

Understanding and addressing violence against women

Sexual violence

Sexual violence encompasses acts that range from verbal harassment to forced penetration, and an array of types of coercion, from social pressure and intimidation to physical force.

Sexual violence ([Box 1](#)) includes, but is not limited to:

- rape within marriage or dating relationships;
- rape by strangers or acquaintances;
- unwanted sexual advances or sexual harassment (at school, work etc.);
- systematic rape, sexual slavery and other forms of violence, which are particularly common in armed conflicts (e.g. forced impregnation);
- sexual abuse of mentally or physically disabled people;
- rape and sexual abuse of children; and
- 'customary' forms of sexual violence, such as forced marriage or cohabitation and wife inheritance.

How common is sexual violence?

The best quality prevalence data on sexual violence come from population-based surveys. Other sources of data on sexual violence include police reports and studies from clinical settings and nongovernmental organizations; however, because only a small proportion of cases are reported in these settings, they produce underestimates of prevalence. For example, a Latin American study estimated that only around 5% of adult victims of sexual violence reported the incident to the police (1).

There are many logical reasons women do not report sexual violence, including:

- inadequate support systems;
- shame;
- fear or risk of retaliation;
- fear or risk of being blamed;
- fear or risk of not being believed;
- fear or risk of being mistreated and/or socially ostracized.

While there remains a need for more research, data on different forms of sexual violence have been collected in population-based surveys such as the

BOX 1. DEFINITIONS OF SEXUAL VIOLENCE

The World Health Organization (WHO) defines sexual violence as: **‘Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work’**(2).

Coercion can encompass:

- varying degrees of force;
- psychological intimidation;
- blackmail; or
- threats (of physical harm or of not obtaining a job/grade etc.).

In addition, sexual violence may also take place when someone is not able to give consent – for instance, while intoxicated, drugged, asleep or mentally incapacitated.

While the WHO definition is quite broad, narrower definitions also exist. For example, for purposes of research, some definitions of sexual violence are limited to those acts that involve force or the threat of physical violence.

The *WHO multi-country study* (3) defined sexual violence as acts through which a woman:

- was physically forced to have sexual intercourse when she did not want to;
- had sexual intercourse when she did not want to, because she was afraid of what her partner might do; or
- was forced to do something sexual that she found degrading or humiliating.

Demographic and Health Surveys (4), CDC Reproductive Health Surveys (5), and the *WHO multi-country study on women’s health and domestic violence against women* (3).¹

Sexual violence by intimate partners

Data available from population-based surveys relate primarily to sexual assault perpetrated by intimate partners, but some also include sexual abuse during childhood and sexual abuse by non-partners. Sexual violence by intimate partners is usually accompanied by physical and emotional violence but can occur on its own.

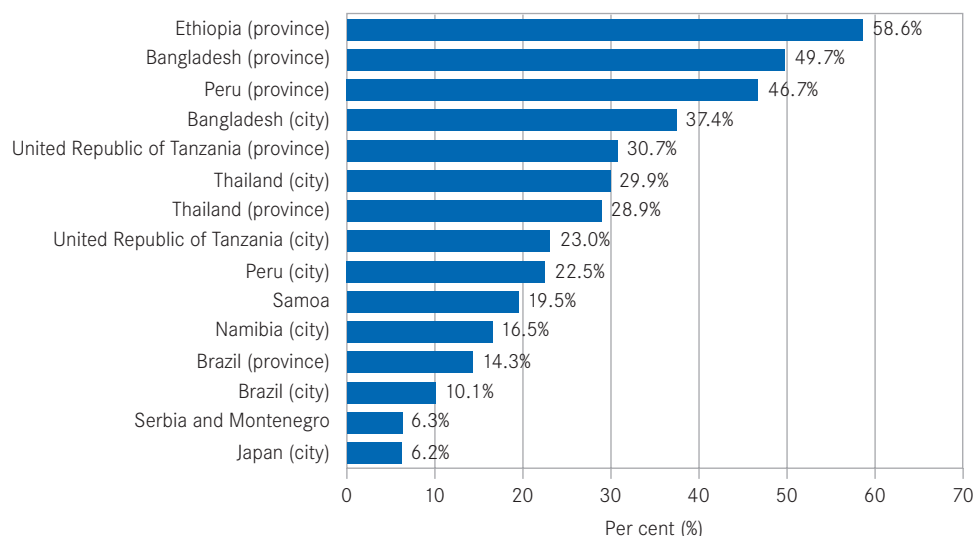
Lifetime prevalence of sexual partner violence reported by women, aged 15 to 49 years, in the *WHO multi-country study* ranged from 6% in Japan to 59% in Ethiopia, with rates in the majority of settings falling between 10% and 50% (**Figure 1**). A comparative analysis of surveys from Latin America and the Caribbean found that rates of sexual partner violence ever ranged from 5 to 15% (6).

Some new data on the prevalence of intimate partner sexual violence are based on reports by perpetrators. For example, in a cross-sectional survey among a randomly selected sample of men in South Africa, 14.3% of men reported having raped their current or former wife or girlfriend (7).

¹ Countries included: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Thailand, the former state union of Serbia and Montenegro, and the United Republic of Tanzania. More recently this study has been replicated in Kiribati, the Maldives, Solomon Islands and Viet Nam.

FIGURE 1

Percentage of ever-partnered women aged 15–49 years who reported sexual intimate partner violence ever, after the age of 15 years (3)



Sexual violence by non-partners

There are few representative studies on sexual violence committed by non-partners, and most available data come from crime surveys, police and justice records, rape crisis centres and retrospective studies of child sexual abuse (8). In the *WHO multi-country study*, 0.3–12% of women reported having been forced, after the age of 15 years, to have sexual intercourse or to perform a sexual act, by someone other than an intimate partner (3). Most studies indicate that women are likely to know their aggressors (e.g. in 8 out of 10 rape cases in the USA) (9,10). The most recent survey of the prevalence of rape in South Africa found that more than one in five men reported raping a woman who was not a partner (i.e. a stranger, acquaintance or family member), while one in seven reported raping a current or former partner (7). Sexual violence in humanitarian crises – particularly during conflict and post-conflict – is also common but, because of its unique characteristics, it is being addressed in a separate information sheet in this series.

Forced sexual initiation

For a substantial proportion of young women, their first sexual intercourse is forced. Data suggest that the younger the age of first sexual intercourse, the greater the likelihood that it is coerced. In the *WHO multi-country study*, women reported that their first sexual intercourse was forced, at rates ranging from less than 1% in Japan to nearly 30% in rural Bangladesh (3). In studies with both men and women, the prevalence of reported rape or sexual coercion has been reported to be higher among women. In Lima, Peru, for instance, the number of young women reporting forced sexual initiation (40%) was four times greater than for men (11%) (11). Moreover, surveys that ask women about ‘unwanted’ sexual debut typically find rates that are several times those of ‘forced’ debut (6).

Childhood sexual abuse

Researching sexual abuse against children is complex, as it remains a taboo and difficult to disclose in many settings. Methodological challenges include, for example, varying definitions of what constitutes 'abuse' and 'childhood', and whether differences in age and/or power between victim and victimizer should be taken into account. There are also ethical challenges to researching abuse among children. Despite these challenges, it is clear that childhood sexual abuse occurs in every country where it has been rigorously studied.

A 2004 WHO review of research estimated the global prevalence of childhood sexual victimization to be about 27% among girls and around 14% among boys (12). More specifically, that review found that the average prevalence of reported childhood sexual abuse among females was around 7–8% in studies from South and Central America and the Caribbean, as well as from Indonesia, Sri Lanka and Thailand. Estimated prevalence was as high as 28% in parts of eastern Europe, the Commonwealth of Independent States, the Asia–Pacific region and north Africa. In general, child sexual abuse was more common among girls than boys; however, recent studies from Asia have found boys to be as affected as girls.

In the WHO *multi-country study*, the reported prevalence of sexual abuse before the age of 15 years by someone other than an intimate partner, ranged from 1% in rural Bangladesh to over 21% in urban areas of Namibia.

Despite the widespread nature of childhood sexual abuse, there have been few studies of the prevalence in certain regions until recently. A number of new studies are currently under way in sub-Saharan Africa. In 2009, a nationally representative sample of 1242 girls and women, aged 13–24 years, in Swaziland, found that 33.2% of respondents reported an incident of sexual violence before they reached the age of 18 years (13). In that study, the most common perpetrators of the first incident were men or boys from the respondent's neighbourhood, boyfriends or husbands. The first incident most often took place in the respondent's home, so included sexual violence by intimate partners and dating sexual violence. A recent study compared the first national, population-based data available on child sexual abuse before the age of 15 years in three Central American countries (14). The prevalence ranged from 4.7% in Guatemala to 7.8% in Honduras and 6.4% in El Salvador, and the majority of reported cases first occurred before the age of 11 years. Perpetrators were usually people known to the victims.

Sexual harassment and violence in schools and at work

Sexual violence, including sexual harassment, frequently occurs in institutions assumed to be 'safe', such as schools, where perpetrators include peers and teachers. In studies from around the world, including Africa, south Asia, and Latin America, studies have documented that substantial proportions of girls report experiencing sexual harassment and abuse on the way to and from school, as well as on school and university premises, including classrooms lavatories and dormitories, by peers and by teachers (15,16).

For example, in a study among primary schools in the Machinga district of Malawi, primary school girls reported experiencing various types of sexual harassment and abuse at school, including sexual comments (7.8%), sexual touch (13.5%), 'rape' (2.3%), and 'coerced or unwanted' sex (1.3%) (17).

That same study found that teachers at 32 out of 40 schools reported knowing a male teacher at their school who had propositioned a student for sexual

intercourse; while teachers at 26 out of 40 schools reported that a male teacher at their school had got a student pregnant.

As an example from a high-income setting, a national representative (online) study of students in US middle and high schools found that out of 1002 female respondents, a majority of girls reported experiencing some form of sexual harassment at school during the 2010–2011 school year (18).

Research on sexual harassment in the workplace is in its infancy, but initial studies indicate that it is widespread, especially as more women enter the workforce. Surveys have found that 40–50% of women in the European Union report some form of sexual harassment or unwanted sexual behaviour in the workplace (19).

Sexual violence against men and boys

While this information sheet focuses on sexual violence against girls and women, it is important to highlight that boys and men also suffer sexual violence. Rape and other forms of sexual coercion against men and boys take place in a variety of settings – including homes, workplaces, schools, streets, the military and prisons. Unfortunately, sexual violence against men is a very sensitive and neglected area of study. Methodological differences in study designs, small sample sizes, varying definitions of coercion, among other reasons, have resulted in wide variations of reported prevalence. Sexual victimization, especially during childhood, is associated with perpetration in later life, so it is important to address this gap in its own right and for prevention of subsequent sexual violence.

What are the root causes of and risk factors for sexual violence?

Understanding the factors associated with a higher risk of sexual violence against women is complex, given the various forms that sexual violence can take and the numerous contexts within which it occurs. The ecological model, which proposes that violence is a result of factors operating at four levels: individual, relationship, community and societal, is helpful in understanding the interaction between factors and across levels.

The following lists of factors, which are common across studies and settings, are adapted primarily from the 2010 publication *Preventing intimate partner and sexual violence against women: taking action and generating evidence* (20) and the 2002 publication *World report on violence and health* (21).

Individual and relationship factors

Research into factors that increase men's risk of committing sexual violence is relatively recent and skewed towards those men who have been apprehended, particularly for rape. Among the factors that have been reported in multiple studies of this type are:

- gang membership;
- harmful or illicit use of alcohol or drugs;
- antisocial personality;
- exposure to intra-parental violence as a child;
- history of physical or sexual abuse as a child (22);
- limited education;

- acceptance of violence (e.g. belief that it is acceptable to beat one's wife or girlfriend);
- multiple partners/infidelity; and
- gender-inequitable views.

More recently, researchers in South Africa have completed a large cross-sectional survey of men in the population and found that having raped was associated with: higher levels of adversity in childhood; having been raped by a man; higher levels of maternal education; less equitable views on gender relations; having had more partners; and other gender-inequitable practices such as transactional sex (7).

Community and societal factors

From a public health perspective, community and societal factors may be the most important for identifying ways to prevent sexual violence before it happens, since society and culture may support and perpetuate beliefs that condone violence. Factors linked to higher rates of men's perpetration of sexual violence include:

- traditional gender and social norms related to male superiority (e.g. that sexual intercourse is a man's right in marriage, that women and girls are responsible for keeping men's sexual urges at bay or that rape is a sign of masculinity); and
- weak community and legal sanctions against violence.

What are the health consequences of sexual violence?

Evidence suggests that male and female survivors of sexual violence may experience similar mental health, behavioural and social consequences (12,23,24). However, girls and women bear the overwhelming burden of injury and disease from sexual violence and coercion (12), not only because they comprise the vast majority of victims but also because they are vulnerable to sexual and reproductive health consequences such as unwanted pregnancy, unsafe abortion and a higher risk of sexually transmitted infections, including from HIV, during vaginal intercourse (**Table 1**) (25). However, it is important to note that men are also vulnerable to HIV in cases of rape.

What are the best approaches to stopping sexual violence?

While approaches in the past to sexual violence have largely focused on the criminal justice system, there is a general movement towards a public health approach, which recognizes that violence is not the result of any single factor but is caused by multiple risk factors that interact at individual, relationship and community/societal levels. Thus, addressing sexual violence requires cooperation from diverse sectors, including health, education, welfare and criminal justice. The public health approach aims to extend care and safety to entire populations and focuses primarily on prevention, while ensuring that people who experience violence have access to appropriate services and support.

Effective interventions to prevent sexual violence

The evidence base is extremely limited in terms of effective interventions for preventing sexual violence. Some interventions aimed at preventing

TABLE 1

Examples of health consequences of sexual violence and coercion for women

Reproductive health	• Gynaecological trauma • Unintended pregnancy • Unsafe abortion • Sexual dysfunction • Sexually transmitted infections including HIV • Traumatic fistulae
Mental health	• Depression • Post-traumatic stress disorder • Anxiety • Sleep difficulties • Somatic complaints • Suicidal behaviour • Panic disorder
Behavioural	• High-risk behaviour (e.g. unprotected sexual intercourse, early consensual sexual initiation, multiple partners, alcohol and drug abuse) • Higher risk of perpetrating (for men) or of experiencing subsequent sexual violence (for women)
Fatal outcomes	Death from: • suicide • pregnancy complications • unsafe abortion • AIDS • murder during rape or for 'honour' • infanticide of a child born of rape

sexual violence against children, through registration of and community notification about local sex offenders, residence restrictions on sex offenders (e.g. prohibiting them from living near schools) and electronic monitoring of sex offenders, have taken place in a limited number of high-income countries. A review and critique of such policies suggests they are largely based on myths about sexual violence and coercion, rather than evidence, and have been ineffective in preventing sex crimes or protecting children (4,26).

Other interventions that aim to prevent sexual violence, or violence against girls and women in general, are designed to be delivered in schools, colleges and universities. A number of strategies to prevent dating violence among young people in high-income countries have been rigorously evaluated, and some evidence suggests they may be effective (20,27). Some school-based initiatives in low- and middle-income countries have also demonstrated promise for reducing levels of sexual harassment and abuse, particularly those that use comprehensive, 'whole-school' and community outreach approaches (28,29).

While interventions aimed at young people in schools are vital, there are other potential venues for intervention. These include homes, where, for example, prenatal and postnatal home-visiting programmes have been shown to reduce the risks of physical and psychological child maltreatment and neglect (30–32). These forms of abuse are known risk factors for sexual violence perpetration and victimization later in life. Health-care settings and services are also potential entry points for prevention of sexual violence, particularly in terms of addressing parenting/child abuse and alcohol misuse. Other promising

initiatives include community mobilization strategies to promote changes in gender norms and behaviours, and community-based efforts to improve the social and economic status of women.

General principles of good practice for addressing sexual violence

In addition to the limited evidence for effective interventions, the literature also provides some principles of good practice for addressing sexual violence.

Provide a comprehensive response to the needs of survivors (33)

Providing comprehensive health care and medico-legal services for rape survivors is paramount. In addition to compassionate care, victims need access to a range of specific health services from trained providers, including:

- psychological support (and referral for mental health care if needed);
- emergency contraception;
- treatment and prophylaxis for sexually transmitted infections;
- prophylaxis for HIV as appropriate;
- information on safe abortion; and
- forensic examination (if a woman decides to pursue prosecution).

From the legal system, survivors need to have access to competent and sensitized professionals who will assist them should they decide to prosecute the perpetrator.

Build the knowledge base and raise awareness about sexual violence

Expanding the knowledge base and disseminating existing and new information will advance the field, leading to better programmes and strategies. Data on prevalence and patterns can also be an important tool to engage governments and policy-makers in addressing this issue and convince them of the public health impact and costs of sexual violence.

Promote legal reforms

Improving existing laws and their implementation may serve to improve the quality of care afforded to survivors and may serve to curb sexual violence by strengthening sanctions against perpetrators. Some steps in this direction include:

- strengthening and expanding laws defining rape and sexual assault;
- sensitizing and training police and judges about sexual violence;
- improving the application of existing laws.

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Further information is available through WHO publications, including:

Preventing intimate partner and sexual violence against women: taking action and generating evidence

http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf

WHO multi-country study on women’s health and domestic violence against women: initial results on prevalence, health outcomes and women’s responses

http://www.who.int/gender/violence/who_multicountry_study/en/

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