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Nonconsensual Sex

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Familiar places that would seem to provide safety from forced sex actually often present considerable risk. A Cambodian woman works close to home in this cover photo by Richard Lord.

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Nonconsensual Sex **Undermines Sexual Health**

Young and old, females and males are at risk.

KEY POINTS

- Forced sex is associated with serious reproductive health problems.
- Many victims are young and female, but older individuals and males are also at risk.
- Nonconsensual sex is a worldwide problem often rooted in long-standing societal norms.

Often and by a variety of means, children, adolescents, and adults — men and women alike — are pressured to have sexual relations that they do not want. Too commonly, the behavior of perpetrators, thoroughly interwoven into long-standing traditions and customs, is condoned. Meanwhile, the stigma that many victims face plunges them into a resigned silence that hinders them from getting help and masks the scope of the problem.

Thus, nonconsensual sex — accepted or merely overlooked — continues unabated. Meanwhile, its full magnitude, risk factors, and physical and mental health consequences remain poorly understood, particularly in the developing world (see article, page 4). Although strong associations between various forms of sexual coercion and adverse reproductive health consequences have been identified, the design of studies usually makes it impossible to determine a direct cause-effect relationship. In fact, the same factors that increase health risks may also increase risks for nonconsensual sex.

But experts warn that nonconsensual sex may underlie some of the most tenacious and often life-threatening reproductive health problems of the time: unintended pregnancy (and its complications) and the acquisition of not only HIV but also other sexually transmitted infections (STIs) that can cause cervical cancer and infertility.[1] The widespread existence of forced sex means that common STI/HIV prevention approaches emphasizing abstinence, faithfulness in relationships, and condom use cannot protect all people from these infections.

Definitions of nonconsensual sex vary, complicating attempts to measure its overall prevalence or to compare its prevalence among various settings. However, all definitions rest on a common foundation: a lack of full and free choice in decisions to engage in sexual relations. Physical force or the threat of it can rob victims of this choice. But intense psychological, emotional, and financial pressure or a fear of social consequences also can compel individuals to relinquish their right to resist unwanted sexual advances. While rape is one of the most extreme and immediately traumatic forms of coerced sex (see article, page 5), other forms may have a greater health impact.

Types and characteristics of nonconsensual sex reported from diverse settings throughout the world cover a broad spectrum. But the following trends are clear:

- Settings that would appear to provide the greatest protection against abuse, such as homes, schools, and even health care facilities, often present considerable risk.
- Most victims know their abusers.
- A substantial proportion of victims are young.
- Most victims are women or girls.
- Such forms of sexual coercion as child or marital sexual abuse are ongoing and may grow worse over time.[2]

Children and young adolescents

Sexual abuse of children and young adolescents is widespread in all societies. The World Health Organization (WHO) estimates that overall prevalence is 25 percent for girls and 8 percent for boys,[3] although these figures differ with the population studied and definitions used. A father or other male relative is the most common perpetrator, but abuse by peers, teachers, child caregivers, family friends, religious leaders, and neighbors also occurs. Boys and girls between ages seven and 13 years are at greatest risk.[4]

Associations between childhood sexual abuse and many short- and long-term adverse mental and physical health effects abound. For example, studies have found childhood sexual abuse to be associated not only with adolescent pregnancy[5] and HIV infection,[6] but also with a tendency for victims to later force someone else to have sex[7] and with an assortment of gynecological and reproductive health problems, including chronic pelvic pain, premenstrual distress, and inadequate or excessive prenatal weight gain. Other adverse mental and physical effects include such emotional problems as depression and anxiety, sexualized behavior, binge eating in women, and substance abuse.[8]

Whether childhood sexual abuse directly causes reproductive and other health problems remains unclear, since many of the factors that put a child at risk for sexual abuse also put a child at risk for adverse health outcomes later in life. These factors include

More Research Needed, But What Next?

More research is needed to create evidence-based policies, programs, and provider practices to prevent and address the widespread problem of nonconsensual sex. Issues that require attention include:

- **Gaps in the research.**
  Limited geographical settings. Programmatic research and studies of interventions from the developed world tend to have been conducted in the United States, while the most extensive research from the developing world comes from Africa and India. Results from these locations may not apply to other countries or cultural settings.[1]

  Underreporting. Nonconsensual sex — particularly childhood sexual abuse and male rape — is probably greatly underreported.[2]

  Limited attention to certain groups. Experiences of nonconsensual sex have been studied more among girls than boys and more among single women than married women.

  Limited understanding of context. The typical sequence of events leading to nonconsensual sex, cultural norms influencing it, motives for it, and how it is perceived and justified require more study.[3]

http://www.who.int/svri/en
The Sexual Violence Research Initiative, supported by the Global Forum for Health Research (GFHR) and the World Health Organization (WHO), seeks to promote and disseminate research and build research capacity to reduce and respond to sexual violence in developing countries.

- **Flawed or inconsistent study methodologies that make comparisons difficult.** Definitions, measurement tools, study designs, and study populations vary widely.[4] Also, studies tend to focus on people who access health services or are otherwise easy to recruit, such as university students; thus, findings may not be generalizable.[5]

- **Lack of clarity about the relationship between nonconsensual sex and adverse health consequences.** Studies on this topic are observational in design and thus limited to establishing associations between sexual coercion and adverse health outcomes. They cannot determine cause-effect relationships.

- **Few evaluations of interventions and their effectiveness.** Available data and expert opinion suggest that promising interventions share several key characteristics, but few efforts to prevent nonconsensual sex have been rigorously evaluated.

n **Kim Best**

References

1 Bennett LR, Manderson L, Astbury J. *Mapping a Global Pandemic: Review of Current Literature on Rape, Sexual Assault and Sexual Harrassment of Women Consultation on Sexual Violence Against Women*. Geneva, Switzerland: Global Forum for Health Research, 2000.

2 Krug EG, Dahlberg LL, Mercy JA, et al., eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization, 2002.

3 Jejeebhoy S, Bott S. *Non-consensual Sexual Experiences of Young People: A Review of Evidence from Developing Countries*. New Delhi, India: Population Council, 2003.

4 Population Council. *The Adverse Health and Social Outcomes of Sexual Coercion: Experiences of Young Women in Developing Countries* [working paper]. New Delhi, India: Population Council, 2004.

5 Bennett.

family instability, parental psychopathology, childhood neglect and physical abuse, lower social class, unemployment, parental alcohol and drug abuse, and poverty.[9] As a result, the interrelatedness of childhood sexual abuse with multiple adverse childhood experiences should be considered in the design of studies, treatment, and programs to prevent childhood sexual abuse.[10]

Sexual abuse of young adolescents can directly and immediately result in unintended pregnancy or STI/HIV acquisition. Over the long term, childhood sexual abuse appears to be associated with these same adverse outcomes by means of two mechanisms. First, such abuse has been linked to sexual risktaking in adolescence. Second, it has been associated with later sexual victimization of women.[11]

In both cases, emotional harm caused by childhood sexual abuse appears to undermine normal, healthy psychological development that would enhance victims' ability to protect their sexual health. In numerous studies, victims have reported guilt, anxiety, and depression; feelings of worthlessness and powerlessness; inability to distinguish sexual from affectionate behavior; difficulty in maintaining appropriate personal boundaries; and inability to refuse unwanted sexual advances.[12]

Sexual risktaking associated with childhood sexual abuse manifests itself in several ways. Compared with nonvictims, victims are more likely to start voluntary sex earlier; have sex with multiple partners; abuse alcohol and use other drugs; trade sex for money or drugs; and not use contraception, including condoms.[13] All of these behaviors may increase risk of unintended pregnancy as well as STIs, including HIV. An association between childhood sexual abuse and a decreased likelihood of having a Pap smear[14] may indicate yet another form of risktaking, since the test helps ensure timely diagnosis and treatment of cervical cancer and its precursors. Cervical cancer is a major killer of women worldwide.

School settings

School, like home, should be a safe haven for young people. Yet, many girls and — to

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Rape by Strangers: Punishment and Terror

Rape by strangers, although less common and less likely to be repeated than forced sex by known perpetrators, still often results in unintended pregnancy and sexually transmitted infections, including HIV. Violent forced sex often results in abrasions and cuts that, coupled with non-use of condoms, put a woman at particularly high risk of acquiring HIV if the rapist is infected. Rape-related pregnancy rates vary among settings, depending on such factors as contraceptive prevalence. While the U.S. rape-related pregnancy rate is an estimated 5 percent per rape among victims ages 12 to 45 years,[1] reported post-rape pregnancy rates in developing world settings such as Ethiopia and Mexico range from 15 percent to 17 percent.[2]

These risks of pregnancy and infection are compounded when the rape involves several men. Gang rape by young men has been reported from settings as diverse as South Africa, Peru, and Cambodia. Perpetrators say that, besides bonding with each other in the process, gang rape enables them to punish girlfriends for perceived infidelity. Other typical victims include girls under the effect of alcohol or drugs or thought to be sexually available, sex workers, girls thought to be virgins, and women perceived as challenging men's dominance and thus defying gender norms.[3]

Women are often the victims of domestic and sexual violence following a natural disaster. For example, rape and sexual molestation were reported in Sri Lanka after the December 2004 tsunami.[4] Punishment, humiliation, and terrorizing of women by means of rape have also long been weapons of war. Extensive sexual violence against women has been reported in many conflict situations, including in Algeria, Bangladesh, Bosnia-Herzegovina, China, East Timor, India, Indonesia, Korea, Liberia, the Philippines, Rwanda, Uganda, the former Yugoslavia, and more recently, in the Democratic Republic of Congo (DRC), Sudan, and northern Uganda. Refugees fleeing conflicts are also at risk of rape in their new settings.[5]

In conflict situations, raped women are often traumatized and stigmatized: In many cultures, women can be abandoned, divorced, and declared unmarriageable if they have been raped. Furthermore, many raped women become impregnated, contract sexually transmitted infections, and suffer gynecological injuries that require reconstructive surgery (see article, page 13). Trauma at the time of rape may be greater and childbirth resulting from rape more difficult if women have been circumcised in the most extreme manner, as is the case of 90 percent of all women in the conflict zone of Darfur, Sudan.[6] Work by FHI to train health care providers in Kosovo to address sexual and domestic violence has shown, unfortunately, that providers often do not know how to address the issue of rape with their clients. This can lead to further distress and shame, notes Jane Schueller, an FHI senior technical advisor who both coauthored an FHI training curriculum about prevention of sexual and domestic violence and facilitated the training in Kosovo.

The cruelty of some attacks, as those reported by Doctors Without Borders/Médecins Sans Frontières[7] — which has been working in the eastern DRC since 1992 — underscores the grim consequences of this most extreme form of nonconsensual sex. A large increase in the rate of HIV infection has been associated with the rape of more than 40,000 women and girls there.[8] (Similarly, an estimated two-thirds of women raped during the 1994 genocide in Rwanda were infected with HIV.[9])

Even when victims are spared HIV infection, the harm is often largely irreparable. "It was one week after I had given birth to my first baby, in July 2000," recalls one young Congolese woman. "I went out to present the baby to my family and accomplish the traditional purification rituals with them." On the way, she ran into Mai Mai (Congolese militia) who "tied me up and six men raped me. The maternity sores were not healed yet; with the rape, my flesh just tore, opening from both sides, even now, I cannot control urination or defecation and both have been coming out from the front."

Subsequently, this woman's baby died. And, she said, "I have no enthusiasm anymore and no self-esteem because of my helplessness in controlling my excrements. I don't even know where my husband is. I haven't seen him again since what has happened to me; but even if I would see him again, what use would it be? I can't even have sexual relations anymore."[10]

n **Kim Best**

References

1 Holmes MM, Resnick HS, Kilpatrick DG, et al. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. *Am J Obstet Gynecol* 1996;175(2):320-25.

2 Mulugeta E, Kassaye M, Berhane Y. Prevalence and outcomes of sexual violence among high school students. *Ethiop Med J* 1998;36(3):167-74; *An Evaluation of a Project to Provide Education, Training and Care for Women and Minors Affected by Sexual Violence, January-December 1990*. Mexico City, Mexico: Asociación Mexicana Contra la Violencia a las Mujeres, 1990.

3 From *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*, New Delhi, India, September 22-25, 2003: Jewkes R. Non-consensual sex among South African youth: prevalence of coerced sex and discourses of control and desire; Cáceres C. The complexity of young people's experiences of sexual coercion: lessons learned from studies in Peru; and Wilkinson JW, Bearup LS, Soprach T. Youth gang-rape in Phnom Penh.

4 Jones R. Gender and natural disasters: why we should be focusing on a gender perspective of the tsunami disaster. Interagency Gender Working Group, January 7, 2005. Available only through LISTSERV Mailing List: *http://www.igwg.org/listserv.htm*; Activists warn of tsunami survivor rapes. Iafrica.com (Cape Town, South Africa). January 4, 2005. Available: *http://iafrica.com/news/worldnews/401686.htm*.

5 Krug EG, Dahlberg LL, Mercy JA, et al., eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization, 2002.

6 Martin S, Mutchler M. *Sudan: For Raped Women in Darfur, Access to Reproductive Health Services Limited*. Washington, DC: Refugees International, 2004.

7 Doctors Without Borders/Médecins Sans Frontières. *Ten Years of Conflict, Violence and Human Suffering*, DRC Special Report, December 20, 2002. Available: *http://www.doctorswithoutborders.org/publications/reports/2002/drc1.pdf*.

8 Rape victims 'dying' in DR Congo. *BBC News*. October 26, 2004.

9 Lederer E. Security council told that sexual violence against women is taking place 'on a massive scale' during and after conflicts. *Associated Press*. October 28, 2004.

10 Doctors Without Borders.

s *Youth living on the street, such as these boys from Mexico City, are at increased risk of experiencing nonconsensual sex.*

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a lesser extent, boys — are sexually harassed and coerced there.[15] Teachers have been reported to offer good or passing grades to girls in exchange for sex.[16] Not uncommonly, peers and older students prey on girls as they walk to school or while they board in dormitories. And "sugar daddies" target girls in the vicinity of schools, luring them into sexual relations with gifts and money. Many girls feel that their survival depends on such arrangements. For example, a quarter of students interviewed in a study in Zimbabwe of school-based sexual abuse said they regularly went hungry.[17]

Research conducted in junior secondary schools in Zimbabwe, Malawi, and Ghana has found that sexual abuse of girls by teachers, older male pupils, and sugar daddies is largely accepted. Authorities may not act against it. Teachers are generally unwilling to report each other's sexual misconduct. And not all girls or their parents necessarily disapprove of sexual relations between teachers or older men and girls.[18] Similar patterns of sexual harassment and rape by teachers or peers have been reported in university settings in such diverse areas as China, Ethiopia, Malawi, South Africa, Sri Lanka, Tanzania, and Zimbabwe.[19]

Boys and young men

Although research about sexual abuse of boys is scarce and study sample sizes are small, 4 percent to 20 percent of adolescent males studied in developing countries report having been victims of sexual assault. In most cases, perpetrators are peers; occasionally they are older men. As with female victims of childhood sexual abuse, male victims are likely to suffer such psychological consequences as anxiety and depression.[20] Largely due to the stigmatization that knowledge of their victimization may cause, few male victims seek help and most tend to suffer in silence. In some cases, their distress may lead to more sexual risktaking (see article, page 11).

Sexual abuse of boys has been associated with their later impregnation of girls. Surveys of some 54,000 sexually experienced female and male high school students in Minnesota, USA, found that impregnation of girls and associated risk behaviors (little or no condom use; regular alcohol or other drug use before sex) were at least twice as common among abused males as among their nonabused peers.[21] A survey that included some 1,600 sexually experienced adolescents in Massachusetts, USA, found that both female and male adolescents with a history of sexual abuse reported greater sexual risktaking than did those without a history; however, the impact of sexual abuse on sexual risktaking appeared to be greater for boys. Notably, researchers pointed out that the boys reported even more dysfunctional family environments than did the girls and that lack of a supportive family in conjunction with the abuse itself could make boys more prone to risktaking behaviors.[22]

In studies conducted in settings as varied as Brazil, Colombia, India, Kenya, the Philippines, and Thailand, forced sex among young men — particularly those living on the street — has been associated with them forcing sex themselves or becoming involved in transactional sex (exchanging sex for money, gifts, or favors) with older men and women.[23]

Older adolescents and men also may be at risk for nonconsensual sex at home, at school, at work, on the street, in the military, during war, in prisons, and in police custody. Usually, perpetrators are other men. But sometimes they are women. About a quarter of some 1,500 male college students or men of college age participating in U.S. and German studies have reported incidents of sexual coercion by women, including sexual intercourse. While women are reported to most commonly use psychological pressure or men's intoxication to engage in unwanted sex, they occasionally use force: hitting, sitting on, tying up, or locking up their victims. Women may succeed in having sexual intercourse with unwilling men because the anger, fear, and pain that such intimidation can evoke, although unwelcome, can cause sexual arousal or even orgasm.[24]

Men do not always report these forced acts to be unpleasant, but researchers estimate that at least one of five men has a strong negative reaction.[25] Most studies of forced sex by women have been conducted among university students in developed countries, but instances of women raping men at gunpoint to deliberately infect

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Traditions Can Imprison Women

Cultural customs and gender norms can lock girls and women into relationships in which nonconsensual sex is inescapable. Child marriage, for example, is a custom that often results in girls experiencing forced and traumatic first sex with their husbands, as well as subsequent forced sex within their marriages.[1] Age 18 has been deemed by many governments and several international agreements to be the minimum legal age for marriage. But, over the next decade, more than 100 million girls in developing countries (excluding China) are expected to be married before age 18.[2]

In many parts of the world, societal gender norms support the notion that marriage entitles men to sex with their wives. Even adult married women may be unable to escape forced sex within marriage. This gender-power gap widens with child marriages, since wives tend to be much younger than their husbands. Research from 16 sub-Saharan African countries found that 15- to 19-year-old wives were, on average, at least 10 years younger than their husbands.[3]

The relative helplessness of girls and female adolescents to negotiate sexual matters and resist sexual coercion within their marriages raises their risk of HIV infection. Forced sex with older, HIV-infected husbands may explain in part why married adolescent girls have some of the highest HIV rates of any group.[4] Data from Kenya and Zambia, for example, show that young married girls are more likely to be HIV-positive than are their unmarried peers because they have sex more often, use condoms less often, are unable to refuse sex, and have partners who are more likely to be HIV-positive.[5]

Coercive marital sex, coupled with a girl's naiveté about sexual matters and unfamiliarity with contraception, may also result in unintended pregnancy.[6] Girls who are married young and become pregnant may feel that they are meeting cultural and familial expectations to prove their fertility. But a young girl whose pelvis is not fully developed may suffer prolonged or obstructed labor during childbirth that can kill or seriously harm both baby and mother.[7]

The long-standing, widespread custom of child marriage has deep historic roots. It has been viewed as a way to maximize fertility, secure family alliances or lineage, and protect a girl from pregnancy outside of marriage. And dowries — the money, goods, or estate that a woman brings to the marriage — are often less costly when brides are young.

Child marriage is also facilitated by the tradition of lobola. Also called bridewealth, this custom is the opposite of a dowry: A man's family gives goods or property to his prospective wife's family as compensation for her obligation to bear children and the loss of her labor. A young girl's high productive and reproductive potential makes her especially valuable in such marital arrangements. Yet, once married, a young woman may have little control over sexual matters. Three-quarters of some 1,000 women responding to a South African survey said that the prevailing view in their culture was that a man who had paid lobola owned his wife and could have sex with her whenever he chose.[8]

Among other cultural traditions that support coercive sex are:

- **Wife inheritance.** This practice can take different forms. Commonly, however, a man may inherit his brother's widow. In Zimbabwe, a widow passes to her deceased husband's brother in a traditional practice called "kugara nhaka," which could fuel HIV transmission if the woman's deceased husband was HIV-infected, she has become HIV-infected, and she transmits the virus to her husband's brother.[9] In Kenya, this custom persists among the Luo, although widows have been reported to resist being inherited and may attempt to protect their sexual health by insisting that their partners use condoms or permanently abstain from sexual intercourse.[10]
- **Virginity testing.** This practice, in which a young girl's mother, aunt, neighbor, or even prospective husband inserts a finger into her vagina to verify her virginity, may take place in ceremonies sanctioned by rural chiefs, as well as in churches and the home in Zimbabwe (see article, page 14). Although performed in the name of culture, "we say the insertion of a finger or anything in a child's vagina is sexual abuse," says Betty Makoni, director of the Girl Child Network (GCN) in Zimbabwe.[11]

n **Kim Best**

References

1 Sharma V, Sujay R, Sharma A. Can married women say no to sex? Repercussions of the denial of the sexual act. *J Fam Welfare* 1998;44(1):1-8.

2 Bruce J, Clark S. The implications of early marriage for HIV/AIDS policy. Brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents. New York, NY: Population Council, 2004.

3 United Nations Children's Fund (UNICEF). *Early Marriage: Child Spouses.* Florence, Italy: UNICEF, 2001.

4 Bruce.

5 Clark S. Early marriage and HIV risks in sub-Saharan Africa. *Stud Fam Plann* 2004;35(3):149-60; Luke N, Kurz K. Cross-generational and transactional sexual relations in sub-Saharan Africa: prevalence of behavior and implications for negotiating safer sexual practices. Washington, DC: International Center for Research on Women and AIDSMARK, 2002.

6 Mathur S, Greene M, Malhotra A. *Too Young to Wed: The Lives, Rights, and Health of Young Married Girls.* Washington, DC: International Center for Research on Women, 2003.

7 Henrion R. Female genital mutilations, forced marriages, and early pregnancies. *Bull Acad Natl Med* 2003;187(6):1051-66.

8 Jewkes R, Penn-Kekana L, Levin J, et al. *He Must Give Me Money He Mustn't Beat Me. Violence against Women in Three South African Provinces, Technical Report.* Pretoria, South Africa: Medical Research Council, 1999.

9 United Nations Office for the Coordination of Humanitarian Affairs. Zimbabwe: tackling the impact of customs on AIDS. Integrated Regional Information Networks (IRIN), August 17, 2004. Available: *http://www.irinnews.org/print.asp?ReportID=42722.*

10 Luginaah I, Elkins D, Maticka-Tyndale E, et al. Challenges of a pandemic: HIV/AIDS-related problems affecting Kenyan widows. *Soc Sci Med* 2005; 60(6):1219-28.

11 United Nations Office for the Coordination of Humanitarian Affairs.

Nonconsensual Sex within Marriage

Percentages of ever-married women ages 15 to 49 years ever reporting physically forced sexual intercourse by husband

Cambodia	Colombia	Dominican Republic	Haiti	Nicaragua	Zambia*
3.4	11.0	6.0	16.7	8.7	5.1

* In Zambia, women were asked whether they had ever been forced to have sex by anyone, including their husbands.

Source: Kishor S, Johnson K. *Profiling Domestic Violence — A Multi-Country Study*. Calverton, MD: ORC Macro, 2004. (Data are derived from Demographic and Health Surveys.)

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those men with HIV have been reported in South Africa.[26]

Older unmarried adolescents and women

Like young adolescents in school settings, older female adolescents may enter sexual relationships with substantially older men in exchange for gifts or money.[27] Similarly, male adolescents have reported being pressured by older women to engage in such transactional sex.[28] Some may freely choose this course. But transactional sex is often motivated by pressing economic need,[29] and thus is essentially nonconsensual.

Regardless of age, women engaging in transactional sex may be at increased risk for HIV infection. In a study conducted in Soweto, South Africa, among nearly 4,000 pregnant women ages 15 to 44 years, transactional sex was associated with HIV seropositivity. Women in transactional sexual relationships may be at increased risk for HIV, the researchers suggested, because they are less likely to use condoms and their male partners are more likely than other men to be HIV-infected, perhaps because they often have multiple sexual partners.[30]

Husbands or steady partners

Women often fear rape by a stranger. But many are more likely to be sexually coerced by the men they know best: their husbands and long-term boyfriends. Sexual assault by husbands is reported two to eight times more often than is assault by strangers.[31] In various studies throughout the world, up to a quarter of women have reported being forced by a current or former husband or cohabiting partner.[32] In some settings, rates may be far higher (see article, page 12).

Not all countries recognize marital rape as a crime or penalize it. Instead, gender norms in many settings result in marriage often being seen as giving men unconditional sexual access to their wives. Furthermore, while rape by a stranger tends to be a one-time event, marital rape may occur repeatedly and thus pose a continuing threat to a woman's reproductive health.

A study conducted in Uttar Pradesh, India, found that unplanned pregnancies were 2.6 times more common among wives of abusive men, especially sexually abusive men who used force, than among wives of nonabusive men.[33] In a study in rural Tamil Nadu, India, among 66 women and 44 of their husbands, nonconsensual sex was the single most important indicator distinguishing women who had terminated their pregnancies from those who had not.[34]

In a study of forced sex among some 750 women accessing services at a women's health clinic in an impoverished area of rural Haiti, women whose current pregnancy was unplanned were 1.7 times more likely to have experienced forced sex than were other women in the study. Of note, forced sex (reported by more than half of the women) was more common in relationships of more than four years. Researchers suggested that the economic dependence of some women in longer-term relationships may increase their risk of forced sex.[35]

"Most of the women in this area of rural Haiti live in harsh poverty, earning U.S. $10 to U.S. $30 monthly, and 80 percent report spending half of their earnings on food," says Dr. Joia Mukherjee, medical director of the U.S.-based Partners in Health, who presented results of the study at the XV International AIDS Conference in Bangkok. "Without poverty alleviation, stressing prevention of unintended pregnancy and STIs/HIV by means of abstinence, faithfulness to partners, or condom use will have very limited utility since many of these women do not have the power to protect themselves. Many are faithful but, because of their economic dependence, they have no power over when and under what circumstances they have sex."

Male extramarital sex, combined with forced marital sex, not only puts wives at risk of STIs/HIV but also can endanger an unborn child. If an HIV-infected man forces sex upon his pregnant wife and she becomes infected, the virus may be transmitted to her fetus. Thus, newborns become the last link in the long chain of victims of nonconsensual sex.

n **Kim Best**

References

1 Pettifor AE, Measham DM, Rees HV, et al. Sexual power and HIV risk, South Africa. *Emerg Infect Dis* 2004;10(11) [serial on the Internet]. Available: *http://www.cdc.gov/ncidod/EID/vol10no11/04-0252.htm*; Wyatt GE, Myers HF, Williams JK, et al. Does a history of trauma contribute to HIV risk for women of color? Implications for prevention and policy. *Am J Public Health* 2002;92(4):660-65; Jenny C, Hooton TM, Bowers A, et al. Sexually transmitted diseases in victims of rape. *N Engl J Med* 1990; 322(11):713-16; Johnson PJ, Hellerstedt WL. Current or past physical or sexual abuse as a risk marker for sexually transmitted disease in pregnant women. *Perspect Sex Reprod Health* 2002;34(2):62-67.

2 Krug EG, Dahlberg LL, Mercy JA, et al., eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization, 2002; Heise L, Moore K, Toubia N. *Sexual Coercion and Women's Reproductive Health: A Focus on Research*. New York, NY: Population Council, 1995; Jejeebhoy S, Bott S. *Non-consensual Sexual Experiences of Young People: A Review of Evidence from Developing Countries*. New Delhi, India: Population Council, 2003; Watts C, Zimmerman C. Violence against women: global scope and magnitude. *Lancet* 2002;359(9313):1232-37.

3 García-Moreno C. Relationship violence experiences of young people: an overview and some findings

from the WHO VAW Study. *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*, New Delhi, India, September 22-25, 2003.

4 Finkelhor D. Current information on the scope and nature of child sexual abuse. *Future Child* 1994; 4(2):31-53.

5 Saewyc E, Magee L, Pettingell S. Teenage pregnancy and associated risk behaviors among sexually abused adolescents. *Perspect Sex Reprod Health* 2004:36(3):98-105; Anda RF, Chapman DP, Felitti VJ, et al. Adverse childhood experiences and risk of paternity in teen pregnancy. *Obstet Gynecol* 2002; 100(1):37-45.

6 Brady S, Gallagher D, Berger J, et al. Physical and sexual abuse in the lives of HIV-positive women enrolled in a primary medicine health maintenance organization. *AIDS Patient Care STDs* 2002; 16(3):121-25; Lindegren ML, Hanson IC, Hammett TA, et al. Sexual abuse of children: intersection with the HIV epidemic. *Pediatrics* 1998;102(4):E46.

7 Andersson N, Ho-Foster A, Matthis J, et al. National cross sectional study of views on sexual violence and risk of HIV infection and AIDS among South African school pupils. *BMJ* 2004;329(7472):952.

8 Johnson CF. Child sexual abuse. *Lancet* 2004;364(9432):462-70.

9 Fergusson DM, Horwood LJ, Lynskey MT. Childhood sexual abuse, adolescent sexual behaviors and sexual revictimization. *Child Abuse Negl* 1997;21(8):789-803; Roosa M, Tein J-Y, Reinholtz C, et al. The relationship of childhood sexual abuse to teenage pregnancy. *J Marriage Fam* 1997;59:119-30; Beitchman JH, Zucker KJ, Hood JE, et al. A review of the short-term effects of child sexual abuse. *Child Abuse Negl* 1991;15(4):537-56.

10 Dong M, Anda RF, Dube SR, et al. The relationship of exposure to childhood sexual abuse to other forms of abuse, neglect, and household dysfunction during childhood. *Child Abuse Negl* 2003;27(6):625-39.

11 Messman-Moore TL, Long PJ. The role of childhood sexual abuse sequelae in the sexual revictimization of women: an empirical review and theoretical reformulation. *Clin Psychol Rev* 2003;23(4):537-71; Stewart L, Sebastiani A, Delgado G, et al. Consequences of sexual abuse of adolescents. *Reprod Health Matters* 1996;7:129-34; Coid J, Petruckevitch A, Feder G, et al. Relation between childhood sexual and physical abuse and revictimisation in women: a cross-sectional survey. *Lancet* 2001;358(9280):450-54; Urquiza AJ, Goodlin-Jones BL. Child sexual abuse and adult revictimization with women of color. *Violence Vict* 1994;9(3):223-32; Desai S, Arias I, Thompson MP, et al. Childhood victimization and subsequent adult revictimization assessed in a nationally representative sample of women and men. *Violence Vict* 2002;17(6):639-53.

12 Stewart; Johnson CF.

13 Somse P, Chapko MK, Hawkins RV. Multiple sexual partners: results of a national HIV/AIDS survey in the Central African Republic. *AIDS* 1993;7(4):579-83; Boyer D, Fine D. Sexual abuse as a factor in adolescent pregnancy. *Fam Plann Perspect* 1992;24(1): 4-11,19; From *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*, New Delhi, India, September 22-25, 2003: Ellsberg M. Coerced sex among adolescents in Latin America and the Caribbean; Gupta A. Incest in Indian families: learnings from a support center for adult women survivors; and Koenig M, Lutalo T, Zablotska I, et al. The sequelae of adolescent coercive sex: evidence from Rakai, Uganda.

14 Farley M, Golding JM, Minkoff JR. Is a history of trauma associated with a reduced likelihood of cervical cancer screening? *J Fam Pract* 2002; 51(10):827-31.

15 Krug; Mirsky J. *Beyond Victims and Villains: Addressing Sexual Violence in the Education Sector*. London, UK: The Panos Institute, 2003.

16 Omaar R, de Waal A. *Crimes Without Punishment: Sexual Harassment and Violence Against Female Students in Schools and Universities in Africa*. London, UK: African Rights, 1994.

17 Leach F, Machakanja P, Mandoga J. *Preliminary Investigation of the Abuse of Girls in Zimbabwean Junior Secondary Schools. Education Research Paper No. 39*. London, UK: Department for International Development, 2000; Mirsky.

18 Leach P, Fiscian V, Kadzamira E, et al. *An Investigative Study of the Abuse of Girls in African Schools. Educational Paper No. 54*. London, UK: Department for International Development, 2003.

19 Mirsky.

20 Krug.

21 Saewyc.

22 Raj A, Silverman JG, Amaro H. The relationship between sexual abuse and sexual risk among high school students: findings from the 1997 Massachusetts Youth Risk Behavior Survey. *Matern Child Health J* 2000;4(2):125-34.

23 Sodhi G, Verma M. Sexual coercion amongst unmarried adolescents of an urban slum in India. In Bott S, Jejeebhoy S, Shah I, et al., eds. *Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia*. Geneva, Switzerland: World Health Organization, 2003; Barker G. Research on AIDS: knowledge, attitudes and practice among street youth. *Child Worldwide* 1993;20(2-3):41-42; Raffaelli M, Campos R, Merritt AP, et al. Sexual practices and attitudes of street youth in Belo Horizonte, Brazil. *Soc Sci Med* 1993; 37(5):661-70.

24 Levin RJ, van Berlo W. Sexual arousal and orgasm in subjects who experience forced or consensual sexual stimulation – a review. *J Clin Forensic Med* 2004;11(2):82-88.

25 Struckman-Johnson C, Struckman-Johnson D. Men's reactions to female sexual coercion. *Psychiatr Times* 2001;17(3). Available: *http://www.psychiatrictimes.com/menreact.html*; Struckman-Johnson C, Struckman-Johnson D. Men pressured and forced into sexual experience. *Arch Sex Behav* 1994; 23(1):93-114; Waldner-Haugrud LK, Magruder B. Male and female sexual victimization in dating relationships: gender differences in coercion techniques and outcomes. *Violence Vict* 1995;10(3):203-15; Krahe B, Scheinberger-Olwig R, Bieneck S. Men's reports of nonconsensual sexual interactions with women: prevalence and incidence. *Arch Sex Behav* 2003;32(2):165-75.

26 Women rape men in AIDS fury. *The Daily Telegraph* (New South Wales, Australia). May 18, 2004.

27 Luke N. Age and economic asymmetries in the sexual relationships of adolescent girls in sub-Saharan Africa. *Stud Fam Plann* 2003;34(2):67-86.

28 Ajuwon A. Research in sexual coercion among young persons: the experiences and lessons learned from Ibadan, Nigeria. *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*, New Delhi, India, September 22-25, 2003.

29 Hunter M. The materiality of everyday sex: thinking beyond 'prostitution.' *Afr Studies* 2002;61(1):99-120; Luke N. Confronting the myth of "sugar daddies": linking age and economic asymmetries and risky sexual behavior in urban Kenya. Annual meeting of the Population Association of America, Atlanta, GA, May 9-11, 2002.

30 Dunkle KL, Jewkes RK, Brown HC, et al. Transactional sex among women in Soweto, South Africa: prevalence, risk factors and association with HIV infection. *Soc Sci Med* 2004;59(2004):1581-92.

31 Eby KK, Campbell JC, Sullivan CM, et al. Health effects of experiences of sexual violence for women with abusive partners. *Health Care Women Int* 1995;16(6):563-76.

32 Krug.

33 Martin SL, Kilgallen B, Tsui AO, et al. Sexual behavior and reproductive health outcomes: associations with wife abuse in India. *JAMA* 1999; 282(20):1967-72.

34 Ravindran TK, Balasubramanian P. "Yes" to abortion but "no" to sexual rights: the paradoxical reasons of married women in rural Tamil Nadu, India. *Reprod Health Matters* 2004;12(23):88-99.

35 Fawzi MC, Lambert W, Singler JM, et al. Factors associated with forced sex among women accessing health services in rural Haiti: implications for the prevention of HIV infection and other sexually transmitted diseases. *Soc Sci Med* 2005;60(4):679-89.

YouthLens

Gender Norms Underlie Sexual Coercion

Nonconsensual sex is an abuse of power commonly rooted in gender norms — societal assumptions and expectations about what it means to be male or female. In many cultures, gender norms for females include submissiveness, deference to male authority, dependence, virginity until marriage, and faithfulness during marriage. Norms for men, in contrast, are built around power and control, independence, not showing emotions, risktaking, using violence to resolve conflict, beginning sexual activity early in life, and having multiple sexual partners.

Research illustrates some of the ways that gender norms may contribute to nonconsensual sex. A study in South Africa suggests that societal acceptance of male dominance has contributed to high rates of rape or attempted rape.[1] Other studies show that young men often feel entitled to sex, with young women frequently agreeing that sex is a man's right.[2] During focus group discussions in South Africa, one adolescent girl remarked: "I actually think forced sex is the norm. It is the way people interact sexually."[3]

Traditional gender norms that condone male violence, support female economic dependency, and stigmatize female sexual activity also contribute to the acceptance of sexual coercion within intimate partner relationships. In a 15-country qualitative study of women's HIV risk, many women reported giving in to men's sexual demands out of fear of the consequences of refusal, such as physical abuse, loss of economic support, and accusations of infidelity.[4]

Various efforts are under way to challenge unhealthy gender norms during young adulthood, since both males and females tend to form belief systems, pattern their behaviors, and begin intimate relationships at this time. Evaluations of some of these interventions throughout the world have found positive changes in knowledge and attitudes, but whether such efforts result in behavioral changes that reduce sexual coercion is largely unknown.[5] However, in Dar es Salaam, Tanzania, a study conducted by researchers from Muhimbili University College of Health Sciences, Johns Hopkins University, and the Population Council's Horizons Program, is evaluating the effects of an intervention involving community theater and peer education to transform attitudes and behaviors related to both violence against sexual partners and HIV/AIDS. The attitudes, knowledge, and behaviors at baseline and one year later of 400 young men ages 16 to 24 years in the intervention group will be compared to those of 400 young men in a control community. Results are expected at the end of 2005.[6] And in three large slum communities in Mumbai, India, a four-month pilot intervention conducted by the Horizons Program and the Indian nongovernmental organization Committee for Resource Organization used peer education to encourage changes in unhealthy attitudes (such as the acceptance of gender-based violence) and behaviors of 106 men ages 15 to 28 years. Data from qualitative interviews with peer leaders and participants suggest that the intervention has resulted in less harassment and domination of women. Final results of the pilot study are expected in 2005.[7]

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YouthNet, coordinated by FHI, is a USAID-funded global program to improve reproductive health and prevent HIV/AIDS among young people.

References

1 Jewkes R. Non-consensual sex of South African youth: prevalence of coerced sex and discourses of control and desire. *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*, New Delhi, India, September 22-25, 2003.

2 Ajuwon A. Research in sexual coercion in young persons: the experiences and lessons learnt from Ibadan, Nigeria. *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*, New Delhi, India, September 22-25, 2003.

3 Varga CA. Links between sexual dynamics and reproductive health behaviour among KwaZulu/Natal youth: qualitative and quantitative perspectives. *Fifth Reproductive Health Priorities Conference*, Drakensberg, South Africa, August 17-20, 1999.

4 Weiss E, Gupta GR. *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention.* (Washington, DC: International Center for Research on Women, 1998)31.

5 Boender C, Santana D, Santillán D, et al. *The 'So What' Report. A Look at Whether Integrating a Gender Focus Into Programs Makes a Difference to Outcomes.* Washington, DC: Interagency Gender Working Group, 2004. Available: *http://www.prb.org/pdf04/TheSoWhatReport.pdf.*

6 Weiss E, Maman S, Lary H, et al. Preventing HIV and partner violence: research guides design of peer education and drama components in Tanzania. *Horizons Report.* Washington, DC: Population Council, 2004.

7 Clarke A, Weiss E, Verma R, et al. "What's a 'real man'?" India study examines perceptions of masculinity as entry point for addressing HIV. *Horizons Report.* Washington, DC: Population Council, 2004.

Voices from the Field

One Boy's Experience: Ashamed and Afraid

By Dr. Surinder Jaswal, Associate Professor, Tata Institute of Social Sciences, Mumbai, India

Thirteen-year-old Mukesh (not his real name) was visiting his aunt when an older boy from the neighborhood lured him to a secluded area and forced him to have sexual relations. Ashamed and afraid of the consequences of reporting the incident, Mukesh did not tell his parents. Nor did he ever indicate that the abuse had occurred more than once. But it likely had, based on the fact that he developed painful anal sores and lesions symptomatic of a sexually transmitted infection. Disturbed by those symptoms, Mukesh informed his brother, who brought him to a hospital for treatment.

Mukesh's experience occurs all too frequently. In studies conducted in India, urban, semi-urban, and rural male youth from both institutional and community-based settings not uncommonly report sexual coercion by male peers and older boys and men.[1] Approximately a quarter of 23 patients seeking sexual abuse treatment at a health care facility in urban Thane City, India, were boys between ages six and 16 years.[2] And a third of 811 higher secondary semi-urban and rural school students (mean age, 16 years) participating in a study in urban Goa, India, reported at least one type of sexual abuse in the previous year. Multiple types of abusive sexual experiences, involving both male and female perpetrators, were common.[3]

Gender norms in India create a situation that is conducive to such male sexual coercion. Compared with girls, boys are afforded much greater freedom of mobility and are questioned little about their whereabouts. Social taboos against boys congregating at "adaas" (local dens where boys meet) do not exist.

Yet, the sexual coercion that is more apt to occur under these conditions is associated with various harmful consequences for many male youth. The nature of the association is unclear but, compared with boys not experiencing coercive sexual relations, boys who have been forced to have sex have poorer educational performance, poorer physical and mental health, more substance abuse, poorer relationships with their parents, and more consensual sex.[4] Sexual abuse has been associated with some young men growing anxious about their sexuality, sexual identity, and how peers perceive them. Many adopt harmful behaviors (such as abusing drugs and alcohol) or engage in risky sexual behaviors (such as unprotected, casual sexual relationships), seemingly to prove their masculinity.[5]

Given the high prevalence of sexual victimization of males in some settings, educational programs for young men that promote healthy sexual attitudes and development are essential. Workshops conducted by trained peers, counselors, and social workers are also needed to address boys' anxieties about sexual behavior and to educate them about the health risks of coerced sex, such as sexually transmitted infections, including HIV.

In school settings, bullying and violence must be aggressively discouraged, and teachers and significant others need to learn to be sensitive to adolescents' and young men's sexual health needs and concerns. Male students should be informed of the risk of sexual abuse and be taught that it is not acceptable. They need to be encouraged to develop and maintain healthy relationships with peers. Special programs to teach parents and older members of the community how to communicate with adolescents and address issues of sexuality and reproductive health should be organized by community-based organizations. Finally, resource centers are needed in communities to provide youth-friendly sexual health information, counseling, and other related services for boys and young men, such as self-help groups for victims.

In one sense, Mukesh was fortunate. Doctors in the hospital's outpatient department had been taught to screen for sexual abuse and were prepared to provide immediate support and referrals for further counseling and sexual health services at the hospital's adolescent center.

Mukesh asked for outpatient services and was counseled to take advantage of them. However, like many boys in his situation, he did not return for follow-up. As a result, his medical condition was never diagnosed or treated at the hospital. Perhaps he did not return for economic reasons or — more likely — because of the shame and stigma associated with his abuse. As in most cultures, admitting that he had been a victim of sexual abuse by another male could well have called Mukesh's masculinity into question. Like many young men, he may have been more willing to risk his health than to have others doubt his masculinity.[6]

References

1 Andrew G, Patel V. Gender, sexual abuse and risk behaviours in adolescents: a cross-sectional survey in schools in Goa. *Natl Med J India* 2001;14(5):263-67; Andrew G, Patel V. Sex, studies or strife? What to integrate in adolescent health services. *Reprod Health Matters* 2003a;11(21):120-29; Andrew G, Patel V. *Health Needs of Adolescents: A Study of Health Needs of Adolescents in Higher Secondary Schools in Goa. Research Report. Second Edition.* Sangath, India: Resource Centre for Adolescent and Child Health, 2003b; Jaswal S. *Child and Adolescent Sexual Abuse in Health Facilities in Thane. Research Report.* Mumbai, India: Tata Institute of Social Sciences, 2002; Jaswal S. *A Study on Male Sexual and Reproductive Health in Thane City. Research Report.* Mumbai, India: Tata Institute of Social Sciences, 2004.

2 Jaswal, 2002.

3 Andrew and Patel, 2001; Andrew and Patel, 2003a.

4 Andrew and Patel, 2001; Andrew and Patel, 2003b; Durham A. Young men living through and with child sexual abuse: a practitioner research study. *Br J Soc Work* 2003;33:309-23.

5 Durham; Jaswal 2004; Verma RK, Rangaiyan G, Singh R, et al. A study of male sexual health problems in a Mumbai slum population. *Cult Health Sex* 2001;3(3):339-52.

6 Rivers K, Aggleton P. *Working with Young Men to Promote Sexual and Reproductive Health.* London, UK: Department for International Development, 2002.

Marital Sexual Violence Is 'A Terrifying Experience'

By Faizal Haque, Communications and Training Manager, Centre for Operations Research and Training, Vadodara, India; Dr. M.E. Khan, Regional Associate Director, Asia and Near East, FRONTIERS Program, Population Council, New Delhi, India; and Dr. John Townsend, Director, FRONTIERS Program, Population Council, Washington, DC

"It was a terrifying experience. When I tried to resist, he pinned my arms above my head. It was so painful and suffocating that I fainted, for I only remember getting up in the morning and finding stains of blood on the bed sheet. My husband was no longer in the room. I slowly got up and went to the toilet, feeling sick and depressed."

This is how 32-year-old Laxmi (not her real name) recalls her first sexual experience at age 13. Like many of the married women interviewed in a qualitative study conducted in 1996 in two villages of Uttar Pradesh, India,[1] Laxmi experienced marital sex as forced and frightening. The study, conducted by the India-based Centre for Operations Research and Training (CORT) among married women ages 15 to 44 years, found that young brides in Uttar Pradesh — where nearly half of all girls are married by the age of 15 — often are unprepared for sex and feel helpless to prevent it. Many girls are simply told one or two days before they are married, "Do not refuse your husband, let him do whatever he does."

Women in the study who had been married for fewer than three years tended to resist sex less than did women who had been married for three or more years. In the first years of marriage, women reported, acquiescing to a husband's sexual demands was the only way they knew to foster a close marital relationship or obtain some power to negotiate family affairs.

When women resisted sex, it was often because they worried about an unintended pregnancy. Ironically, refusing sex often led to sexual coercion and the very outcome they feared: Most of the women in the study who reported sexual violence in their marriages had experienced one or two unintended pregnancies.

In the study, two-thirds of some 100 women reported marital sexual coercion. When women refused sex, most husbands angrily reminded them, "What else have I married you for?" or "What good are you if you cannot do this for me?" Some husbands threatened to have sexual relations with other women or demanded that their wives return to their parents.

These findings are similar to those from studies conducted by the Population Council in Bangladesh and by CORT in Gujarat, India. In the study in Bangladesh, 71 percent of 160 women ages 15 to 35 years reported that forced sex had occurred in their marriages.[2] In contrast, the study in Gujarat, India, conducted among newly married men and women, found that only 16 percent of 25 women reported nonconsensual marital sex, while about a third of 25 married men confessed that they had forced sex on their wives.[3]

In these studies, forced sex had immediate adverse consequences: Women suffered depression, loss of self-esteem, and unintended pregnancies. The Bangladeshi study further revealed that compared with other women, those experiencing domestic and sexual violence did not use oral contraceptives as consistently and did not use emergency contraception as often to prevent unintended pregnancy after unprotected sex. Many women in the Bangladeshi study also reported that they feared acquiring sexually transmitted infections, including HIV. Since they often lacked the ability to negotiate safe sex in their marriages and were likely to experience forced marital sex, they left everything to fate. "I know my husband goes to commercial sex workers," said a 25-year-old woman with three children. "But what I can do? Neither will he stop going to outside women, nor can I convince him to use condom. I know one day he will infect me with AIDS . . . this is our fate."

Both the Indian and Bangladeshi studies also found that women experiencing sexual coercion lost interest in sex sooner than did those who were not sexually coerced. Consequently, they were more apt to refuse to have sex with their husbands, leading to further sexual coercion and violence.

How can this violence that women face in their own homes be addressed? Over the long term, the root causes of gender inequities must be addressed and eliminated. Systematic and persistent advocacy to mobilize the community against gender-based violence is also needed. Enforcing the law in India that prohibits marriage before the age of 18 would protect more young women from early marriage and the sexual helplessness they feel in such arrangements. In the short term, introducing family life education into schools and having family planning workers counsel newly married couples may deter sexual violence in marriage by preparing adolescents for married life and helping them develop positive attitudes toward sexuality. Young women who were informed about sexual matters and who entered marriage later (at age 19 years or older) were more likely to be able to negotiate sex with their partners and reported better marital sexual lives than did younger, less informed girls, the Bangladeshi study showed.

References

1 Khan ME, Townsend J, Sinha R., et al. Sexual violence within marriage. *Seminar* 1996;447:32-35.

2 Khan ME, D'Costa S, Rahman M. Prevalence and nature of violence against women in Bangladesh. *The 129th Annual Meeting of the American Public Health Association*, Atlanta, GA, October 21-25, 2001.

3 Khan ME, Barge S, Sadhwani H, et al. *Reflections on Marriage and Sexuality: Experience of Newly Married Men and Women in Gujarat, India.* Vadodara, India: Centre for Operations Research and Training, 2004.

'I Was Alive But Not Living . . .'

By Trish Hiddleston, Head of Protection, United Nations Children's Fund (UNICEF)/ Democratic Republic of Congo

"It was April 2002. They knocked on the door of our home and we opened it up because we thought it must be the neighbors stopping by to say hello. But it wasn't the neighbors. It was six armed men. They pushed their way into our home with their guns. . . . They forced me to have sex with them many times." Safi (not her real name), 19, was then taken by the men to their camp in the forest where she was held for more than a year. *"During that whole time, I felt like I was going crazy. I was like a person unconscious. I was alive but not living. . . . Every day they raped me. Before going out to steal or kill, they would rape me — sometimes one, sometimes all. . . ."*[1]

During more than five years of outright war in the Democratic Republic of Congo (DRC), rape and other forms of sexual abuse greatly increased as armed groups used sexual violence to weaken communities and force them into submission. And, despite the creation of a transitional government in 2003, conflict and sexual violence continue, particularly in the eastern DRC.

Women raped in this conflict situation have suffered many immediate, serious, and sometimes life-threatening health consequences. Safi was impregnated by one of her rapists. At a hospital in Goma where she was treated after escaping her captors, other girls and women have given birth to babies conceived during rape. But a considerable number of patients seen at the hospital, which is run by Doctors on Call for Service and receives substantial support from the United Nations Children's Fund (UNICEF), have come for surgical operations to repair a stigmatizing injury. The injury, called a fistula, is a hole torn between the bladder and the vagina or between the rectum and the vagina, leaving a woman incontinent.

Many girls and young women in the DRC are prone to developing a fistula for a number of reasons. Commonly in poor health and married before their bodies have matured, their vaginal or rectal walls may be weakened or damaged by even non-violent marital sexual intercourse. Repeated, violent rape (sometimes by insertion of sharp objects into the vagina) can exacerbate this damage, if not cause it directly. Also, girls who are impregnated during rape and give birth before their bodies have fully matured may develop a fistula as a result. Between April and September 2003, more than 150 fistula operations were performed on girls and women referred to the hospital in Goma. During that period, the hospital registered 973 female victims of sexual violence, ranging from 7-year-old girls to 80-year-old great-grandmothers. Twelve percent of the hospital's female patients had been infected with HIV, and nearly 40 percent had other sexually transmitted infections.[2]

Emergency contraception can help prevent unwanted pregnancy, and postexposure prophylaxis may help prevent HIV infection. However, the treatments are seldom available in the DRC. Even when they are available, medical workers there rarely know how to provide them. Furthermore, many rape victims do not know of the benefits of these treatments. Even if they do, such obstacles as ongoing conflict, lack of transportation, or inability to pay prevent most victims from accessing available services in time for them to be effective. (Emergency contraception should be provided within 120 hours; postexposure prophylaxis, within 72 hours.)

There are other reasons why many victims do not seek medical, let alone legal, help. They may fear retribution by their perpetrators. And, because rape carries enormous stigma in the DRC, victims try to keep it secret. Disclosure may lead to ostracism by family and community. Such fierce stigmatization and resulting isolation means that many rape victims have no way to ensure their basic survival and thus may often feel compelled to begin exchanging sex for basic necessities: food, money, shelter, or security.

A combination of factors sustains sexual violence in this setting. First, the displacement, family separation, and community disintegration resulting from conflict weaken such traditional protective mechanisms as asking family members, neighbors, chiefs, or elders for help. And war establishes violence as the norm. As a result, sexual violence by those in positions of relative power and strength — soldiers, police, teachers, and common criminals — has increased.

However, rape — rarely reported in the DRC due, in part, to an ineffective judicial system as well as gender norms that maintain women's low status and lack of power — is increasingly gaining attention. And strategies to prevent it and to alleviate its consequences are being undertaken, including:

- Neighborhood watch collaborations are being created.
- The DRC government, the United Nations, and nongovernmental agencies have joined in a national initiative to fight sexual violence.
- When populations are displaced, UNICEF staff and nongovernmental agencies try to prevent family separation, ensure speedy family reunification, and ensure that camp design does not facilitate rape.
- Post-rape kits are being supplied by UNICEF, the United Nations Population Fund, the World Health Organization, and nongovernmental agencies to a few health centers. Mobile teams are being created to care for victims when conflict areas become accessible.

These organizations and agencies are also providing training on basic principles of confidentiality, security, respect, and nondiscrimination — as well as medical and psychosocial care — to health centers, religious groups, community-based organizations, law enforcement agents, and others.

Still, the needs of Congolese women who have been raped or are at high risk of being raped remain largely unmet. Increased funding for a coordinated, multidimensional approach to preventing and responding to sexual violence in the DRC is sorely needed.

References

1 Page K. *Safi's Story: A Courageous Young Woman Moves Beyond Her Past Experience of Sexual Violence*. Democratic Republic of Congo: United Nations Children's Fund, 2003.

2 Page.

Virginity Testing Raises Many Questions

By Cleopatra Ndlovu, Communications Officer, Women's Action Group, Zimbabwe

Imagine being Rudo (not her real name), a 16-year-old girl living in an area of Zimbabwe where girls are tested for virginity.

Rudo's turn to be examined comes. An elderly woman asks her to lie down, opens her legs, and then inserts into her vagina a finger — which has been inserted in other girls' private parts that day — to see if she is still a virgin. How do you think Rudo feels?

Unfortunately, the practice of virginity testing has been resuscitated over the years, with people claiming that it preserves their African identity, their culture. Various groups — sometimes tribes, churches, or families — perform virginity testing in Malawi, South Africa, Swaziland, Zimbabwe, and other African countries. Girls as young as five years old may be tested. If a girl is found to be a nonvirgin, the price a man pays for her as his bride will be lower, or he may refuse to marry her. Even if the man agrees to marry her, the girl and her family are often shamed and ridiculed.

GISELE WULFSOHN/PANOS PICTURES

S *In South Africa, girls line up to receive a certificate confirming that they have passed a virginity test.*

Boys, in contrast, are not subjected to such intimate examinations. Boys and men are not even expected to remain abstinent before or faithful during marriage. Their sexual "purity" is not questioned. In Zimbabwe, as in many other places, male sexual experience is often encouraged and male infidelity tends to be condoned.

Why is virginity testing done? First, it is meant to ascertain girls' sexual purity at marriage. Second, it is intended to discourage girls from engaging in sexual activities prior to marriage and, thus, may be considered a way to combat the spread of HIV/AIDS.

This is the case in Zimbabwe, which has one of the highest HIV infection rates in the world. For example, Chief Naboth Makoni of the Makoni district 180 kilometers from Harare includes virginity testing as part of his anti-AIDS campaign. He has said virginity testing of girls helps prevent HIV infection in his district (which, ironically, has the highest rate of HIV infection in the country) by making premarital sex shameful and thus discouraging it. Thousands of young girls have been tested in Chief Makoni's area.

It is true that — for both girls and boys — abstaining from sex until entering a mutually monogamous marriage protects against the sexual transmission of HIV. But virginity testing is not necessarily an effective way to achieve this goal. Nor is it fair. For example, some girls fail the test because they have been victims of rape or incest. When their loss of virginity is discovered during testing, they become stigmatized while the perpetrators often go unpunished. In other cases, girls may have had to exchange sex for food just to survive. Also, a girl's hymen may have broken naturally. Although she has never had sexual relations, she may be declared a nonvirgin and suffer the consequences. Finally, the practice of virginity testing implies that girls' sexuality, but not that of boys, is the root cause of HIV transmission.

Virginity testing is likely to be harmful for many girls, regardless of whether they pass the test. First, this intimate examination strips a girl of her dignity. Virginity testing is said to be voluntary, but parents under societal pressure may coerce or persuade their daughters to undergo the practice. Girls who fail the test are often stigmatized by their families and the community for months or years, and their marital value falls. To preserve their virginity, girls and young women sometimes will have anal sexual intercourse, which — if the sexual partner is HIV-infected — poses more risk of HIV infection than vaginal sexual intercourse.

Some girls say that they feel happy when they pass a virginity test. In a newspaper interview, a young school girl in Zimbabwe said, "If you are a virgin, you feel proud and have self-esteem and confidence in what you are doing." However, some girls who pass the test are at risk: They may be married off to older men whose virginity and HIV status were not tested and who may already be infected with HIV. In fact, HIV-infected men may seek young virgins for marriage because they believe the myth that having sexual intercourse with a virgin can cure the infection.

Virginity testing in Zimbabwe is controversial, and people have different opinions about it. But let us ask ourselves these questions: Is virginity testing really a good way to curb the spread of HIV/AIDS? Does it not violate young women's rights and deprive them of power and control over their bodies and sexuality? What is being done to help girls who have lost their virginity due to rape? What are the health risks posed by using on several girls the same gloves or fingers not necessarily washed well? To whom are these girls married after being tested? Are their husbands HIV-negative? Why is the virginity of boys not being questioned? Why do these double standards of sexual purity for boys and girls exist?

So many questions: Let's think about them.

Helping Victims of Sexual Coercion

Provider's role depends on available resources and support.

KEY POINTS

- Reproductive health care providers may be able to offer counseling, medical, and referral services.
- Addressing nonconsensual sex and other forms of violence against women within reproductive health services can improve quality of care.
- Effective services require clear policies and procedures, positive provider attitudes toward victims, institutional support, and referral networks.
- Research is needed to determine the impact of provider interventions.

"When the physician told me that my health problems were related to what was happening in my house, I started to understand what was going on with me. It was as if a screen was lifted from my eyes, and I started to think that I did not deserve this."

— Survivor of intimate partner violence, the Dominican Republic

This woman's experience illustrates how, by defining violence as a health threat, medical professionals can encourage victims of sexual coercion or of physical or psychological abuse by intimate partners to consider making positive changes in their lives.[1]

Reproductive health care providers are often particularly well placed to detect sexual coercion and to care for its predominantly female victims since many women routinely attend family planning or primary health care clinics. Reproductive health care providers also often see the effects of sexual coercion on their clients' health, such as recurrent sexually transmitted infections and unintended pregnancies.[2]

But providers in family planning clinics and other health facilities rarely have the knowledge, skills, resources, and support necessary to identify cases of sexual coercion; offer medical, counseling, and referral services to those who experience it; or document evidence of sexual assault.

"Sexual and reproductive health programs are largely premised on consensual sex," notes Dr. Shireen Jejeebhoy, a senior program associate in the Population Council's office in New Delhi, India, in a recent review of the nonconsensual sexual experiences of young people in developing countries.[3] "At the same time, programs that deal explicitly with nonconsensusal sex are often narrowly focused on improving the management of the few rape cases reported to the police."

Addressing sexual coercion more comprehensively within reproductive health and women's health care services poses challenges but also offers opportunities to improve quality of care. Providers who understand how sexual coercion can affect clients' health are more likely than others to provide relevant family planning and sexual risk-reduction counseling, and they are less likely to misdiagnose chronic complaints resulting from abuse. Strengthening services for victims of violence can also benefit clients because staff members are more aware of the need to protect clients' privacy and maintain the confidentiality of medical records.[4]

NANCY DURRELL-MCKENNA/PANOS PICTURES

s *Providers may not be adequately trained to help clients who have experienced sexual coercion, even in settings with high rates of reported rape, such as South Africa.*

s ***During routine counseling sessions, providers at clinics associated with the International Planned Parenthood Federation in the Dominican Republic, Peru, and Venezuela are expected to screen all clients for experience with physical or sexual violence.***

Challenges for providers

Providers are often reluctant to address sexual coercion or other forms of violence experienced by their clients. Perceived barriers to helping victims include an inability to spend enough time with clients, limited training and skills, lack of referral services or effective interventions, concern about legal consequences, and fear of offending clients.[5]

Many providers simply do not know how to help clients who have experienced sexual coercion. In South Africa, only about a quarter of 354 providers interviewed at hospitals and primary care centers had received any training in sexual assault services, and training that had occurred focused largely on medical and forensic issues, with little attention to psychosocial aspects or provider attitudes.[6]

Training should address providers' attitudes because it may be difficult for providers to offer nonjudgmental, sensitive counseling and care to victims if they share common misconceptions about violence and have negative attitudes toward victims.[7] In a survey of reproductive health care providers in the Dominican Republic, Peru, and Venezuela, for example, more than half of 79 respondents thought that some women's behavior was "inappropriate" and thus provoked their husbands' aggression.[8]

Some providers' own experience as victims or perpetrators of sexual coercion may affect their attitudes toward clients. In a study among South African public health nurses, 11 of 36 female nurses reported sexual abuse by an intimate partner, and six of eight male nurses admitted abusing a partner. Both male and female nurses thought violence against women was sometimes justified.[9]

Many providers are concerned about the effects of sexual coercion and other forms of violence. But they often report frustration that they cannot "fix" the problem and that some clients ignore their advice.[10] Trainers can help providers understand the difficulties abused clients face and the value of offering emotional support.[11]

Transforming systems

Lack of institutional support, community resources, referral networks, and evidence of effective interventions compromises providers' ability to help victims of sexual coercion or other forms of violence against women.[12] Providers are often expected to implement such services on their own after attending a single training session or workshop on sexual violence.

Many experts emphasize that effective service provision requires that policies and procedures for managing cases of sexual violence against women become standard practice throughout an entire health care system.[13] This "systems approach" requires attention to details of clinical infrastructure, such as ensuring that a facility has a cabinet with a lock for storing clients' records and a room where clients can be asked about violence without being overheard by partners, relatives, or other clients.[14] It also involves supporting staff through ongoing training and supervision and, perhaps, by designating a staff violence specialist or holding monthly meetings to discuss difficult cases and help providers cope with emotional stress.[15]

In one example of such a systems approach, the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) and its member associations in the Dominican Republic, Peru, and Venezuela reviewed all aspects of their health programs before beginning to screen clients for experience with sexual coercion, sexual abuse in childhood, and violence within their families. Aspects that were evaluated included patient flow, clinic infrastructure, staff training, treatment protocols, clinical history forms, data systems, and agreements with referral organizations. The member associations even changed their hiring procedures to ask job candidates about their views on violence against women, seeking out people who shared the organizations' commitment to assist victims.[16]

Evidence needed

IPPF/WHR and its member associations in the Dominican Republic, Peru, and Venezuela were able to both identify cases of sexual, physical, or psychological abuse of women and offer comprehensive services in their clinics or through referrals. [17] Meanwhile, a growing number of other organizations are taking on the challenges of detecting, treating, and preventing sexual coercion and other forms of violence against women.

In Brazil, the number of public hospitals providing comprehensive care to women who experience sexual violence rose from just three in 1996 to 63 in 2001 through the advocacy and training efforts of obstetrical and gynecological societies. Screening clients for violence and then offering victims counseling and referrals is being tested in primary health care centers in São Paulo.[18] Another initiative by the USAID-funded PRIME II project raised awareness about physical, sexual, psychological, and economic abuse of women and the need for legal protection against such abuse. It also established screening, counseling, and referral services for abused clients in a busy reproductive health clinic in the Armenian capital of Yerevan.[19] In South Africa, an alliance of individuals and organizations is working with the government to change policies, raise community

Advisability of Screening for Violence Debated

Fearing disbelief, blame, or retribution, many victims of forced sex tell no one about their experiences — unless they are asked.[1] Routine screening for physical and sexual abuse by intimate partners is recommended by several professional associations in the United States and the United Kingdom,[2] and a growing number of organizations in developing countries are training providers to ask all clients[3] or all clients with certain symptoms[4] about such abuse. Some experts question, however, whether such screening is advisable or even ethical in most resource-poor settings.

Proponents of screening say that failing to inquire about sexual coercion or other forms of violence compromises quality of care and misses opportunities to save women from potentially life-threatening situations. Others insist that screening should not take place unless the necessary support, policies, procedures, and referral networks are in place to ensure clients' safety.

At the heart of the debate is the question of what is an effective intervention: Is providing emotional support to women who have disclosed sexual coercion or other forms of violence beneficial in itself, or is screening effective only when it prevents further abuse?

The evidence to date suggests that screening efforts can improve detection of sexual coercion and other abuse.[5] In most surveys among women who have experienced violence, the majority of women support screening, and many express relief and gratitude for the chance to talk about their abuse, often for the first time.[6] But whether disclosure has a positive effect on women's health and safety is still in question.[7]

Researchers at the State University of New York in Albany, New York, USA, and Johns Hopkins University in Baltimore, Maryland, USA, are conducting a randomized controlled trial to assess whether screening and intervention for partner violence among women receiving primary care services reduces their exposure to future violence. The trial, which is sponsored by the U.S. Centers for Disease Control and Prevention (CDC), will also measure the impact of provider intervention on the women's quality of life and mental and physical health. Results are expected in 2005. Additional studies are needed to determine when and how to screen for violence in different settings, particularly in developing countries.[8]

In the meantime, based on the experience of family planning associations in the Dominican Republic, Peru, and Venezuela, the International Planned Parenthood Federation's Western Hemisphere Region office recommends that health facilities establish routine screening only when they can ensure clients' privacy, safety, and confidentiality. Managers should also help ensure that providers have positive attitudes toward victims of violence and can offer clients who disclose violence some assistance on-site or through referrals.

Even when screening policies and protocols are not in place, some clients will seek care for the effects of abuse or disclose their experiences to a provider. Therefore, providers need to be prepared to respond sensitively to victims of violence and to care for women in crisis.[9]

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References

1 García-Moreno C. Sexual violence. *IPPF Med Bull* 2003;37(6):1-2; Jejeebhoy S, Bott S. *Non-consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries*. New Delhi, India: Population Council, 2003.

2 García-Moreno C. Dilemmas and opportunities for an appropriate health-service response to violence against women. *Lancet* 2002;359(9316):1509-14.

3 Bott S, Guedes A, Guezmes A. The health service response to sexual coercion/violence: lessons from IPPF/WHR members associations in Latin America. *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*, New Delhi, India, September 22-25, 2003.

4 Schraiber LB, d'Oliveira AF. Violence against women and Brazilian health care policies: a proposal for integrated care in primary care services. *Int J Gynaecol Obstet* 2002;78(Suppl 1):21-25.

5 Bott; Velzeboer M, Ellsberg M, Clavel Arcas C, et al. *Violence Against Women: The Health Sector Responds*. Washington, DC: Pan American Health Organization, 2003; Waalen J, Goodwin MM, Spitz AM, et al. Screening for intimate partner violence by health care providers: a review of barriers and interventions. *Am J Prev Med* 2000;19(4):230-37.

6 Bott S, Guedes A, Claramunt MC, et al. *Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. New York, NY: International Planned Parenthood Federation, Western Hemisphere Region, 2004; Parsons L, Goodwin MM, Petersen R. Violence against women and reproductive health: toward defining a role for reproductive health care services. *Matern Child Health J* 2000; 4(2):135-40.

7 Nelson HD, Nygren P, McInerney Y, et al. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 2004;140(5):387-96; Family Violence Prevention Fund Research Committee. Review of the U.S. Preventive Services Task Force draft recommendation and rationale statement on screening for family violence. San Francisco, CA: Family Violence Prevention Fund, 2003. Available at: *http://endabuse.org/programs/healthcare/files/FullResponse.pdf*; Ramsay J, Richardson J, Carter YH, et al. Should health professionals screen women for domestic violence? Systematic review. *BMJ* 2002;325(7359):314-18.

8 García-Moreno, 2002.

9 Bott, Guedes, Claramunt.

awareness, and improve health sector responses to sexual violence.[20] Program implementation there has lagged behind policy reform,[21] but guidelines for clinical management of victims of sexual assault have been developed, and the government plans to train service providers to use them.

Similar pilot programs are also under way in countries such as Bangladesh, Costa Rica, India, Nicaragua, the Philippines, and Venezuela.[22] Few efforts have been evaluated, however, and most evaluations that have been conducted have been limited to measuring detection rates or changes in provider attitudes or practices. Measuring the impact of provider intervention is difficult because of the need to rely on self-reported experiences of violence and ethical concerns about withholding services from members of study comparison groups.

Because limited evidence is available on how screening and other provider interventions affect clients' health or exposure

How Providers Can Help

Providers can help clients cope with the effects of sexual coercion and prevent further abuse in many ways. They can:

Recognize warning signs. Warning signs — such as recurrent sexually transmitted infections (STIs), unplanned pregnancy, depression, self-destructive behavior, or a history of chronic, unexplained physical symptoms — can alert providers that a client may have experienced sexual assault or other types of nonconsensual sex.[1]

Assess safety. A provider can help a woman who discloses abuse determine whether she may be in immediate danger of further abuse and, if so, help her find a safe place to stay.

Provide sensitive, nonjudgmental counseling. Clients interviewed after visiting clinics in three Latin American countries where providers routinely screened for sexual, physical, and psychological abuse appreciated providers' nonjudgmental attitudes, respect for confidentiality, belief in their accounts, and emotional support.[2] Providers should assure clients who have experienced forced sex that the abuse was not their fault.[3]

Confront myths. Analyzing personal beliefs and prevailing myths about nonconsensual sex can help providers become more effective counselors. It is important to understand, for example, that sexual violence is driven by anger and a need to control victims rather than by sexual desire, and that rape can occur within marriage.[4]

Counsel clients on contraception and STI prevention. Women who experience any kind of sexual coercion need special counseling about how to protect themselves from HIV, other STIs, and unintended pregnancy. A client may need a clandestine form of contraception if a coercive partner does not want her to use family planning. Negotiating condom use is rarely an option for a woman in an abusive relationship.[5]

Offer emergency contraception. Clients who have had forced sexual intercourse within the past five days should be offered emergency contraception; a woman who has waited more than five days to seek help should be advised to return for pregnancy testing if she misses her next period.[6] Emergency contraception can help prevent pregnancy for up to five days but is most effective within 72 hours of intercourse.[7]

Provide timely, appropriate STI testing and treatment. Local protocols should guide decisions about which STI tests to offer a victim of sexual violence and whether to offer postexposure prophylaxis for STIs. If postexposure prophylaxis for HIV infection is available, a thorough discussion of its risks and benefits can help a client make an informed decision (see article, page 20).[8]

Know the legal requirements. To avoid compromising future investigations or court hearings, providers should have a thorough understanding of local regulations governing sexual abuse. In cases of rape, for example, forensic services should be performed by someone the courts recognize as qualified to document evidence of rape.[9]

Build and maintain a referral network. Few health facilities can offer victims of sexual coercion all the medical, psychological, legal, and social services they need. Providers should know what referral services are available and should develop cooperative relationships with referral agencies.[10]

Redefine nonconsensual sex as a health problem. By raising awareness of the serious health consequences of forced sex, health care providers can help change societal attitudes that condone or even encourage it. They can ensure that their own institutions do not tolerate coercion. Also, they can educate clients and help influence policies that guide medical, legal, and social responses to nonconsensual sex.

The appropriate level of services to offer in a given setting depends on the resources available. Some hospitals may be able to provide comprehensive services, while providers at primary health centers focus on education, detection, basic medical care, and referrals. The United Nations Population Fund (UNFPA) helps program managers establish one of the following three levels of services for victims of sexual violence: displaying information in clinics, screening all clients and referring them for care and support, or screening clients and providing care and support on-site.[11]

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References

1 Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. *Popul Rep* 1999;27(4):22-23; Stevens L. *A Practical Approach to Gender-based Violence: A Programme Guide for Health Care Providers and Managers.* (New York, NY: United Nations Population Fund, 2001)12-13.

2 Bott S, Guedes A, Guezmes A. The health service response to sexual coercion/violence: lessons from IPPF/WHR members associations in Latin America. *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*, New Delhi, India, September 22-25, 2003.

3 Stevens.

4 World Health Organization (WHO). *Guidelines for Medico-legal Care for Victims of Sexual Violence.* Geneva, Switzerland: WHO, 2003.

5 Stevens.

6 WHO.

7 International Consortium for Emergency Contraception. Regimen Update, June 2003. Available: *http://www.cecinfo.org/files/ICEC%20%20Dosage%20and%20Timing%20Policy%20Statement%202003.pdf.*

8 WHO.

9 Jejeebhoy S, Bott S. *Non-consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries.* New Delhi, India: Population Council, 2003.

10 WHO.

11 Stevens.

to further violence (see article, page 17), experts have called for more rigorous evaluation of such interventions. This includes, in a variety of health care settings, randomized controlled trials and qualitative research among women who have experienced physical or sexual abuse to analyze which interventions they think are effective, and why.[23]

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References

1 Bott S, Guedes A, Guezmes A. The health service response to sexual coercion/violence: lessons from IPPF/WHR members associations in Latin America. *Non-consensual Sexual Experiences of Young People in Developing Countries: A Consultative Meeting*. New Delhi, India, September 22-25, 2003.

2 Stevens L. *A Practical Approach to Gender-based Violence: A Programme Guide for Health Care Providers and Managers*. New York, NY: United Nations Population Fund, 2001; Watts C, Mayhew S. Reproductive health services and intimate partner violence: shaping a pragmatic response in sub-Saharan Africa. *Int Fam Plann Perspect* 2004; 30(4):207-13.

3 Jejeebhoy S, Bott S. *Non-consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries*. New Delhi, India: Population Council, 2003.

4 Bott S, Guedes A, Claramunt MC, et al. *Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries*. New York, NY: International Planned Parenthood Federation, Western Hemisphere Region, 2004.

5 García-Moreno C. Dilemmas and opportunities for an appropriate health-service response to violence against women. *Lancet* 2002;359(9316):1509-14; Waalen J, Goodwin MM, Spitz AM, et al. Screening for intimate partner violence by health care providers: a review of barriers and interventions. *Am J Prev Med* 2000;19(4):230-37; Guedes A, Stevens L, Helzner J. Addressing gender-based violence in a reproductive and sexual health program in Venezuela. In Haberland N, Measham D, eds. *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning*. New York, NY: Population Council, 2002.

6 Christofides N, Webster N, Jewkes R, et al. *The State of Sexual Assault Services: Findings from a Situation Analysis of Services in South Africa*. Pretoria, South Africa: South African Gender-based Violence and Health Initiative, 2003.

7 García-Moreno; Jejeebhoy.

8 Guedes A, Bott S, Cuca Y. Integrating systematic screening for gender-based violence into sexual and reproductive health services: results of a baseline study by the International Planned Parenthood Federation, Western Hemisphere Region. *Int J Gynaecol Obstet* 2002;78(Suppl 1):57-63.

9 Kim J, Motsei M. "Women enjoy punishment": attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Soc Sci Med* 2002;54(8):1243-54.

10 García-Moreno; Guedes, Stevens, Helzner.

11 Bott, Guedes, Claramunt.

12 García-Moreno.

13 Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. *Popul Rep* 1999;27(4):36.

14 García-Moreno; Stevens.

15 Stevens; Parsons L, Goodwin MM, Petersen R. Violence against women and reproductive health: toward defining a role for reproductive health care services. *Matern Child Health J* 2000;4(2):135-40; Llorens M, Medina S. Support groups for providers. *Basta*! March 2002. Available: *http://www.ippfwhr.org/publications/download/serial_issues/basta200203_e.pdf*.

16 Bott, Guedes, Guezmes.

17 Bott, Guedes, Guezmes.

18 Faúndes A, Andalft J. Sexual violence against women. The role of gynecology and obstetrics societies in Brazil. *Int J Gynaecol Obstet* 2002;78(Suppl 1):67-73; Schraiber LB, d'Oliveira AF. Violence against women and Brazilian health care policies: a proposal for integrated care in primary care services. *Int J Gynaecol Obstet* 2002;78(Suppl 1):21-25.

19 Newman C, Sargsyan I, Kohler R, et al. *Improving Primary Providers' Response to Violence Against Women in Reproductive Health Services in Armenia*. Yerevan, Armenia: PRIME II Armenia, 2004.

20 Christofides.

21 Guedes A. *Addressing Gender-based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis*. Washington, DC: Poptech, 2004.

22 Haque YA, Clarke JM. The Woman Friendly Hospital Initiative in Bangladesh setting: standards for the care of women subject to violence. *Int J Gynaecol Obstet* 2002;78(Suppl 1):45-49; Stevens.

23 García-Moreno; Nelson HD, Nygren P, McInerney Y, et al. Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 2004;140(5):387-96; Gazmararian JA, Petersen R, Spitz AM, et al. Violence and reproductive health: current knowledge and future research directions. *Matern Child Health J* 2000;4(2):79-84.

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Research on **Postexposure Prophylaxis for HIV**

Antiretroviral treatment of rape victims definitely or probably exposed to HIV during their assaults can be cost-effective in countries with high HIV prevalence. It also may be affordable in a middle-income country like South Africa, a recent modeling study conducted there shows.[1]

Such treatment, called postexposure prophylaxis (PEP), has been available through the South African public health system since 2002. "In one year between April 2002 and March 2003, nearly 53,000 rapes and attempted rapes were reported in South Africa, although the actual rate may be up to nine times greater," says Nicola Christofides, the study's principal author and a senior scientist with the Medical Research Council of South Africa. With 14 percent to 28 percent of rapists in South Africa estimated to be HIV-infected, their victims face considerable infection risks. Providing all rape victims with PEP may be substantially less costly than later treating only those who become infected. In South Africa, the difference could be as great as U.S. $2,000 per person.

In the modeling exercise, researchers made several assumptions. First, they assumed that the use of PEP after rape would be at least 80 percent effective. This reflects results from a retrospective case-control study indicating that the odds of HIV infection were reduced by about 81 percent among health care workers who took PEP after exposure to HIV via needle-stick injuries.[2] A substantial body of other research also supports the effectiveness of PEP after occupational exposures to HIV in health care settings. PEP has become the standard of care in such settings, and the United States has national guidelines for occupational PEP. Nevertheless, the efficacy of occupational PEP has not been proven, and failure of PEP to prevent HIV infection has been reported.[3]

Limited data exist about PEP's effectiveness when given after sexual exposure to HIV. A small Brazilian study among homosexual men exposed to HIV found that PEP reduced seroconversion by 83 percent.[4] Otherwise, efficacy has been largely assumed on the basis of animal and human data including occupational, perinatal, and nonoccupational exposures to HIV. Several European nations, Australia, and some U.S. states — New York, Rhode Island, Massachusetts, and California — have issued guidelines for the use of PEP after sexual or other forms of nonoccupational exposure to HIV.[5] The U.S. Centers for Disease Control and Prevention (CDC) had not recommended for or against the use of PEP after nonoccupational exposure to HIV because it lacked information on PEP's effectiveness at curbing infection.[6] But in January 2005, after considering recent animal and lab studies, the CDC began recommending a 28-day course of antiretroviral therapy for persons seeking care within 72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV-infected, when that exposure represents a substantial risk of infection.[7]

Nevertheless, the question of how to determine whether the risks of HIV infection justify use of PEP remains. Most exposures to HIV will not result in infection. In the case of sexual assault, considerations include the infectiousness of the rapist (e.g., viral loads are higher in recently seroconverted individuals) and the risk of infection based on the victim's age. For biological reasons, younger women are more susceptible. (Notably, the South African researchers estimated that women under age 18 years had twice the risk of infection than did adult women.) Also to be considered is the degree of vaginal trauma and abrasions caused by rape. Risk of HIV infection after unforced vaginal intercourse with an infected man has been estimated to be 0.1 percent to 0.2 percent per act,[8] but traumatic, forced sex could quadruple that risk, the South African researchers estimated. This heightened risk approximates that associated with occupational needlestick exposure, which may be as high as 0.36 percent.[9]

Even when HIV risk is clearly high and thus use of PEP seems most appropriate, type of treatment and compliance to treatment regimens need to be considered.

PEP involves taking a brief course (usually 28 days) of antiretroviral medications as soon as possible after exposure, preferably beginning within 36 hours. Usually, a regimen of two nucleoside reverse transcriptase inhibitors — ideally, zidovudine and lamivudine (otherwise, lamivudine and stavudine, or stavudine and didanosine) — is recommended. This approach is especially advised if the source is of unknown HIV status but presumed to be at low risk of infection. A regimen that includes a third drug — usually a protease inhibitor such as indinavir or nelfinavir — may be warranted for exposures that pose an especially high risk of HIV transmission (for example, when the source is definitely HIV-positive or at very high risk of infection).[10]

The potential benefits of PEP must be carefully weighed against its potential dangers. All approved antiretroviral drugs have substantial drug interactions and adverse side effects that are occasionally serious; thus, PEP is not justified for exposures posing a negligible risk for HIV infection.[11] (Regardless of HIV risk, nevirapine is not recommended for PEP for safety reasons.[12]) The health risks associated with PEP are of particular concern when treatment is considered for adolescents or children, and great care must be taken in its administration.[13]

Among the factors that the South African researchers considered in their PEP cost-effectiveness model was that of treatment compliance, which can be poor. Analysis of a registry of some 450 U.S. health care workers who received PEP (often consisting of at least three antiretroviral drugs) after exposure to HIV found that nearly half of the workers discontinued all drugs and another 13 percent modified their drug regimen, commonly in response to adverse side effects.[14] Even with support and counseling of patients, discontinuation of PEP can be high.[15]

In the South African cost-effectiveness study, a two-drug regimen of zidovudine and lamivudine was modeled. Whether to use a two- or three-drug regimen is debated.[16] Because a two-drug regimen is likely to be less costly, less toxic, have fewer side effects, and be better tolerated than a three-drug regimen, it may be less frequently discontinued and may actually result in lower HIV transmission rates.[17] In a study of PEP that primarily involved two reverse transcriptase inhibitors, 78 percent of some 400 individuals treated for four weeks completed treatment.[18]

A multidisciplinary team approach to PEP provision for rape victims may increase adherence even to the three-drug regimen, a small study in London suggests.[19] Although evidence-based guidelines are needed, essential services suggested for rape victims receiving PEP include HIV testing for at least six months after exposure; counseling about the importance of completing the drug regimen, possible drug interactions and side effects, and how to minimize side effects and recognize serious side effects; and medical evaluation for toxicity at baseline and again two weeks after starting PEP.

In middle- and low-income countries, particularly those with generalized HIV epidemics, research is urgently needed on how PEP can be included in patient care.[20] But, in South Africa, the researchers who found PEP for rape victims to be cost-effective have conducted additional research to explore how women themselves want PEP to be delivered.[21] Interviews with 292 women, 159 of whom had accessed sexual assault services, revealed that they preferred PEP to be offered with other related sexual assault services. Such services included provision of HIV testing before PEP begins, increased availability of counseling, easily remembered information about side effects, and medications to alleviate the common side effect of nausea. Finally, the interviewed women preferred delivery of all PEP drugs at an initial visit. Although not current practice, this approach appears to increase compliance, which was only 44 percent, says study coauthor Christofides.

n **Kim Best**

References

1 Christofides N. Postexposure prophylaxis after rape. *XV International AIDS Conference*, Bangkok, Thailand, July 11-16, 2004.

2 Cardo DM, Culver DH, Ciesielski CA, et al. A case-control study of HIV seroconversion in health care workers after percutaneous exposure. Centers for Disease Control and Prevention Needlestick Surveillance Group. *N Engl J Med* 1997;337(21): 1485-90.

3 U.S. Centers for Disease Control and Prevention (CDC). Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis. *MMWR* 2001;50(RR-11):1-42; Fournier S, Maillard A, Molina J-M. Failure of postexposure prophylaxis after sexual exposure to HIV. *AIDS* 2001;15(3):430.

4 Schechter M, Lago RF, Ismerio R, et al. Acceptability, behavioral impact, and possible efficacy of post-sexual exposure chemoprophylaxis (PEP) for HIV. *9th Conference on Retroviruses and Opportunistic Infections,* Seattle, WA, February 24-28, 2002.

5 New York State Department of Health AIDS Institute. *HIV Prophylaxis Following Non-occupational Exposure Including Sexual Assault.* New York State Department of Health AIDS Institute, 2004. Available: *http://www.hivguidelines.org*; Mayer KH, Merchant RC, Browning CA. *Nonoccupational Human Immunodeficiency Virus Postexposure Prophylaxis Guidelines for Rhode Island Healthcare Practitioners.* Brown University AIDS Program and the Rhode Island Department of Health, 2004. Available: *http://www.health.ri.gov/disease/NPEPFinalDraftJuly26.pdf*; Massachusetts Department of Public Health. *HIV Prophylaxis Following Non-Occupational Exposures Recommended Protocol Components.* Massachusetts Department of Public Health, 2002. Available: *http://www.mass.gov/dph/aids/guidelines/exposure_nonwork.htm*; Myles JE, Bamberger J. *Offering HIV Prophylaxis Following Sexual Assault: Recommendations for the State of California.* San Francisco Department of Public Health, California HIV PEP after Sexual Assault Task Force, California State Office of AIDS, 2001. Available: *http://www.dhs.ca.gov/ps/ooa/Reports/PDF/HIVProphylaxisFollowingSexualAssault.pdf;* Stephenson J. PEP talk: treating nonoccupational HIV exposure. *JAMA* 2003;289(3):287-88.

6 U.S. Centers for Disease Control and Prevention (CDC). Management of possible sexual, injecting-drug-use, or other nonoccupational exposure to HIV, including considerations related to antiretroviral therapy. *MMWR* 1998;47(RR-17):1-14.

7 U.S. Centers for Disease Control and Prevention (CDC). Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States. *MMWR* 2005;54(RR-02):1-20; Health officials hail government's decision to extend emergency AIDS treatment to rape victims, drug users. *Associated Press*, January 21, 2005.

8 Mastro TD, de Vincenzi I. Probabilities of sexual HIV-1 transmission. *AIDS* 1996;10(Suppl A):75-82.

9 Tokars JI, Marcus R, Culver DH, et al. Surveillance of HIV infection and zidovudine use among health care workers after occupational exposure to HIV-infected blood. *Ann Intern Med* 1993;118(12):913-19.

10 CDC, 2001; Olshen E, Samples CL. Postexposure prophylaxis: an intervention to prevent human immunodeficiency virus infection in adolescents. *Curr Opin Pediatr* 2003;15(4):379-84; Sarrazin U, Brodt R, Sarrazin C, et al. Postexposure prophylaxis after occupational exposure to HBV, MCV and HIV. *Radiologe* 2004;44(2):181-94; Alvarado-Ramy F, Beltrami E. New guidelines for occupational exposure to blood-borne viruses. *Cleveland Clin J Med* 2003;70(5):457-65. Available: *http://www.ccjm.org/pdffiles/Alvarado-Ramy503.pdf.*

11 CDC, 2001.

12 Patel SM, Johnson S, Belknap SM, et al. Serious adverse cutaneous and hepatic toxicities associated with nevirapine use by non-HIV-infected individuals. *J Acquir Immune Defic Syndr* 2004;35(2):120-25.

13 Havens PL, American Academy of Pediatrics Committee on Pediatric AIDS. Postexposure prophylaxis in children and adolescents for nonoccupational exposure to human immunodeficiency virus. *Pediatrics* 2003;111(6 Pt 1):1475-87.

14 Wang SA, Panlilio AL, Doi PA, et al. Experience of healthcare workers taking postexposure prophylaxis after occupational HIV exposures: findings of the HIV Postexposure Prophylaxis Registry. *Infect Control Hosp Epidemiol* 2000;21(12):780-85.

15 Rabaud C, Bevilacqua S, Beguinot I, et al. Tolerability of postexposure prophylaxis with zidovudine, lamivudine, and nelfinavir for human immunodeficiency virus infection. *Clin Infect Dis* 2001;32(10):1494-95.

16 Kim JC, Martin LJ, Denny L. Rape and HIV post-exposure prophylaxis: addressing the dual epidemics in South Africa. *Reprod Health Matters* 2003;11(22):101-12.

17 Bassett IV, Freedberg KA, Walensky RP. Two drugs or three? Balancing efficacy, toxicity, and resistance in postexposure prophylaxis for occupational exposure to HIV. *Clin Infect Dis* 2004;39(3):395-401; Katz MH, Gerberding JL. Postexposure treatment of people exposed to the human immunodeficiency virus through sexual contact or injection-drug use. *N Engl J Med* 1997;336(15):1097-100.

18 Kahn JO, Martin JN, Roland ME, et al. Feasibility of postexposure prophylaxis (PEP) against human immunodeficiency virus infection after sexual or injection drug exposure: the San Francisco PEP Study. *J Infect Dis* 2001;183(5):707-14.

19 Limb S, Kawsar M, Forster GE. HIV post-exposure prophylaxis after sexual assault: the experience of a sexual assault service in London. *Int J STD AIDS* 2002;13(9):602-5.

20 Krug EG, Dahlberg LL, Mercy JA, et al., eds. *World Report on Violence and Health.* Geneva, Switzerland: World Health Organization, 2002.

21 Muirhead D, Christofides N, Jewkes R, et al. Including the provision of post exposure prophylaxis for the prevention of HIV after rape into sexual assault services in South Africa: how do women want services delivered? *XV International AIDS Conference*, Bangkok, Thailand, July 11-16, 2004.

Keys to Preventing Nonconsensual Sex

Promising interventions include multifaceted approaches, specific targets.

KEY POINTS

- More interventions to prevent nonconsensual sex in the developing world need to be well documented and evaluated.
- A multifaceted approach to prevention is recommended.
- Interventions should have specific targets and address particular risk factors.

Strong support of health and medicolegal services for victims of sexual violence is imperative, but it is wise to also think about financial support of prevention initiatives and their rigorous evaluation.

Some prevention efforts have already been implemented, mostly in the United States and other industrialized countries. "It would seem that there are also many programs aimed at the prevention of nonconsensual sex in developing countries, but most of these programs are not documented, making it difficult to describe the current range of interventions they deliver and the risk factors and target groups they aim to influence," says Dr. Alexander Butchart, coordinator of violence prevention at the World Health Organization (WHO). "Since so few of these programs have been evaluated, saying how successful they are is also difficult."

Nevertheless, based on reviews of programs evaluated worldwide and on discussions among prevention experts, some general characteristics that seem to help prevention efforts succeed have been identified.

Many contributing factors, strategies

At an individual level, a young man's abuse of alcohol or drugs may make him more likely to force a woman to have sex. Or a woman may not recognize that nonconsensual sex is inappropriate. She may feel that it is normal or even that she deserves it. But nonconsensual sex is by no means simply an individual problem. Evidence suggests that relationship, community, and societal factors also contribute.[1] And most underlying causes of forced sex, which seem related to women's low status and to gender inequities,[2] are deeply rooted.

Due to these multiple contributing factors, prevention efforts need to be implemented at many levels. Consequently, a range of general approaches and specific prevention interventions have been documented (see chart below).

Within a specific prevention effort, either a single approach or several of these approaches can be employed. The possible benefits of implementing — but also the possible difficulties in evaluating — a multifaceted approach have been demonstrated by a study to prevent violence, including nonconsensual sex, among young female hawkers in Nigeria.[3]

Hawking, which is common in West Africa among women of all ages, is an informal way to make money by trading food, clothing, and other household goods. The study was conducted between April 2000 and August 2001 in six of the largest motor parks where hawking occurs in

Approaches to Preventing Sexual Violence

Approach	Interventions
Individual	Life skills and other educational programs, programs for perpetrators, psychological care and support for victims
Developmental	Targeting individuals at multiple life stages such as childhood, adolescence, and young adulthood
Health care	Medicolegal responses, training for health care professionals, comprehensive care for victims
Community-based	Media and other prevention campaigns, community activism by men, school-based programs
Legal and policy	Reporting and handling cases of perpetration, legal reform, international treaties that set standards of unacceptable behavior

Source: Krug EG, Dahlberg LL, Mercy JA, et al., eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization, 2002.

southwest Nigeria. The research, funded by the United Nations Development Fund for Women (UNIFEM), included 345 semi-structured interviews with hawkers at baseline, a five-month intervention, and an interview-based evaluation among 374 hawkers one year later.

The five-month intervention involved distribution of more than 1,000 copies of educational materials about various forms of violence against women. Six three-day workshops for nearly 600 hawkers (and a one-day workshop for community members who were interested in preventing violence in the motor parks) included training on the definition and consequences of violence, the development of assertiveness skills, and care and support for victims. Finally, selected hawkers received loans of U.S. $20 for personal or educational purposes, intended to promote sound investments and accountability.

The reported rate of forced sexual intercourse decreased from 11.3 percent at baseline to 1.9 percent after the intervention, and the reported rate of rape decreased from 5.5 percent to nearly 0 percent. Rates of sexual harassment and attempted rape also declined significantly.

The study team from University College Hospital in Ibadan, Nigeria, and FHI acknowledge, however, certain limitations of the study. The reduction in rape should be interpreted with caution, they say, since underreporting of rape is common in the motor parks and because of the short interval between the intervention and the evaluation. Also, the populations interviewed at baseline and at the one-year evaluation were not identical. This is because not all hawkers necessarily participated in the interviews and because some hawkers may have moved into the area, while others may have stopped hawking or moved away, after the intervention.

"Hawkers are a very mobile group, but we hope that the knowledge and skills they acquired during the intervention will remain with them when they move and will influence their decisions in the future," says the study's principal investigator, Dr. Olufunmilayo Fawole of University College Hospital. An intended reevaluation of the intervention has not taken place because of lack of funding, but Dr. Fawole and colleagues recently implemented a similar project among vulnerable apprentices in the hairdressing, sewing, and medicine-selling sector in southwest Nigeria. Results are expected in 2005.

Appropriate targets

Multifaceted prevention strategies such as this one should have very specific targets, experts tend to agree. In a recent international review of interpersonal violence, WHO strongly encourages prevention efforts in low-resource settings to target subpopulations at highest risk.[4]

Many high-risk populations exist because nonconsensual sex is perpetrated in so many settings and under various circumstances. In many countries, one high-risk population is married women. Nonconsensual sex within marriage often

Focus on Primary Prevention

Prevention efforts fall into the two main categories of primary and secondary prevention. Primary prevention aims to intervene before nonconsensual sex can occur, such as by implementing community campaigns to alter gender norms. Secondary prevention seeks to prevent subsequent acts of nonconsensual sex or to minimize its adverse consequences by providing rehabilitation services for perpetrators and care and support services for victims.

"To date, the emphasis in regards to sexual violence has been on secondary prevention," says Dr. Alexander Butchart, coordinator of violence prevention at the World Health Organization (WHO). "The provision of such services will always be essential, but the evidence suggests that perpetrator and victim services alone are of limited value in reducing new instances of violent behavior. Thus, the importance of primary prevention strategies cannot be overemphasized."

WHO recommends prioritizing the following primary prevention activities:

- prevention programs in communities, schools, and refugee settings
- programs that address underlying socioeconomic causes of sexual violence, reduce women's vulnerability, and promote gender-equitable norms of masculinity
- programs that address the prevention of sexual violence by promoting gender equality
- culturally sensitive and participatory approaches for changing attitudes and behavior

Meanwhile, WHO recommends that the problem of nonconsensual sex also be addressed through strategies that attempt to change the social, behavioral, and environmental factors that cause violence, by means of legal or policy reforms and international treaties that set standards for national legislation that penalizes sexual violence.[1]

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http://www.who.int/violence_injury_prevention/publications/violence/en/
This Web site from the Department of Injuries and Violence Prevention at the World Health Organization (WHO) provides access to nine publications related to the prevention of violence, including nonconsensual sex. It also provides links to prevention fact sheets and newsletters and to information on WHO's Global Campaign for Violence Prevention.

Reference

1 Krug EG, Dahlberg LL, Mercy JA, et al., eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization, 2002.

Programs for Perpetrators

The idea of preventing nonconsensual sex by rehabilitating perpetrators is beginning to spread from industrialized countries to the developing world. Thus, recommendations on how to make these treatment programs most effective could not be more timely.

The effectiveness of efforts to rehabilitate perpetrators of nonconsensual sex is largely unknown. But most efforts focus on discussing gender roles in society and teaching perpetrators how to take responsibility for their actions, cope with anger and stress, and empathize with others.[1] According to a recent international review by the University of London,[2] evaluations of treatment programs suggest they work best if they also:

- continue for longer rather than shorter periods;
- change men's attitudes enough so they can discuss their behavior;
- sustain men's participation; and
- collaborate with criminal justice systems.

One promising developing-world pilot program that incorporates these recommendations is Brothers for Change, established in the parish of St. Ann's Bay, Jamaica, in 1999 by the Jamaican Family Planning Association (FAMPLAN).

The idea of Brothers for Change was conceived after family planning providers in St. Ann's Bay repeatedly noticed that female clients experienced sexually transmitted infections, unintended pregnancies, and other gynecological disorders in association with nonconsensual sex and other forms of domestic violence. In response, FAMPLAN began collaborating with local probation officers, correctional services, and judges to offer group counseling to male perpetrators referred to the program by the courts.[3] All men were expected to attend counseling sessions held by FAMPLAN staff and probation officers at least once a week for 20 weeks. During the sessions, movies and discussions were used to increase the men's awareness of the consequences of their actions and to identify better ways to behave, reports Pauline Pennant, the program's former coordinator.

More than 40 perpetrators participated in Brothers for Change between 1999 and 2000, says Pennant. Through a community campaign, FAMPLAN has also reached more than 3,000 additional adolescent boys and men in schools, youth groups, churches, correctional facilities, and other venues.[4]

Through a survey-based program evaluation, FAMPLAN social workers identified several indicators that the program was working for regular participants. For example, men's partners reported that they were less violent. Also, the men were increasingly able to identify various forms of violence, control their anger, and take responsibility for their actions. According to Pennant, results of the evaluation also suggested that the program could be improved by collaborating more extensively with the criminal justice system and, given more resources, by working with partners and families of perpetrators and by increasing monitoring and evaluation of its activities.

Initial funding for Brothers for Change ended in 2002, and probation officers in St. Ann's Bay have since taken over the program's counseling component. "We feel, however, that this is a very necessary program given the rising levels of domestic violence in Jamaica," says Peggy Scott, executive director of FAMPLAN.

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References

1 Krug EG, Dahlberg LL, Mercy JA, et al., eds. *World Report on Violence and Health.* Geneva, Switzerland: World Health Organization, 2002.

2 Mullender A, Burton S. *Reducing Domestic Violence: What Works? Perpetrator Programmes.* London, UK: Policing and Reducing Crime Unit, Home Office, 2000.

3 International Planned Parenthood Federation. Brothers for Change: working with male perpetrators of violence in Jamaica. *Forum* 2001;15(1):2-3.

4 International Planned Parenthood Federation.

occurs because of an underlying assumption, reinforced by social norms, laws, and policies, that a man does not need consent to have sex with his wife. CHANGE, a London-based international nongovernmental organization, is working to change this assumption through activities to promote women's sexual and human rights in marriage and to help men recognize and respect them.[5]

In the prevention effort conducted in Nigeria, hawkers were chosen as targets since "they are vulnerable because of their age, low socioeconomic status, and, ultimately, poverty," Dr. Fawole said. Thus, the intervention included efforts to decrease women's risks of nonconsensual sex by offering them educational and economic opportunities.

Another risk factor for the hawkers was the environment in which they worked. Motor parks are frequented by drivers, bus conductors, auto mechanics, and other predominantly male workers who are often accused of social and moral misconduct, including sexual exploitation of young female hawkers.[6]

In general, men are an especially important group to involve in prevention efforts since they are "the main perpetrators of most types of violence," Dr. Butchart says. Men themselves can act as advocates for policies or laws that discourage or penalize nonconsensual sex. They can also participate in programs and organizations to raise awareness of or change (at the individual, family, or societal level) gender norms, perceptions, and beliefs that condone forced sex.[7] One such organization is the White Ribbon Campaign, the largest global effort of men working to end violence against women. Members work to increase awareness of the problem, support local women's groups, and raise money for international educational efforts. Established more than a decade ago in Canada, the campaign now has a presence in more than 30 countries, including Brazil, Cambodia, China, and the Philippines.[8]

Some secondary prevention programs have also targeted men by establishing treatment programs for those who commit violence (see articles, pages 24 and 25). But to

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Men Giving Up **Violence**

By Dr. Carlos F. Cáceres and Dr. Miguel Ramos, Professors of Public Health, Cayetano Heredia University, Lima, Peru

An increasing number of men in Peru apparently wish to change their lives because their physical or sexual abuse of female partners has created a life crisis: Those female partners have either already left them or plan to do so.

Recognizing the harm that their behavior has caused, these men seek models of masculinity that do not include partner violence. And, for the first time in Peru, a program is being implemented to support such men's efforts. Begun by Cayetano Heredia University in June of 2004 at two locations in Lima, the program encourages men to reflect on their personal experiences and to commit themselves to nonviolence at home. They learn techniques to avoid violence and to resolve conflicts with partners and children. Men are also encouraged to explore ways to express their masculinity while simultaneously treating partners with affection, respecting women's rights, and valuing equality within an intimate relationship.

The Peruvian program is based on other programs, such as the Mexico-based Collective of Men for Equitable Relationships, that work directly with male aggressors to confront and discourage traditional attitudes about gender roles that may condone violence against women. Such traditional attitudes are often so deeply ingrained during the socialization process that men consider them to be "natural." The consequences of these views are reflected in reports of partner violence: In a recent study, up to 51 percent and 69 percent of 1,090 women in Lima and 1,536 women in Cuzco, respectively, reported being victims of physical or sexual violence by their partners at least once. Sexual violence, in particular, was reported by 23 percent and 46 percent of the same women in Lima and Cuzco, respectively.[1]

The program in Peru consists of two-hour weekly sessions for about one year as men pass through three levels lasting four months each. The first step is to attend an initial session to learn about the program. Eighty men, ages 25 to 55 years, have already done so. Sixteen men — most living in poverty — then joined the first-level group, in which participants examine their violent behavior, consider its consequences, and recognize their responsibility for the behavior. At this level, they also consider the possibility of not becoming violent in situations of conflict and become acquainted with techniques to avoid violence. Eight mostly middle-class men have also just begun this level.

Meanwhile, the initial 16 participants have advanced to the second level, where they reflect on their personal experiences since childhood and question their beliefs, values, and attitudes. Participants progressing to the third level will try to establish equitable relationships and find nonviolent solutions to conflicts with their partners.

How effective are such efforts to help men abandon violence against their partners? This remains unknown. The Mexico-based Collective of Men for Equitable Relationships lacked financial resources to formally evaluate the impact of its program. But the entry of additional men into the program upon the recommendation of former participants who felt that the program had helped them reduce their violent behavior was considered a measure of success sufficient to result in the replication of the initiative in six or seven Mexican states by nongovernmental organizations and public institutions.

It is too early to fully evaluate the young program in Peru. But referral of new men to the program by other men or by feminist organizations indicates that it is having a social impact. And, for the short term, the program's impact on individual men is being measured via attendance records, monthly self-evaluations, observations by facilitators, and follow-up of men who abandon the program. Before men are promoted to the second level, behavioral changes occurring after participation in the first level will be assessed by female partners who have remained with the men. Notably, however, about 70 percent of the men have already been abandoned by their female partners.

Sometimes the changes in attitude or behavior are unambiguous. "I have learned to value myself and to identify and stop my violence," a 35-year-old man in the first-level group clearly stated on a self-evaluation. But even gradual change can be promising. "I started to do some domestic work at the beginning of this program, although I was feeling this was not my job," one 32-year-old participant in the second-level group reflected. "But the last time I helped her, I felt that the domestic work was not necessarily my wife's job, and I felt good about that change in my attitude."

Reference

1 Guezmes A, Palomino N, Ramos M. *Violencia Sexual y Física contra las Mujeres en el Perú. Estudio Multicéntrico de la Organización Mundial de la Salud.* Lima, Peru: Universidad Peruana Cayetano Heredia, 2003.

s ***Bicycling in the Peruvian highlands, a man stops briefly to rest.***

A Link between Nonconsensual Sex and HIV Prevention

Evidence from the literature supports integrating components of nonconsensual sex prevention into HIV prevention programs and, conversely, including HIV prevention messages in programs to prevent nonconsensual sex.

Analysis of data from community-based surveys conducted in 1998 and 1999 among more than 4,000 reproductive-age women in Uganda found that women who perceived their partners to be at risk of HIV were more than twice as likely to report being victims of sexual coercion than were women who thought their partners were unlikely to be at risk. Authors of the analysis suggest that women who perceive their partners to be at high risk of HIV are more likely to refuse sex, which may trigger sexual coercion by the partners. This illustrates the need for HIV prevention programs to teach such women how to negotiate sex, rather than simply refuse it, with the ultimate goal of preventing coercion.[1]

A review of 29 studies of violence and HIV in the United States and sub-Saharan Africa highlights several other ways that nonconsensual sex can be addressed in HIV prevention programs, and vice versa:[2]

- HIV voluntary counseling and testing centers can screen individuals for a history of nonconsensual sex, both to identify those at high risk of HIV infection and to refer those who have recently experienced nonconsensual sex to care and support services.
- Staff of HIV prevention programs need to keep in mind that women at risk for nonconsensual sex usually do not have enough control in their relationships to use HIV prevention methods, especially male-controlled condoms, during sex.
- Programs to prevent nonconsensual sex can identify and counsel individuals who are at high risk of HIV and other sexually transmitted infections.

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References

1 Koenig MA, Lutalo T, Zhao F, et al. Coercive sex in rural Uganda: prevalence and associated risk factors. *Soc Sci Med* 2004;58(4):787-98.

2 Maman S, Campbell J, Sweat MD, et al. The intersections of HIV and violence: directions for future research and interventions. *Soc Sci Med* 2000;50(4):459-78.

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be effective, says Dr. Butchart, primary prevention should address the underlying risk factors for both male and female behavior, such as early developmental experiences, poor parenting practices and family dysfunction, poverty and social isolation, and social and cultural norms that maintain or increase economic and social inequalities.

Working with youth

Youth are another general but important target, as research consistently shows that youth are at heightened risk of sexual victimization.[9] Working with youth also provides an opportunity to reverse gender norms that fuel sexual violence by teaching more egalitarian ways for young men and women to interact and by introducing concepts of equity, respect, and social justice.

A recent review of the prevalence, risk factors, and consequences of sexual assault among youth highlights the need for interventions to begin educating children, even before puberty, on issues related to nonconsensual sex.[10] "Early intervention can help shape the attitudes, knowledge, and behavior of children when they are more open to positive influences, and can affect their behavior over their lifetimes," Dr. Butchart says.

Most interventions, however, have been conducted among older youth. Many have taken place in educational settings, perhaps because conducting research there is convenient.[11] Nevertheless, schools are an ideal setting for prevention efforts since many young women experience nonconsensual sex there.[12] Schools are also "places where students learn values, as well as the information and skills they need to pass exams," says Judith Mirsky, co-director of the Panos Institute's Reproductive Health and Gender Programme, in a recent report on addressing sexual violence in the educational sector.[13] "As such, they [schools] can help break the cycle of violence. They need to address it vigorously where it happens, and ensure that curricular and extracurricular opportunities equip young people to navigate their sexual lives without violence," she says.

In 1996, the Tanzania-based HIV/AIDS project TANESA implemented a program to protect students in 185 primary schools from sexual exploitation, and a program evaluation that year demonstrated early success.[14]

For each school, one female teacher whom students could consult about sexual violence, sexual harassment, and other reproductive and sexual health issues was selected and trained as a "guardian." Structured interviews among female students, guardians, and other teachers from 40 schools with a guardian and 22 schools without one showed that having a guardian significantly increased the likelihood of school girls seeking help from guardians or other female teachers for sexual violence, sexual harassment, and other issues.

Guardians informed the school boards, courts, or district authorities about cases of rape, most of which were perpetrated by teachers and men from the community. Although punishment was often minor and alleged perpetrators were not always caught, educational authorities did prevent at least two teachers from continuing to teach at their current schools after they were accused of raping students. One of the most important initial effects of the program, it appeared, was that "sexual abuse of school girls by teachers has become less hidden and may have become more difficult than in the past, and that the negative publicity surrounding such events has probably had a preventive effect," reported the study team.

For cases of sexual harassment, most of which were perpetrated by school boys, the guardians held private talks with those involved, and boys were often punished with cane beatings or threatened with suspension from school. Research from Nigeria suggests that rape tends not to be an isolated incident; rather, it is often preceded by sexual harassment and increasingly violent behavior.[15] Thus, the guardian program may have thwarted rapes by increasing the school's awareness of sexual harassment and punishing perpetrators before their actions could escalate.

Evaluations

At the University of North Carolina at Chapel Hill, USA, Dr. Vangie Foshee and colleagues have conducted the first randomized controlled trial to determine the long-term effects of a school-based intervention that is one component of a program, called Safe Dates, to prevent nonconsensual sex and other forms of dating violence.[16]

The school-based component includes a theatrical production, classes, and a poster contest to change norms about dating abuse and to teach conflict-management skills to prevent violence. All participants are also encouraged to seek help if they become victims. The Safe Dates program also has a community-based component that enhances services to prevent dating violence, such as a crisis hot line and support groups. The community-based component also features training of local providers to more effectively help teen perpetrators and victims of dating abuse.

Between October 1994 and March 1999, the randomized controlled trial was conducted among nearly 2,000 eighth- and ninth-grade students (approximately ages 13 and 14) from 14 public schools in rural North Carolina. Students from seven randomly allocated schools were exposed to both school- and community-based activities, while students from the other seven schools were exposed only to community-based activities and served as controls. The project was then evaluated several times over four years for outcomes that included rates of forced sexual intercourse.

Analyses found that adolescents who were exposed to school-based as well as community-based Safe Dates activities reported less sexual dating violence perpetration at one, two, three, and four years after the program, than adolescents in the control group. However, potential limitations of the study were high attrition of student participants and reliance on self-reports of dating violence. This illustrates the considerable difficulty of rigorously evaluating such interventions.

"Whatever the approach, whatever the intervention, and whatever the sector involved in implementation, every prevention program needs to provide data-driven answers to three key questions," Dr. Butchart says. "These are 'What is the problem? What are the causes? And what works to prevent violence?' Programs answer the third question by indicating how interventions are designed, tested, and evaluated for efficacy. In this way, assessments of effectiveness are based on solid empirical evidence."

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References

1 Butchart A, Phinney A, Check P, et al. *Preventing Violence. A Guide to Implementing the Recommendations of the World Report on Violence and Health*. Geneva, Switzerland: World Health Organization, 2004.

2 Jewkes R, Abrahams N. The epidemiology of rape and sexual coercion in South Africa: an overview. *Soc Sci Med* 2002;55(7):1231-44.

3 Fawole OI, Ajuwon AJ, Osungbade KO, et al. Interventions for violence prevention among young female hawkers in motor parks in south-western Nigeria: a review of effectiveness. *Afr J Reprod Health* 2003;7(1):71-82.

4 Krug EG, Dahlberg LL, Mercy JA, et al., eds. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization, 2002.

5 CHANGE. *Non-consensual Sex in Marriage: A Worldwide Programme*. Information sheet. London, UK: CHANGE, 1998.

6 Fawole.

7 Lang JL. Working with men to end gender-based violence: lessons for the South Asian context. In *Elimination of Violence against Women in Partnership with Men. Gender and Development Discussion Paper Series No. 15*. Bangkok, Thailand: United Nations Economic and Social Commission for Asia and the Pacific, 2003.

8 Kaufman M. *Speech to White Ribbon Campaign Public Meeting in Beijing*. Toronto, Ontario: The White Ribbon Campaign, 2002.

9 Danielson CK, Holmes MM. Adolescent sexual assault: an update of the literature. *Curr Opin Obstet Gynecol* 2004;16(5):383-88.

10 Danielson.

11 Bennett LR, Manderson L, Astbury J. *Mapping a Global Pandemic: Review of Current Literature on Rape, Sexual Assault and Sexual Harassment of Women Consultation on Sexual Violence against Women*. Geneva, Switzerland: Global Forum for Health Research, 2000.

12 Krug.

13 Mirsky J. *Beyond Victims and Villains: Addressing Sexual Violence in the Education Sector*. London, UK: The Panos Institute, 2003.

14 Mgalla Z, Schapink D, Boerma JT. Protecting school girls against sexual exploitation: a guardian programme in Mwanza, Tanzania. *Reprod Health Matters* 1998;6(12):19-30.

15 Ajuwon AJ, Olley BO, Akin-Jimoh I, et al. Experience of sexual coercion among adolescents in Ibadan, Nigeria. *Afr J Reprod Health* 2001;5(3):120-31.

16 Foshee VA, Bauman KE, Ennett ST, et al. Assessing the effects of the dating violence prevention program "Safe Dates" using random coefficient regression modeling. Unpublished paper. University of North Carolina at Chapel Hill, 2004; Foshee VA, Bauman KE, Ennett ST, et al. Assessing the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *Am J Public Health* 2004;94(4):619-24.

Resources

Sexual Violence Web Resources

Reviews

http://www.globalforumhealth.org/filesupld/vaw/litrev.html
Mapping a Global Pandemic: Review of Current Literature on Rape, Sexual Assault and Harassment of Women Consultation on Sexual Violence against Women (2000) provides analysis and a searchable database with more than 2,000 references.

http://www.prb.org/pdf04/AddressGendrBasedViolence.pdf
Addressing Gender-based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis (2004) includes annotated bibliographies on programs addressing intimate partner violence and sexual violence.

http://econ.worldbank.org/files/39678_wps3438.pdf
Addressing Gender-based Violence in the Latin American and Caribbean Region: A Critical Review of Interventions (2004) emphasizes interventions to prevent intimate partner violence or sexual coercion and provide services to victims.

http://www.popcouncil.org/pdfs/wp/seasia/seawp16.pdf
Non-consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries (2003) includes a discussion of programmatic and research priorities.

In Conflict

http://www.dd-rd.ca/frame2.iphtml?langue=0
The Right to Survive: Sexual Violence, Women and HIV/AIDS (2004), from the Canadian organization Rights & Democracy, describes the role of sexual violence in the Rwandan genocide and its effects on survivors. This report also analyzes the links between sexual violence, HIV, and armed conflict in sub-Saharan Africa and makes recommendations for upholding victims' rights to rehabilitation and reparation.

In School Settings

http://www.panos.org.uk/resources/reportdetails.asp?id=1060
Beyond Victims and Villains: Addressing Sexual Violence in the Education Sector (2003), from The Panos Institute, describes the extent and significance of sexual violence in schools and provides examples of interventions in educational settings.

Involving Men

http://www.unescap.org/esid/GAD/Publication/DiscussionPapers/15/series15-main-text.pdf
Elimination of Violence against Women in Partnership with Men (2003) describes efforts to involve men in reducing gender-based violence in South Asia and provides a global inventory of organizations working with men to prevent violence against women.

Provider Guidance

http://whqlibdoc.who.int/publications/2004/924154628X.pdf
Guidelines for Medico-legal Care for Victims of Sexual Violence (2003), from the World Health Organization, outlines standards for providing health care and forensic services to victims of sexual violence. A limited number of printed copies are available free of charge from the Department of Injuries and Violence Prevention, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland. E-mail: violenceprevention@who.int.

http://www.ippfwhr.org/publications/publication_detail_e.asp?PubID=63
Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries (2004), from the International Planned Parenthood Federation/Western Hemisphere Region, offers tools and detailed recommendations for managers of reproductive health and other health care clinics or organizations.

http://www.unfpa.org/publications/detail.cfm?ID=69&filterListType=1
A Practical Approach to Gender-based Violence: A Programme Guide for Health Care Providers and Managers (2001), from the United Nations Population Fund, helps reproductive health facilities establish projects to address sexual assault, childhood sexual abuse, and domestic violence.

Syntheses/Additional Resources

http://www.guttmacher.org/pubs/journals/3015504.html
http://www.guttmacher.org/journals/toc/ifpp3004toc.html
The December 2004 issue of *International Family Planning Perspectives* examines the effects of physical assault and sexual coercion on sexual risk behavior and reproductive health outcomes.

http://www.who.int/gender/violence/sixteendays/en
Information bulletins from the World Health Organization describe the connections between two types of violence — intimate partner violence and sexual violence in conflict — and HIV/AIDS.

http://www.popcouncil.org/genfam/violence.html
Research briefs from the Population Council, the World Health Organization, and FHI's YouthNet project summarize the adverse health and social outcomes of sexual coercion, forced sexual relations among married young women in developing countries, and young men's experiences as victims and perpetrators of sexual coercion. To order free copies of these briefs, please contact: Population Council, Office of Publications, One Dag Hammarskjold Plaza, New York, NY 10017-2201, USA. Telephone: (212) 339-0514. Fax: (212) 755-6052. E-mail: publications@popcouncil.org.

http://www.fhi.org/en/Youth/YouthNet/Publications/YouthLens+English.htm
Nonconsensual Sex among Young People, number 10 in the YouthLens series by FHI's YouthNet project, outlines key issues that emerged during a global consultative meeting held in New Delhi, India, in September 2003 on nonconsensual sex among youth in developing countries. To order copies, which are available in English, French, and Spanish, please contact: YouthNet, Family Health International, 2101 Wilson Boulevard, Suite 700, Arlington, VA 22201. Telephone: (703) 516-9779. Fax: (703) 516-9781. E-mail: youthnet@fhi.org.