

SEXUAL AND GENDER BASED VIOLENCE IN AFRICA:

LITERATURE REVIEW



Photo: Georgina Cranston

SEXUAL AND GENDER BASED VIOLENCE IN AFRICA

LITERATURE REVIEW

February 2008

ACKNOWLEDGEMENTS

We would like to thank Ms Victoria Rumbold, a consultant to the Population Council, for researching and preparing this review. Several members of the Council's Sexual and Gender Based Violence partnership made valuable contributions of advice and information. We gratefully acknowledge the Swedish Norwegian (S-N) Regional HIV & AIDS team in Africa for providing funding for the literature review.

Table of Contents

Acronyms	iii
Introduction	1
1. Characteristics of Sexual Violence and Survivors of Sexual Violence	4
1.1 What is sexual and gender based violence?	4
1.2 Prevalence, consequences and risk factors associated with sexual violence	6
1.3 Ethical considerations for researching SGBV	11
1.4 Approaches to managing child survivors of sexual violence	12
1.5 Approaches developed for encouraging and enabling presentation by male survivors	14
2. Medical and Psychosocial Management of Survivors	16
2.1 Medical management of sexual violence at point of first contact with sexual abuse survivors	16
2.2 Psychological counselling of rape survivors	23
3. LEGAL AND JUDICIAL ASPECTS OF SEXUAL VIOLENCE	26
3.1 Procedures developed for collecting forensic evidence and for creating a “chain of evidence”	26
3.2 Referral linkages between police and health facilities and medico-legal services	28
3.3 Experiences with ensuring prosecutions initiated by the police are sustained through the judiciary	30
4. DEVELOPING INSTITUTIONAL AND COMMUNITY LINKAGES	33
4.1 Community-based prevention strategies linked to medical and police structures	33
4.2 Addressing physical and psychological violence between domestic or intimate partners:.....	35
ANNEX I: SGBV DEFINITIONS AND CLASSIFICATIONS	38
ANNEX II: INSTRUMENTS OF LAW, POLICY AND PRACTICE ON SGBV	40
ANNEX III: THE AFRICAN UNION PROTOCOL TO THE AFRICAN CHARTER ON THE RIGHTS OF WOMEN IN AFRICA (2003)	43
Plan of Action on Violence Prevention in Africa: Third session of the African Union Conference of Ministers of Health (Johannesburg, South Africa, 2007).	44
ANNEX IV: SAMPLE INFORMED CONSENT FORM	45
BIBLIOGRAPHY	46

Acronyms

AIDS	Acquired Immuno-deficiency Syndrome
ART	Anti-retroviral Therapy
ARV	Anti-Retrovirals
BCC	Behaviour Change Communication
CBD	Community-Based Distributor
DHS	Demographic and Health Survey
DTC	Diagnostic Testing & Counselling
EC	Emergency Contraception
ECP	Emergency Contraceptive Pill
ECSA	Eastern, Central and Southern Africa
FGM/C	Female Genital Mutilation/Cutting
FPC	First Point of Contact
GAA	Global AIDS Alliance
GVRC	Gender Violence Recovery Centre
HIV	Human Immuno-deficiency Virus
HRW	Human Rights Watch
IASC	Inter Agency Steering Committee
IFPP	International Family Planning Perspectives
IGWG	Interagency Gender Working Group
IPV	Intimate Partner Violence
IPPF	International Planned Parenthood Federation
LVCT	Liverpool Voluntary Counselling and Testing
MAP	Men as Partners
MSM	Men who have Sex with Men
NASCOP	National Aids & STDs Control Programme
NGO	Non Governmental Organisation
PEP	Post Exposure Prophylaxis
PRC	Post Rape Care
RADAR	Rural AIDS and Development Action Research Programme
RHRCC	Reproductive Health Response in Conflict Consortium



SGBV	Sexual and Gender-Based Violence
STI	Sexually Transmitted Infection
TVEP	Thohoyandou Victim Empowerment Trust
UNFPA	United Nations Fund for Population Activities
UNGA	United Nations General Assembly
UNHCR	United Nations High Commission for Refugees
VCT	Voluntary Counselling and Testing
VEP	Victim Empowerment Programme
WHR	Western Hemisphere Region
WHO	World Health Organization

Introduction

1 Sexual and Gender Based Violence (SGBV), in its various forms, is endemic in communities around the world, cutting across class, race, age, religion and national boundaries. Exposure to gender-based violence and sexual coercion significantly increases girls' and women's chances of early sexual debut, experiencing forced sex, engaging in transactional sex, and non-use of condoms. The impact of sexual and gender-based violence resonates in all areas of health and social programming: survivors of sexual violence experience increased rates of morbidity and mortality, and violence has been shown to exacerbate HIV transmission, among other health conditions (IGWG of USAID, 2006). While girls are the most visible survivors of sexual violence, they are far from being the only ones who suffer from the consequences: children of both sexes constitute the majority of abuse survivors, and adult men and the handicapped are minority groups who are often neglected in research and interventions.

There is growing awareness of the links between sexual and gender-based violence, health, human rights and national development in East, Central and Southern Africa (ECSA). However, there are few programmes that simultaneously address the determinants and consequences of SGBV in an integrated and comprehensive manner, with responses being implemented separately by the NGO and public sectors, and by separate line ministries within national governments. In addition to this, few guidelines or frameworks exist to guide policymakers and programme managers in developing and implementing the comprehensive response necessary to address the health and criminal justice consequences of violence, and to reduce the determinants of violent behaviour within communities. Moreover, in most situations, organizations and ministries are undertaking activities without reference to or liaison with other key actors and networks within their country or more widely in the region.

Objectives of the review

This literature review is intended to inform partners in the Population Council-coordinated regional network that aims to develop a multi-sectoral and comprehensive response to SGBV in Eastern, Central and Southern Africa. The review is structured around seven components collectively designed to meet the medical, psychological and justice needs of survivors of sexual violence. The components consist of a comprehensive review of region-specific policies, programmatic experiences and best practices relating to the appropriate medical management of sexual violence, enabling effective criminal justice responses to all SGBV cases, and the reduction of levels of violence at the community level.

Scope and limitations

The review aims to synthesise published and unpublished literature on the relevant aspects of SGBV. There are certain limitations:

- ✓ Firstly, this review aspires to contextualise the specific components of the SGBV partnership programme. Lateral aspects of SGBV, such as violence in conflict settings and female genital mutilation/cutting (FGM/C), are deliberately not explored.

- ✓ Secondly, this review has a specific purpose: to inform the SGBV partnership. There are a number of existing literature reviews on post rape care (PRC) and interventions for survivors of sexual violence, which have collectively proved a valuable resource for this review. While this review may indicate gaps in research or programming, it is not the primary objective.
- ✓ Thirdly, the review focuses on evidence from Eastern, Central and Southern Africa, with material from outside the region used only where deemed relevant in the African context.
- ✓ Finally, the review aims to synthesise the findings from evidence-based interventions. However, there is little published evidence on many aspects of the framework, especially those outside medical management. The relative absence of well-designed and monitored research interventions conducted in resource-poor settings indicates a critical need for monitoring and documentation of SGBV programmes in the ECSA region.

Structure of the review

The review is envisaged as an information resource to enable the development of a comprehensive model of care, support and prevention that partner countries can adapt, as a whole or as particular components. The seven components are presented in Box 1:

Framework for a comprehensive model of care, support and prevention of SGBV

1. Medical management of sexual violence at point of first contact with the survivors.
2. Psychological counselling of rape survivors.
3. Sensitive approaches to managing child survivors of sexual violence (of both sexes), and to encouraging and enabling presentation by male survivors.
4. Collection of forensic evidence (at health facility during medical management and/or at police station) and creation of a chain of evidence that can be used during a prosecution.
5. Strong links between police and health facility to enable incidents to be referred in either direction so that, if desired, a prosecution can be initiated. Ensure prosecutions initiated by the police are sustained through the judiciary.
6. New or strengthened community-based prevention strategies that are relevant and appropriate for the local context and that are directly linked to the nearest medical/police structures.
7. Physical (and psychological/emotional) violence between domestic or intimate partners addressed through:
 - a. Messages communicated during the prevention strategies;
 - b. Screening for signs and symptoms of such violence during routine health consultations.

The review is divided into four thematic sections, into which the seven programmatic components are classified:

1. Characteristics of sexual and gender-based violence and of survivors of sexual violence
2. Medical and psychosocial management
3. Forensic and judicial aspects of sexual violence
4. Developing institutional and community linkages

3

The first section defines the terminology used throughout the review, and discusses the prevalence and consequences of SGBV. It considers the implications of the disproportionate programmatic focus on adult women survivors, and explores approaches to managing child and male survivors of sexual violence. The second section presents regional policies and programming relating to the medical and psychosocial management of survivors. The third section discusses the forensic, referral and judicial requirements of successful prosecutions. It examines the necessary constituents of a “chain of evidence”, and the prevalence and characteristics of referral linkages between institutions. The fourth section considers the role that community and institutional linkages play in the prevention of SGBV, and examines the extent to which violence is addressed through messages communicated during prevention strategies, and through routine screening.

1. Characteristics of Sexual Violence and Survivors of Sexual Violence

1.1 WHAT IS SEXUAL AND GENDER BASED VIOLENCE?

4

There is no single or universal definition of gender-based or sexual violence. Understandings differ according to country, community and legal context. For instance, prevalent definitions of sexual violence exclude children. The lack of a clear and commonly accepted language inhibits the development of an effective reporting system and/or databases, and thus restrains prevention, monitoring and advocacy efforts¹ (Baker, 2007).

The term **sexual and gender based violence**, in its widest sense, refers to the physical, emotional or sexual abuse of a survivor. This review focuses exclusively on the sexual elements of abuse, and discusses the management of physical and emotional abuse only where it relates to accompanying sexual abuse. The classification of violence and abuse is explored in more detail in Annex 1.

This document adopts the inclusive terminology employed by the World Health Organization, which defines **sexual violence** as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work”. The scope of the definition is here expanded to include the forced sex, sexual coercion and rape of adult and adolescent men and women, and child sexual abuse. The definition also includes:

- ✓ The use of physical violence or psychological pressure to compel a person to participate in a sexual act against their will, whether or not the sexual act is consummated.
- ✓ A sexual act (whether attempted or consummated) involving a person who is incapable of understanding the nature or significance of the act, or of refusing, or of indicating his or her refusal to participate in the act, e.g. because of disability, or because of the effect of alcohol or other substances, or because of intimidation or pressure.
- ✓ Abusive sexual contact (WHO, 2003b; Saltzman et. al., 1999).

The term **sexual violence** is used to represent much behaviour that may otherwise fall under the rubrics of sexual abuse, sexual assault, and any other sexual violations, such as sexual harassment and voyeurism. The term **gender-based violence** is widely used as a synonym for **violence against women**, in order to highlight the gender inequality in which much violence is rooted (IGWG of USAID, 2006). However, while this review acknowledges that the overwhelming recipients of violence are female, the term **gender-based violence** is here used to encompass all women, men, girls and boys who have experienced sexual violence.

¹An evaluation conducted by UNHCR on its GBV programmes in Tanzania found that each implementing body counted and classified SGBV incidents differently, resulting in significant variations in monthly incident reports (UNHCR, 2000).

Although many who work in the field of sexual violence use the word "victim" to describe the person on whom the sexual violence is inflicted, the word "survivor" is used in this review in an effort to reflect the positivity encouraged in psychosocial care.

1.2 PREVALENCE, CONSEQUENCES AND RISK FACTORS ASSOCIATED WITH SEXUAL VIOLENCE

Overview

Social, economic, and gender issues are increasingly recognized as significant factors in countries of east and southern Africa that underlie the HIV epidemic, keep maternal mortality and fertility rates high, and increase the likelihood that sex will not be safe, voluntary, or pleasurable. Violence against women and children, of both sexes, has gained international recognition as a serious social and human rights concern affecting all societies. Epidemiological evidence shows that violence is a major cause of ill health among women and girls, as seen through death and disabilities due to injuries, and through increased vulnerability to a range of physical and mental health problems (Krug et al., 2002; Mugawe & Powell, 2006). Female survivors of sexual violence not only sustain physical injuries, but are more likely than other women to have unintended pregnancies, report symptoms of reproductive tract infections, have multiple partners, and less likely to use condoms and other contraceptives (IFPP, 2004; Campbell & Self, 2004). Violence, and the fear of violence, severely limits women's contribution to social and economic development, thereby hindering achievement of the Millennium Development Goals and other national and international development goals. Rape and domestic violence account for 5-10% of healthy years lost by women (WHO, 2001).

As described by the World Bank's Gender and Development Group, such violence can include, but is not limited to:

- ✓ Physical violence (slapping, kicking, hitting, or use of weapons)
- ✓ Emotional violence (systematic humiliation, controlling behaviour, degrading treatment, threats)
- ✓ Sexual violence (coerced sex, forced into sexual activities considered degrading or humiliating)
- ✓ Economic violence (restricting access to financial or other resources with the purpose of controlling a person).

Violence may be experienced at separate and multiple stages of the life cycle:

Table 1: Types of Violence commonly experienced at various phases of the life cycle


Phase	Type of Violence
Prenatal	Prenatal sex selection, battering during pregnancy, coerced pregnancy (rape during war)
Infancy	Female infanticide, emotional and physical abuse, differential access to food and medical care
Childhood	Genital cutting; incest and sexual abuse; differential access to food, medical care, and education; child prostitution
Adolescence	Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, forced prostitution
Reproductive	Abuse of women by intimate partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities
Old Age	Abuse of widows, elder abuse (which affects mostly women)

Source: Heise, L. 1994. *Violence Against Women: The Hidden Health Burden. World Bank Discussion Paper. Washington, D.C. The World Bank*

Both men and women can be survivors or perpetrators of violence. It is important to recognise, however, that although male against female violence is more common, a not insignificant proportion of males, and especially boys, suffer all four types of violence outlined above.

Prevalence

Gender-based violence and forced sex are highly prevalent in the region:

- 
- ✓ In **Zambia**, DHS data indicate that 27 percent of ever-married women reported being beaten by their spouse/partner in the past year; this rate reaches 33 percent of 15-19 year-olds and 35 percent of 20-24 year-olds. 59 percent of Zambian women have ever experienced any violence by anyone since the age of 15 years (Kishor & Johnson, 2004).
 - ✓ In **South Africa**, 7 percent of 15-19 year-olds had been assaulted in the past 12 months by a current or ex-partner; and 10 percent of 15-19 year-olds were forced or persuaded to have sex against their will (South Africa DHS, 1998).
 - ✓ In **Kenya**, 43% of 15-49 year old women reported having experienced some form of gender-based violence in their lifetime, with 29% reporting an experience in the previous year; 16% of women reported having ever been sexually abused, and for 13%, this had happened in the last year (Kenya DHS, 2003).
 - ✓ In rural **Ethiopia**, 49% of ever-partnered women have ever experienced physical violence by an intimate partner, rising to 59% ever experiencing sexual violence (WHO, 2005).
 - ✓ In rural **Tanzania**, 47% of ever-partnered women have ever experienced physical violence by an intimate partner, while 31% have ever experienced sexual violence (WHO, 2005).

Consequences

Such violations of bodily integrity and freedom from violence are of concern as adverse outcomes in and of themselves, and because they are correlated with poor reproductive health. Studies from diverse settings – e.g., China, Peru, the USA, and Uganda – have found that girls and/or young women who had previously experienced sexual coercion are significantly less likely to use condoms, and more likely to experience genital tract infection symptoms, unintended pregnancy and a higher incidence of unsafe abortion (Gazmararian et al., 1995; Campbell & McPhail, 2002). Lack of sexual autonomy and control stemming from actual or threatened violence, together with fear of repercussion from use of condoms or contraception, are direct pathways to unwanted pregnancy and increased risk of STIs (Kishor & Johnson, 2004). Moreover, intimate partner violence has been found to be independently associated with HIV infection (Fonck et al., 2005; Auerbach et al., 2005).

The following table outlines the potential physical, reproductive health, psychological and behavioural consequences of sexual and gender-based violence:

Table 2: Fatal and non-fatal outcomes of SGBV

Non-fatal outcomes			Fatal outcomes
Physical injuries and chronic conditions	Sexual and reproductive sequelae	Psychological and behavioural outcomes	
<ul style="list-style-type: none"> ▪ Fractures ▪ Abdominal/thoracic injuries ▪ Chronic pain syndromes ▪ Fibromyalgia ▪ Permanent disability ▪ Gastrointestinal disorders ▪ Irritable bowel syndrome ▪ Lacerations and abrasions ▪ Ocular damage 	<ul style="list-style-type: none"> ▪ Gynaecological disorders ▪ Pelvic Inflammatory disease ▪ Unsafe abortion ▪ Unwanted pregnancy ▪ Pregnancy complications ▪ Sexual dysfunction ▪ Miscarriage / low birth weight ▪ Sexually-transmitted infections, including HIV 	<ul style="list-style-type: none"> ▪ Depression and anxiety ▪ Eating and sleep disorders ▪ Drug and alcohol abuse ▪ Phobias and panic disorder ▪ Poor self-esteem ▪ Post-traumatic stress disorder ▪ Psychosomatic disorders ▪ Self harm ▪ Unsafe sexual behaviour: <ul style="list-style-type: none"> ✓ high-risk views on sexual violence & HIV infection ✓ less likely to use condoms & contraceptives 	<ul style="list-style-type: none"> ▪ Femicide ▪ Suicide ▪ AIDS-related mortality ▪ Maternal mortality

Sources: Adapted from Heise and Garcia Moreno, 2002; and Heise, Ellsberg and Gottemoeller, 1999.

The impact of SGBV resonates further than the primary victim. Research indicates a link between maternal experience of violence and evidence of increased mortality and undernutrition among children of abused mothers (Jejeebhoy, 1998; Ganatra et al., 1998; Asling-Monemi et al., 2003, in Kishor & Johnson, 2004). DHS data from Zambia signifies a link between short birth intervals (less than two years) and the mother’s experience of violence. The association between short birth intervals and infant health and survival is well documented (Lawn & Kerber, 2006). This link additionally illustrates the disintegration of reproductive autonomy amongst those who experience violence.

Sexual and gender-based violence both contributes to, and is exacerbated by, the economic and socio-political discrimination experienced by women in many countries. Women’s lack of economic empowerment is reflected in lack of access to and control over economic resources in the form of land, personal property, wages and credit (UN-GA, 2006). Power,

and the lack of power, is a recurring factor in all types of violence: the powerlessness of survivors, whether women, men or children, is also manifest in their relative lack of resources and access to support institutions.

Causes and risk factors

Certain community and societal-level risk factors are associated with higher or more severe rates of sexual and gender-based violence. The World Health Organization identifies the following evidence-supported factors (Krug et al., 2002):

- ✓ Traditional gender norms that support male superiority and entitlement
- ✓ Social norms that tolerate or justify violence against women
- ✓ Weak community sanctions against perpetrators
- ✓ Poverty
- ✓ High levels of crime and conflict in society more generally

Research on violence against women shows an increased risk of current physical or sexual violence among women of a younger age, especially those aged 15 to 19 (Krug et al., 2002; WHO, 2005a; Kishor & Johnson, 2004). Women who are separated or divorced (or, to a lesser degree, cohabiting) report a higher lifetime prevalence of all forms of violence (WHO, 2005a). Alcohol or drug consumption, and previous experience of sexual abuse, also correlate with sexual violence in adulthood (Krug et al., 2002).

The literature holds differing opinions on the relationship of education to sexual violence. The World Report on Violence and Health (Krug et al., 2002) cites South African and Zimbabwean studies that show a correlation between higher levels of female education and increased vulnerability to sexual violence. The authors reason that female empowerment is accompanied by a resistance by women to patriarchal norms, which in turn provokes men to violence in an attempt to regain control (Jewkes et al., 2002). However, they suggest that female empowerment confers greater risk of physical violence only up to a certain level, after which it confers protection (Jewkes, 2002). This theory is supported by evidence from the WHO multi-country study, which found that the protective effect of education started only when women's education progressed beyond secondary school (2005a).

Factors increasing men's risk of committing rape

Research into individual-level risk factors indicates violence is a learned behaviour: for instance, boys who witness or experience violence as children are more likely to use violence against women as adults, and a history of sexual abuse distorts perceptions about sexual violence and the risk of HIV infection (IGWG, 2006; Andersson et al., 2004).

Table 3: Factors influencing men’s risk of committing rape

Individual factors	Relationship factors	Community factors	Societal factors
<ul style="list-style-type: none"> Alcohol and drug use Coercive sexual fantasies and other attitudes and beliefs supportive of sexual violence Impulsive and antisocial tendencies Preference for impersonal sex Hostility towards women History of sexual abuse as a child Witnessed family violence as a child 	<ul style="list-style-type: none"> Associate with sexually aggressive and delinquent peers Family environment characterized by physical violence and few resources Strongly patriarchal relationship or family environment Emotionally unsupportive family environment Family honour considered more important than the health and safety of the victim 	<ul style="list-style-type: none"> Poverty, mediated through forms of crisis of male identity Lack of employment opportunities Lack of institutional support from police and judicial system General tolerance of sexual assault within the community Weak community sanctions against perpetrators of sexual violence 	<ul style="list-style-type: none"> Societal norms supportive of sexual violence Societal norms supportive of male superiority and sexual entitlement Weak laws and policies related to sexual violence Weak laws and policies related to gender equality High levels of crime and other forms of violence

Source: Krug, Etienne, Linda Dalhberg, James Mercy, Anthony Zwi, and Rafael Lozano, Eds. 2002. *World Report on Violence and Health*. Geneva: WHO.

Programmatic flaws

Many sub-Saharan African counties lack systematic and reliable data on sexual and gender-based violence. There is need for systematic data collection on the prevalence and forms of SGBV in SSA, which would in turn inform the development of meaningful strategies. Programme design is hampered by the absence of evaluation of the impact of former preventative or responsive interventions. The UN Secretary-General’s report on violence against women includes valuable suggestions for the collection of data, and also highlights the programmatic areas that are currently under-researched (UN-GA, 2006).

The overwhelming focus, in both research and programmatic interventions, is on researching and alleviating the impact of sexual violence on women. However, the majority – not the minority – of sexual abuse survivors presenting for services are children of both sexes, and not adult women, who are the default group for whom most services are designed (Askew & Ndhlovu, 2006; WHO, 2001). Programme managers and policy makers continue to see adult women as the norm and modal group. There are limited examples of programmes that have explicitly sought to address the needs of children, males or other minority groups (such as the physically or mentally handicapped), rather than trying to serve them as an additional or special category. The following sections examine approaches to enabling presentation and managing cases of child and male survivors.

1.3 ETHICAL CONSIDERATIONS FOR RESEARCHING SGBV

The ethical principles of confidentiality and respect are especially relevant in the research field of SGBV, due to the traumatic and sensitive nature of the subject material. Ill-conceived or implemented research may have dangerous consequences for the respondents and/or interviewers. Research designs should consider issues of confidentiality, problems of disclosure, and the need to ensure adequate and informed consent (Ellsberg & Heise, 2005).

11

The basic ethical principles of research involving human subjects include:

- ✓ Respect for persons (including respect for confidentiality, the need to protect vulnerable populations, and respect for autonomy);
- ✓ Nonmaleficence (minimizing harm);
- ✓ Beneficence (maximizing benefits); and
- ✓ Justice.

The key ethical principles of research are universally applicable, but the details may need to be adapted to local settings, in order to minimise misunderstandings or potential harm. Researchers are under obligation to consider how the information will be used and reported, and to whom, and who will benefit from it, and when. These considerations may be especially important in conflict environments (WHO, 2007).

The principle of respect for persons incorporates two fundamental ethical principles: respect for autonomy and protection of vulnerable persons. These are commonly addressed by individual informed consent procedures that ensure that respondents understand the purpose of the research and that their participation is voluntary (see Annex IV for template of informed consent form) (Ellsberg & Heise, 2005).

The following recommendations have proved effective guidelines for research on violence:

BOX 2: ETHICAL AND SAFETY RECOMMENDATIONS FOR RESEARCHING SGBV

- ✓ The safety of respondents and the research team is paramount and should infuse all project decisions.
- ✓ Prevalence studies need to be methodologically sound and to build upon current research experience about how to minimize the underreporting of abuse.
- ✓ Protecting confidentiality is essential to ensure both participants' safety and data quality.
- ✓ All research team members should be carefully selected and receive specialized training and ongoing support.
- ✓ The study design must include a number of actions aimed at reducing any possible distress caused to the participants by the research.
- ✓ Fieldworkers should be trained to refer participants requesting assistance to available sources of support. Where few resources exist, it may be necessary for the study to create short-term support mechanisms.
- ✓ Researchers and donors have an ethical obligation to help ensure that their findings are properly interpreted and used to advance policy and intervention development.
- ✓ Violence questions should be incorporated into surveys designed for other purposes only when ethical and methodological requirements can be met.

1.4 APPROACHES TO MANAGING CHILD SURVIVORS OF SEXUAL VIOLENCE

Children are especially vulnerable to sexual violence by nature of their relatively weak social position, economic dependence and lack of political protection. The World Health Organization estimated in 2001 that 40 million children are annually subjected to physical or sexual abuse: the number of abused children several years on will in all probability have risen (WHO, 2001). Myths that sex with young virgins can cleanse the perpetrator of the HIV virus have contributed to the rising phenomenon of child rape in Africa (Kim et al., 2003). There are increasing cases of forced sexual initiation, particularly among girls. Population-based surveys in South Africa recorded 28% of girls reporting forced sexual initiation (Matasha et al., 1998, in Krug et al., 2002). In provincial Tanzania and urban Namibia, 43% and 33% respectively of women reporting first sex before the age of 15 years described that experience as forced (WHO, 2005a).

The consequences of sexual abuse during childhood are widely recognised. Child sexual abuse has far-reaching emotional and physical implications, and people who themselves experienced abuse during childhood are more likely to perpetrate abuse against others. A study among adolescents in South Africa found that 66% of males and 71% of females who admitted to forcing someone else to have sex had themselves been forced to have sex (Andersson et al., 2004). Moreover, a history of forced sex was a powerful determinant of high-risk views on sexual violence and risk of HIV infection (*ibid.*).

The perpetrators of child sexual abuse across sub-Saharan Africa are frequently either known to the family, or a family member. Children are relatively more likely to present to police or health facilities than adults (Keesbury et al., 2006; RADAR, 2006; Kilonzo & Taegtmeier, 2005), which may reflect the widespread perception that sexual abuse of children is a crime, as opposed to the more complex attitudes towards sexual abuse of adults. Although more children present, this trend is not necessarily representative of abuse in the general population. However, the disproportionate numbers of children seeking services, relative to adults, does suggest that the current focus on adult medical management should be balanced with protocols relating specifically to child survivors. The medical, psychological and legal needs of children are not adequately addressed and require revision.

Management of child sexual abuse

The dynamics of child sexual abuse differ from those of adult sexual abuse. Children tend to disclose as part of a process rather than a single event, over a longer period of time than adults (WHO, 2003), which can have negative implications for medical management and the collection of forensic evidence. The evaluation of children requires special skills and techniques in history taking, forensic interviewing and examination (*ibid.*). The health provider may need to reassure and counsel the carers or parents of the child, and address issues of consent and reporting of child abuse. Many countries have laws requiring mandatory reporting of cases of child abuse to the local authorities or police, and health care workers should be aware of the obligations in their own country.

The medical and psychosocial management of child survivors is explored in more detail in section 2.

Programmatic implications

Two studies piloting PEP in Kenya and Malawi observed that the majority of child abuse survivors present in time for PEP with adherence and completion rates similar to those in adults, but children show lower rates of follow-up HIV testing at six weeks (Speight et al., 2005; Ellis et al., 2005). Ellis posits that reasons may be carer or child related, and may include lack of awareness of the purpose of follow-up or lack of access to child-care or traumatic associations among child survivors. Community-based follow up and awareness-raising may assist children and their carers to benefit from long-term support.

Studies conducted in Kenya, Zambia and South Africa discovered that most child survivors report to the police, prior to referrals to health facilities. This pattern, as discussed above, reflects the widespread perception of child abuse as a criminal act, and also illustrates a pervasive lack of awareness about available health services. The involvement of the police at this early stage emphasises the need for police sensitisation and for the development and reinforcement of effective referral networks. Most children report within 72 hours, with positive implications for PEP, EC (when eligible) and the collection of forensic evidence (Keesbury et al., 2006; Speight et al., 2005).

The policy environment across ECSA does not address the needs or characteristics of abused children. For instance, although the South African government has developed national guidelines for PEP treatment for individuals 14 years and older, there are no corresponding guidelines for children under 14. Many health care providers consequently lack basic information about how, and even in what circumstances, to provide PEP to children under fourteen (HRW, 2003).

The abuse of children, and particularly adolescents, often occurs within the school environment, and is perpetrated either by teachers or school peers. Just as police and health personnel require sensitisation on child needs and rights, teachers and other education professionals also need training to recognize child abuse, as well as referral links to medical or social services. Preventive programmes and counselling would also serve to protect children from abuse (WHO, 2005).

1.5 APPROACHES DEVELOPED FOR ENCOURAGING AND ENABLING PRESENTATION BY MALE SURVIVORS

Prevalence and experiences of male sexual abuse

Sexual abuse of male adults and children is vastly under-reported and poorly understood. The limited research in this area suggests that sexual violence against boys and men is endemic in many areas of the world. Population-based studies conducted among adolescents in developing countries indicate that 3.4% of males in Namibia and 13.4% in Tanzania have experienced a sexual assault. 11% of male adolescents in South Africa and 29.9% in Cameroon reported forced sexual initiation (Krug 2002). Men who have sex with men (MSM) are frequently targets of homophobic violence, which may or may not be sexual. In Kenya, nearly 40 percent of men who had sex with men reported having been raped outside their home and 13 percent report having been assaulted by the police (Niang et al. 2002 in Barker and Ricardo, 2005). Men most commonly experience sexual violence in the form of receptive anal intercourse, forced masturbation of the perpetrator, receptive oral sex, or forced masturbation of the victim (WHO, 2003).

Sexual abuse is not solely perpetrated by males. Women are also responsible for coercing males, particularly adolescents, into sexual acts (Ganju, 2004; Jejeebhoy & Bott, 2003). In Zimbabwe, 30% of secondary school boys reported sexual abuse; half of these cases involved abuse by women (FOCUS, 1998, in Barker & Ricardo, 2005). In the baseline study for Stepping Stones evaluation in the Eastern Cape of South Africa, almost 3 percent of men reported having been coerced into sex by a man and 12 percent reported being coerced by a woman (Sikweyiya et al., forthcoming, in Betron & Doggett, 2006).

Yet, with the exception of research of male sexual abuse in specific contexts, such as on the street and in prison, there is a dearth of research on the nature and prevalence of sexual violence against men (Barker & Ricardo, 2005). The data that exists is likely an under-representation of male rape survivors, as males are even less likely than females to report their experience of sexual assault due to prejudices regarding male sexuality that compound guilt, fear, and shame (Krug et al., 2002; Jejeebhoy & Bott, 2003). Pervasive cultural attitudes and legal discrimination can also inhibit male survivors from seeking medical care, or legal or psychosocial support: for instance, men having sex with men is criminalised in certain countries across ECSA, and injuries or trauma resulting from homophobic rape may not be treated with due attention by police or health personnel.

Medical management of adult male survivors of sexual violence

Male survivors of sexual violence require the same physical examination and medical interventions as women, although the genital examination requires a specific approach. Men require treatment for STIs, hepatitis B and tetanus, and need an HIV-test followed by HIV prophylaxis, if eligible. Male survivors tend to be reluctant to access counselling due to the perceived and actual stigma related to the abuse. However, men have the same psychological needs as women, and should be encouraged to receive trauma and follow-up

counselling (WHO, 2003)². Counsellors may need to reassure male survivors about perceived challenges to their sexuality or masculinity.

Experiences in encouraging and enabling presentation by male survivors

15

Programmatic interventions targeting male abuse survivors are extremely limited and there is little evidence of effective approaches towards preventing and managing male abuse. Researchers in Dakar, Senegal, found little support for a special facility due to the perception that this resource would risk reinforcing MSM ostracism (Niang et al., 2003). Concerns over stigma act as a barrier to seeking care for anal symptoms, although less for penile symptoms. This finding reinforces other sources that observe anxiety about interpretations of sexuality among male survivors of rape.

The Gender Violence Recovery Centre in Nairobi Women's Hospital treats sexual abuse survivors of all ages and genders. The presentation of male survivors (albeit 85% 15 and under) has increased steadily over the last four years, which is attributed to increased awareness among the population (personal communication, 2006 with GVRC counsellor). The hospital conducts awareness campaigns, during which they advertise the availability of services to male survivors. Services, both medical and psychological, are broadly the same as those offered to women, with the exception of pregnancy prevention.

Men rarely seek legal redress, due to the stigma attached (Ganju et al., 2004). The consensus among the literature is that health providers, the police and judiciary require sensitization on the needs and concerns of male survivors of sexual violence. The existing research and programmatic focus on female survivors should be expanded to include men who experience sexual abuse. RADAR in South Africa has developed protocols for all elements of post-rape care that include a tailored approach to managing sexual violence experienced by males.

² Young men who experienced coercive sex in Nicaragua reported significantly higher suicidal ideation and behaviour (Ellsberg, in Ganju et al. 2004).

2. Medical and Psychosocial Management of Survivors

2.1 MEDICAL MANAGEMENT OF SEXUAL VIOLENCE AT POINT OF FIRST CONTACT WITH SEXUAL ABUSE SURVIVORS

Rationale for a response to sexual violence

16

There is a moral and public health imperative to provide post-rape care services

- ✓ Rape is an offence against the integrity of a person and is a crime
- ✓ Rape is a significant risk factor for sexually transmitted infections (STIs) and HIV
- ✓ Rape may result in unwanted and unintended pregnancy and in unsafe abortion
- ✓ Rape is associated with increased sexual risk-taking behaviour among survivors
- ✓ Rape increases the risk of health problems in survivors
- ✓ The long-term psycho-social effects of sexual assault are severe and influence the recovery of a survivor (Kilonzo & Taegtmeier, 2005).

Components of a medical management 'package'

Comprehensive post-rape care aims to reduce the physical and psychological consequences of sexual violence (NAS COP, 2004a, 2004b; Kenya MoH, 2004). An integrated care package includes:

- ✓ Treatment of injuries and clinical evaluation
- ✓ Pregnancy testing and emergency contraception (EC)
- ✓ Prophylaxis of sexually transmitted infections (STIs)
- ✓ HIV diagnostic testing and counselling (DTC) and Post Exposure Prophylaxis (PEP)
- ✓ Forensic examination
- ✓ Trauma counselling.

Treatment of injuries and clinical evaluation

Survivors of sexual abuse may have physical injuries that require immediate attention. Life-threatening injuries take precedence over other components of medical management. Health care providers are advised to ensure that they do not take actions that will jeopardise forensic evidence. Where qualified, health providers need to collect and conserve evidence for forensic analysis.

The components of the clinical evaluation – forensic examination, specimen collection, analysis and documentation – act as a vital link between health care and the judicial system. The examination includes establishing the background of the survivor, taking the history of the occurrence, a medical history and a full body physical examination that is efficiently documented (Kilonzo & Taegtmeier, 2005). Care should be taken to minimise additional trauma by providing initial comfort counselling and a full explanation of the logic and process of the procedures. A co-ordinated approach to delivering medical services is advised to eliminate the need for referrals and delay (Ellis et al., 2005).

Medical management of children

While the medical management of children is broadly similar to that of adults, there are certain crucial deviations in care and the administration of drug regimens. Children manifesting severe physical injuries may be examined under anaesthesia, while children with less physical trauma can be treated and then referred (Kenya MoH, 2004). Sedation should only be used if the child is highly agitated and immediate treatment is vital. Most examinations in pre-pubertal children are non-invasive and should not be painful. Speculums or anoscopes and digital or bimanual examinations do not need to be used in child sexual abuse examinations unless medically indicated.

Children should never be left alone during their time in the facility, and should remain with parents or a designated caregiver whenever possible (WHO & UNHCR, 2002.). **Under no circumstances should a child survivor ever be left with a parent or guardian who is a suspected offender.**

Ideally, the medical history should be obtained from a caregiver, or someone who is acquainted with the child, rather than from the child directly: however, this may not always be possible. There is a debate over whether open-ended or close-ended questions are more appropriate when counselling a child, or when taking a medical history. Flexibility, patience and sensitivity are important during these sessions.

Pregnancy testing and Emergency Contraception (EC)

Pregnancy resulting from rape is generally unwanted and traumatic. Additional trauma is experienced in countries without legal recourse to abortion, as is true throughout much of ECSA. EC should be available to all female survivors of rape who are of reproductive age, and who are: not pregnant, not consistently using a reliable form of contraception, and who show signs of secondary sexual development (Kilonzo & Taegtmeier, 2005).

A pregnancy test is not required prior to administering EC. A pregnancy test is desirable, however, to determine eligibility. It is important to reassure clients that the EC pills will cause no harm to an existing foetus or to the course of the pregnancy (WHO, 2004b).

In environments where dedicated EC drugs are not available, health providers can offer combinations of oral contraceptive pills. WHO advises “there are no restrictions for use of ECPs in cases of rape” (WHO, 2004b).

EC can be administered within 120⁵ hours of unprotected intercourse, but is most effective at an earlier stage, so provision is a priority, along with HIV prophylaxis (Kenya MoH, 2004). An antiemetic can be offered alongside EC to reduce the chance of vomiting. The most common regimens of EC include levonorgestrel and combined oral contraceptive pills. WHO (2005) also identifies the insertion of a copper-bearing IUD within 5 days of the rape as an

⁵ The window of opportunity for EC has recently been revised upwards from 72 to 120 hours by WHO and ICEP. However, EC remains most effective the earlier it is taken.

efficient form of emergency contraception. However, this may not prove a valid option in resource-poor settings, and may cause additional trauma to the survivor.

An innovative study in Zambia was structured around an intervention that uses the provision of EC as a catalyst for integrating survivors into the broader institutional support system (Keesbury et al., 2006). The study found that the majority (91%) of sexual abuse survivors in Zambia's Copperbelt seek support from the police before seeking healthcare, reflecting widespread beliefs that sexual assault is primarily a criminal rather than a health concern (ECAFrique, 2004). Although 82 percent of all survivors arrived at health facilities within EC's window of effectiveness, only 37% received EC from hospital staff. Even fewer, 24 percent, received post-exposure HIV prophylaxis. These results led to the training of police officers as CBD (community-based distributor) agents, qualified to administer EC to survivors at their chosen FPC. Projected calculations suggest that police provision of EC could benefit up to 59 percent of women at risk of pregnancy, with little difference between rural and urban locations. The intervention is guided by the assumption that increased access to EC will encourage more survivors to enter into the institutional support system, while at the same time directly reducing the longer-term health and psychosocial effects of unwanted pregnancy (Keesbury et al., 2006).

Prophylaxis of sexually transmitted infections (STIs)

Survivors of sexual abuse are vulnerable to a number of sexually transmitted infections (STIs). When appropriate, WHO recommends that patients be tested for chlamydia, gonorrhoea, trichomoniasis, syphilis and hepatitis B, although this may vary according to local environments and protocols. WHO does not recommend the routine prophylactic treatment of all patients, on the understanding that survivors experience different degrees of exposure to infection and there is scant evidence on the effectiveness of STI prophylaxis provision to abuse survivors (WHO, 2003). However, medical management protocols in high STI-prevalence settings differ on this issue. For instance, the Kenyan protocol advises STI prophylaxis to be offered to all rape survivors (Kenya MoH, 2004). The incubation periods of different STIs vary, and follow-up tests are advisable. Treatment may relieve a source of stress, but the decision about whether to receive prophylactic treatment or wait for results of STI tests should be made by the survivor (WHO, 2005c).

Post-exposure prophylaxis of STIs should be commenced at an early stage of treatment, but need not be administered at the same time as the initial doses of PEP and EC as the pill burden may prove uncomfortable, and may reduce adherence to drug courses. The STI prophylaxis should, however, be prescribed and taken within 24 hours (Kenya MoH, 2003). Antiemetics can reduce feelings of nausea. When STI testing is not feasible, the Kenyan MoH recommends that post-exposure prophylaxis of STIs should be commenced at an early stage of treatment (within 24 hours). To reduce the pill burden and to encourage adherence, the doses should be spread out and taken with food and antiemetics to reduce nausea (Kenya MoH, 2004; WHO, 2005c).

The STIs most commonly contracted by abuse survivors include chlamydia, gonorrhoea, trichomoniasis and syphilis. National protocols may differ on the drug regimens provided for each STI. Different doses are recommended for non-pregnant adults (men and women),

pregnant women, and for children. A pregnancy test should be administered to women prior to prescription of STIs in order to determine their status.

Management of STIs in children

The epidemiology, diagnosis and transmission modes of STIs in children differ from those in adults (WHO, 2003). Routine administration of STI prophylaxis is recommended in high prevalence settings, although the dosage levels are child-specific. WHO observes that STI cultures may take up to one week to emerge, and therefore recommends a follow-up visit in cases where sexual abuse has recently occurred.

HIV diagnostic counselling and testing (DTC) and Post Exposure Prophylaxis (PEP)

The rationale for HIV prophylaxis (PEP)

The risk of sero-conversion following rape is likely to be higher than following consensual sex, given the increased physical trauma, especially in children (Speight et al., 2005). The increased violence of intercourse, and the lack of lubrication, can result in both microscopic and mucosal tears. Forced anal penetration is thought to carry a commensurably higher risk of HIV transmission (Kenya MoH 2004). The increased risk of infection is especially the case in the high HIV-prevalence settings of sub-Saharan Africa (Ellis et al., 2005).

PEP regimen

Post-Exposure Prophylaxis involves the administration of one or a combination of anti-retroviral drugs (ARVs) to HIV negative persons for a period of 28 days after exposure to the HIV virus. The administration of PEP within 72 hours of sexual penetration, followed by a course of PEP drugs, is thought to significantly reduce the likelihood of sero-conversion (Roland 2001). Although there is limited evidence of the effectiveness of PEP among survivors of sexual violence, the drugs have been proved effective after consensual sex in high-risk groups (Kenya MoH, 2004).

PEP is recommended for men, women, boys and girls who have experienced oral, anal or vaginal penetration. Fixed dose combinations are recommended, where available, as they reduce the number of pills to be taken and thus increase compliance (Kenya MoH, 2004). WHO points out that PEP is an ever-changing practice, and that health workers should remain aware of current recommendations and adhere to local guidelines. Studies have demonstrated low efficacy if PEP is commenced after 72 hours from exposure (Kenya MoH, 2004). In such circumstances, survivors should be availed of all other aspects of post-rape care, with the exception of PEP.

Because of the high risk of HIV transmission in high prevalence settings, it is recommended that PEP should be available at the first point of entry to a health facility (Kilonzo & Taegtmeier, 2005). The short window of opportunity (72 hours) also emphasises the need for an efficient referral system if the first point of contact (FPC) is other than a health facility. Non-availability of VCT at time of presentation may be a serious bottleneck, and

because most patients present to hospital after-hours, VCT should be made available 24-hours a day (Kim et al., 2007)

In rural areas, few patients are able to return to hospital after the initial presentation. Therefore, wherever possible, all diagnostic tests and treatment should be provided on the first visit. For those who are HIV negative, a full 28-day course of PEP should be dispensed on the first visit. Same-day provision of anti-emetics and medication counselling are important for encouraging adherence (Kim et al., 2007).

PEP for children

Regimens for children can consist of syrups or tablets, or a combination of both (Kenya MoH 2004; WHO). Children require lower dosage than adults, and with tablets, weight bands can be used to determine paediatric doses, an approach that has “greatly simplified the appropriate and early administration of paediatric PEP” (Speight et al. 2005). Otherwise, the doses are calculated according to the child’s weight and/or surface area. The dosage must be taken two or three times a day, depending on the regimen, and thus the guidance and co-operation of a guardian is required to ensure the child’s compliance. Side-effects from ARVs are significantly less common in children than in adults (Ellis et al., 2005).

Paediatric PEP protocols state that HIV testing need not precede PEP provision, to reduce delays (Malawi, Kenya and South Africa protocols). Children may be considered ineligible for PEP if they have a history of sexual assault, or if they show no physical signs of abuse. If the child tests positive for HIV, he/she should be referred for on-going medical care. If negative, the child is provided with a two-week course of PEP, followed by an appointment where the child is reviewed for side-effects and issued with another two weeks of PEP. HIV tests are recommended at 6 weeks and 3 months (Malawi, Kenya and South Africa protocols).

Adherence

Low rates of completion have been observed in both high and low-income environments. Research conducted by LVCT among abuse survivors in Thika, Kenya, observed a low completion rate for PEP, which has also been noted in other studies (Speight et al., 2005; Ellis et al., 2005; Martin et al., 2006). Out of 133 rape survivors who attended casualty, 88 of whom commenced PEP, only 30 completed the full 28-day course. The attrition was primarily due to late presentation (after 72 hours), non-attendance at the clinic and non-adherence to follow up, and the side effects of the ARV drugs. Studies worldwide have also observed that many patients do not return to the healthcare setting for scheduled follow-up appointments (Martin et al., 2006).

The Kenyan MoH (2004) advises that ARVs be provided for one week at a time, rather than the entire period of 28 days, in order to encourage re-attendance for clinical follow-up, counselling and adherence support. They do acknowledge that exceptions may need to be made in circumstances where the survivor lives far away, or is unlikely to return.

A South African study that explored women's preferences for services after rape concluded that patients clearly prefer to receive all of their HIV prophylaxis at the initial visit (Christofides et al., 2006). The rural test site that practised this approach observed significantly higher rates of PEP completion than the urban test site that doled out weekly doses. The study results also implied completion is positively influenced by the provision of antiemetics (to counter the side-effect of nausea), information, and – even more importantly – a home follow-up service and the provision of food supplements.

HIV diagnostic testing and counselling (DTC) is recommended to precede the administration of PEP. However, in circumstances where the 72-hour deadline is approaching, it is generally recognised that PEP will precede an HIV test, and will be discontinued in the event that the patient tests positive for the virus. The HIV test needs to be accompanied by appropriate counselling to reduce any additional trauma, and a delay of up to three days is permissible in cases where the patient is not psychologically prepared (Kenya MoH, 2004). Contrary to concerns about the potentially deterrent properties of HIV-testing, the need to test for HIV before receiving PEP did not deter South African women from seeking services (Christofides et al., 2006). Follow-up HIV testing is recommended at six weeks and three months from baseline.

Programmatic implications

First points of contact (FPCs) vary according to cultural perceptions of the gravity of abuse, to existing levels of awareness about available services for sexual abuse survivors, and to the quality and availability of rape management services. As discussed above, the majority of abuse survivors in Zambia seek initial support from police facilities. In environments with higher awareness of the medical needs of abuse survivors, the latter may identify a health facility as the first point of contact. Commentators are divided on the optimal location and range of post-rape services. Some argue that all medical services should be available at the FPC, while others believe that strengthening referral networks and awareness raising are priority measures.

The geographical proximity of all components of a comprehensive post rape care service naturally facilitates referrals and reduces trauma. The logical apex of this approach to managing sexual violence is the specialised or 'one-stop' clinic, such as the Thuthuzela care centres in South Africa, which aim to offer medical, counselling and legal services to patients in one location³. Evidence suggests that abuse survivors benefit from the integration of services offered by 'one-stop' centres. Such centres reduce bureaucracy and duplication, lessen secondary trauma to survivors, increase the efficiency of medical management, and increase the likelihood of successful criminal investigation and prosecution. Despite the effectiveness of this approach, it is capital and labour intensive, and may not be an appropriate option in rural or resource-poor settings.

An integrated approach involves improving and linking services at the health facility level. Inadequate linkages currently hamper the management of sexual abuse survivors. The lack of structured referral mechanisms between units within a health facility, such as the family

³ Thuthuzela Care Centres: www.unicef.org/southafrica/hiv_aids_998.html

planning clinics for emergency contraception, the HIV care clinics for PEP, mean that survivors can often become lost, sometimes literally, within the facility while trying to obtain all necessary treatment (Askew & Kilonzo, 2005). The success of an integrated approach depends on the quality of internal referrals (between casualty, the laboratory, counsellors, and the PEP clinic) and on the levels of co-ordination with forensic and legal services (Kilonzo & Taegtmeyer, 2005).

There are widespread calls for the revision of policies and laws relating to gender and sexual-based violence. Across ECSA the prevailing legal and social climate not only perpetuates incidents of abuse, but also constrains survivors from accessing medical care and legal services. However, a case in South Africa highlights the challenges implicit in legislative reform. A revised sexual offences bill now links the provision of PEP to filing criminal charges, and no longer requires other services, including counselling, to be delivered to rape survivors. The bill affords no special protections for children and also allows perpetrators to be forced into an HIV test (Global AIDS Alliance, 2006). This bill has damaging implications for the welfare of survivors, and for the identification and prosecution of sexual offenders. Research has demonstrated that the threat of social and economic hardship inhibits the reporting of abuse (Bott et al., 2005; Keesbury et al., 2006). The cultural implications of policy revision need to be considered in order not to jeopardise the medical management of abuse survivors.

The training and attitudes of health providers exert a considerable influence on survivors' experiences of care. Providers who view violence as a "social rather than a health issue" may provide an inadequate quality of care and may neglect to recognize women in danger (Bott et al., 2005). A South African research team interviewed 124 clinicians (doctors and nurses) from 31 randomly selected hospitals in 9 provinces in South Africa. Practitioners who offered better quality care were more likely to perceive rape as a serious medical problem, to have more experience in caring for rape survivors, and to have previously worked in a clinic with a rape treatment protocol (Christofides et al., 2005).

2.2 PSYCHOLOGICAL COUNSELLING OF RAPE SURVIVORS

Emotional consequences expressed in the ‘rape trauma syndrome’ are often longer lasting and more difficult to diagnose and deal with than physical symptoms. They include behaviour changes and personality changes that are manifested in a wide range of ways: physical manifestations include pain, nausea, vomiting, and headaches; behavioural manifestations may include eating disorders, sleep disturbances, abuse of drugs and alcohol and changes in normal day-to-day functioning. Self-blame, guilt and humiliation are psychological influences that lower self-esteem (Hanson, 1992). Clinical trials suggest life-long emotional trauma that is often compounded by the prejudice and stigma associated with rape (Rose, 1986).

Counselling has been identified as a key for speeding the recovery process that is often individualised and may last many years (Campbell & Self, 2004; Roland et al., 2001). Counselling in this context requires trauma prevention, HIV pre and post-test counselling, and PEP adherence counselling as the side effects of PEP may be difficult to distinguish from those of rape trauma (Kim et al., 2003). There is need for counselling to prepare survivors for the justice system, while enabling access to legal counsel and aid increases the likelihood that a survivor will complete the legal process⁴. The need for counselling is not necessarily limited to the survivor: the family and/or partners also undergo trauma and may require support (Kilonzo, 2003).

Counselling is ideally conducted by an experienced general counsellor who has received specialised training in trauma counselling and HIV-testing in the context of sexual violence (Kenya MoH, 2004). Privacy and confidentiality are central to reassuring survivors and securing their long-term safety. There are three categories of counselling, all of which are judged beneficial to the short- and long-term welfare of sexual abuse survivors:

- ✓ Trauma counselling for crisis prevention aims to reduce immediate rape trauma disorder and long-term post-traumatic stress disorder, and needs to be prioritised for all patients, regardless of their time of presentation.
- ✓ HIV pre and post test counselling is recommended for all patients before he or she is tested for HIV, even if this requires that EC and PEP be administered prior to the HIV test.
- ✓ PEP adherence counselling has been shown to be effective in increasing adherence to PEP, and is recommended to coincide with PEP clinic follow-ups (Askew & Kilonzo, 2005; Kenya, MoH 2004).

The follow-up of patients is important for their long-term well being:

- ✓ Appropriate referrals for on-going care should be made and documented in appropriate clinical records. Lists of local support services and telephone numbers would aid referrals.

⁴ The paragraphs above are drawn from *Policy Issues and a Policy Implementation Framework for Integrating Sexual Violence Services into the Reproductive Health Policy*, a background document prepared for the Gender and Reproductive Health Rights Working Group in 2005 by Population Council and LVCT.

- ✓ Sick leave recommendation for the survivor should take consideration of psychological impact as well as the physical injuries. WHO recommends that such documentation be non-specific as to the cause of absenteeism (Askew & Kilonzo, 2005; WHO, 2003).

There are special cases that require a modified counselling approach:

- ✓ Male survivors of abuse experience many of the same physical and psychological trauma symptoms as women. However, they are likely to have additional concerns about their masculinity and sexuality. The relative rarity of male survivors may also contribute to stigma and feelings of powerlessness (WHO, 2003).
- ✓ The evaluation and counselling of children requires especial sensitivity and is of crucial importance in minimising the long-term physical and psychological consequences of sexual abuse. The carers or parents of abused children may need to be offered support and counselling. They need to give consent for the child's HIV test and to be prepared for a possible positive result (WHO, 2003; Kenya MoH, 2004).

WHO emphasises the need for respect and compassion throughout the medical examination and subsequent treatment. Appropriate and sensitive language and demeanour will reassure the patient, while conversely, insensitive language can contribute towards the re-victimization of the patient. The behaviour and attitudes of health providers are a significant influence on the counselling process and outcome. Studies conducted among health providers have indicated that their perceptions towards gender roles and sexual violence can influence the quality of service delivery (Christofides et al., 2005; Bott et al., 2005).

Programmatic implications

In many resource-poor settings, formal counselling services are not well or widely established. Individual psychotherapy is a relatively high-cost intervention, and may not be a cost-effective or feasible approach in low resource environments (Bott et al., 2004). In such contexts, informal systems of support can be of great value to the patient. Support groups represent a relatively low-cost alternative to individual counselling, and are believed to be especially helpful to survivors with limited social support resources as they decrease feelings of isolation, and encourage survivors to share their experiences and establish their own informal support networks (WHO, 2003; Bott et al., 2004; RADAR, 2006). In South Africa, the Rural AIDS and Development Action Research Programme (RADAR) is exploring opportunities to establish support groups for rape survivors and the carers of abused children, using volunteers from the local police station's Victim Empowerment Programme (VEP).

In countries where survivors face social or economic deprivation as a consequence of their abuse or quest for justice, counselling may be perceived as less important than access to social services. These may include legal advice, economic support, advice on child support and custody, and emergency shelter (Bott et al., 2005; Bott et al., 2004). Counselling needs to be an adaptive mechanism that responds to the survivors' concerns. RADAR recognises the importance of extending support beyond the immediate psychological needs of the abuse survivor. The organisation is developing a comprehensive support strategy that will

involve assisting survivors through the court process; providing legal counselling; and accessing legal and advisory services (RADAR, 2006).

Researchers in South Africa explored aspects of delivery of health services that exerted the greatest influence on the choice of services. They discovered that access to a sensitive healthcare provider who could provide counselling is perceived as more important to rape survivors than the travel time. The availability of counselling was a powerful incentive to return to a facility, with 96% of respondents indicating that they would return for this service (Christofides et al., 2006). The association between counselling and PEP adherence was also noted in Kenya: a situation analysis conducted by LVCT from 2003 to 2005 indicated that survivors who received initial trauma and HIV counselling were 2.7 times more likely to complete HIV PEP medication, though there was no association between other counselling sessions and PEP completion as a short-term health care outcome (Kilonzo & Taegtmeyer, 2005). Given that low rates of completion of HIV prophylaxis have been widely observed (Vetten & Haffejee, 2004; Kim et al., 2003), this motivation to access counselling may represent a window of opportunity to deliver a full-term and comprehensive package of services.

There are few staff in health facilities qualified in appropriate counselling, in trauma and in the context of HIV testing and PEP management, partly due to the lack of recognition of counselling as a key service (Askew & Kilonzo, 2005). In Kenya, LVCT have developed a manual for training rape trauma counsellors, and have included psychological care and support in a 'post rape care systems algorithm' designed to deliver an integrated package of care to survivors of sexual violence. Preliminary data from their intervention shows that 65% of survivors have been able to access HIV PEP and counselling support for up to four weeks (Kilonzo & Taegtmeyer, 2005).

3. LEGAL AND JUDICIAL ASPECTS OF SEXUAL VIOLENCE

3.1 PROCEDURES DEVELOPED FOR COLLECTING FORENSIC EVIDENCE AND FOR CREATING A “CHAIN OF EVIDENCE”

Forensic procedures

26

Forensic evidence is needed to confirm the occurrence of sexual assault and to prove or disprove a link between the alleged perpetrator and the assault (WHO, 2003; Kenya MoH, 2004). Forensic examination, specimen collection, analysis and documentation provide the vital link between the health and criminal justice systems (Kilonzo & Taegtmeier, 2005), and are crucial components in securing prosecution and sentencing. An efficient system requires a “chain of evidence” that allows forensic evidence collected from the health facility to proceed to a forensic laboratory for analysis and hence to the police for action.

The health provider conducting the medical assessment should ideally provide the forensic service, although this may not be appropriate or feasible in certain contexts. The following principles for examination and specimen collection are recommended (WHO, 2003; Kilonzo & Taegtmeier, 2005):

- ✓ Full occurrence and medical history, documented with a government-approved form, which is admissible as evidence in court.
- ✓ Careful collection, avoiding contamination, and appropriate handling, storage and transport of specimens (to include torn or soiled clothing, any depositions on the survivor’s body, and a vaginal, anal or oral swab).
- ✓ Timely collection – the value of the evidentiary material undergoes a significant decrease 72 hours after the assault.
- ✓ Accurate labelling and efficient documentation of all collection and handling procedures.
- ✓ Documentation of the chain of custody of specimens.
- ✓ The specimens collected will vary according to the specifics of each case and to the resources (personnel and material) available. There is usually only one opportunity for a medical examination.

Where the FPC is a health facility, the decision to report to the police should be that of the abuse survivor alone. They should be given appropriate assistance and support. In cases where survivors first report to a police station, the police should encourage and assist them to seek care from a health facility, if possible within the 72-hour management window for forensic collection and administration of EC, PEP and STI prophylaxis.

Barriers and issues

Forensic evidence is often poorly collected at health facilities due to inadequate legislation, resources and training. Emphasis on collection of evidence by medical ‘experts’ can lead to delays (Askew & Kilonzo, 2005). Limited communication between police, forensic analysts

and medical personnel can also inhibit an effective forensic process. This situation is compounded by a pervasive absence of national minimum standards and effective referral mechanisms (Kilonzo, 2003). There exists a pervasive lack of awareness among the general population of the correct procedure after rape (i.e. not washing and keeping clothes) and of the window of opportunity for medical attention and forensic examination (*ibid.*). Protracted documentation can cause delays in service delivery: women in Zimbabwe were denied abortions due to documentation delays (Watts & Mayhew, 2004).

DNA samples are recognised as the most efficient means of proving or disproving a link to sexual assault. However, low-income settings may not have the capacity or resources to offer this service. In such circumstances the time-consuming and traumatic process of collecting samples for DNA may not be appropriate (Kilonzo, 2003; Kenya MoH, 2004).

Experiences with forensic collection

Liverpool Voluntary Counselling and Testing (LVCT) in Kenya developed a tool for clinical evaluation adopted by the Kenyan MoH to facilitate forensic examination and specimen collection and analysis. An emphasis on documentation means that clinical information is available to survivors, medical personnel and police for use within the criminal justice system. The intervention aims to support medical and police facilities (depending on the first point of contact) to collect forensic evidence that is appropriate for the “chain of evidence”.

A study conducted among female recipients of post-rape services in South Africa found that women trade off distance travelled for longer medical examinations, with the possibility of a court hearing (Christofides et al., 2006). This finding challenges WHO research that suggests that examinations are a major source of stress, but indicates the psychological significance of forensic services to survivors of sexual abuse. The finding also implies that strengthening forensic services and creating a “chain of evidence” may encourage presentation.

A pilot intervention study in Zambia’s Copperbelt discovered significant disparities in the range and quality of medical services offered to sexual abuse survivors. One concomitant of this disparity is the unequal resource base of individual facilities (Keesbury et al., 2006). The study observed that survivors are motivated more by a quest for social justice than medical care, and that under-reporting is partly due to distrust of the police and to the fear of social stigma. The post-study intervention focused on equipping first points of contacts with the requisite knowledge, skills and resources for managing and referring survivors of sexual assault. It also prioritised communication between the health, police and judicial sectors with the aim of improving medical and forensic procedures through increased understanding and collaboration (*ibid.*).

3.2 REFERRAL LINKAGES BETWEEN POLICE AND HEALTH FACILITIES AND MEDICO-LEGAL SERVICES

Inter-sectoral collaboration is a key determinant of the quality of comprehensive post-abuse services. Lack of basic information on rights inhibits many survivors from seeking support from institutions, let alone persevering with medical services (including prophylaxis and counselling) and legal procedures. The scarcity of referral linkages also acts as a barrier to receiving appropriate care and support. Confusion over protocols and procedures causes delays and often unnecessary expense and trauma to survivors. The 72-hour ‘window of opportunity’ for forensic examination and medical management signifies the importance of quick and efficient referrals. Effective referral mechanisms need to be established simultaneously with strengthening the component services.

Research in Malawi found that only 43% of the women who reported to the police were informed of their right to a medical examination (Pelser et al., 2005). Conversely, survivors who initially seek help from health facilities, and who wish to seek legal justice, may not be assisted to report the abuse to the police.

Referral linkages between health and police facilities, and between other legal and social services, tend to be more advanced in urban areas. The lack of referral services in rural and marginalised areas can pose a major challenge to securing even basic services for abuse survivors. The process of seeking help may even increase the vulnerability of the survivor: the IPPF observes that in certain countries it is not safe for a physician to advise a woman to file a complaint alone at the police station (Bott et al., 2004). The compilation of local referral directories may improve awareness of and access to existing services, and can help to identify duplication and gaps. Health facilities should also gather information on the quality and location of governmental services (such as police, public prosecutors and forensic medical exams) and use this opportunity to create or reinforce working relationships with these services (*ibid.*).

Improved linkages between health and police systems may have unanticipated – and not wholly positive – consequences. The WHO observes that such linkages can create a barrier to access to medico-legal services due to survivors’ concerns about involving police and the potential consequences to themselves, or occasionally to their assailant (WHO, 2004a). WHO cites the example of a medico-legal centre in Hamburg⁵ that avails forensic and medical services to the survivor without the obligation to make an official police complaint. Forensic and biological evidence is stored for two years pending a decision to pursue or abandon the case (*ibid.*). This approach may not prove feasible or cost-effective in resource-poor settings, but the principles of confidentiality and forensic integrity are universally applicable.

⁵ The Hamburg Medico-Legal Competence Centre

Referral linkages

Formal referral linkages between police and health facilities are rare in the existing literature. Where links exist, they tend to be informal relationships with no or unclear protocols for referrals. There is evident need for clear guidelines on the mechanics of referrals, including advice on the timeframe, referral companions and the requisite skills of involved personnel.

29

Liverpool Voluntary Counselling and Testing (LVCT) in Kenya has established strong links between health centres and police, social, forensic and legal support services to enable referrals so that, if desired, a prosecution can be initiated. The 'chain of evidence' is an integral component of this process. LVCT respects the right of the survivor to decide on whether or not to report sexual abuse, and provides information and support to clients undergoing the litigation process (Speight et al., 2005; Kilonzo & Taegtmeier, 2005). The Gender Violence Recovery Centre (GVRC) in Nairobi Women's Hospital benefits from relationships with local police centres and legal aid NGOs, which together constitute the main sources of referrals. In the other direction, the GVRC refers eligible clients to long-term shelters and for legal support and counselling (personal communication with GVRC counsellor, 2006).

Many survivors cannot access the justice system unless they first obtain information about their rights, about how to report cases to the police and/or how to find legal aid services. Consequently, nongovernmental organizations worldwide have integrated basic referral services and legal services into community-based health programs, social services, and economic development programs (Bott et al., 2005). Increasing women's access to social services aids police and courts to enforce laws. In South Africa, the availability of community services to assist women and children with emergency shelter, long-term housing and economic enabled police to enforce orders of protection, prosecuting cases, and imposing jail sentences (Paranee, 2001).

There is increasing emphasis on the development of community-based networks for coordinating services to sexual abuse survivors, improving access to justice and promoting violence prevention (World Bank, 2006c; UN-GA, 2006). Multi-sectoral initiatives have pioneered services that include telephone hotlines, emergency shelters, police intervention, legal assistance, psychological and other counselling, psychological care, support groups, income-generation programs, and programs for batterers, women police stations and child welfare services (*ibid.*). Rapidly expanding communication networks provide the potential for emergency phone services offering free and confidential advice (UN-GA, 2006). A telecommunications provider in Kenya currently sponsors a helpline for abused children, with links to referral services. Research indicates a positive impact of comprehensive services on awareness and access, but the evidence is as yet inconclusive on whether these services reduce the probability of recurring abuse.

3.3 EXPERIENCES WITH ENSURING PROSECUTIONS INITIATED BY THE POLICE ARE SUSTAINED THROUGH THE JUDICIARY

Legal and judicial climate

The legal enforcement and justice sectors play a key role in preventing sexual and gender based violence. At the highest level, national policy and legislative framework influence institutional perceptions of and responses to sexual violence. Adherence to international conventions and resolutions on human rights both symbolise and enable government commitment to preventing violence (UN-GA, 2006). At lower levels, the individual responses of police or health personnel can exacerbate or ameliorate the negative impact of a coercive experience. Research suggests that justice sector reform can contribute to a reduction in gender-based violence by sanctioning the perpetrators of crimes and sending a clear message to the population that such actions will not be tolerated; by increasing awareness throughout society that physical and sexual violence are criminal acts; by increasing access to the legal system; and by improving institutional responses to the survivors of violence (Bott et al., 2005).

The current climate in many countries across ECSA does not encourage abuse survivors to report abuse to police, let alone pursue a prosecution. A study in Malawi found that only 4% of women sought help from the police, and most received a service that differed significantly from protocol (Pelser et al., 2005). The creation of a safe and confidential system for reporting violence against women, and protection of complainants from any possible acts of retaliation, form part of effective investigation procedures (UN-GA, 2006). Research in Zambia and South Africa showed that the overwhelming majority of survivors presenting to the police were children (Keesbury et al., 2006; RADAR, 2006), presumably due to social perceptions of child sexual abuse as an unequivocal crime, as opposed to more ambiguous attitudes towards adult sexual violence.

Barriers and issues

The barriers to seeking care and justice have been widely observed:

- ✓ Lack of awareness among survivors of the content and availability of medical and legal services;
- ✓ Lack of trust in the legal enforcement and judicial agencies;
- ✓ Absence of clear guidelines and protocols relating to SGBV for members of the police and judiciary;
- ✓ Lack of training and sensitisation among the police and judiciary;
- ✓ High dismissal rates of cases by police and prosecutors;
- ✓ High withdrawal rates of complaints by victims;
- ✓ Low prosecution and conviction rates;
- ✓ Failure of courts to apply uniform criteria, particularly in relation to measures to protect victims;
- ✓ Lack of legal aid and high costs of legal representation in courts;
- ✓ Practices that deny women legal control over their lives, such as detaining women for their “protection” without their consent;

- ✓ Inadequacy of forensic procedures and the ‘chain of evidence’ contribute to the perception that prosecution creates additional trauma without necessarily achieving sanctions (Pelser et al., 2005; Bott et al., 2005; Betron & Doggett, 2006; Kilonzo, 2003; UN-GA, 2006).

Once in the justice system, the prevailing emphasis is on punishing the perpetrator, rather than restoring the safety of the survivor. The paucity of legal and psychological support services for abuse survivors may exacerbate the trauma and reduce the likelihood of pursuing conviction. Commentators question whether criminal sanctions are the most appropriate response to situations where the abuse survivors are financially dependent on the perpetrator. Tough sentencing is thought to inhibit survivors from reporting family members for fear of the social and economic consequences (Bott et al., 2005; Keesbury et al., 2006; World Bank, 2006b).

Programmatic implications

Research shows that female survivors express more interest in legal tools that will increase their personal and household security, such as divorce, division of marital property, child custody and child support, than in pursuing justice (Guedes et al., 2002; World Bank, 2006b). Both female and male survivors need improved access to legal advice and resources, and require counselling and support along the medical and legal continuum. This involves building the capacity of local para-legal and community organizations, improving the range and quality of referrals, and taking steps to ensure sufficient and consistent funding and monitoring (UN-GA, 2006).

In Zambia’s Copperbelt region efforts are underway to develop a more responsive, flexible judiciary. While courts in the Copperbelt are adept at prosecuting sexual assault cases there are concerns that high prosecution and conviction rates are deterring survivors from seeking institutional support. Police, in some cases, have encouraged survivors to resolve cases through other means in order to bypass the excessively punitive system. To help rationalize sentencing in these cases, and make the courtroom a less daunting place for survivors, the Population Council is developing strategies for sensitising the judiciary on sexual assault issues (Keesbury et al., 2006). Zambia and South Africa have taken steps to clarify legal and judicial responses to SGBV by compiling detailed standards for the management of domestic violence and sexual assault cases⁶.

Experiences with institutional reforms indicate that this approach has a positive impact on the efficacy and responsiveness of legal and judicial systems. The training of police and judiciary has been shown to improve attitudes towards abuse survivors⁷, although

⁶ Zambia draft protocol, 2007; South African Police Service National Instruction No. 22/1998 “Sexual offences: Support to victims and crucial aspects of the investigation”; South African Police Service National Instruction (no. 16); National Prosecutors’ Directives.

⁷ In Pakistan, Rozan (an Islamabad-based NGO), conducted 21 trainings for police officers to explore communication skills, anger and stress management, gender norms, gender stereotypes, issues of violence and the role of police officers in violence against women. The most significant increase was from 8% to 47% in participants’ sensitivity to GBV issues (Rashid, 2001).

implementing sensitised attitudes requires reformed policies and resources, as well as the commitment and involvement of all personnel levels (Bott, 2005). Women in Law and Development Africa, an NGO, has compiled legal training kits for judges⁸. Programmes to enhance the gender-sensitivity of judges include “Towards a Jurisprudence of Equality”, developed by the International Association of Women Judges and its partners in Africa and Latin America, which aims to strengthen the capacity of judges and magistrates to apply international and regional human rights law to cases involving violence against women (UN-GA, 2006). A number of countries have introduced closed court hearings for survivors of sexual violence; closed-circuit television testimony, and separate waiting areas for vulnerable witnesses or survivors; and new rules for prosecutorial evidence – such as Tanzania’s elimination of testimonial corroboration for rape (World Bank 2006b).

Designated sexual violence units⁹ can facilitate medical and legal procedures and increase survivors’ willingness to report abuse. Referral linkages appear to increase the likelihood that survivors will receive services such as forensic exams, counselling, emergency contraception and STI prophylaxis (Betron & Dogett, 2006; Bott et al., 2005; GAA, 2006). The Thohoyandou Victim Empowerment Trust (TVEP) in Limpopo, South Africa, supports survivors through the judicial process by preparing them for court, stationing chaperones at the courts to provide reassurance and assistance, and by caring for and feeding child witnesses (Ndhlovu et al., 2006).

The “one-stop” Thutuzela Care Centres in South Africa attribute improved prosecution and conviction rates to the high degree of co-operation between survivors and service providers throughout the medical and legal procedures. They also report a significant reduction in the time spent to investigate, prosecute and convict perpetrators, from approximately 3-5 years to less than 6 months today. However, weaknesses of specialised units include inadequate resources, infrastructure and trained staff (HRW, 1997), and efforts may be undermined by insensitive law enforcement personnel and inappropriate legal policies (Bott et al., 2005). These experiences highlight the importance of a multisectoral capacity-building and reform strategy.

The Centre for Women’s and Children’s Studies in Bangladesh developed a training manual for police officers that reflects the needs of survivors and defines the role of law enforcement in combating domestic, sexual and dowry-related violence, trafficking and acid throwing (UN-GA, 2006).

⁸ For example, For a World Free of Violence against Women in Ghana: legal training kit compiled by WiLDAF/FeDDAF Ghana, available at: http://www.wildafao.org/eng/IMG/pdf/soc_ss_violence_Ghana.pdf.

⁹ For instance, the Victim Empowerment Program and Family Child Services units in South Africa and the Victim Support Units in Zambia.

4. DEVELOPING INSTITUTIONAL AND COMMUNITY LINKAGES

4.1 COMMUNITY-BASED PREVENTION STRATEGIES LINKED TO MEDICAL AND POLICE STRUCTURES

33

There are many community-based prevention programmes that tackle aspects of sexual and gender-based violence, but initiatives linked to medical and police structures are less common. Moreover, there is a dearth of research on the effectiveness, quality and impact of programmes in developing countries. The role of community initiatives in preventing and managing sexual abuse is especially important in resource-poor settings, where governments may not have the means or inclination to develop formal support networks. Evidence shows that survivors are more likely to confide in family and friends than in formal services, and indicates the need to increase general community capacity to respond in a sensitive and appropriate manner (WHO, 2005a).

From an institutional perspective, the involvement of community members in the design of specialised, yet culturally relevant, services is an essential complement to the improvement of service delivery. Health, illness and care-seeking behaviour are culturally defined, and local norms and understandings need to be taken into account when designing and implementing services. Special attention should be paid to planning services for people who face intense social stigma as survivors of particular types of violence, in order to prevent further stigmatization (WHO, 2004a).

Approaches to community-based prevention

A review of existing literature suggests that community-based prevention efforts with links to medical or police structures are in a minority. Many initiatives talk about 'community members' or 'stakeholders', but rarely specify professional personnel. There are exceptions to this rule: the Thohoyandou Victim Empowerment Program (TVEP) in South Africa is strengthening existing community-based prevention strategies that are directly linked to the existing medical and police structures. TVEP conducts campaigns in villages, schools and clinics, through the 'zero tolerance village alliance', that aim to raise awareness on where and how to report abuse. An 'Access to Justice' cluster aims to ensure the provision of a multi-sectoral, one-stop service to survivors of sexual assault, child abuse and/or domestic violence, and strategic linkages have been formed with other governmental and civil society organizations to facilitate access to services.

TVEP has developed some innovative approaches to supporting abuse survivors. The organisation responded to the high number of withdrawals from the trauma centres (currently around 50%) by creating a Case Management team to follow-up and monitors all cases. Issues of financial and physical access have been tackled through a partnership with local bus companies; TVEP prints its own post-dated bus tickets and issues them to destitute survivors, who are then enabled to attend workshops, receive counselling, and return to the hospital for follow-up blood tests. TVEP's Positive Support Services promote access to ART

and compliance with the regimen, with particular emphasis on children, through a team of volunteer advisors, counsellors and advocacy officers. There are flaws in the system: referral links require strengthening, there is currently no 'chain of evidence' to enable prosecutions, and the services are not tailored or marketed to minority groups. However, TVEP has made significant advances in creating a supportive environment for survivors of sexual violence, and in generating an environment where SGBV is culturally unacceptable (Ndhlovu et al., 2006).

A multi-sectoral community-level prevention strategy called 'Raising Voices', first piloted in Uganda, has been widely adopted across east and southern Africa. The project has developed a resource guide for use by community-based organisations working in the field of sexual and gender-based violence. The five phases include guidelines for raising awareness and building support within the community and professional sectors, (i.e. police, social and health services, law enforcement, teachers and religious communities). These steps are followed by efforts to integrate action against violence within institutions and to ensure their sustainability and progress. A preliminary qualitative evaluation observed reduced tolerance to violence by local police, councils and the general community (Michau & Naker, 2003; Bott et al., 2005).

In Rwanda, WE-ACTx (Women's Equity in Access to Care and Treatment) has launched a legal programme that aims to train paralegals and medical personnel on the rights of persons who have experienced sexual violence and those living with HIV/AIDS. Rwanda experienced high levels of ethnically-motivated sexual violence during the 1994 genocide, and the medical, psychological and legal needs of the survivors have been inadequately addressed. The programme includes forensic principles and guidelines on the management of child sexual abuse, as well as support strategies that will enable women to testify against their assailants in local genocide tribunals (GAA, 2006).

Community-based networks are aptly positioned to co-ordinate local services targeted towards abuse survivors and to improve access to medical, psychosocial and legal support (World Bank, 2006c). In South Africa and Uganda the creation of formal or informal networks, coalitions and task forces, at all levels, have contributed towards the development of referral networks and a more comprehensive response to abuse survivors (IGWG, 2006). These networks serve to sustain awareness of SGBV among both the providers and recipients of services, and can help to mobilize public support for survivors while reducing tolerance to incidents of sexual violence.

4.2 ADDRESSING PHYSICAL AND PSYCHOLOGICAL VIOLENCE BETWEEN DOMESTIC OR INTIMATE PARTNERS:

- a. THROUGH SCREENING FOR SIGNS AND SYMPTOMS OF SUCH VIOLENCE DURING ROUTINE HEALTH CONSULTATIONS
- b. THROUGH MESSAGES COMMUNICATED DURING THE PREVENTION STRATEGIES

a. Routine screening

35

The question of whether, when and how to routinely screen women for sexual and gender-based violence has aroused vigorous debate. Routine screening is now considered the standard of care within many industrialised countries, and research indicates that providers identify significantly fewer women requiring assistance with physical or sexual violence without the screening tool (Bott et al., 2005). Advocates for violence prevention argue that screening enhances healthcare responses and helps women to access available services (WHO, 2004a). Routine screening may improve sexual and reproductive health-related diagnosis, treatment and counseling, by helping providers to understand the underlying cause behind many conditions (Bott et al., 2004). However, others argue that routine screening may have a negative impact on women in environments where providers are unable to respond appropriately, where there is no guarantee of privacy and confidentiality, and where adequate referral services and linkages are lacking. Routine screening may not be feasible in settings where time and resources are typically scarce (Bott et al., 2005). Moreover, there is concern that providers, without adequate training and sensitisation, may inflict additional trauma on clients who disclose abuse (Kim & Motsei, 2002).

Debate exists on whether routine screening may have a potential impact on the reduction of HIV transmission. Research indicates a strong association between women's HIV status and partner violence, which supports the theory that violence plays a role in women's risk for HIV infection (Maman et al., 2001).

The debate will likely continue until the effectiveness of screening interventions is meticulously evaluated. However, certain principles are understood to be universally applicable: clients who disclose abuse must be afforded privacy and confidentiality, and any screening process must be conducted in a safe and non-judgemental way (WHO, 2004a).

A needs assessment conducted prior to the integration of routine screening and referral services into clinics in three South American countries revealed that health provider bias may jeopardise screening. 53% of clinicians interviewed felt that women's inappropriate behaviours provoked their husbands' aggression, while 41% believed that adolescents may provoke sexual assault (Guedes, Bott & Cuca, 2002). Encouragingly, 94% of the clinicians indicated that it is important to ask about sexual violence as other clinical problems (*ibid.*).

Sensitisation of health providers (and of police, where applicable) is an effective tool to help providers to address underlying attitudes, and to overcome barriers to responding appropriately to abused clients (*ibid.*). In conclusion, the International Planned Parenthood Federation strongly recommends that a routine screening policy only be implemented when

facilities have the resources to protect women who disclose women and to enable women to benefit from disclosure (Bott et al., 2004).

b. Messages communicated during prevention strategies

The primary prevention of sexual and gender-based violence rests on changing the gender-related beliefs, attitudes and practices of both men and women, at both the individual and societal level. Advocacy, awareness-raising and community mobilisation play important roles in tackling the roots of discrimination and violence. Activities aim to contest the values that accept intimate partner and domestic violence as normal, and to challenge the passive acceptance that contributes towards low reporting and care-seeking rates among abuse survivors, as well as the sub-quality delivery of services. Prevention efforts take many forms, including multimedia campaigns, 'edutainment' and community mobilisation and sensitisation, among others.

Intimate partner violence in ECSA contexts has been linked to specific behaviours and cultural beliefs. For instance, factors that increase the risk of men perpetrating violence include involvement in physical conflict outside the home, problematic alcohol use, having more than one current partner and abusing partners verbally (Abrahams et al., 2004). Successful prevention-focused initiatives respond to these causal factors: they acknowledge the role of gender relations in violence, and have introduced the concept of non-violent conflict resolution as a pre-emptive measure against IPV (Raising Voices, 2003; IGWG of USAID, 2006).

One of the most commonly cited prevention initiatives is the Stepping Stones programme, active across much of eastern and southern Africa. The programme tackles the gender inequalities that lead to gender-based violence through community-wide meetings, knowledge-building workshops, peer group discussions and drama. Evaluations have noted increased gender equity and communication between partners, and the Gambia programme reduced the social acceptability of wife-beating and an apparent corresponding drop in that behaviour (Bott et al., 2005; Renton et al., 2000; Gordon & Welbourn, 2001).

An innovative approach to community mobilisation has been adopted by Soul City, a health and development communications organisation based in South Africa that uses educational entertainment (or "edutainment") to transmit messages to its audience. Prime-time television and radio shows, school-based work, IEC materials and other media all provide channels to address gender, violence, sexuality and rights issues (Bott et al., 2005; Betron & Doggett, 2006). An extensive population-based impact evaluation of Series 4 of Soul City found that it reached 82% of the South African population and recorded a 10% decrease in beliefs that intimate partner violence is a private affair, and a small increase in viewers' likelihood to report abuse (Scheepers, 2001).

The rapid evolution of information and communications technologies is increasingly providing new and innovative means to disseminate information and enable interaction between diverse stakeholders. The Tanzanian Media Women's Association ran a multimedia campaign in 1998 to publicise the enactment of the Sexual Offences Special Provision Act, a law criminalising female genital cutting (FGC). As well as employing surveys, radio

and television programmes and educational materials, they developed a website, www.stopfgm.org in English, French and Arabic (UN-GA, 2006), a tool which is now widely used to disseminate information and promote the sharing of best practices.

The literature is ambiguous on the effectiveness of behaviour change communication (BCC) in positively influencing attitudes and behaviour. Results from a BCC approach in South Africa indicate benefits at both the individual and community level. The Men as Partners (MAP) programme, part of EngenderHealth in South Africa, is widely perceived to successfully induce positive behaviour change among its participants. Educational workshops with men and mixed-sex audiences are based on the premise that gender inequity exacerbates gender-based violence and AIDS (Bott et al., 2005; Betron & Doggett, 2006). An evaluation found that 82% of participants did not condone wife-beating, compared to 38% in the control group (Levack, 2001), and revealed that adolescent boys are more open to amending their view of masculinity than older men (Bott et al., 2005), a finding that has important implications for future prevention efforts. Adolescence is the period during which values are formed and patterns of behaviour established, and there is scope for innovative programmes that encourage young people to reassess understandings of sex and violence (Maman et al., 2001).

However, a sensitive and cautious approach is advised: peer education among youths in South Africa has been shown to mirror and reinforce negative gender roles (Mirsky, 2003), and other studies suggest that responses among adolescents to communication about behaviour change may be less positive than believed (Campbell & McPhail, 2002).

ANNEX I: SGBV DEFINITIONS AND CLASSIFICATIONS

One of the key challenges facing international research on sexual and gender-based violence is the absence of meaningful cross-cultural definitions on different types of violence and abuse (WHO 2005a). Individuals and communities have diverse understandings of violence, and what may constitute a crime in one culture, may represent normality in another. It is possible to argue that case definitions derived from local legislation are important for designing prevention and response activities. However, contextual definitions need not prevent the development of standard and universally implemented GBV case definitions (Baker, 2007).

38

Gender-based violence is “physical, mental, or social abuse that is directed against a person because of his or her gender or gender role in a society or culture. In these cases, a person has no choice to refuse or pursue other options without severe social, physical, or psychological consequences” (UNHCR 2000). The UNFPA Gender Theme Group (1998) extends the definition of gender-based violence to include sexual abuse and harm.

The term **gender-based violence** is used interchangeably with the term **violence against women**, although the UN has narrowed the definition of **violence against women** to refer to “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life” (UNGA 1993).

Intimate partner violence (IPV) is “actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner” (Saltzman et al. 2003). The term **intimate partner violence** is increasingly replacing the synonymous term **domestic violence** (WHO 2005a).

Domestic violence is elsewhere more widely defined as the “past or present physical and/or sexual violence between former or current intimate partners, adult household members, or adult children and a parent. Abused persons and perpetrators (may) be of either sex, and couples (may) be heterosexual or homosexual” (Sugg et al. 1999).

Sexual violence is an umbrella term that includes, at least, rape, attempted rape, sexual abuse and sexual exploitation. It involves “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work” (IASC, 2005).

- **Rape** is an act of non-consensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Any penetration is considered rape. Efforts to rape someone which do not result in penetration are considered **attempted rape** (IASC, 2005).

- **Sexual abuse** denotes other non-consensual sexual acts, not including rape or attempted rape. Sexual abuse includes acts performed on a minor (RHRCC 2004).
- **Sexual exploitation** includes sexual coercion and manipulation by a person in a position of power who uses that power to engage in sexual acts with a person who does not have power. The exploitation may involve the provision of assistance in exchange for sexual acts (RHRCC 2004).
- **Sexual coercion** is "...the act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against her/his will... It includes a wide range of behaviours from violent forcible rape to more contested areas that require young women to marry and sexually service men not of their choosing" (Heise, Moore and Toubia 1995).

ANNEX II: INSTRUMENTS OF LAW, POLICY AND PRACTICE ON SGBV¹⁰

Sexual and gender-based violence has been widely recognised as a human rights issue, a theme reflected in internationally-binding resolutions and conventions. In 1996, the Forty-ninth World Health Assembly adopted Resolution WHA49.25, declaring violence a major and growing public health problem across the world, and “noting with great concern the dramatic worldwide increase in the incidence of intentional injuries affecting people of all ages and both sexes, but especially women and children” (Krug et al., 2002).

40

International conferences on SGBV and Violence Against Women

- 1993 World Conference on Human Rights (Vienna)
- 1994 International Conference on Population and Development (ICPD- Cairo)
- 1995 World Summit for Social Development (WSSD – Copenhagen)
- 1995 Fourth World Conference on Women: Action for Equality, Development and Peace (Beijing)
- 1995 Crime Congress (Cairo)
- 1996 Second UN Conference on Human Settlements (Istanbul).

International treaties

- Convention on the Elimination of All Forms of Discrimination against Women
- Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women
- International Covenant on Civil and Political Rights and Optional Protocol
- International Covenant on Economic, Social and Cultural Rights
- International Convention on the Elimination of All Forms of Racial Discrimination
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Convention on the Rights of the Child and Optional Protocols
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
- Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime
- Rome Statute of the International Criminal Court
- Geneva Convention relative to the Protection of Civilian Persons in Times of War (Fourth Geneva Convention)

Regional treaties

- Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belém do Pará)
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa

¹⁰ Adapted from: United Nations General Assembly (UN-GA). 2006. *In depth study on all forms of violence against women: Report of the Secretary-General*.

- South Asian Association for Regional Cooperation Convention on Preventing and Combating Trafficking in Women and Children for Prostitution

International policy instruments

- Vienna Declaration and Programme of Action, adopted at the World Conference on Human Rights
- Programme of Action of the International Conference on Population and Development
- Beijing Declaration and Platform for Action, adopted at the Fourth World Conference on Women
- Outcome document of the twenty-third special session of the General Assembly entitled: "Women 2000: Gender equality, development and peace for the twenty-first century" (General Assembly resolution S-23/3)

Selected UN General Assembly resolutions

- Declaration on the Elimination of Violence against Women, resolution 48/104
- Crime prevention and criminal justice measures to eliminate violence against women, resolution 52/86
- United Nations Millennium Declaration, resolution 55/2
- Traditional or customary practices affecting the health of women and girls, resolution 56/128
- Elimination of domestic violence against women, resolution 58/147
- Working towards the elimination of crimes against women and girls committed in the name of honour, resolution 59/165
- Trafficking in women and girls, resolution 59/166
- Violence against women migrant workers, resolution 60/139
- 2005 World Summit Outcome, resolution 60/1

Security Council resolution

- Resolution 1325 (2000) on women and peace and security

Commission on Human Rights resolution (most recent)

- Elimination of violence against women, resolution 2005/41

United Nations treaty bodies

- Committee on the Elimination of Discrimination against Women: general recommendation No. 12, violence against women
- Committee on the Elimination of Discrimination against Women: general recommendation No. 14, female circumcision
- Committee on the Elimination of Discrimination against Women: general recommendation No. 19, violence against women,
- Committee on the Elimination of Racial Discrimination: general recommendation No. 25, gender related dimensions of racial discrimination
- Human Rights Committee: general comment No. 28, equality of rights between men and women (article 3)
- Committee on Economic, Social and Cultural Rights: general comment No. 14, the right to the highest attainable standard of health

- Committee on Economic, Social and Cultural Rights: general comment No. 16, the equal right of men and women to the enjoyment of all economic, social and cultural rights (article 3)

Inter-Parliamentary Union

- How Parliaments can and must promote effective ways of combating violence against women in all fields, resolution of 12 May 2006

ANNEX III: THE AFRICAN UNION PROTOCOL TO THE AFRICAN CHARTER ON THE RIGHTS OF WOMEN IN AFRICA (2003)

Article 2, Sub-article 1: Elimination of Discrimination against Women

State parties are urged to:

- a. include in their national constitutions and other legislative instruments, if not already done, the principle of equality between men and women and ensure its effective application;
- b. enact and effectively implement appropriate legislative or regulatory measures, including those prohibiting and curbing all forms of discrimination including those harmful practices which endanger the health and general well-being of women and girls;
- c. integrate a gender perspective in their policy decisions, legislation, development plans, programmes and activities and all other spheres of life;
- d. take corrective and positive action in those areas where discrimination against women in law and in fact continues to exist;
- e. support the local, national, regional and continental initiatives directed at eradicating all forms of discrimination against women.

Article 4, Sub-article 2: The Rights to Life, Integrity and Security of Person

State parties are urged to:

- a. enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public;
- b. adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women;
- c. identify the causes and consequences of violence against women and take appropriate measures to prevent and eliminate such violence;
- d. actively promote peace education through curricula and social communication in order to eradicate elements in traditional and cultural beliefs, practices and stereotypes which legitimize and exacerbate the persistence and tolerance of violence against women;
- e. punish the perpetrators of violence against women and implement programmes for the rehabilitation of women victims;
- f. establish mechanisms and accessible services for effective information, rehabilitation and reparation for victims of violence against women.

Article 8: Right to Information and Legal Aid

State parties are urged to:

- a. take all administrative and appropriate measures to ensure equal access of women to legal aid services;
- b. support local, national, regional and continental initiatives directed at giving women access to legal aid services;
- c. set up adequate structures including appropriate educational structures for all social strata, with particular attention to women and sensitize and inform them of the rights of women and girls;

- d. ensure that law enforcement organs at all levels are aware of gender equality and women's human rights and enforce the law in a gender responsive manner.

Plan of Action on Violence Prevention in Africa: Third session of the African Union Conference of Ministers of Health (Johannesburg, South Africa, 2007).

The overall **goal** of the Plan of Action is contribute to the improvement of health in Africa. Its **objective** is to enhance violence prevention and care of victims through raising awareness about the problem of violence in Africa, and to make the case that violence is preventable and that public health has a crucial role to play in addressing its causes and consequences. Strengthening the health care services system to deal with violence will also be a key component.

ANNEX IV: SAMPLE INFORMED CONSENT FORM¹¹

45

Hello, my name is [*]. I work for [*]. We are conducting a survey in [study location] to learn about women's health and life experiences. You have been chosen by chance (as in a lottery/raffle) to participate in the study.

I want to assure you that all of your answers will be kept strictly secret. I will not keep a record of your name or address. You have the right to stop the interview at any time, or to skip any questions that you don't want to answer. There are no right or wrong answers. Some of the topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk.

Your participation is completely voluntary but your experiences could be very helpful to other women in [country].

Do you have any questions?

(The interview takes approximately [*] minutes to complete). Do you agree to be interviewed?

NOTE WHETHER RESPONDENT AGREES TO INTERVIEW.

DOES NOT AGREE TO BE INTERVIEWED
THANK PARTICIPANT FOR HER TIME AND END INTERACTION.

AGREES TO BE INTERVIEWED.

Is now a good time to talk?

It's very important that we talk in private. Is this a good place to hold the interview, or is there somewhere else that you would like to go?

TO BE COMPLETED BY INTERVIEWER

I CERTIFY THAT I HAVE READ THE ABOVE CONSENT PROCEDURE TO THE PARTICIPANT.

SIGNED:

¹¹ Used in the WHO Multi-country Study on Women's Health and Domestic Violence Against Women (Ellsberg & Heise, 2005).

BIBLIOGRAPHY

Abrahams, N., Jewkes, R., Hoffman, M. & R. Laubsher. 2004. Sexual violence against intimate partners in Cape Town: prevalence and risk factors reported by men. *Bulletin of the World Health Organization* 2004; 82 (4).

Asling-Monemi, K., R. Pena, M.C. Ellsberg, & L.A. Persson. 2003. Violence against women increases the risk of infant and child mortality: A case-referent study in Nicaragua. *Bulletin of the World Health Organization* 81(1): 10-18

Andersson, N. *et al.* 2004. National cross-sectional study on views on sexual violence and risk of HIV infection and AIDS among South African school pupils. *BMJ* 2004: 329; 952-957.

Artz, L., Smythe, D., & Leggett.T. 2003. An Investigation into the Causes of the Low Investigation and Arrest Rates of Sexual Offences channelled through the Thutuzela Care Centre. Gender, Law and Development Project, Institute of Criminology, Faculty of Law, UCT.

Askew, I. *et al.* 2006. *Care and support for children following sexual assault*. IGWG presentation.

Askew, I. & L. Ndhlovu. 2006. *Developing a multisectoral and comprehensive response to Sexual and Gender Based Violence in East and Southern Africa*. Project proposal to Swedish International Development Assistance from Population Council.

Askew, I. & Kilonzo, N. 2005. *Policy Issues and a Policy Implementation Framework for Integrating Sexual Violence Services into the Reproductive Health Policy in Kenya*. Population Council; Liverpool VCT, Care & Treatment. Background Document prepared for the Division of Reproductive Health/Ministry of Health, Kenya.

Auerbach, J., Bryam, E. & S. Kandathil. 2005. *Gender-Based Violence and HIV among Women: Assessing the Evidence*. Amfar: Issue Brief No. 3, June 2005.

Baker, L. 2007. Gender-based Violence Case Definitions: Towards Clarity in Incident Classification. International Research Committee: circulated paper.

Barker, G. & C. Ricardo. 2005. *Young Men and the Construction of Masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, Conflict, and Violence*. Social Development Papers: Conflict Prevention and Reconstruction. Paper No. 26 / June 2005. World Bank.

Betron, M. & E. Doggett. 2006. Linking Gender-Based Violence Research to Practice in East, Central and Southern Africa: A Review of Risk Factors and Promising Interventions. USAID/POLICY.

Bott, S., Morrison, A. and M. Ellsberg. 2005. *Preventing and Responding to Gender-based Violence in Middle and Low-income Countries: A Global Review and Analysis*. World Bank Working Paper Series 3618. Washington, DC: World Bank.

http://econ.worldbank.org/external/default/main?pagePK=64165259&theSitePK=469372&piPK=64165421&menuPK=64166093&entityID=000112742_20050628084339

Bott, Sarah, Alessandra Guedes, María Cecilia Claramunt, Ana Güezmes. 2004. *Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Managers in Developing Countries*. New York: IPPF, Western Hemisphere Region (IPPF/WHR). http://www.ippfwhr.org/publications/publication_detail_e.asp?PubID=63

Campbell, C. & C. McPhail. 2002. Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth. *Soc Sci Med* 2002;5:5, 13-22.

Campbell, R & T. Sefl. 2004, "The Impact of Rape on Women's Sexual Health Risk Behaviours", *Health Psychology*, vol. 23, no. 1, pp. 67-74.

Christofides, N.J. *et al.* 2006. Women's experiences of and preferences for services after rape in South Africa: interview study. *BMJ* 2006; 332; 209-213.

Christofides, N.J. *et al.* 2005. "Other patients are really in need of attention" – the quality of health services for rape survivors in South Africa. *Bulletin of World Health Organization* 2005; 83 (7): 495-502.

ECAfrique. 2004. EC and care for sexual assault. *ECAfrique bulletin*. Vol. 22, May 2004.

Ellis, J.C., Ahmad, S. & E.M. Molyneux. 2005. "Introduction of HIV post-exposure prophylaxis for sexually abused children in Malawi". *Arch Dis Child*. 90: 1297-1299.

Ellsberg, M. 2006. Violence against women and the Millennium Development Goals: Facilitating women's access to support. *International Journal of Gynecology and Obstetrics* 2006; 94, 325–332

Ellsberg, Mary and Lori Heise. 2005. *Researching Violence against Women: A Practical Guide for Researchers and Advocates*. Washington, DC: WHO, Center for Health and Gender Equity. http://www.path.org/files/GBV_rvaw_complete.pdf

Focus. 1998. *Sexual Abuse and Young Adult Reproductive Health*. <http://www.pathfind.org/pf/pubs/focus/IN%20FOCUS/sexabuseinfofocus.html>

Fonck, K. *et al.* 2005. "Increased Risk of HIV in Women Experiencing Physical Partner Violence in Nairobi, Kenya". *AIDS and Behaviour*.

Funk, A., Lang, J. & J. Osterhaus. 2005. *Ending Violence against Women and Girls – Protecting Human Rights: Good Practices for Development Co-operation*. GTZ.

- Ganatra, B.R., K.J. Coyaji, and V.N. Rao. 1998. Too far, too little, too late: A community-based case-control study of maternal mortality in rural west Maharashtra, India. *Bulletin of the World Health Organization* 76(6): 591-598.
- Ganju, D. et al. 2004. *Sexual Coercion: Young men's experiences as victims and perpetrators*. Population Council.
- Gender-Based Violence and HIV among Women: Assessing the Evidence*. 2005. Issue Brief No. 3, June 2005. Amfar.
- Gender-Based Violence and Reproductive Health & HIV/AIDS: A summary of a technical update*. 2002. USAID.
- Global AIDS Alliance (GAA). 2006. *Zero Tolerance: Stop the Violence Against Women and Children, Stop HIV/AIDS*. Washington, DC: Global AIDS Alliance.
- Gordon, G. & A. Welbourn. 2001. "Stepping Stones, Life Skills and Sexual Well-being: A desk-based review". UNICEF.
- Guedes, A. 2004. *Addressing Gender-Based Violence from the Reproductive Health Sector: A Literature Review and Analysis*. IGWG-USAID.
www.prb.org/pdf04/AddressGendrBasedViolence.pdf
- Guedes, A. et al. 2002. "Gender-based violence, Human Rights and the Health Sector: Lessons from Latin America". *Health and Human Rights*. Vol. 6 (1): 177-194.
- Guedes, A., Bott, S. & Y. Cuca. 2002. "Integrating systematic screening for gender-based violence into sexual and reproductive health services: results of a baseline study by the International Planned Parenthood Federation, Western Hemisphere Region". *International Journal of Gynecology and Obstetrics* 2002; 78(Supplement 1): S57-S63.
- Hanson, D. 1992. *What is Rape Trauma Syndrome?* Occasional Paper 4-92, Institute of Criminology, University of Cape Town.
- Heise, L. 1998. Violence against women: an integrated, ecological framework. *Violence Against Women*, 1998, 4:262-290.
- Heise, L. Moore, K. & N. Toubia. 1995. *Sexual coercion and women's reproductive health: a focus on research*. New York: Population Council.
- Heise, L. 1994. *Violence Against Women: The Hidden Health Burden*. World Bank Discussion Paper. Washington. D.C. The World Bank
- Human Rights Watch (HRW). 2003. *Policy Paralysis: A call for action on HIV/AIDS related Human Rights Abuses against Women and Girls in Africa*. New York, NY: HRW.

Inter-Agency Standing Committee (IASC). 2005. *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*.

IGWG of USAID. 2006. *Addressing Gender-Based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers*. Washington, DC.

IFPP. 2004. Gender-Based Violence and Reproductive Health. *International Family Planning Perspectives*, 30(4). December 2004. Special GBV issue.

Jejeebhoy, S. & S. Bott. 2003. *Non-consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries*. New Delhi: Population Council. <http://www.popcouncil.org/pdfs/wp/seasia/seawp16.pdf>

Jejeebhoy, S. 1998. Associations between wife-beating and fetal and infant death: Impressions from a survey in rural India. *Studies in Family Planning* 29(3): 300-308.

Jewkes, R. 2002. Intimate partner violence: causes and prevention. *Lancet*, 359:1423-1429.

Jewkes, R., L. Penn-Kekana & J. Levin. 2002. Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine*, 55:1603-1617

Keesbury, J., Skibiak, J. & M. Zama. 2006. *Reducing unwanted pregnancy among victims of sexual assault: New windows of opportunity for Emergency Contraception*. Draft paper: Population Council.

Kenya Ministry of Health/Division of Reproductive Health. 2004. *National Guidelines on the Medical Management of Rape/Sexual Violence (1st edition)*. Nairobi, Kenya, Tonaz Agencies.

Kilonzo, N & M. Taegtmeier. 2005. *Comprehensive Post-Rape Care Services in Resource-Poor Settings: Lessons learnt from Kenya*. Liverpool School of Tropical Medicine. Nairobi, Kenya, Liverpool VCT Kenya. Policy Briefings for Health Sector Reform: No. 6, September 2005.

Kilonzo, N. 2003. *Conceptualising Vulnerability to Sexual Violence & HIV: Implications for Practical Responses*. LVCT & CARE.

Kim, J. et al. 2007. "Developing an integrated model for post-rape care and HIV post-exposure prophylaxis in rural South Africa," *FRONTIERS Final Report*. Washington, DC: Population Council.

Kim, J. & Motsei, M. 2002. "'Women enjoy punishment': attitudes and experiences of gender-based violence among PHC nurses in rural South Africa". *Social Science and Medicine* 54: 1243-1254.

Kim, J. C., Martin, L. J., & Denny, L. 2003, "Rape and HIV post-exposure prophylaxis: addressing the dual epidemics in South Africa", *Reprod. Health Matters.*, vol. 11, no. 22, pp. 101-112.

Kishor, S. & K. Johnson. 2004. *Profiling Domestic Violence – A Multi-Country Study*. Calverton, Maryland: ORC Macro.

Krug, Etienne, Linda Dalhberg, James Mercy, Anthony Zwi, and Rafael Lozano, Eds. 2002. *World Report on Violence and Health*. Geneva: WHO.

http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf

Lang, J. 2003. *Elimination of violence against women in partnership with men*. UNESCAP.

Lary, H., Maman, S., Katebalila, M. & J. Mbwambo. 2004. “Exploring the Association between HIV and Violence: Young People’s Experiences with Infidelity, Violence and Forced Sex in Dar es Salaam, Tanzania”. *International Family Planning Perspectives*, 2004, 30(4): 200–206.

Lawn, J. & K. Kerber, eds. 2006. *Opportunities for Africa’s Newborns (OAN): Practical data, policy and programmatic support for newborn care in Africa*. The Partnership for Maternal, Newborn and Child Health.

Levack, A. 2001. “*Educating Men in South Africa on Gender Issues*”. Unpublished report. SIECUS: New York.

Malawi MoH. Guidelines for Post-Exposure Prophylaxis after Sexual Abuse.

Maman, S. *et al.* 2001. *HIV and Partner Violence: Implications for HIV Voluntary Counseling and Testing Programs in Dar es Salaam, Tanzania*. Horizons/Population Council.

Martin. S., Young, S., Billings, D. & C. Bross. 2006. Healthcare-Based Interventions for Sexual Violence Victims: A Review of the Literature. Submitted to *Trauma, Violence & Abuse: A Review Journal*, April 17, 2006.

Men, Gender Equity and Health: Summary Chapter Six: Violence and Injuries

Michau, L., and D. Naker. 2003. *Mobilizing Communities to Prevent Domestic Violence: A Resource Guide for Organizations in East and Southern Africa*. Nairobi: Raising Voices. <http://www.raisingvoices.org/publications.php>

Mirsky, J. 2003. *Beyond victims and villains: Addressing sexual violence in the education sector*. The Panos Institute.

Mugawe, D. & A. Powell. 2006. *Born to High Risk: Violence Against Girls in Africa*. The African Child Policy Forum.

NASCOP. 2004a. *Kenyan National ARV Guidelines*. National AIDS and STD Control Programme, Ministry of Health, Nairobi.

NASCOP. 2004b. *Kenyan National Clinical Manual for ARV providers*. National AIDS and STD Control Programme, Ministry of Health, Nairobi.

Ndhlovu, L. et al. 2006. *Gender-Based Violence and HIV in the Thulamela Municipality of Limpopo Province*. Final report (draft). Population Council, Thohoyandou Victim Empowerment Programme & University of Venda.

Niang, C. et al. 2003. 'It's raining stones': stigma, violence and HIV vulnerability among men who have sex with men in Dakar, Senegal. *Culture, Health & Sexuality*. Volume 5: 6, pp. 499-512.

Niang, C., M. Diagne, Y. Niang, A. Moreau, D. Gomis, M. Diouf, K. Seck, A. Wade, P. Tapsoba, & C. Castle. 2002. *"Meeting the Sexual Health Needs of Men who Have Sex with Men in Senegal."* Washington, DC: Horizons.

Paranee, P. 2001. "While Women Wait...Monitoring the Domestic Violence Act". *Nedbank ISS Crime Index*. Vol. 5 (3) May-June.

Pelser, E. et al. 2005. *Intimate Partner Violence: Results from a National Gender-Based Violence Study in Malawi*. Crime & Justice Statistical Division, National Statistical Office.

RADAR. 2006. *Developing an integrated model for post-rape care and HIV post-exposure prophylaxis in rural South Africa*. Population Council Frontiers in Reproductive Health Program: Program Report 5. RADAR & Population Council.

Raising Voices. 2003. *Mobilising Communities to Prevent Domestic Violence*. Impact Assessment. Kampala, Uganda: Raising Voices.

Rashid, M. 2001. *Giving Men Choices: A Rozan project with the Police Force in Pakistan*. Working Paper Series on Men's Roles and Responsibilities in Ending Gender Based Violence Working Paper No. 2. United Nations International Research and Training Institute for the Advancement of Women (INSTRAW).

Renton, L. et al. 2000. *"The Stepping Stones Approach to Involving Men in the Prevention of Violence and HIV transmission"*. Action Aid: London.

RHRCC. 2004. *Gender-based Violence Tools Manual: For Assessment & Program Design, Monitoring & Evaluation*.

Roland M, et al. 2004. *Sero-conversion following non-occupational post-exposure prophylaxis*. 11th Conference on Retroviruses and Opportunistic Infections. San Francisco, 2004. Abstract No. 888.

Roland, M. E., Martin, J. N., Grant, R. M., Hellmann, N. S., Bamberger, J. D., Katz, M. H., Chesney, M., Franes, K., Coates, T. J., & Kahn, J. O. 2001, "Postexposure prophylaxis for human immunodeficiency virus infection after sexual or injection drug use exposure: identification and characterization of the source of exposure", *J. Infect. Dis.*, vol. 184, no. 12, pp. 1608-1612.

Rose D, 1986, "Worse than Death: Psychodynamics of Rape Victims and the Need for Psychotherapy", *The American Journal of Psychotherapy*, 143:7

Saltzman, L., Fanslow, J., McMahon, P. and G. Shelley. 1999. Intimate partner violence surveillance: uniform definitions and recommended data elements. National Centre for Injury Prevention and Control.

Scheepers, E. 2001. *Soul City 4 Impact Evaluation – Violence Against Women Volume I. Houghton, South Africa, Institute for Health and Development Communication*. Soul City: South Africa.

Speight, C.G. *et al.* 2006. Piloting post-exposure prophylaxis in Kenya raises specific concerns for the management of childhood rape. *Transactions of the Royal Society of Tropical Medicine and Hygiene*. 100, 14–18.

Suffla, S., Seedat, M. & A. Nascimento. 2001. *Evaluation of medico-legal services in Gauteng: implications for the development of best practices in the after-care of rape survivors*. Pretoria: Institute for Social and Health Sciences and Centre for Peace Action, University of South Africa.

Sugg, N., Thompson, R., Thompson, D., Maiuro, R., and F. Rivara. 1999. Domestic Violence and Primary Care: Attitudes, Practices and Beliefs. *Archives of Family Medicine*. 8: 301-306.

The DTS Consortium. No date. *Unsafe Schools: A Literature Review of School-Related Gender-Based Violence in Developing Countries*. USAID.

Thuthuzela Care Centers: www.unicef.org/southafrica/hiv_aids_998.html

UNHCR. 2000. *How to Guide: Reproductive Health in Refugee Situations: Monitoring and Evaluation of Sexual and Gender-based Violence Programs*.

United Nations General Assembly (UN-GA). 2006. *In depth study on all forms of violence against women: Report of the Secretary-General*.

United Nations General Assembly (UN-GA). 1993. Declaration on the elimination of violence against women. Proceedings of the 85th Plenary Meeting, Geneva, Dec. 20, 1993.

United Nations Population Fund (UNFPA). 2003. *Addressing violence against women: piloting and programming*. New York: UNFPA.

United Nations Population Fund (UNFPA). 1998. *Violence against Girls and Women: A Public Health Priority*. UNFPA Gender Theme Group, Interactive Population Centre. New York: UNFPA.

USAID & UNICEF. 2006. *Strategic Framework for the Prevention of and Response to Gender-based Violence in Eastern, Southern and Central Africa*.

USAID. 2006. *Understanding the Issue: An Annotated Bibliography on GBV*.

Velzeboer, Marijke, Mary Ellsberg, Carmen Clavel Arcas, and Claudia García-Moreno. 2003. *Violence Against Women: The Health Sector Responds*. Washington, DC: PAHO. <http://www.paho.org/English/AD/GE/VAWHealthSector.htm>

Vetten, L. & S. Haffejee. 2004. *Factors affecting adherence to post-exposure prophylaxis in the aftermath of sexual assault: key findings from seven sites in Gauteng Province*. Johannesburg, South Africa: Centre for the Study of Violence and Reconciliation.

Watts, C. & S. Mayhew. 2004. Reproductive Health Services and Intimate Partner Violence: Shaping a Pragmatic Response In Sub-Saharan Africa. *International Family Planning Perspectives*. Volume 30, Number 4.

World Bank. 2006a. *Violence against Women: Health Sector Responses*. Sector Operational Guide for the World Bank Gender and Development Group.

World Bank. 2006b. *Reducing Violence against Women: Justice Sector Perspectives*. Sector Operational Guide for the World Bank Gender and Development Group.

World Bank. 2006c. *Addressing Violence against Women in Middle and Low-Income Countries: A Multi Sectoral Approach*. Sector Operational Guide for the World Bank Gender and Development Group.

World Health Organization. 2007. *WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*. Geneva, World Health Organization.

World Health Organization. 2005a. *WHO Multi-country Study on Women's Health and Domestic Violence against Women: summary report of initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization.

World Health Organization. 2005b. *Sexually Transmitted and Other Reproductive Tract Infections: A guide to essential practice*. Geneva, World Health Organization.

World Health Organization. 2005c. *Sexually Transmitted and Other Reproductive Tract Infections*. Geneva: World Health Organization.

World Health Organization. 2004a. *Preventing violence: A guide to implementing the recommendations of the World report on violence and health*. Geneva: WHO.

World Health Organization. 2004b. *Medical eligibility criteria for contraceptive use (3rd edition)*. Geneva: WHO.

World Health Organization. 2003. *Guidelines for Medico-legal Care for Sexual Violence Victims*. Geneva: WHO. <http://whqlibdoc.who.int/publications/2004/924154628X.pdf>

World Health Organization. 2003b. *Protocols for the medical management of persons who experienced sexual violence*. Geneva: WHO.

World Health Organization. 2002. "Facts: Intimate Partner Violence." Geneva: WHO. http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/ipvfacts.pdf

World Health Organization. 2002. "Facts: Sexual Violence." Geneva: WHO. http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/sexualviolencefacts.pdf

World Health Organization & UNHCR. 2002. *Clinical Management of Survivors of Rape*. Geneva:WHO.

World Health Organization. 2001. *Putting women first: Ethical and safety recommendations for research on domestic violence against women*. Geneva: WHO.

World Health Organization and United Nations High Commissioner for Refugees. 2002. *Clinical Management of Survivors of Rape*. Geneva: WHO.

Wulfsohn, A. 2003. *Post-Exposure Prophylaxis for HIV after Sexual Assault in South Africa*. National HIV Prevention Conference. Atlanta, 2003. Abstract No. M3-C0304.

Websites:

Gender Based Violence Prevention Network

www.preventgbvafrica.org

Global Forum for Health

www.globalforumhealth.org

Interagency Gender Working Group (IGWG)

www.igwg.org

Population Council

www.populationcouncil.org

RADAR (Rural AIDS and Development Action Research Programme)

www.wits.ac.za/radar

Reproductive Health Outlook

www.rho.org

Reproductive Health Response in Conflict Consortium

www.rhrc.org

Sexual Violence Research Institute

www.svri.org

TVEP (Thohoyandou Victim Empowerment Program)

www.usaid.gov/missions/sa/success1.2.html

UNICEF

www.unicef.org

UNFPA

www.unfpa.org

UNFPA: 16 days of activism to end violence against women

www.unfpa.org/16days/forms_violence.htm

UN Millennium Goals

www.un.org/millenniumgoals/

Violence Against Women Online Resources

www.vam.umn.edu/

World Health Organization

www.who.int/gender/violence

The African Regional SGBV Network

Countries	Implementing partner	Project description
Zambia	Zambia Ministry of Health; Zambia Police Service	Developing and testing protocols for comprehensive care in existing health care and police settings.
South Africa	Tshwaranang Legal Advocacy Centre	Introducing and strengthening the legal and mental health components of an integrated model for post-rape care and HIV PEP
	Thohoyandou Victim Empowerment Program	Reducing the incidence and impact of SGBV through sustainable implementation of a multi-sectoral prevention and support strategy
	PEPFAR implementing partners	Strengthening the capacity of local partners and institutions to deliver quality healthcare services including PEP to survivors of sexual violence.
Kenya	Liverpool VCT, Care and Treatment	Development of standards for a 'custody of evidence' chain for post-rape services
Zimbabwe	Musasa Project, Zimbabwe National Family Planning Association	Building capacity of community based distributors to deliver SGBV services
Malawi	Human Resources Centre	Developing a national network of key stakeholders, and building cross-sectoral capacity
Ethiopia	Ethiopian Society of Obstetricians and Gynaecologists	Strengthening model clinic services and nationalizing guidelines on comprehensive management for survivors of sexual assault
Senegal	Centre de Formation et de Recherche en Santé de la Reproduction	Documenting the characteristics of sexual and domestic violence survivors in Dakar health facilities
Rwanda	Drew University, Columbia University, IntraHealth, Catholic Relief Services	Strengthening the capacity of local partners and institutions to deliver quality healthcare services including PEP to survivors of sexual violence.
Uganda	Northern Uganda Malaria, Tuberculosis and HIV/AIDS Program; Uganda People's Defense Force; Makerere University Joint AIDS Program	Strengthening the capacity of local partners and institutions to deliver quality healthcare services including PEP to survivors of sexual violence.



Population Council

www.popcouncil.org

Sub-Saharan Africa Region,

Nairobi Office,

Population Council

P.O. Box 17643-00500 Nairobi, Kenya

Tel: +254-20-2713480-3 Fax: +254-20-2713479

Email: infonairobi@popcouncil.org

Copyright © 2008. The Population Council Inc.

