SVRI Forum 2009

Conference Report

6-9 JULY 09

JOHANNESBURG

SOUTH AFRICA

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Donors and partners in the SVRI Forum 2009 include: Oxfam Novib, UN Action, Global Forum for Health Research, Medical Research Council South Africa, Path, Population Council, International Centre for Research on Women, GBV Prevention Network and the World Health Organisation.

The SVRI was established in 2002, with the support of the World Health Organisation, as an initiative of the Global Forum for Health Research and is currently hosted by the Gender and Health Research Unit, Medical Research Council of South Africa.

The SVRI is guided by a Coordinating Group of experts on research on sexual violence. The members of the SVRI Coordinating Group are: Jill Astbury, Gary Barker, Claudia Garcia-Moreno, Alessandra Guedes, Rachel Jewkes, M.E. Khan, Nduku Kilonzo, Mary Koss, Sylvie Olifson-Houriet, Tandiar Samir and Iatamze Verulashvili. The SVRI secretariat manages the day to day activities. Members of the SVRI Secretariat are: Rachel Jewkes, SVRI Secretary; Elizabeth Dartnall, SVRI Programme Officer and Lizle Loots, SVRI Researcher.

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SVRI FORUM

6-9 JULY 2009

In July 2009, 194 people from around the world came together to share and discuss research on sexual violence. The Sexual Violence Research Initiative, hosts of the SVRI Forum 2009, in partnership with the Global Forum for Health Research; Oxfam Novib; Medical Research Council, South Africa; U.N. Action (against sexual violence in conflict); and partners, including Path, Population Council and many others, through this event, sought to promote research on sexual violence, particularly in developing countries; highlight innovative work in the field; and, encourage sharing and networking in what is still a relatively young field of knowledge and knowledge building. This report summarises the proceedings of this unique global event.

THE SEXUAL VIOLENCE RESEARCH INITIATIVE

Sexual violence is defined in the World Report on Violence and Health (Jewkes et al 2002) as: *"any sexual act, attempts to obtain a sexual act, or acts to traffic for sexual purposes, directed against a person using coercion, and unwanted sexual comments, harassment or advances made by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."*

Sexual violence has long been neglected both as a public health problem and a violation of multiple human rights. Rape is a threat to global security, and constitutes a crime against humanity (UN Security Council 2008). No rape free societies exist today (Wang & Rowley 2008). In many settings, 20-30% of women report having experienced sexual violence at some stage in their lives (Jewkes et al 2002). Women and girls who are additionally socially marginalised due to, for example, youth, poverty, mental incapacity or participation in sex work, are most vulnerable to sexual violence (Sanday 1981). Rape impacts on the health and well-being of women in many ways and developing high quality health care services for them is very important, as is developing interventions for prevention.

Sexual violence is the least understood and researched form of violence against women. Research is critical in highlighting the extent of the problem, and strengthening public health services and prevention programmes. Lack of evidence hampers the development of good quality, evidenced based policies, services and programmes for women and children survivors of sexual violence. This in turn results in secondary victimisation, discrimination and human rights violations. The SVRI is a network of experienced researchers, policy-makers, activists, donors and others committed to the promotion of research on sexual violence in low and middle income countries and to generating empirical data to ensure that sexual violence is recognised as a priority public health issue and profound human rights violation. The SVRI was established in 2002, with the support of WHO, as an initiative of the Global Forum for Health Research. It is now hosted by the Gender and Health Research Unit, Medical Research Council, South Africa.

The SVRI uses an innovative mix of evidence based information, communication and technology media, and capacity building workshops and events to promote and build capacity in research on sexual violence globally.

Key activities of the SVRI include:

- Capacity-building workshops and training events. The SVRI organizes workshops and training events to build the capacity of researchers and practitioners in various areas related to sexual violence. Recent workshops have included: a regional training event on the care and support for sexual violence survivors; a workshop on promoting and strengthening research skills; and a training on strengthening the medico-legal response to sexual violence through multi-disciplinary collaboration. Read more: http://www.svri.org/activities.htm#cap

- SVRI-commissioned papers. The SVRI commissions papers and desk reviews which seek to fill gaps in the field of sexual violence. Recent papers have included: Background Paper for the Development of Guidelines for Researchers on Doing Research with Perpetrators of Sexual Violence; Rape: How Women, the Community and the Health Sector Respond; The Uses and Impacts of Medico-Legal Evidence in Sexual Assault Cases: A Global Review. For SVRI publications go to: http://www.svri.org/publications.htm.
- The SVRI website/online discussion forum. The SVRI website, which is home to over 380 pages, provides SVRI members and website visitors with sexual violence related resources and research tools. The SVRI website also hosts an online discussion forum where members and website visitors can interact online and discuss issues related to sexual violence and research. To access the SVRI website/online discussion forum visit www.svri.org.
- The SVRI listserv. The listserv provides our members with regular updates on sexual violence related resources including: publications; journal articles; funding opportunities; vacancy alerts; international events and news items. Currently the SVRI listserv is home to over 1800 members from 80 different countries. To join, visit: http://www.svri.org/activities.htm#email.

MESSAGE FROM THE CONFERENCE CHAIR

Dr Claudia Garcia-Moreno, Conference Organising Chair

As part of our international efforts to promote research to inform efforts, to both stop sexual violence and strengthen service provision for rape survivors, the SVRI was honoured to host our first global conference: SVRI Forum 2009: Coordinated evidence-based responses to end sexual violence in Johannesburg, 6-9 July 2009. The aim of the SVRI Forum was to promote research on sexual violence, highlight innovation and encourage sharing and networking in the area of sexual violence, with emphasis given to practices and experiences from resource poor and developing country settings.

This unique global event provided participants with a platform for networking; knowledge building; action and sharing of ideas on how to address sexual violence, even in the most disadvantaged situations. The programme was packed with quality presentations, and exciting and productive exchanges that will undoubtedly assist to further global efforts to promote innovative evidence based practices to address sexual violence in accordance with our conference themes: prevention, HIV, mental health, conflict and emergency settings and sectoral responses to sexual violence. As a researcher from Nicuaragua writes, *"Perhaps the most valuable aspect [of the Forum] was the opportunity to meet colleagues doing similar work or sharing similar interests. I am hopeful that these contacts will lead to collaborative projects in the future that will help further expand our knowledge about sexual violence."*

For many of the presentations in the programme, it was the first time the findings were presented in an international forum such as this. For example, delegates heard about findings from a study on men's use of physical and sexual violence against women in Croatia, India and South Africa. Delegates also learnt how systems in India, Bangladesh, Sub Saharan Africa and Latin America respond to rape and the challenges therein. A number of sessions focussed on how sexual violence manifests itself across countries and cultures, including the sessions entitled, "Sexual Violence in Global Diversity I & II" and "Sexual Violence in Muslim Societies". Rape as a threat to global security came under discussion in presentations on sexual violence in conflict and emergency settings, including in the Democratic Republic of Congo, Liberia and Uganda. Sessions also addressed child sexual abuse; mental health; sexual violence and HIV; and men as victims and perpetrators of sexual violence. In addition to Africa, special effort was made to include people from Latin America and the Caribbean (LAC). Oxfam Novib funded five researchers from the region to present on issues related to sexual violence. In support of the LAC thread running through the Forum, we also held a special roundtable on sexual violence in LAC.

In addition to promoting research on sexual violence, the SVRI also works to build research capacity to conduct ethically sound, policy relevant and methodologically rigorous research on sexual violence. The SVRI Forum provided us with an important opportunity to encourage emerging researchers to meet and discuss their work with key thinkers in the field of sexual violence research. The extent to which we achieved this goal can be measured through the words of participants:

"The SVRI conference was a much-needed and unique chance to hear about all of the work being done in the sometimes isolating field of sexual violence research. In particular, I wanted to let you know that the conference provided a rare opportunity for young professionals to network and share ideas. I think many

of the younger crowd felt a great amount of support and mentorship from professionals who are more well-established in the field - something which is often lacking. I have certainly brought many new ideas and knowledge back and feel re-energized for our future projects." (SVRI Forum 2009 Delegate)

"The conference was so informative and challenging on my part as an upcoming researcher and the opportunity to rub shoulders with high placed people at the international level was such an experience." (SVRI Forum 2009 Delegate)

I would like to take this opportunity to thank our donors who gave their support to this initiative including, the South African Medical Research Council, Oxfam Novib, UN Action, the Global Forum for Health Research, and our many partners including Path, Population Council, the GBV Prevention Network and others who utilized the Forum as a meeting place and supported the attendance of many from developing countries to this event. I would also like to thank the many senior persons working in the field of sexual violence and those from key national and international agencies, who willingly gave their time to chair and facilitate sessions. A special thanks goes to our key note speaker, Advocate Thoko Majokweni, who spoke eloquently on the importance of research for driving the agenda for policy and programme development, particularly if we want to ensure that good policies do indeed translate into effective sexual violence services and prevention programmes. Finally, thank you to the SVRI team who worked so diligently in pulling this event together, the scientists who put time to reviewing abstracts, and helping us to pull together such a quality programme and of course the presenters and delegates whose contributions will help continue to drive forward our knowledge in this young field.

We are more than delighted by the positive feedback that we have received on the SVRI Forum 2009, and we are sure that through the Forum and the ongoing work of the SVRI we will continue to encourage the use of research to highlight the magnitude of the problem and to help us better understand the nature and causes of sexual violence to guide our policies and service and programme responses.

C. Garcia-Moreno

Dr Claudia Garcia-Moreno
SVRI Forum 2009 Chair / WHO

SVRI FORUM 2009:

COORDINATED EVIDENCE-BASED RESPONSES TO END SEXUAL VIOLENCE

"I don't think I need to tell this group about the problem of sexual violence, the dire statistics, the grim consequences to the health, well being and lives of so many. We are all here because we know and we care about these issues, we recognize sexual violence has been neglected and we want to do something about this. We want to make sure that our health care responses are guided by the needs and concerns of survivors, that our prevention strategies tackle not just the immediate determinants but the difficult structural issues behind violence including gender inequality."
Claudia Garcia-Moreno, SVRI Forum 2009 Conference Chair

The SVRI Forum 2009: Coordinated evidence-based responses to end sexual violence was held in Johannesburg, South Africa, from the 6th – 9th of July. The conference brought together almost 200 participants from over 28 countries.

The Forum aimed to:

a) promote research on sexual violence,

b) highlight innovative work in the field; and

c) encourage sharing and networking in what is still a relatively young field of knowledge and knowledge building.

Delegates were provided with a rich and varied array of topics pertaining to sexual violence in the form of workshops, roundtables, book launches and parallel sessions.

Conference Themes

Based on the SVRI's research priorities[1], and guided by feedback from SVRI members via our email list-serve and our web discussion groups, the Forum was structured around the following 5 themes:

- Sexual violence and prevention
- Sexual violence and HIV
- Sexual violence and mental health
- Sexual violence and conflict/crises settings
- Health sector responses to sexual violence

[1] SVRI Research Agenda, http://www.svri.org/agenda.pdf

Conference Programme

"The communications/presentations were of high quality. Learning about what is going on concerning studies, the prevention or management of sexual violence in different countries was a rich experience for me." (SVRI Forum 2009 Delegate)

The conference programme was created through a rigorous, anonymous abstract review process that served to ensure abstract selection was meritorious and that the SVRI Forum 2009 programme was packed with educational, globally diverse, topical and technically sound oral and poster presentations and roundtable sessions. A total of 265 abstracts from around the world and of excellent quality were submitted, of which 58 oral presentations focusing on the 5 conference themes were selected. The conference programme also included 40 poster presentations, 3 roundtable sessions, a book launch, satellite meetings and 5 pre-conference workshops. Details on the abstract review process can be found in Appendix A.

Report Launch:

"Masculinities and Public Policy in South Africa: Changing Masculinities and Working Toward Gender Equality". This report on policy approaches to changing masculinities and working with men and boys for gender equality in South Africa was officially launched at the SVRI Forum 2009, and forms part of a broader multi-country project. This project aims to compare public policies (including legislation) related to men, masculinities and gender across a range of countries. The goals of the project include obtaining comparative data on men and gender equality and reaching policymakers and programme planners with information on how to achieve large-scale impact in changing men's attitudes and behaviours. Report is available online at: http://www.genderjustice.org.za/

Promoting Research and Building Capacity

The SVRI Forum provided us with a fabulous opportunity to promote research and build capacity to undertake research on sexual violence. To encourage and support quality research, we implemented a prize giving process. The SVRI Coordinating Group, Secretariat and other selected researchers were invited to join the panel of judges for the prizes of the SVRI Forum 2009. Panelists were asked to give their opinion on every presentation they attended at the Forum and for every poster they saw – efforts were made to ensure every presentation and poster was reviewed by at least two members of the panel. Judges were asked to score each presentation and poster. The dimensions scored were: Science – the scientific merit of the work based on an assessment of methods, results and interpretation of these; Contribution to Knowledge - importance of research for contributing to knowledge on sexual violence; Value for Advancing Programming and Policy on Sexual Violence; and Clarity of the Presentation/Poster and Appearance.

Prizes were awarded in the following categories: Oral; Poster and Young Researcher. The winners for each category were:

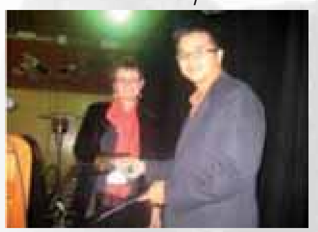
<table>
<tr><th colspan="2">Category: Oral</th></tr>
<tr><td>Best

Women War Survivors of the 1989-2003 Conflict in Liberia: The Health Consequences of Sexual Torture.
Ruth Ojiambo-Ochieng (received by Helen Liebling-Kalifani)</td><td>Runner-up

Labelled for life: A study on Witches and Witchcraft in Rajasthan.
Prof Kanchan Mathur</td></tr>
<tr><th colspan="2">Category: Young Researcher</th></tr>
<tr><td>Best

Experiences and Attitudes of Militia Members Towards the Conflict and Sexual Violence in Eastern DRC: A Qualitative Study
Jocelyn Kelly</td><td>Runner-up

SASA! Generating Evidence for VAW Primary Prevention Programs
Evelyn Letiyo</td></tr>
<tr><th colspan="2">Category: Poster</th></tr>
<tr><td>Best

Developing an Intervention to Prevent Intimate Partner Violence among Adolescents
Aník Gevers</td><td>Runner-up

Prevalence and Correlates of Coercive Sex among Men and Women in Botswana and Swaziland
Alexander Tsai</td></tr>
</table>

A series of pre-conference workshops were also held on various topics, including ethics and research, evaluating services from a women's perspective, using research for advocacy and writing for publication. Feedback from delegates was extremely positive. In responding to a question about how the Forum has helped in your work, one delegate noted, *"The acquired skills will be applied in my adolescent health care project to empower young people to explore gender differences"*; whilst another wrote, *"We brought back a lot of material/documents that will help us to better organise our activities on sexual violence and improve our training curriculum"* and another, *"I have enrolled in an online writing workshop"* and *"the opportunity to present my research findings was a great career opportunity for me."* Details on the workshops can be found in Appendix B.

Regional Perspectives – Sexual Violence in Latin America and the Caribbean

The SVRI identified the LAC region as a priority region for 2009 and, in partnership with regional groups, is undertaking several actions to strengthen research on sexual violence in the region. One such effort was to ensure the active participation of Latin American researchers, advocates, activists in the SVRI Forum 2009. This event was used as a vehicle to promote the development and strengthening of regional and sub-regional networks for research on sexual violence in the LAC region, with particular emphasis on researchers, advocates, policy makers and survivors. With support from Oxfam Novib, researchers from the region were able to attend and present their work at the Forum. A roundtable on sexual violence in the region was also held. Box 1 refers. The success of these efforts for delegates is highlighted in the following quote: *"The Latin America Round-table was extremely useful for getting to know people working in Latin America and the Caribbean and learning more about their re search interests. A very helpful overview about sexual violence in the region and the range of research conducted to date – along with an assessment of strengths and weaknesses, areas well covered and glaring gaps – was presented and helped guide and contextualise the discussion" [Oxfam Novib Bursary Delegate, Nicaragua]*

> ***Box 1: Roundtable: Sexual Violence in the Latin American and Caribbean Region***
>
> The roundtable on sexual violence explored the extent of sexual violence in Latin America and the Caribbean (LAC) and how research can strengthen services for women survivors of sexual violence and reduce violence. It specifically focused on the issue of sexual violence in LAC, raising awareness of the extent and consequences of sexual violence in the region and promoting high quality research in this region. For more information contact: SVRI at svri@mrc.ac.za

SVRI Forum 2009: Conference Report

This report provides you with a synopsis of the conference proceedings, the outcomes of which we hope will help us to continue to shape and evolve a research agenda for the field that we can promote and advocate for among researchers, policy makers and funders. The report provides a detailed account of the sessions in accordance with the conference themes and ends with recommendations for future research. The presentations and materials from the SVRI Forum are all available online for download, to access them please visit the SVRI Forum 2009: http://svriforum2009.svri.org/

PRIMARY PREVENTION: STOPPING VIOLENCE BEFORE IT HAPPENS

Prevention of sexual violence is ultimately the most important goal in the field of sexual violence and there are many different approaches to prevention. A primary prevention approach helps to promote social change, respect, gender equality and works to prevent perpetration through addressing power imbalances, child sexual abuse, and other driving factors behind sexual violence. Currently, primary prevention strategies include early childhood and family-based interventions, alcohol and substance abuse interventions, community-based interventions and a growing number of interventions that seek to involve men and boys in building gender equality and preventing violence. This session examined gender-based inequalities and practices of manhood in different communities and how community-based interventions with men can help to address the prevention of sexual violence. Rachel Jewkes presented the International Men and Gender Equality Survey (IMAGES) findings from India, Croatia and South Africa. Her presentation underlined the need for research on men who perpetrate sexual violence in order to understand the nature of rape perpetration and its associated risk factors. Preliminary findings from the study found substantial differences in the prevalence and patterns of rape in the three countries and highlighted important differences in how rape is understood, prevented and responded to between settings. This study has important implications for prevention as it identified factors such as childhood trauma, gender inequality, and high levels of alcohol consumption as risks factors for rape perpetration.

Christine Ricardo's evaluation of engaging boys and young men in the prevention of violence against girls and women in Brazil showed how changing attitudes can reduce perpetration of violence. Ricardo points out that effective prevention needs to be addressed at many different levels and that changing beliefs and discourses about gender and power relations is necessary for prevention efforts to succeed. In fostering gender equality and women's empowerment, it is also important to explore policy and structural approaches to primary prevention of sexual violence. Melanie Heenan presented a creative blend of strategies to rebuild cultural environments and relationships between men and women that are equal, respectful and non-violent. These strategies were developed to provide the Australian Government with an evidence-based framework to use in its planning to prevent violence against women. One priority setting exercise identified for action sports and recreation was where

Box 2: Taking the primary prevention of sexual violence seriously - Australian initiatives

The roundtable on Primary Prevention gave an overview of recent Australian national and state policy initiatives that provide a renewed focus on the primary prevention of sexual violence. Discussions included key outcomes of the new National Plan to Reduce Violence Against Women and their Children, the development of the Victorian primary prevention framework to guide prevention activities that focus on capacity building in key settings such as local government and the workplace, and the development of national standards for sexual assault prevention education. Key questions in the session included: How do we progress primary prevention of sexual violence? What kind of public policy supports primary prevention? What are the strengths and challenges of the new strategic approaches designed to achieve significant cultural change so that sexual violence is no longer acceptable? How do we work towards this goal in ways that are ethical, culturally respectful and measurable? For more information contact: *Dr Melanie Heenan, VicHealth, and Vanessa Swan, Yarrow Place Rape & Sexual Assault Service, Australia* – see: http://svriforum2009.svri.org/participants.htm

the Australian Football League (AFL) used football clubs as a vehicle for social change. The quote by the AFL CEO, *"…This policy tells us to look into the heart of our Game and into the culture of football and see what needs to change…"* illustrates how the framework created awareness around shifting attitudes and understanding inequitable behaviour within the sporting culture.

The development of poverty-reduction strategies may also serve as key to preventing sexual violence and women's vulnerability in the home. Jeannie Annan presented on the International Rescue Committee's (IRC) innovative savings and loans programmes for women in Burundi, combined with discussion groups between men and women in order to reduce violence and increase women's access to economic resources. Annan's evaluation showed that although the impact of savings programmes alone is not clear, discussion groups between men and women have proven to increase joint decision making in the home, and have the potential to decrease domestic violence. This project not only highlighted the social cohesion created by access to economic resources and autonomy created by such access, but also the positive effects of households engaging in discussion about decision-making, planning and spending.

The discussions and presentations on primary prevention at the SVRI Forum highlighted the progress made in preventing sexual violence, and the long way we still need to travel. A central task is to empower women and to change dominant constructions of masculinity into ones which are gender equitable and non-violent. We need more robust evidence on what works and more effort to scale up effective interventions. We need to venture into and do research on emerging areas, including parenting interventions to reduce exposure to trauma in childhood, reducing alcohol abuse and structural interventions to address gender inequality and empower women.

SEXUAL VIOLENCE AND MENTAL HEALTH

"One of the things I heard over and over again in the presentations is that very little is known about how to address the immediate and long-term psychosocial needs of victims of sexual violence in low-resource settings. Facilitating such an understanding is a perfect example of the way that research can/should be linked to the concrete needs of sexual abuse victims"
(SVRI Forum 2009 Delegate)

Sexual violence has a profound impact on survivors and has been associated with a number of mental health and behavioural problems in later life. Women who have experienced sexual violence are at risk of developing a range of symptoms associated with Post Traumatic Stress Disorder (PTSD), as well as problems such as sleep difficulties, depression, substance abuse and aggressive behaviour. This session explored the mental health outcomes after sexual violence and aspects of service delivery which form part of the broader support which is significant to survivors' healing process. Shazneen Commissariat-Limjerwala presented an ethnographic exploration into the experiences of rape victims in Gujarat, India, that highlighted the high levels of stigma, shame, prejudice and in some cases the indifference rape victims have to endure at the hands of poorly trained, often under-resourced health services. Commissariat-Limjerwala's presentation highlighted the devastation of rape for survivors and their families, and the critical need for services to recognise and address stigma and shame particularly as barriers to support and healing post rape.

"Now that such a thing has happened and everyone knows about it, who is going to take her? ....Her life has been ruined now. You only tell us now. Her life has been wasted. Who is going to take her now? Anyone will know that such a thing has happened to her. Then who will take her?" (mother of 18 year old rape victim, Gujarat, India).

Locally appropriate, quality psychosocial services can mitigate post rape psychological harm. However, in many countries mental health services for rape victims are lacking, even in well resourced settings such as Australia. Jill Astbury, presented a study on the prevalence, patterning and mental health outcomes of forced sex in young Australian women. The study found that forced sex is associated with poor mental health, chronic sleep problems, multiple high risk behaviours and complex mental health care needs, and survivors reported higher levels of dissatisfaction than non-abused women with the health care they receive including mental health care.

In an effort to understand what locally appropriate might mean, particularly in resource poor settings, Sarah Spencer from the IRC, presented an evaluation of essential services delivered to survivors of sexual violence in South Kivu, DRC, through partnerships with local NGOs. These partnerships focus on building the capacity of counselors to provide psychosocial support and referrals to medical services. The evaluation sought to measure change in the psychological and social well-being of survivors based on their own priorities of what was important to them on a daily basis including locally described mental health symptoms. Initial findings show a high level of symptom severity pre-intervention, and a significant decrease in symptoms and an increase in functioning for clients who received counseling.

These studies reflect on the importance of psychosocial services for addressing post rape related harm, and highlight the general absence of mental health services globally for rape survivors. The IRC study is an exciting and important step, in that it shows us that it is indeed possible to provide locally relevant services that address the psychosocial needs of survivors and promote well being in resource limited and complex regions. Research is needed to help us identify what mental health interventions are effective and feasible within resource poor settings, along with appropriate strategies for their implementation.

SEXUAL VIOLENCE AND HIV

The link between sexual violence and HIV is well established. It is, in part, directly biological as women may be exposed to HIV during rape, and partly mediated through gender power inequalities and the impact of sexual violence on women's sense of self and ability to negotiate safer sex. Current research on sexual violence and HIV was explored in two sessions of the SVRI Forum. In plenary, Rachel Jewkes, through research undertaken in South Africa, showed how gender inequality and men's violence against women are substantial forces in the HIV epidemic in South Africa. Her ground breaking presentation highlighted that men who conform to the dominant patriarchal views of masculinity in South Africa are more likely to have HIV and to have perpetrated intimate partner violence. Findings presented by both Jewkes, and Mazeda Hossain show that women who are exposed to abuse are vulnerable to depression, post-traumatic stress disorder with dissociation, substance abuse, potentially placing them at long term risk of further abuse and HIV. This highlights the importance of psychosocial and mental health care post rape, and the need for comprehensive HIV prevention responses that include referral to post rape care services and HIV services, as well as legal, and socio-economic support.

Post-exposure prophylaxis (PEP) to prevent HIV after rape should form a fundamental part of a comprehensive rape/HIV prevention response, particularly in high HIV prevalence settings. Adherence to PEP remains a barrier to post rape HIV prevention efforts. Naeemah Abrahams pointed out that taking PEP medication is enormously complex and adherence requires a lot of determination and effort. Moreover, adhering to PEP, particularly post rape, is challenged by additional emotional barriers, including shame, blame, fear, guilt and anxiety. Counter-intuitively, this study found that fear of HIV did not promote adherence but rather undermine the taking of medication. As one key informant explains *'I took the tablets and when I got home it was like they said I was HIV positive. For two weeks taking the tablets became more and more difficult knowing that I am taking HIV tablets... I think maybe if I did not know that they were for HIV maybe I would have taken the tablets with more enthusiasm.'* As Abraham notes, "Such barriers are working to ensure that women are not receiving the highly prized protection from HIV." These powerful and overwhelming fears must be addressed if we are to successfully develop effective interventions for HIV prevention post rape. Core to such interventions is psycho-social support during PEP provision to support both adherence and redress the trauma of the rape. This finding is supported by findings of a study that looked at adherence to PEP for HIV among victims of sexual violence in Monrovia, Liberia. The only significant factor associated with adherence was the number of follow up visits - those women with four or more visits recorded were more likely to have adhered to treatment. Dedicated staff and access to transportation were seen as key to supporting and promoting PEP adherence.

Roundtable: Bridging the Gap: Cross-Cutting Strategies to Address the Intersection of HIV and Sexual Violence from the Perspective of HIV Positive Women:

This roundtable explored the extent to which the failure to adequately address the intersection of sexual violence and HIV impacts on both policy development and programme design; subsequently leading to not only failing to respond to women's, and especially positive women's realities and needs, but also heightening women's risks and vulnerabilities to HIV and rights abuses. Particular attention was placed on emerging legislative and policy trends in West and Southern Africa. For more information contact: *Johanna Kehler*. Visit http://svriforum2009.svri.org/participants.htm for contact details.

There is an enormous gap in research with children, and not surprisingly this gap is even bigger when we look for research on child sexual abuse (CSA), and the linkages between CSA and HIV. Eunice Lyn Garura, in her research at a CSA clinic based in Zimbabwe found that orphan children were disproportionately represented among clinic clients compared to community samples and that the proportion presenting with HIV was more than three times the national estimate for children. Very few, however, presented to the clinic in time to qualify for HIV prophylaxis. This study provided key lessons for service provision, highlighting the importance of promoting strong links between clinics and community-based organisations to encourage early reporting of sexual abuse and the particular vulnerabilities of sub-sets of children.

Key themes running through the sessions on HIV and sexual violence are both the importance of, but general lack of psychosocial support post rape; and the urgency of work to build more gender equitable masculinities and address structural barriers that continue to fuel these dual epidemics. The successes reported here are drawn from small pilot studies. If we are to prevent rape and HIV, we must continue in our efforts to develop, implement, test and scale up promising, innovative practices, particularly for vulnerable populations and resource poor settings. In particular, we need to link prevention of violence with HIV, develop strategies that help to improve the uptake of and adherence to PEP and develop interventions that address violence against women in HIV testing and counselling services.

RESPONDING TO SEXUAL VIOLENCE

Good quality holistic care for rape victims can play a critical role in both recovery and supporting the transition from rape victim to survivor. Many survivors/victims of sexual violence receive assistance, care and support from family and friends and often a range of other agencies, including non-governmental organisations, social services, health workers, the police and legal systems. Globally, responses are very diverse, with differences influenced by the level of resources, status of women, and a range of other factors. In many settings, what services are being provided, by whom, and what works at what level still remains unknown. In the sessions on responses to sexual violence, a number of presentations on current services were provided. For example, Ipas and the International Planned Parenthood Federation (IPPF) presented studies from Latin America. Their studies highlighted a dearth of services for sexual violence victims in this region, and that where services do exist, many deficiencies were noted. From Nigeria, again a setting where very few services exist, a presentation on health sector responses to sexual violence found that although health workers were willing to discuss sexual violence, they lacked fundamental knowledge and had poor attitudes toward victims of sexual violence. On a positive note, the IPPF study found, that although working in resource poor settings is challenging, low cost interventions can make a difference to the lives of survivors, and that all levels of health care workers can be trained to respond to sexual violence victims sensitively and appropriately.

In a study from South Africa, Rachel Jewkes highlighted the importance of providing good quality health care for rape victims not just for meeting their health needs but also for providing evidence for cases in court. This cross-sectional study looked at the contribution of medical findings and evidence to case progression through the criminal justice system and legal outcomes for rape cases. The study found that medical evidence, particularly documentation of injuries, impacted positively on case outcomes whilst DNA evidence did not. The importance of this finding is that it shows us that low technology medical responses can be a powerful tool for victims when trying to access justice, and that the medical system has the potential to contribute positively to justice seeking for rape survivors through the provision of sound low technology post rape health care.

Implementing post rape care in many places remains a challenge. Lisa Vetten in her presentation on a rural healthcare rape service in South Africa, emphasised that efforts to strengthen health services are at risk of failure if they are not accompanied with institutional buy-in to new policies and practices, and that there are substantial barriers to accessing medical care and justice including poor coordination both within and between the health and the justice sectors. For example, some respondents in her study reported having to repeat their stories up to ten times to ten different providers, resulting in further trauma to the victim.

Another pivotal presentation on health sector responses at the SVRI Forum 2009 was delivered by Jill Keesbury. Drawing on both programmatic experience and an exhaustive review of literature on sexual and gender based violence programming in Africa, Keesbury's presentation provided a number of important take home messages for rape service development in resource poor settings, including:

- Legislation and policies, guidelines, protocols, and validated training curricula are **necessary, but not sufficient** for ensuring coordinated responses to Sexual and Gender-Based Violence (SGBV);
- "One stop shops" are not the only – or the ideal – model for delivering SGBV services; (for more detailed country specific presentations visit: http://svriforum2009.svri.org/programme.htm)

- Majority of survivors reporting sexual assault are children or adolescents...yet services are commonly designed for adult women; and
- Medico-legal procedures can serve as a barrier to accessing medical and other care and treatment services.

Keesbury confirmed that research and knowledge is limited on how to address both the immediate and long-term psychosocial/mental health needs of survivors in developing countries; and on the feasibility, safety and effectiveness of addressing Intimate Partner Violence (IPV) in low-resource health services.

A greater understanding of priorities for services for survivors/victims of sexual violence, including their families, communities and what interventions are effective in responding to sexual violence in different settings continues to be a priority and demands partnerships be established between researchers, policy makers and practitioners. Furthermore, these studies show us that low technology health interventions can assist rape survivors to access justice; and delivering post rape health care in resource poor settings is possible, but victims continue to face many barriers when attempting to access these services. We must therefore prioritise an operations research agenda to understand these barriers and how to deliver good quality services for women, men and children. We also need to develop clarity on what strategies work to address effectively both intimate partner violence and non-partner sexual violence in a comprehensive manner. Our models of care must be victim/survivor-centred, evidence based and appropriate for the settings in which they are provided.

SEXUAL VIOLENCE IN CONFLICT AND EMERGENCY SETTINGS

"There are so many linkages between research on sexual violence in conflict and non-conflict settings, but the two worlds sometimes seem to function separately. It was great to see conflict-related sexual violence research directly integrated into the more broadly-focused sexual violence research forum." *(SVRI Forum 2009 Delegate)*

Rape in war-time has reached epidemic proportions. Rape is used to brutalize and humiliate civilians, as a tactic of war and political power and in campaigns of ethnic cleansing. Women and girls who have experienced rape have been psychologically and physically injured, and in the aftermath often find themselves at the margins of society. The UN Security Council identifies rape as a threat to global security.

The short and long-term health effects of sexual violence in war are difficult to estimate. The violence and the inequalities that women face in crises do not exist in a vacuum but are the direct results and reflections of the violence, discrimination and marginalization that women face in times of relative peace. There are, however, particular aspects relevant to sexual violence in conflict. This session examined the complexity of sexual violence in conflict and crises settings in order to understand better the vulnerabilities of women and children in conflict. It also explored the extent to which support and clinical services are available and accessed by survivors of sexual violence and how the health sector responds to the needs of survivors.

Alex Muhereza and Veronica Nakijoba highlighted issues of accessibility and utilisation of services in post-conflict Northern Uganda. The 20 year conflict in Northern Uganda has left many families and communities destroyed and health services have been severely disrupted. The studies found that the health sector in Northern Uganda lacked capacity to address sexual violence and that poor response to survivors in rural health facilities is a determining factor in under-utilisation of services. Health workers showed good general knowledge of the needs of survivors but they were not comfortable in providing these services. In the words of one health worker: *"No one wants to involve himself/herself…there is some element of not trusting their ability."* These findings have important implications for the field and one recommendation is that periodic supervision, monitoring and training of health workers take place.

In support of this, Elizabeth Rowley found that refugee women and girls settling in Ugandan communities lack camp security and are equally, if not more vulnerable to sexual exploitation, forced prostitution, rape and sexual slavery. Health services in these settings need to be assessed, protocols developed and staff trained to appropriately respond to sexual violence. Walter Odhiambo described the use of Emergency Contraception (EC) as an entry point to providing comprehensive sexual and reproductive health care services in emergency settings. The post-election violence in Kenya provided a particular challenge due to the chaos and sheer number of victims. Over 3000 women were raped during the violence and many girls were forced to trade sex for food, shelter and protection. Through providing EC at Marie Stopes care centres, a strategic opportunity was opened to respond comprehensively to sexual violence, including integration of services such as sexual violence, sexually transmitted diseases, safe motherhood and adolescent sexual and reproductive health.

"Sexual violence is moral and psychological destruction. It is carried out in front of the whole world – it is a form of assassination." This quote encapsulates the rape epidemic that is currently experienced by men and women in the Eastern Democratic Republic of the Congo (DRC). In an attempt to understand

the complexity of sexual violence in war, Jocelyn Kelly explored Mai Mai Militia attitudes toward combat and sexual violence in original research undertaken in the DRC. Kelly's study provided valuable insights into the causes of sexual violence and which factors influence soldiers' behaviour in combat. Despite showing eagerness to end the war, Militia reported that they *"become addicted to rape because intelligence or mind doesn't work normally."* The study found that interventions could promote awareness of sexual violence issues through messages given in command meetings and through radio. Exploring the gender construction in what supports, enables and/or condones rape as a weapon of war, Jill Trenholm highlighted the perceptions of local leaders in the Eastern DRC of rape and raped women in the context of war. The study found that mass rape and the methods of perpetration created chaos, destroying communities and society at large. Trenholm suggested that humanitarian aid was inappropriate with the quote *"Peace, not beans"* showing how the population perceived international aid efforts. The study concluded that traumatisation at a community level is often overlooked when the focus is exclusively on raped women and that a deeper understanding is needed into the complexity of sexual violence in war in order to provide appropriate humanitarian assistance and public health interventions.

Mass trauma has devastating effects on a population. Isis-WICCE highlighted the mental health effects and trauma women experienced during the civil war in Liberia. Extensive physical, psychological and sexual torture was carried out and Liberia's social, economic, transport and health infrastructure was largely destroyed. The consequences of brutality and displacement left serious effects on the lives of women and girls and many became heads of households during the war. The study found that post-war, the entire population suffers a wide range of psychological difficulties and substance abuse is a major problem. The study pointed out that Post Traumatic Stress Disorder (PTSD) is primarily a western concept and proposed an alternative model of trauma as *"deconstruction of identity"*. They argued that PTSD is not gendered and cannot account for the social and cultural reality, experiences and effects described by participants in the study. The study concluded by highlighting the importance of a post-conflict recovery policy to address the psychological, social, medical, legal and reproductive health needs of war survivors, with women's health as a priority.

This session addressed a range of far-reaching consequences of sexual violence which is continuing with impunity in today's wars. It is important that strategies be developed to protect and respond adequately to survivors of war-related sexual violence as this has a profound impact on the survivor and the population as a whole. With the threat of HIV/AIDS in some settings and other health complications, it is also important that health workers be adequately trained in order to provide appropriate services to survivors which in turn will contribute to timely and full utilisation of services after experiencing sexual violence.

Research on sexual violence in conflict settings, must assist us to better understand the context of rape in different conflicts in a more nuanced way and we need to prioritise research that:

- Engages the community in prevention and response, particularly addressing stigma, fear and rejection;
- Looks at the role of economic empowerment in women's recovery/prevention;
- Investigates ways in which to integrate mental health responses into sexual and reproductive health services;
- Includes men as victims of rape;
- Addresses children of rape; and
- Increases our understanding of perpetration, and the role of command structures in it.

CHILD SEXUAL ABUSE

Childhood Sexual Abuse (CSA) is "any act which exposes the child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards" The Australian Institute of Health and Welfare (1995 p.46).

Child sexual abuse is a reality in all societies of the world, cutting across race, social class, economic and religious boundaries. Appropriate, quality responses to CSA are needed to address the profound short, medium and long term impacts of CSA. Treatment and prevention efforts in health care, social and legal systems and the impacts of CSA however remain underdeveloped and under-researched.

Experiences of survivors and their carers from South Africa, show us that the mental health impacts of CSA can be both profound and persistent, but that the road to accessing services is replete with obstacles and frustrations. In a study on the mental health needs of children post rape and to what extent existing services meet these needs, the Medical Research Council, South Africa found high levels of persistent psychological distress in CSA victims. The caregivers interviewed in this study reported an inability to deal with the abuse, preferring not to disclose it or access services. Fear, anxiety, shame and pain were some of the barriers they identified. Structural barriers such as work demands also competed as a priority, over accessing services for themselves and their children. For those who did attempt to access support, their efforts were thwarted by bureaucratic obstacles, and resulted in disillusionment and frustration. One carer describes her feelings towards services, *"I did not feel right at all, I did not like it, it felt like there was no help at all".* This study highlighted the central role caregivers play as gatekeepers to services for children post sexual abuse and that services must take into account both the needs of the child and the caregivers when responding to CSA.

Abbie Fields presented a study involving 18 children aged 6-17 from Nicaragua on key factors associated with the risk of childhood sexual abuse, the severity of victims' clinical responses and impact of short-term therapeutic interventions. The study used the Achenbach Child Behaviour Checklist to measure psychological changes after 3-4 months of semi-structured group interventions. Using this measure, findings of the study showed that most successful psychological recovery was among younger children (below 12 years). In terms of going forward, Fields recommended that programmes assisting recovery should specifically target the youngest victims of child sexual abuse.

> 100% of victims knew their abuser
> *[43% of females were abused by fathers or stepfathers]*
> *Findings from Nicaragua study*

Young women are especially vulnerable to childhood sexual abuse. This vulnerability is associated with subsequent behaviours that can increase the risk of HIV infection. The importance of overcoming barriers to accessing services both in terms of addressing mental health consequences but also as a critical strategy for HIV prevention was highlighted by a study from Argentina. Emily Herzberg examined the link between childhood sexual abuse and HIV risk among female adolescents and youth in Greater Buenos Aires. The study found that female adolescents and youth who experienced childhood sexual abuse were more likely to have sex in exchange for goods and reported having had more than one sexual partner in their lives. The adolescents and youth who experienced childhood sexual abuse were also less knowledgeable about HIV and HIV transmission placing them at risk for contracting the illness through sexual behaviours reported in the study.

The longer term impacts of CSA and how to address them, was discussed in a study from Australia. In this study researchers spoke with survivors of CSA, asking them how post natal service delivery for CSA survivors could be improved. Key themes from these investigations were that clinical encounters were perceived as risky for survivors, and that survivors experienced issues with trust, sexualisation, found examinations traumatic and could be hyper-vigilant during examinations, as the following quote highlights:

"When I am alone in the room I'm looking for signs….He would spend a long time feeling my tummy, but during that period, maybe his hip would touch my arm or his tummy would touch my arm and I would go … oh … what are you doing? Then I would realise now he's not doing it abusively … he's just trying to do his job. Things like that still affect you strongly, so you know that you're on edge worrying. I don't think we would ever get over it. I think we just need to learn how to live with it and that's it." (CSA Survivor).

Survivors spoke about the importance of continuity of care giver to enable the development of a trusting relationship; and the importance for healthcare professionals to have knowledge of trauma based responses. Providing patients with explanations and asking for consent before touching was also seen as helpful in building trust and minimising distress for the patients. As a result of this study, a set of "universal precautions" for perinatal professionals responding to women and their children have been developed. (See Box 3).

Box 3. Universal Precautions For Perinatal Service Delivery with Survivors of CSA

- Never assume consent.
- Explain any professional touch, including examination or procedures, what is to be done, how it will be done and why it is necessary. Where possible explain and offer alternatives.
- Explain baby examinations as carefully as an adult one.
- No procedure or examination should be "routine" as most professionals will be unaware of the patient's (or the patient's mother's) past history of CSA.
- Obtain informed consent for maternal and baby touch, including examinations and procedures.
- Check in with the patient (or patient's mother) during examinations: Ask "Are you comfortable with this?" or "Is this OK with you?"
- Stop or slow examinations at the patient's request or in response to patient distress.

(Source: Coles, J. and K. Jones, "Universal Precautions": Perinatal Touch and Examination after Childhood Sexual Abuse. Birth, 2009. 36 (3 September 2009).

These presentations showed that lack of good data on the nature and extent of child sexual abuse continues to hamper the development of effective prevention programmes and services for survivors/victims of child sexual abuse. Prevention efforts and policies must directly address children, their caregivers and the environments in which they live in order to prevent abuse from occurring and to deal effectively with cases of abuse and neglect that have taken place. Fields suggests the following as important questions to move the research agenda on CSA and to assist prevention efforts:

- How does the nature of child sexual abuse vary from country to country?
- How does poverty increase the risk of child sexual abuse?
- Are there significant differences in clinical responses to child sexual abuse, or do children all over the world react in similar ways?
- How should treatment approaches be adapted to different cultural contexts?

SEXUAL VIOLENCE IN GLOBAL DIVERSITY

Violence against women takes place across diverse cultural settings in a number of different ways. These may include marital rape and intimate partner violence, sexual harassment, trafficking and forced prostitution, traditional harmful practices and many more acts against the sexual and bodily integrity of women. This session brought together manifestations of sexual violence across diverse settings with a specific focus on traditional harmful practices (e.g. persecution of witches, female genital mutilation and forced marriage) and intimate partner violence. Summaries of some of the presentations are provided below:

Traditional Harmful Practices: Violence perpetrated against women, especially in the context of traditional harmful practices, can be attributed to the low status of women in society and strong patriarchal attitudes. In Rajastan, patriarchal notions within institutions of family and community are instrumental in controlling women's bodies and their sexuality. Various forms of violence exist that have debilitating effects on Indian women. Persecution of women, or witchcraft, is one form of violence where women face extreme physical and mental torture. In her study on witches and witchcraft in Rajastan, Kanchan Mathur found that the major reasons for labelling women as witches included superstition, property disputes, personal rivalry, death of a child or woman resulting from lack of medical care, infertility, physical deformities or disability, being assertive and low caste or class of women. Acts of violence against women labelled as witches ranged from verbal abuse to battery and murder. Women labelled as witches face severe stigma and are ostracised by their communities. The fundamental impact that this type of violence has on women is highlighted by the following quote, *"The violence in its various heinous forms impact women's psyche and well being, loss of mental balance, creating feelings of helplessness, fear and powerlessness."* The presentation highlighted a grave human rights violation which needs to be addressed at national and community levels. Awareness should be created as part of primary education as cultural values of inequality become part of the justification for discrimination and violence against women.

Gender Based Violence in Egypt: Gender-based violence in Egypt is an everyday reality and despite recent progressive laws banning female genital cutting/mutilation (FGC/M) and raising the minimum age of marriage to 18 years, harmful practices still persist. Yehia Gado assessed domestic violence, sexual exploitation, female genital mutilation, forced marriage, gender-based discriminatory practices, and street children violence in samples from both men and women in upper and lower Egypt. These practices have been shown to have profound health consequences for their victims including drug abuse, unwanted pregnancy, illegal abortions, reproductive tract infections and mental health problems. Gado highlighted the important role of reproductive health agencies in reducing violence through proper identification of victims and providing appropriate support and counseling. This presentation showed

Box 4: FGC/M in Jos, Nigeria

Findings from interviews with expectant mothers at the Jos University Teaching Hospital were shared at the SVRI Forum 2009. The findings showed that:

- Culture and ethnicity rather than religion influenced attitudes toward the practice in this setting.
- Health education for women is lacking and needs to be addressed in order to safeguard the health of young girls in Nigeria.
- Communities, service providers, policy makers and other role players should be empowered through knowledge in order to effectively respond to the dire health consequences of FGC/M.

that in countries such as Egypt, it is of critical importance that support is mobilised from health, religious and justice structures/sectors in order to advocate for the protection of both men and women's fundamental human rights.

> *"He thinks 'she is my legal wife..., she doesn't have a place to go, no salary, no money, no future, she has kids.... , what is she to do, she can't go, no matter how much I torment her, I can do whatever I want, she won't leave..'" Study participant, Turkey*

Intimate Partner Violence (IPV): Women who experience intimate partner violence carry a tremendous health burden. The short and long term health consequences may range from gynaecological and gastro-intestinal complications, mental health problems to severe physical injuries or death. Global studies have shown that nearly half of female murders are by intimate partners after an extended period of physical and/or sexual abuse. In many countries, sexual abuse of a partner is considered a private family matter and some countries still do not offer legal protection against sexual intimate partner violence. One such country where sexual abuse in marriage is not considered a crime is Pakistan. Mufiza Kapadia sketched the lives of women experiencing sexual intimate partner violence in Karachi. The study found that one in five women is sexually abused by their husbands. This finding raises serious reproductive health concerns for Pakistani women. Similarly, in Nigeria, sexual intimate partner violence and domestic violence are generally supported by social norms which value men's power and authority over women. The following quote shows how women experience their relationships in terms of power and abuse, *"My husband has this uncanny way of showing his authority over me. As far as he is concerned, I must succumb to his sexual advances all the time without complaint."*

Henrica Jansen explored sexual intimate partner violence in Turkey, and found the prevalence of lifetime and current sexual intimate partner violence to be 15% and 7% respectively. These findings reveal much about a society where conversations about sex and sexual violence are considered inappropriate and where women are believed to be under the control of their husbands, and therefore not allowed to refuse sexual advances from them. The implications for prevention are highly complex in contexts where attitudes such as the following prevails: *"He thinks 'she is my legal wife..., she doesn't have a place to go, no salary, no money, no future, she has kids.... , what is she to do, she can't go, no matter how much I torment her, I can do whatever I want, she won't leave..."* and prevention efforts would require reaching into the core of social norms in order to create change.

These sessions highlighted some of the many forms sexual violence may take in different settings, all of which are profound violations of human rights and have potentially severe short, medium and long term psychosocial impacts on the victims. Researchers need to engage with the many forms of sexual violence and develop strategies for their prevention and appropriate responses for when they do occur. We must develop a research agenda that is underscored by gender equality and equity. We also need to learn from others working in this area of research, drawing lessons from their experiences and applying/adapting them to our own settings.

YOUTH AND SEXUAL VIOLENCE IN THE AFRICAN REGION

This session highlighted sexual violence, interpersonal violence and victimisation experienced and/or perpetrated by adolescents and young adults in the African region. Youth violence is a pertinent problem across the globe, and studies have shown evidence of a continuity of violence and aggression from adolescence into adulthood. Both adolescence and young adulthood are developmental periods when violence, and other behaviours are often expressed more intensely and reports of sexual initiation are often forced or unwanted. In South Africa, sexual violence in adolescent and young adult relationships is a significant problem which can have a negative impact on the health of women and young girls. Anik Gevers provided personal narratives of adolescents' constructions and conceptualisations of intimate relationships and how these intersect with sexual violence. Adolescent girls in this school-based study reported that they needed education to address issues such as sexual activity, violence and substance misuse. An adolescent girl shared her perception of sex as, *"...you have to have sex [in a relationship] otherwise you won't have a boyfriend"*, which points out complex relationship factors and pressures which may lead to unwanted or coerced sex.

> *"...you have to have sex [in a relationship] otherwise you won't have a boyfriend". (Adolescent girl, South Africa)*

Sharing experiences of young women's vulnerability at a Nigerian university, Bridget Nwagbara revealed victimisation of undergraduate female students by university lecturers. Nwagbara highlighted the low reporting rate to law enforcement agencies and the social barriers to talking about rape. Social barriers and low reporting was also an outcome in the presentation by Tsitsi Masvawure, who found that rape on campus and in Zimbabwe in general, is often surrounded by "a thick cloak of silence and shame." Her presentation highlighted how men at university have to compete for sexual partners with financially stable, non-university men, who often have the economic upper-hand over young male students. Masvawure argued that male university students used sexual violence to retaliate for their perceived sexual undesirability.

The studies presented in this session, show how gender-based power inequalities in adolescent and young adult sexual relationships can disadvantage young women in terms of negotiating safe sex, refusing unwanted sex and reporting acts of violence perpetrated against them. Not being in control of decision-making and not being able to communicate within relationships places young women at risk of adverse physical and mental health consequences. It is important that strategies and interventions be developed to deepen our understanding of the unique issues that youth around the globe face today and that socialisation of young boys and girls be examined in order to address gender-based inequalities.

MEN AS VICTIMS IN SOUTH AFRICA

"...the horrific scourge of sexual violence that plagues [South African] prisons where appalling abuses and acts of sexual perversion are perpetrated on helpless and unprotected prisoners."

Men as victims of sexual violence are seldom the focus of research nor does the coercion of men gain prominence in discourse around policy making and service provision. Yet, as Yandisa Sikweyiya highlighted in his presentation, men's coercion and rape is reported in all settings and increasingly, evidence, including from South Africa, points to the health risks associated with sexual coercion of men by men. This is particularly pertinent in a country facing dual epidemics of violence and HIV, and high rates of men in prisons. Just Detention International, reported that rape in South African prisons is directly related to the HIV/AIDS crisis and that the rate of infection of prisoners is estimated to be double that of the general South African population. Moreover, South Africa releases an estimated 360,000 inmates back into society each year, which holds very specific challenges and consequences for communities, particularly when one considers the rate of sexual violence in South African correctional facilities. Sasha Gear, revealed how prison violence endorsed and generated destructive and harmful masculine identities which are at the heart of much sexual violence generally, and which will inform inmates' future interactions in prison and when they return to society. These identities disallow male vulnerability and make fearlessness and a capacity for violence conditions of "manhood". Gear noted, *"Solutions to the extreme levels of violence in South African society are only to come about with the celebration of alternative ideas of manhood that do not link respect to violence."*

In an effort to explore meanings of sexual coercion of young men and boys by men and women, one-on-one in-depth interviews were undertaken with heterosexual men aged 18-25 years who were volunteers in a HIV prevention behavioural intervention evaluation in the Eastern Cape. Findings from this small qualitative study showed that men's experiences of coercion by other men strongly resembled the situations of rape of women, and involved abuse of trust and age-related power, temptation through material goods, as well as use of aggression.

> *"...he was around 13 years old, he says this father called him, he was coming out of the mielie [maize] fields and he called him to come inside the mielie field, because of age he went in and that is when he jumped at him and grabbed him, undressing him showing him a knife and he raped him."*

The narratives were notable for the anger that was caused by these assaults. *"Inside me I had this thing that this guy has done this terrible thing and I do not like it."* In contrast, coercion by women was framed as 'temptation'. In some cases young men were tempted by much older women and those in a position of trust and the experience did not make them feel good. The difference with accounts of force by men, to the reports of pressure from women was notable, in that sexual coercion by women was something that made most of the men 'feel good'. When they did not feel good, the age gap between the man and the woman was the source of unease as it was taboo for men in this community to have sex with older women.

This session on men's experiences of sexual violence both in the community and in prisons, strongly supports the recommendation that research on sexual abuse of men needs to explore and adapt to the nuances of meaning in local settings. Moreover, these studies show us that rape of men and boys is not uncommon, and that victims are willing to report sexual coercion. Understanding the immediate, medium and long term impacts of sexual coercion of men is important for prevention efforts, and we have much to learn both in terms of resilience and the critical role such events can play in men's approaches to sexuality, gender equality, and future relationships.

SEXUAL VIOLENCE: MOVING THE AGENDA FORWARD

Emerging from the presentations, discussions and debates at the Forum, an important output of the SVRI Forum 2009 was the identification of some key research priorities on sexual violence. Priorities identified at the SVRI Forum include:

Primary Prevention:

- Need more robust evidence of effective interventions that can be scaled up.
- Need to explore new areas: parenting, emotional literacy, structural interventions.
- Need to develop gender equality interventions at all levels (e.g. social policies on paternity/maternity leave, childcare arrangements; school based interventions that promote gender equality, etc.)
- Need stronger evaluation of work with men/boys and scale up.

Health Sector Responses:

- Need an operations research agenda to understand barriers to access and use of services and how to deliver good quality services for women, men and children.
- Need to develop clarity on what kind of mental health services are feasible in resource poor settings.
- Need to identify strategies to effectively address both intimate partner violence and sexual violence by non-partners in a comprehensive and sustainable manner.

Conflict and Crisis:

Need to understand the context of rape in different conflicts in a more nuanced way, and more focused research on:

- Engaging the community in prevention and response, particularly addressing stigma, fear and rejection.
- Role of economic empowerment in women's recovery/prevention.
- Integration of mental health responses in sexual reproductive health services.
- Men as victims of sexual violence.
- Children of rape.
- Perpetration and the role of command structures in it.

HIV:

- Need to link prevention of violence with prevention of HIV.
- Need to develop interventions to address gender inequality (that can impact on both).
- Improve uptake of/adherence to PEP (understand role of stigma, side effects, etc.)
- Interventions to address violence against women in HIV testing and counseling services.

Cross Cutting Issues:

- Ethics of doing research on this issue, particularly where no services are available or where safety cannot be guaranteed.
- Need to have a more complex understanding of rape – study of perpetrators, their motivations and underlying factors.
- Gender equality research agenda.
- Links with poverty reduction and development agenda.
- Need for multi-sectoral engagement.

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APPENDIX A: SCIENTIFIC REVIEW COMMITTEE[2]

The SVRI Forum 2009 Abstract Review Committee consisted of experts in the field of sexual and gender-based violence (researchers, advocates, service providers, policy makers, others). The experts were identified by the SVRI Secretariat based on each reviewer's knowledge and experience in the field. Reviewers were invited via email to participate in the review process. Thirty-four reviewers agreed to participate. The abstract review period took place from the 17th of April to the 8th May 2009. The aim of the review process was to create an educational and informative Forum 2009 consisting of technical (oral) and poster presentations and roundtable sessions that address topical and timely issues on sexual violence.

	Reviewer name	Organisation
1	Alessandra Guedes	International Health Consultant
2	Claudia Garcia-Moreno	World Health Organisation
3	Debbie Billings	IPAS Latin America and the Carribean
4	Deepmala Mahla	Oxfam, GB
5	Dinys Luciano	Development Connections
6	Doris Bartel	Care International
7	Elizabeth Westley	Family Care International
8	Elizabeth Dartnall	Sexual Violence Research Initiative
9	Gary Barker	International Center for Research on Women
10	Ia Verulashvili	Women's Center Georgia
11	Janice Du Mont	University of Toronto
12	Jill Astbury	Victoria University
13	Jill Keesbury	Population Council
14	Kanchan Mathur	Institute of Development Studies India
15	Kristen Dunkle	Emory University
16	Lenore Manderson	Monash University
17	Malcolm Cowburn	Sheffield Hallam University
18	Mary Koss	University of Arizona
19	Michael Flood	Australia Institute
20	Muborak Sharipova	Open Asia; Consultant and Socio-Political Analyst
21	M.E. Khan	Population Council
22	Naeemah Abrahams	Medical Research Council, South Africa
23	Nguyen Thi Hoai Duc	Institute for Reproductive and Family Health
24	Nicola Christofides	University of the Witwatersrand

[2] The SVRI would like to acknowledge and send our sincere thanks to Lynne Stevens who unfortunately was unable to participate in this review, due to her untimely death. Thank you Lynne for your unstinting support to the work of the SVRI.

	Reviewer name	Organisation
25	Pamela Scully	Emory University
26	Rachel Jewkes	Medical Research Council, South Africa
27	Sarah Bott	Consultant IPPF/WHR
28	Sarah Martin	Médecins Sans Frontières
29	Sasha Gear	Centre for the Study of Violence and Reconciliation
30	Shanaaz Mathews	Medical Research Council of South Africa
31	Tandiar Samir	Center for development Services Egypt
32	Theresa Batangan	University of the Philippines
33	Tufail Muhammad	Pakistan Paediatric Association
34	Wynne Russell	Freelance Consultant - CSDev Associates

APPENDIX B: BUILDING CAPACITY AND SUPPORTING RESEARCH THROUGH WORKSHOPS

A key priority for the SVRI Forum 2009 was to support researchers to undertake ethically sound and rigorous research. A series of pre-conference workshops were offered to delegates that focused on using research for advocacy; identifying and addressing challenges in measuring violence against women; medico-legal responses to sexual violence; evaluating health services for sexual violence from women's perspectives; and writing for publication. Details of these follow:

Workshop 1: Demystifying research data for advocacy purposes

Facilitators: Monique Widyono (*PATH*, USA) and Shanaaz Mathews (*Medical Research Council,* South Africa)

The objective of this workshop was to engage in dialogue and take a closer look at the role that research can play as key tool in strengthening sexual violence advocacy. Drawing on experiences from Latin America, South Africa and other regions the workshop provided delegates with an interactive platform to discuss and debate a range of questions, including: What information/data have been most useful in strengthening advocacy around sexual violence, and what are the gaps in knowledge that need to be filled? How can research agendas be more closely merged with the needs of advocates and community members? How can research findings be presented to ensure that people who can make a difference take notice and galvanize action? What responsibilities do researchers bear with respect to the use and possible misuse, or misrepresentation of their data and findings? Delegates were provided with information on steps for developing an advocacy strategy, and a short paper highlighting the issues discussed during this workshop along with the workshop presentation which is available online.

Workshop 2: Medico-legal responses to sexual violence

Facilitator: Prof. Rachel Jewkes (*Medical Research Council,* South Africa)

Recovery after rape can be strongly influenced by the quality of care provided by the health sector, as can the possibility of optimally using legal avenues to punish offenders. Post rape care that is provided by well trained, sensitive, non-judgmental health professionals can make an important contribution to recovery. Similarly incompetent and insensitive providers can magnify the harm experienced by rape victims. Recognising that post rape care has been largely underdeveloped in many settings, the Sexual Violence Research Initiative has a project strengthening health sector responses to rape. This workshop focused on what needs to be done to strengthen health sector responses to sexual violence. Drawing on experiences from South Africa and other countries of the African region this workshop discussed how to use research to assess the state of post rape responses in the health sector, how to build alliances for change within countries and regions, reflected on and shared experiences of developing models of care for different resource settings and some of the tools which are accessible and invaluable for the processes of strengthening services, including policy, practice guidelines, and curriculum.

Workshop 3: Challenges in Measuring Violence Against Women

Facilitators: Dr. Claudia Garcia-Moreno (*WHO,* Switzerland) and Dr. Henrica A.F.M. (Henriette) Jansen (*Senior Consultant,* Switzerland)

There is a lack of reliable information, particularly from developing countries, on the prevalence of different forms of violence against women and its impact on health. Sexual violence in particular is highly stigmatized and this stigma often prevents individuals and communities from addressing this problem. This workshop talked to some of the challenges in measuring violence against women. More specifically, the workshop objectives were: to discuss some essential principles and challenges when working with and researching women affected by violence; and to provide participants with access to the tools and resources to measure violence against women. This session evaluated past studies undertaken by the WHO, looked at questionnaire development for research, translation of questionnaires, interpreting service based data and discussed challenges around the measurement of child sexual abuse. This workshop also addressed important ethical and methodological challenges raised by research on sexual violence.

Workshop 4: Evaluation of programmes and services from women's perspectives.

Facilitators: Alessandra Guedes (*Health Consultant,* Brazil) and Prof. Jill Astbury (*Victoria University,* Australia)

High quality, appropriate services for victim/survivors of sexual violence are essential in reducing all health related harms. Such services can not only treat injuries, physical and psychological, but can minimize harm and suffering in the short and long term; reduce the likelihood of secondary victimization by service providers and reduce the risk of repeat victimization. To assess the quality of existing services to victim/survivors of sexual violence, it is essential that women's perspectives on both the quality and appropriateness of services inform the evaluation of services. The SVRI offered this workshop to familiarise participants with methodologies that have been developed to assess services from women's perspectives and to consider, with workshop participants, the relevance and appropriateness of these methodologies in the various country settings in which they work.

Workshop 5: A South-South Collaboration for Teaching Writing for Academic Publication on Gender and Sexuality - The Ese:o Methodology and Experience

Presenter: Dr. Soledad Falabella (*ESE:O*, Chile)

The purpose of this workshop was to create awareness of access barriers that prevent researchers from the South to publish in leading peer-reviewed journals in the field of sexual and reproductive health and rights, gender and sexuality. The workshop shared the experience of a South-South collaboration project of online academic writing courses. Participants in this workshop were able to familiarise themselves with issues surrounding the politics of academic international publication in the field and were given an opportunity to come into contact with a strategic approach to this issue. They were also given an opportunity to interact through Ese:o's online platform, as an example of a virtual tool for learning about academic writing.

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