CHAPTER 6

Sexual violence

Background

Sexual violence occurs throughout the world. Although in most countries there has been little research conducted on the problem, available data suggest that in some countries nearly one in four women may experience sexual violence by an intimate partner (*1–3*), and up to one-third of adolescent girls report their first sexual experience as being forced (*4–6*).

Sexual violence has a profound impact on physical and mental health. As well as causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences (*4, 7–16*). Its impact on mental health can be as serious as its physical impact, and may be equally long lasting (*17–24*). Deaths following sexual violence may be as a result of suicide, HIV infection (*25*) or murder – the latter occurring either during a sexual assault or subsequently, as a murder of ''honour'' (*26*). Sexual violence can also profoundly affect the social well-being of victims; individuals may be stigmatized and ostracized by their families and others as a consequence (*27, 28*).

Coerced sex may result in sexual gratification on the part of the perpetrator, though its underlying purpose is frequently the expression of power and dominance over the person assaulted. Often, men who coerce a spouse into a sexual act believe their actions are legitimate because they are married to the woman.

Rape of women and of men is often used as a weapon of war, as a form of attack on the enemy, typifying the conquest and degradation of its women or captured male fighters (*29*). It may also be used to punish women for transgressing social or moral codes, for instance, those prohibiting adultery or drunkenness in public. Women and men may also be raped when in police custody or in prison.

While sexual violence can be directed against both men and women, the main focus of this chapter will be on the various forms of sexual violence against women, as well as those directed against young girls by people other than caregivers.

How is sexual violence defined?

Sexual violence is defined as:

> any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

Coercion can cover a whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail or other threats – for instance, the threat of physical harm, of being dismissed from a job or of not obtaining a job that is sought. It may also occur when the person aggressed is unable to give consent – for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation.

Sexual violence includes *rape*, defined as physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as *attempted rape*. Rape of a person by two or more perpetrators is known as *gang rape*.

Sexual violence can include other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus.

Forms and contexts of sexual violence

A wide range of sexually violent acts can take place in different circumstances and settings. These include, for example:

- rape within marriage or dating relationships;
- rape by strangers;
- systematic rape during armed conflict;
- unwanted sexual advances or sexual harassment, including demanding sex in return for favours;
- sexual abuse of mentally or physically disabled people;
- sexual abuse of children;
- forced marriage or cohabitation, including the marriage of children;
- denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases;
- forced abortion;

— violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity;
— forced prostitution and trafficking of people for the purpose of sexual exploitation.

There is no universally accepted definition of trafficking for sexual exploitation. The term encompasses the organized movement of people, usually women, between countries and within countries for sex work. Such trafficking also includes coercing a migrant into a sexual act as a condition of allowing or arranging the migration.

Sexual trafficking uses physical coercion, deception and bondage incurred through forced debt. Trafficked women and children, for instance, are often promised work in the domestic or service industry, but instead are usually taken to brothels where their passports and other identification papers are confiscated. They may be beaten or locked up and promised their freedom only after earning – through prostitution – their purchase price, as well as their travel and visa costs (*30–33*).

The extent of the problem

Sources of data

Data on sexual violence typically come from police, clinical settings, nongovernmental organizations and survey research. The relationship between these sources and the global magnitude of the problem of sexual violence may be viewed as corresponding to an iceberg floating in water (*34*) (see Figure 6.1). The small visible tip represents cases reported to police. A larger section may be elucidated through survey research and the work of nongovernmental organizations. But beneath the surface remains a substantial although unquantified component of the problem.

In general, sexual violence has been a neglected area of research. The available data are scanty and fragmented. Police data, for instance, are often incomplete and limited. Many women do not report sexual violence to police because they are ashamed, or fear being blamed, not believed or otherwise mistreated. Data from medico-legal clinics, on the other hand, may be biased towards the more violent incidents of sexual abuse. The proportion of women who seek medical services for immediate problems related to sexual violence is also relatively small.

Although there have been considerable advances over the past decade in measuring the phenomenon through survey research, the definitions used have varied considerably across studies. There are also significant differences across cultures in the willingness to disclose sexual violence to researchers. Caution is therefore needed when making global comparisons of the prevalence of sexual violence.

Estimates of sexual violence

Surveys of victims of crime have been undertaken in many cities and countries, using a common methodology to aid comparability, and have generally included questions on sexual violence. Table 6.1 summarizes data from some of these surveys on the prevalence of sexual assault over the preceding 5 years (*35, 36*). According to these

FIGURE 6.1
Magnitude of the problem of sexual violence

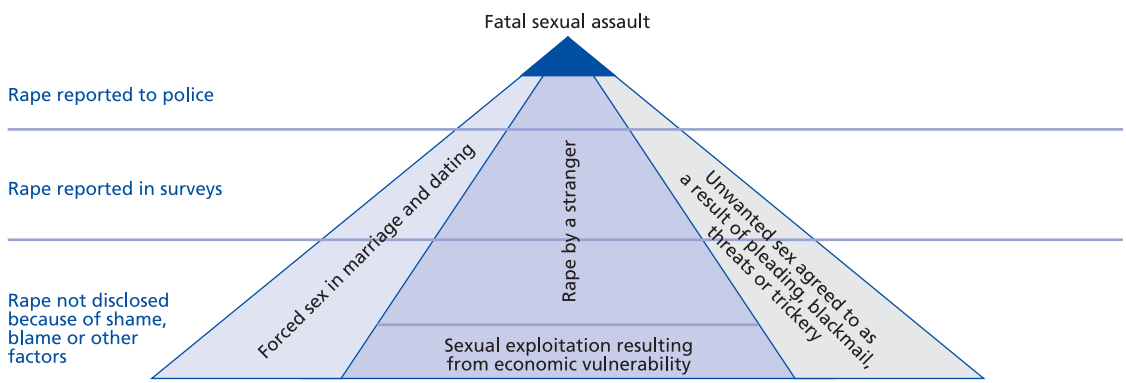

TABLE 6.1

Percentage of women aged 16 years and older who report having been sexually assaulted in the previous 5 years, selected cities, 1992–1997

Country	Study population	Year	Sample size	Percentage of women (aged 16 years and older) sexually assaulted in the previous 5 years (%)
Africa				
Botswana	Gaborone	1997	644	0.8
Egypt	Cairo	1992	1000	3.1
South Africa	Johannesburg	1996	1006	2.3
Tunisia	Grand-Tunis	1993	1087	1.9
Uganda	Kampala	1996	1197	4.5
Zimbabwe	Harare	1996	1006	2.2
Latin America				
Argentina	Buenos Aires	1996	1000	5.8
Bolivia	La Paz	1996	999	1.4
Brazil	Rio de Janiero	1996	1000	8.0
Colombia	Bogotá	1997	1000	5.0
Costa Rica	San José	1996	1000	4.3
Paraguay	Asunción	1996	587	2.7
Asia				
China	Beijing	1994	2000	1.6
India	Bombay	1996	1200	1.9
Indonesia	Jakarta and Surabaya	1996	1400	2.7
Philippines	Manila	1996	1500	0.3
Eastern Europe				
Albania	Tirana	1996	1200	6.0
Hungary	Budapest	1996	756	2.0
Lithuania	Ðiauliai, Kaunas, Klaipêda, Panevêžys, Vilnius	1997	1000	4.8
Mongolia	Ulaanbaatar, Zuunmod	1996	1201	3.1

Source: references *35* and *36*.

studies, the percentage of women reporting having been a victim of sexual assault ranges from less than 2% in places such as La Paz, Bolivia (1.4%), Gaborone, Botswana (0.8%), Beijing, China (1.6%), and Manila, Philippines (0.3%), to 5% or more in Tirana, Albania (6.0%), Buenos Aires, Argentina (5.8%), Rio de Janeiro, Brazil (8.0%), and Bogotá, Colombia (5.0%). It is important to note that no distinction has been made in these figures between rape by strangers and that by intimate partners. Surveys that fail to make this distinction or those that only examine rape by strangers usually underestimate substantially the prevalence of sexual violence (*34*).

Apart from crime surveys, there have been a small number of surveys, with representative samples, that have asked women about sexual violence. For instance, in a national survey conducted in the United States of America, 14.8% of women over 17 years of age reported having been raped in their lifetime (with an additional 2.8% having experienced attempted rape) and 0.3% of the sample reported having been raped in the previous year (*37*). A survey of a representative sample of women aged 18–49 years in three provinces of South Africa found that in the previous year 1.3% of women had been forced, physically or by means of verbal threats, to have non-consensual sex (*34*). In a survey of a representative sample of the general population over 15 years of age in the Czech Republic (*38*), 11.6% of women reported forced sexual contact in their lifetime, 3.4% reporting that this had occurred more than once. The most common form of contact was forced vaginal intercourse.

Sexual violence by intimate partners

In many countries a substantial proportion of women experiencing physical violence also experience sexual abuse. In Mexico and the United States, studies estimate that 40–52% of women experiencing physical violence by an intimate partner have also been sexually coerced by that partner (*39, 40*). Sometimes, sexual violence occurs without physical violence (*1*). In the Indian state of Uttar Pradesh, in a representative sample of over 6000 men, 7% reported having sexually and physically abused their wives, 22% reported using sexual violence without physical violence and 17% reported that they had used physical violence alone (*41*).

Table 6.2 summarizes some of the available data on the prevalence of sexual coercion by intimate partners (*1–3, 37, 42–53*). Findings from these

TABLE 6.2

Percentage of adult women reporting sexual victimization by an intimate partner, selected population-based surveys, 1989–2000

Country	Study population	Year	Sample size	Percentage assaulted in past 12 months	Percentage ever assaulted	
				Attempted or completed forced sex (%)	Attempted or completed forced sex (%)	Completed forced sex (%)
Brazil[a]	Sao Paulo	2000	941[a]	2.8	10.1	
	Pernambuco	2000	1 188[a]	5.6	14.3	
Canada	National	1993	12 300		8.0	
	Toronto	1991–1992	420		15.3[b]	
Chile	Santiago	1997	310	9.1		
Finland	National	1997–1998	7 051	2.5	5.9	
Japan[a]	Yokohama	2000	1 287[a]	1.3	6.2	
Indonesia	Central Java	1999–2000	765	13.0		22.0
Mexico	Durango	1996	384		42.0	
	Guadalajara	1996	650	15.0	23.0	
Nicaragua	León	1993	360		21.7	
	Managua	1997	378	17.7		
Peru[a]	Lima	2000	1 086[a]	7.1	22.5	
	Cusco	2000	1 534[a]	22.9	46.7	
Puerto Rico	National	1993–1996	7 079			5.7[b]
Sweden	Teg, Umeå	1991	251		7.5[c]	
Switzerland	National	1994–1995	1 500		11.6	
Thailand[a]	Bangkok	2000	1 051[a]	17.1	29.9	
	Nakornsawan	2000	1 027[a]	15.6	28.9	
Turkey	East and south-east Anatolia	1998	599			51.9[b]
United Kingdom	England, Scotland and Wales	1989	1 007			14.2[d]
	North London, England	1993	430	6.0[b]	23.0[b]	
United States	National	1995–1996	8 000	0.2[b]	7.7[b]	
West Bank and Gaza Strip	Palestinians	1995	2 410	27.0		
Zimbabwe	Midlands Province	1996	966		25.0	

Sources: references *1–3, 37, 42–53*.

[a] Preliminary results from the *WHO multi-country study on women's health and domestic violence*. Geneva, World Health Organization, 2000 (unpublished). Sample size reported is the denominator for the prevalence rate and not the total sample size of the study.

[b] Sample group included women who had never been in a relationship and therefore were not at risk of being assaulted by an intimate partner.

[c] Offenders reported to be husbands, boyfriends and acquaintances.

[d] Weighted estimate; unweighted prevalence rate was 13.9%.

studies show that sexual assault by an intimate partner is neither rare nor unique to any particular region of the world. For instance, 23% of women in North London, England, reported having been the victim of either an attempted or completed rape by a partner in their lifetime. Similar figures have been reported for Guadalajara, Mexico (23.0%), León, Nicaragua (21.7%), Lima, Peru (22.5%), and for the Midlands Province in Zimbabwe (25.0%). The prevalence of women sexually assaulted by an intimate partner in their lifetime (including attempted assaults) has also been estimated in a few national surveys (for example, Canada 8.0%, England, Wales and Scotland (combined) 14.2%, Finland 5.9%, Switzerland 11.6% and the United States 7.7%).

Forced sexual initiation

A growing number of studies, particularly from sub-Saharan Africa, indicate that the first sexual experience of girls is often unwanted and forced. In a

case–control study, for example, of 191 adolescent girls (mean age 16.3 years) attending an antenatal clinic in Cape Town, South Africa, and 353 non-pregnant adolescents matched for age and neighbourhood or school, 31.9% of the study cases and 18.1% of the controls reported that force was used during their sexual initiation. When asked about the consequences of refusing sex, 77.9% of the study cases and 72.1% of the controls said that they feared being beaten if they refused to have sex (*4*).

Forced sexual initiation and coercion during adolescence have been reported in many studies of young women and men (see Table 6.3 and Box 6.1). Where studies have included both men and women in the sample, the prevalence of reported rape or sexual coercion has been higher among the women than the men (*5, 6, 54–60*). For example, nearly half of the sexually active adolescent women in a multi-country study in the Caribbean reported that their first sexual intercourse was forced, compared with one-third of the adolescent men (*60*). In Lima, Peru, the percentage of young women reporting forced sexual initiation was almost four times that reported by the young men (40% against 11%, respectively) (*56*).

Gang rape

Rape involving at least two or more perpetrators is widely reported to occur in many parts of the world. Systematic information on the extent of the problem, however, is scant. In Johannesburg, South Africa, surveillance studies of women attending medico-legal clinics following a rape found that one-third of the cases had been gang rapes (*61*). National data on rape and sexual assault in the United States reveal that about 1 out of 10 sexual assaults involve multiple perpetrators. Most of these assaults are committed by people unknown to their victims (*62*). This pattern, though, differs from that in South Africa where boyfriends are often involved in gang rapes.

Sexual trafficking

Each year hundreds of thousands of women and girls throughout the world are bought and sold into prostitution or sexual slavery (*30–32, 63, 64*). Research in Kyrgyzstan has estimated that around 4000 people were trafficked from the country in 1999, with the principal destinations being China, Germany, Kazakhstan, the Russian Federation, Turkey and the United Arab Emirates. Of those trafficked, 62% reported being forced to work without pay, while over 50% reported being physically abused or tortured by their employers (*31*). A World Organization against Torture (OMCT) report suggested that more than 200 000 Bangladeshi women had been trafficked between 1990 and 1997 (*65*). Some 5000–7000 Nepali

TABLE 6.3

Percentage of adolescents reporting forced sexual initiation, selected population-based surveys, 1993–1999

Country or area	Study population	Year	Sample		Percentage reporting first sexual intercourse as forced (%)	
			Size[a]	Age group (years)	Females	Males
Cameroon	Bamenda	1995	646	12–25	37.3	29.9
Caribbean	Nine countries[b]	1997–1998	15 695	10–18	47.6[c]	31.9[c]
Ghana	Three urban towns	1996	750	12–24	21.0	5.0
Mozambique	Maputo	1999	1 659	13–18	18.8	6.7
New Zealand	Dunedin	1993–1994	935	Birth cohort[d]	7.0	0.2
Peru	Lima	1995	611	16–17	40.0	11.0
South Africa	Transkei	1994–1995	1 975	15–18	28.4	6.4
United Republic of Tanzania	Mwanza	1996	892	12–19	29.1	6.9
United States	National	1995	2 042	15–24	9.1	–

Source: references *5, 6* and *54–60*.

[a] Total number of adolescents in the study. Rates are based on those who have had sexual intercourse.

[b] Antigua, Bahamas, Barbados, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica and Saint Lucia.

[c] Percentage of adolescents responding that their first intercourse was forced or ''somewhat'' forced.

[d] Longitudinal study of a cohort born in 1972–1973. Subjects were questioned at 18 years of age and again at 21 years of age about their current and previous sexual behaviour.

BOX 6.1

Sexual violence against men and boys

Sexual violence against men and boys is a significant problem. With the exception of childhood sexual abuse, though, it is one that has largely been neglected in research. Rape and other forms of sexual coercion directed against men and boys take place in a variety of settings, including in the home, the workplace, schools, on the streets, in the military and during war, as well as in prisons and police custody.

In prisons, forced sex can occur among inmates to establish hierarchies of respect and discipline. Sexual violence by prison officials, police and soldiers is also widely reported in many countries. Such violence may take the form of prisoners being forced to have sex with others as a form of ''entertainment'', or to provide sex for the officers or officials in command. Elsewhere, men who have sex with other men may be ''punished'', by rape, for their behaviour which is perceived to transgress social norms.

The extent of the problem

Studies conducted mostly in developed countries indicate that 5–10% of men report a history of childhood sexual abuse. In a few population-based studies conducted with adolescents in developing countries, the percentage of males reporting ever having been the victim of a sexual assault ranges from 3.6% in Namibia and 13.4% in the United Republic of Tanzania to 20% in Peru. Studies from both industrialized and developing countries also reveal that forced first intercourse is not rare. Unfortunately, there are few reliable statistics on the number of boys and men raped in settings such as schools, prisons and refugee camps.

Most experts believe that official statistics vastly under-represent the number of male rape victims. The evidence available suggests that males may be even less likely than female victims to report an assault to the authorities. There are a variety of reasons why male rape is under-reported, including shame, guilt and fear of not being believed or of being denounced for what has occurred. Myths and strong prejudices surrounding male sexuality also prevent men from coming forward.

Consequences of sexual violence

As is the case with female victims of sexual assault, research suggests that male victims are likely to suffer from a range of psychological consequences, both in the immediate period after the assault and over the longer term. These include guilt, anger, anxiety, depression, post-traumatic stress disorder, sexual dysfunction, somatic complaints, sleep disturbances, withdrawal from relationships and attempted suicide. In addition to these reactions, studies of adolescent males have also found an association between suffering rape and substance abuse, violent behaviour, stealing and absenteeism from school.

Prevention and policy responses

Prevention and policy responses to sexual violence against men need to be based on an understanding of the problem, its causes and the circumstances in which it occurs. In many countries the phenomenon is not adequately addressed in legislation. In addition, male rape is frequently not treated as an equal offence with rape of women.

Many of the considerations relating to support for women who have been raped — including an understanding of the healing process, the most urgent needs following an assault and the effectiveness of support services — are also relevant for men. Some countries have progressed in their response to male sexual assault, providing special telephone hotlines, counselling, support

BOX 6.1 (continued)

groups and other services for male victims. In many places, though, such services are either not available or else are very limited — for instance, focusing primarily on women, with few, if any, counsellors on hand who are experienced in discussing problems with male victims.

In most countries, there is much to be done before the issue of sexual violence against men and boys can be properly acknowledged and discussed, free of denial or shame. Such a necessary development, though, will enable more comprehensive prevention measures and better support for the victims to be implemented.

women and girls are illegally traded to India each year and trafficking of Thai women to Japan has also been reported (*32*). Trafficking of women also takes place internally within some countries, often from rural areas to cities.

North America is also an important destination for international trafficking. A study undertaken under the auspices of the United States Central Intelligence Agency, estimated that 45 000–50 000 women and children are trafficked annually to the United States (*63*). Over 150 cases of trafficking were prosecuted between 1996 and 1999 by the United States Department of Justice (*63*). The problem also exists in Europe. A study conducted by the International Organization for Migration estimated that 10–15% of 2000 known foreign prostitutes in Belgium had been forcibly sold from abroad (*30*). In Italy, a study of some 19 000–25 000 foreign prostitutes estimated that 2000 of them had been trafficked (*66*). Most of these women were under 25 years of age, many of them between 15 and 18 years (*30, 66*). Their origin was mainly central and eastern Europe, particularly Albania, as well as Colombia, Nigeria and Peru (*66*).

Sexual violence against sex workers

Whether trafficked or not, sex workers are at high risk for both physical and sexual violence, particularly where sex work is illegal (*67*). A survey of female sex workers in Leeds, England, and Glasgow and Edinburgh, Scotland, revealed that 30% had been slapped, punched or kicked by a client while working, 13% had been beaten, 11% had been raped and 22% had experienced an attempted rape (*68*). Only 34% of those who had suffered violence at the hands of a client reported it to police. A survey of sex workers in Bangladesh revealed that 49% of the women had been raped and 59% beaten by police in the previous year; the men reported much lower levels of violence (*69*). In Ethiopia, a study of sex workers also found high rates of physical and sexual violence from clients, especially against the child sex workers (*70*).

Sexual violence in schools, health care settings, armed conflicts and refugee settings

Schools

For many young women, the most common place where sexual coercion and harassment are experienced is in school. In an extreme case of violence in 1991, 71 teenage girls were raped by their classmates and 19 others were killed at a boarding school in Meru, Kenya (*71*). While much of the research in this field comes from Africa, it is not clear whether this reflects a particularly high prevalence of the problem or simply the fact that the problem has had a greater visibility there than in other parts of the world.

Harassment of girls by boys is in all likelihood a global problem. In Canada, for example, 23% of girls had experienced sexual harassment while attending school (*72*). The research done in Africa, however, has highlighted the role of teachers there in facilitating or perpetrating sexual coercion. A report by Africa Rights (*28*) found cases of schoolteachers attempting to gain sex, in return for good grades or for not failing pupils, in the Democratic Republic of the Congo, Ghana, Nigeria, Somalia, South Africa, Sudan, Zambia and Zimbabwe. A recent national survey in South Africa that included questions about experience of rape before the age of 15 years found that schoolteachers were

responsible for 32% of disclosed child rapes (*34*). In Zimbabwe, a retrospective study of reported cases of child sexual abuse over an 8-year period (1990–1997) found high rates of sexual abuse committed by teachers in rural primary schools. Many of the victims were girls between 11 and 13 years of age and penetrative sex was the most prevalent type of sexual abuse (*73*).

Health care settings

Sexual violence against patients in health facilities has been reported in many places (*74–79*). A study of physicians disciplined for sexual offences in the United States, for instance, found that the number of cases had increased from 42 in 1989 to 147 in 1996, with the proportion of all disciplinary action that was sex-related rising from 2.1% to 4.4% over the same period (*76*). This increase, though, could reflect a greater readiness to lodge complaints.

Other documented forms of sexual violence against female patients include the involvement of medical staff in the practice of clitoridectomy in Egypt (*80*), forced gynaecological examinations and the threat of forced abortions in China (*81*), and inspections of virginity in Turkey (*82*). Sexual violence is part of the broader problem of violence against women patients perpetrated by health workers that has been reported in a large number of countries and until recently has been much neglected (*83–87*). Sexual harassment of female nurses by male doctors has also been reported (*88, 89*).

Armed conflicts and refugee settings

Rape has been used as a strategy in many conflicts, including in Korea during the Second World War and in Bangladesh during the war of independence, as well as in a range of armed conflicts such as those in Algeria (*90*), India (Kashmir) (*91*), Indonesia (*92*), Liberia (*29*), Rwanda and Uganda (*93*). In some armed conflicts – for example, the ones in Rwanda and the states of the former Yugoslavia – rape has been used as a deliberate strategy to subvert community bonds and thus the perceived enemy, and furthermore as a tool of ''ethnic cleansing''. In East Timor, there were reports of extensive sexual violence against women by the Indonesian military (*94*).

A study in Monrovia, Liberia, found that women under 25 years were more likely than those aged 25 years and over to report experiencing attempted rape and sexual coercion during the conflict (18% compared with 4%) (*29*). Women who were forced to cook for a warring faction were at significantly higher risk.

Another inevitable consequence of armed conflicts is the ensuing economic and social disruption which can force large numbers of people into prostitution (*94*), an observation that applies equally to the situation of refugees, whether they are fleeing armed conflicts or natural disasters such as floods, earthquakes or powerful storms.

Refugees fleeing conflicts and other threatening conditions are often at risk of rape in their new setting. Data from the Office of the United Nations High Commissioner for Refugees, for instance, indicated that among the ''boat people'' who fled Viet Nam in the late 1970s and early 1980s, 39% of the women were abducted or raped by pirates while at sea – a figure that is likely to be an underestimate (*27*). In many refugee camps as well, including those in Kenya and the United Republic of Tanzania, rape has been found to be a major problem (*95, 96*).

''Customary'' forms of sexual violence

Child marriage

Marriage is often used to legitimize a range of forms of sexual violence against women. The custom of marrying off young children, particularly girls, is found in many parts of the world. This practice – legal in many countries – is a form of sexual violence, since the children involved are unable to give or withhold their consent. The majority of them know little or nothing about sex before they are married. They therefore frequently fear it (*97*) and their first sexual encounters are often forced (*98*).

Early marriage is most common in Africa and South Asia, though it also occurs in the Middle East and parts of Latin America and Eastern Europe (*99, 100*). In Ethiopia and parts of West Africa, for instance, marriage at the age of 7 or 8 years is not

uncommon. In Nigeria, the mean age at first marriage is 17 years, but in the Kebbi State of northern Nigeria, the average age at first marriage is just over 11 years (*100*). High rates of child marriage have also been reported in the Democratic Republic of the Congo, Mali, Niger and Uganda (*99, 100*).

In South Asia, child marriage is especially common in rural areas, but exists also in urban areas (*100–102*). In Nepal, the average age at first marriage is 19 years. Seven per cent of girls, though, are married before the age of 10 years, and 40% by the age of 15 years (*100*). In India, the median age at first marriage for women is 16.4 years. A survey of 5000 women in the Indian state of Rajasthan found that 56% of the women had married before the age of 15 years, and of these, 17% were married before they were 10 years old. Another survey, conducted in the state of Madhya Pradesh, found that 14% of girls were married between the ages of 10 and 14 years (*100*).

Elsewhere, in Latin America for instance, early age at first marriage has been reported in Cuba, Guatemala, Honduras, Mexico and Paraguay (*99, 100*). In North America and Western Europe, less than 5% of marriages involve girls younger than 19 years of age (for example, 1% in Canada, Switzerland and the United Kingdom, 2% in Belgium and Germany, 3% in Spain, and 4% in the United States) (*103*).

Other customs leading to violence

In many places, there are customs other than child marriage that result in sexual violence towards women. In Zimbabwe, for instance, there is the custom of *ngozi*, whereby a girl can be given to a family as compensation for a death of a man caused by a member of the girl's family. On reaching puberty the girl is expected to have sexual intercourse with the brother or father of the deceased person, so as to produce a son to replace the one who died. Another custom is *chimutsa mapfiwa* – wife inheritance – according to which, when a married woman dies, her sister is obliged to replace her in the matrimonial home.

What are the risk factors for sexual violence?

Explaining sexual violence against women is complicated by the multiple forms it takes and contexts in which it occurs. There is considerable overlap between forms of sexual violence and intimate partner violence; many of the causes are similar to those already discussed in Chapter 4. There are factors increasing the risk of someone being coerced into sex, factors increasing the risk of an individual man forcing sex on another person, and factors within the social environment – including peers and family – influencing the likelihood of rape and the reaction to it. Research suggests that the various factors have an additive effect, so that the more factors present, the greater the likelihood of sexual violence. In addition, a particular factor may vary in importance according to the life stage.

Factors increasing women's vulnerability

One of the most common forms of sexual violence around the world is that which is perpetrated by an intimate partner, leading to the conclusion that one of the most important risk factors for women – in terms of their vulnerability to sexual assault – is being married or cohabiting with a partner. Other factors influencing the risk of sexual violence include:

- being young;
- consuming alcohol or drugs;
- having previously been raped or sexually abused;
- having many sexual partners;
- involvement in sex work;
- becoming more educated and economically empowered, at least where sexual violence perpetrated by an intimate partner is concerned;
- poverty.

Age

Young women are usually found to be more at risk of rape than older women (*24, 62, 104*). According to data from justice systems and rape crisis centres in Chile, Malaysia, Mexico, Papua New Guinea, Peru and the United States, between

one-third and two-thirds of all victims of sexual assault are aged 15 years or less (*62, 104*). Certain forms of sexual violence, for instance, are very closely associated with a young age, in particular violence taking place in schools and colleges, and trafficking in women for sexual exploitation.

Alcohol and drug consumption

Increased vulnerability to sexual violence also stems from the use of alcohol and other drugs. Consuming alcohol or drugs makes it more difficult for women to protect themselves by interpreting and effectively acting on warning signs. Drinking alcohol may also place women in settings where their chances of encountering a potential offender are greater (*105*).

Having previously been raped or sexually abused

There is some evidence linking experiences of sexual abuse in childhood or adolescence with patterns of victimization during adulthood (*24, 37, 105–108*). A national study of violence against women in the United States found that women who were raped before the age of 18 years were twice as likely to be raped as adults, compared with those who were not raped as children or adolescents (18.3% and 8.7%, respectively) (*37*). The effects of early sexual abuse may also extend to other forms of victimization and problems in adulthood. For instance, a case–control study in Australia on the long-term impact of abuse reported significant associations between child sexual abuse and experiencing rape, sexual and mental health problems, domestic violence and other problems in intimate relationships – even after accounting for various family background characteristics (*108*). Those who had experienced abuse involving intercourse had more negative outcomes than those suffering other types of coercion.

Having many sexual partners

Young women who have many sexual partners are at increased risk of sexual violence (*105, 107, 109*). It is not clear, though, if having more sexual partners is a cause or consequence of abuse, including childhood sexual abuse. For example, findings from a representative sample of men and women in León, Nicaragua, found that women who had experienced attempted or completed rape during childhood or adolescence were more likely to have a higher number of sexual partners in adulthood, compared with non-abused or moderately abused women (*110*). Similar findings have been reported in longitudinal studies of young women in New Zealand and Norway (*107, 109*).

Educational level

Women are at increased risk of sexual violence, as they are of physical violence by an intimate partner, when they become more educated and thus more empowered. Women with no education were found in a national survey in South Africa to be much less likely to experience sexual violence than those with higher levels of education (*34*). In Zimbabwe, women who were working were much more likely to report forced sex by a spouse than those who were not (*42*). The likely explanation is that greater empowerment brings with it more resistance from women to patriarchal norms (*111*), so that men may resort to violence in an attempt to regain control. The relationship between empowerment and physical violence is an inverted U-shape – with greater empowerment conferring greater risk up to a certain level, beyond which it starts to become protective (*105, 112*). It is not known, though, whether this is also the case for sexual violence.

Poverty

Poor women and girls may be more at risk of rape in the course of their daily tasks than those who are better off, for example when they walk home on their own from work late at night, or work in the fields or collect firewood alone. Children of poor women may have less parental supervision when not in school, since their mothers may be at work and unable to afford child care. The children themselves may, in fact, be working and thus vulnerable to sexual exploitation.

Poverty forces many women and girls into occupations that carry a relatively high risk of sexual violence (*113*), particularly sex work (*114*). It also creates enormous pressures for them to find

TABLE 6.4
Factors increasing men's risk of committing rape

Individual factors	Relationship factors	Community factors	Societal factors
• Alcohol and drug use • Coercive sexual fantasies and other attitudes and beliefs supportive of sexual violence • Impulsive and antisocial tendencies • Preference for impersonal sex • Hostility towards women • History of sexual abuse as a child • Witnessed family violence as a child	• Associate with sexually aggressive and delinquent peers • Family environment characterized by physical violence and few resources • Strongly patriarchal relationship or family environment • Emotionally unsupportive family environment • Family honour considered more important than the health and safety of the victim	• Poverty, mediated through forms of crisis of male identity • Lack of employment opportunities • Lack of institutional support from police and judicial system • General tolerance of sexual assault within the community • Weak community sanctions against perpetrators of sexual violence	• Societal norms supportive of sexual violence • Societal norms supportive of male superiority and sexual entitlement • Weak laws and policies related to sexual violence • Weak laws and policies related to gender equality • High levels of crime and other forms of violence

or maintain jobs, to pursue trading activities and, if studying, to obtain good grades – all of which render them vulnerable to sexual coercion from those who can promise these things (*28*). Poorer women are also more at risk of intimate partner violence, of which sexual violence is often a manifestation (*41, 115*).

Factors increasing men's risk of committing rape

Data on sexually violent men are somewhat limited and heavily biased towards apprehended rapists, except in the United States, where research has also been conducted on male college students. Despite the limited amount of information on sexually violent men, it appears that sexual violence is found in almost all countries (though with differences in prevalence), in all socioeconomic classes and in all age groups from childhood onwards. Data on sexually violent men also show that most direct their acts at women whom they already know (*116, 117*). Among the factors increasing the risk of a man committing rape are those related to attitudes and beliefs, as well as behaviour arising from situations and social conditions that provide opportunities and support for abuse (see Table 6.4).

Alcohol and drug consumption

Alcohol has been shown to play a disinhibiting role in certain types of sexual assault (*118*), as have some drugs, notably cocaine (*119*). Alcohol has a psychopharmacological effect of reducing inhibitions, clouding judgements and impairing the ability to interpret cues (*120*). The biological links between alcohol and violence are, however, complex (*118*). Research on the social anthropology of alcohol consumption suggests that connections between violence, drinking and drunkenness are socially learnt rather than universal (*121*). Some researchers have noted that alcohol may act as a cultural ''break time'', providing the opportunity for antisocial behaviour. Thus men are more likely to act violently when drunk because they do not consider that they will be held accountable for their behaviour. Some forms of group sexual violence are also associated with drinking. In these settings, consuming alcohol is an act of group bonding, where inhibitions are collectively reduced and individual judgement ceded in favour of that of the group.

Psychological factors

There has been considerable research in recent times on the role of cognitive variables among the set of factors that can lead to rape. Sexually violent men have been shown to be more likely to consider victims responsible for the rape and are less knowledgeable about the impact of rape on victims (*122*). Such men may misread cues given out by women in social situations and may lack the inhibitions that act to suppress associations between

sex and aggression (*122, 123*). They have coercive sexual fantasies (*122, 123*), generally encouraged by access to pornography (*124*), and overall are more hostile towards women than men who are not sexually violent (*106, 125, 126*). In addition to these factors, sexually violent men are believed to differ from other men in terms of impulsivity and antisocial tendencies (*105*). They also tend to have an exaggerated sense of masculinity.

Sexual violence is also associated with a preference for impersonal sexual relationships as opposed to emotional bonding, with having many sexual partners and with the inclination to assert personal interests at the expense of others (*125, 127*). A further association is with adversarial attitudes on gender, that hold that women are opponents to be challenged and conquered (*128*).

Peer and family factors

Gang rape

Some forms of sexual violence, such as gang rape, are predominantly committed by young men (*129*). Sexual aggression is often a defining characteristic of manhood in the group and is significantly related to the wish to be held in high esteem (*130*). Sexually aggressive behaviour among young men has been linked with gang membership and having delinquent peers (*126, 131*). Research also suggests that men with sexually aggressive peers are also much more likely to report coercive or enforced intercourse outside the gang context than men lacking sexually aggressive peers (*132*).

Gang rape is often viewed by the men involved, and sometimes by others too, as legitimate, in that it is seen to discourage or punish perceived ''immoral'' behaviour among woman – such as wearing short skirts or frequenting bars. For this reason, it may not be equated by the perpetrators with the idea of a crime. In several areas in Papua New Guinea, women can be punished by public gang rape, often sanctioned by elders (*133*).

Early childhood environments

There is evidence to suggest that sexual violence is also a learnt behaviour in some men, particularly as regards child sexual abuse. Studies on sexually abused boys have shown that around one in five continue in later life to molest children themselves (*134*). Such experiences may lead to a pattern of behaviour where the man regularly justifies being violent, denies doing wrong, and has false and unhealthy notions about sexuality.

Childhood environments that are physically violent, emotionally unsupportive and characterized by competition for scarce resources have been associated with sexual violence (*105, 126, 131, 135*). Sexually aggressive behaviour in young men, for instance, has been linked to witnessing family violence, and having emotionally distant and uncaring fathers (*126, 131*). Men raised in families with strongly patriarchal structures are also more likely to become violent, to rape and use sexual coercion against women, as well as to abuse their intimate partners, than men raised in homes that are more egalitarian (*105*).

Family honour and sexual purity

Another factor involving social relationships is a family response to sexual violence that blames women without punishing men, concentrating instead on restoring ''lost'' family honour. Such a response creates an environment in which rape can occur with impunity.

While families will often try to protect their women from rape and may also put their daughters on contraception to prevent visible signs should it occur (*136*), there is rarely much social pressure to control young men or persuade them that coercing sex is wrong. Instead, in some countries, there is frequently support for family members to do whatever is necessary – including murder – to alleviate the ''shame'' associated with a rape or other sexual transgression. In a review of all crimes of honour occurring in Jordan in 1995 (*137*), researchers found that in over 60% of the cases, the victim died from multiple gunshot wounds – mostly at the hands of a brother. In cases where the victim was a single pregnant female, the offender was either acquitted of murder or received a reduced sentence.

Even though poverty is often the driving force behind child marriage, factors such as maintaining

the sexual purity of a young girl and protecting her from premarital sex, HIV infection and unwelcome sexual advances are also reasons commonly given by families to justify such marriages (*100*).

Community factors

Poverty

Poverty is linked to both the perpetration of sexual violence and the risk of being a victim of it. Several authors have argued that the relationship between poverty and perpetration of sexual violence is mediated through forms of crisis of masculine identity (*95, 112, 138–140*). Bourgois, writing about life in East Harlem, New York, United States (*138*), described how young men felt pressured by models of ''successful'' masculinity and family structure passed down from their parents' and grandparents' generations, together with modern-day ideals of manhood that also place an emphasis on material consumption. Trapped in their slums, with little or no available employment, they are unlikely to attain either of these models or expectations of masculine ''success''. In these circumstances, ideals of masculinity are reshaped to emphasize misogyny, substance abuse and participation in crime (*138*) – and often also xenophobia and racism. Gang rape and sexual conquest are normalized, as men turn their aggression against women they can no longer control patriarchally or support economically.

Physical and social environment

While fear of rape is typically associated with being outside the home (*141, 142*), the great majority of sexual violence actually occurs in the home of the victim or the abuser. Nonetheless, abduction by a stranger is quite often the prelude to a rape and the opportunities for such an abduction are influenced by the physical environment.

The social environment within a community is, however, usually more important than the physical surrounding. How deeply entrenched in a community beliefs in male superiority and male entitlement to sex are will greatly affect the likelihood of sexual violence taking place, as will the general tolerance in the community of sexual assault and the strength of sanctions, if any, against perpetrators (*116, 143*). For instance, in some places, rape can even occur in public, with passers-by refusing to intervene (*133*). Complaints of rape may also be treated leniently by the police, particularly if the assault is committed during a date or by the victim's husband. Where police investigations and court cases do proceed, the procedures may well be either extremely lax or else corrupt – for instance, with legal papers being ''lost'' in return for a bribe.

Societal factors

Factors operating at a societal level that influence sexual violence include laws and national policies relating to gender equality in general and to sexual violence more specifically, as well as norms relating to the use of violence. While the various factors operate largely at local level, within families, schools, workplaces and communities, there are also influences from the laws and norms working at national and even international level.

Laws and policies

There are considerable variations between countries in their approach to sexual violence. Some countries have far-reaching legislation and legal procedures, with a broad definition of rape that includes marital rape, and with heavy penalties for those convicted and a strong response in supporting victims. Commitment to preventing or controlling sexual violence is also reflected in an emphasis on police training and an appropriate allocation of police resources to the problem, in the priority given to investigating cases of sexual assault, and in the resources made available to support victims and provide medico-legal services. At the other end of the scale, there are countries with much weaker approaches to the issue – where conviction of an alleged perpetrator on the evidence of the women alone is not allowed, where certain forms or settings of sexual violence are specifically excluded from the legal definition, and where rape victims are strongly deterred from bringing the matter to court through the fear of being punished for filing an ''unproven'' rape suit.

Social norms

Sexual violence committed by men is to a large extent rooted in ideologies of male sexual entitlement. These belief systems grant women extremely few legitimate options to refuse sexual advances (*139, 144, 145*). Many men thus simply exclude the possibility that their sexual advances towards a woman might be rejected or that a woman has the right to make an autonomous decision about participating in sex. In many cultures women, as well as men, regard marriage as entailing the obligation on women to be sexually available virtually without limit (*34, 146*), though sex may be culturally proscribed at certain times, such as after childbirth or during menstruation (*147*).

Societal norms around the use of violence as a means to achieve objectives have been strongly associated with the prevalence of rape. In societies where the ideology of male superiority is strong – emphasizing dominance, physical strength and male honour – rape is more common (*148*). Countries with a culture of violence, or where violent conflict is taking place, experience an increase in almost all forms of violence, including sexual violence (*148–151*).

Global trends and economic factors

Many of the factors operating at a national level have an international dimension. Global trends, for instance towards free trade, have been accompanied by an increase in the movement around the world of women and girls for labour, including for sex work (*152*). Economic structural adjustment programmes, drawn up by international agencies, have accentuated poverty and unemployment in a number of countries, thereby increasing the likelihood of sexual trafficking and sexual violence (*153*) – something particularly noted in Central America, the Caribbean (*114*) and parts of Africa (*113*).

The consequences of sexual violence

Physical force is not necessarily used in rape, and physical injuries are not always a consequence. Deaths associated with rape are known to occur, though the prevalence of fatalities varies considerably across the world. Among the more common consequences of sexual violence are those related to reproductive, mental health and social well-being.

Pregnancy and gynaecological complications

Pregnancy may result from rape, though the rate varies between settings and depends particularly on the extent to which non-barrier contraceptives are being used. A study of adolescents in Ethiopia found that among those who reported being raped, 17% became pregnant after the rape (*154*), a figure which is similar to the 15–18% reported by rape crisis centres in Mexico (*155, 156*). A longitudinal study in the United States of over 4000 women followed for 3 years found that the national rape-related pregnancy rate was 5.0% per rape among victims aged 12–45 years, producing over 32 000 pregnancies nationally among women from rape each year (*7*). In many countries, women who have been raped are forced to bear the child or else put their lives at risk with back-street abortions.

Experience of coerced sex at an early age reduces a woman's ability to see her sexuality as something over which she has control. As a result, it is less likely that an adolescent girl who has been forced into sex will use condoms or other forms of contraception, increasing the likelihood of her becoming pregnant (*4, 16, 157, 158*). A study of factors associated with teenage pregnancy in Cape Town, South Africa, found that forced sexual initiation was the third most strongly related factor, after frequency of intercourse and use of modern contraceptives (*4*). Forced sex can also result in unintended pregnancy among adult women. In India, a study of married men revealed that men who admitted forcing sex on their wives were 2.6 times more likely to have caused an unintended pregnancy than those who did not admit to such behaviour (*41*).

Gynaecological complications have been consistently found to be related to forced sex. These include vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain and urinary tract infections (*8–15*). Women who experience

both physical and sexual abuse from intimate partners are at higher risk of health problems generally than those experiencing physical violence alone (*8, 14*).

Sexually transmitted diseases

HIV infection and other sexually transmitted diseases are recognized consequences of rape (*159*). Research on women in shelters has shown that women who experience both sexual and physical abuse from intimate partners are significantly more likely to have had sexually transmitted diseases (*160*). For women who have been trafficked into sex work, the risks of HIV and other sexually transmitted diseases are likely to be particularly high. The links between HIV and sexual violence, and the relevant prevention strategies, are discussed in Box 6.2.

Mental health

Sexual violence has been associated with a number of mental health and behavioural problems in adolescence and adulthood (*17–20, 22, 23, 161*). In one population-based study, the prevalence of symptoms or signs suggestive of a psychiatric disorder was 33% in women with a history of sexual abuse as adults, 15% in women with a history of physical violence by an intimate partner and 6% in non-abused women (*162*). Sexual violence by an intimate partner aggravates the effects of physical violence on mental health.

Abused women reporting experiences of forced sex are at significantly greater risk of depression and post-traumatic stress disorder than non-abused women (*14, 18, 22, 23*). Post-traumatic stress disorder after rape is more likely if there is injury during the rape, or a history of depression or alcohol abuse (*24*). A study of adolescents in France also found a relationship between having been raped and current sleep difficulties, depressive symptoms, somatic complaints, tobacco consumption and behavioural problems (such as aggressive behaviour, theft and truancy) (*163*). In the absence of trauma counselling, negative psychological effects have been known to persist for at least a year following a rape, while physical health problems and symptoms tend to decrease over such a period (*164*). Even with counselling, up to 50% of women retain symptoms of stress (*165–167*).

Suicidal behaviour

Women who experience sexual assault in childhood or adulthood are more likely to attempt or commit suicide than other women (*21, 168–173*). The association remains, even after controlling for sex, age, education, symptoms of post-traumatic stress disorder and the presence of psychiatric disorders (*168, 174*). The experience of being raped or sexually assaulted can lead to suicidal behaviour as early as adolescence. In Ethiopia, 6% of raped schoolgirls reported having attempted suicide (*154*). A study of adolescents in Brazil found prior sexual abuse to be a leading factor predicting several health risk behaviours, including suicidal thoughts and attempts (*161*).

Experiences of severe sexual harassment can also result in emotional disturbances and suicidal behaviour. A study of female adolescents in Canada found that 15% of those experiencing frequent, unwanted sexual contact had exhibited suicidal behaviour in the previous 6 months, compared with 2% of those who had not had such harassment (*72*).

Social ostracization

In many cultural settings it is held that men are unable to control their sexual urges and that women are responsible for provoking sexual desire in men (*144*). How families and communities react to acts of rape in such settings is governed by prevailing ideas about sexuality and the status of women.

In some societies, the cultural ''solution'' to rape is that the woman should marry the rapist, thereby preserving the integrity of the woman and her family by legitimizing the union (*175*). Such a ''solution'' is reflected in the laws of some countries, which allow a man who commits rape to be excused his crime if he marries the victim (*100*). Apart from marriage, families may put pressure on the woman not to report or pursue a case or else to concentrate on

BOX 6.2

Sexual violence and HIV/AIDS

Violent or forced sex can increase the risk of transmitting HIV. In forced vaginal penetration, abrasions and cuts commonly occur, thus facilitating the entry of the virus — when it is present — through the vaginal mucosa. Adolescent girls are particularly susceptible to HIV infection through forced sex, and even through unforced sex, because their vaginal mucous membrane has not yet acquired the cellular density providing an effective barrier that develops in the later teenage years. Those who suffer anal rape — boys and men, as well as girls and women — are also considerably more susceptible to HIV than would be the case if the sex were not forced, since anal tissues can be easily damaged, again allowing the virus an easier entry into the body.

Being a victim of sexual violence and being susceptible to HIV share a number of risk behaviours. Forced sex in childhood or adolescence, for instance, increases the likelihood of engaging in unprotected sex, having multiple partners, participating in sex work, and substance abuse. People who experience forced sex in intimate relationships often find it difficult to negotiate condom use — either because using a condom could be interpreted as mistrust of their partner or as an admission of promiscuity, or else because they fear experiencing violence from their partner. Sexual coercion among adolescents and adults is also associated with low self-esteem and depression — factors that are associated with many of the risk behaviours for HIV infection.

Being infected with HIV or having an HIV-positive family member can also increase the risk of suffering sexual violence, particularly for women. Because of the stigma attached to HIV and AIDS in many countries, an infected woman may be evicted from her home. In addition, an AIDS-related illness or death in a poor household may make the economic situation desperate. Women may be forced into sex work and consequently be at increased risk for both HIV/AIDS and sexual violence. Children orphaned by AIDS, impoverished and with no one to care for them, may be forced to live on the streets, at considerable risk of sexual abuse.

Among the various ways of reducing the incidence of both sexual violence and HIV infection, education is perhaps the foremost. For young people, above all, there must be comprehensive interventions in schools and other educational institutes, youth groups and workplaces. School curricula should cover relevant aspects of sexual and reproductive health, relationships and violence. They should also teach life skills, including how to avoid risky or threatening situations — related to such things as violence, sex or drugs — and how to negotiate safe sexual behaviour.

For the adult population in general there should be full and accessible information on sexual health and the consequences of specific sexual practices, as well as interventions to change harmful patterns of behaviour and social norms that hinder communication on sexual matters.

It is important that health care workers and other service providers receive integrated training on gender and reproductive health, including gender-based violence and sexually transmitted diseases such as HIV infection.

For rape victims, there should be screening and referral for HIV infection. Also, the use of postexposure prophylaxis for HIV — given soon after the assault, together with counselling — may be considered. Similarly, women with HIV should be screened for a possible history of sexual violence. Voluntary counselling programmes for HIV should consider incorporating violence prevention strategies.

obtaining financial ''damages'' from the rapist's family (*42, 176*). Men may reject their wives if they have been raped (*27*) and in some countries, as mentioned previously, restoring lost honour calls for the woman to be cast out – or in extreme cases, murdered (*26*).

What can be done to prevent sexual violence?

The number of initiatives addressing sexual violence is limited and few have been evaluated. Most interventions have been developed and implemented in industrialized countries. How relevant they may be in other settings is not well known. The interventions that have been developed can be categorized as follows.

Individual approaches

Psychological care and support

Counselling, therapy and support group initiatives have been found to be helpful following sexual assaults, especially where there may be complicating factors related to the violence itself or the process of recovery. There is some evidence that a brief cognitive-behavioural programme administered shortly after assault can hasten the rate of improvement of psychological damage arising from trauma (*177, 178*). As already mentioned, victims of sexual violence sometimes blame themselves for the incident, and addressing this in psychological therapy has also been shown to be important for recovery (*179*). Short-term counselling and treatment programmes after acts of sexual violence, though, require considerable further evaluation.

Formal psychological support for those experiencing sexual violence has been provided largely by the nongovernmental sector, particularly rape crisis centres and various women's organizations. Inevitably, the number of victims of sexual violence with access to these services is small. One solution to extend access is through establishing telephone helplines, ideally ones that are free of charge. A ''Stop Woman Abuse'' helpline in South Africa, for example, answered 150 000 calls in the first 5 months of operation (*180*).

Programmes for perpetrators

The few programmes targeting perpetrators of sexual violence have generally been aimed at men convicted of assault. They are found mainly in industrialized countries and have only recently begun to be evaluated (see Chapter 4 for a discussion of such programmes). A common response of men who commit sexual violence is to deny both that they are responsible and that what they are doing is violent (*146, 181*). To be effective, programmes working with perpetrators need to make them admit responsibility and to be publicly seen as responsible for their actions (*182*). One way of achieving this is for programmes that target male perpetrators of sexual violence to collaborate with support services for victims as well as with campaigns against sexual violence.

Life-skills and other educational programmes

In recent years, several programmes for sexual and reproductive health promotion, particularly those promoting HIV prevention, have begun to introduce gender issues and to address the problem of sexual and physical violence against women. Two notable examples – developed for Africa but used in many parts of the developing world – are ''Stepping Stones'' and ''Men As Partners'' (*183, 184*). These programmes have been designed for use in peer groups of men and women and are delivered over several workshop sessions using participatory learning approaches. Their comprehensive approach helps men, who might otherwise be reluctant to attend programmes solely concerned with violence against women, participate and discuss a range of issues concerning violence. Furthermore, even if the men are perpetrators of sexual violence, the programmes are careful to avoid labelling them as such.

A review of the effect of the Stepping Stones programme in Africa and Asia found that the workshops helped the men participating take greater responsibility for their actions, relate better to others, have greater respect for women and communicate more effectively. As a result of the programme, reductions in violence against women have been reported in communities in Cambodia, the Gambia, South Africa, Uganda and the United Republic of Tanzania. The evaluations to date, though, have generally used qualitative methods and further research is needed to adequately test the effectiveness of this programme (*185*).

Developmental approaches

Research has stressed the importance of encouraging nurturing, with better and more gender-balanced parenting, to prevent sexual violence (*124, 125*). At the same time, Schwartz (*186*) has developed a prevention model that adopts a developmental approach, with interventions before birth, during childhood and in adolescence and young adulthood. In this model, the prenatal element would include discussions of parenting skills, the stereotyping of gender roles, stress, conflict and violence. In the early years of childhood, health providers would pursue these issues and introduce child sexual abuse and exposure to violence in the media to the list of discussion topics, as well as promoting the use of non-sexist educational materials. In later childhood, health promotion would include modelling behaviours and attitudes that avoid stereotyping, encouraging children to distinguish between ''good'' and ''bad'' touching, and enhancing their ability and confidence to take control over their own bodies. This intervention would allow room for talking about sexual aggression. During adolescence and young adulthood, discussions would cover myths about rape, how to set boundaries for sexual activity, and breaking the links between sex, violence and coercion. While Schwartz's model was designed for use in industrialized countries, some of the principles involved could be applicable to developing countries.

Health care responses

Medico-legal services

In many countries, where sexual violence is reported the health sector has the duty to collect medical and legal evidence to corroborate the accounts of the victims or to help in identifying the perpetrator. Research in Canada suggests that medico-legal documentation can increase the chance of a perpetrator being arrested, charged or convicted (*187, 188*). For instance, one study found that documented physical injury, particularly of the moderate to severe type, was associated with charges being filed – irrespective of the patient's income level or whether the patient knew the assailant, either as an acquaintance or an intimate partner (*188*). However, a study of women attending a hospital in Nairobi, Kenya, following a rape, has highlighted the fact that in many countries rape victims are not examined by a gynaecologist or an experienced police examiner and that no standard protocols or guidelines exist on this matter (*189*).

The use of standard protocols and guidelines can significantly improve the quality of treatment and psychological support of victims, as well as the evidence that is collected (*190*). Comprehensive protocols and guidelines for female victims of assault should include:

- recording a full description of the incident, listing all the assembled evidence;
- listing the gynaecological and contraceptive history of the victim;
- documenting in a standard way the results of a full physical examination;
- assessment of the risk of pregnancy;
- testing for and treating sexually transmitted diseases, including, where appropriate, testing for HIV;
- providing emergency contraception and, where legal, counselling on abortion;
- providing psychological support and referral.

In some countries, the protocol forms part of the procedure of a ''sexual assault evidence kit'' that includes instructions and containers for collecting evidence, appropriate legal forms and documents for recording histories (*191*). Examinations of rape victims are by their nature extremely stressful. The use of a video to explain the procedure before an examination has been shown significantly to reduce the stress involved (*192*).

Training for health care professionals

Issues concerning sexual violence need to be addressed in the training of all health service staff, including psychiatrists and counsellors, in basic training as well as in specialized postgraduate courses. Such training should, in the first place, give health care workers greater knowledge and awareness of sexual violence and make them more able to detect and handle cases of abuse in a sensitive but

effective way. It should also help reduce instances of sexual abuse within the health sector, something that can be a significant, though generally unacknowledged, problem.

In the Philippines, the Task Force on Social Science and Reproductive Health, a body that includes doctors, nurses and social scientists and is supported by the Department of Health, has produced training modules for nursing and medical students on gender-based violence. The aims of this programme are (*193*):

- To understand the roots of violence in the context of culture, gender and other social aspects.
- To identify situations, within families or homes that are at a high risk for violence, where it would be appropriate to undertake:
  - — primary interventions, in particular in collaboration with other professionals;
  - — secondary interventions, including identifying victims of violence, understanding basic legal procedures and how to present evidence, referring and following up patients, and helping victims reintegrate into society.

These training modules are built into the curricula for both nursing and medical students. For the nursing curriculum, the eleven modules are spread over the 4 years of formal instruction, and for medical students over their final 3 years of practical training.

Prophylaxis for HIV infection

The possibility of transmission of HIV during rape is a major cause for concern, especially in countries with a high prevalence of HIV infection (*194*). The use of antiretroviral drugs following exposure to HIV is known in certain contexts to be reasonably effective. For instance, the administration of the antiretroviral drug zidovudine (AZT) to health workers following an occupational needle-stick exposure (puncturing the skin with a contaminated needle) has been shown to reduce the subsequent risk of developing HIV infection by 81% (*195*).

The average risk of HIV infection from a single act of unprotected vaginal sex with an infected partner is relatively low (approximately 1–2 per 1000, from male to female, and around 0.5–1 per 1000 from female to male). This risk, in fact, is of a similar order to that from a needle-stick injury (around 3 per 1000), for which postexposure prophylaxis is now routine treatment (*196*). The average risk of HIV infection from unprotected anal sex is considerably higher, though, at around 5–30 per 1000. However, during rape, because of the force used, it is very much more likely that there will be macroscopic or microscopic tears to the vaginal mucosa, something that will greatly increase the probability of HIV transmission (*194*).

There is no information about the feasibility or cost-effectiveness in resource-poor settings of routinely offering rape victims prophylaxis for HIV. Testing for HIV infection after rape is difficult in any case. In the immediate aftermath of an incident, many women are not in a position fully to comprehend complicated information about HIV testing and risks. Ensuring proper follow-up is also difficult as many victims will not attend further scheduled visits for reasons that probably relate to their psychological coping following the assault. The side-effects of antiretroviral treatment may also be significant, causing people to drop out from a course (*195, 197*), though those who perceive themselves as being at high risk are much more likely to be compliant (*197*).

Despite the lack of knowledge about the effectiveness of HIV prophylaxis following rape, many organizations have recommended its use. For instance, medical aid schemes in high-income countries are increasingly including it in their care packages. Research is urgently needed in middle-income and low-income countries on the effectiveness of antiretroviral treatment after rape and how it could be included in patient care.

Centres providing comprehensive care to victims of sexual assault

Because of the shortage of doctors in many countries, specially trained nurses have been used in some places to assist victims of sexual assault (*187*). In Canada, nurses, known as ''sexual assault nurse examiners'', are trained to provide

comprehensive care to victims of sexual violence. These nurses refer clients to a physician when medical intervention is needed. In the province of Ontario, Canada, the first sexual assault care centre opened in 1984 and since then 26 others have been established. These centres provide or coordinate a wide range of services, including emergency medical care and medical follow-up, counselling, collecting forensic evidence of assault, legal support, and community consultation and education (*198*). Centres that provide a range of services for victims of sexual assault, often located in places such as a hospital or police station, are being developed in many countries (see Box 6.3). Specialized centres such as these have the advantage of providing appropriately trained and experienced staff. In some places, on the other hand, integrated centres exist providing services for victims of different forms of violence.

Community-based efforts

Prevention campaigns

Attempts to change public attitudes towards sexual violence using the media have included advertising on hoardings (''billboards'') and in public transport, and on radio and television. Television has been used effectively in South Africa and Zimbabwe. The South African prime-time television series *Soul City* is described in Box 9.1 of Chapter 9. In Zimbabwe, the nongovernmental organization Musasa has produced awareness-raising initiatives using theatre, public meetings and debates, as well as a television series where survivors of violence described their experiences (*199*).

Other initiatives, besides media campaigns, have been used in many countries. The Sisterhood Is Global Institute in Montreal, Canada, for instance, has developed a manual suitable for Muslim communities aimed at raising awareness and

BOX 6.3

Integrated services for rape victims in Malaysian hospitals

In 1993, the first ''One-Stop Crisis Centre'' for battered women was established in the accident and emergency department of Kuala Lumpur Hospital in Malaysia. Its aim was to provide a coordinated interagency response to violence against women, in such a way as to enable victims of assault to address their medical, legal, psychological and social problems at a single location. Initially, the centre dealt exclusively with domestic violence, but has since extended its scope to cover rape, with specific procedures for victims of rape.

At Kuala Lumpur Hospital, a crisis intervention team handles around 30 rape cases and 70 cases of domestic violence each month. This team brings in expertise from the hospital itself and from various women's groups, the police, the department of medical social workers, the legal aid office and the Islamic Religious Bureau.

In 1996, the Malaysian Ministry of Health decided to extend this innovative health care strategy and to establish similar centres in every public hospital of the country. Within 3 years, 34 such centres had been set up. In these centres, psychiatrists, counsellors and medical social workers carry out counselling on rape, and some of the clients become outpatients in the hospital's psychiatric department. Trained social workers need to be on call 24 hours a day.

As the ''One-Stop Crisis Centre'' programme developed, various problems came to light. One was the need for hospital staff to be better trained in handling issues of sexual violence with sensitivity. Some hospital workers were seen to blame victims of rape for the violence they had suffered, while others regarded the victims with voyeuristic curiosity instead of concentrating on providing support. There was also a lack of forensic medical officers and of sufficient sheltered accommodation for rape victims. Identifying these problems was an important first step towards improving the programme and providing a higher quality of service for rape victims.

stimulating debate on issues related to gender equality and violence against women and girls (*200*). The manual has been pilot-tested in Egypt, Jordan and Lebanon and – in an adaptation for non-Muslim settings – used in Zimbabwe.

A United Nations interagency initiative to combat gender-based violence is being conducted in 16 countries of Latin America and the Caribbean (*201*). The campaign is designed:

— to raise awareness about the human, social and economic costs of violence against women and girls;

— to build capacity at the governmental level to develop and implement legislation against gender violence;

— to strengthen networks of public and private organizations and carry out programmes to prevent violence against women and girls.

Community activism by men

An important element in preventing sexual and physical violence against women is a collective initiative by men. Men's groups against domestic violence and rape can be found in Australia, Africa, Latin America and the Caribbean and Asia, and in many parts of North America and Europe. The underlying starting point for this type of initiative is that men as individuals should take measures to reduce their use of violence (*202*). Typical activities include group discussions, education campaigns and rallies, work with violent men, and workshops in schools, prisons and workplaces. Actions are frequently conducted in collaboration with women's organizations that are involved in preventing violence and providing services to abused women.

In the United States alone, there are over 100 such men's groups, many of which focus specifically on sexual violence. The ''Men Can Stop Rape'' group in Washington, DC, for instance, seeks to promote alternative forms of masculinity that foster non-violence and gender equality. Its recent activities have included conducting presentations in secondary schools, designing posters, producing a handbook for teachers and publishing a youth magazine (*202*).

School-based programmes

Action in schools is vital for reducing sexual and other forms of violence. In many countries a sexual relation between a teacher and a pupil is not a serious disciplinary offence and policies on sexual harassment in schools either do not exist or are not implemented. In recent years, though, some countries have introduced laws prohibiting sexual relations between teachers and pupils. Such measures are important in helping eradicate sexual harassment in schools. At the same time, a wider range of actions is also needed, including changes to teacher training and recruitment and reforms of curricula, so as to transform gender relations in schools.

Legal and policy responses

Reporting and handling cases of sexual violence

Many countries have a system to encourage people to report incidents of sexual violence to the police and to improve the speed and sensitivity of the processing of cases by the courts. The specific mechanisms include dedicated domestic violence units, sexual crime units, gender training for the police and court officials, women-only police stations and courts for rape offences. Some of these mechanisms are discussed in Chapter 4.

Problems are sometimes created by the unwillingness of medical experts to attend court. The reason for this is frequently that the court schedules are unpredictable, with cases often postponed at short notice and long waits for witnesses who are to give short testimonies. In South Africa, to counter this, the Directorate of Public Prosecutions has been training magistrates to interrupt proceedings in sexual violence cases when the medical expert arrives so that testimonies can be taken and witnesses cross-examined without delay.

Legal reform

Legal interventions that have been adopted in many places have included:

— broadening the definition of rape;

— reforming the rules on sentencing and on admissibility of evidence;

— removing the requirements for victims' accounts to be corroborated.

In 1983, the Canadian laws on rape were reformed, in particular removing the requirement that accounts of rape be corroborated. Nonetheless, an evaluation has found that the prosecutors have tended to ignore this easing of the requirement for corroboration and that few cases go to court without forensic evidence (*203*).

Several countries in Asia, including the Philippines, have recently enacted legislation radically redefining rape and mandating state assistance to victims. The result has been a substantial increase in the number of reported cases. Campaigns to inform the general public of their legal rights must also take place if the reformed legislation is to be fully effective.

To ensure that irrelevant information was not admitted in court, the International Criminal Tribunal for the Former Yugoslavia drew up certain rules, which could serve as a useful model for effective laws and procedures elsewhere. Rule 96 of the Tribunal specifies that in cases of sexual assault there is no need for corroboration of the victim's testimony and that the earlier sexual history of the victim is not to be disclosed as evidence. The rule also deals with the possible claim by the accused that there was consent to the act, stating that consent as a defence shall not be allowed if the victim has been subjected to or threatened with physical or psychological violence, or detention, or has had reason to fear such violence or detention. Furthermore, consent shall not be allowed under the rule if the victim had good reason to believe that if he or she did not submit, another person might be so subjected, threatened or put in fear. Even where the claim of consent is allowed to proceed, the accused has to satisfy the court that the evidence for such a claim is relevant and credible, before this evidence can be presented.

In many countries, judges hand out particularly short sentences for sexual violence (*204, 205*). One way of overcoming this has been to introduce minimum sentencing for convictions for rape, unless there are extenuating circumstances.

International treaties

International treaties are important as they set standards for national legislation and provide a lever for local groups to campaign for legal reforms. Among the relevant treaties that impinge on sexual violence and its prevention include:

- the Convention on the Elimination of All Forms of Discrimination Against Women (1979);
- the Convention on the Rights of the Child (1989) and its Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography (2000);
- the Convention Against Transnational Organized Crime (2000) and its supplemental Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2000);
- the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984).

A number of other international agreements set norms and limits of behaviour, including behaviour in conflicts, that necessitate provisions in national legislation. The Rome Statute of the International Criminal Court (1998), for instance, covers a broad spectrum of gender-specific crimes, including rape, sexual slavery, enforced prostitution, forced pregnancy and forced sterilization. It also includes certain forms of sexual violence that constitute a breach or serious violation of the 1949 Geneva Conventions, as well as other forms of sexual violence that are comparable in gravity to crimes against humanity. The inclusion of gender crimes in the definitions of the statute is an important historical development in international law (*206*).

Actions to prevent other forms of sexual violence

Sexual trafficking

Initiatives to prevent the trafficking of people for sexual purposes have generally aimed to:

- create economic programmes in certain countries for women at risk of being trafficked;
- provide information and raise awareness so that women at potential risk are aware of the danger of trafficking.

In addition, several government programmes and nongovernmental organizations are develop-

ing services for the victims of trafficking (*207*). In Cyprus, the Aliens and Immigration Department approaches women entering the country to work in the entertainment or domestic service sectors. The Department advises the women on their rights and obligations and on available forms of protection against abuse, exploitation and procurement into prostitution. In the European Union and the United States, victims of trafficking willing to cooperate with the judicial system in prosecuting traffickers can receive temporary residence permits. In Belgium and Italy, shelters have been set up for victims of trafficking. In Mumbai, India, an anti-trafficking centre has been set up to facilitate the arrest and prosecution of offenders, and to provide assistance and information to trafficked women.

Female genital mutilation

Addressing cultural practices that are sexually violent requires an understanding of their social, cultural and economic context. Khafagi has argued (*208*) that such practices – which include female genital mutilation – should be understood from the perspective of those who perform them and that such knowledge can be used to design culturally appropriate interventions to prevent the practices. In the Kapchorwa district of Uganda, the REACH programme has been successful in reducing rates of female genital mutilation. The programme, led by the Sabiny Elders' Association, sought to enlist the support of elders in the community in detaching the practice of female genital mutilation from the cultural values it purported to serve. In its place, alternative activities were substituted, that upheld the original cultural tradition (*209*). Box 6.4 describes another programme, in Egypt, to prevent female genital mutilation.

Child marriage

Child marriage has a cultural basis and is often legal, so the task of achieving change is considerable. Simply outlawing early marriages will not, of itself, usually be sufficient to prevent the practice. In many countries the process of registering births is so irregular that age at first marriage may not be known (*100*). Approaches that address poverty – an important factor underlying many such marriages – and those that stress educational goals, the health consequences of early childbirth and the rights of children are more likely to achieve results.

Rape during armed conflicts

The issue of sexual violence in armed conflicts has recently again been brought to the fore by organizations such as the Association of the Widows of the Genocide (AVEGA) and the Forum for African Women Educationalists. The former has supported war widows and rape victims in Rwanda and the latter has provided medical care and counselling to victims in Sierra Leone (*210*).

In 1995, the Office of the United Nations High Commissioner for Refugees released guidelines on the prevention of and response to sexual violence among refugee populations (*211*). These guidelines include provisions for:

- the design and planning of camps, to reduce susceptibility to violence;
- documenting cases;
- educating and training staff to identify, respond to and prevent sexual violence;
- medical care and other support services, including procedures to avoid further trauma to victims.

The guidelines also cover public awareness campaigns, educational activities and the setting up of women's groups to report and respond to violence.

Based on work in Guinea (*212*) and the United Republic of Tanzania (*96*), the International Rescue Committee has developed a programme to combat sexual violence in refugee communities. It includes the use of participatory methods to assess the prevalence of sexual and gender-based violence in refugee populations, the training and deployment of community workers to identify cases and set up appropriate prevention systems, and measures for community leaders and other officials to prosecute perpetrators. The programme has been used in many places against sexual and gender-based violence, including Bosnia and Herzegovina, the Democratic Republic of the Congo, East Timor, Kenya, Sierra Leone and The former Yugoslav Republic of Macedonia.

BOX 6.4

Putting an end to female genital mutilation: the case of Egypt

Female genital mutilation is extremely common among married women in Egypt. The 1995 Demographic and Health Survey found that the age group in which the practice was most frequently used was 9–13 years. Nearly half of those performing female circumcisions were doctors and 32% were midwives or nurses. Sociological research has found that the main reasons given for practising female circumcision were to uphold tradition, to control the sexual desires of women, to make women ''clean and pure'' and, most importantly, to make them eligible for marriage.

Largely stemming from the public awareness created by the International Conference on Population and Development held in Cairo in 1994, a movement against female genital mutilation, spanning a broad range of sectors, was built up.

In terms of the response from health officials and professionals, a joint statement in 1998 from the Egyptian Society of Gynaecology and Obstetrics and the Egyptian Fertility Care Society declared that female genital mutilation was both useless and harmful, and constituted unethical practice for a doctor. The Egyptian Minister of Health and Population also issued a decree banning anyone from performing female genital mutilation.

Religious leaders in the Muslim world also voiced their opposition to the practice. The Grand Mufti put out a statement pointing out that there was no mention of female circumcision in the Koran and that sayings (*hadith*) attributed to the Prophet Muhammad on the subject were not definitively confirmed by evidence. Furthermore, in 1998, the Conference on Population and Reproductive Health in the Muslim World adopted a recommendation calling on Islamic countries to move to end all forms of violence against women, with a reminder that under Islamic law (*sharia*) no obligation existed to circumcise girls.

Egyptian nongovernmental organizations have mobilized on the issue, disseminating information on female genital mutilation and including it in community development, health awareness and other programmes. A task force of some 60 nongovernmental organizations has been set up to combat the practice.

Several nongovernmental organizations — often working through male community leaders — are now actively involving men, educating them about the dangers of female genital mutilation. In this process, young men are being encouraged to declare that they will marry uncircumcised women.

In Upper Egypt there is a programme aimed at various social groups — including community leaders, religious leaders and professional people — to train them as campaigners against female genital mutilation. Counselling is also offered to families who are considering not circumcising their daughters and discussions are conducted with health workers to dissuade them from performing the practice.

Recommendations

Sexual violence has generally been a neglected area of research in most parts of the world, yet the evidence suggests that it is a public health problem of substantial proportions. Much more needs to be done both to understand the phenomenon and to prevent it.

More research

The lack of an agreed definition of sexual violence and the paucity of data describing the nature and extent of the problem worldwide have contributed to its lack of visibility on the agendas of policy-makers and donors. There is a need for substantial further research on almost every aspect of sexual violence, including:

— the incidence and prevalence of sexual violence in a range of settings, using a standard research tool for measuring sexual coercion;
— the risk factors for being a victim or a perpetrator of sexual violence;
— the health and social consequences of different forms of sexual violence;
— the factors influencing recovery of health following a sexual assault;
— the social contexts of different forms of sexual violence, including sexual trafficking, and the relationships between sexual violence and other forms of violence.

Determining effective responses

Interventions must also be studied to produce a better understanding of what is effective in different settings for preventing sexual violence and for treating and supporting victims. The following areas should be given priority:

- Documenting and evaluating services and interventions that support survivors or work with perpetrators of sexual violence.
- Determining the most appropriate health sector responses to sexual violence, including the role of prophylactic antiretroviral therapy for HIV prevention after rape – with different basic packages of services being recommended for different settings, depending on the level of resources.
- Determining what constitutes appropriate psychological support for different settings and circumstances.
- Evaluating programmes aimed at preventing sexual violence, including community-based interventions – particularly those focusing on men – and school-based programmes.
- Studying the impact of legal reforms and criminal sanctions.

Greater attention to primary prevention

Primary prevention of sexual violence is often marginalized in favour of providing services for survivors. Policy-makers, researchers, donors and nongovernmental organizations should therefore give much greater attention to this important area. Priority should be given to the following:

— the primary prevention of all forms of sexual violence through programmes in communities, schools and refugee settings;
— support for culturally sensitive and participatory approaches to changing attitudes and behaviour;
— support for programmes addressing the prevention of sexual violence in the broader context of promoting gender equality;
— programmes that address some of the underlying socioeconomic causes of violence, including poverty and lack of education, for example by providing job opportunities for young people;
— programmes to improve child rearing, reduce the vulnerability of women and promote more gender-equitable notions of masculinity.

Addressing sexual abuse within the health sector

Sexual violence against patients in the health sector exists in many places, but is not usually acknowledged as a problem. Various steps need to be taken to overcome this denial and to confront the problem, including the following (*83, 85*):

— incorporating topics pertaining to gender and sexual violence, including ethical considerations relevant to the medical profession, in the curricula for basic and postgraduate training of physicians, nurses and other health workers;
— actively seeking ways to identify and investigate possible cases of abuse of patients within health institutions;
— utilizing international bodies of the medical and nursing professions, and nongovernmental organizations (including women's organizations) to monitor and compile evidence of abuse and campaign for action on the part of governments and health services;
— establishing proper codes of practice and complaints procedures, and strict disciplinary procedures for health workers who abuse patients in health care settings.

Conclusion

Sexual violence is a common and serious public health problem affecting millions of people each year throughout the world. It is driven by many factors operating in a range of social, cultural and economic contexts. At the heart of sexual violence directed against women is gender inequality.

In many countries, data on most aspects of sexual violence are lacking, and there is a great need everywhere for research on all aspects of sexual violence. Of equal importance are interventions. These are of various types, but the essential ones concern the primary prevention of sexual violence, targeting both women and men, interventions supporting the victims of sexual assault, measures to make it more likely that perpetrators of rape will be caught and punished, and strategies for changing social norms and raising the status of women. It is vital to develop interventions for resource-poor settings and rigorously to evaluate programmes in both industrialized and developing countries.

Health professionals have a large role to play in supporting the victims of sexual assault – medically and psychologically – and collecting evidence to assist prosecutions. The health sector is considerably more effective in countries where there are protocols and guidelines for managing cases and collecting evidence, where staff are well-trained and where there is good collaboration with the judicial system. Ultimately, the strong commitment and involvement of governments and civil society, along with a coordinated response across a range of sectors, are required to end sexual violence.

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