ARROWs For Change

Women's and Gender Perspectives in Health Policies and Programmes

September 1998 Vol 4 No 2

ISSN 1394-4444

Addressing Rape: The Urgency for Action

Incest, coerced pregnancy, mass rape, ethnic cleansing, forced prostitution (comfort women of World War Two), date rape, marital rape, rape in prison, rape as revenge, political rape, gang rape, rape in conflict situations and rape as a weapon of war—are not about violent sex (which may imply consensual sex) but power or sexual violence. That one out of every five women is a survivor of rape (whose attackers are mostly known) constitutes the prevalence of rape globally, and 40–60 per cent of known sexual assaults are committed against girls aged 15 years and younger.[1] The reality and fear of rape affects women and girls throughout their lives: gender violence—violence perpetrated against women and girls because they are female—can occur when they are a mere infant, girl, adolescent, woman of reproductive age to that of an elderly woman.[2] Yet to what extent would the recognition of the health impacts of rape serve as a preventive, not merely curative measure in lobbying towards a zero tolerance of gender violence at state and grassroots levels?

graphic Sharon Alston

Violence against women needs to be recognised as a public health problem not only within the Asia-Pacific region, but globally. Gender violence accounts for an estimated five to 16 per cent (depending upon region) of the healthy years of life which are lost to women of reproductive age. Data from rape crisis centres in Korea and Thailand indicate that 15–18 per cent of their clients become pregnant because of rape.[3] According to a US study, medical care costs of women who were raped or assaulted were 2.5 times higher than the costs of non-victims.[4] In addition, rape survivors can potentially suffer from these health (reproductive and psychological) problems:

- Physically—pelvic inflammatory disease, chronic pelvic pain, asthma, irritable bowel syndrome, partial or permanent disability, even delayed physical effects such as arthritis, hypertension and heart disease, unwanted pregnancy including teenage pregnancy resulting in pregnancy complications/ premature labour, miscarriage, low-birthweight babies with reduced chances of survival and maternal mortality from excessive bleeding of infection, STDs (including HIV infections) and death.
- Psychologically—Rape Trauma Syndrome and Post Traumatic Stress Disorder (see "Definitions", p. 11), injurious sexual/health behaviours (smoking or unprotected sex with multiple partners, prostitution and alcohol/drug abuse).[5]
- Emotionally—humiliation, guilt, shame, embarrassment, self-blame, anger and helplessness.[6]

Thus ill-health, both of women at risk and those who are raped, is the direct fall-out of gender violence. As a holistic definition of health encompasses indicators such as educational achievement, quality of life and economic productivity, the compounded hidden costs of rape burden health care systems, drain resources and obstruct socio-economic development by lowering educational attainment, work productivity, safe reproduction and maternal and child health care.

Gender violence as a health issue should become a salient reference point in affording state, medical/therapeutic, legislative, community-based and media interventions for rape survivors, respectively through: 1) exercising political will to actualise across-the-board reforms; 2) integrating gender-sensitive and inclusive values regarding violence, racism, sexism and economic disadvantage into health education and clinical and police training (as well as ensuring the availability and accessibility of specialised health services); 3) criminalising gender violence through separate legislation/reform laws on rape, domestic violence, sexual harassment and incest; 4) gender-sensitising support groups and families of rape survivors (as well as promoting support services for the latter);

and 5) raising public consciousness and unshackling prejudicial mindsets through alternative and affirmative images and treatment of women in the media.

Some of the above strategies for change are evident within Asia-Pacific. For instance, the ground-breaking Anti-Rape Law of 1997 (Act No. 8353) and the Rape Victim Assistance and Protection Act of 1998 (Act No. 8505) of the Philippines, not only broadens the definition of rape, but legislates state-funded rape crisis centres in every province and city and a women's desk in every police precinct, nationally (for detailed provision of health services, refer to "Monitoring Country Activities", p. 6). In addition, specialised rape crisis centres have also been established in Bangladesh, Fiji, Indonesia, Japan, Malaysia and Thailand (see "Spotlight", p. 3 and "Factfile", p. 12). However, these government-NGO (non-governmental organisation) initiatives need to be galvanised, if we are to protect women and communities from quantifiable set-backs in progress which are threatened by the health costs of gender violence. A rape survivor is often doubly victimised through discrimination arising from existing social structures. Thus, the political will to effect legal reforms, rape crisis centres, gender-sensitised training programmes for legal and law enforcement officers, health providers and the community at large, recognises that women and girls' rights are inalienable, integral and indivisible in themselves.

Uprooting Culture and Religion

Yet, these initiatives in themselves do not necessarily reflect nor effect a paradigm shift from the devaluation of women/girls through repressive constructions of femininity/sexuality (valued as a vessel of purity or procreation), to an affirmation of their inherent worth and spiritual integrity. Cultural tradition and religious tenets that "sanction" male domination-female subordination are equally accountable and culpable in justifying the discriminatory treatment, perception and status of women and girls and manifest gender violence.

Particularly in an Asian context where culture and religion are deeply entrenched, the empowerment and healing for women violated sexually, emotionally, psychologically, physically and spiritually, begin at the roots, through:

- Reinterpreting discriminatory religious texts and teachings where biased interpretations foster gender violence (to recognise that marital rape can and does happen);
- Removing cultural relativity from our understanding of rape and its impact. Violence against women is a breach of basic women's rights, regardless of cultural biases (that the loss of virginity is not shameful, that "honour killing" of rape survivors is wrong, and marriage to one's rapist does not negate the violation);
- Gender-sensitising religious institutions (through gender equality programmes, services, policies, practices, research, at international, regional, national and community levels to the grassroots) to effect a long-term process of reconciliation and renewal within the community so that rape survivors are no longer stigmatised, but affirmed.

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[1] _____. 1998. "Violence against women: an issue of human rights". *Women in Action* Issue No. 1. p. 11.

[2] **Heise, Lori [et al.].** 1994. *Violence Against Women: The Hidden Health Burden.* World Bank Discussion Papers No. 255. Washington: The World Bank. p. 5.

[3] Ibid. pp. 17 & 20.

[4] **WHO.** 1996. *Violence Against Women.* WHO Consultation, Geneva, 5–7 February, 1996. p. 14.

[5] **Heise**, Op. cit. p. 18.

[6] **Lim Kah Cheng (ed.).** 1990. *Working with Rape Survivors: A Handbook.* (Malaysia) Penang: Women's Crisis Centre. pp. 8–10.

SAB

***ARROWs* For Change** is published three times a year and is a bulletin primarily for Asian-Pacific decision-makers in health, population, family planning, and women's organisations. It provides: ♦ Women's and gender perspectives on women and health, particularly reproductive health ♦ A spotlight on innovative policy development and field programmes ♦ Monitoring of country activities post-ICPD, Cairo and post-FWCW, Beijing ♦ A gender analysis of health data and concepts ♦ Resources for action.

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The Swedish International Development Cooperation Agency (Sida) funds the bulletin. Contributions are welcome. Please send them to:

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Responding to the Rape of Indonesian Chinese Women and Girls

A hundred and sixty eight women and girls were gang raped and 1,200 Indonesians of mostly Chinese descent died as a result of the mid-May 1998 Jakarta riots (New Straits Times [NST][1], August 18, 1998, p. 20). How does a nation begin to heal such broken bodies and spirits in the aftermath?

Highlighted is the 400 strong Humanity Volunteer Team, Violence Against Women Division and its notable efforts at survivors' assistance counselling (hotline, medico-legal services and shelter), investigation and case/data documentation, public education through forums and follow-up monitoring. Set up in early June, in humanitarian response to the crisis, this autonomous non-governmental organisation (NGO) aims to galvanise the tide of public empathy and international Human Rights pressure groups to condemn the objectification and brutal violation of Indonesian Chinese women and girls. Its volunteers consist of a mixed ethnic group who provide funding as well as services and expertise, and are of diverse vocational backgrounds: activists, religious workers, psychologists, lawyers, housewives, teachers, health workers and students. They are accepted as part of the team based on their commitment to the team's principles (justice based on anti-gender and anti-racial discrimination), their willingness to be trained, to follow demanding work/time allocation and to work without pay. Striving for almost 24 hours a day to engender physical and psychological healing for women and girls affected (and their families), the compassionate volunteers persevere despite anonymous threats to their lives, the non-compliance of survivors in coming forward for fear of stigmatisation and reprisals, and state and military apathy. Their courageous in-depth investigation strongly suggests that the riots and rapes were systematically organised, allegedly perpetrated by renegade military forces (The Sunday Times[1], August 16, 1998, p. 20). The public (and cyber) release of relevant data (including information about the kidnapping, torture and murder of activists), precipitated state accountability to the widespread and systematic rapes which in turn led to the initiation of an anti-rape task force, headed by President Habibie's wife, Hasri Ainun Habibie and Women's Affairs Minister, Tutty Alawiyah (Asiaweek July 24, 1998, p. 30).

The volunteers' holistic assistance approach which includes religious services and socio-economic support, complements existing health services that are primarily curative in alleviating the symptoms (not cause) of gender violence. Virtually all rape survivors are now in very poor psychological/physical health conditions. They suffer from or are at risk of damaged reproductive organs, Rape Trauma Syndrome, Post Traumatic Stress Disorder (see "Definitions", p. 11), psycho-neuroses, suicide, mental illness and a life of fear and desperation. According to NGO sources, there are at least ten one-stop women's crisis centres with additional ones set up after the riots. These are not hospital-based, but managed by NGOs: there is one in Yogyakarta, Surabaya and Lombok and the remaining seven are in Jakarta (including at least four shelters in collaboration with churches). The Humanity Volunteer Team has the co-operation of private hospitals for the supply of medical/psychological treatment, as well as STD (including HIV) check-ups and abortions on demand.

A prevailing climate of fear impacts on the availability and accessibility of these rape crisis centres and medical treatment, for according to the *Report of the Humanity Volunteer Team*[2], speaking about and listening sympathetically to the survivors of the mass rape is still considered subversive. The survivors and their families, including the medical staff and volunteers have allegedly been intimidated via telephone threats, anonymous letters, distribution of photographs of those raped and rumours about further riots and rapes by military renegades. As such, many rape survivors have reportedly resorted to seeking treatment and refuge from hospitals abroad, such as Singapore, Hong Kong Special Administrative Region of the Republic of China, Australia, Malaysia and the United States.

A knee-jerk reaction such as the soaring demand for modern-day chastity belts (made of stainless steel and fake leather and secured with a combination lock) (NST[1], August 15, 1998, p. 18), are designed to control women and girls' sexuality, rather than to protect them. In contrast, long-term preventive and reconciliatory strategies should include: 1) a state apology to rape survivors and their communities (not merely condemnation of these heinous acts); 2) an independent probe to expose the identity of the perpetrators; and 3) the protection of the civil rights of individuals and minorities (ethnic Chinese comprise just four per cent of Indonesia's population of 202 million) (NST[1], August 18, 1998, p. 20) in reaffirming nationalistic integrity.

■ **References:**

[1] Newspapers in Malaysia.

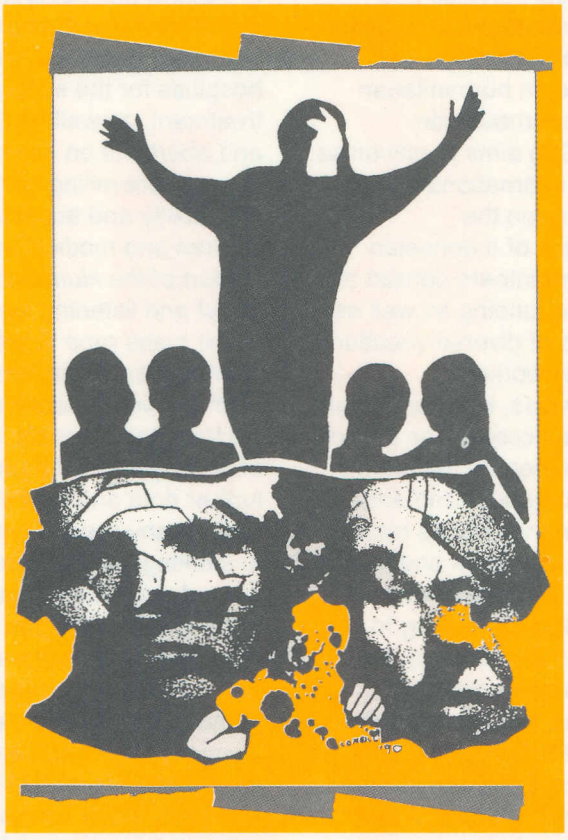
[2] **Humanity Volunteer Team.** 1998. "Mass rape in the recent riots: the climax of an uncivilised act in the nation's life". [Unpublished]. This report can be obtained from The Humanity Volunteer Team at Jalan Arus Dalam No. 1, Rt. 001/Rw.012 Cawang. Dewi Sartika, Jakarta 13630 INDONESIA, Tel./Fax: 021 809 4531, E-mail: galih@indo.net.id

SAB

Government-Funded Services Against Sexual Assault

by Di Surgey

The goal of the National Women's Health Policy (NWHP) in Australia is to improve the health and well-being of women, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of women. Amongst the seven health issues prioritised by the NWHP is violence against women. Amongst the initiatives funded by the Commonwealth and State governments under the Women's Health Program is a Sexual Assault Program. Service provision to survivors of sexual assault is achieved through a complex network of service providers which varies from State to State and which may include generic, community or women's health services. Points of access to the general service system will vary with the particular needs of the survivor, including their gender and age.



Service Provision for Survivors of Sexual Assault

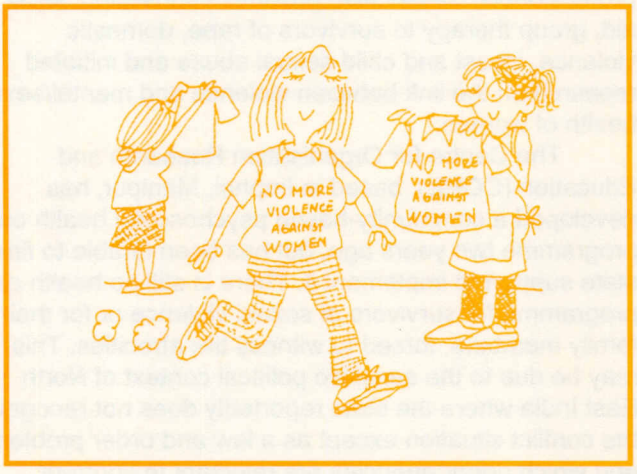
In Victoria, there are also fifteen specialist sexual assault services, often known as Centres Against Sexual Assault (CASAs), to which a survivor is likely to be referred. There is a CASA in every geographic "region" in the State. Although part of the Women's Health Program, CASAs are not gender specific. However, Victorian CASAs share a feminist philosophy and recognise that sexual assault is a gender issue. The philosophical position that rape is about power, not sex, informs service delivery and education programs. Whilst men may be employed as project officers to work with male survivors, most commonly counsellors of women are women.

CASAs provide services to children and adults who have at any time been subjected to sexual assault. All CASAs offer crisis care, counselling, support groups, advocacy and support for court hearings, professional training, community information and education. Each CASA offers as well, its own mix of services in response to available resources and local planning priorities, including outreach services or specific research projects.

Most CASAs are based in hospitals but only a few of them run their own medical care services. For example, the Northern CASA (NCASA), which covers about one sixth of Victoria's population (2,337,000 females), is based in a major hospital with its own discrete crisis care centre which is more personal and more "woman-friendly" than the rest of the hospital. Here, the NCASA will advocate for and support a client in crisis[1] at the time of her contact with medical or forensic experts and co-ordinate responses to her immediate and longer term needs, including legal issues. Participation in an individual counselling programme or in support groups (e.g., adult survivors of childhood assault) may occur at the NCASA offices at the hospital or at another organisation where NCASA outposts counsellors. A bicultural woman may access an NCASA counsellor at a women's health service which focusses on the needs of non-English speaking background women or an adolescent may see a member of the NCASA youth outreach team at a youth centre.

A recent evaluation of the NWHP in Victoria found that CASAs commonly prefer a non-clinical service model. Most practitioners in CASAs are social workers or community development workers. In 1995/96, the Victorian Sexual Assault Program employed approximately 105 full-time staff ranging from 1.5 equivalent full-time positions in a rural service to 15 full-time positions in a state-wide service. (The NCASA employs approximately 10.5 full-time positions.) In general, the demand for services outweighs the supply due to lack of resources. Thus, a central telephone counselling and information service co-ordinates crisis response after hours, with provision to mobilise the on-call staff of the relevant local CASA to provide immediate assistance at the point of crisis. The on-call staff will liaise with medical practitioners and police if

required, organise emergency accommodation and monitor police investigations to ensure that these processes are consistent with the Police Code of Practice for Sexual Assault. Every CASA in Victoria co-operates with this after-hours telephone service to ensure crisis services are deliverable when and where they are required across the State, free of charge, even overnight. Recent evaluation of the Victorian women's health program (1997) found that three-quarters of CASA's users, used the service because it guaranteed confidentiality and that a vast majority were satisfied with the quality of service received, the respect accorded to them and that their needs as a woman were understood by CASA's service providers. Most felt that they had enough time to discuss the issues that brought them to the service and that, as a result of the service, they were more able to make decisions about their health and well-being.



MATCH International Centre. 1990. *Linking Women's Global Struggles to End Violence*. p. 63

Collaboration for Change

CASAs are expected to network with mainstream health services. Linkages in the form of agreed protocols for referrals between agencies, outpost agreements, joint projects or representation on joint planning committees, may be factored into service "contracts" between government departments (the purchasers) and CASAs (the service providers). Besides community education or professional training programmes, services in the sexual assault field also seek to maximise opportunities for cross-sectoral improvements in women's health. To that end, CASAs interact with the Departments of Health, Community Services, Justice, Police, Education and Employment. Committees or government services which in turn seek consultation or cross referral with CASAs include the Department of Public Prosecutions Witness Assistance Service, Crimes Compensation Tribunal, the Rape Squad and Community Policing Squad, or the Victorian Community Council Against Violence, among others.

MATCH International Centre. 1990. *Linking Women's Global Struggles to End Violence*. p.38

Thus CASAs, though non-governmental, in working within a policy context set by both state and Commonwealth governments, are affected either directly or indirectly by shifts in policy at either or both of these levels. To illustrate, the introduction of mandatory reporting of child sexual abuse has meant that CASAs must deal with an increasing complexity of casework with children. Similarly, CASAs are under pressure to supply more services to men (the number of male clients attending one CASA, for example, increased three-fold between 1990/91 and 1995/96 to 15.5 per cent of all clients). The CASA Forum, as a peak advocacy body, enables issues which may impact on CASA's capacity to deliver gender-sensitive services, to be taken up between CASAs as service providers and government as purchasers.

■ For more information, e-mail Jo Fuller of NCASA at <ncasa@austin.unimelb.edu.au>.

■ **Reference:**

[1] Evaluation of the Second phase of the National Women's Health Program in Victoria, Success Works Pty. Ltd. and Centre for Development and Innovation in Health, 1997, for the Department of Human Services, Victoria, Australia.

■ ***Di Surgey*** *has been a member of the ARROW Advisory Committee since 1994, having worked in women's health and gender specific organisations in Australia since 1974. She has researched, authored, designed and illustrated a number of significant women's health information and education resources, and has worked with women of diversity.*

Bangladesh

There is reportedly a significant increase in gang rapes and police rape with victims as young as two years old. The forensic department in hospitals has no women doctors and as a result, most survivors (and/or their families) are reluctant to have physical examinations performed by male doctors. Such delays result in crucial medical evidence being lost, thus reducing the probability in convicting the offenders in most cases. Besides government shelters, women NGOs such as Ain O Salish (Centre for Legal Awareness and Aid), Madaripur Legal Aid Association, Bangladesh Mahila Parishad and BLAST (Bangladesh Legal Aid Services Trust), have started to provide shelters, legal aid and counselling for these women. Although there are enough laws protecting the rights of women and girls, there is inadequate enforcement. The new proposed Act called the Suppression of Oppresssion of Women and Children Act 1998 (in draft form and available only in Bangla), which will be submitted in parliament this year, has raised an outcry among women activists and lawyers because of its ambiguities. Women NGOs working on legal aid, have lobbied the government to remove parts of the Act (relating to anti-terrorism) and to incorporate their recommendations in order to minimise the loopholes.

Fiji

The (non-governmental) Fiji Law Reform Commission (FLRC), is debating a draft bill on Sexual Assault submitted by the Fiji Women's Rights Movement in 1997. Reviewed are laws on corroboration and the admissibility of the past sexual history of survivors as evidence during sexual assault hearings. Sexual Offences Units were established within the Fiji Police force in 1996, but their role is limited to investigating sexual offences and its staff are not trained to provide gender-sensitised counselling. In a related development including marital rape within domestic violence, the Fiji Police Force introduced a No Drop Policy (to replace a reconciliatory approach) with respect to domestic violence (DV) in 1996, which, though inadequately implemented, requires all DV cases within conjugal relationships to go to court. The Fiji Women's Crisis Centre (FWCC), has submitted a draft DV bill to the FLRC for review and is conducting a national research on DV and sexual assault in Fiji.

Gender-sensitised health services for rape survivors are available only at the Colonial War Memorial Hospital (CWM). As Fiji's largest and best equipped hospital, its gynaecological ward makes provision for survivors of sexual assault to be treated in privacy by physicians who are sensitive to their trauma. Another avenue of psychological counselling and emotional support is provided by FWCC and its branches in Ba, Labasa and Lautoka. FWCC continues to lobby for gender sensitivity training for members of the medical and legal profession.

India

To facilitate gender sensitisation of the judiciary, Sakshi, a violence intervention centre for women, organised the "Asia Pacific Advisory Forum on Judiciary Education on Equality Issues" (January 1997) and a workshop on "Gender Equality Education" (April 1998). Sakshi and other NGOs have filed a writ demanding a broader definition of rape (as Sections 375 and 376 of the Penal Code narrowly defines rape as penile-vaginal penetration). In collaboration with medical and legal professionals, Sakshi also provides counselling, legal aid, group therapy to survivors of rape, domestic violence, incest and child sexual abuse and initiated research on the link between violence and mental/sexual health of women.

The Centre for Organisation Research and Education (CORE), based in Imphal, Manipur, has developed a community-based psychosocial health care programme two years ago, but has been unable to find state support to implement it. There is still no health care programme for survivors of sexual violence or for their family members, forced to witness the atrocities. This may be due to the sensitive political context of North East India where the state reportedly does not recognise the conflict situation except as a law and order problem, and which donor agencies are reluctant to confront.

Philippines

The Anti-Rape Law of 1997 (Act No. 8353) declares rape not as a crime against chastity (which discriminates non-virgins such as single/women who are sexually active and prostitutes), but a crime against person (without sex discrimination). It broadens the definition of rape: in addition to forced penile penetration of the vagina is, the insertion of the penis into another person's mouth or anal orifice, or of any instrument or object into the genital or oral orifice of another person—albeit less punitive—six years and one day to 12 years imprisonment as opposed to the sentence of 20 years and one day to 40 years for the "classic" rape (*Beijing Watch: Monitoring Philippine Commitments,* 1997, Vol. 1 No. 1, p. 1). The provision of "Rape Shield" in prosecutions of rape (Section 6 of the Rape Victim Assistance and Protection Act of 1998 [Act No. 8505]), allows for evidence of the rape survivor's past sexual conduct and opinion of his/her reputation, only if the court deems it relevant to the case.

SIBOL's (formed by 11 women's organisations) inexhaustive lobbying spanned two legislative terms, that of the Ninth (1992–1995) and Tenth Congress (1995–1998). Despite a hallmark victory, SIBOL remains critical of legislative concessions such as: 1) marital rape though obliquely recognised as a crime, can be negated with the forgiveness of the offended/wife; 2) though SIBOL condemns the death penalty as a violation of human rights, the Act in considering rape a heinous crime, imposes the death penalty under ten aggravating circumstances, which include: for rape/attempted rape resulting in homicide; rape of a minor (seven years or younger); if the victim is under police/military custody; if the offender is HIV positive (or is infected with STDs); if the rape results in permanent mutilation/disability; and, if familial members are forced to watch.

The Rape Victim Assistance and Protection Act of 1998 mandates the establishment and operation of Rape Crisis Centres in every province and city to: 1) provide rape survivors (and their families) with psychological counselling, medical and health services including their medico-legal examination (the attendant physician to be of the same gender as the offended); 2) secure free legal assistance or service, when necessary; 3) ensure the privacy and safety of rape survivors; 4) develop and undertake a training programme for law enforcement officers (a women's desk to be established in every police precinct), public prosecutors, lawyers, medico-legal officers, social workers and barangay officials on human rights and responsibilities, gender sensitivity and legal management of rape cases; and 5) adopting and implementing programmes for the recovery of rape survivors.

Three bills on incest were filed in the Tenth Congress which differentiates between an "incestuous relations with consent" (between consenting parties 18 years and above) and "incestuous rape". However, the bill reflects a narrow view of the perpetrator of incestuous rape—as legal or natural father, stepfather, common law father or de facto father—thus not recognising the rape and sexual abuse of female children by other members of the family or household (i.e., godfather or neighbour given kin status under the cultural practice of extended clan system) (Centre for Legislative Development 1997 "Monitoring the Philippine Government's Implementation of the Platform for Action: Focus on Legislative Initiatives on Violence Against Women in the 10th Congress [1995–1998]", Occasional Paper No. 2, pp. 13–14). In punishing the "mother" (including "any female person in whose legal or physical custody the victim is found at the time of the commission of the incestuous rape"), who refrains from proceeding against the father-rapists or tolerates the commission of the crime, it fails to account for her disempowerment within that abusive relationship.

Viet Nam

■ Between January 1993 and March 1997, there were 2,545 rape cases reported of which 817 were committed on children. The girl child between ten and 13 years of age are mostly victimised. In recognition that the crime of child sexual abuse is as widespread as prostitution and homicide, the President on May 22, 1997, declared amendments to Penal Code stipulations on the crime of child rape. Revision of articles 112, 113 and 114 effect punitive measures for child rapists, which range from two to 15 years imprisonment to life imprisonment or the death penalty (for statutory rape of children below 13 years). The National Committee for Protection and Care of Children, as in the National Plan for the Advancement of Vietnamese Women to the Year 2000 (as a post-Beijing follow-up), is committed to protecting the girl child by collaborating actively with the Ministry of Labour, War Invalid and Social Affairs, Ministry of Justice, and Ministry of Interior (Police).

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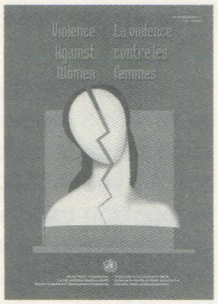
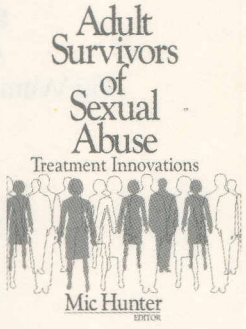


_____. 1997. *Violence Against Women: A Priority Health Issue.* Geneva: Family and Reproductive Health, WHO. v.p.

This folder in the WHO series, Women's Health and Development, provides a good overview of violence against women (VAW) as a health issue. It is intended to be an information tool to further discussions and actions to curb VAW. It contains short chapters of two to three pages each on the definition and scope of the problem, VAW in families, rape and sexual assault, VAW in situations of armed conflict and displacement, the girl child, health consequences, what health workers can do, what WHO is doing, and what NGOs are doing. The brief information provided is drawn from a wide range of research papers and other publications to present a global overview. This resource also lists the human rights documents, UN declarations and treaties which are pertinent to the issue of VAW, as well as selected readings. It quotes in full the 49th World Health Assembly, 1996 resolution 49.25 (which in itself is an important advocacy tool), on "Prevention of violence: a public health priority".

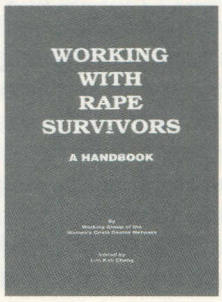
■ **Source:** Women's Health and Development, Family and Reproductive Health, World Health Organization (WHO), 1211, Geneva 27, Switzerland.

Hunter, Mic (ed.). 1995. *Adult Survivors of Sexual Abuse: Treatment Innovations.* Thousand Oaks: Sage. 204 p.



This book, offering useful treatment innovations, begins with a review of dynamic theories that provides a solid introduction to understanding and treating adult survivors of sexual abuse and provides a theory for understanding the effects of child sexual abuse using an extreme stress response model. The three chapters of the first part deal with various sexual problems of adult survivors, including sexual dysfunction and sexual compulsivity; and touch on interventions for treating couples whose sexual relationship has been damaged by a history of sexual abuse during childhood. The second part examines clients with special needs like the very difficult survivor with personality disorders, chemically dependent survivors, male survivors and partners of survivors. Not only are the successes described, but also the difficulties in coping and the failures of the therapists. This book is a valuable source for practitioners in the fields of clinical psychology, counselling, social work and mental health.

■ **Source:** SAGE Publications, Inc. 2455 Teller Road, Thousand Oaks, California 91320. E-mail: <order@sagepub.com>.



Lim Kah Cheng (ed.). 1990. *Working with Rape Survivors: A Handbook.* Penang: Women's Crisis Centre. 79 p.

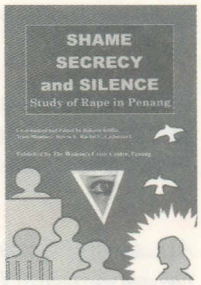
This handbook on the basic principles and guidelines for working with women in crisis was written by a working group of the Women's Crisis Centre Network. The handbook has been written for groups working directly with rape. It has five parts. Part 1 (Understanding Rape) explains the Crisis Centre's stand and definition of rape, clarifies some myths concerning rape, and details the effects of rape on survivors. Part 2 (Understanding The Crime) gives the legal definition of rape and shows the inadequacies of the law and makes recommendations for change. It also includes the shortcomings and recommendations for change of the police procedures, the medical procedures, as well as the trial, and lists the rights of rape survivors in the legal context. Part 3 (Working Towards Strength) lists the different methods of working with a rape survivor and gives a lot of useful practical tips, as well as details the qualities of the workers who help them. Part 4 (Service Options) gives practical advice (including such topics as staff, accommodation, management of services, etc.) on setting up a rape crisis unit; establishing a sexual assault/rape crisis service; linking the woman to appropriate referral points, drop-in centre, support group, hotline, shelter for women in crisis; and lists possible action on empowering women who have survived violence. The last part (Other Helpful Information) provides some short information on the rape laws of Malaysia, Singapore, India, and some other countries. A bibliography, information guidelines for rape survivors, and the members' list of the Women's Crisis Centre Network, conclude the publication.

■ **Source:** Women's Crisis Centre, 24-D Jalan Jones, 11250 Pulau Pinang, Malaysia.

Rohana Ariffin (ed.). 1997. *Shame, Secrecy and Silence: Study on Rape in Penang.* Penang: Women's Crisis Centre. 264 p.

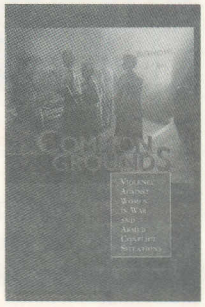
This book is the result of two and a half years of research on rape in the Malaysian state of Penang. It

consists of eight chapters. Chapter 1 focusses on the purpose of the research and the methodology used while chapter 2 looks at literature on rape. Chapter 3 contains a review of the role of the legal system, including the police department, the deputy public prosecutor's office, defence lawyers and the court. Chapter 4 looks at the role of the medical system and examines the procedures used by medical staff. Chapter 5 studies the role of the welfare department in providing assistance to rape survivors and their families. Chapter 6 explores the feelings of rape survivors, starting with the rape incident right up to the trial. Chapter 7 discusses the rapists, their socio-economic profile and their perception of the rape incident; and in chapter 8, the research team provides recommendations based on the research findings. The general recommendations include an extensive campaign on rape, training and awareness programmes, amendment to the rape laws, specific therapy for survivors and offenders, and better housing and infrastructure. Specific recommendations ask for more consistent procedures in the legal process, the formation of a special unit in the medical system for sexual abuse and rape survivors, improvement of the one-stop crisis centre, a review of the questionnaire used for assessing the medical history/examination of rape survivors, and better networking among NGOs.



■ **Source:** Women's Crisis Centre, 24-D Jalan Jones, 11250 Pulau Pinang, Malaysia.

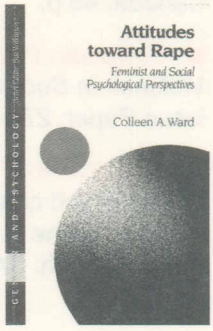
Sajor, Indai Lourdes (ed.). 1998. *Common Grounds: Violence Against Women in War and Armed Conflict Situations.* Quezon City: Asian Center for Women's Human Rights. 358 p.



The International Conference on "Violence Against Women in War and Armed Conflict Situations" held in Tokyo, 30 October–3 November 1997, highlighted the human rights violations done to women. The presentations focussed on the enormity of the tragedy the women have had to live with, the unprecedented human rights violations, the vastness of its scale in terms of the number of women affected and the sheer ruthlessness of the perpetrators, the denial of justice and repatriation, and the immeasurable ruin of human life. This book brings together the conference papers with the following objectives: to identify the various manifestations of violence against women (VAW) in war and armed conflict; to redefine and broaden the definition of wartime rape to include sexual slavery, genocide, trafficking, physical experiments, mutilations etc. as war crimes; to gather statistics and cases of violence against women in armed conflict in order to help to describe the issues and to establish the pattern of violations; to concretise the role and capacity of women's human rights groups; and to explore legal strategies in national and international courts in order to demand accountability, justice and compensation. Altogether there are 23 papers collected in this publication. The result of the conference, the Tokyo Declaration, concludes this publication and has been submitted to Ms. Radhika Coomaraswamy, United Nations Special Rapporteur for VAW.

■ **Source:** Asian Centre for Women's Human Rights (ASCENT), Suite 306 MJB Building, 220 Tomas Morato Avenue, Quezon City, Philippines. E-mail: <ascent@mnl.cyberspace.com.ph>.

Ward, Colleen A. 1995. *Attitudes Toward Rape: Feminist and Social Psychological Perspectives.* London: Sage. 232 p.



The objectives of this book are to: introduce feminist theory and research on rape myths in society; review and synthesise what is known about all-pervasive rape ideologies; consider practical application of this research; incorporate a cross-cultural perspective; and evaluate psychological research from a feminist perspective. The author examines feminist and psychological theory and research on attitudes toward rape. Drawing on a wide range of case studies, survey research, experiments, fieldwork and action-oriented research from Europe, North America and Asia, she combines qualitative and quantitative approaches to understand sexual violence. The book first highlights the negative consequences for rape survivors of biased and prejudicial perceptions of sexual violence, including those of legal, medical and helping professionals, and the impact of these attitudes on the survivors' self-perception.

In the second part of the book, the author takes a critical look at feminist action-oriented research as well as social psychological research studies, and analyses and compares their methodological preferences and research techniques. One of the most distinctive features of feminist research is power-sharing between the researcher and the research participants, a horizontal or egalitarian association; whereas the researcher, in a structured interview in social psychology, is expected to remain aloof from the

discussed topic. However, in the final analysis, it is found that there is a lot of common ground in social psychology and feminist understanding of attitudes toward rape and rape survivors.

■ **Source:** SAGE Publications Ltd., 6 Bonhill Street, London EC2A 4PU.

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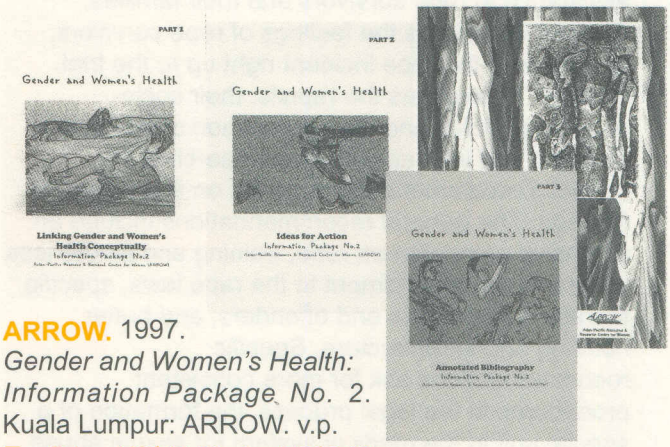
■ **Stark, Evan and Flitcraft, Anne.** 1996. *Women at Risk: Domestic Violence and Women's Health.* London: SAGE Publications. 264 p.

■ **Wiehe, Vernon R. and Richards, Ann L.** 1995. *Intimate Betrayal: Understanding and Responding to the Trauma of Acquaintance Rape.* London: SAGE Publications. 214 p.

■ **Wyatt, Gail Elizabeth [et al.].** 1993. *Sexual Abuse and Consensual Sex: Women's Developmental Patterns and Outcomes.* London: SAGE Publications. 250 p.

ARROW'S PUBLICATIONS



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■ *Price: US$10.00 plus US$3.00 postal charges. Payment accepted in bank draft.*

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■ *Differential pricing. For more information, please contact ARROW.*

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■ *Price: US$10.00 plus US$3.00 postal charges. Payment accepted in bank draft.*

ARROW. 1994. *Reappraising Population Policies and Family Planning Programmes: An Annotated Bibliography.* Kuala Lumpur: ARROW. 101 p.

■ *Price: US$5.00 plus US$3.00 postal charges. Payment accepted in bank draft.*

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Rape

Vaginal, anal and oral penetration of any orifice by physical force or threat of force/injury (penile, digital, or through the use of objects).
Source: Heise, Lori [et al.]. 1994. *Violence Against Women: The Hidden Health Burden.* Washington: The World Bank. p. 47.

From the Latin word *rapere*, meaning to steal.
Source: Rohana Ariffin (ed.). 1997. *Shame, Secrecy and Silence: Study on Rape in Penang.* Penang: Women's Crisis Centre. p. 21.

Ethnic Cleansing

The politicised and systematic rape of women for the purpose of "contaminating" the future generations of opposing forces, in a deliberate attempt to clean (to move, resettle, exile) them. Women are willfully impregnated in great numbers and released only after abortion is impossible.
Source: Rohana Ariffin (ed.). 1997. *Shame, Secrecy and Silence: Study on Rape in Penang.* Penang: Women's Crisis Centre. pp. 62–63.

Post Traumatic Stress Disorder

Is "a normal reaction to the extreme external stresses of [a traumatic experience, such as] rape". The rape survivor (or "complainant" in diagnostic terms) persistently re-experiences the traumatic event through: 1) recurrent, intrusive and distressing recollections and dreams of the event; 2) intense psychological distress at exposure to events that symbolise or resemble an aspect of the traumatic event; 3) an inability to recall an important aspect of the trauma; 4) a markedly diminished interest in significant activities; feelings of detachment or estrangement from others; 5) nagging symptoms of increased arousal (i.e. difficulty falling asleep and staying asleep, hyper-vigilance and an exaggerated startled response).
Source: Hansson, Desirée. 1993. *Rape Trauma Syndrome: A Psychological Assessment for Court Purposes.* Occasional Paper Series. Cape Town: Institute of Criminology, University of Cape Town. pp. 13–14.

Rape Trauma Syndrome

Rape experienced as trauma, is listed as one of the triggering events for Post Traumatic Stress Disorder. It is widely accepted by the mental health profession as a valid diagnostic tool, because certain of the symptoms set it apart (from other traumas), in particular impairment in sexual functioning, specific fears of men and of being touched, obsessional thoughts of contamination and associated compulsive washing. It results in a range of other specific physical (sleep and eating disturbances), psychological (dreams and/or nightmares related to the alleged rape, feelings of contamination) and behavioural symptoms (disruptions of intimate relationships, change in or loss of job).
Source: Hansson, Desirée. 1993. *Rape Trauma Syndrome: A Psychological Assessment for Court Purposes.* Occasional Paper Series. Cape Town: Institute of Criminology, University of Cape Town. pp. 15–16.

Rape: An Underreported Crime

Statistics on the incidence of rape are usually based on available police records. More often, these are inaccurate and not a true representation of the problem, for cultural and social stigmatisation associated with rape act as significant barriers to women reporting rape. Furthermore, women are more likely not to report rape if there is little support from their families, law enforcement agencies and the health sector.

In the Asia-Pacific region, national statistics on rape for many countries are difficult to obtain. Table 1 highlights the extent of the problem in the respective countries which could well include a significant rise in the different kinds of rape, such as gang rape, police rape and rape of the young. In Bangladesh for example, in 1997, an estimated 753 cases of rape had been reported, out of which 255 cases were gang rapes. There has also been incidence of women in detention being raped by police personnel.[1] In Malaysia, 55.85 per cent of rapes (1,323 cases) in the same year involved under 16-year olds. In the Philippines, it is estimated that a rape occurs every day and that half of the inmates on death row are rapists.

Table 1. Rape Situation in Selected Countries of the Region

Country	Reported cases of Rape (1997)	Legislative reforms on rape	Rape crisis services/centres available
Bangladesh	753[b]	No[a]	Yes[a]
Fiji	18[c]	No[a]	Yes[a]
Japan	1854[d]	No[e]	Yes[e]
Lao PDR	48[f]	No[f]	No[f]
Malaysia	1323[g]	Yes[a]	Yes[a]
Philippines	794 (Jan-Apr)[h]	Yes[h]	Yes[a]
Thailand	140 (Jan-Aug)[i]	in process[i]	Yes[i]

■ **Data Sources:**

[a] **APDC.** 1998. *Asia-Pacific Post-Beijing Implementation Monitor.* Kuala Lumpur: APDC. p. 141.

[b] **Ain O Salish Kendra.** 1997. *Rape 1997.* Bangladesh: Documentation Unit.

[c] **Fiji Women's Crisis Centre.** 1998. "Sexual assault statistics (reported)". [Unpublished].

[d] _____. 1998. *White Paper on Men and Women Co-participation.* Japan: Prime Minister's Office. p. 80.

[e] ARROW's participation at the seminar discussion of the *Asia-Pacific Women's Forum, 25 & 26 July 1998, Okinawa, Japan; organised by the Okinawa Women's Foundation and the Okinawa Perfectural Government.*

[f] **Chanlivong, Niramonh.** 1998. "Indicators of action on women's health and rights after Beijing: Lao PDR country paper", [paper prepared for the] *Regional Research Project on the Southeast Asian Government Organisations and Non-Government Organistions Capacity to Implement and Monitor the Health Section of the Beijing Platform for Action;* co-ordinated by the Asian-Pacific Resource & Research Centre for Women (ARROW). pp. 34–36.

[g] **Royal Malaysia Police, Perak.** 1998. *Statistics on Rape Cases According to Contingents For the Years 1995, 1996 and 1997.* Malaysia.

[h] _____. 1998. "New rape law sides with victims—Philippines". *Balance.* Fiji: Fiji Women's Rights Movement (FWRM). March–April. p. 5.

[i] _____. 1997. "Women's rights situation in Thailand". *Friends of Women Newsletter.* Vol 8, January–December. p. 7.

Figure 1. Conducive Factors which Increase Women's Willingness to Report Rape

- Laws protecting confidentiality and disclosure of survivor's name
- Public education about acquaintance rape
- Expanding counselling and advocacy services
- Accessibility of abortion services for rape survivors
- Mandatory HIV/AIDS testing for those indicted for rape
- Confidentiality from testing for HIV/AIDS or STDs

■ **Source: National Victim Centre** and **Crime Victims Research and Treatment Center.** 1992. *Rape in America: A Report to the Nation.* p. 11.

Information such as rape incidence is vital, for any type of intervention to take place. However, the flipside is that rape is considered an offence only when it is reported and in many instances, it goes unreported. So why are women still unable or unwilling to seek help? Figure 1 illustrates some of the factors that may encourage women who have been raped to come forward with their cases. In order to address rape, the concerns of rape survivors have to be taken seriously. Police personnel, religious authorities and health workers need to be sensitised in dealing with rape survivors. Already in some countries, government organisations and NGOs have taken the initiative to set up crisis centres for rape survivors in collaboration with the different sectors of the community. Moreover, countries which have recently passed laws or reformed their penal codes to broaden the definition of rape (which includes marital rape), have done so as an outcome of the lobbying efforts of women's groups. The challenge to make sure that the law is not prejudicial against women remains, and that the law is properly enforced to ensure the protection of women. By providing suitable legal support and health services, it is hoped that the responsibility of dealing with rape would fall on society rather than on women, and survivors would then feel encouraged to come forward to report rape.

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[1] **Tabibul Islam.** 1997. "Bangladesh: police role in rape case triggers huge protests". World News, Inter Press Service. [From the Internet, http://www.oneworld.org/ips2/aug/bangladesh.html]

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