Sexual Violence and the MDGs

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ABSTRACT. Sexual violence is multi-faceted. Three (overlapping) categories can be distinguished: violence that is sexual in nature, gender-based violence, and sexuality-based violence. The latter refers to violence against persons *because of their sexuality and/or their (presumed) sexual behavior*. Being female, young, poor, and living in a sexually conservative culture and/or in conflict areas appear to be important risk factors for sexual violence. Sexual violence is widespread (one in five girls worldwide are sexually abused in childhood and up to three-quarters of women in some countries have been victimized by a partner), but prevalence figures around the globe are hard to compare. Both the individual and society suffer from sexual violence. The eradication of sexual violence is directly relevant to achieving the Millennium Development Goals (MDGs) related to infant and maternal health and mortality, and combating HIV/AIDS. And certainly no less important, it is very closely linked to the MDGs related to gender equality and the empowerment of women, poverty, and primary education for all. Campaigning against sexual violence against women has been presented as one of the 'quick wins' in progress towards achieving the MDGs by the UN Millennium Project. Many good practices have been employed in political-legal, awareness raising, prevention, and health care domains, but important setbacks are noteworthy as well. Priority number one for the World Association for Sexual Health now seems to be to adequately and strategically contribute to the continuous efforts to integrate sexual health into the Millennium Development framework.

KEYWORDS. Sexual violence, gender-based violence, sexual health, MDGs, international policies

INTRODUCTION

The World Association for Sexual Health has issued a Declaration of Sexual Health for the Millennium (WAS, 2008) in which one of the main points is the condemnation of all forms of sexuality-related violence. WAS stresses the fact that sexual health cannot be attained until people are free of stigma, discrimination, sexual abuse, coercion and violence. This article contains the background information from which this position was derived. I start off describing the nature, extent and consequences of sexual violence. Next, I argue the inevitability of the fight against sexual violence in light of attaining the Millennium Development Goals (MDGs). Finally, I outline (evidence-based) strategies to combat sexual violence and formulate recommendations for action.

WHAT COMPRISES SEXUAL VIOLENCE?

In 2002, the World Health Organization (WHO) issued a *World Report on Violence and Health*, in which sexual violence is defined as 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relation to the victim, in

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any setting, included but not limited to home and work' (Krug, Dahlberg, Mercy, Zwi, & Lozano-Ascencio, 2002, p. 149). It is added that coercion may involve physical force, psychological intimidation, blackmail or other threats or may occur when the person aggressed is unable to give consent, for instance when drugged, asleep or mentally incapable of understanding the situation.

Other descriptors of violence that are closely related to sexual violence, sometimes even referring to the same, and often used in conjunction are: gender-based violence, violence against women, and domestic violence. A group of international experts convened by WHO in February 1996 agreed that the definition of Violence against Women as adopted by the United Nations General Assembly provides a useful framework for the Organization's activities. The *Declaration on the Elimination of Violence against Women* (1993) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." For this article, yet other forms of violence are considered relevant that are not yet necessarily captured by these two definitions. What is referred to are forms of discrimination and violence against persons *because of their sexuality and/or their (presumed) sexual behavior*. Groups targeted in particular with such discrimination are homosexual, bisexual and transgender persons, but any kind of non-normative sexual behavior, e.g. that of sex workers, may be met with discrimination and stigma. For this article the following three (overlapping) clusters of sexual violence are therefore distinguished: violence that is sexual in nature, gender-based violence, and sexuality-based violence.

Violence that is Sexual in Nature

Children or adults may be victims of violence that is sexual in nature which is often called abuse in the first case. Child sexual abuse (CSA) is commonly understood as any sexual experience under the age of 16 that was against one's will but could not be refused because of force and violence, threats and blackmail or a power/status differential. Sometimes the age of 18 is used, sometimes 12. CSA also includes forced sexual initiation and the sexual exploitation of children.

Sexual violence against adults is understood as any experience that is sexual in nature and that is non-consensual or against one's will. It comprises any form of assault involving a sexual organ, including but definitely not limited to rape (physically forced or otherwise coerced penetration of the vulva or anus, using a penis, other body part or object), attempted rape, gang rape and systematic rape during armed conflict. It also encompasses force into any sexual behavior that is found degrading or humiliating and unwanted sexual advances or sexual harassment, including demanding sex in return for favors. Violence that is sexual in nature can take place within marriage or dating relationships, in schools, at the workplace, or by strangers. Recently, sexual harassment and violence through the internet have been added to the list of possible violations.

Gender-Based Violence

Violence that is sexual in nature is often gender-based, specifically directed against women and affecting them disproportionately. I will use the terms gender-based violence and violence against women interchangeably. Gender-based violence comprises all of the above when committed against women but is not limited to violence that is sexual in nature. Gender-based violence may also be physical or psychological in nature. It includes so-called domestic or intimate partner violence (physical and psychological violence by intimate partners, also including coercive or controlling behaviors), forced marriage or cohabitation, including the marriage of children (child marriage), denial of the right to use contraception or to adopt other measures to protect against STIs, violence during pregnancy, and induced and forced abortions. It also comprises all violent acts against the sexual integrity of women, including female genital mutilation (FGM) and obligatory inspections for virginity. FGM is defined as any procedure that involves the partial or total removal of the external female genitalia or other injury to the female organs for cultural or other non-therapeutic

reasons (WHO, 1998). Gender-based violence also includes forced prostitution and trafficking of people for the purpose of sexual exploitation; sexual trafficking may involve physical violence and coercion, deception, and bondage incurred through forced dept. In addition, sex selective abortion and the neglect or even killing of girl-children within families is considered a form of gender-based violence. And there are a number of traditional practices that are coercive, violent and gender-based, such as the custom of *ngozi* in Zimbabwe, whereby a girl is given to a family as compensation for a death of one of their men at the hand of a family member of the girl, or wife inheritance, whereby a sister is obliged to replace her sister that died in the matrimonial home. Other coercive or harmful traditional practices are child marriage, acid burning, dowry-related violence, and widow inheritance and cleansing (see UNFPA, 2005a), with femicide or honor killings as the most extreme form of gender-based aggression. Recently, UNFPA (2006) called attention to, among others, "bridenapping" (the abduction, rape and forced marriage of young women) and 'breast-ironing' (crushing the breasts of young girls in order to deter male attention) as examples of violence against women that are often ignored and under-reported.

The UN definition of gender-based violence cited above states that violence against women encompasses, inter alia, "physical, sexual and psychological violence occurring in the family and in the general community, including battering, sexual abuse of children, dowry-related violence, rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state." Some also define certain societal or legal situations that are harmful to women as gender-based violence. UNFPA, UNIFEM, and OSAGI (2005), for instance, in their joint report *Combating Gender-Based Violence: A Key to Achieving the MDGs*, include violence on the state level, such as "poorly drafted or unenforceable laws for violence against women, law enforcements agents who violate women, the lack of facilities and education for prevention and treatment of women exposed to violence, the sanctioning and reinforcement of unequal gender relations. The state's indifference and neglect in creating opportunities and entitlements for women in regard to employment, education, participation and access to social services also perpetuates gender-based violence" (ibid., p. 6). Although the situations mentioned are definitely violent in nature and provide a risky context for all forms of sexual violence mentioned before, I would propose to prevent inflation of the concept of gender-based violence and reserve it for direct violent acts, committed by a (group of) perpetrator(s) against a (group of) victim(s), notably women and girls.

Sexuality-Based Violence

With the term sexuality-based violence I refer to all stigmatization on the basis of one's sexuality and connected (social, legal) discrimination and aggression, also called hate-crimes. Sexuality-based violence may be committed against sexual minorities such as homosexual, bisexual and transgender people, against people (perceived to be) living with HIV/AIDS, against sex workers, and basically against anyone (perceived to be) showing other evidence of non-normative sexuality (e.g. being sexually active outside marriage, being pregnant outside marriage, or having had an abortion). All sexualities that fall "lower in the hierarchical valuation of sex acts" (Rubin, 1984) are more likely to be met with sexuality-based violence: "the individuals who practice them are subjected to a presumption of mental illness, disreputability, criminality, restricted social and physical mobility, loss of institutional support and economic sanctions" (ibid., p. 279). In addition, they suffer loss of protection from unscrupulous, violent and criminal behavior by others, less access to police protection and less recourse to the courts (ibid., p. 293).

Sexuality-based violence also encompasses perhaps the most painful, poignant form of sexual violence of them all: stigmatization of victims of sexual violence and connected negative social reactions to (disclosure of) the victimization, so-called secondary victimization.

In secondary victimization, the victim is held responsible for the violence bestowed upon her and is often met with disbelief. Victims of rape may be "punished" with being ostracized by their community (the threat of which makes rape often go unreported). In some communities, raped women and girls are subsequently killed (in public) as they are seen as having dishonored their families. If one could conceive other forms of honor killings as less poignant, the murdering of a rape victim could probably be considered the most poignant of them all.

PREVALENCE OF SEXUAL VIOLENCE

The exact extent of sexual violence is very hard to know. Generally speaking, sexual violence tends to go unregistered and be vastly underreported (Krug et al., 2002). Most of what we know about prevalence and incidence of various forms of sexual violence stems from police statistics, clinical settings and (population) survey research. But there is a wide range of figures reported, depending on the country, setting and/or sample studied, the definitions and operational definitions used and data collection methods and procedures. Cultures vary strongly in their willingness and capacity to register; peoples differ in their possibilities to report and their willingness to disclose sexual violence to researchers. And researchers use all kinds of different methodologies, making it extremely hard to compare findings in even only one country or continent. Making global comparisons is an extremely perilous undertaking.

In connection to the prevalence/incidence figures for sexual violence, the paradoxical situation arises that the higher figures may be reported in countries where sexual violence has been the subject of public debate, where attitudes towards sexuality and sexual violence have become more open, and when awareness of sexual violence among the population has risen. Often there is no way of knowing to what extent rising reports are due to actual shifts in experience or shifts in interpretation thereof by those experiencing them. Sometimes these mechanisms can be seen clearly illustrated when higher registered incidence is a direct consequence of campaigning or programming against violence. For instance, Burundi with support of UNFPA launched a national campaign addressing sexual violence against women, including sponsoring research on the magnitude of sexual violence among displaced populations. In 2004, the campaign saw a 53% increase in the number of women victims of sexual violence seeking services at NGO centers supported by UNFPA. Likewise, in the Netherlands, the number of registered cases of help seeking in relation to sexual violence in services providing medical-sexological support and care rises as the professional capacity (people power) within a given service rises. Considering these mechanisms it is clear that incidence and prevalence figures must always be interpreted with great caution.

For this article, I have studied a number of (review) publications that provide figures (Draijer, 1990; Hagemann-White, 2001; Höing, van Engen, Ensink, Vennix, & Vanwesenbeeck, 2003; Krug et al., 2002, Kury, Obergfell-Fuchs, & Woessner, 2004; Putnam, 2003; Römkens, 1989; Rozee & Koss, 2001; Tjaden & Thoennes, 2000; UNFPA, 2005a; van Berlo, Höing, & Vanwesenbeeck, 2004; Visser et al., 2003; WHO, 2002, 2003, 2005). Below I will give some indication of the ranges reported for some forms of sexual violence.

Child Sexual Abuse and Forced Sexual Initiation

Evidence suggests that, in some countries, up to one-third of girls are sexually abused in childhood. Community samples typically range from 12% to 35% of women and 4% to 5% of men reporting an unwanted sexual experience prior to age 18 years (Putnam, 2003). The WHO (Krug et al., 2002) reports a mean life-time prevalence rate of child sexual victimization on the basis of international studies conducted since 1980 of 20% among women and 5–10% among men. In the review carried out as the basis for the WHO's World Health Report of the same year (WHO, 2002), prevalence estimates for various types of CSA were available from 39 countries. After controlling for differences between studies, the prevalence of non-contact, contact and

intercourse types of CSA in females was about 6%, 11% and 4%, respectively. In males it was about 2% for all categories. In the Netherlands, one-third of women have reported unwanted sex before age 16, 40% of which comprised (attempted) rape; 16% of women experienced sexual abuse by a family member (Draijer, 1990). More recently, 19% of women and 4% of men in a Dutch population-based study reported having experienced sexual coercion before the age of 16 (van Berlo et al., 2007). In population-based surveys 1993–1999 the percentage of adolescent girls found to report forced sexual initiation varies from 7% in Dunedin New Zealand to an average of 48% in nine countries in the Caribbean. (Krug et al., 2002, p. 153). The figures for boys in these studies were, respectively, 0.2% in Dunedin and 32% in the Caribbean. The multi-country study by WHO (2005), conducted in Bangladesh, Brazil, Peru, Thailand, Tanzania, Ethiopia, Japan, Namibia, Samoa, and Serbia and Montenegro, found over 5% of women in 10 out of 15 settings reported their first sexual experience as forced, with the relatively high proportions (14% and more) in Bangladesh, Ethiopia, Peru and Tanzania. In Asia, at least 60 million girls are 'missing' due to prenatal sex selection, infanticide or neglect (UNFPA, 2005a).

Life-Time Prevalence of Sexual Coercion, Assault and Rape

Life-time prevalence of rape (or attempted rape) among adult women has, in the Western world, been found to range from 15% to 23% (Rozee & Koss, 2001). Prevalence rates for (wider defined) sexual abuse often near one-third of women. In Australia the figures for life-time prevalence of sexual coercion were found to be 21% among women (Visser et al., 2003). The multi-country study executed by the WHO (2005) found up to 12% of women reported having been sexually forced by a non-partner only since the age of 15 years. Some of any sort of sexual aggression (varying from unwanted touching to rape, only verbal abuse excluded) was recently reported by 39% of women and 7% of men in a Dutch population-based study (van Berlo et al., 2007).

Sexual coercion and violence among men is much less studied. In the US the life-time prevalence of completed rape for men is found to be 2% (Tjaden & Thoennes, 2000) and in Australia life-time prevalence of sexual coercion among men was found to be 5% (Visser et al., 2003). Although it is certain that men are victims of sexuality-related violence much less often than women are, they may also be more inclined to under-report their negative sexual experiences. In addition, scientists as well as clinicians, guided by the normative heterosexual script, may well be relatively insensitive to the possibility of sexual victimization of men. Future research will have to shed more light on its prevalence and consequences.

Life-Time Prevalence of Domestic or Intimate-Partner Violence

In the multi-country study by WHO (2005), the proportion of ever-partnered women who had ever experienced either physical or sexual violence or both at the hand of a male partner, ranged from 15% to 71%, with most sites falling between 29% and 62%. The greatest amount of violence was reported by women living in provincial (most rural) settings in Bangladesh, Ethiopia, Peru and Tanzania. The UNFPA (2005a) estimates that about one in four women is abused during pregnancy.

Specifically for physical violence, the life-time prevalence percentages among women ranged from 13% in Japan to 61% in provincial Peru in the WHO study (2005). In Europe, a figure said now to be typical for (severe) physical violence and abuse is recently found in Spain at 13% of women (reviewed by Kury et al., 2004). In the Netherlands, 21% of women have reported having been the victim of partner violence in the past, of which two-thirds was categorized as (very) severe (Römkens, 1989). Reports of one year prevalence of intra-familial physical violence appear to be round about 4% for Europe (Hagemann-White, 2001), although Krug et al. (2002: 91) refer to a figure of 12% for the United Kingdom. In this same overview a figure of 58% of women in Turkey ever having

suffered physical assault by a partner is reported. UNFPA (2005a), drawing on data from Australia, Israel, South Africa and the US, says that 40–70% of female murder victims were killed by their partners.

In relation to sexual violence by an intimate partner, UNFPA (2005a) reports that population-based studies show that 12–25% of women have experienced attempted or completed forced sex by an intimate partner or ex-partner at some point in their lives. In some countries, half of women may have experienced forced sex by an intimate partner or ex-partner, WHO reports (Krug et al., 2002). Specifically for sexual violence, the multi-country WHO study (2003) came up with (again) the lowest level for Japan at 6% of women and the highest figure of 59% being reported in Ethiopia. For Europe a figure like 16% of women to ever have suffered (severe) sexual abuse by a partner is presented as typical (Kury et al., 2004). Generally speaking, women (also) experience sexual abuse in 1 of 4 cases of domestic violence. Emotional abuse in the form of, for instance, insults, belittling, and intimidation, was experienced at least once during the past 12 months by 20–75% of women in the multi-country WHO study (2005).

Trafficking and Forced Prostitution

Reports of trafficking in women come from nearly every world region. UNFPA (2005a) reports that the greatest number of victims are believed to come from Asia (about 250,000 per year), the former Soviet Union (about 100,000), and from Central and Eastern Europe (about 175,000). An estimated 100,000 trafficked women have come from Latin America and the Caribbean, with more than 50,000 from Africa. These figures do not include the substantial number of women and girls who are bought and sold within their own countries, for which there are scant data. If we encompass working sex under force and under exploitative conditions to this form of sexual violence, reliable figures are extremely hard to come by. Estimates of numbers of women working sex are very hard to determine in the first place (varying between estimates of, for instance, 100,000 and 600,000 for a city like Bombay), given the lack of figures and documentation of what in most countries is an outlawed and underground activity, and the multiplicity of activities worldwide that constitute sex work. Besides, trafficking is often not very well distinguished from more general figures on sex work across national boundaries and self-controlled migration for prostitution (see Vanwesenbeeck, 2001a).

In working sex, experiences with violence from clients often is more of a risk than HIV infection is. In the international literature, a very high prevalence of violence against sex workers is often reported (ranging from half to 'all but one'), but many studies focus exclusively on street workers, who are, at least in the Western world, significantly more vulnerable than women indoors. In my own study among indoor working women in the Netherlands, 1 in 4 had experienced one or other form of violence (treats, physical, sexual) on their working sites during the past year. Almost half of the women interviewed had experienced violent episodes with colleagues near to them (see Vanwesenbeeck, 2001a).

Female Genital Mutilation

The UNFPA (2005) reports that female genital mutilation/cutting affects an estimated 130 million women and girls worldwide. Each year, 2 million more undergo the practice. A WHO study group on female genital mutilation and obstetric outcome conducted a study among women who presented for singleton delivery at 28 obstetric centers (in Burkino Faso, Ghana, Kenya, Nigeria, Senegal and Sudan) and found only 25% of all participating women with no evidence of genital mutilation (WHO Study Group on Genital Mutilation, 2006). The other three-quarters of participants were about evenly divided among a quarter with FGM-I (excision of the prepuce, with or without excision of part or all of the clitoris), a quarter with FGM-II (excision of the clitoris with partial or total removal of the labia minora) and a quarter with FGM-III (excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening, infibulation).

RISK FACTORS AND RISK GROUPS

Sexual violence is a complex social phenomenon: multi-faceted and multi-determined. Like all complex phenomena, it is rooted in a variety of cultures, contexts, institutions and practices. The *World Report on Violence and Health* states: 'Certain factors appear to be strongly predictive, although direct causal relations are often hard to establish. For sexual violence these comprise individual and family factors such as hostile masculinity or growing up in an abusive family, community factors such as asymmetrical gender relations and rigid sexual ideologies, health care factors such as lack of service opportunities, and institutional factors such as inadequate legal sanctions' (Krug et al., 2002, p. 243). Clearly, not all run equal sexual risk.

Individual Risk Factors

The first and foremost factor implying risk is being female and the second one is being acquainted with males. Most sexual violence is committed against women by men that they know. This is already true for the risk of (early onset, level of force and longer duration of) CSA for girls as opposed to boys. Other risk factors for CSA are disabilities (especially those that impair a child's perceived credibility such as blindness, deafness and mental retardation) and parental dysfunction (Putnam, 2003). For adult women being married or cohabiting is a notable risk factor: gender-based violence is most commonly perpetrated by an intimate partner. Cohabiting women appear to be slightly more at risk than married women (WHO, 2005). Another risk factor is being young. According to data from justice systems and rape crisis centers, as much as one- to two-thirds of all victims of sexual assault are aged 15 years or under (WHO, 2002, p. 158). The likelihood of forced sexual initiation is also higher the younger a woman/girl is at the time of her first experience of sexual intercourse.

The experience of CSA makes one more vulnerable to revictimization later in life. Having been sexually violated before generally is a risk factor for subsequent violation. The reasons for this will be further discussed under "consequences" of sexual violence, but relevant here is the fact that CSA increases the likelihood of finding oneself in sexually risky situations again. Sexual acting out, having many sexual partners, using alcohol or drugs, and engagement in sex work may be more likely after CSA; surely they increase one's risk of being sexually violated (again). In part this risk is created through the workings of stigma that bestowed upon sexually active women (among which sexual victims), not in the least upon sex workers. People who are stigmatized and are imputed a "spoiled identity" (Goffman, 1963) run a higher risk of being undervalued, socially excluded and discriminated and aggressed against. Sexual stigma notably increases the risks of further sexual aggression. Nonetheless, focusing on sex workers, stigma does not affect all to the same extent. Substantial variation exists in the amount of negative social reactions encountered and violence experienced. It has been argued that the experience of violence among sex workers in relation to stigma may be a function of a snowball effect in which the more positively (less exclusively financially and/or by force by third parties) motivated sex workers less readily settle for uncomfortable working conditions, are more demanding, and are more inclined to safeguard themselves from negative interactions and experiences. As a result, they may be less easily perceived as "cheap" and may be treated with more respect. In turn, this will enhance their sense of self-worth, feelings of control, and positive relation to the work, putting them less at risk of victimization and other negative health consequences (Vanwesenbeeck, 2005).

Situational Risk Factors

The relationship between the educational level of women and gender-based violence seems to be an inverted U-shape, with improvement of educational/economic situation conferring greater risk up to a certain level (men may resort to violence in an attempt to regain control), beyond which it starts to become protective (WHO, 2005, p. 158). The protective effect of education may relate to a greater range of choice in partners when educated to a higher level, with more ability to choose to marry or not, and more

skills to negotiate greater autonomy and control of resources within marriage.

Poverty is, generally speaking, definitely a risk factor for sexual violence, as it brings about more risky daily routines (e.g. walking home late at night, work in the fields) and forces many women and girls into relatively risky occupations. One of the reasons why women and girls living in poverty are often more vulnerable to rape is because their neighborhoods and commutes to work or school are more dangerous. In India it has been shown that women without property reported physical violence much more often (49%) compared to women who owned assets (7%) (cited in UNFPA, 2005). The conditions of poverty make women more vulnerable to sexual exploitation in a diversity of situations, such as seeking employment or engaging in trade. Poverty also pushes women into prostitution and forces families to sell their children to traffickers.

In particular in situations of (armed) conflict and war, and in the refugee camps that accompany those or follow from other large scale displacements, women seem to be completely sexually outlawed and at extreme risk of sexual violence by enemy groups. Sexual violence has been used as a weapon of war in many recent (and less recent) conflicts. In Darfur, among others, women who collect firewood are now accompanied by peacekeepers to protect them from being raped, who in their turn are sometimes found guilty of sexual aggression.

Among the more general, non-war situations and contexts with increased risk of sexual and gender-based violence are many settings where women and men closely interact socially or professionally. Mentionable are schools, workplaces and health care settings. Organizations with a slanted (asymmetrical) gender ratio (with women being underrepresented) provide more risk for sexual harassment, which explains the relatively high prevalence in the military and the police. Other factors contributing to the likelihood of sexual harassment are a masculine organizational culture, tolerance of sexual harassment by management, and unprofessional working routines (e.g. European Commission, 1999).

Societal Risk Factors

Sexual violence against women is more likely under relatively strong patriarchal regimes. Cross-cultural reviews provide evidence that the larger the asymmetry in societal power is to the disadvantage of women in a given culture, the more likely control of female sexuality as well as sexual violence against women (Wood & Eagly, 2002). For Europe, it has been suggested that the factors primarily explaining the differing prevalence rates in family or domestic violence in European countries are deprived economic living conditions, traditional attitudes towards women and children, and a general tolerance of violent behavior in a given society (Kury et al., 2004). Some forms of violence are sometimes considered "normal", e.g. some cultures do not consider wife-beating to be a form of violence. Sexual violence in all its forms is rooted in cultures of (other forms of) violence and aggression. This surely contributes to its relative high prevalence in war situations.

Sexual violence is also rooted in sexual cultures. Traditional attitudes towards women and children often coincide with and are mutually reinforced by conservative sexual ideologies. Among these are traditional, strongly gender scripted ideals of masculinity, ideologies of male superiority and female submissiveness and, last but not least, of male sexual entitlement. The sexualization of girls and women in the media and other public spheres may play an increasingly negative role in this context (APA, 2007). In particular the notion of sexuality as inherently a *male*, uncontrollable drive and connected gender typed sexual scripting, not only deprive women of their rights of sexual agency and pleasure, but also make it harder for them to refuse sexual initiative by men. A girl's "no" will only have its proper meaning and impact when she is fully allowed to say "yes" as well.

In addition, traditional sexual cultures are likely to stigmatize and support sexuality-based violence against those whose behaviors and attitudes are non-traditional. Legal systems are less likely to protect sexual minorities and potential victims and to appropriately sanction perpetrators. Victims are less likely to acknowledge their experiences as violations of their human rights

and to disclose their experiences. They are more likely to feel shame and guilt and to become re-victimized and secondarily victimized. All these not only worsen the personal trauma and options for recovery, but also mask the violent nature of the sexual culture altogether and worsen options for social change.

Specific social and economic developments may aggravate women's situation and the risks of sexual violence. Social, economic, political and environmental factors may, for instance, contribute to the migration of women from rural areas into the cities or into other countries, often into exploitative and sexually risky jobs or into prostitution. In relation to migration of women in general, socio-cultural factors including the matrilineal family structure and women's responsibilities, the religious belief system, and the double standard of gender are all crucial. Both tourism and development have, in addition, had their negative impact. In Thailand, for instance, "development" has resulted in unequal income distribution, loss of farmland, resettlement of hill tribe people and consequent marginalization of women, leading many of them into prostitution (Mensendiek, 1997).

Risk Factors for Perpetrating Sexual Violence

In addition to the cultural and societal factors described above, theory and research have also been directed towards trying to explain the etiology of sexual aggression or delinquency in the individual. Malamuth's (1990) hierarchical confluence model and Marshall and Barbaree's (1990) biopsychosocial learning theory are leading in this field and all point to a complex phenomenon in which biological, social, psychological and situational factors mutually influence each other. Rather well documented are factors such as early sexual victimization and problematic attachment in childhood, sexual preoccupation, lack of social competence, and "hostile masculinity." In recent years, there has been heated debate over the influence of the availability of sexually explicit (pornographic) materials and the (increasing) sexualization of society in general on the risks of sexual violence. Endorsers of the adage "pornography is the theory, rape the practice" have now joined forces with those that worry about the abundant availability of sexually tainted information in the public sphere and of pornographic (often women unfriendly) images under the touch of a button, readily accessible to everyone with access to the internet. However, empirical support for a link between exposure or availability of porn and sexual aggression is far from convincing (see, for instance, Malamuth, Addison, & Koss, 2000). The evidence for a connection between porn laws and incidence of sexual aggression is strongly contradictory. Effects of porn consumption may also weaken with prolonged exposure. Many sexual delinquents do not use porn at all and those who do often do not see it bearing relation to their aggressive behavior. Overall it seems most probable that the general societal sexualization and specifically the consumption of pornographic images may have negative influences on men who are cursed with unfriendly and hostile attitudes towards women in the first place but not on others. Likewise, there is evidence that among women watching sexually explicit sex on TV, the more vulnerable may get hurt whereas the least vulnerable ones may profit (Vanwesenbeeck, 2001b). The notion that exposure to sexually explicit materials and porn should be seen as a cyclical process of information processing, rather than as a one way effect, now starts to gain ground. Overlooking the evidence on sexual cultures related to sexual aggression, there seems to be more support for the detrimental effects of patriarchal, restrictive, "sex negative" cultures than of those of open, tolerant, "sex positive" cultures.

CONSEQUENCES OF SEXUAL VIOLENCE

Long Term Health Consequences of Early Trauma (CSA)

A range of symptoms and disorders is associated with child sexual abuse. They may take the form of a post-traumatic stress syndrome (PTSS) and other emotional problems (e.g. anxiety, depression), behavioral problems (e.g. suicide and sexual acting out), cognitive

problems (e.g. distorted/negative cognitions and negative body image), amnesia and dissociative disorders, personality disorders (e.g. borderline personality disorder), neurobiological changes (e.g. damage to the regulative brain functions due to higher cortisol), physical problems (e.g. headaches, sleeping disorders), and sexual problems (e.g. arousal or relational difficulties). For male victims specifically, the child abuse may remain unnoticed relatively often, among others because men more often wind up in the judicial system than in the health care system. Between 7% and 8% of the burden of disease of depression and of alcohol and drug use by women is attributable to CSA, between 4% and 5% in men. The attributable fraction for panic disorders is higher (13% among women and 7% among men) and higher still for PTSD (33% and 21%, respectively). For suicide attempts 11% and 6% have been calculated, respectively (Andrews, Corry, Slade, Issakidis, & Swanston, 2004).

The likelihood of revictimization and the accumulation of trauma are greater because traumatized people may repeat the trauma and reengage in burdening situations, hoping to be able to control them this time. They may have acquired a "learned helplessness" and have fewer possibilities to defend themselves. CSA may make people less convinced of the fact that they matter as people and they may feel less deserving of or entitled to comfort, fortune, protection and respect. They may lower their standards for self-enhancement, emotionally, socially, or financially. Early trauma may set up a chain of fatal interaction between individuals and their surroundings, causing a snowball effect of increasing social division and inequality, the so-called "Matthew-effect" (for St. Matthew wrote: "For unto everyone that hath shall be given, and he shall abundance; but from him that hath not shall be taken away even that which he hath"). This sad social process is in part due to the workings of social stigma. Social stigma is also inherent to what is here called sexuality-based violence. As said, victims of sexual violence may be stigmatized in the same way as sexual minorities and all those with (presumed) non-conventional sexual behavior may be confronted with social stigma. Important social and economic opportunities may get blocked as the consequence of stigma and overall life chances diminish. The stigmatized are likely to be troubled by feelings of shame and guilt and to draw back from many forms of social interaction. The influence of stigma on a person's behavior can be so pervasive that it may be considered more important than the influence of personality characteristics (Schur, 1984).

Health Consequences of Sexual Violence for Adult Victims

Evidence is accumulating that physical and sexual violence critically increases women's (and men's) chances of experiencing a variety of adverse health outcomes. Its relation to sexual and reproductive health (SRH) will be treated separately below. In addition to those, experiences with sexual violence may also have a variety of (other) physiological and psychological consequences. The WHO (Krug et al., 2002) reports that rape and domestic violence explain an estimated 5–16% of the total burden of disease in women of reproductive age. Direct physical injuries (wounds, scars, bruises, fractures) were found among 19% to 55% of ever-abused women in the multi-country WHO study (2005). Brutal rape such as reported in situations of armed conflict can result in fistula, perforated sexual organs and other related injuries. Longer term physical complaints that victims of sexual violence have reported relatively often are stomach aches, premenstrual syndrome, nausea, lack of appetite and headaches. Such physical complaints may be found in up to half of victims even after several years of victimization (van Berlo et al., 2004). Women who experienced intimate partner violence in the aforementioned multi-country study report worse general health than women who have not. Recent experiences of ill-health were associated with life-time experiences with violence, suggesting that the physical effects of violence may last long after the violence has ended, or that cumulative abuse affects health more strongly (WHO, 2005). As for the physical consequences documented for FGM specifically, they include great pain, excessive bleeding, shock, painful sexual intercourse, risks of HIV and other infections from the use

of unsanitary tools, chronic pelvic inflammation and even death. Psychological effects include anxiety and depression (UNFPA, 2005). The WHO Study Group on FGM and Obstetric Outcome (2006) documented significantly more adverse obstetric outcome in women with FGM and this risk to be greater with more extensive FGM.

Psychological problems associated with sexual violence in general are the post-traumatic stress syndrome, anxiety, depression, sexual and relational difficulties, and eating disorders. Reports of fear and anxiety when studied one year after the assault are given by about three-quarters of rape victims; 30–40% still suffers PTSS at that time (van Berlo et al., 2005). Suicide ideation has also been regularly found in victims of (attempted) rape with percentages between 33% and 50% reported. Clearly, not all victims experience any or all of these symptoms. Among the factors influencing the amount of problems encountered by victims of sexual violence are characteristics of the assault, cognitive and emotional processes and reactions of the victim during and right after the assault, earlier experiences with victimization, and social support received.

Sexual and Reproductive Health Consequences of Sexual Violence

Sexual violence is significantly linked to sexual and reproductive ill-health in multiple ways. First, it may have a number of direct negative reproductive health outcomes, including unwanted pregnancy and miscarriage. Pregnancy rates as high as 15–18% have been reported by rape crises centers in Mexico and a pregnancy rate of 5% among victims has been found in the US (Holmes, Resnick, Kilpatrick, & Best, 1996; WHO, 2002, p. 162). Experiencing assault *during* pregnancy is associated with a range of negative reproductive outcomes including miscarriage and stillbirth, delayed antenatal care, premature labor and childbirth, ante-partum hemorrhage, fetal injury, and low birth-weight babies (UNFPA, 2005). In addition, the WHO (2005) presents some evidence that women who report partner violence may be less likely to have received postnatal care for their most recent live birth than women who did not report partner violence. Violence during pregnancy is said to quadruple the risk of low birth-weight and to double the risk of miscarriage. In Nicaragua, abuse of expectant mothers accounts for 16% of low birth-weight infants. In some districts of India, 16% of deaths during pregnancy were attributed to domestic violence (UNFPA, 2005). Clinical studies, for example in Hong Kong SAR, China and Uganda, found that about 30% of women who had abortions reported abuse as the main reason for terminating their pregnancies.

Violence can also be an important factor in the acquisition of STIs including HIV. Forced penetrative sex, both vaginal and anal, can increase the risk of HIV transmission through abrasions and injuries. In particular young girls are susceptible to HIV infection because their vaginal mucous membrane has not yet acquired the cellular density that develops in the later teenage years and provides an effective barrier. Those who suffer anal rape are also considerably more susceptible to HIV since anal tissues can be easily damaged, allowing the virus an easier entry into the body.

Sexual violence may also be associated with sexual risk-taking such as early first sex and multiple partnering. Sexual coercion among adolescents and adults is associated with low self-esteem, depression, and substance abuse, factors that are associated with many of the risk behaviors for HIV infection. Exposure to HIV may be seen as a form of self-destructive behavior. Victims may also lack ego-strength to set safe limits, fail to internalize safe-sex guidelines or lack motivation to follow recommendations (for an overview see Vanwesenbeeck, van Zessen, Inham, Jaramozovic, & Stevens, 1999). Or they may "simply" be infected while violated. Sexual coercion is now considered a significant factor in the continuing rise of HIV among young women (UNFPA, 2005). The threat of, or actual, violence within sexual partnerships constrains women's ability to develop equitable partnerships with men, and can complicate their struggles to achieve healthy sexual lives. In particular, a woman's reduced autonomy in many inequitable and coercive relationships impacts negatively on their ability to make sexual choices

and negotiate the conditions of sexual intercourse, including the use of condoms and contraception. Exposure to violence thus increases directly with rape and indirectly through fear of negotiating condom use. HIV/AIDS prevention in South Africa reveals that one of the barriers to safe sex is the widespread prevalence and acceptance of coercive heterosexual sex, with women lacking the power and resources to refuse sex. The fact that violent men tend to have more partners outside of marriage adds to the risks. European research reveals that young people have very uncertain ideas of what "consensual sex" means, suggesting that public health/safe sex messages across the globe should begin from a principle that safe sex requires consent (Kelly, 2005, p. 9).

The relations between sexual violence and HIV risks also work the other way around (WHO, in press). Being infected with HIV or having an HIV-positive family member can also increase the risk of suffering sexual violence, particularly for women. For HIV-positive women, disclosure of their status to their partners may cause violence. Infected women may be evicted from their homes, as a consequence of the stigma attached to HIV and AIDS in many countries. AIDS-related illness or death in a poor household may make the economic situation desperate, so that women may be forced into sex work and consequently be at increased risk of both HIV/AIDS and sexual violence. And finally, children orphaned by AIDS, impoverished and with no one to care for them, may be forced to live on the streets, at considerable risk of sexual abuse.

Sexual violence has also been shown to have negative impact on sexual (dys)function (WHO, in press). Negative sexual experiences have been associated with basically all dysfunctions in women, such as sexual aversion, problems with desire, arousal and orgasm difficulties, dyspareunia and vaginismus. A recent Dutch study suggests that the sexual functioning of men is affected to a lesser extent by sexual victimization than women's (van Berlo, van Engen, & Mooren, 2007). Nevertheless, those dealing with function problems may be extremely bothered by them. However, others are not or to a lesser extent, sometimes because they choose to refrain from sexual interaction. It also needs to be stressed that certain reactions to experiences with violence that culminate in these so-called sexual dysfunctions should rather be called *functional*. Nonetheless, they hamper satisfactory sexual expression.

Societal Consequences of Sexual Violence

Sexual and gender-based violence has been ranked sixth in the global health burden by the World Bank in 1994 (Heise, Pitanguy, & Germain, 1994). The WHO (Krug et al., 2002) reports that rape and domestic violence account for an estimated 5–16% of healthy years of life lost in women of reproductive age. Clearly, gender-based violence burdens health care systems. Studies from Nicaragua, the United States and Zimbabwe (cited by UNFPA, 2005) indicate that women who have been physically or sexually assaulted use health services more than women with no history of violence. For the Netherlands, it has been estimated that at least 1 in 5 of all clients in the mental health care system has experienced some form of sexual or gender-based violence during childhood or adolescence (Höing et al., 2003). A Dutch population survey on sexual health has recently evinced that 3.9% of all adult women in the population (0.2% of adult men) had a need for professional healthcare because of experiences (ever) with sexual violence *in the last year*, 2.6% of women and 0.1% of men had actually received sexual violence-related health care in the past year (Bakker & Vanwesenbeeck, 2006). Violence against women has high costs in terms of national expenditures on health, courts and police, as well as losses in educational achievement and productivity. To assess the costs of CSA alone, Fromm (2001, cited in Waters et al., 2004, p. 28) reviewed a variety of sources and calculated an aggregate total of $94 billion in annual costs to the USA economy resulting from child abuse—1.0% of the gross domestic product. This total included direct medical costs and the related costs of legal services, policing and incarceration, as well as the value of indirect productivity losses, psychological costs and future criminality. Hospitalization accounted for $3.0

billion, mental health treatment costs for $425 million, and child welfare costs for $14.4 billion. The largest single component of Fromm's estimate was adult criminality related to child abuse, for which he calculated an annual figure of $55.4 billion.

Gender-based violence has also been shown to have substantial economic consequences as it represents a drain on the economically productive workforce (UNFPA, 2005). Canada's national survey on violence against women reported that 30% of battered wives had to cease regular activities due to the abuse, and 50% of women had to take sick leave from work because of the harm sustained (cited in UNFPA, 2005). In the United States, intimate partner violence is estimated to cost some $12.6 billion a year (UNFPA, 2005). The average rape has been calculated to cost about $100,000 in the US (Waters et al., 2004). UNFPA reports further that, in India, a survey showed that for each incidence of violence, women lost an average of 7 working days. A study of abused women in Managua, Nicaragua, found that abused women earned 46% less than women who did not suffer abuse, even after controlling for other factors that affect earnings.

SEXUAL VIOLENCE IN CONNECTION TO THE MDGs

The eradication of sexual violence and achieving the MDGs are mutually related. Gender-based violence directly jeopardizes the achievement of the MDGs related to gender equality and the empowerment of women, infant and maternal health and mortality, and combating HIV/AIDS. And likewise, achieving MDGs related to poverty, education, gender equality, infant and maternal health, and HIV/AIDS may help the eradication of sexual violence (UNFPA, 2005). In the previous paragraph, the relation between sexual violence on the one hand and child mortality, maternal health and infection with HIV/AIDS on the other have already been tangled. Relations with poverty and women's status have only been touched upon. They will be elaborated upon a bit further below.

Sexual Violence Related to Poverty, Primary Education, and Gender Equality

Poverty is feminizing. Women constitute 70% of the 82 million people in Africa by which the population of people living in poverty increased during the past decade, despite poverty reduction programs (UNFPA et al., 2005). The major causes of women's poverty are embodied in unequal power relations, discriminatory inheritance rights and lack of access to property and productive resources. In general, without the right to own land, women's economic and physical security is compromised and leaves them more vulnerable to violence. Poor women are also more vulnerable to violence because they typically live in uncertain and dangerous environments. In addition, the excessive demand on poor women's time creates tensions that may lead to domestic violence. In turn, violence hampers empowerment processes and it imposes obstacles to the full participation of women in social, economic, and political life. In the UN Beijing Declaration and Platform for Action (1996, p. 75), it is described as follows: "The fear of violence including harassment is a permanent constraint on the mobility of women and limits their access to resources and basic activities. . . . Violence against women is one of the crucial social mechanisms by which women are forced into subordinate positions."

Women with greater opportunities for work and education are also more likely to send their daughters to school. Under gender asymmetric rule, girls' education has lower priority than that of boys. Lower education and connected less likely economic independence makes girls more vulnerable to abuse and, the vice versa, sexual abuse may lower girls' educational motivation and success. Empowered girls with access to contraceptives are less likely to become pregnant and drop out of school. Sexual violence is therefore reciprocally linked to educational attainment of victims as well as their daughters and mutually and closely related to gender equity. The pivotal role of gender equality in achieving all the other MDGs is beginning to be acknowledged by the world leaders. "The world is starting to grasp that there is no policy more effective in promoting development, health and

education than the empowerment of women and girls," Kofi Annan was cited (*The Independent*, March 8, 2006). Combating violence against women and girls is seen as one of the important strategic priorities critical to women's empowerment (UN Millennium Project, 2004).

Improving Sexual Health and Reducing Sexual Violence as "Quick Wins"

The UN Millennium Project's report (2005), *Investing in Development*, has argued for the implementation of a core set of "necessary, affordable, and effective actions that can speed progress toward achieving the goals," the so-called "quick wins." Among these are the following:

1. expanding access to sexual and reproductive health information and services including family planning and contraceptive information and services, and closing existing funding gaps for supplies and logistics;
2. launching national campaigns to reduce violence against women.

Measures to reduce sexual violence are also promoted by UNFPA (2005) with the argument that investment in prevention and protection are critical to the Millennium Declaration's pledge to "create an environment . . . conducive to development and to the elimination of poverty" (chapter 7, p. 3). In addition, cost-effective payoffs are predicted. Costs of effective measures to reduce violence are insignificant in comparison to the human, social, and economic impact on present and future generations, UNFPA argues. In the US, the 1994 Violence Against Women Act has provided an estimated net benefit of $16.4 billion, proving that prevention costs far less than inaction.

Sexual and reproductive health is, next to energy and transport services, considered one of three main essential inputs to achieving the Goals by the UN Millennium Project. In addition to being part of Goals 4, 5, and 6, sexual and reproductive health services are described as:

> essential for reducing extreme poverty and hunger, ensuring educational opportunities and gender equality, and attaining environmental sustainability. These services affect the allocation of recourses within the family, the prospects for household savings, the household choices about education and health investment, the exercise of the right to choose the number, timing and spacing of one's children, and the capacities for women's social and economic participation and other practical life decisions. At the macro level, these services affect population dynamics. A demographic transition to lower fertility and mortality (including that from HIV/AIDS), creates an opportunity to escape poverty traps and to accelerate economic and social development, a "demographic bonus" that can be realized through appropriate governance, policies and investments. (UN Millennium Project, 2005, p. 30)

The UN Millennium Project calls for sexual and reproductive health services to be included in national, regional and international poverty reduction efforts.

To concretize the integration of sexual health into the MDG framework, the UN Millennium Project advises adding several targets and indicators related to sexual and reproductive health to targets and indicators of the various MDGs. It is, for instance, recommended that the target "universal access to reproductive health services by 2015 through the primary health care system" be added to Goal 5. In terms of indicators, additions have been recommended such as "HIV-prevalence among 15–24 year old women" (to Goal 6), "proportion of births attended by skilled birth attendants" and "availability of emergency obstetric care" (to Goal 5), "proportion of demand for family planning satisfied" and "adolescent fertility rate" (to Goals 3 and 5) (Family Care International, 2005). However, advocating for the integration of sexual health into the MDGs has so far been unsuccessful. An Interagency Expert Group on the Millennium Development Goals Indicators (IAEG) was not offered enough political "breathing space" to revise the MDGs' targets and indicators according to the

ambitions formulated above. Neither have sexual health provisions been included in international poverty reduction efforts. To the contrary, sexual health policies, provisions and services worldwide have had a serious setback recently with changing US policy in providing developmental funds. In general, development programs concerning gender equality, population and reproductive health are massively under-funded. Donors meet little over half of the targets set at the Cairo conference in 1994 (UNFPA, 2005). Things have deteriorated even more after introduction of the so-called Gag Rule, which rules that NGOs and countries have to 1) abstain from offering abortion health care and 2) formally state that prostitution is dehumanizing and degrading, in order to be eligible for AIDS prevention grants from USAID. As a consequence, many NGOs have been confronted with serious cutbacks in their finances. The substantial deterioration of the sexual health situation in several countries has already become visible even in this short time, for instance in the Philippines (Malayang, 2005).

STRATEGIES FOR THE ERADICATION OF SEXUAL VIOLENCE

As sexual violence is a multi-faceted and multi-determined reality, strategies for its eradication are necessarily manifold as well. Levels on which successful action and good practice has been employed have varied from educating the public, to improving services and legal arrangements. Relevant groups targeted with various interventions have been (potential) victims as well as (potential) perpetrators, and the public at large as well as professionals and policy makers. Good practice has served primary prevention (preventing violence happening in the first place), secondary prevention (limiting the negative consequences), and tertiary prevention, including care and cure for victims and cure and control of perpetrators. A number of examples of (larger and smaller scale) good practices (and, in some cases, the obstacles to their implementation and efficacy) that have been described in the literature will be discussed below. The categories in which these are presented are somewhat artificial, overlapping and mutually supportive.

Political Legal Action and Advocacy

Clearly, much good work has already been done in the political domain, not least by the UN Millennium Project and the IAEG. Other important organizations are UNFPA, UNIFEM, IPPF, Choike and others and a number of conferences and international treaties have been of great importance. Some landmark happenings and achievements are listed below.

- the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979)
- the Convention on the Elimination of Violence Against Women (1993)
- the International Conference on Population and Development (ICPD) (Cairo, 1994) and its Platform for Action
- the Fourth World Conference on Women (Beijing, 1995) and its Platform for Action
- the African Plan of Action to Accelerate the Implementation of the Dakar and Beijing Platforms for Action for the Advancement of Women (1999)
- the Convention Against Transnational Organized Crime and its supplemental Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2000)
- UN Resolution 1325 on Women Peace and Security (2000)
- Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (2003)

International treaties, such as the Convention on the Elimination of All Forms of Discrimination Against Women (1979), set standards for national legislation and provide a lever to campaign for legal reforms. In particular the shift from a needs-based approach to a rights-based approach in sexual health (in which ICPD was pivotal) has been important in relation to sexual violence. The human rights framework has,

among others, helped to officially recognize the experience of violence as a violation of human rights, it has helped challenge the false public/private dichotomy of international law, has provided a feminist vocabulary to international political documents, and has played a role in forming coalitions: "The status of women of all regions and the diverse violations to their human rights, which were previously hidden and silenced, have all surfaced, linking local movements to a global women's movement that continues to grow" (Obando, 2004). However, it has also been voiced that the human rights framework is not yet "gendered" enough. Although governments have committed to condemning sexual violence as a human rights violation, the implementation of these commitments is left entirely to the will of states (Choike, 2006) and, because states and governments are often dominated by (explicit and implicit) patriarchal value systems, good intentions are most often not translated into action with enough effective resources, conditions, strategies and sanctions.

The UN Millennium Project Report (2004) proposes to mobilize leadership at the national, regional and global levels to make violence unacceptable. The Network of African Women Ministers and Parliamentarians has already made a commitment to combating gender-based violence by taking the lead in developing innovative interventions including: drafting and lobbying for appropriate legislation; raising awareness through advocacy; building partnership by enhancing national, regional and international networks; and raising community awareness about gender-based violence (UNFPA et al., 2005).

Awareness of sexual violence as a widespread violation of human rights has also brought about (some) progress in the legal and justice system. A couple of examples: An initiative has been realized in Honduras to train police officers to become more gender-sensitive when they intervene in cases of domestic violence. The curriculum on gender-based violence is now part of the regular police-training program (UNFPA, 2005a). Many countries have implemented additional often relatively 'simple' organizational and logistic measures to stimulate report of sexual violence and improve sensitivity among police and judiciary: the installation of dedicated domestic violence units and sexual crime units, female examiners/investigators to perform (internal) forensic examinations with the victim (forensic nurses), female court officials, and women-only police stations and courts for rape offences (Krug et al., 2002, p. 169). The International Criminal Tribunal for the Former Yugoslavia specified that the earlier sexual history of the victim is not to be disclosed as evidence and that consent as a defense shall not be allowed if the victim has been subjected to or threatened with violence or detention or has reason to fear such violence. Other examples of good legal reform are a broadening of the legal definition of rape, removing the requirements for victims' accounts to be corroborated, the introduction of minimum sentences for rape (extenuating circumstances notwithstanding), a campaign to inform the general public of their legal rights, and focusing on the (much more common) *known* offender in processes and guidelines (Kelly, 2005; WHO, 2002).

Community-Based Initiatives

The media has been used effectively to raise awareness and to campaign against domestic and sexual violence, e.g. in the South African prime-time series Soul City, or in a Zimbabwean series where survivors of violence describe their experiences (cited in Krug et al., 2002). Examples of national campaigns are Turkey's "Stop Violence Against Women" and Thailand's "Love and Peace in the Home." Other initiatives extended over national borders: the Sisterhood Is Global Institute in Montreal has developed a manual suitable for Muslim communities, and a UN interagency initiative to combat gender-based violence has successfully been conducted in 10 countries in the Caribbean and Latin America to raise awareness, build capacity at the governmental level and strengthen networks of public and private organizations. An intercontinental alliance between a Planned Parenthood in Ithaca, New York and the Namibian Planned Parenthood Association in Windhoek has learned that "connecting to communities matters" in community-based sexuality education programs, and that it is important to learn the community norms, find the

opinion leaders, and "actively engage as learners, not just as teachers" (Maurer & Kelly, 2005).

It has proven effective to involve celebrities, sportspeople, religious leaders, etc. in campaigning through the media, as well as to involve the private sector in sponsoring and championing the cause. An original example of involving celebrities is one in a campaign launched by ECOS in Brazil, where well-known comic actors appeared in a video stating that violence against women is "not funny" (cited in UNFPA, 2005a). In Panama, the First Lady and high-level officials were involved in handing out postcards at the national airport promoting safe tourism instead of sex tourism.

Other successful public responses are, for instance, Montreal's "Between Two Stops," which allows women to get off a bus as close to their destination as possible at night, and Bangkok's "Lady Bus" service. Some anti-violence efforts focus on women's economic empowerment and already these are sometimes included in existing services for survivors. The National Women's Bank in Venezuela is integrating violence prevention into its credit service. Bank officers regularly receive refresher training on gender-based violence and reproductive health to better meet the non-financial needs of female clients (UNFPA, 2005a).

The ICPD Program for Action decisively places men in the center of the process if change is to be achieved. It encourages men to take responsibility for their sexual and reproductive behavior, as well as their social and family roles. Many community-based initiatives to prevent sexual violence have since then successfully involved men. The White Ribbon campaign, for instance, founded in Canada, is based on the idea that all men and boys must take responsibility for ending violence against women. Wearing a white ribbon is a personal pledge never to commit, condone, or remain silent about violence against women. In Cambodia, Men Against Violence Against Women supports annual campaigns against gender-based violence and works to provide young men with role models. And the "Men Can Stop Rape" group in Washington DC seeks to promote alternative forms of masculinity that foster non-violence and gender equality.

Public Health Educational and Prevention Efforts

Many life skills and other educational programs, empowerment programs, and sex education programs have been developed and implemented in recent years. Various programs for the promotion of sexual health now acknowledge gender as an important issue and address the problem of sexual violence. The WHO World Report on Violence and Health in 2002 already mentioned two notable examples, developed in Africa and also used in many parts of the developing world: "Stepping Stones" and "Men as Partners" (WHO, 2002, p. 165). These have been designed for use in peer groups of men and women and are delivered over several workshop sessions using participatory learning approaches. They are specifically tuned to reaching men. Since then, many more programs developed for the primary prevention of sexual violence have been developed, directed at children and adults and at women and men. Many programs explicitly target sexual violence while many others are more general sexuality programs in which aggressive sexual behaviors or sexual transgressions are treated as problematic. However, few of these programs have been well evaluated. Evaluative studies, when conducted, have often not used control groups. Besides, evaluative studies have often focused upon the goals the program aimed at reaching, but did not look at whether indeed they succeeded in preventing or reducing sexually aggressive behavior. "Abstinence-only" programs have been proven ineffective in light of teenage pregnancy, sexual activity and condom use (Kirby, 2002; Trenholm et al., 2007), but their (lack of) efficacy in light of sexual violence has not been looked at. Programs to prevent sexual violence have been evaluated much less than, for instance, programs to improve HIV-preventive behavior. Moreover, empirical support for the efficacy of programs to prevent sexual violence is relatively scarce.

Nevertheless, some conclusions regarding effective elements can be drawn. In general, it has been shown that public interventions in the area of sexual health need to be comprehensive, theory-based, and gender-specific in order to be effective and there is no reason why this

would not be true for programs against sexual violence. They also need to be culture sensitive and well tailored to the specific target group. Looking specifically at primary prevention, it appears that programs targeting children and youth to enhance their resistance to sexual and aggressive behavior of others and thus to prevent child sexual abuse are more successful when they involve at least four sessions, are spread over time and make use of repetition, not only use verbal methods but also use modeling through film or theater, not only enhance knowledge but also improve skills through practicing new behaviors, and also involve significant others such as teachers and parents (e.g. van Oosten & Höing, 2004; MacIntyre & Carr, 2000). In general, sex education programs have been proven more successful when developed from a social-cognitive theoretical perspective, aimed at training communicative, assertive and interactive/negotiation skills through demonstration and modeling, active learning, feedback and reinforcement (e.g. Kirby, 2001; Schaalma, Reinders, & Kok, 2004). Besides, not least in the area of sexual violence, the risks, the socio-emotional context of sexuality and (thus) the educational needs of women/girls and men/boys differ. Therefore prevention programs should be gender specific or, at least, gender sensitive. In the US, a short sexual assault prevention program specifically for women has been shown to reduce the chances of being victimized, although the program, even when adapted, did not succeed for women who were victimized before (Hanson Breitenbecher, & Gidycz, 1998). Perhaps longer term therapeutic intervention is needed to break the cycle of victimization. Several short term programs for men have been shown to be successful with regard to attitude change and/or victim empathy (e.g. Yeater & O'Donohue, 1999), although success has not been shown among higher risk men with higher likelihood to abuse. Moreover, it is not known how long the effects of such interventions last.

It has been suggested that prevention programs take too little account of the contexts in which sexual violence takes place. Besides, they may be relatively often tuned to an anonymous perpetrator and give too little attention to the much more prevailing perpetrator that is an acquaintance or family member. Some doubt has been raised as to the efficacy of programs targeting the individual in the first place. In relation to sexual violence, it may be more effective to reach out to communities rather than to individuals (cf. WHO, in press). In general, preventive efforts should always be embedded in broader local/national cultures and policies. Nevertheless, special attention must always be given to specific forms of violence as well as to groups that are specifically at risk, such as already victimized women (and men) and high-risk men with negative attitudes towards women. In this context, real primary, developmental approaches such as better and more gender-balanced parenting or a prevention model with interventions before birth (addressing parenting skills), during childhood and in adolescence and young adulthood (see Krug et al., 2002, p. 166) may be promising, although it is far from easy to have them widely implemented.

The Netherlands is often recognized for its successful approach to (adolescent) sexual health. Indeed sexual health programs are widely implemented in Dutch schools and many more educational materials are offered outside the school context, most of them issued by government supported organizations. Generally speaking, the "Dutch approach" to (young) people and sexual health may be characterized as open, liberal, acceptant of young people's sexuality and comprehensive (Ferguson, Vanwesenbeeck, & Knijn, in press). Considering the country's low rates of teen pregnancy and high contraceptive use among young people, this approach has proven effective. However, there is no data available allowing reliable comparison to other countries in the area of sexual violence. Nevertheless, sexual violence as a topic and gender sensitive approaches in general, have increasingly come to the fore in Dutch educational materials during the last decade. "Weerbaarheid," a Dutch word referring to "interactional competence" is one of the major topics and encompasses social skills such as acknowledgment of one's personal norms, values and feelings, assertiveness and communication. Within this domain, there is a focus on two particular areas 1) establishing personal boundaries and 2) communicating personal boundaries to others. A defining

characteristic of Dutch materials is that they do not tell young people what to do, but rather encourage the individual to think about what he/she wants in advance and develop the necessary skills to communicate and maintain those boundaries. "Only do what you want to do" and "no means no" are two key messages in this domain. Within sexuality materials, boundary setting and communication are applied to two specific skills: 1) encouraging young people to think about how far they want to go with sexual activities and 2) how to communicate about sexual desires and boundaries (Ferguson et al., in press).

A tool to raise awareness in developing countries used by the Dutch development organization Youth Incentives, is the promotion of the "RAP-rule," in which RAP refers to young people's sexual **R**ights, the **A**cceptance of young people as sexual beings, and their **P**articipation in the development of policy and programs. The RAP rule was developed as a counterpart of the "ABC rule" promoted by US-based international programs, referring to the advice for young people to, first, practice **A**bstinence, second **B**e faithful, and only as a last resort, use **C**ondoms. Youth Incentives advocates that only open, accepting and positive attitudes towards (young people's) sexuality among policy makers, program officers and (young) people themselves, may ensure good sexual health and, among others, a social climate in which sexual violence becomes unacceptable (Youth Incentives, 2002). A closed or judgmental social environment makes it very difficult to discuss or overcome negative experiences, and feeds into shame, guilt, denial sexual ill-health and frustration and (once more) abuse. Open discussion of sexuality has been found to be an effective tool in reducing stigma and sexuality-based discrimination. Openness about sexuality may also help acknowledging violent sexuality as violent, not as "normal," and helps victims to acknowledge their experiences as violations of their human rights, thereby helping them to overcome the trauma.

When education on sexual violence and sexual health are at stake, one important aspect is the prevention of sexual violence in schools as a setting in the first place. Making schools safe is an essential step for attaining the MDG education targets (UNFPA, 2005). In some countries, parents keep their daughters out of school for fear of sexual abuse or rape. National programs to prevent sexual abuse of girls in schools (such as developed by the Government of Panama with UNFPA support) are useful tools in this respect.

Developments in Health Care and the Health Care System

Many adaptations and innovations to the health care system have been proposed and implemented in recent years to improve its response to sexual violence. The role of the health care system is crucial in identifying, supporting, referring, and providing appropriate treatment and care for victims of violence, as well as for perpetrators. Identifying and addressing victims and perpetrators is step one, because many people use health care services without revealing their experiences with violence. A recent review of health service models for provision of comprehensive care to victims of sexual assault found that services were very diverse (Kelly, 2004; WHO, 2005). Few have been properly evaluated. Nevertheless, there is evidence in favor of integrated health care services (e.g. de Koning et al., 2005).

Integrated services may exist in various ways. One obvious one is to address violence against women in reproductive health settings, which may be cost-effective (UNFPA, 2005). Violence is a cause of recurring health problems and prevents a woman from protecting herself against unwanted pregnancies and STIs. Routine screening of women in reproductive health settings can help reduce the risks for both women and infants. Many affiliates of IPPF expanded their reproductive health services to include a gender-based violence component and detection, and referral rates of abused women have risen dramatically as a consequence. It also expanded the network of services available to women beyond the health sector. Governments are also increasingly making contraception available as a component of post-rape care. Another form of integration is where all different functions for victims are combined. Malaysia was among the first countries to establish "one-stop crisis centers" that offered both medical and legal

services. "One Stop Shops" typically integrate services for sexual and domestic violence or even all forms of gender-based violence. Kelly (2005) also mentions Sexual Assault (Referral) Centers (SARCs/SACs) as promising. These offer comprehensive care outside police stations to anyone who has experienced recent sexual assault, thus they are also available to men and, sometimes, children, whereas Rape Crisis Centers—by women for women—are typically only available to women. Essential to integrated services like these is that the various processes after assault, e.g. first contact (be it by telephone or face to face), the assessment, support, police report, medical-forensic examinations, etc., are well-tuned and performed by trained, specialized staff.

Adequate early care and support can help reduce the negative consequences and prevent worse. In a study in the Netherlands (Ensink & van Berlo, 1999) 39 female victims of sexual assault were interviewed (at 3 points in time after the assault) about their experiences with the police, with the medical-forensic examination, and with the psychosocial support they received. Their post-traumatic stress, depression, anxiety and psychosocial well-being were measured as well. It appeared that negative experiences with the police were related to post-traumatic stress and psychological unwell-being of the victims 9 months after the assault, and that dissatisfaction with the medical examination was related to depression and well-being. There is additional evidence that a brief cognitive-behavioral program administered shortly after assault can diminish the negative consequences and improve the recovery process (Foa & Rothbaum, 1998). Addressing the (characterological) self-blame victims often employ appears to be beneficial for the recovery process, although much more evaluation research is needed in this area. Nevertheless, improving victim access to "quick" psychological support definitely deserves recommendation. Besides its benefits to the recovery process, appropriate physical examination performed right after an assault provides the opportunity to, when and where advisable, administer emergency contraception or prophylaxis for HIV infection. The medico-legal documentation obtained can increase the chances of a perpetrator being arrested, charged and convicted. Improvement of immediate services with protocols and guidelines to obtain a "sexual assault evidence kit" (Krug et al., 2002, p. 166) can thus serve multiple goals: help to reduce victim stress, enhance the recovery process and support prosecution of the perpetrator.

Longer term therapeutic interventions that have been shown to be effective (e.g. see van Berlo et al., 2004) comprise, for instance, systematic desensitization, exposure and cognitive reprogramming. Examples are Stress Inoculation Training, Prolonged Exposure, Cognitive Processing Therapy and EMDR (Eye Movement Desensitization and Reprocessing). Pharmacotherapy, notably with SSRIs, may be effective in treating PTSS. However, the number of therapists adequately equipped to provide the therapeutic interventions here mentioned is limited in most countries. Training of health care workers to improve their skills in treating victims of sexual violence seems a prerequisite to effectuate possible benefits. Specifically in relation to CSA victims, family support approaches, including training in parenting, have been developed and may be worth recommending, although these responses still need rigorous evaluation, according to WHO experts (Krug et al., 2002). Finally, a relatively new venue for victim support and treatment, added to the already existing telephone help lines, is worth mentioning: the interactive internet support site. There is some evidence that internet-driven treatment of post-traumatic stress in general is effective (Lange, van de Ven, & Schrieken, 2003). Treatment via the internet for victims of abuse certainly holds promise for the future.

In the area of sex offender treatment much has been done in recent years (e.g. van Beek et al., 2004). The so-called relapse prevention model or self-regulation model works from the adage "no cure but control." The idea is t-at the sex offender learns how to monitor and control his aggressive behavior. These cognitive-behavioral treatment programs have been shown to have reasonable effect in driving back recidivism. However, results are limited. Therefore, detention and other forms of external supervision, in particular when psychopathy or sexual

deviance are part of the offender's personality, will remain necessary. Biomedical interventions should not be excluded either in some cases.

One important prerequisite for effective care and support of victims (or perpetrators) is the availability of well-trained staff. Health personnel often do not have the knowledge, tools or skills to deal with women who have been sexually abused. They may be judgmental and unsympathetic. It is thus crucial to provide gender-sensitive training for staff, as well as developing tools and guidelines to improve the services' response to violence and to change the attitudes and practices of health providers (Heise & Garcia-Moreno, 2002). Pre- and in-service training, during which staff learn to discuss sexuality, ask the right questions in a non-judgmental way, and identify victims and high risk situations, is a prerequisite for integration of gender-based violence into reproductive health services. Training and awareness raising also help health professionals advocate for violence prevention. Training is even more important in countries where domestic violence is the social norm. In these societies, health staff may accept such violence or may have experienced intimate partner violence themselves (Kim & Motsei, 2002). In a study in South Africa, more than one-third of female nurses had been physically abused and an equal number had been sexually abused (Garcia-Moreno, 2002). Other PHC nurses in South Africa did not intend to refer abused patients to the police or judicial system. Only some female nurses would "hear [the woman's] side of the story," and most of them would try to resolve the issue within the family (Kim & Motsei, 2002). Training should address the notion that there are no quick answers, as well as the need for a rights-based approach (i.e. private spaces for consultation, respect of patients' confidentiality). And last but not least, training of staff and health care workers in a variety of health care settings may help reduce instances of sexual abuse within the health sector itself.

Additional Actions against Specific Forms of Violence

In the fight against *trafficking of women* (and boys) for the purpose of sex work, both economic programs and programs that provide information and raise awareness among potential victims have been developed. In some countries, victims are granted temporary residence permits when they cooperate in prosecuting traffickers. In the Netherlands, however, it has been found that the temporary nature of these permits detracts from the protective effect that the measure should have and that permanent permits are advisable. The Netherlands also has, next to some other parts of the US, Australia and Germany, experience with decriminalization of sex work. As history has shown, a general criminalization of sex work is not an adequate strategy toward protection. It is at odds with women's human right to economic and sexual initiative and self-determination as well as with sex workers' rights. In addition, criminalization enhances sex workers' vulnerability to stigma and related exploitation and victimization and it forbids authorities adequate instruments and strategies to prevent and fight these abuses. Openness and education about sex work as a profession, combined with well-organized support in making alternative choices, could, however, be a first step to protect women for whom sex work would probably be a wrong choice. Clearly, decriminalization of sex work is a prerequisite for the development and implementation of such interventions. In addition, research has shown that work relations, support structures, organizational cultures, and protection of personnel from violence on the work site matter in protection of sex workers (further) victimization and negative health consequences (Vanwesenbeeck, 2005). A process towards better work relations, worker protection, and an improved status of sex workers, once facilitated by a legislative system as now available in the Netherlands, certainly needs further (government) support.

In relation to sexual *violence during armed conflicts*, it is noteworthy to mention that the UNHCR released guidelines in 1995, including adequate design and planning of refugee camps, documentation of cases, education of staff and medical care and other support.

Regarding *FGM*, WHO has issued the recommendation that health workers should not be involved in the medicalization of FGM, since this is not only contrary to the ethics

of health care, but also legitimizes a harmful practice. Health workers at all levels should be trained in the prevention of FGM, including community-based interventions. Health workers need training in managing the many physical, psychological and sexual complications associated with the practice (de Koning et al., 2005, p. 89). Other good practice reported by WHO comprises, for instance, declarations by health officials that FGM is useless and harmful and constitutes unethical practice for a doctor, religious leaders voicing opposition and pointing out that there is no mention of female circumcision in the Koran, offering counseling to families considering FGM, and including the issue in community development, health awareness and other programs. Also the involvement of male community leaders, e.g. young men declaring that they will marry uncircumcised women, deserves recommendation.

RECOMMENDATIONS FOR ACTION

Action must be taken in multiple domains. Distinguished are the political-legal, (public health) education, and health care domains. Finally some recommendations for further research are presented.

The Political-Legal Domain

- Advocate for gender equality and women's human rights;
- Promote women's economic rights and strengthen the economic position of women;
- Repeal laws and policies that are discriminatory in relation to gender and sexuality;
- Challenge political structures and legislation unsupportive of (women's) sexual rights;
- Promote legislation against sexual violence and harassment;
- Monitor adherence to international treaties, laws and other relevant mechanisms;
- Sensitize legal and justice systems to sexual violence and the needs of victims;
- Disseminate understandable legal information to inform people about their legal rights;
- Advocate for funding of programs on gender equality and of sexual health services;
- Advocate for "good leadership" and strengthened national commitment;
- Advocate for an equal distribution of wealth and against war.

The Domain of (Public Health) Education

- Raise awareness of and campaign against sexual violence;
- Involve men and offer alternatives to sexually aggressive machismo;
- Establish public–private partnerships in campaigning against sexual violence;
- Promote primary prevention of sexual violence;
- Develop developmental and parent support approaches for the prevention of CSA;
- Develop theory-based and gender-specific sexuality education programs for youth;
- Structurally implement comprehensive sexuality education for all;
- Involve the education sector and involve youth;
- Develop and implement well-tailored programs in specific risky settings;
- Develop and implement well-tailored empowerment and skills-building programs;
- Integrate sexual violence into HIV/AIDS prevention programs;
- Make schools safe for girls;
- Fight antigay attitudes and violence in schools.

The Health Care Domain

- Develop a comprehensive health sector response to the impact of sexual violence;
- Build capacity for integrated sexual health services;
- Incorporate (responses to) sexual violence in the curricula for health personnel;
- Promote pre- and in-service training and skills-building for health care workers;

- Adhere to WHO (2003) standards in support and care for victims;
- Implement theory-based and gender-sensitive treatment methods for victims;
- Implement theory-based treatment and relapse prevention methods for perpetrators;
- Make the health care system safe for women and girls;
- Fight antigay attitudes and behaviors in the health care setting.

Further Research

Generally speaking, more research is needed:

- into causes, consequences, and costs of all forms of sexual violence for a greater understanding of the problem;
- to establish systems to adequately identify, register and monitor sexual violence;
- and to stimulate (evaluative) research to facilitate the design of cost-effective and appropriate prevention, intervention and treatment programs.

WHO (2005) specifically recommends studies on methods of screening for gender-based violence, to determine the most effective, safe and reliable ways to identify and support women who suffer from violence and its consequences without putting them at additional risk. I might add that the same is needed for certain groups of men at risk. In addition, there is a specific need for more systematic documentation of the range of health sector interventions being tried in different settings, together with assessment of their effectiveness and costs, in order to develop good practices that can be replicated in other countries.

CONCLUSION

A lot of work is still to be done. The World Association for Sexual Health works to stimulate and contribute to the necessary action on all levels mentioned. Priority number one now seems to be to adequately and strategically contribute to the continuous efforts to integrate sexual health into the Millennium Development framework. This background article hopefully provides some of building stones to do so.

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