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Helping victims of sexual coercion

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Every day people in countries throughout the world – men and women, children and adolescents, married and single individuals – are pressured to have sexual relations that they do not want.

The definitions of nonconsensual sex vary, but they all involve a lack of full and free choice in decisions to engage in sexual relations. Physical force or the threat of it can rob a person of this choice. Intense psychological, emotional, or financial pressure, or a fear of social consequences, also can compel individuals not to resist unwanted sexual advances.

In most cases, nonconsensual sex occurs among people who know each other. A study among 24 000 women in 10 countries, for example, found that the proportion of the women interviewed in each country who had ever experienced nonconsensual sex with an intimate partner ranged from 6% in urban Japan to 59% in a province in Ethiopia (see Table 1). The proportion in most countries fell between 10 and 50%.¹

Although a direct causal relationship between sexual coercion and adverse effects on reproductive health has not been established, experts warn that nonconsensual sex contributes to some of the world's most tenacious and often life-threatening reproductive health problems: unintended pregnancy and its complications, sexually transmitted infections (STIs) that can cause cervical cancer and infertility, and HIV infection.²

How can physicians and other health professionals respond to this threat to reproductive health? Answers are beginning to emerge as more health professionals and programmes begin to provide services for those who experience nonconsensual sex.

Role of providers

Providers of reproductive healthcare are often particularly well placed to detect sexual coercion and to care for its predominantly female victims because many women routinely seek such services. Moreover, such providers often see warning signs of sexual coercion.

Addressing sexual coercion within reproductive health services poses challenges. But it also offers opportunities to improve the quality of those services. Health professionals who understand how sexual coercion can affect a client's health are more likely than others to provide relevant counselling. They are also less likely to misdiagnose chronic complaints resulting from abuse. And strengthening services for those who experience violence benefits all clients, because staff members become more aware of the need to protect clients' privacy and to maintain the confidentiality of medical records.³

Challenges for providers

Physicians and other health professionals are often reluctant to address sexual coercion or other forms of violence that their clients experience. Perceived barriers include an inability to spend enough time with each client, lack of referral services or effective interventions, concern about legal consequences, and fear of offending clients.

Most health professionals do not have the knowledge, skills, resources, and support necessary to identify cases of sexual coercion, to offer services to those who experience it, or to document evidence of sexual assault. When they do receive any training in services for survivors of sexual assault, the training usually addresses medical and forensic issues, with little attention to the

Table 1 Prevalence of sexual violence among women in four sites in sub-Saharan Africa

Site	Percent who have experienced sexual violence by an intimate partner		Percent who have experienced sexual violence by a non-partner
	Ever	Currently	Ever
Ethiopia (1 province)	58.6	44.4	0.3
Namibia (1 city)	16.5	9.1	6.4
Tanzania (1 city)	23.0	12.8	11.5
Tanzania (1 province)	30.7	18.3	9.4

Source: García-Moreno C, Jansen HAFM, Ellsberg M, et al. WHO Multi-country Study on Women's Health and Domestic Violence against Women. Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland: World Health Organization, 2005.



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Health professionals can use counselling sessions, like this one in Kenya, to recognise the warning signs of sexual coercion.

psychological and social aspects or to provider attitudes. Such training should address attitudes because it is difficult for a healthcare provider to offer nonjudgmental, sensitive counselling and care if he or she believes common misconceptions about violence or has negative attitudes toward survivors.

Many physicians and other health professionals are concerned about the effects of sexual coercion and other forms of violence, such as physical and psychological abuse by an intimate partner. But they often report frustration that they cannot adequately address the problem and that some clients ignore their advice. Trainers can help providers understand the difficulties abused clients face and the value of offering emotional support.

Transforming systems

Lack of institutional support, community resources, referral networks, and evidence of effective interventions compromise health professionals' ability to help victims of sexual coercion or other forms of violence. Physicians are often expected to implement such services on their own after attending a single training session or workshop on sexual violence.

Many experts emphasise that service provision is most effective when policies and procedures for managing cases of sexual violence against women are standard practice throughout an entire healthcare system.⁴ This 'systems approach' requires attention to the details of clinical infrastructure, such as ensuring that a facility has a cabinet with a lock for storing clients' records and a room

where clients can be asked about violence without being overheard by partners, relatives, or other clients. It also involves supporting staff through continued training and supervision, and by providing access to information about where those who experience forced sex can be referred for further counselling.

A growing number of organisations are taking on the challenges of detecting, treating, and preventing sexual coercion and other forms of violence. In South Africa, for example, an alliance of individuals and organisations is working with the government to change policies, raise community awareness, and improve the response of the health sector to sexual violence.⁵ In Brazil, the number of public hospitals providing comprehensive care to women who experience sexual violence rose from just 3 in 1996 to 63 in 2001 through the advocacy and training efforts of obstetric and gynecological societies.⁶ Few such efforts have been evaluated, however, and most of the evaluations that have been conducted have been limited to detecting rates of nonconsensual sex or measuring changes in provider attitudes or practices.

What providers can do

Physicians and other health professionals can help their clients cope with the effects of sexual coercion and prevent further abuse in many ways. The appropriate level of services to offer in a given setting depends on the resources available, but all healthcare providers can:

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

Assess safety. A health professional can help a client who discloses abuse determine whether she or he may be in immediate danger of further abuse and, if so, help her or him find a safe place to stay.

Provide sensitive, nonjudgmental counselling. Clients interviewed after visiting clinics where screening for sexual, physical, and psychological abuse is routine appreciated their healthcare providers' nonjudgmental attitudes, respect for confidentiality, belief in their accounts, and emotional support.⁷ A provider should assure a client who has experienced forced sex that the abuse was not his or her fault.

Confront myths. Analysing their own beliefs and the prevailing myths about nonconsensual sex can help health professionals become more effective counsellors. It is important to understand, for example, that sexual violence is driven by anger and a need to control another person rather than by sexual desire, and that rape can occur within marriage.⁸

Counsel clients about contraception and STI prevention.

A woman who is coerced into sex needs special counselling about how to protect herself from HIV, other STIs, and unintended pregnancy. A client may need a clandestine form of contraception if a coercive partner does not want her to use family planning. Negotiating condom use is rarely an option for a woman in an abusive relationship.

Offer emergency contraception. Clients who have had forced unprotected sexual intercourse within the past 5 days should be offered emergency contraception; a woman who has waited more than 5 days to seek help should be advised to return for pregnancy testing if she misses her next period.⁹ Emergency contraception can help prevent pregnancy for up to 5 days but is most effective within 72 hours of intercourse.¹⁰

Provide or refer clients for timely, appropriate STI testing and treatment. Local protocols should guide decisions about which STI tests to offer a survivor of sexual violence and whether to offer postexposure prophylaxis for STIs. If postexposure prophylaxis for HIV infection is available, a thorough discussion of its risks and benefits can help a client make an informed decision.

Know the legal requirements. To avoid compromising future investigations or court hearings, health professionals should have a thorough understanding of local regulations governing sexual abuse. In cases of rape, for example, forensic services should be performed by someone the courts recognise as qualified to document the evidence of rape.¹¹

Build and maintain a referral network. Few health facilities can offer those who experience sexual coercion all the medical, psychological, legal, and social services they need. Health professionals should know what referral services are available and should develop cooperative relationships with referral agencies.

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

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Web resources

http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/index.html

Guidelines for Medico-legal Care for Victims of Sexual Violence

<http://www.ippfwhr.org/site/apps/ka/ec/product.asp?c=kuLRJ5MTKvH&b=2798037&en=ctILIXMFLiISJXOIjJPJZORILQI4POJhJUKgPYKxG&ProductID=457905>

Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries

<http://www.unfpa.org/publications/detail.cfm?ID=69&filterListType=1>

A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers

Screening for violence

'My late husband left me with two daughters whose ages are 6 and 4 years. In January, I left my children with their grandmother and travelled to my natal village. She left them in the evening to buy fish at a nearby market. Upon her return, she found my eldest daughter bleeding profusely due to repeated rape by my brother-in-law. She washed the girl and told her to remain silent.

I returned home 4 days later, and my daughter narrated her ordeal. My mother-in-law said she had not taken the girl to hospital to avoid stigmatising her son and grandchild. I took my daughter to the Busia District Hospital, where she was counselled and treated. The nurse was unhappy about the delayed treatment and advised me to take legal action. A medical report was written, but I lack proof of a sexual assault offence that is required by the law. The family of my deceased spouse has chased me for exposing a "family matter." I feel betrayed that my daughter's health was put at risk to protect the family's image.'

– Kenyan participant in a 2006 study¹

This woman's story, related to an interviewer during a study conducted to help guide HIV-prevention efforts in Kenya, illustrates why many people who experience forced sex never seek the help they need from healthcare providers. Too often, the behaviour of the perpetrators is overlooked or even condoned. Fearing disbelief, blame, or retribution, many who experience coercive sex tell no one about their experiences – unless someone asks about them.

Routine screening for physical and sexual abuse by intimate partners is recommended by several professional associations in the United States and the United Kingdom.² And more organisations in developing countries are training providers to ask all clients³ or all clients with certain symptoms⁴ about such abuse.

Proponents of screening say that failing to inquire about sexual coercion or other forms of violence compromises quality of care and misses opportunities to save women from potentially life-threatening situations. The evidence to date suggests that screening efforts can detect sexual coercion and other abuse.⁵ In most surveys among women who have experienced violence, the majority of women support screening, and many express relief and gratitude for the chance to talk about their abuse, often for the first time.⁶

Other experts question whether screening is advisable

or even ethical in most resource-poor settings, and whether disclosure has a positive effect on women's health and safety is still in question. Thus, additional studies are needed to determine when and how to screen for violence in different settings.

In the meantime, some experts recommend that health facilities establish routine screening only when they can ensure clients' privacy, safety, and confidentiality. Managers should also help ensure that health professionals have positive attitudes toward those who experience violence and can offer assistance to clients who disclose violence, either directly or through referrals.

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

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