Sexual violence is a public health problem of global magnitude. A World Health Organization (WHO) report of 2013 stated that 25.4% of women and girls in the WHO European Region have been sexually and/or physically victimized by an intimate partner and 5.2% sexually victimized by non-partners (1). No data were provided on male victimization and female perpetration “due to insufficient data” (1). Yet, more research is revealing male victimization. A recent study in young adults (18-27 years) in 10 European countries (Austria, Belgium, Cyprus, Greece, Lithuania, the Netherlands, Poland, Portugal, Slovakia and Spain) for example, demonstrated that 27.1% of the young men and 32.2% of the young women already had been victimized since the age of consent (2). In addition to women, children, adolescents and young people, research has shown that lesbian, gay, bisexual and transgender people are particularly vulnerable (3). Also migrants, and more specifically young refugees, asylum seekers and undocumented migrants, have been found to be at high risk. Keygnaert et al found up to 28.6% of male and 69.3% of female migrants have been sexually victimized since their arrival in Europe (4). The bulk of the sexual violence consisted of rape with multiple perpetrators, with gang rape appearing to be a common practice. It was often combined with psychological, physical and socio-economic violence. Perpetrators were (ex)partners in a third of the cases, with European professionals and citizens found to be the perpetrators in respectively a fifth and a third of the incidents (4). The pivotal determinant in their vulnerability is their restricted legal status, which hampers their active participation in society, puts them at risk of exploitation and abuse and inhibits their access to health care (4).

Age
Regardless of all the above-mentioned socio-demographic determinants, it has been robustly demonstrated that people who were personally victimized (direct exposure) or who personally witnessed sexual, physical and psychological violence during childhood, e.g. among their parents (indirect exposure), are not only prone to subsequent (re) victimization but also to perpetration (5). This was also confirmed by the study on young adults in 10 European countries: 16.3% of the young men and 5.0% of the young women had already committed sexual violence to either an (ex)partner, acquaintance or stranger (2). Violence exposure in the young leads thus to more violence in adulthood in both genders. In order to stop this pattern from continuing and given that young people face multiple vulnerabilities in several domains of their life, future sexual violence prevention strategies do need to invest above all in children, adolescents and young adults at all stages of the life course where potential problem development and vulnerabilities may present. In this regard it is crucial that prevention actions stem from a positive view on sexual health and that individual’s sexual health development opportunities are not curtailed as a special argument for preventing them from being put at risk of sexual violence. Taking a life course approach that includes comprehensive sexuality education that focuses on positive sexual relationships and sexuality lies at the heart of preventing coercion and violence.

Gender
So far and by far, women and girls have been found to be the most vulnerable to sexual violence worldwide (1). The lack of knowledge on male victimization has been mostly attributed to underreporting, to less legal redress for male victims and to a lack of appropriate services (6). On the other hand, it has been argued that current prevailing legal, policy and research frameworks on violence stem from a dichotomist paradigm in which a priori men are being considered as sole perpetrators and women as victims, a paradigm that per definition generates gender-biased results. This creates a bias in research by not providing the possibility of identifying real dynamics in violence in females, males and transgenders. Subsequently, it impacts policy framework development, as these frameworks are based on research data and international action plans. This is problematic, since it ignores a number of victims and perpetrators in all genders who are in need of effective interventions and whom are now left unaddressed (4). Furthermore, this ignorance leads to ill health consequences and enhances the risk of subsequent perpetration and victimization in current and future generations in all genders. In order to be effective and qualitative, it is thus urgently time for a gender-sensitive paradigm on sexual violence victimization and perpetration that reveals and acknowledges the different dynamics of violence in all genders in different societies.

Migration
Currently, the WHO European Region is being challenged in addressing and accommodating an enormous migration inflow generated by conflicts and disasters. Refugees, asylum seekers and undocumented migrants have been shown to be at tremendous risk of sexual victimization in their country of origin, during their flight and even upon accommodation in Europe. The first two ones are rather difficult to challenge but could be better incorporated in transnational action plans as for example in the frame of the European Neighbourhood Policy. Yet, the third one could be easily at reach by two fairly new policy frameworks.

The first one is the recast of the European Directive on minimum standards for reception of asylum seekers (2013/33/EU) requesting that European Union (EU) Member States take “appropriate measures that prevent gender-based violence including sexual assault and harassment” within reception centres and accommodation facilities and to ensure “access to appropriate medical and psychological treatment or care for vulnerable groups”, which now include victims of a range of sexual violence forms. These requirements remain limited but might be a starting point for more holistic prevention and response policies. Member States had until July 2015 to translate these
provisions into national law. Yet, with the current asylum influx, in many countries the biggest challenge now is to accommodate the asylum seekers and get their asylum claims registered. The ability to provide health checks cannot be guaranteed within the first week(s) let alone that sensitive issues as sexual violence can be addressed. This is a hazardous situation that should immediately be rectified. In international humanitarian crises there are the guidelines from the UNHCR on the “Minimum Initial Service Package for Reproductive Health in Crisis Situations (MISP)” that are applied. This is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence, reduce HIV transmission, prevent excess maternal and newborn morbidity and mortality and plan for comprehensive reproductive health services. As they are what is stated in their name, guaranteeing that both the MISP as well as the Directive for minimum standards of reception are implemented should thus be the absolute minimum throughout the whole European Region.

The second potentially fruitful instrument is the European “Istanbul” Convention on “Preventing and combating violence against women and domestic violence”, which endorses a definition of sexual violence based on the absence of consent. It also proposes that multiple perpetrators or repeated offences are to be considered aggravating circumstances in legislation. Moreover, a full chapter (VII) is dedicated to migration and asylum, broadening opportunities regarding residence status, gender-based asylum claims and non-refoulement. The Convention entered into force in 2014. Several countries of the WHO European Region have already ratified it, which implies that in addition to the abovementioned facts, they should also provide holistic (medical, psychosocial and forensic) care to victims of sexual violence and contribute in the development of sexual assault referral centres in which this holistic care can be provided. This requires also that protocols on prevention and response to sexual violence are put in place, which is still a challenge for many health systems throughout the Region. Yet, implementing this convention in many European countries would mean a tremendous step forward in the optimal care for victims. The only other challenge, but a necessary step to take from a human rights and public health approach, is to evolve to a system in which all victims are cared for alike, regardless of their gender or sex or legal status.

Indicators
Finally, in order to monitor prevalence, incidence and effectiveness of intervention measures, common indicators are needed. They are currently lacking at levels of age, gender and legal/migration status. Yet, data collection is deemed essential to inform policy-making and monitor the impact of future interventions. The Convention of Istanbul stipulates that the ratifying countries should register cases of sexual victimization. We argue that in order to compare throughout the European Region, that sexual assertiveness, transgressive behaviour and experiences with sexual violence victimization and perpetration, as well as, migration history, age and gender should be routinely incorporated in all sexual health datasets. In that way, we can better assure that sexual violence policies are evidence-based and take multiple vulnerabilities into account, thus reflecting reality.

References

Ines Keygnaert, PhD,
Postdoctoral researcher & Team Leader,
International Centre for Reproductive Health,
Ghent University, Belgium,
Ines.Keygnaert@UGent.be