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Enhancing a Regional Response to Crimes of Sexual Violence: Regional Roundtable Discussion Summary

Program on Sexual Violence in Conflict
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Acknowledgments

Physicians for Human Rights convened the “Enhancing a Regional Response to Crimes of Sexual Violence Roundtable Gathering” at the Lukenya Getaway in Athi River, Kenya. We gratefully acknowledge our sponsors, The Sigrid Rausing Trust, the United Nations Trust Fund to End Violence Against Women, the U.S. Department of State Bureau of International Narcotics and Law Enforcement Affairs, the Office of Global Women’s Issues, and the Bureau for African Affairs for their support.

We also thank each of our participants for their time and invaluable contributions to the discussion.

This report is dedicated to the memory of our esteemed partner, colleague, and friend, Victor Inyanje Kabaka.
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Overview

The Program on Sexual Violence in Conflict Zones (the Program) at Physicians for Human Rights (PHR) convened a three-day regional roundtable discussion (Roundtable) between February 25 and 27 at the Lukenya Getaway in Athi River, Kenya. The purpose of the gathering was to bring together colleagues from the medical, law enforcement, and legal communities in the Democratic Republic of the Congo (DRC) and Kenya who partner with the Program. This was the first such regional gathering to take place in East Africa to bring together these professionals, including doctors, nurses, police officers, lawyers, magistrates, judges, government officials, civil society activists, journalists, academics, and sexual violence survivors.

During the Roundtable, participants exchanged ideas in a series of interactive plenary sessions and smaller working groups on subjects delineated below to share, brainstorm on, and problem-solve the challenges of supporting survivors of sexual violence, and to plan for a regional response to improve ways to prosecute and hold accountable those who commit these crimes. Discussions were open, frank, friendly and confidential. A key product resulting from the three-day gathering was a regional action plan that addresses the scale-up of cross-sectoral trainings and regional advocacy opportunities through litigation and grassroots activism, and identifying autonomous network leaders who can coordinate with their counterparts across the region and who will continue to lead efforts in parallel with PHR’s engagement.

The purpose of this report is to provide a summary of the discussions that took place during the Roundtable in order to capitalize on the ideas and lessons learned from stakeholders in the DRC and Kenya who are so actively engaged with efforts to end impunity for sexual violence in their respective communities as well as with PHR’s training and advocacy program.

This report is divided into the following sections: (1) overview of the goals and objectives of the Roundtable; (2) background, including the Program’s history of cultivating networks; (3) a two-part summary of the Roundtable, including (A) best practices and lessons learned for Program network expansion, survivor engagement, regional collaboration, and mentorship; and (B) broader themes that emerged during the course of the three-day Roundtable; and (4) regional and country-specific action plans.

This report provides a summary of the Roundtable discussion without attribution to specific participants as the forum was governed by Chatham House Rules.

1. Roundtable Goals and Objectives

The Roundtable aimed at creating a unique opportunity for a South-to-South dialogue, where key PHR partners grappling with widespread sexual violence in conflict zones could (i) share their challenges, successes, and lessons learned regarding forensic evidence collection techniques, improving prosecutions, and care for survivors; (ii) build a regional network of leaders for regional advocacy and peer support; and (iii) develop an action plan for sustainable training and mentoring initiatives in the region for the next three to five years.

The Roundtable provided opportunities for first responders and key stakeholders from these various communities to:

- exchange ideas and opportunities for deepening cross-sectoral training;
- plan for training new trainers and scaling up trainings in their communities;
- ease professional isolation by establishing and reinforcing peer networks and new channels of communication;
- raise the profile and stature of professionals working to document and prosecute cases;
- brainstorm opportunities for collaboration on advocacy initiatives, for example, concerning the enforcement of reparations, leverage the power of regional advocacy for effective responses to, and ending impunity for, sexual violence; and
- identify long-term strategy priorities and goals for a regional network, as well as potential leaders who can spearhead implementation of the action plan.

The Roundtable offered participants ways to mitigate and overcome some of the identified challenges by collaborating and coordinating responses across sectors and communities, shining a spotlight on obstacles, and advocating for policy reforms. Despite the differences in legal cultures and languages and varying access to resources in the DRC and Kenya, these frank, confidential discussions fostered and deepened professional relationships and collaborations across these communities. While the emergence of regional professional peer groups further reinforces best practices for evidence gathering techniques as delineated in the forensic trainings, working on a systemic and regional level will bolster capacity more widely for local prosecutions.
In 2011, PHR launched the Program on Sexual Violence in Conflict Zones (Program), a multi-year training and advocacy initiative, with the aim of forging coalitions among medical, law enforcement, and legal experts at local, national, and regional levels. The Program piloted the initiative in the DRC and Kenya – two countries with recent experience of mass sexual violence in conflict and widespread impunity for perpetrators of these crimes. PHR’s goal has been to dramatically increase local and regional capacity for the collection of court-admissible evidence of sexual violence in order to support effective local, regional, and international prosecutions of these crimes.

To accomplish its goals, PHR has been convening basic and advanced training workshops on the collection, documentation and preservation of forensic evidence of sexual violence in close partnership with medical, law enforcement, and legal stakeholders in multiple communities in eastern DRC and Kenya.

An essential goal of the Program is also to support the building of cross-sectoral networks across communities in both urban centers and remote regions. By cultivating these networks, doctors, nurses, police officers, lawyers, and judges learn from each other, share challenges, and identify best practices and lessons learned. These stakeholders, as peers, also share information about how to overcome scarce resources and infrastructural challenges, security risks, and other obstacles to justice. The Program has prioritized network cultivation across regions and jurisdictions as an essential element of building capacity and sustainability for best practices.

The Program started to experiment with regional network cultivation across communities in October 2013, when PHR and partners’ co-convened a gathering in the Netherlands for international and Congolese judges to discuss their experiences of adjudicating cases of mass sexual violence across national and international jurisdictions. This judicial colloquium allowed colleagues to learn from each other, exchange best practices, and establish crucial peer groups for advice, support, and the dissemination of relevant case law.

Building on these fruitful discussions, PHR brought a delegation of nearly 30 participants from seven countries – doctors, lawyers, police investigators, human rights advocates, and judges – to the Global Summit to End Sexual Violence in Conflict (Global Summit) held in London in June 2014. The Global Summit offered a rare opportunity for some of PHR’s partners from both the DRC and Kenya to meet each other and discuss pertinent issues of sexual violence that are widespread in their communities. PHR subsequently proposed a regional roundtable in Nairobi, Kenya to continue the rich exchange that commenced at the Global Summit.

The regional roundtable discussion (Roundtable) in Nairobi, Kenya was a continuation of work by the Program on Sexual Violence in Conflict Zones at Physicians for Human Rights, and was the first time that regional network members convened in the Global South. This forum provided stakeholders from both the DRC and Kenya with a platform to share best practices and lessons learned in combatting the impunity of sexual violence while simultaneously discussing the challenges and frustrations in the various intersections with the justice system in handling sexual violence cases. The overarching and broad themes emerging from such dialogue informed a regional plan that focused on staying connected and coordinated at both the regional and country levels.

The objectives for the Roundtable were ambitious. The Roundtable aimed to tackle the process-oriented questions such as how to standardize forensic medical evidence and gather evidence for mass crimes in both countries, as well as how to properly train and develop capacity within the medical, legal, and law enforcement sectors and expand such knowledge-creation through mentorship and training a cadre of trainers. Discussions also intended to develop advocacy strategies that would more effectively engage survivors, develop network cultivation, devise methods for tracking cases throughout the sectors, and explore new ways to harness technology to support accountability. The summary that follows touches upon each of these topics in two ways: the first section discusses the best practices and lessons learned with respect to 1) cross-sectoral network growth and expansion, 2) greater incorporation of survivors in programmatic work, and 3) regional collaboration among Kenyan and Congolese colleagues; and the second section discusses the broader themes that emerged during the Roundtable.
Part 1: Best Practices and Lessons Learned

1. Network Expansion and Formalization

The power and utility of the network surfaced as a key message from the regional roundtable discussion (Roundtable). Participants highlighted several successes influenced by robust cross-sectoral network engagement including efficient and timely responses to survivors, collection and documentation of forensic evidence, investigations and prosecutions of sexual violence cases. Over the course of the Roundtable, participants identified innovative ways to harness the power of the existing networks and expand the impact of trainings by Physicians for Human Rights (PHR). Participants identified using networks as vehicles for the mentorship of colleagues, cross-national collaboration, and country-specific advocacy. Representatives from the Democratic Republic of the Congo (DRC) put forth a plan for a secretariat that would formalize disparate networks across the country and provide a sustainable path for continued collaboration. A formalized network will allow stakeholders to clarify individual roles and responsibilities and work together in a more systematic fashion. Short of formalized networks, participants pointed to leveraging network members to conduct sensitization of professionals and members of their own communities, both lay and professional. Additionally, representatives from Kenya offered the successful model of the Court Users Committee (CUC), an initiative spearheaded by the National Council for the Administration of Justice, pursuant to Kenya’s Judiciary Service Act, 2011. The CUC model exemplifies how judges in certain counties in Kenya are actively and regularly engaging with stakeholders from multiple sectors who work with the law courts. Kenyan delegates involved in the CUCs offered to share the standard operating procedures with their Congolese counterparts, in the event a similar initiative can be launched in the DRC. Participants from both Kenya and the DRC further noted the need to expand the networks to include other key actors and stakeholders such as the media and private sector.

2. Greater Incorporation of Survivors in Network and Program Activities

The powerful voices of survivors of sexual violence participating in the Roundtable reinforced the notion that survivors must be central to all network and training activities. Psycho-social care and support for survivors of sexual violence should be prioritized in training workshops and mentorship efforts. Trainings for networks should provide sensitization to first responders on how to work with survivors and how to improve the survivor experience in navigating the medical and legal systems of care and treatment, support, and justice processes and reparations. Moreover, Roundtable participants pointed to the engagement of survivors in networks as a means to ensure that medical-legal networks take their voices, views and concerns into account in their work.

3. Regional Collaboration

The Roundtable demonstrated the importance of South-to-South collaboration in finding concrete solutions to problems faced by professionals working with survivors of sexual violence in different contexts. During the Roundtable, participants exchanged challenges in working in their respective countries and helped to understand common ways to advance their own practice. For example, the Kenyan delegation was keenly interested in Congolese advancements to improve the adjudication of cases of sexual violence in mobile military courts. Additionally, Congolese representatives provided a series of cases exemplifying how they have held senior military leaders to account in military tribunals using legal doctrines like command responsibility, meaning the holding of superiors responsible for the action of their subordinates. The DRC, like Kenya, has implemented legislation that domesticates the Rome Statute of the International Criminal Court into national law, so that provisions under this statute are applicable in national courts. Given the fact that the same provisions would also apply in Kenya under the International Crimes Act, the Kenyan delegation was interested to learn about the application of the command responsibility doctrine in the DRC.

Congolese colleagues working to introduce a standard medical intake form in the DRC for documenting forensic medical evaluations were encouraged to learn more about the existence and use of a nationally legislated Post-Rape Care (PRC) form in Kenya. The Congolese delegation expressed interest in holding up the PRC form as a model for advocating for a similar kind of national medical certificate in the DRC.

Part 2: Major Themes

1. Shared Success and Continued Obstacles

The regional roundtable discussion (Roundtable) opened with a session for participants to identify and share their successes in combatting impunity for sexual violence. For those first responders on the front line, these success stories act as motivators to continue with this hard work. In celebrating their successes, Roundtable contributors also acknowledged the challenges in their work.

Colleagues from the Democratic Republic of the Congo (DRC) presented key successes in the fight against impunity for perpetrators of sexual violence in their own context. Military courts in the DRC are beginning to have strategic successes in prosecuting senior military officers. Congolese participants referred to the conviction and sentencing of Lieutenant Colonel Bedi Mobuli Engangela (also known as “Colonel 106” after the battalion he commanded), a high-ranking colonel in the Congolese military who was found guilty of committing...
human rights violations. Additionally, Congolese participants noted the successful prosecution of General Jerome Kakwavu, convicted of rape in November 2014. One participant noted that a positive shift in the military justice leadership – due to advocacy efforts by international organizations, including Physicians for Human Rights (PHR) – has contributed to recent successful prosecutions. Another reason cited for increased prosecution at the military justice level was the increased coordination among sectors, particularly the police and justice sectors. While there may be improvements in the prosecution of these crimes, Congolese participants acknowledged survivors’ difficulties in obtaining reparations awarded to them in the judgments.

Even though some participants provided anecdotal and unspecified cases of survivors obtaining monetary reparations, participants acknowledged the culture of nonpayment of reparations due to indigent perpetrators, a lack of political will within the government to enforce dissemination of awards, or the government’s failure to contribute funds to cover damages.

An additional success shared by Congolese law enforcement officials was the positive effects of sensitization campaigns to disseminate information to survivors, encouraging them to come forward to report sexual violence crimes. Though social stigma remains a high barrier for survivors to enter the justice system, a Congolese participant noted that campaigns seem to be working in Kinshasa. However, the same participant noted that despite a survivor’s willingness to report sexual violence, the identity of the perpetrator influenced the system’s response and capacity to investigate; if the perpetrator is a senior person in civil or military hierarchy or is a person with political or financial means, then cases are typically “fast-tracked,” meaning no proper investigation is conducted. This challenge is almost impossible for the survivor to overcome.

One Kenyan participant shared an example of a successful collaboration between the police and a magistrate to overcome the rampant corruption often faced while prosecuting sexual violence. Despite efforts by the perpetrator to intervene and disrupt the criminal case against him using political channels, the matter was still prosecuted in court because of the strong network of professionals working together across different sectors. Though this particular case did proceed to court, the Kenyan participant noted most cases falter due to corruption, and this remains a significant problem that requires the attention of people in positions of power to combat it.

Standardization of medical documentation was also identified as a major success in Kenya especially with the introduction of the Post-Rape Care (PRC) form. The PRC form is a detailed sexual assault report filled out by the medical sector. To proceed with police investigations, Kenyan police also require a P3 form to be completed by clinicians to document sexual violence. However, because the PRC form is a relatively new document, Kenyan participants expressed frustration that it is not more widely used in court. Kenyan participants also noted that although the law makes provision for free medical treatment for survivors of sexual violence, many health facilities and practitioners across the country were still requiring fees for completion of the PRC form.

The DRC and Kenyan participants both highlighted the significant value of PHR’s training in enhancing knowledge and skills on effective collection, documentation and handling of forensic evidence within their communities. However, they reported that frequent transfers of trained professionals without proper replacements and lack of capacity building at lower regional levels remains an obstacle to sustained high quality medico-legal responses to sexual violence.

2. Engagement of Survivors

The Roundtable discussion benefited from the strong presence of survivors of sexual violence, who were able to share their unique perspectives on the justice gap and the hurdles they faced in accessing the justice system in their communities. These survivors articulated challenges that included the lack of police sensitization, which perpetuates a culture of intimidation and corruption, stigma and shame surrounding reporting sexual violence, lack of psycho-social support for survivors (especially for marginalized populations), high costs associated with accessing treatment and legal support, and lack of support and protective measures for survivors in the course of judicial proceedings. The panelists in this session called on clinicians, police officers, lawyers, and judges to increase engagement with survivors of sexual violence to inform network development. Survivors’ voices and experiences should also inform policy discussions centered on prevention, reparations, economic empowerment, advocacy efforts including the need for specialized units for investigations and prosecutions of gender-based crimes, and training of the medical, law enforcement, and legal sectors. The panelists also called for increased inclusion of and engagement with men and religious institutions on the problems of prosecuting sexual violence crimes.

3. Enhanced Collaboration and Network-Creation and Maintenance

Throughout the Roundtable, participants affirmed the need for greater collaboration in the collection of sexual violence documentation and network-creation among the medical, law enforcement, and judicial sectors. This collaboration and network-building is critical to ensure effective response to both individual cases and cases of mass crimes, and multi-sectoral coordination is needed in both a formal and informal manner. Roundtable participants discussed the coordination of individual cases of sexual violence and how such cases are referred from one sector to the next. Participants from both the DRC and Kenya indicated that one of the
major gaps is the lack of clarity on the specific roles and responsibilities of providers within each sector, including how doctors and nurses are supposed to communicate with police to help survivors report cases, and whether or not it is the doctor’s job to ensure that the medical certificate is properly filed with the police. Other challenges participants noted included a lack of resources and the impact of statutes of limitations and other procedural deadlines.

For example, in both the DRC and Kenya, once a case is filed, the police are required to meet deadlines, but it is difficult to do so because of the dearth of medical experts and health care facilities available to gather probative evidence to support the investigation of a case.

Participants further highlighted the lack of mechanisms and standardized tools to ensure effective follow-up and tracking of cases across sectors as a critical obstacle in ensuring that survivors access effective medical, psychosocial and legal assistance. They noted that enhanced multi-sectoral collaboration and coordination could provide an opportunity for development of harmonized tools and systems to support proper tracking of cases, which would enable providers to identify gaps and develop solutions for improved service provision to survivors.

Though there are many challenges blocking coordination among professionals from each sector, Roundtable contributors offered some solutions. The power of the network can be leveraged to forge better coordination between sectors. For example, in the DRC, a doctor indicated that following the training with PHR, clinicians are now better positioned to reach out to specific law enforcement officials within the cross-sectoral network to collaborate on a case and then work with individual lawyers (also within the same network) to ensure proper submission of evidence in court. Further, the Legal Aid Center in Eldoret and SOFEPADI from the DRC shared their models of operation that have proved useful in supporting sexual violence survivors to access relevant medical and psychosocial assistance and navigate the complex justice systems. This includes provision for lawyers to watch brief during court proceedings and working with social workers, paralegals and community health workers as case managers. In Kenya, another more formal solution has emerged with the creation of Court Users Committees (CUCs). By increasing public, multi-sectoral participation in the judicial process, these CUCs help providers coordinate with each other to overcome gaps within specific cases before the law courts. An electronic case management system established within the law courts in Eldoret, Kenya, was also highlighted as a useful model for tracking prosecutions and adjudication of cases. It includes a database that is updated from inception of the case and after every mention or hearing in court, as well as a mobile phone SMS system through which survivors are updated on the status of and upcoming court proceedings. The database can also generate printed copies with a summary of court proceedings.

In addition to coordination across sectors on individual sexual violence cases, participants also discussed the need for greater collaboration and network-creation more broadly. Participants noted that formal or informal networks created within the communities (whether related to PHR networks or other multi-sectoral collaborative associations) can provide leadership on the documentation and response to mass crimes (see below for more on mass crimes). If networks are created within the communities across different sectors, participants indicated that networks can then respond to mass crimes more quickly, efficiently, and appropriately (as a rapid response mechanism), and collaborate in the collection and preservation of evidence of mass crimes. These network members will also be able to provide local insight into the context and issues surrounding an emerging, quickly evolving situation of mass human rights abuses.

Participants from both the DRC and Kenya also noted the need for the development of formal and standardized local networks with defined lines of communication and roles for different sectors. Currently, all information sharing for cases of sexual violence between the various sectors is informal and fragmented. In many cases, information is shared through informal networks of professionals, such as post-basic training PHR networks or existing professional networks within the community. Despite these networks, a high volume of professional mobility, transfer, and turnover can cause collaboration and coordination to cease. There are no formalized, entrenched systems for official collaboration or referral among sectors involved in the collection, documentation, and preservation of forensic evidence of sexual violence or for those practitioners who provide care, support, and counsel to survivors of sexual violence. Kenyan participants discussed the existence of the Gender-Based Violence Working Group in Nakuru, a local, formal network that includes police, doctors and nurses, prosecutors, children’s department, gender department, magistrates, prison worker, community health workers, community mobilizers, and paralegals. The Working Group meets on a regular basis to discuss emerging cases of sexual violence, the quality of response across sectors, challenges experienced by service providers and strategies for enhanced services to survivors.

Participants also discussed the challenge of maintaining networks and the difficulties in creating sustainable participation and ongoing motivation for such networks. Some of the related concerns highlighted by participants included lack of resources and a high dependency on donor funding as factors that hinder network autonomy and a sense of ownership among network members. One Congolese participant proposed that the formalization of network collaboration may strengthen network stability, sustainability, and commitment of individual members. This may be achieved through establishment of a technical committee consisting of representatives from each sector to provide leadership...
or rotational leadership by different sectors; development of a clear vision, mission and strategic goals for the networks; and implementation of joint work plans including advocacy projects to motivate active and sustained engagement. Another participant suggested expanding networks to include other sectors such as members of the private sector, other government agencies, media and civil society. One participant suggested that such networks should be decentralized and responsibility and accountability should be transferred to the members themselves.

4. Standardizing Documentation

Participants discussed the importance of standardizing forensic medical documentation. Standardization allows healthcare workers, including doctors and nurses, to more effectively and efficiently collect comprehensive quality medical information necessary to support prosecutions of sexual violence crimes in a systematic and consistent manner.

In Kenya, police must complete a P3 form to file a complaint of sexual violence. The P3 form includes a basic medical examination report to be filled by a medical officer/practitioner. In 2013, the Kenyan government adopted the national PRC form pursuant to the Sexual Offences Act of 2006 and 2012 Medical Treatment Regulations, which entitle survivors to free medical treatment with completion of the PRC form as part of the minimum standard of treatment. The PRC form prompts clinicians to collect more comprehensive details than the medical portion of the P3 form. Though there is a legal requirement and growing recognition by stakeholders (and court-users) in Kenya of the need to standardize the medical documentation of sexual violence cases, there are still some practical challenges to using these forms, including questions about who is eligible to complete them and how clinicians can avoid duplication with the P3 form (and avoid a situation where a survivor is subjected to two medical evaluations). Lastly, some stakeholders remarked that despite the existence of these forms, more training was needed to ensure medical professionals properly complete the form in its entirety.

In the DRC, there is no national form to collect forensic medical information. Recognizing this gap, PHR’s Program on Sexual Violence in Conflict Zones (the Program) convened multiple network meetings in 2012 and 2013 to facilitate the creation of a standard medical intake form also referred to as the Medical Certificate. This standard medical form is now being used in eastern DRC in certain hospitals. Congolese participants noted that it was particularly enlightening to learn from their Kenyan counterparts about the national standardization of the PRC form. The Congolese delegates were particularly interested in learning about any analytical data the Kenyans may have gathered with respect to the impact the PRC form may be having in that country and the degree to which it may be improving the outcome of sexual violence cases. This data would be useful to share with Congolese policymakers who may consider adopting a national form in the future.

5. Sector-Specific Themes

A significant benefit of bringing together the Congolese and Kenyan delegations, was the rich exchange of ideas that occurred on the sector-specific level. Participants from the medical, law enforcement, and legal sectors had the opportunity to discuss challenges within their areas and brainstorm possible solutions, informed by their current experiences during smaller, focused group discussions. What follows is a summary from these breakout sessions.

A. Medical Sector

The Congolese and Kenyan health care workers discussed the merits of standardizing medical information, including the specifics of the respective country’s forms: the PRC Form used in Kenya and the medical certificate used in certain health care sites in the DRC (DRC Standard Medical Certificate). As referenced above, the Kenyan experience of adopting a national medical form for sexual assault documentation was particularly interesting to the Congolese delegates who are eager to develop procedures to nationally standardize forensic medical information in their country. In discussing the substantive content of the forms, the Congolese delegates noted that their form should build in more space for clinicians to include psychological observations and findings. The Kenyans informed the group that a revised version of the PRC form (updated in 2014) now includes a new section specifically devoted to documenting the clinicians’ observations of the survivor’s psychological status, and that all clinicians – not just psychiatrists or psychologists – are eligible and expected to complete that section.

In addition to discussing the content of the forms, both Kenyan and Congolese clinicians discussed the onerous process of completing the documentation and the lengthy time that it takes to do so. Clinicians from both countries noted how constrained they feel by the number of patients they must see and treat in a limited period of time, and that they are obligated to fill out hospital patient charts which takes time. Completing an additional form (Kenyan PRC form or the DRC Standard Medical Certificate) can feel like an additional burden or duplication of effort.

Delegates identified that more work will need to be done at each medical institution to train clinicians on more efficient ways of completing the form (i.e., during the actual exam with the patient) as well as optimizing documentation policies at hospitals to avoid duplication. Despite these challenges, there was consensus among all clinicians that a standard medical intake form did help improve efficiency of medical documentation and was useful for capturing more comprehensive evidence in sexual violence cases.
Clinicians from the DRC and Kenya also acknowledged the importance of informed consent and shared how such consent is obtained in each country. Clinicians noted that they generally see survivors only once because few survivors return for follow-up visits. Given that, after a patient departs the clinic, these doctors are not able to update clinical information following laboratory analysis or order follow-up tests. Additionally, because informed consent should be obtained before the medical forms are passed along to investigating police officers or magistrates, the doctor’s ability to obtain informed consent is hampered if the survivor is difficult to locate, potentially compromising the legal process to advance the claim.

B. Law Enforcement
In the breakout session for law enforcement officials, participants discussed examples of success in using forensic medical evidence in the prosecution of sexual violence cases. Despite these successes, however, participants also discussed some of the challenges in obtaining the forensic medical evidence in the first place. Police officers noted that it is the responsibility of the clinics to collect forensic medical evidence during the physical exam. They also noted that it is problematic when clinicians only partially complete the medical forms. When components of the medical certificate or PRC form are left blank, clinicians do a disservice to the survivor who is trying to pursue a legal claim as the court and defense counsel seize on the opportunity to identify holes in the prosecution’s case. Additionally, participants discussed the challenges of preserving physical evidence and maintaining chain of custody. Law enforcement officers from both the DRC and Kenya cited lack of adequate storage facilities as a significant problem. In Kenya, for instance, the police noted that most stations have exhibit stores, but with very limited capacity often resulting in loss, mix up and contamination of forensic evidence stored therein. Participants were also concerned with the lack of measures to ensure confidentiality and protection of chain of custody for obtained evidence, including lack of specific forms to record transmission of evidence from one sector or officer to another. In the DRC, participants noted that evidence is often compromised due to complex procedures that involve several different officers at various stages of investigations and prosecutions. In Kenya, law enforcement may be susceptible to corruption, which results in frequent withdrawal of cases because physical evidence can often “disappear.” A standardized process for complying with chain of custody and secure storage of evidence was proposed to mitigate this challenge.

The break out session further provided an opportunity for the law enforcement participants from the DRC and Kenya to share and learn from their distinctly varied investigations and prosecutions procedures based respectively on civil and common law systems. Distinctions were noted in the procedures for initiation of investigations, involved investigating officers, specific duration for investigations, and custody and transmission of evidence to and interaction with state prosecutors. Nonetheless, participants observed that despite the varied systems, they experienced common challenges and could learn from each other’s experiences on strategies to overcome identified difficulties.

C. Legal: Prosecution and Judiciary
Participants within the justice sector discussed the challenges in prosecuting and adjudicating sexual violence cases in both the DRC and Kenya. While adjudicating sexual violence cases, judges shared that some medical forms (Kenyan PRC form and the DRC Standard Medical Certificate) were often missing crucial details including key aspects of the history of the victim. In addition, these judges discussed the missing elements from law enforcement’s investigative files, including evidence from the crime scene. One judge stated that a case would be strengthened if prosecutors included more information concerning the crime scene, and suggested that police include a sketch, as well as details of what was found and not found at the crime scene, and in what position the victim was found (if this is relevant). Another judge asked why more photos were not introduced as evidence as “photos don’t lie.” The judges clearly indicated their eagerness for additional evidence and data points to support their ability to adjudicate these cases.

Participants also discussed the pressure often asserted on stakeholders to determine the age of the victim and the inherent challenges associated with that task. It was acknowledged that the age of the victim may be particularly important in Kenya, for example, as it determines which set of laws or sentencing guidelines the judges must apply to the case pursuant to the Sexual Offences Act. Participants noted that clinicians had emphasized that age determination is not possible from a medical standpoint and, consequently, it should be the responsibility of the police officers to locate a victim’s birth certificates, baptism cards, or school records to ascertain the age of a victim.

Participants discussed the role of the doctor in the prosecution of sexual violence cases. All justice sector participants agreed that the role of the doctor was not to determine whether a rape in fact occurred. Instead, the clinician must determine whether or not, based on the medical evidence presented, the medical findings are consistent with allegations of sexual assault. Participating judges also noted that it was important for clinicians to provide clear findings and that ambiguity was unhelpful for the survivor. One judge stated that doctors should be able to defend in a court of law what they wrote in a medical form about sexual violence.

Congolese participants from the legal sector also acknowledged the difficulties of prosecuting superior military officers for sexual violence. These participants noted that Congolese military law holds that in order to prosecute a high-ranking military officer, the case must be tried by an officer of equal or higher rank. Given how few high ranking military judges there are, the system is
thus skewed towards de facto impunity for superior officers.

Participants also raised the significant concern of "disappeared" victims and witnesses to crimes of sexual violence. While emerging witness protection programs may help mitigate these concerns, there is a general lack of political will to implement them widely. In trying to prosecute superior officers, participants considered the role of civil society to help victims navigate the complicated and often-fraught justice system. Judges at the Roundtable suggested they play a more ‘activist’ role and serve as "teachers" for court users. Judges noted that, where possible and relevant, they should ask stakeholders for additional evidence, especially medical evidence. They should ensure that the court is a secure space for victims and witnesses to testify, and that vulnerable witnesses should be able to testify in camera with utmost security protections. The judges acknowledged that it is their responsibility to ensure that additional measures are taken to support the security and protection of victims and witnesses.

6. PHR’s Training Activities

PHR’s Program has taken concrete steps towards providing the training necessary to enhance the capacity of medical, law enforcement, and legal sectors to collect, document, and preserve forensic evidence of sexual violence. PHR’s training workshops have also helped to inform and sensitize media and non-government advocacy stakeholders. Despite these advances, the number of people trained to work with forensic evidence of sexual violence remains limited in the DRC and Kenya. Participants expressed frustration regarding the limited number of trained professionals within their specific geographic networks who are able to gather forensic evidence. This dearth of skilled colleagues increases the stress and pressure placed on the professionals who have been trained either by PHR or other organizations. Participants also noted that the limited forensic professionals in a specific region trained to collect or investigate sexual violence cases may stall or postpone the collection of crucial evidence.

Participants noted a need to scale up forensic training efforts targeting doctors, nurses, and other health professionals, to collect, document, and preserve forensic evidence of sexual violence, and that, where possible, outreach to additional stakeholders (i.e., media) should be a priority for PHR’s training efforts.

Participants discussed how best to increase the number of professionals trained within the sectors (see below for the section on Training of Trainers). One challenge that a participant raised was that in the medical sector, there are very few people who are qualified to conduct forensic medical examinations and these specialists may be impeded by local legal constraints. For example, in the DRC, there is an understanding that only "forensic" doctors should collect forensic evidence and complete forensic medical certificates. If this pool of trained clinicians could be expanded, then it would minimize the strain on the limited number of trained specialists.

In Kenya, where the 2012 Sexual Offences (Medical Treatment) Regulations permit nurses and clinical officers to conduct forensic examinations, complete the PRC form, and present expert testimony in court, the practice of requiring only medical officers to provide these services persists.

More work is needed to sensitize officials in the medical and justice sectors that all clinicians could, in principle, conduct a forensic medical exam and their findings and documentation should be accepted in court. This would help mitigate the fact that there are so few forensic doctors available to conduct these medical exams in a timely and efficient manner. This would also empower nurses to play a larger role in documenting forensic evidence. This is significant because many remote health clinics are staffed only by nurses. This point was somewhat contentious, however, given that one stakeholder present felt that only specialized clinicians should be qualified to conduct forensic exams and complete forensic documentation. Another suggestion from a participant was the request to incorporate more on-site training. Along with mentorship (please see the next section on Mentorship), on-site training would allow for the possibility of more people within that particular sector and location (hospital, police station, and/or courthouse) to receive training within the context in which they work. It was suggested that PHR spend some time in the location in order to better understand the knowledge gaps and then provide trainings to fill those gaps to enhance skills and capacity.

Due to this limited capacity, many participants felt that they would require additional training on advanced topics related to the collection, documentation, and preservation of forensic evidence before feeling comfortable training others on the topic. Some participants suggested that PHR conduct advanced trainings for specific cohorts of practitioners (from across all sectors) to build their expertise in advance of formalized Training of Trainers. Participants suggested integrating PHR’s training model within medical and law schools and police academies to ensure that coordinated forensic evidence collection, documentation, and preservation techniques are taught using the same standards of best practices from the outset.

In addition, participants also discussed the need for constant reinforcement of materials taught during trainings through continued and sustained mentorship and refresher workshops.

Participants also encouraged PHR to support community and public sensitization efforts aimed at enhancing awareness on preservation of forensic evidence and the need to report cases of sexual violence. They further called on PHR to facilitate continued sharing and learning of effective strategies and best practices between professionals from the DRC and Kenya, including through short in-country exchange programs and an electronic platform to brainstorm on difficult
cases and share emerging jurisprudence, laws, policies and other developments.

7. Mentorship and Training of Trainers

Participants emphasized their desire for mentorship within each of the different sectors. Stakeholders expressed their eagerness for constant, ongoing engagement among informed and educated professionals within the specific sectors to help reinforce new techniques identified in the training workshops. Participants noted that mentorship would also support knowledge-transfer among those who have participated in PHR trainings and those who have not.

Participation in the network was one way of increasing opportunities of mentorship. In addition, participants identified the critical need to educate those professionals who would then serve as mentors themselves. Participants requested increased opportunities for trainings on mentoring. Once people are identified within their sectors as experts in the collection and documentation of forensic evidence, they can then serve as trainers for others in their institutions or field.

Partners identified on-site peer mentorship as a vital next step in solidifying PHR’s gains in multi-sectoral training in the region. In one small group discussion, representatives from different professional sectors identified the need for mentorship to enhance the skill-level of colleagues and fill in gaps in education. Moreover, participants identified PHR networks as potential drivers of mentorship within facilities where professionals work.

Mentorship naturally informed the discussions around Training of Trainers initiatives (ToT). ToT is necessary to bring the training initiative to scale and to train the next generation of professionals to gather forensic evidence. There are many challenges to implementing a ToT initiative, including training professionals to master competency in a certain skill area, then training these professionals to effectively teach other potential trainers how to train others on the collection, documentation, and preservation forensic evidence within the specific sectors, and lastly identifying the right people to become trainers. In addition, resources (financial and material) for ToT as well as logistics were also cited as challenges.

8. Tracking Cases through the Justice System

Participants also discussed the challenges with tracking cases through the justice system. Health care workers and law enforcement officials expressed frustration in not knowing the outcome of cases that they themselves have reported and filed. Participants lamented the absence of tracking systems and case management databases with the justice systems in both the DRC and Kenya, rendering stakeholders unable to follow a case to its legal conclusion and keep the survivors informed on the status of their files.

Participants also expressed a desire to learn the reasons why certain cases fail, and what they could do next time to enhance cases going forward. In addition, participants discussed ways for sexual violence survivors to track their own cases and suggested better integrating and financially supporting social workers, paralegals, or case managers to help these survivors track the progress of their cases in both the DRC and Kenya. As referenced above, enhanced local networks could also help fill the void. In addition, other participants suggested that specific units devoted to sexual violence cases within either the law enforcement or medical sectors could play a bigger role in helping to bridge the communication gap among sectors, especially with the judicial sector.

Participants also noted how each of the sectors uses a unique reference system to identify individual sexual violence cases. In Kenya, it was noted that the police may use one specific case number (based on the occurrence book entry) and the courts assign a different file number for the same case, rendering it difficult for the police to track a case once it advances to court. In the DRC, each file at the police station is given a specific reference number and that number should, in theory, then be used to identify cases for court purposes, but this system does not always work. It is also not possible in either country to track a case between the medical and legal sector, especially if the case originated at a medical facility. Moreover, in both countries there is limited ability to track multiple cases to aggregate the data to reveal trends or patterns in sexual violence. Participants acknowledged that the creation of a larger database of cases would be helpful in both countries and that technology may help in monitoring case management and data aggregation. In Eldoret, Kenya, a computerized case management system was initiated by the law courts with USAID support, which has had a significant impact in that community in its ability to track the progress of cases and keep survivors and witnesses informed on the status of the legal process. Emerging technologies, including PHR’s mobile app MediCapt (described in more detail below), could serve as potential mechanisms for resolving some of these case-tracking problems.
9. Use of Technology

Participants engaged in a lively discussion around the use of emerging technologies as tools to help survivors of sexual violence access justice. The discussion included a presentation on the use of DNA in Kenya in the forensic analysis of a crime and the specifics of how DNA can be collected and what is necessary for DNA collection at a crime scene. There are many barriers to realizing the potential of DNA evidence, including the frequent failure of law enforcement officers to identify and collect appropriate DNA evidence from crime scenes, poor storage of DNA containing material, limited resources, poor chain of custody evidence, and the inability to compare reference samples against source samples to determine a genetic match.

While the use of DNA in prosecuting sexual violence cases could be helpful in certain instances, participants noted that for low-resourced communities that exist in parts of the DRC and Kenya, the ability to prosecute cases without relying upon DNA was not only important but necessary to realize justice for sexual violence survivors. To that end, participants also discussed the harm of relying solely upon DNA evidence to corroborate allegations of sexual violence especially in light of the 2014 judgment in Fredrick Wadla Masanju v Republic of Kenya in the Mombasa High Court, which mandated the presence of DNA collection to successfully prosecute rape charges.

Participants also spoke about the role of emerging technologies as an important avenue to advance collaboration amongst and within networks. Mobile-phone applications can help form communities where practitioners can share challenges and solutions, and network members can stay connected to broader professional communities and reduce professional isolation through information sharing. In recognition of the utility of cross-national partnerships and information sharing, participants pointed to the need for an international platform for professional communities to exchange advice, best practices, and opportunities for collaboration. Such a platform could take the form of a website, mobile phone messaging group, or an email list-serv. For such a group to have success, the platform must include functionality to automatically translate messages in a variety of languages (at a minimum French, English, Kiswahili, and Lingala) for all stakeholders to be able to effectively communicate with one another.

PHR also shared information about the mobile application, MediCapt, which it is developing to help doctors and nurses with the collection, documentation, and preservation of forensic medical information of sexual violence for court purposes. PHR explained that MediCapt will be piloted first in the DRC with the aim of making the mobile app more broadly available in the coming years. Participants shared their enthusiasm in using such an application to facilitate their documentation efforts especially in remote areas where such evidence collection and transmission remains problematic. The Kenyan participants expressed interest in piloting MediCapt there as well.

10. Gathering Evidence in Mass Crime Cases

In both the DRC and Kenya, the existence of mass crimes and the propensity for future mass crimes remains relatively high. Discussions around gathering evidence in a mass crimes context centered on issues of time – whether the evidence was being collected during the actual conflict or whether such evidence was being collected after the mass crime was perpetrated. Participants acknowledged that evidence collection during an active conflict is significantly more difficult and the security for those collecting evidence remains a major concern.

Additionally, with large population movements during an active conflict, it is often difficult to fully identify victims of sexual violence until after the conflict has subsided. For mass crimes committed in the past, participants acknowledged that often most of the physical evidence of sexual violence has been destroyed or has been improperly stored leaving witness testimony as the strongest evidence available. Another complication of mass crime evidence collection is determining who is responsible for such evidence collection. Because mass crimes are generally perpetrated during times of conflict, the state generally cannot ensure adequate security to investigators. In some cases, the police or the military are implicated in the crimes, and therefore cannot be expected to investigate these cases. Thus, the onus must be placed on civil society to fill the gaps. Participants asked whether it was the responsibility of humanitarian organizations to help gather evidence. Others acknowledged that there are a lot of organizations focused on evidence collection of mass crimes during times of conflict and better coordination among these organizations was needed.

Participants suggested that network members coordinate plans (a standard operating procedure) for evidence gathering before mass crimes begin so that people know who is responsible for what task. Participants also expressed a need for increased training on how to collect such evidence during a mass crime, including knowledge of the specific elements required to prove such crimes as international crimes. Such training should include other key actors e.g. the media and non-governmental organizations that are often first on the ground during and/or following mass crime, especially to ensure that they understand the value of safeguarding forensic evidence and protection of survivors. A comprehensive review and revision of existing laws, policies and protocols in both the DRC and Kenya was cited as a critical step to further enhance prospects for effective and timely responses to survivors and access to justice.

One participant offered the solution of a mobile lab or mobile investigators who would be deployed during times of mass crimes to collect necessary evidence of
such violence. Other participants focused on the need to enhance more comprehensive rapid response teams consisting of all relevant actors with effective coordination and collaboration among network members (see above for more on this).

An additional hurdle to overcome in the case of mass crimes is the low likelihood of identifying the perpetrator(s). As mentioned above, participants discussed the useful doctrine of command responsibility, holding superiors responsible for the action of their subordinates, as a means for survivors of mass sexual violence to access the justice system. Congolese participants noted several cases where command responsibility was employed as a tool to secure accountability for senior officials directly or indirectly responsible for these crimes. For example, in the Baraka case in 2011, Lt. Col. Mutua Daniel Kibibi was convicted in the South Kivu military court for crimes against humanity, including rape, which occurred after he ordered his troops to attack the village of Fizi on New Year’s Day.

The Kenyan delegation pointed to another useful tactic for survivors to access the justice system for mass sexual violence through civil public interest litigation. PHR’s Kenya coordinator discussed the current public interest litigation filed on behalf of eight survivors of post-election violence in Kenya between 2007 and 2008, with PHR and three Kenyan NGOs also serving as co-petitioners. In that case, the petitioners claim that the government is responsible for preventing mass violence, and – in the event mass crimes take place – the government must protect civilian populations from harm. It is also the government’s responsibility to provide meaningful police investigations and prosecutions for these crimes and to ensure survivors have access to adequate medical care and treatment as well as reparations. The case is currently being tried in the Kenyan High Court.

11. Secondary Trauma, Resilience Strategies, and Psycho-Social Support for First Responders

A core element of the Roundtable was to acknowledge the professional challenges and isolation often experienced by stakeholders who support survivors and carry out this work under tremendous stress each day. The Roundtable aimed to reduce some of that isolation and stress by enabling participants from different communities across the region to discuss their challenges in combating impunity for sexual violence. During the course of the three days, participants acknowledged the stress and pressure they feel on a regular basis as they provide support for survivors and experience threats directed against them and their families due to the sensitive nature of their work. The impact of the violence and the trauma endured by their patients or clients has had lasting effects on these medical, law enforcement, and legal stakeholders. Colleagues discussed the effects of secondary or vicarious trauma, the effects of listening and responding to the first-hand trauma endured by survivors, and the need for these stakeholders to prioritize time for self-care and enhance their strategies for resilience. The final session of the Roundtable emphasized the need for participants to learn strategies for self-care and resilience and how to relieve their stress in productive ways so as to minimize burnout and other medical complications that may result from secondary trauma.

Participants also discussed the impact of being one of very few people in their respective communities with the expertise to handle such sexual violence cases. Being the only doctor or police officer working on such cases has subjected these first responders to additional risk and insecurity. If their expertise is known in the communities, they can be subject to attacks or threats to their safety or their family’s safety. We discussed the need for more trained professionals in these areas as well as ensuring open communication with network members to enhance safety in specific regions.
Part 3: Action Plan/Recommendations

At the conclusion of the regional roundtable discussion (Roundtable), partners from the Democratic Republic of the Congo (DRC) and Kenya formed country-specific working groups to define and delineate actions for next steps within the next 12 to 24 months. Country-specific working groups allowed participants to identify plans of action appropriate for each country-context and to then apply such plans to the creation of a regional network and cross-regional activities.

Country-specific working groups then shared the following action plans:

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<tr>
<th>Country</th>
<th>National Level Actions / Interventions</th>
<th>Regional Actions / Interventions &amp; Cross-cutting Strategies</th>
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<tbody>
<tr>
<td>DRC</td>
<td>1. Network creation and expansion:</td>
<td>1. Establish and deepen strategic partnerships with institutions and networks to undertake training and advocacy efforts:</td>
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<td></td>
<td>• Establish a network in Kinshasa (national network)</td>
<td>• Develop a database on organizations that have capacity on the identified focus issues and their levels of engagement (examples are universities, medical schools, law schools, nongovernmental organizations, and international NGOs)</td>
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<td>• Develop and consolidate networks in Goma and Bukavu</td>
<td>• Continue close collaboration with Physicians for Human Rights on the Program on Sexual Violence in Conflict Zones</td>
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<td>• Select two people to act as focal points (one in Bukavu, one in Goma), and two national coordinators</td>
<td>• Create Google hangout and WhatsApp groups to inform each other on forensic, legal, and other developments and interventions at the regional and national levels</td>
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<td>2. Training of trainers:</td>
<td>• Encourage collaboration between international, regional, and national NGOs and networks to a) leverage resources b) ensure that related initiatives respond to contextual needs of the two countries</td>
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<td></td>
<td>• Establish a pool of PHR trainers and have subjects that can be taught across sectors</td>
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<td>• Enhance knowledge base of the Training of Trainers (ToT) trainers through additional trainings on general and specialized subjects</td>
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<td>• Sectoral trainings in specific professional areas followed by a multi-sectoral ToT with the perspective of the survivors included in ALL the training sessions</td>
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<td>3. Advocacy Interventions:</td>
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<td>• Advocacy to create a uniform standardized medical certificate</td>
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<td></td>
<td>• Advocacy for legal and policy reform (e.g. creation of standard operating procedures)</td>
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<tr>
<td>Country</td>
<td>National Level Actions / Interventions</td>
<td>Regional Actions / Interventions &amp; Cross-cutting Strategies</td>
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| Kenya   | 1. **Network creation and expansion:**  
  - Establishment of linkages between networks from sub-county, county and national levels  
  - Inclusion of military officers, administration police officers and general service unit officers within networks as they are often first responders in conflict situations  
  - Inclusion of medical professionals from private entities that provide emergency response and services for sexual violence e.g. Red Cross, St. John’s Ambulance, and MSF  
  
  2. **Advocacy interventions:**  
  - Harnessing the power of networks to influence legal, policy and institutional reforms, including by working with influential allies.  
  - Potential advocacy themes include: increased resource allocation to support effective collection, documentation and analysis of forensic evidence, including decentralized DNA laboratories; meaningful and timely state provision of reparations to survivors of sexual violence, including medical assistance and rehabilitation; and protection of survivors’ rights while accessing justice.  
  
  3. **Training:**  
  - Empower professionals within networks to carry out training of trainers.  
  - Advanced training for professionals within networks, with a priority on law enforcement officers and crime scene investigations.  
  - Support pre-service training, especially nursing and medical training schools.  
  - Share knowledge through written journals and articles.  
|         | • Exchange visits between network members at both national and regional levels  
• Regular roundtable discussions between the DRC and Kenyan networks  
• Develop a common advocacy plan to implement the International Protocol on Documenting Sexual Violence  
• Use new technologies to support network efforts and collaboration with local and DRC counterparts |

**Next Steps and Conclusion**

The Roundtable demonstrates a significant advancement in the development of South-to-South partnerships of professionals working to provide support for survivors of sexual violence on their path to justice. Through the sharing of best practices, experiences, and enthusiasm to continue the movement, the Roundtable gave first responders and other stakeholders the opportunity to plan next steps and identify means of communication to continue working together. Such opportunities for partnership and collaboration across sectors, communities, and countries will help advance support for survivors of sexual violence in the DRC, Kenya, and across sub-Saharan Africa, and will serve as a model for effective responses to sexual violence globally.
Endnotes

1 The format of the three-day regional roundtable discussion (Roundtable) included a combination of plenary sessions, small group workshops, and brainstorming discussions. Designated participants served as facilitators for each session, but all participants actively participated in the discussions. The Roundtable also included working lunches where participants were divided into groups by sector and were asked to discuss certain questions. There was also an opportunity for informal discussions at the end of each day. Formal sessions were supported with simultaneous French-English translation to facilitate discussion.

2 PHR’s partners included the Brandeis University’s International Center for Ethics, Justice and Public Life and the Institute for Historical Justice and Reconciliation.

3 Section 8 of the Kenyan Sexual Offences Act of 2006 prohibits defilement of children -defined as any person under the age of 18 years- and provides minimum sentences based on the age of the child as follows: life imprisonment for defilement of children below 11 years; 20 years imprisonment for defilement of children between 12 and 15 years; and 15 years imprisonment for children between 16 and 18 years.


5 One significant issue is that there are people who document human rights violations who are not at all trained on protecting the integrity of evidence. Different groups/civil society organizations have competing agendas, which can result in the inadvertent loss of critical evidence.

6 Constitutional Petition no. 122 of 2013, COVAW and Others vs. the Attorney General and Others.