assault care and the holistic management of survivors. Participants were given the opportunity to practice verbal and non-verbal aspects of listening to survivors, to explore their understanding of the forensic nature of sexual assault consultations and to recognise their role in the criminal justice system.

Module 3: Managing health problems

The third module dealt with the various health problems arising from rape. In the first section of this module, mental health outcomes were explored through the responses of service providers, family members and people within the broader support networks of the survivor. Participants were provided with tools to convey non-judgmental, supportive attitudes, and basic trauma-focused cognitive behavioural therapy techniques were introduced. The second section of this module dealt with prevention of pregnancy, HIV and sexually transmitted infections. Participants were also challenged to think through certain issues such survivors' adherence to medication and follow up consultations.

Module 4: Examining survivors and documenting injuries

Module four aimed to improve skills in the provision of high quality medical care. This module focussed on combining conventional teaching of anatomy with more novel approaches to skills building e.g in completing injury documentation on body maps. Countries participating in the training

shared their different medico-legal documentation materials in order to create an understanding of its role, good practice and how documentation may influence legal outcomes. Examination procedures for survivors with special needs were also considered in this module and participants had to develop objective and scientifically based opinions in terms of the causative mechanism for injuries.



Module 5: After the initial consultation

Module five emphasised the legal framework of sexual offences. Each participating country was required to present a brief overview of the law relating to sexual offences in their respective countries. The South African legal system was explained to participants in order to create an understanding as to why certain changes were made, what role the health, legal and justice sectors play and how the law can best be used to strengthen prosecutions. Participants were challenged to think through their own legal obligations and how vulnerable witnesses should be utilised and protected. The module concluded with a practical approach to dealing with vicarious trauma and developing appropriate indicators to monitor and evaluate services, programmes and interventions. This module also included a panel discussion on what constitutes evidence in sexual assault. The panel constituted members from the legal, police, forensic science and NGO sectors. Participants were encouraged to ask panel members questions with regard to identification and collection of evidence, the nature of forensic evidence, analysis of forensic evidence and value of medical forensic evidence in prosecution of sexual assault cases.

Module 6: Site Visits and Country Plans

The training provided participants with space to create and strengthen collaborative partnerships. Participants had the opportunity to visit services in South Africa (health facilities, crisis centres and a magistrate court), where they met South African counterparts to debate models of care, health sector policy initiatives and legal responses to rape. To conclude the training programme, country teams were required to develop plans for advocacy/lobbying, training, policy/legislation and research. Countries were tasked to identify needs for technical support and support for processes to develop policy, models of care, inter-sectoral working and training for health professionals. These are detailed in the following section of this report.

SECTION 3: COUNTRY CONTEXTS AND PLANS

Throughout the training, country teams were afforded the opportunity to discuss and develop plans for strengthening sexual assault services in their countries. This section summarises the key outcomes of these discussions by country:

Kenya



Kenya, like most African countries in the region, experiences high levels of rape and sexual violence, driven by patriarchal and traditional beliefs (Rumbold 2008; Mwangi & Jaldesam 2009). The 2003 Kenya DHS found, 16% of women aged 15-49 reported having ever been sexually abused (Rumbold 2008). Although services for rape survivors are limited, strides have been made politically in terms of the development of legislation and protocols for the management of rape survivors. Kenya has national guidelines for the management of rape survivors, along with national curriculum for medico-legal responses to sexual violence. In terms of legislation, in 2006, Kenya implemented Sexual Offences Act 1-46.2006.52. The implementation of this act has faced multiple challenges. To address these challenges, the Hon. Attorney General established a national Task Force on the Act. The Task Force provides for inter relations between for example the police, health, civil society and other legal sectors workers, and provides fertile ground for strengthening responses to sexual violence in Kenya. Against this background, the Kenya team prioritised a number of key activities as important for strengthening their sexual assault services. In no order of priority the Kenya team highlighted the following as key areas for action:

- Document and review health policies and practices relating to sexual violence
- Develop a position paper and framework for services
- Draft discussion document on establishment of a one stop centre
- Lobby to review Medical Professions Act to change definition of medical practitioner to include professional nurse
- Review the Kenya medico-legal form - P3

- Support health officials to be better equipped technically to provide quality services to survivors through training
- Equipping police stations to better handle survivors

Malawi



The high levels of violence against women in Malawi are driven by strong patriarchal and pervasive traditional beliefs. One in five women report sexual violence from an intimate partner in Malawi at sometime in their lives (Pelser 2005); and 38 percent of girls report their first sexual experience as forced (Moore et al 2007). There is increasing recognition on behalf of the Malawian government of the need to respond to sexual violence and provide appropriate services for survivors. The government has created protocols for Post Exposure Prophylaxis (PEP) after sexual violence. Research indicates that rape victims do not access formal services and that if they do, protocols are not adhered to. Pelser (2005) for example, found that only 4% of women sought help from the police, and most received a service that differed significantly from available protocols. Of those women who did report to the police, only 43% were informed of their right to a medical examination. The Malawi penal code definition of rape excludes marital and male rape. The legal system is adversarial and rape is tried under common law. The lack of a specific legislative framework and key gaps in the definition of rape are key challenges to providing quality services for rape survivors. There is limited research to guide service provision and inform advocacy campaigns, but as already noted, there is increasing political support.

It is in this context that the Malawi team identified the following as key priority areas for strengthening services for survivors of sexual violence:

- Undertake research on the social context of rape, effectiveness and the appropriateness of sexual violence services in 3 districts, including emergency contraception services
- Conduct a similar study as the Tracking Justice study conducted in South Africa
- Develop a Malawi national training curriculum for health, police and legal service providers who provide care and support to survivors of sexual assault and rape;
- Undertake a training needs assessment and conduct a train-of-trainer to train service providers (health, police and legal)
- Develop standardised forms and protocols to guide service provision
- Develop a monitoring and evaluation system

Nigeria



Nigeria is a large and complex country. It is home to 36 states and a Federal Capital Territory, and three different penal codes. It is also home to multiple human rights abuses and although rates are unavailable, anecdotal evidence suggests the existence of pervasive, high levels of rape and sexual violence (Brightman and Emily, 2008). Nigeria ratified the UN Convention on the Elimination of All Forms of Discrimination against Women in 1985. In 2008 a Bill to implement the Convention failed to pass in the National Assembly. The Domestic Violence and Other Related Matters Bill was passed by the Lagos House of Assembly. At federal level, a bill addressing domestic violence failed to become law. The Nigeria Law Reforms Commission proposed in August that rape should carry a 15-year jail term (Amnesty International 2008).

³ Tracking Justice investigated attrition and causes thereof of rape cases in the criminal justice system from the initial police report to the eventual court outcomes. Full report available online at: www.tlac.org.za/images/documents/tracking%20justice_web.pdf

A culture of impunity exists in Nigeria. Services for rape survivors are limited or non-existent. In court, rape survivors are not adequately provided for e.g. no in camera trials, and there are no regulations or protocols to guide service provision. Little research exists on sexual violence, and rape is not included in training of medical professionals. Given the limited availability of research, protocols, policies, and training efforts in Nigeria, the team identified the importance of gaining political support to drive change within the country. Advocacy was seen as an important first step, along with the development of protocols for medico-legal services and research. Key first steps outlined included:

- Undertake a hospital based study on sexual violence services
- Conduct a knowledge and attitude study of health workers
- Brief hospital staff and management on the work being done in the region on services for sexual violence along with context of sexual violence in Nigeria
- Advocacy in states and university, and engage the Association of Women Academics, Nigerian Bar Society and Association of Judges with regard to sexual violence
- Develop and test protocols to standardise aspects of service provision e.g. medico-legal form

Zambia



Sexual violence remains a serious concern in Zambia. Similar to Malawi, violence against women in Zambia is spurred by customary law and traditional beliefs. Between January and August 2008, the Zambian Victim Support Unit in Lusaka alone received 65 cases of adult rape and 626 cases of child rape (Human Rights Watch, World Report 2009). Although rape is a criminal offence and the rape of a child is punishable with life imprisonment, no specific legislation for sexual and gender-based violence currently exists and the Penal Code does not provide a definition for rape. Furthermore, marital rape and male rape is not recognised under the current Zambian Penal Code. Despite the availability of victim-friendly courts, support units within the police service and a seemingly high report rate in Lusaka, rape and sexual assault remains under-reported in Zambia. To address these issues, strong collaborations have been forged with the relevant sectors.

The Population Council has undertaken a project in the Copperbelt Province of Zambia to provide comprehensive care for survivors of rape and sexual assault. During 2007, the focus of the project expanded to increase survivors' access to justice, health care and counseling services. Against this background of multi-sectoral collaboration and the need for legislative reform, the Zambian team developed the following key priority areas to ensure comprehensive care for survivors in Zambia:

- Develop a research agenda to guide service development, with priority given to the following:
 - o A review on the magnitude and health impact of rape.
 - o Replicate the Tracking Justice study conducted in South Africa (see footnote 4.)
 - o A situation analysis of rape services in all sectors
- Field test multi-sectoral protocols for service delivery.
- Strengthening and roll-out of one-stop centres in all provincial capitals
- Establish and expand services for children.

Zimbabwe



Zimbabwe is currently experiencing high levels of political unrest and uncertainty. Political turmoil is often accompanied by high levels of violence and population mobility. During such times, women and children are particularly vulnerable to rape and sexual violence. Zimbabwe is no exception. In response, and under difficult circumstances, the Zimbabwe country team reported that they are in the process of launching Harare's first adult rape clinic. There is no forerunner for providing a comprehensive service to adult rape victims in Zimbabwe, and hence wanted to use the South African experience as a blue print given the cultural similarities between the two countries. Attending the training and site visits was a critically important step that they wanted to make before opening the clinic. In terms of training, a draft training programme is already in place, along with tools and a draft manual

⁴For more information on Population Council work in the region visit: <http://www.svri.org/popcouncil.htm>

for the management of sexual assault survivors. On returning to Zimbabwe they have identified the following as key for strengthening and expanding sexual assault services:

- Open first clinic by March 2009, and open clinics in all provinces by year-end
- Training of care-givers
- Fund raising and resource mobilisation
- Undertake the following:
 - o Develop a monitoring and evaluation plan and tools for the launch of the new clinic and subsequent roll-out to all provinces
 - o Explore community perceptions towards rape
 - o Conduct a similar study as the Tracking Justice study conducted in South Africa (See Footnote 4.)
- Expand the Safe Houses initiative
- Develop and initiate an advocacy campaign

Rwanda



In Rwanda, high levels of ethnically-motivated sexual violence were experienced during the 1994 genocide, and the medical, psychological and legal needs of the survivors have been inadequately addressed. It is estimated that approximately 70% of survivors raped during the Rwanda genocide have contracted HIV (Landesman, 2002). During July 1996, the International Tribunal formed a sexual assault committee to coordinate the examination and investigation of sexual and gender-based violence as no formal laws were in place to address rape and sexual assault. Currently, a Gender-based Violence Bill exists within the country, but it has, to date, not been passed as an Act (Rumbold 2008). In the absence of a comprehensive legal framework, innovative means have been created to address the needs

of survivors by public and private organisations in Rwanda. Keeping this in mind, the Rwanda country team identified the following priority areas for research and service delivery:

- Develop mental health care programme for survivors
- Promote a multidisciplinary approach for the care and support of rape survivors by involving justice and legal sectors in providing services for rape survivors.
- The Rwanda team consisted of three health professionals and had no police or lawyers involved in the training. For this reason the team indicated training of lawyers since they were not involved in the process. Police in Rwanda have started initiatives to train members.
- Brief colleagues and plan training of doctors in hospitals.
- Develop monitoring and evaluation tools.
- Meeting with the Ministry of Health for the development of a health policy and guidelines.
- Advocate forensic evidence and development of standardised medical form for sexual assault survivors.
- Draft a plan for technical assistance.
- Link prosecutors in sexual assault cases with regional network.
- Create community awareness through the development of an advocacy campaign

Uganda



During the 21-year conflict between the Lord's Resistance Army and Ugandan government forces, abduction and rape was endemic. Although the country has stabilised in the last few years, the northern parts of Uganda still experiences conflict and is characterised by widespread human rights abuses, with adverse health consequences and a high HIV prevalence. Very little focus is placed on medical care of rape survivors which is especially evident in the lack of medical professionals in the country (LVCT/SVRI, Joint workshop report on medico-legal responses to sexual violence, 2008). The NGO sector is mainly involved in providing services and support to survivors but follow up of survivors between the health and police service is poor. Sexual violence is mostly treated as a justice/legal matter

and rape cases are only heard in the High Court. In 1990, the Penal Code definition of rape was expanded to include rape of men and boys. Conviction of rape cases is low. Training guidelines do exist, but have not as yet been rolled out country wide. Against this background, the following priorities to strengthen linkages between the health, legal and justice sector were identified:

- Identify stakeholders and establish a stakeholders' forum (nationally and regionally).
- Plan and undertake a situational analysis study
- Conduct a similar study as the Tracking Justice study conducted in South Africa (Footnote 4 refers)
- Create awareness of sexual violence through an advocacy campaign
- Establish/strengthen structures for care of survivors;
- Formalize referral systems at national and regional level
- Develop protocols for service provision: PEP, STI.
- Adapt and conduct training for health workers on the management of rape and sexual violence survivors.
- Present training programme and outcomes to Programme Managers

SECTION 4: LESSONS AND REFLECTIONS

A number of key lessons were learned through the process of organising and running this workshop. Reflections from organisers, trainers, workshop participants and the workshop evaluation, provided the following key lessons:

- **Promoting Collaboration:**

“the lawyers/legal practitioners are the ones who cross examine and defend perpetrators so they need to understand the nature of injuries and medical circumstances surrounding sexual assault” [Course participant representing the justice/legal sector, February 2009]

For more effective collaborations in sexual violence services, there is a need to ensure that all stakeholders are acquainted with services provided by partners and have technical insight into developments in related sectors. This is important since justice, health and police sectors are interdependent and interrelated in the provision of post rape services and ensuring that survivors' needs are comprehensively addressed. As such, participants felt it important that the justice and police sector representatives participate in the entire training rather than just the first week.

- **Team Selection and Participants**

Selection of participants / country teams is a critical success factor. It is essential that people who participate are in positions in their own settings to implement change. Where possible, a team should include a senior government official from either the health or justice sectors or both. The number of course participants was also an important factor. In future courses we will reduce the number of participating countries per training. This will allow for more intimate discussions and more time for group work and feedback.

- **Course length**

To prevent training fatigue and promote opportunities for participants to spend time together outside of organised training activities, it was suggested that future courses should not run into weekends. Country specific adaptations will also need to consider local realities when thinking about how to implement this training, in terms of length, content and other organisational issues e.g. residential versus other options.

- **Course Content**

Course participants evaluated the course content as highly relevant to their work. Findings from the daily evaluation of the course are summarised in the table below. Site visits, rape and the law; mental health, adult and child sexual assault were rated the highest. The child sexual assault session was rated especially high. Participants reported very few specialised child assault services in their settings and viewed this session as particularly important to them.

Day:	Not useful	Somewhat useful	Useful	Very Useful	Unknown
Day 1: Social Context of Rape; Gender and Sexual Rights	0%	0%	34%	66%	0%
Day 2: Social Context and Rape Research in Participating Countries; Communication Skills	0%	6%	31%	63%	0%
Day 3: Rape and The Law	0%	3%	19%	75%	3%
Day 4: Forensic Evidence / Medico-legal forms	0%	3%	34%	63%	0%
Day 5: Site Visits	0%	3%	19%	78%	0%
Day 6: Monitoring and Evaluation / Sexual Assault Policy Guidelines	0%	3%	38%	50%	9%
Day 7: Taking History/consent/Prevention and Management of Pregnancy/HIV/STIs	0%	5%	32%	63%	0%
Day 8: Mental Health	0%	5%	16%	79%	0%
Day 9: Adult Sexual Assault	0%	0%	11%	79%	10%
Day 10: Child Sexual Assault	0%	0%	11%	89%	0%
Day 11: Country plans	0%	0%	26%	58%	16%

There were few suggested changes to course content, except to broaden the session on communication skills to include interpersonal skills. This was deemed an essential addition to the programme, particularly as working in this area and in multi-disciplinary teams demands a high level of interpersonal skill. There was also a suggestion to include research in the training curriculum.

- **Research, Monitoring and Evaluation**

“We would appreciate if time was given to research and methodology since its an important aspect of improving and assessing health care provided to victims of sexual violence”. (Course participant, February 2009)

It was notable that all countries identified research and M&E as key areas for intervention in their post course plans. Skills building and support for research is an important mechanism by which the SVRI and our partners can assist countries to begin developing evidence based plans for strengthening rape services within the region. It is also critical to ensure monitoring and evaluation plans and tools are built in to any post course activities, and the sharing of lessons learnt through regional networks and activities. Anything we do and learn through this process must be shared with our partners so that we minimise duplication. In so saying it is recommended that research tools, monitoring and evaluation plans and methods for adapting and developing in country curriculum be shared among partners.

- **Ongoing Technical Support**

“Such meetings should, if possible be done twice a year where country members would be able to narrate what they have done and what challenges they are experiencing.” (Course participant, February 2009)

The course provided participants with a unique opportunity for countries to discuss strategies, and ideas for rape survivors and the subsequent challenges and successes they have experienced. This mutual exchange across countries can be a catalyst for fast tracking change. The challenge is how best to maintain the momentum gathered at this meeting so that it translates into sustainable and meaningful change for rape survivors at country level.

POST COURSE REFLECTIONS

Feedback from participants' pre and post the course has been incredibly positive. People reported feeling empowered and motivated to return to their counties to begin implementing the plans they had identified during the programme. We are delighted to report that most countries have already initiated some post course activities and are well on their way to finalising and even implementing country plans.

In summary, the training programme provided a number of valuable lessons for future trainings, and through participation in the programme, participants have begun to prioritise reframing and strengthening services for rape survivors. The SVRI with support from our partners in the region will continue to support them to do so through the provision of technical and financial support as and when needed.

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Appendix A: List of Training Participants

	Last Name	First Name	Title	Organisation	Country
1	Abeid	Essam	Dr	Coast General Provincial Hospital	KENYA
2	Adhiambo Ogola	Pamela	Ms	Population Council	KENYA
3	Keesbury	Jill	Dr	Population Council	KENYA
5	Mogeni	Jacqueline	Ms	Nile Basin Initiative	KENYA
6	Ng'ang'a	Lucy	Ms	Population Council	KENYA
7	Odongo	Milly	Ms	Task Force On The Implementation Of The Sexual Offences Act	KENYA
8	Ogola	Pamela	Ms	Population Council	KENYA
9	Ondieki	Alice	Mrs	Department Of Public Prosecutions	KENYA
10	Chimaimba	Bernard	Mr	Malawi Police Services	MALAWI
11	Kayuni	Steven	Mr	Ministry Of Justice And Constitutional Affairs	MALAWI
12	Makhambera	Mercy	Mrs	Malawi Human Rights Resource Centre	MALAWI
13	Masepuka	Prisca	Ms	Ministry Of Health	MALAWI
14	Mbale	Emmie Wakupa	Dr	Ministry Of Health Malawi	MALAWI
15	Msango-Njawili	Patricia	Ms	Malawi Police Service	MALAWI
16	Alemika	Emily	Ms	University Of Jos- Plateau State	NIGERIA
18	Maduike	Veronica, Ikechi	Ms	Jos Univesity Teaching Hospital	NIGERIA
19	Ocheke	Amaka Ngozi	Dr	Jos University Teaching Hospital	NIGERIA
20	Osagie	Osayande	Dr	Jos University Teaching Hospital	NIGERIA
21	Alphonse	Kayiranga	Mr	Catholic Relief Service (CRS)	RWANDA
22	Hakuzimana	Alex	Dr	IntraHealth International Inc.	RWANDA
23	Munezero	Didine	Ms	ICAP / Rwanda-Columbia University	RWANDA
25	Kusasira	Stephen	Mr	Uganda Peoples Defence Forces	UGANDA
26	Nakinsige	Anne	Dr	Mulago-Mbarara Teaching Hospitals' Joint Aids Program (MJAP)	UGANDA
27	Muhereza	Alex	Dr	Northern Uganda Malaria, AIDS And Tuberculosis Programme (NUMAT)	UGANDA
28	Namagala Mutyaba	Elizabeth	Dr	STD/AIDS Conrol Programme	UGANDA
29	Betron	Myra	Ms	Future Group International	USA
30	Kaliel	Deborah	Ms	USAID	USA
31	Settergren	Susan	Ms	Centers For Disease Control And Prevention	USA
33	Kapakala	Thomas	Mr	Arthur Davison Children's Hospital	ZAMBIA
34	Kenema	Christopher	Mr	Zambia Police Services	ZAMBIA
35	Mbewe	Reuben Kamoto	Dr	Ministry of Health	ZAMBIA
36	Mupeta	Stephen	Dr	University Teaching Hospital	ZAMBIA
37	Zama	Mary Thole	Ms	Population Council	ZAMBIA
38	Kurangwa	Magina	Ms	University Of Zimbabwe	ZIMBABWE
39	Murombedzi	Jonathan	Mr	Justice - Public Prosecutions	ZIMBABWE
40	Mushangwe	Velda	Dr	University Of Zimbabwe	ZIMBABWE
41	Mutema	Francis	Mr	Zimbabwe Republic Police	ZIMBABWE
42	Takawira	Eunice	Mrs	Ministry Of Health And Child Welfare	ZIMBABWE
43	Monica	Molatlhegi	Dr	South African Defence Force	South Africa

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