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Reproductive Health

Social and Behavioral Science Research (SBSR)

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2019

## Meeting report of the International Conference on the Great Lakes Region's Regional Training Facility: Working with the police sector to meet the needs of sexual violence survivors in the Great Lakes Region

Nathan Byamukama

Chi-Chi Undie  
*Population Council*

Sharon Asiimwe

George Odwe  
*Population Council*

Nachela Chelwa  
*Population Council*

*See next page for additional authors*

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### Recommended Citation

Byamukama, Nathan, Chi-Chi Undie, Sharon Asiimwe, George Odwe, Nachela Chelwa, Harriet Birungi, and Michael Mbizvo. 2019. "Meeting report of the International Conference on the Great Lakes Region's Regional Training Facility: Working with the police sector to meet the needs of sexual violence survivors in the Great Lakes Region." Kampala: ICGLR-RTF and Population Council.

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**Authors**

Nathan Byamukama, Chi-Chi Undie, Sharon Asiimwe, George Odwe, Nachela Chelwa, Harriet Birungi, and Michael Mbizvo

# Meeting Report of the International Conference on the Great Lakes Region's Regional Training Facility (ICGLR-RTF) and the Population Council

## Working with the Police Sector to Meet the Needs of Sexual Violence Survivors in the Great Lakes Region



Lake Victoria Serena Hotel  
Kigo, Uganda

April 8-9, 2019

Regional Training Facility on  
Prevention and Suppression of Sexual  
and Gender Based Violence  
in the Great Lakes Region



Centre Régional de Formation sur  
la Prévention et Suppression des Violences  
Sexuelles Basées sur le Genre dans  
la Région des Grands Lacs



**ICGLR Regional Training Facility**  
**Yusufu-Luwaga Lane**  
**Plot 1349 (off Salama Road), Munyonyo**  
**P. O. Box 1386**  
**Kampala**  
**Uganda**

The ICGLR Regional Training Facility was established by 12 Member States of the International Conference of the Great Lakes Region (ICGLR) of Africa. It was set up as an implementation arm of the ICGLR to operationalize Article 6(9) of the ICGLR Protocol on the Prevention and Suppression of Sexual Violence against Women and Children (2006). It is a special regional facility for training and sensitizing judicial officers, police units, social workers, medical officers and other categories of persons who handle cases of sexual violence in the Great Lakes Region. Launched on 18 February 2014, the Regional Training Facility is based in Kampala, Uganda. It is a decentralized organ of the ICGLR Secretariat based in Bujumbura, Burundi, and includes the following ICGLR Member States: Angola, Burundi, Central Africa Republic, Democratic Republic of Congo, Republic of Congo (Congo Brazzaville), South Sudan, Sudan, Kenya, Rwanda, Tanzania, Uganda and Zambia.

Suggested citation: Nathan Byamukama, Chi-Chi Undie, Sharon Asimwe, George Odwe, Nachela Chelwa, Harriet Birungi, Mike Mbizvo. 2019. 'Meeting Report of the International Conference on the Great Lakes Region's Regional Training Facility: Working with the Police Sector to Meet the Needs of Sexual Violence Survivors in the Great Lakes Region.' ICGLR-RTF and Population Council.

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## List of Acronyms

<b>CAR</b>	<b>Central African Republic</b>
<b>CBD</b>	<b>Community-Based Distributor</b>
<b>DRC</b>	<b>Democratic Republic of Congo</b>
<b>EAC</b>	<b>East African Community</b>
<b>EC</b>	<b>Emergency Contraception</b>
<b>GBVRC</b>	<b>Gender-based Violence Recovery Centre</b>
<b>ICEC</b>	<b>International Consortium for Emergency Contraception</b>
<b>ICGLR</b>	<b>International Conference on the Great Lakes Region</b>
<b>IGP</b>	<b>Inspector General of Police</b>
<b>MoH</b>	<b>Ministry of Health</b>
<b>RTF</b>	<b>Regional Training Facility</b>
<b>GBV</b>	<b>Sexual and Gender-Based Violence</b>
<b>VSU</b>	<b>Victim Support Unit</b>

## Background

The Regional Training Facility (referred to as 'ICGLR-RTF') on the Suppression of Sexual Violence was established by 12 Member States of the International Conference on Africa's Great Lakes Region (ICGLR) an implementation arm to operationalize Article 6(9) of the ICGLR Protocol on the Prevention and Suppression of Sexual Violence against Women and Children (2006). ICGLR-RTF is a special facility for training and sensitizing judicial officers, police units, social workers, medical officers, and other persons who handle sexual violence cases in the Great Lakes Region. Launched in 2014 in Kampala, Uganda, it is a de-centralized organ of the ICGLR Secretariat based in Bujumbura, Burundi.

ICGLR-RTF partners provide financial and technical support to the institution in implementing ICGLR-RTF activities for combating SGBV in the Great Lakes Region. The Population Council is one such partner that has collaborated with ICGLR-RTF to address SGBV in the region through technical and financial support since 2016. For over a decade, Population Council and its coalition of partners (referred to as the 'Africa Regional SGBV Network') have provided technical assistance (TA) and conducted research to strengthen the evidence base of sexual and gender-based violence (SGBV) programming in East, Horn, and Great Lakes region of Africa. This Network of partners has continuously developed, implemented, and evaluated core elements of a comprehensive, multi-sectoral response model since 2006. This response model incorporates the shared and complementary responsibilities of core sectors (police and justice, health, education, social services). It also recognizes that while SGBV survivors require access to all available services within these sectors, it may not be feasible, appropriate, nor cost effective to deliver all of these services in one location.

*Africa Regional SGBV Network* studies demonstrate that police services are often the first (and sometimes only) point of contact for sexual violence survivors<sup>1</sup>—and in refugee settings rates of unintended or unwanted pregnancy due to rape can be extraordinarily high. A recent Network study found that over half of refugee women in the region who reported ever experiencing non-partner rape have also experienced rape-related pregnancy as a result (56%).<sup>2</sup> These realities necessitate police sector coordination with other sectors (particularly the health sector) to meet survivors' immediate needs. Within the first 72 hours after an assault, both medical and legal responses are necessary to ensure both a survivor's health as well as the ability to prosecute a case. The necessity of coordinating medico-legal responses within a limited time makes links between these sectors a pre-requisite for effective institutional response to sexual violence, particularly in refugee settings.

Under the *Africa Regional SGBV Network*, the Population Council and its partners (Zambia Police Service and Zambia Ministry of Health) developed and tested an intervention specifically including police response to sexual violence survivors, with police provision of emergency contraception (EC) for survivors who present at police stations within 120 hours of an assault involving penetrative sex, followed referrals of these survivors to a health facility for further care.<sup>3</sup>

This innovative response model has been successfully tested by the Network with police in Zambia<sup>1</sup> and Malawi<sup>4</sup>. Both studies reveal that EC provision by trained police to sexual violence survivors is both feasible and effective. During both interventions, trained Victim Support Unit (VSU) police provided EC to sexual violence survivors, with no adverse events or misuse reported. Trained VSU officers also consistently referred survivors to health facilities for further care after providing EC as appropriate.

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<sup>1</sup> Keesbury J, M Zama, S Shreeniwas. 2009. The Copperbelt Model of Integrated Care for survivors of rape and defilement: Testing the feasibility of police provision of emergency contraceptive pills. Population Council: Lusaka. [www.popcouncil.org/uploads/pdfs/2009RH\\_ZambiaCopperbeltModelIntCare.pdf](http://www.popcouncil.org/uploads/pdfs/2009RH_ZambiaCopperbeltModelIntCare.pdf)

<sup>2</sup> Undie C, H Birungi et al. 2016. Effectiveness of a Community-Based SGBV Prevention Model in Emergency Settings in Uganda: Testing the 'Zero Tolerance Village Alliance' Intervention. Nairobi, Kenya: Population Council. [www.popcouncil.org/uploads/pdfs/2016RH\\_SGBVPreventionUgandaZIVA.pdf](http://www.popcouncil.org/uploads/pdfs/2016RH_SGBVPreventionUgandaZIVA.pdf)

<sup>3</sup> EC is an essential element of post-rape care preventing unwanted pregnancy if taken within 120 hours of unprotected sex. EC contains the same hormones as oral contraceptive pills, and can be a discrete product (such as the brands Pregnon or Postinor-2) or high doses of oral contraceptives. Both regimens are proven safe and effective in preventing pregnancy. EC is not an abortifacient and will not harm an existing pregnancy.

<sup>4</sup> MHRRC, Malawi Police Service, MoH. 2012. Testing the feasibility of police provision of emergency contraception in Malawi. MHRRC: Malawi [www.svri.org/MHRRCEVALUATIONREPORT.pdf](http://www.svri.org/MHRRCEVALUATIONREPORT.pdf)

Results from these studies prompted the Government of Zambia to request Population Council TA to scale this model nationally, and today Zambia's national police training curriculum specifies police EC provision. Study results also gained attention regionally, culminating in a meeting co-convened by Population Council and the East African Community (EAC)'s Department of Peace and Security, in Kigali, Rwanda, 3 to 5 December 2014. This meeting brought together police officers from the EAC, serving as a mechanism for informing them of the police-led model. The meeting resulted in a series of regional recommendations, including publicizing the model among EAC inspectors general of Police for their official endorsements.

## Meeting Objectives and Participation

In response to the encouraging evaluation findings and regional recommendations for police EC provision, and prompted by the need to work more effectively with the police sector to respond to the needs of sexual violence survivors in the region, in April 2019 ICGLR-RTF and Population Council co-convened a meeting in Kigo, Uganda. This meeting aimed to:

1. Broaden awareness among police and health sector decision-makers of the innovative, police-led response model
2. Inform these decision-makers about an ongoing ICGLR-RTF initiative, for training National Trainers in each ICGLR Member State on various SGBV service delivery models, including police EC provision
3. Foster policy commitment to the promotion of this model in refugee and non-refugee settings
4. Foster expansion of the police EC provision model in East Africa refugee settings, and ultimately
5. Contribute to meeting the needs of sexual violence survivors on a wider scale.

ICGLR-RTF and Population Council worked with EAC's Department of Peace and Security to increase the visibility of the response model among critical decision-makers in the police and health sectors, and to promote the model's adoption in the region. The involvement of health sector decision-makers was critical, as EC use and distribution is part of the health sector's mandate.

The meeting drew participants (n=55) from nine countries in the Great Lakes region: Burundi, Central African Republic, Democratic Republic of Congo, Kenya, Republic of Congo, South Sudan, Sudan, Uganda, Zambia. Participants included inspectors general of Police (IGPs) and their representatives, national reproductive health (RH) division heads (from Ministries of Health) and their representatives, EAC's Peace and Security Department, and staff from ICGLR-RTF and Population Council's Kenya and Zambia offices. Two IGPs (from Democratic Republic of Congo and South Sudan) and two Assistant IGPs (from Uganda and Zambia) attended, while other countries' police sectors were represented by senior officials. Seven directors of national RH divisions also participated.

The meeting was structured around plenary sessions (which included presentations and discussion) and intra-national discussions:

- *ICGLR-RTF Training Program on Combatting SGBV: Member States' Progress and Future Activities*
- *Member States' Presentations on Health and Police Sector Collaborations to Address SGBV*
- *Introduction to the Africa Regional SGBV Network*
- *Emergency Contraception: A Technical Briefing*
- *The Testimony of an SGBV Survivor from the Great Lakes Region*
- *Presentation of an Innovative, Police-led SGBV Intervention: 'The Police Provision of Emergency Contraception' Model*
- *Police EC Provision: History of Regional Policy Engagement*
- *Police EC Provision: Discussion by Police Chiefs and MoH Representatives.*



## Summary of Presentations

All presentations are in the Appendix, but this section summarizes key points from the presentations.

### ICGLR-RTF Training Program on Combatting SGBV

The first presentation discussed how ICGLR-RTF is a regional Center of Excellence that trains SGBV providers from a range of sectors (police, judiciary, medical, psycho-social) to promote a regional multi-sectoral SGBV response. ICGLR-RTF draws on a cascading model, via layers of trainers until a final target group is reached. ICGLR-RTF maintains 10 regional Master Trainers, and 120 National Trainers (10 per Member State), all selected through a competitive process. Training on various aspects of SGBV response is cascaded from the regional to national level through these sets of trainers. Master Trainers monitor the National Trainers, who then directly training a range of professional providers in each country, who then ensure survivors are reached with needed service delivery approaches. Over 1,000 providers have been trained through this mechanism, in a range of professional sectors.

### Member States' Presentations on Collaborations Between Health Sectors and Police to Address SGBV

Presentations by Ministry of Health (MoH) delegates focused on existing SGBV health and police sector collaborations in each country. Presentations demonstrated that the vast majority of ICGLR-RTF Member States already recognize the importance of police and health sector collaborations, providing numerous examples. Some countries have prioritized early detection of SGBV survivors through community-based early warning systems, which foster a multi-sectoral approach and utilize mobile phones (as in Burundi), while others focus on rapid multi-sectoral services to survivors through special, non-health facility government units (e.g. 'Mixed Unit for Rapid Intervention and Repression' in Central African Republic).

Delegates also reported instances where the police and health sectors directly collaborate. In Kenya, police representatives act as trainers in MoH's national SGBV training initiatives. In some countries, police are signatories on the national post-rape care form (Kenya, South Sudan), while in others police were involved in revising these forms to ease survivors' access to justice (as in Uganda). Extant memoranda of understanding between the police and health sectors also ensure comprehensive care for survivors (South Sudan), and of medical and psycho-social management of survivors by the Ministry of Security (rather than solely under MoH), demonstrating further multi-sectoral commitment (in the Central African Republic).

South Sudan, Uganda, and Zambia have incorporated SGBV instruction in the pre-service training of their police colleges, while the Republic of Congo began planning to introduce a police-led EC intervention, but has experienced funding issues with training costs and training manual development.

### Introduction to the Africa Regional SGBV Network

The Network was described as specifically comprising SGBV-focused service delivery organizations ('Network partners') who, under Population Council leadership, work together to respond to SGBV regionally, through police stations, health facilities, schools, and communities, in addition to national policy. A mechanism for learning, exchange, and strategic action, the Network provides TA for SGBV interventions, including intervention design, capacity-building for intervention implementation, intervention monitoring, evaluation and documentation, and strategic dissemination of information for wide utilization of SGBV interventions. The Network's focus is on countries in the East, Horn, and Great Lakes regions of Africa, representing the majority of countries in the ICGLR region. The Africa Regional SGBV Network's current work centers on refugee settings, and transferring the Network's tested SGBV interventions to refugee contexts, while continuing to influence policy and programming in the region.

## Testimony of an SGBV Survivor from the Great Lakes Region

A critical part of the meeting was the live testimony by a rape survivor from Kenya. The woman's assault occurred nearly a decade ago, and she is thriving after long term (of years) psycho-social support at the Gender-Based Violence Recovery Centre (GBVRC) at Kenyatta National Hospital, Nairobi. At the time of the incident, this survivor was an unemployed single mother, who had traveled from Nairobi to another town in response to a job advertisement. The rape occurred at an office in a multi-story building in a busy part of the city center. She entered the building to submit her application and was subsequently raped at knifepoint.

The survivor unsuccessfully sought help at a nearby police station, due to the inadequate response of the available female police officer, who evidently had no training in proper SGBV protocol. The incident occurred on a Friday and the victim was asked to return to the station on Monday. Having no support and no further information, she did not preserve her clothing nor any other evidence. Discouraged by the lack of support and traumatized by the incident, she returned home.

Several weeks later, the victim began to feel nauseated and discovered she was pregnant—which traumatized her further and led to suicidal thoughts. After several unsuccessful attempts at pregnancy self-termination, she resigned herself and had a second child. For years, she viewed the child as a symbol of her trauma and struggled emotionally. Through the painstaking support of GBVRC, she eventually found solace and is currently a successful businesswoman who shares her story with providers to put a human face to decisions affecting SGBV programming and policy.

Had the police officer the survivor encountered been trained on SGBV as well as police EC provision, the unintended pregnancy could easily have been averted, and the rape-induced trauma could have been limited. This testimony was a significant precursor to the presentation on police EC provision.

## Emergency Contraception: A Technical Briefing

A technical briefing on EC preceded the presentation on the police EC provision model, which is based on recommendations from the International Consortium for Emergency Contraception (ICEC) and Population Council. The presentation aimed to dispel common EC myths, specifying what exactly EC is, why it is used, and how, emphasizing its safety and importance in post-rape care. An important aspect of the presentation focused on the timing of EC's effects, such as the fact EC pills work before fertilization and do not work after the fertilization process.

## Presentation of an Innovative, Police-led SGBV Intervention: 'Police Provision of Emergency Contraception' Model

The police EC provision model was developed by Population Council in collaboration with Zambia's Police Service and MoH as part of the Africa Regional SGBV Network. The model emerged in response to findings from a Population Council formative study revealing that police in Zambia are often the first and only points of contact for survivors seeking services. Survivors were thus at increased risk for unintended pregnancy.

As a means of enhancing survivors' access to care, the intervention specifically trained VSU police officers for provision of EC to eligible sexual violence survivors of reproductive age who present at police stations, combining this service with referrals (either through information or by actual accompaniment) to a health facility for comprehensive care. Survivors ages 10 and older are screened by VSU police officers for EC eligibility, using a checklist.

The intervention involves close collaboration between the police and health sectors, including joint training of police and health providers in addition to cross-sectoral training (with health providers training police to administer EC), EC supply for police by the health sector, joint supervision by the police and health sectors, and cross-sectoral steering committees with meetings at police stations or health facilities chaired by senior host institution staff.

A 2006 evaluation of the intervention revealed that over three years VSU police officers in the Zambia study sites successfully provided nearly 400 doses of EC to sexual violence survivors who presented at police stations, with no adverse events or complaints. The vast majority of survivors who received EC (85% were children ages 18 and younger) were also referred to a health facility for comprehensive care.

Police provision of EC has been scaled up in Zambia: It is fully integrated within the country's current (2012) national guidelines for managing SGBV survivors, and has been incorporated in Zambia's police pre-service and in-service training curricula.

### Police Provision of Emergency Contraception: History of Regional Policy

This presentation reminded delegates that regional conversations about the police EC provision model began in 2014 at a police officers' meeting convened by EAC's Peace and Security Department and Population Council. At this meeting, police officers were informed about two Africa Regional SGBV Network police-centric models: police EC provision and multi-sectoral SGBV training of both police and health providers (led by Network partner LVCT Health).<sup>5</sup> This 2014 meeting led to the 2019 convening by ICGLR-RTF and Population Council, as it culminated in recommendations to EAC chiefs of Police at their ensuing meeting, where they:

1. Directed the Secretariat to organize learning exchange visits of EAC police to Zambia's and Kenya's police services to facilitate adaptation of the (two police-focused Africa Regional SGBV Network) models to suit EAC or individual countries, and
2. Directed Partner States to consider incorporating the police EC provision model within the EAC Partner States' Police Training Curriculum.

### The Police Provision of EC Intervention: Discussion by Police Chiefs and Ministry of Health Representatives

All Member States concluded that the police EC provision model would be feasible to implement in their own countries. The table summarizes the plenary discussions and reports by individual countries:

Member State	Comments on the Police EC Provision Model
<i>Burundi</i>	<p>The model can be adopted/adapted. If community health workers can distribute EC, can police can, who must be trained. MoH and police must decide how to collaborate.</p> <p>Things to think about:</p> <ul style="list-style-type: none"> <li>• Transfer of EC from MoH to Police</li> <li>• Documentation</li> <li>• What type of training needed; who will train?</li> <li>• Must incorporate intervention in pre-service training, with refresher course</li> <li>• Referral mechanisms</li> </ul>
<i>Central African Republic</i>	<p>The model is feasible for implementation, and would help promote decentralization:</p> <ul style="list-style-type: none"> <li>• Workshop with police and their heads</li> <li>• Outline plan of action</li> <li>• Mapping of police posts close to health facilities in various regions</li> <li>• Identify SGBV training needs of police</li> </ul>
<i>Democratic Republic of Congo</i>	<p>It is possible to adapt this model:</p> <ul style="list-style-type: none"> <li>• Police in DRC have an SGBV Unit at provincial level</li> <li>• Training police at police stations and posts would be needed</li> <li>• Health facilities in proximity to police stations permit collaboration</li> <li>• Need to ensure careful oversight of the dispensing of EC by police</li> </ul>

<sup>5</sup> More information: Ajema C, W Mukoma, R Kotut, R Mulwa. 2015. Documenting medico-legal evidence in Kenya: Potential strategies for improvement. *BMC Proceedings* 9(Suppl 4): A2. [www.ncbi.nlm.nih.gov/pmc/articles/PMC4496633](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4496633); Ajema C, W Mukoma, C Mugenyi, M Meme, R Kotut, R Mulwa. 2012. Improving the collection, documentation and utilisation of medico-legal evidence in Kenya; LVCT Kenya.

<i>Kenya</i>	<p>It is possible to implement the model in Kenya due to existing structures (policies, etc.) and goodwill (from Independent Police Oversight Authority):</p> <ul style="list-style-type: none"> <li>• All police stations in Kenya have Gender Desks; then MoH supply chain; each county has health facilities. Contraceptives are free</li> <li>• The intervention should begin with the Gender Desk officers</li> <li>• Commodity supply should come from health facilities nearby police stations</li> <li>• Awareness-creation around the model at national level would be needed; can be done through police forums ('community policing') and the media</li> <li>• Need for a simple reporting tool for police stations, and for referral</li> </ul>
<i>Republic of Congo</i>	<ul style="list-style-type: none"> <li>• About to start implementing a police-led model involving EC, but not heard about Zambian model: Would like Network TA</li> <li>• Need funding for training and developing a manual for police and EC</li> </ul>
<i>South Sudan</i>	<ul style="list-style-type: none"> <li>• The model is appropriate for application in South Sudan</li> <li>• Formative research needed, including baseline: Who are survivors? Where do they actually tend to report first (police, like in Zambia)? This will help identify gaps, and help sensitization and awareness-raising</li> <li>• Develop a concept note and proposal for this model</li> </ul>
<i>Sudan</i>	<p>Same comments as Burundi (initial discussion together)—model is feasible in Sudan:</p> <ul style="list-style-type: none"> <li>• Consider transfer of EC from MoH to Police</li> <li>• Documentation</li> <li>• What type of training needed; who will train</li> <li>• Must incorporate intervention in pre-service training, with a refresher course</li> <li>• Referral mechanisms</li> </ul>
<i>Uganda</i>	<p>This is a feasible model, and Uganda shall adopt it.</p> <ul style="list-style-type: none"> <li>• Directorate of Health resources, police clinics, health workers, training schools (curricula include SGBV), and collaborations with MoH, would make it easy to do</li> <li>• National health policy allows community EC provision, so police won't be an issue</li> <li>• Present model to top Police Council (of which the Director of Health is part) for policy change; when Council approves, joint health and police training can occur</li> <li>• Requirements: MoH supply commitments, accurate inventories, tool development</li> <li>• Need for funding to make this model happen</li> <li>• Topics on EC provision by police can be included into their police training curricula</li> </ul>
<i>Zambia</i>	<p>The Zambian delegation appreciates Member State approval of the model:</p> <ul style="list-style-type: none"> <li>• Next steps in Zambia include scaling up the model further (beyond the 2 regions with largest populations, Copperbelt and Lusaka). The plan is to implement the model through the police sector by targeting the country's 10 provinces</li> <li>• Community-based distributors (CBDs) in Zambia already know how to administer EC. CBDs should therefore work with police posts as a means of scale up</li> <li>• The model is now part of <u>both</u> police pre-service and in-service training curricula</li> <li>• Transportation services between police stations and health facilities need to be strengthened to enhance efficacy—how outlined recently in a Network study<sup>6</sup></li> </ul>

## Regional Resolutions

In an unprecedented manner, the testimony of the SGBV survivor from the Great Lakes Region permeated the plenary discussion of regional resolutions developed by the delegates. Many of the resolution suggestions from delegates were prefaced by references to this testimony, and the need for the proposed resolutions.

<sup>6</sup> Chelwa N, K Hemal, GM Phiri, MT Mbizvo, C Undie. 2017. Enhancing access to post-rape care for child survivors in the context of police and health services in Zambia: Report on a police response model tested in Zambia. Lusaka: Population Council, [www.popcouncil.org/uploads/pdfs/2017RH\\_PoliceResponseSGBV-Zambia.pdf](http://www.popcouncil.org/uploads/pdfs/2017RH_PoliceResponseSGBV-Zambia.pdf).

## Preamble

- Recognizing that SGBV is a pervasive problem in all ICGLR Member States, adversely affecting the lives of citizens
- Acknowledging the urgent health and psycho-social support needs of survivors
- Realizing that the police EC provision to sexual violence survivors has been tested elsewhere in the region (Zambia and Malawi) and has been proven feasible and effective
- We (Member States) agree on the following resolutions, urging the following:

## Resolutions

1. ICGLR-RTF to support the training of a range of professionals to ensure the establishment of a multi-sectoral approach in the Great Lakes Region to combat SGBV
2. Member States' chiefs of Police to integrate EC provision by trained police officers to sexual violence survivors within police station services in the region
3. ICGLR-RTF and its partners to support Member States to effect such integration
4. Member States' Police chiefs and MoH to develop working relationships to facilitate integration
5. ICGLR-RTF and its partners to support formative research in selected countries to generate information to facilitate adaptation of the police EC provision model
6. ICGLR-RTF to standardize SGBV training curricula for police and health sectors in the Great Lakes
7. ICGLR-RTF to integrate the police EC provision model into training curricula
8. Population Council to widely disseminate research findings of police EC provision model in the Great Lakes region, and continue to generate and share other SGBV-related evidence
9. Member States' chiefs of Police to ensure creation of safe spaces for attending to survivors (including both physical spaces and police attitudes), and
10. Member States to strengthen mechanisms for handling SGBV perpetrators to bring them to justice and fight impunity.

## Next Steps

The regional resolutions will be employed by ICGLR-RTF and its partners as advocacy ammunition to advocate for programs, funds, and other resources to foster integration of the police EC provision model at police stations in Member States (including refugee contexts) and beyond. In collaboration with ICGLR-RTF and EAC Department of Peace and Security, the Population Council-led *Africa Regional SGBV Network* will explore the possibility of a regional training for ICGLR-RTF Master Trainers and EAC police trainers on the model's implementation.

# Appendices

## Appendix 1: Meeting agenda

Day 1: Monday, April 8, 2019			
	TOPIC	FACILITATORS	CHAIR
8:30-9:00	Registration	ICGLR-RTF and Population Council	
9:00-9:30	Opening Ceremony	Statements from: <ul style="list-style-type: none"> <li>▪ National Coordinator, Uganda</li> <li>▪ ICGLR Chair, Republic of Congo</li> <li>▪ IGP, Uganda</li> <li>▪ ICGLR Executive Secretary</li> <li>▪ Guest of Honor</li> </ul>	MC
9:30-9:40	Review of Meeting Agenda	Chi-Chi Undie Population Council	IGP, Kenya
9:40-10:00	ICGLR- RTF Training Program on Combatting SGBV: Progress and Future Activities with ICGLR Member States	Nathan Byamukama ICGLR-RTF	
10:00-10:30	Q&A—Remarks from the Floor on Member States' Needs in Relation to the Training Program	George Odwe Population Council	
10:30-10:50	TEA BREAK		
10:50-12:00	Member States' presentations on collaborations between health and police sectors to address SGBV <i>Presentations are to be brief, no more than 5 to 8 mins. We ask each MoH delegate for 1 slide with no more than 3 to 5 bullet points on any such collaborations of which they are aware. The list is not meant to be exhaustive, just to highlight key collaborations. If there are any gaps after each presentation, IGPs from each country are welcome to add to the presentation.</i>	Jane Harriet Namwebya Population Council (facilitator) <ul style="list-style-type: none"> <li>▪ Burundi delegation</li> <li>▪ Central African Republic delegation</li> <li>▪ Republic of Congo delegation</li> <li>▪ Democratic Republic of Congo delegation</li> <li>▪ Kenya delegation</li> <li>▪ South Sudan delegation</li> <li>▪ Sudan delegation</li> <li>▪ Uganda delegation</li> <li>▪ Zambia delegation</li> </ul>	IGP, Congo
12:00-12:10	Introduction to Africa Regional SGBV Network	Chi-Chi Undie, Population Council	IGP, South Sudan
12:10-12:45	A Survivor's Testimony (Great Lakes Region) and Discussion		
12:45-13:00	Emergency Contraception: A Technical Briefing		
13:00-14:00	LUNCH	Wilson Liambila Population Council	
14:00-15:00	Presentation of an Innovative, Policed SGBV Intervention: <i>The Police Provision of Emergency Contraception Model</i>	George M. Phiri, Zambia Police Jonathan K. Mwansa, Zambia MoH	IGP, Zambia
15:00-15:30	The Police Provision of Emergency Contraception: History of Regional Policy Engagement	Didacus Kaguta, EAC Department of Peace and Security	
15:30-16:00	The Police Provision of EC Intervention: Discussion and Q&A	Nachela Chelwa, Population Council	
16:00	Wrap Up and TEA BREAK	Nathan Byamukama, ICGLR-RTF	

<b>Day 2: Tuesday, April 9, 2019</b>			
<b>9:00-9:15</b>	<b>Recap of Day One</b>	<b>Mike Mbivzo, Population Council</b>	<b>IGP, CAR</b>
<b>9:15-10:00</b>	<b>Integrating the Police Provision of EC Model into the Police Sector in the Great Lakes Region: Response from Police Chiefs and MoH representatives</b>		
<b>10:00-11:15</b>	<b>Deliberation by Police Chiefs over Potential Policy Commitments/Statements with support from MoH Representatives Reporting by Member States</b>		
<b>11:15-11:45</b>	<b>TEA BREAK</b>		
<b>11:45-12:15</b>	<b>Discussing the Outcome Document: Presentation of consolidated policy statement/commitment for approval by Member States; Discussion</b>	<b>ICGLR-RTF</b>	<b>IGP, DRC</b>
<b>12:15-12:30</b>	<b>Deliberation over Strategies for employing the Statement/Commitment to promote utilization of the Police Provision of EC Model in the Region</b>		
<b>12:30-13:00</b>	<b>Wrap Up and Closing</b>	<b>ICGLR Population Council Guest of Honor</b>	

## Appendix 2: Meeting Participants

**Burundi**—Dr. Juma Ndereye

**Democratic Republic of Congo**—Col. Ebua Gobula Sebastien • Dr. Lily Mokako  
Gen. Philemon Patience

**Central African Republic**—Dr. Aime Dodane

**Kenya**—Alice N. Mwangangi • Dr. Chi-Chi Undie • Dr. George Odwe • Joyce Ombeva  
Linda Munyendo Chief of Police Symon Nyaga • Wilson Liambila

**Republic of Congo**—Col. Jean Roger Kouni-Okogna • Miambazila Matoko • Dr. Paul Oyere

**South Sudan**—Dr. Alexander Dimiti • Kuol Gabriel • Gen. Majak Malik • Mark Mayon • Martha John

**Sudan**—Dr. Manal Hassan Taha



**Uganda**—Adrine Atwine • Azokire John • ACP Basalirwa Jamal • AIGP Grace Tulyagumanawe  
Gudo Isaac • Innocent Byaruhanga • Jane Harriet Namwebya • J.B. Mugerwa • Jotham Kabuusu  
Kaboneva S. • Dr. Kamy John • SP Katusa Marion • ASP Kayongo Aisha • Lucy Ladir  
Paul Mukumbya Natamba Derrick • Moses Karuhanga • Muchunguzi Moses • Nathan Byamukama  
Natukewa Philemon Ngobi James • Dr. Nuwamanya Emmanuel • Patience Bahiira  
ACP Polly Namaye • Sharon Asiimwe • Twinamasiko Amon • Tumesime Robert

**Zambia**—Dr. Angel Mwiche • Dr. George Msipu Phiri • Chief of Police Lombe Bwalya Kamukoshi  
Dr. Mike Mbizvo • Dr. Mwansa J. Kaunda • Nachela Chelwa •

**EAC Secretariat**—ACP Didacus Kaguta



## Appendix 3: Presentations

**COLLABORATION ENTRE LE SECTEUR DE LA SANTE  
ET LE SECTEUR DE LA POLICE POUR LUTTER  
CONTRE LA VIOLENCE SEXUELLE ET SEXISTE AU  
BURUNDI**

**Par Docteur JUMA Ndereye**

Période	Nombre total des cas reçus pour VSBG	Assistance juridique	Procès-verbaux après les enquêtes d'investigation policière	Procès-verbaux au parquet	Procès-verbaux par le parquet	Procès-verbaux en affaires au parquet
1 <sup>er</sup> trimestre 2018	546	139	126	62	30	25
2 <sup>ème</sup> trimestre 2018	474	213	245	140	104	36
3 <sup>ème</sup> trimestre 2018	823	204	386	114	86	27

En plus des provinces de MAKAMBA, CIBITOXE et MUYINGA les parquets et la police judiciaire collaborent avec le MSPLS dans la production des preuves à charge et à décharge sur des cas de VSBG via les réquisitions à expert. Un système d'alerte rapide des cas de VSBG via les téléphones portables de la communauté vers toutes les autres structures impliquées (médical, police, administration) a été aussi mis en place dans les 3 provinces ci-haut mentionnées.

2


**RÉUNION DE SENSIBILISATION  
SUR LA VIOLENCE SEXUELLE ET SEXISTE**  
 POUR LES CHEFS DE POLICE ET LES CHEFS NATIONAUX DE LA DIVISION DE  
 SANTÉ REPRODUCTIVE  
 DANS LA RÉGION DES GRANDS LACS  
 (Entiébé du 08-09/04/2019)

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**Collaboration SANTE-POLICE**

Dr Aimé Théodore DODANE;  
 Médecin de Santé Publique  
 MD, MPH-RHS; UniGev  
 Expert SSRVSBG

1


**RÉUNION DE SENSIBILISATION  
SUR LA VIOLENCE SEXUELLE ET SEXISTE**  
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RCA : Prévention et lutte contre les VSBG = Deux Approches Holistique

- Approche Holistique intégré dans les Hôpitaux;
- Approche Holistique en dehors des Hôpitaux : **UMIRR** ( Unité Mixte d'Intervention Rapide et de Répression ) des violences sexuelles faites aux femmes et aux enfants sous le Ministère de la Sécurité.

2



## Contexte et justification

Les Violences Sexuelles et Basées sur le Genre (VSBG), longtemps ignorées en RCA ont pris de l'ampleur en 2002-2003 et entre 2012-2013 aux plus forts moments des crises militaro-politiques qui ont secoué le pays.

Les statistiques de sources autorisées et disponibles à ce jour établissent par milliers le nombre de victimes formellement identifiées et particulièrement répandues parmi une frange de la population la plus vulnérable.

En effet, seuls les femmes et les enfants payent le lourd tribut des affres des VSBG. Cette situation alarmante a suscité les réactions des autorités centrafricaines et de la communauté internationale.

Dans le cas de la RCA, **pour lutter contre l'impunité de ces graves violations des Droits de l'homme et prendre en charge les victimes des VSBG**, l'engagement de la communauté internationale et des autorités centrafricaines a été matérialisé entre autres par la création de l'**UMIRR**.

## Introduction

L'UMIRR est une structure de l'Etat Créée par décret n°15-007 du 08 janvier 2015, financée par le PNUD, la MINUSCA ,UNWOMEN

D'une composition mixte et d'une compétence nationale, l'UMIRR a son siège à Bangui, en attendant son extension sur toute l'étendue du territoire national.

Objectif: soutenir le gouvernement centrafricain dans la lutte contre les violations graves des droits de l'homme et la protection des communautés, y compris les groupes vulnérables.

## Vision

Promouvoir en RCA, un cadre **propice et approprié pour la prévention et la répression** des infractions relatives aux violences basées sur le genre et aux violations des droits de l'enfant, **ainsi qu'à la prise en charge efficace et efficiente des victimes** et partant, assurer un cadre de vie idéal aux femmes et aux enfants.

## Mission


L'UMIRR a trois missions principales:

- Prévenir en prenant toute mesure contre les VSBG, les violations des droits de l'enfant et d'assurer la sensibilisation de la population contre les réticences des victimes à dénoncer ces types de violences;
- Appliquer et vulgariser les outils et principes standards en matière d'enquêtes et de prise en charge intégrée des cas de VSBG et des victimes, y compris en matière de protection de l'enfant victime ou en conflit avec la loi;
- Contribuer à la répression des VSBG ainsi que des violations des droits de l'enfant dans le cadre de la chaîne pénale

## Structure

L'UMIRR à une direction composée de **quatre services**:

- Un service de Prévention, d'Intervention et d'Alerte;
- un service d'Enquêtes et d'Investigations;
- un **Service de Prise en Charge Médicale et Psychosociale**;
- un Service d'Assistance Juridique et Judiciaire.




RÉUNION DE SENSIBILISATION  
SUR LA VIOLENCE SEXUELLE ET SEXISTE  
POUR LES CHEFS DE POLICE ET LES CHEFS NATIONAUX DE LA DIVISION DE  
SANTÉ REPRODUCTIVE  
DANS LA RÉGION DES GRANDS LACS  
(EntMbé du 08-09/04/2019)

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**MERCIE DE VOTRE AIMABLE ATTENTION**

**« SINGUILA MINGUI »**

Dr Alina Thelma OGDANE



Government of Kenya


## Collaborations between the Health Sector and Police Sector in SGBV response

Ministry of Health, Kenya

Presenter: Mwangangi, A.N. (RMHSU, MOH)

SGBV Sensitization meeting for Police Chiefs and RH Division Heads


8<sup>th</sup>-9<sup>th</sup> April, 2019, Entebbe



## Health & Police Collaboration in SGBV Response -Kenya

Police officers are key stakeholders in SGBV response. We have collaborated as follows:

1. Part of the trainers during SGBV trainings of Health care Providers
2. We have severally conducted police officers sensitizations on SGBV and their role in SGBV response
3. They are members of our Technical Working Group (TWG) at national level
4. They are stakeholders in the county court users committees
5. They are signatories of the Kenya Post rape care form



# IMPLEMENTATION DE LA CONTRACEPTION D'URGENCE

MODELE CONGOLAIS (RC)  
ENTEBBE LE 09 AVRIL 2019

- CONTEXTE
- \_\_L'EXISTENCE D'UN PROJET VBG DANS LA POLICE
- \_\_DOCUMENTS DU PROJET( directives et guide)
- \_\_NUMERO VERT 1444
- \_\_DISPONIBILITE DES CONTRACEPTIFS
- \_\_POLITIQUE DES INTERVENTIONS A BASE COMMUNAUTAIRE DE SANTE
- \_\_FORMATION DES FORMATEURS
- IDENTIFICATION DES COMMISSARIATS PIOTES

## ACTIVITES A MENER

- \_\_FORMATION SUR LA CONTRACEPTION D'URGENCE ET IST/VIH DES POLICIERS FORMATEURS
- \_\_DOTATION CONTRACEPTION D'URGENCE DES COMMISSARIATS PIOTES
- \_\_SUIVIEVALUATION
- \_\_VULGARISATION DE LA DEMARCHE AU NIVEAU DE L'ECOLE NATIONALE SUPERIEURE DE LA POLICE

## BESOINS

- \_\_APPUI FINANCIER POUR LES FORMATIONS
- \_\_APPUI FINANCIER POUR L'ELABORATION DU MANUEL DE LA CONTRACEPTION D'URGENCE AU SEIN DE LA POLICE

• THANK YOU VERY MUCH

## South Sudan MOH & Police collaboration in Gender and GBV :



- Partnership of appropriately trained Health and Police personnel to ensure establishment of Special Protection Units (SPU) within police stations and health facilities to provide sensitive services to GBV survivors.
- Conduct training of health and police SPU officers on appropriate GBV case management.
- Provide pre-service training on gender and GBV to all health and police personnel.
- Cooperate with Police (MOU) to ensure comprehensive services that include examination of survivors, provision of required treatment (PEP, EC, STI), collection of forensic evidence, Receive complaints from GBV survivors, provide immediate psychosocial counselling.
- Cooperate with police in Conducting Proper investigation and documentation of GBV cases, ensuring availability and accessibility of police form 8 free of charge.

# SGBV IN SUDAN



SUDAN

By Dr MANAL TAHA

## Country profile

Sudan is located in northeastern Africa.

It is bordered by Egypt to the north, the Red Sea to the northeast, Eritrea and Ethiopia to the east, South Sudan to the south, the Central African Republic to the southwest, Chad to the west and Libya to the northwest.

Sudan is the third largest country in Africa. It had been the largest until the 2011 independence of South Sudan.



Total population of the country	37,585,700
Percentage of urban population	30.8
Number and percentage of women of reproductive age (15-49 years)	24.2%
Total fertility rate	5.2
Birth rate	28.5
Average annual population growth rate	3%
Proportion of teenage among adolescents under 15 years of age	11.9

## Continuum and characteristics of the services

- MOH is responsible to provide medical responses GBV
- MOH and MOSA integrate and social aspect of GBV will be under MOH
- Ministry of Justice is responsible for safety and security and legal aid of survivors
- Police and MOI is mandate to provide SGBV services to child and families through CFPUs

- GBV health services is not institutionalized
- Services provided include physical examination
- Psychological examination forensic examination only at hospital
- Testing of STI HIV
- Post exposure prophylaxis
- Emergency contraception
- CMR
- counselling
- Reporting of GBV incidence to police is not mandatory to receive medical treatment

## Information management system

- There is no central for data registry
- Manually collecting data is available
- No of patients received the treatment reported

THANKS

## PRESENTATION BY UGANDA

*Meeting the Needs of Sexual Violence Survivors in  
the Great Lakes Region  
by Working with the Police Sector.*

*April 8-9<sup>th</sup> 2019 Lake Victoria Serena Hotel*

## What has been achieved?

### ➤ SGBV POLICY FORMULATION

Government through the ministry of health formulated SGBV policy and guidelines this works as a standard of laws covering areas of Screening for SGBV cases at point care

Reporting in the SGBV register

Diagnosis procedures

Examination, referral and report writing

## Continuation

### ➤ Enabling laws

In addition to the penal code, Uganda parliament passed a law to enforce SGBV related cases.

### ➤ Ministry of health police and JLOS

Spear headed revision of police medical forms PF3A and PF244.

The revised forms permitted medical practitioners other than doctors to examine survivors.

## Continuation

### ➤ Police child and family protection units. (PCFPU).

The force used a special unit to handle SGBV cases and is run by officers trained and oriented in SGBV area. SGBV now integrated into training schools for all police officers.

➤ Government through JLOS partnership with police CID created a fund to facilitate medical examination of SGBV.



# ZAMBIA SCALE UP PLAN

## WHERE MODEL TESTED

- Copperbelt and Lusaka have implemented model

## CHALLENGES IN MODEL IMPLEMENTATION

- Limited Transport
- Supply chain – access to the drug for police sites
- High turn over of offices



## STRENGTHS IN MODEL IMPLEMENTATION

- Presence of community based distributors
- Model incorporated in the curriculum in Police and nursing schools (Pre-service and In-service)


## NEXT STEPS

- Target Provincial roll-out: All provincial police stations to start EC distribution
  - Train provincial and district police officers with EC provision by Police
- Assess VSU monthly returns to identify high incidence of rape and defilement and target those for scale-up.
- In addressing supply chain issues – MoH to support the training of Police along with CBD in respective communities to allow trained police obtain drugs from clinics in locality of Police station/posts.
  - Discuss this with FFTWG to plan actual training for scale up.

**END**

**An introduction to the Population Council-led 'Africa Regional SGBV Network'**



ICGLR-RTF SGBV Sensitization Meeting for Police Chiefs and National RH Division Heads in the Great Lakes Region

April 8-9, 2019  
Lake Victoria Serena Hotel, Near Kampala, Uganda

### The Africa Regional SGBV Network

**net·work**  
**'net work/**

- 'A group of people or organizations that are closely connected and that work with each other.'
- 'A group of people who exchange information, contacts, and experience for professional ... purposes.'



### What it is

- Made up of SGBV-focused service delivery organizations ('Network partners')
- Focuses on East, Southern, and Horn of Africa region
- Working together to respond SGBV on a regional level in **police stations**, health facilities, schools, communities, and at policy level
- A platform for learning, exchange, and strategic action, and dissemination



### Why it came about

- In response to the lack of SGBV response interventions
- Has since incorporated prevention interventions

### What it does




Photo by Uganda Association of Women Police

- Provides technical assistance for SGBV interventions
  - Design
  - Capacity-building
  - Implementation
  - Evaluation and documentation
  - Strategic dissemination
  - Utilization

### Where it has worked previously

(PHASES I to III: 2005-2018)

- Ethiopia
- Kenya
- Malawi
- Rwanda
- South Africa
- Swaziland
- Uganda
- Zambia
- Zimbabwe



## Where it is working currently

(PHASE IV: 2018-2020)

- Djibouti
- Ethiopia
- Rwanda
- South Sudan
- Sudan
- Tanzania
- Uganda
- Zambia



## What it's doing now


(PHASE IV: 2018-2020)


- ✓ Focusing **exclusively** on refugee settings
- ✓ Moving **more** tested SGBV interventions into refugee settings
- ✓ Still working to influence **policy** and **programming** in the region



## Thank you



  
**EMERGENCY CONTRACEPTION:  
TECHNICAL UPDATES**  
*Meeting the Needs of Sexual Violence  
Survivors in the Great Lakes Region  
by Working with the Police Sector*  
 Wilson Liambila-Population Council  
 April 8-9, 2019, Lake Victoria Serena Hotel, Kampala, Uganda



**THE NEXT 15 MINUTES ...**

- What is EC?
- Why do women use EC?
- Types of EC
- ECP Regimen updates
- How EC pills work
- How safe EC is
- Repeated use of EC
- Other clinical considerations
- Counseling Women on EC

**WHAT IS EMERGENCY CONTRACEPTION?**

- Emergency contraception (EC) refers to the use of certain contraceptive methods by women to prevent pregnancy after unprotected sexual intercourse. EC provides emergency protection (prevents pregnancy) for about 75-95 % of those at risk.
- EC can reduce unwanted pregnancies that might lead to:
  - ✓ child neglect,
  - ✓ abandonment,
  - ✓ unsafe abortions, and
  - ✓ maternal deaths.
- EC is an important element in post-rape care and in the PMTCT of HIV, and it is an essential component of quality FP service provision.

**WHY DO WOMEN USE EC?**



- Condom broke
- Late for an injection
- Forgot to take daily birth control pills
- Did not abstain from sex during fertile period
- Sex was not planned
- Unable to negotiate contraceptive use with partner
- Sexual assault

**Any woman who had unprotected sex and does not want to get pregnant can use EC**

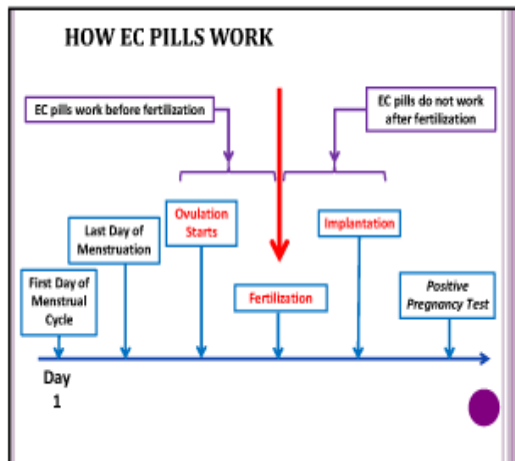
**TYPES OF EC**

- Pills
  - Levonorgestrel ECPs, 1.5mg or 0.75mg (most common type)
  - Regular oral contraceptive pills in higher doses (Yuzpe regimen)
  - Other pills (such as ulipristal acetate)
- Copper IUD

**This presentation focuses primarily on levonorgestrel ECPs. Some common brand names include Postinor-2 and Norlevo.**

**ECP REGIMEN: UPDATES**

- **Timeframe:** ECPs are more effective the sooner they are taken after unprotected sex, but can provide some protection for up to 5 days (120 hours).
- **Dosage:** Women can take LNG ECPs as a single dose of 1.5 mg. When using the two-pill product, women can take both pills at the same time.
  - 1 dose of 1.5 mg is as effective as 2 doses of 0.75 mg.
  - Taking 1 dose is simpler than taking 2 doses 12 hours apart.



### HOW SAFE IS EC?

- No effect on future fertility
- No increased risk of cancer, stroke, or ectopic pregnancy
- Will **not** harm a fetus or cause birth defects if a woman is already pregnant

**WHO fact sheet on EC:**  
 "Levonorgestrel-alone emergency contraception pills are **very safe** and **do not cause abortion or harm future fertility**. Side-effects are uncommon and generally mild."

### WHAT ABOUT REPEAT USE OF EC?

- Most importantly: repeat use of EC is safe.
- The WHO's 2015 Medical Eligibility Criteria states: "there are no restrictions on repeated use" of ECPs.
- It is safe even when women take it more than once in the same menstrual cycle.
- Taking ECPs is **ALWAYS** safer than carrying an unwanted pregnancy to term or resorting to unsafe abortion.
- Using a regular, ongoing method is recommended as the most effective way to prevent pregnancy.

### CLINICAL CONSIDERATIONS

- Is a pregnancy test needed?
  - WHO guidance does not support pregnancy testing as a requirement for EC provision.
- When during a woman's cycle should EC be offered?
  - Anytime during the woman's cycle, as it is difficult to predict the timing of ovulation.
- Should anti-emetics be administered?
  - Prophylactic administration of anti-emetics not needed for LNG ECPs.
- Who should be offered EC?
  - All female survivors of rape, no matter their age, can/should be offered EC, if they have begun menstruating or are otherwise believed to be at risk of pregnancy (are there signs of secondary sex characteristics?)

### COUNSELING WOMEN ON EC

- What info should be provided to women?
  - Take as soon as possible; take both pills together if using the 2-pill regimen
  - ECPs are very safe and cannot cause an abortion or affect an existing pregnancy
  - EC may cause some minor side effects which will resolve on their own. There are no long-term side effects.
  - ECPs are effective but not 100%; if you do not get your period within one week of when it's expected, see a health care provider

### IN CONCLUSION

**It's always better safe than sorry.**

(EC pills are so SAFE that they should ALWAYS be offered if there is ANY risk of unwanted pregnancy.)

THANK YOU VERY MUCH!

- Any questions?
- Contact information:

- Wilson Liambila
- [wliambila@pocouncil.org](mailto:wliambila@pocouncil.org)

Acknowledgement

ICEC-colleagues

[www.emergencycontraception.org](http://www.emergencycontraception.org)



## The police as part of the public health response to SGBV: An innovative task-sharing model developed in Zambia

Dr. Jonathan Kaunda Mwansa (Zambia Ministry of Health)  
 Dr. George Phiri (Zambia Police Service)

SGBV Sensitization Meeting  
 for Police Chiefs and National Reproductive Health Division Heads  
 in the Great Lakes Region  
 Kampala, Uganda  
 April 5-9, 2010

## Copperbelt Model of Integrated Care (CMIC) for sexual violence survivors

- Operations research study conducted from 2005-2008 in Copperbelt Province, Zambia



- Aimed to enhance access to services for survivors of sexual violence (SV)

### Formative research: Purpose and methods

- Conducted a formative assessment in 2005 to inform the intervention:
  - ✓ Review of SV records at **33 police stations & posts** and **19 health facilities** in Copperbelt Province from January 2001 – December 2004

### Key formative research findings from 2005

- **Police often first and only point of contact for SV survivors**
  - 91% of all survivors first reported to the police
  - Number of SV cases reported to the police twice as many as the number that reported to health facilities during the same period
- **SV services weak at health facilities**
  - 82% of cases arrived in time for emergency contraception; but only 37% received it

**Possible Solution: Collaboration between police and public health sector**

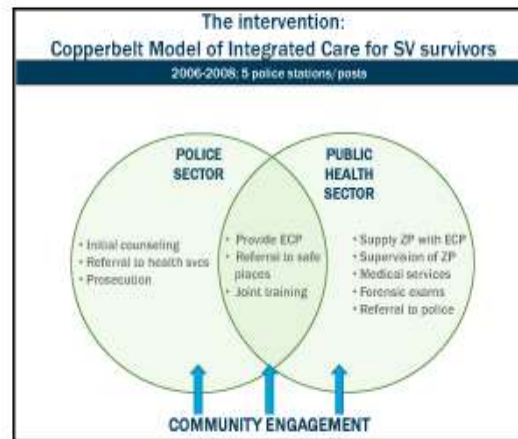
### Overview of collaboration between the police and the public health sector

- ✓ Joint stakeholders' workshop (MoH, MHA, etc.) to review formative study findings and generate recommendations
- ✓ **Initial joint training of police & health providers**
- ✓ Later, cross-sectoral training (i.e., health providers trained police)
- ✓ **Joint police and health sector supervision**
- ✓ Cross-sectoral steering committee, held at police station or health facility, chaired by senior staff of hosting institution

### Stakeholders' workshop



- A stakeholders' meeting including representatives from Ministry of Health, Ministry of Home Affairs, Ministry of Community Development and Social Services, NGOs, and churches, was held in 2005
- Formative assessment findings were reviewed and recommendations developed for improving the response to SV across police and public health sectors



### On-site training

- VSU officers who attended classroom trainings were expected to return to their facilities and train any officers that did not attend
- Trained **health providers** assisted the **VSU officers** with the on-site trainings

### ECP provision at police stations and posts

Each station given a set of basic supplies:

1. Secured, locked box for ECP
2. Provider aids
  - a. Client screening checklists
  - b. Standard operating procedures
3. Record-keeping tools
  - a. Survivor logbook
  - b. Monthly report form
4. ECP commodities & instructions

### Excerpt from client screening checklist

(Adapted from Resources for Emergency Contraceptive Pill Programming: A Toolkit, PATH 2004)

1. Was the client raped/defiled?	Yes (go to 2)	No Client not eligible
2. Did the assault involve penetrative sex?	Yes (go to 3)	No Client not eligible
3. Did the assault occur within the past 72 hours?	Yes (go to 4)	No Client not eligible
4. Has the client had her first menstrual period?	Yes (go to 5)	No Client not eligible
5. Does the client want to prevent pregnancy?	Yes (go to 6)	No Client not eligible
If client answered 'YES' to questions 1-5, she is eligible for EC. Proceed. If client answered 'NO' to ANY of the questions above, she is not eligible. STOP.		
6. Is the client currently pregnant?	Yes Client not eligible	No (go to 7)
If the client's pregnancy status is unclear, EC may still be given, but with the explanation that it will not work if she is already pregnant and will not harm the fetus.		

### Joint police and health sector supervision

- **District reproductive health coordinator and VSU coordinator** conducted monthly supervisory visits to each participating police station & post:
  - Collected monthly reporting forms
  - Reviewed all ECP checklists for accuracy and proper ECP provision
  - Provided support & discussed challenges with VSU officers
  - Re-supplied ECP stocks and forms as needed



**Result 1** (analysis of service statistics and checklists)  
**Police safely and effectively provided EC**

- 357 doses of EC provided to SV survivors over 3 years
- No adverse events or complaints
- All doses provided to women and girls of reproductive age; never given to girls below age 10 (per study protocol)

**Result 2** (analysis of service statistics)  
**Police referred clients at high rates**

- Intervention definition of 'referral': provision of info on services available at health facilities, or accompanying survivor to a health facility

Percent of all survivors referred to health facility, by station and year (n=612)				
Station	2006 %	2007 %	2008 %	Average %
Chifubu	100	100	100	100
Kanshenshi	100	100	100	100
Masala	77	100	100	92
Kafulata	92	86	0	59
Ndola Central	5	3	8	5

**Reflections**

**Surprising fact ...**

- Most survivors reporting to police were adolescents
- 49% < age 14; 85% < age 19

**Could've done better if ...**

- We could control turnover of trained police

**Need to think more about ...**

- How to address transportation needs of referred clients

**How this intervention has been scaled up so far**

- Replicated successfully by **police in Malawi** (2011-2012)
- Incorporated into **Zambia's national guidelines** for managing SGBV survivors (2012)
- EC provision by police is included in **Zambia's police training curriculum** for new recruits
- The intervention is being considered by **UNHCR Regional Service Center** for replication in selected refugee settings in the East & Horn of Africa region

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**Thank you!**

### The police as part of the public health response to SGBV: An innovative task-sharing model developed in Zambia

Dr. Jonathan Kaunda Mwansa (Zambia Ministry of Health)  
 Dr. George Phiri (Zambia Police Service)

SGBV Sensitization Meeting  
 for Police Chiefs and National Reproductive Health Division Heads  
 in the Great Lakes Region  
 Kampala, Uganda  
 April 6-9, 2010

### Copperbelt Model of Integrated Care (CMIC) for sexual violence survivors

- Operations research study conducted from 2005-2008 in Copperbelt Province, Zambia



- Aimed to enhance access to services for survivors of sexual violence (SV)

### Formative research: Purpose and methods

- Conducted a formative assessment in 2005 to inform the intervention:
  - ✓ Review of SV records at **33 police stations & posts** and **19 health facilities** in Copperbelt Province from January 2001 – December 2004

### Key formative research findings from 2005

- **Police often first and only point of contact for SV survivors**
  - 91% of all survivors first reported to the police
  - Number of SV cases reported to the police twice as many as the number that reported to health facilities during the same period
- **SV services weak at health facilities**
  - 82% of cases arrived in time for emergency contraception, but only 37% received it

**Possible Solution: Collaboration between police and public health sector**

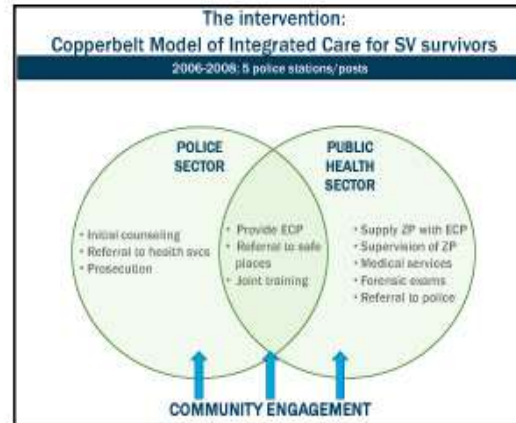
### Overview of collaboration between the police and the public health sector

- ✓ Joint stakeholders' workshop (MoH, MHA, etc.) to review formative study findings and generate recommendations
- ✓ **Initial joint training of police & health providers**
- ✓ Later, cross-sectoral training (i.e., health providers trained police)
- ✓ **Joint police and health sector supervision**
- ✓ Cross-sectoral steering committee, held at police station or health facility, chaired by senior staff of hosting institution

### Stakeholders' workshop



- A stakeholders' meeting including representatives from Ministry of Health, Ministry of Home Affairs, Ministry of Community Development and Social Services, NGOs, and churches, was held in 2005
- Formative assessment findings were reviewed and recommendations developed for improving the response to SV across police and public health sectors



### On-site training

- VSU officers who attended classroom trainings were expected to return to their facilities and train any officers that did not attend
- Trained **health providers** assisted the **VSU officers** with the on-site trainings

### ECP provision at police stations and posts

Each station given a set of basic supplies:

1. Secured, locked box for ECP
2. Provider aids
  - a. Client screening checklists
  - b. Standard operating procedures
3. Record-keeping tools
  - a. Survivor logbook
  - b. Monthly report form
4. ECP commodities & instructions

### Excerpt from client screening checklist

(Adapted from Resources for Emergency Contraceptive Pill Programming: A Toolkit PATH 2004)

1. Was the client raped/defiled?	Yes (go to 2)	No Client not eligible
2. Did the assault involve penetrative sex?	Yes (go to 3)	No Client not eligible
3. Did the assault occur within the past 72 hours?	Yes (go to 4)	No Client not eligible
4. Has the client had her first menstrual period?	Yes (go to 5)	No Client not eligible
5. Does the client want to prevent pregnancy?	Yes (go to 6)	No Client not eligible
If client answered 'YES' to questions 1-5, she is eligible for EC. Proceed. If client answered 'NO' to ANY of the questions above, she is not eligible. STOP.		
6. Is the client currently pregnant?	Yes Client not eligible	No (go to 7)
If the client's pregnancy status is unclear, EC may still be given, but with the explanation that it will not work if she is already pregnant and will not harm the fetus.		

### Joint police and health sector supervision

- **District reproductive health coordinator** and **VSU coordinator** conducted monthly supervisory visits to each participating police station & post:
  - Collected monthly reporting forms
  - Reviewed all ECP checklists for accuracy and proper ECP provision
  - Provided support & discussed challenges with VSU officers
  - Re-supplied ECP stocks and forms as needed

**Result 1** (analysis of service statistics and checklists)  
Police safely and effectively provided EC

- 357 doses of EC provided to SV survivors over 3 years
- No adverse events or complaints
- All doses provided to women and girls of reproductive age; never given to girls below age 10 (per study protocol)

**Result 2** (analysis of service statistics)  
Police referred clients at high rates

- Intervention definition of 'referral': provision of info on services available at health facilities, or accompanying survivor to a health facility

Percent of all survivors referred to health facility, by station and year (n=612)				
Station	2006 %	2007 %	2008 %	Average %
Chitubu	100	100	100	100
Kanshenshi	100	100	100	100
Masala	77	100	100	92
Katufufuta	92	86	0	59
Ndola Central	5	3	8	5

## Reflections

**Surprising fact ...**

- Most survivors reporting to police were adolescents
- 49% < age 14; 85% < age 19

**Could've done better if ...**

- We could control turnover of trained police

**Need to think more about ...**

- How to address transportation needs of referred clients

## How this intervention has been scaled up so far

- Replicated successfully by **police in Malawi** (2011-2012)
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Thank you!

## EAST AFRICAN COMMUNITY



### Meeting the Needs of Sexual Violence Survivors in the EAC Region Through Working with the Law Enforcement- The Police Forces/Service

By:  
ACP Didacus B. Kaguta  
Department of Peace and Security,  
EAC Secretariat

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## Goal of the W/shop



- To provide a forum for Police and Ministry of Health stakeholders to interact and explore ways of strengthening SGBV interventions within the EAC region.
- To explore the possibility of expanding two key interventions in SGBV across the EAC, in order to meet the needs of sexual violence survivors in the region.

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## 1<sup>st</sup> Interventions



1. Provision of emergency contraception (EC) by trained Police to SGBV survivors within 120 hours of an assault involving penetrative sex, followed by referral of these survivors to a health facility for further care.
- Police in the EAC region mostly first responders to survivors of SGBV and can therefore play an important role in **pregnancy prevention** for survivors of rape and defilement, and **HIV prevention (PEP)**.
  - Model been successfully tested with Police in Zambia and Malawi with excellent feasible & effective results (*no adverse effects or misuse*)
  - Outcome results prompted Zambia to scale up the model country wide, including PEP for HIV.
  - The EC model been now integrated in the National police<sub>3</sub> training curriculum in Zambia

## 2nd Intervention



- Involves a multi-sectoral provider training model to improve the collection, documentation, and utilization of medico-legal evidence.
- This training model (involving police and health providers) was tested in Kenya by LVCT Health in collaboration with the Ministry of Health and the police.
- Results: - significant improvement in police and health providers accurately completing relevant police forms and post-rape care forms for survivors.
- Proper completion of these forms enhanced survivors' access to justice and facilitated timely prosecution of offenders.

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## Rep of Burundi



- Police receives the victim and provides a referral to the public hospital, whose findings facilitate court processes.
- There are plans to establish a one-stop center in Burundi.
- there is need to recruit more female police, as there are few in the country.
- Burundi had 5 regions with 17 units. Each unit has a dispensary, but the health service provision is not adequate.

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## Rep of Kenya



- Most laws in place
- Need to Create a one-stop center for survivors at County level, staffed with medical personnel, police, and paralegals staff
- Joint training for police, magistrates, community leaders, chiefs on SGBV
- SGBV be incorporated into pre-service police training
- Develop a multi-sectoral training manual for the country on SGBV

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## Rep of Rwanda



- RNP has Isange one stop centre, which works closely with police and is situated in a Police Hospital.
- Isange is an EAC Regional Centre of Excellence on SGBV & currently finished developing the Regional SOPs on GBV.
- All services at this Center are free, and the OSC itself provides basic SGBV training.
- SGBV part of the initial training curriculum in RNP
- Need for Joint training for Police officer on SGBV investigative techniques
- Need constant inservice trainings on SGBV specialized skills & scale up countrywide

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## United Rep of Tanzania



- Have a training manual to train police specifically on how to respond to children and women victims of SGBV.
- SGBV is incorporated into the police training curriculum.
- Two One-Stop Centers for SGBV have been established in the country
- Need to train police officers who work at gender and child protection desks on police provision of EC model
- SGBV should be incorporated in both advanced/promotional & command courses trainings

## Rep of Uganda



- SGBV has been incorporated into the initial training for police in Uganda.
- Regions and Metropolitan area have access to EC and each District Pol station has a medical unit.
- Each district has a dedicated Gender desk to handle Child and Family Protection Services including SGBV
- Need to conduct a feasibility study to see how the police provision of EC is working
- Kenyan model been going on in Uganda, but with limitations on escorting victims to the health facility and recovering the PF3A from the doctors.

25-Sep-19

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## General Observations



- Bench mark with 2 response models (Zambia & Kenya) by all Partner States
- Joint training on EC by EAC and Pop Council to enhance convergence in investigations of SGBV
- National scale up of sensitisation by a multi sectoral partnerships very important
- Integration of SGBV in all training programmes of police at all levels
- Develop a single joint, standard training manual for EAC Partner States on SGBV
- SGBV cases on the increase in all Partner States –need to develop comprehensive interventions at both national and regional levels to respond effectively;
- Address Police attitudes towards SGBV

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## Gen Observn Cont'd



- Enhance staffing within Police Gender Departments to ensure effective response;
- EAC to adopt the EAPCCO Standard Operating Procedures on SGBV;
- Emphasis on alcohol and narcotic drugs consumption as one of the major causes of SGBV
- Emphasis on preventive measures against SGBV essential
- Institute EAC a Thematic Working Group on Gender to address SGBV related issues in the region.

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## Recommendations



1. Direct the EAC Secretariat to mobilize resources and facilitate multi-sectoral trainings at national and regional levels on sexual and gender-based violence to enhance national and regional responses;
2. Direct the Secretariat to Partner with Population Council and organize learning exchange visits of the EAC police to Zambia Police Services and Kenya Police Service to facilitate the adaptation of the models described above to suit the EAC context and individual country contexts;
3. **Direct the Secretariat to convene a meeting of experts drawn from Partner States to develop a regional training manual and Standard Operating Procedures on SGBV;**
4. Organize Command Post exercises in response to SGBV at the finalization of the above manual and SOPs;

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## Recommendations cont'd

5. Direct Partner States to consider incorporating the police provision of EC model into the EAC Partner States Police Training Curriculum;
6. Direct Partner States to incorporate SGBV education into the community policing function;
7. Direct Partner States who have not established One-Stop Centers on SGBV to do so;
8. **Direct the Secretariat to adopt the EAPCCO Standard Operating Procedures on SGBV into EAC instruments**
9. **Direct the Secretariat to establish a Thematic Working Group on Gender to address SGBV related issues in the region.**
10. Direct Partner States police services to collaborate closely with other stakeholders to foster strong multi-sectoral coordination in SGBV and related causative crimes.

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## Legal basis & Related Initiatives

- Initiatives on SGBV anchored in the provisions of the Treaty.
- Responses on SGBV cuts across many sectors of EAC such as Health, immigration, social sectors, Peace and security, etc.
- The EAC gender policy recognizes engendering P&S Protocol, institutionalization of gender parity in peace & security negotiations /mediation including addressing issues of SGBV
- EAC –APSA support Programme provides for implementation of the UNSCR 1325 which encompasses issues of Gender including SGBV
- So far trained two groups (62) Women security Officers on 1325 and managing conflict situations where SGBV is one of issues high on the agenda, 3<sup>rd</sup> training upcoming soon.

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## Related Initiatives

- Establishing Gender forum by 3<sup>rd</sup> quarter of 2019 and a gender thematic group to steer various gender related responses.
- Draft EAC Regional Framework on UNSCR 1325 to be concluded and adopted this year by the Council of Ministers
- Regional Center of Excellence on SGBV finalized SOPs on SGBV. Now drafting its Regional training manual.
- Stakeholders in SGBV multi-sectoral in nature, coordinated by the Interstate Security.
- Main stakeholders at EAC: Peace & Security (Police, Immigration, prisons, GAL) Health, EALA, EACJ, CTC.

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*THE END*

THANK YOU FOR LISTENING

**ASANTENI SANA KWA KUNISIKIRIZA**

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