COMPARING SEXUAL ASSAULT INTERVENTIONS

Mapping the current situation:

Findings from the telephone interviews with stakeholders

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CONTENTS

Acknowledgements
Health Action Partnership International gratefully acknowledges the support of all the people who gave their time to be interviewed or contributed information in other ways. A list of all those who were interviewed is included as appendix 1. In addition, we would like to thank the project partners and associate partners who provided advice on the methodology and suggested stakeholders to invite for interview. Finally, we would like to thank those who completed the survey questionnaire and other project contacts who suggested stakeholders to interview.

Explanatory note
This report summarises and synthesises the views of a range of stakeholders from different countries and sectors. It is intended to present the perspectives of those stakeholders, rather than to provide a comprehensive description of services available. The views in this report do not represent those of the European Commission, HAPI, the project partners and associate partners or any single individual or organisation interviewed as part of the research.

1 Background

1.1 About the project

The *Comparing Sexual Assault Interventions* project is funded by the European Union (EU) as part of the DAPHNE III Programme 2007-2013 that aims to contribute to the protection of children, young people and women against all forms of violence.

The goal of the *Comparing Sexual Assault Interventions* project is to improve the effectiveness, appropriateness and humanity of sexual assault services by reviewing current practice and taking on board user attitudes to interventions following sexual assault, and therefore decrease the social, mental and health harm caused to the victims of sexual assault. The project objectives are:

1. Define the evidence base of policies and programmes for dealing with sexual assault by reviewing the international literature.
2. Explore what models of intervention for victims of sexual assault exist in EU Member States and EFTA/EEA countries.
3. Examine the positive and negative impacts of these models of intervention on the health, social and criminal justice outcomes of victims of sexual assault, from the point of view of the victims.
4. Compare the acceptability, transferability, effectiveness and efficacy in achieving their outcomes, including by seeking women's views of services provided.
5. Develop recommendations on good practice, and tools and training materials to build capacity and promote excellence.

The project began in April 2011 and is due to be complete by April 2013. The project is coordinated by the National Heart Forum / Health Action Partnership International (HAPI) and is supported by a steering group of project partners including Liverpool John Moores University (UK), Victim Support (Malta), the Latvian Association of Gynaecologists and Obstetricians (Latvia), the East European Institute for Reproductive Health (Romania) and the Educational Institute for Child Protection (Czech Republic). The Department of Health (England) and the European Regional Office of the World Health Organization are associate project partners. The project has four workstreams as follows:

- Workstream 1: Mapping the current situation
- Workstream 2: Developing a research & evaluation tool
- Workstream 3: Dissemination of findings
- Workstream 4: Developing training materials and trainers.

1.2 Overview of workstream 1: mapping the current situation

The aim of workstream 1 of the project is to map the current situation in the EU in terms of models of intervention for victims of sexual assault and to identify key stakeholders across the EU. The outcomes of this will be used to develop and inform workstreams 2, 3 and 4.

Workstream 1 includes three activities:

- A literature review;
- A survey of WHO health ministry violence prevention focal points; and
- Telephone interviews with stakeholders.

This report presents the findings from the telephone interviews with stakeholders. The literature review and survey findings are each presented in a separate stand alone report. A policy briefing summarises the findings and analysis from these three research reports.

1.3 Scope of the project and definitions

The scope of the project is limited to women aged over 16. This is because there are particular issues involved in criminal cases, medical treatment and other services for young women and girls aged under 16. In addition, while the project recognises that sexual assault also affects men and boys, their needs for services are in some respects different from those of women. Therefore, this project is limited to exploring services for women.

This report uses the term *sexual assault* throughout to describe rape and other forms of sexual violence.

2 Methodology for the telephone interviews

2.1 Purpose of the telephone interviews

The project description outlines the purpose of this activity as:

> *to conduct telephone interviews with key informants to identify pros and cons of various models and how transferable they are to different social and cultural settings with different delivery mechanisms and legislative frameworks.*

2.2 Selecting countries

Interviews were conducted with stakeholders in seven different EU member states. Focusing on a smaller number of countries, rather than seeking to interview a stakeholder from each of the 31 countries included in the scope of the project, meant that several stakeholders could be interviewed from each country. This approach was designed to ensure the telephone interviews captured the complexity of issues and reflected different perspectives.

Countries were selected to ensure a spread of geographical coverage across the EU. The seven countries selected are as follows:

- Austria
- Bulgaria
- Denmark

- Latvia
- Romania
- Spain
- UK: England and Wales

2.3 Process for selecting interviewees and setting up interviews

The telephone interviews were set up by HAPI, with support from the project partners and associate partners. Stakeholders who were invited to participate in the interviews were identified by respondents to the project survey questionnaire, by project partners and by asking interviewees to suggest other people who might have useful information and perspectives. For each of the countries selected the aim was to undertake interviews with three stakeholders from different sectors and/or disciplines in order to get different perspectives. In particular, efforts were made to interview those engaged with service delivery, as well as those involved at a strategic or policy level, and representatives from NGOs.

Initial requests for interviews were sent out on 2nd January 2012 by e-mail. A copy of this is attached as appendix 2. A brief overview of the project was also sent out as an attachment to the e-mail. A reminder was sent to each stakeholder who had not responded on 16th January. Stakeholders were asked to suggest an alternative person whom we could request for interview if they did not feel they were able to participate themselves. Project partners and interviewees were also requested to suggest additional stakeholders for those countries where the responses had been low.

At the end of the process between three and six stakeholders had been invited to be interviewed from each country. A total of 20 telephone interviews were carried out with between two and four stakeholders interviewed from each country. Two stakeholders also gave information by e-mail. More details about the interviewees are provided in section 3 of this report.

2.4 Design and implementation of the interviews

The telephone interview questionnaire was drafted by HAPI and amended and approved by the project partners and associate partners. A semi-structured questionnaire using open-ended questions was used. This meant each interviewee was asked the same standard open questions. In addition, the interviewer asked follow-up or probing questions to explore relevant issues in more detail. The interviewer gave examples as prompts where requested or if the interviewee did not understand the question. The main questions, follow-up and prompts were as follows:

1 Can you please describe your organisation and your role?
2 Could you describe the models of service delivery for women who have been sexual assaulted that are available in your country? *Prompt: Models include medical treatment in a hospital, forensic*

examination in a hospital or police station, other support services or a single integrated service.	
If service models were described:	***If no service models were described:***
2.1 Which model has been most effective?	2.1 If a woman is sexually assaulted if your country, is there any support available for her?
2.2 What do you consider has been particularly effective?	2.2 Are there any particular factors that limit or block the provision of services? *Prompt: This could include lack of awareness about the issue, lack of funding, no staff capacity, no political commitment.*
2.3 What are the factors that have made it effective? *Prompt: This could include high level support, training for staff, information to publicise services.*	2.3 What could support the development of services? *Prompt: This could include awareness raising, training, dedicated funding.*
2.4 Do you think these service models might be transferable to other countries? *Prompt: This depends on whether there are any unique factors specific to your context that make them effective.*	2.4 Do you think examples of services from other countries might be helpful
2.5 Has there been any evaluation of these services?	
2.6 Are there any services that do not work so well or are not so well used?	
2.7 If so, what are the reasons for this?	
3 What is or would be a good measure of the effectiveness and appropriateness of services in your country? *Prompt: For example, women attending for medical care or counseling, follow-up outcomes, conviction rates.*	
4 Are there any particular social, cultural or other factors that impact on how women use sexual assault services in your country?	

Prompt: This could include things like acceptability of sexual assault, stigma about sexual assault, women's empowerment.
5 Are there any particular legal or political issues that influence sexual assault services in your country? *Prompt: This could include things like high support and strategies for women's empowerment, legal definitions.*
6 Is there anyone else you think it would be useful for us to talk to?

Interviews were conducted by HAPI. At the start of the interview, the interviewer gave a brief overview of the project, described the purpose of the telephone interviews and explained that direct quotes would not be attributed. The interviewee was asked if they consented to their names being included in the list of interviewees provided in the report. The interviewer asked if the interviewee had any questions or additional information that had not been covered at the end and thanked them. The interviewees were informed they would be sent the report and the details of the project web site.

Of the 20 interviews, 17 were conducted in English and three were conducted in Spanish. All the interviews in English were conducted by a single interviewer to ensure consistency. The interviews in Spanish were also all conducted by a single interviewer. The two interviewers worked closely together and used the same materials for the interview (request for interview, project overview, interview questions, interview record sheet).

2.5 Analysis of the telephone interviews

Interviewers took detailed notes of interviews which were then written up in a standardized interview record format immediately afterwards. Interview notes of the interviews conducted in Spanish were translated into English.

Interview notes were entered into an excel spreadsheet using the following classifications:

- Country
- Name
- Organisation
- Role
- Sector
- Models of service delivery
- Most effective
- Why effective
- Transferable
- Evaluation
- Not so effective
- Why
- Blocks to services

- Support required
- Examples from other countries
- Good measure of effectiveness
- Social, cultural or other factors
- Legal or political issues

This was used to identify key messages for each country included in the telephone interviews and common themes between countries. Issues of divergence or different opinions were also identified.

2.6 Timescale

Initial requests for interview were sent out on 2nd January 2012. Interviews were carried out between 6th January 2012 and 28th February 2012. Analysis was undertaken between 15th and 28th February 2012.

2.7 Limitations of the telephone interviews

Telephone interviewing as a research method has several acknowledged limitations. Firstly, the time the interviewee has available is likely to be more limited than with face to face interviews which meant some interviewees did not answer all questions in the same detail. Secondly, visual cues that help explain and contextualise questions and answers are missing so interviewees may have had different understandings of the questions. Finally, in this case some interviewees spoke English more fluently than others which may have impacted on the level of detail provided by different interviewees.[1]

It is also important to stress that the number of interviewees and the way interviewees were selected was in no way intended to provide a representative sample. The purpose of the interviews was instead to gather information from people engaged in designing and delivering services for women who have been sexually assaulted about their views and perspectives about these services.

Following on from this, it should be emphasised that it was outside the scope of the interviews to verify whether the information provided by interviewees was factually correct. Because interviewees came from different sectors and disciplines, they brought different perspectives. Some of these perspectives differ from each other. Therefore, the findings reported in each country section do not represent the views of all the interviewees from that country, but rather include significant issues raised by the different interviewees. Where there are marked differences in the views of interviewees or where all the interviews agreed on a particular issue, the report highlights this.

[1] All interviewees were asked if they were comfortable to be interviewed in English in the invitation e-mail.

For all the above reasons this report does not provide a quantitative analysis of the information provided by interviewees. Such an analysis would be misleading as it would suggest there is direct comparability between interviewees and the information they each provided. Instead the report draws out the common themes, key issues, important challenges and contextual factors described during interviews by stakeholders involved in designing and delivering services for women who have been sexually assaulted and raped.

It is also important to stress that the views in this report do not represent those of the European Commission, HAPI, the project partners and associate partners or any single individual or organisation interviewed as part of the research.

3 Overview of interviewees

In total 20 stakeholders were interviewed and two provided information by email. The breakdown of these interviewees by sector, role and country is given in the table below.

Country	***No. of interviewees***	***Sector***			***Role***		
		NGO	***Regional/ national gov***	***Other (hospital, service provider)***	***Policy or strategy***	***Forensic /criminal justice***	***Service provider/ advocacy***
Austria	2	0	1	1	1	0	1
Bulgaria	2	2	0	0	0	0	2
Denmark	3	1	0	2	0	0	3
Latvia	6[2]	1	5	0	3	2	1
Romania	3	0	0	3	0	1	2
Spain	3	1	1	1	1	0	2
UK	3	1	1	1	2	0	1
TOTAL	*22*	*6*	*8*	*8*	*7*	*3*	*12*

4 Findings from each country included in the telephone interviews

4.1 Austria

Overview of services described by interviewees:

- There are six regional rape crisis centres that provide counselling and support. One is open round the clock.
- There is a 24 hour free women's helpline that also covers sexual violence.

[2] 2 of whom provided information by e-mail.

- There are violence protection centres established under legislation around family violence.
- Counselling centres provide legal advice and counselling.
- There is an intervention centre for women trafficking (Austria is a country of transfer and destination).
- Hospitals have victim protection teams.
- There are guidelines for medical professionals.
- Kits have been developed for doctors in hospitals to do forensic examinations. Evidence is then stored for 1 year so the woman can decide whether to make a complaint to the police. This means one doctor does forensic examination and the examination for treatment.
- There are specially trained women police officers who can take a complaint of rape.
- The overall system is considered good. Sometimes it does not work, for example a doctor may report to the police without the women's knowledge. But this is where individuals do not follow the system, rather than poor systems or a lack of systems.

Issues raised by interviewees:

- One interviewee said it is important to have a helpline open 24 hours a day, 7 days a week. If a woman decides to call and then gets an answer machine, sometimes she will not call back. Many services stop at 6pm just when a woman is most likely to call as she is arriving home from work. To date in Austria everybody accepts there has to be a 24 hour service. There has not to date been any attempt to restrict the service.
- The collaboration between police, hospitals and victim support services in Vienna is good.
- There is a very high level of underreporting. Going through criminal procedures is perceived as being an ordeal. Judges have too little knowledge and sensitivity. In cases of rape, there are 2 lay judges as well as a trained judge. But it is very difficult to train these lay judges because they are selected randomly.
- The numbers affected by sexual violence is very high. A November 2011 study interviewed 1,300 women. One third had experienced sexual violence.
- It is difficult to know how much the fear of reporting is based on reality, incorrect perceptions or stigma. This really needs further research.
- Much has been done on domestic violence to change attitudes. The same needs to be done on sexual violence.
- A recent study found that two thirds of women who experienced violence in the family also experienced sexual violence. There is a strong overlap.
- If services are integrated with other services for women, women may not talk about sexual violence. Sexual violence is still much more difficult for women to talk about than domestic violence. It is much more of a taboo.
- Language and availability of translation is important.

- Age is also important. An older woman is unlikely to want to be supported by a younger woman. Older women often find it more difficult to talk about sexual violence. There is a lot of taboo.
- Women may prefer to be supported by someone from their own culture but not always. Sometimes they need distance. They may be worried they will have acquaintances in common or will be judged more by a member of their own community.
- Women from better off backgrounds rarely use public services. Mainly poorer women use rape crisis centres. Maybe women from better off backgrounds prefer private services as there is stigma attached to public services.
- The closer the perpetrator is the more difficult it is too talk about.
- Language is important. The community gets to know if there is a counsellor that speaks that language. Interpreters take time to organise. If an interpreter needs to be arranged for a future date, sometimes the women do not come back for this appointment.
- Domestic violence gets more attention because there is less taboo.

4.2 Bulgaria

Overview of services described by interviewees:

- There is no specialised service for women who have been raped. There are only general services for domestic violence and discrimination. These services also deal with children and families. Women will not talk about sexual violence, only physical violence, in these services. There is a need for separate rape crisis centres to deal with the under reporting.
- Very few women go to the police. Many women clients believe that the police are not trusted. They re-victimise women by blaming them for the assault.
- Women would only go to hospital if there is a physical injury requiring treatment.
- Women are most likely to go to one of the women's NGOs. These provide psychological support and other crisis services.
- Women often go to an NGO for counselling. This means they miss out on forensic examination and the chance to take their case to court.
- Sometimes where they report to the police the police will refer them to an NGO.
- One interviewee said there may be a specialist police unit in Sofia for sexual violence but did not know any details.
- Medical services, for example emergency contraception, are available but many women do not use them.

Issues raised by interviewees:

- Interviewees reported very significant under-reporting of sexual violence. One suggested only 10% of cases are reported. There are very strong gender stereotypes. Women are considered to cause sexual violence through their

behaviour. There is a predominate attitude of blaming women for sexual violence. Most women do not even tell their families. Community education is needed to change this.

- There is no recognition that the state needs to provide services in this area.
- There is no money at the municipal level. All funds are held by central government.
- There is a very poor trust of institutions.
- More staff training is needed.
- More funding is required.
- There is a need for more support through networks with organisations that provide similar services to share experiences.
- The most important services are psychological support, assistance and education for family members so they can help the woman, education and awareness raising for professionals and communities.
- There is a strong resistance to gender politics, for example there is no plan for violence against women. This may be a legacy of the formal equality under socialism.
- Sexual violence is very strongly stigmatised. There is support for domestic violence prevention, but nobody will talk about sexual violence.
- There are more blaming attitudes towards women in the Roma community. Girls start having sex younger – often aged 12 or 13. It is very difficult for Roma women to get help. Roma communities are very suspicious of outsiders.

4.3 Denmark

Overview of services described by interviewees:

- There are specialist centres for rape victims. The biggest is in Copenhagen which sees around 300 clients a year. They see men and women, though the vast majority are women. There are other centres in Aarhus and other towns which see smaller numbers.
- Typically women who have been sexually assaulted will go to the police and the police will bring them to the nearest centre.
- People who do not report to the police can come direct to the centre themselves.
- At the centre the woman will be met by a specially trained nurse who will stay with them. They have a forensic examination and if they have more serious injuries they can also be seen by a trauma physician. The next day the lead psychologist calls the women and asks her to come for a face to face interview.
- Some women come for counselling a long time, some come just once.
- The centres can also support the woman by accompanying her to court if needed and can liaise with police to follow up on her case. The centres have close links with the police.
- If women come out of service hours they will see the gynaecologist on call.

- The centres are currently only available to people who have experienced the assault in the previous 3 days. One interviewee said this is likely to be extended soon to the previous 6 months.
- Joan-Søstrene, an independent organisation run and staffed entirely by volunteers, provides telephone support and counselling to women who have suffered sexual assault and advocates for legal and social change and service improvements.

Issues raised by interviewees:

- There is a wide variation in the quality of services between urban and rural areas. Women who don't report to the police are often not getting help because they can't get transport to the specialist centres (unless they report to the police who can take them). There is a new national working group looking at this. They are exploring a hub and satellite model where there will be 3 or so specialist centres and smaller centres that take clients to the bigger ones where needed.
- It is a big challenge to get women to come for follow-up. Around 50% of the women are under 25. Many have other problems. Sexual assault may be one part of a bigger picture. Follow-up is an important opportunity to help these women. But this is a real challenge because it is difficult to get them to see the follow-up as important.
- Early on some of the centres decided to have only women doctors. But recent research indicates that as long as male doctors are respectful, women don't mind seeing them. A female nurse is always present.
- Collaboration between the police, the medical service, forensics, research and psychology is seen key to the success of the centres. This helps each player to understand the different roles each play.
- One interviewee said the pro-active offer of psychological help is very important. Many women would not ask for this themselves if not offered.
- Another interviewee said that the psychological help available for victims was very inadequate.
- The fact that all the help is offered together from one centre is important. Some women would get all the services otherwise.
- User evaluation is undertaken at the centres. In general this is quite positive. Some women do not return the questionnaire and it is not possible to chase these in case it is traumatic for the woman to complete this.
- Some research is currently being undertaken to look at whether doing a 6 month follow up of women to see if they are experiencing PTSD symptoms causes trauma. In most cases this does not seem to be so. However, some women do get upset.
- The time limit in accessing the centres is restrictive. At the moment women need to come within three days of the assault or they can't use the service. This is not long enough. Many women try to cope alone and only later realise they need help.
- The centres currently do not have enough resources.

- There is not enough research on the acute psychological needs of women who have been raped. This means it can be difficult to design services that meet their needs.
- Many women have broader problems so it is difficult to disentangle symptoms of the rape from symptoms of other problems.
- A significant minority of clients are very socially burdened with low social status. It may be that higher social status women are not accessing the services because they are less likely to report the attack and/or because the experience is more contradictory to their views of themselves.
- Muslim women come in very small numbers and the centres are doing work to try to encourage them to come. When Muslims do come they have particular problems. They often don't want their families to know. They are often worried about their hymens.
- Sex workers are unlikely to come.
- One of the reasons the centres were set up was to integrate services for people who have been raped so they are not examined with just male police officers in the police station, thereby supporting women reporting to the police. There has been no change in the numbers of women who report to the police since the centres were open. At the Copenhagen Centre around 30% of clients don't report to the police. Conviction rates remain very low.
- One interviewee said the attitudes, sensitivity and awareness amongst police are very poor and women are blamed and re-victimised in encounters with the police.

4.4 Latvia

Overview of services described by interviewees:

- There are no specialist units for providing dedicated services to sexual assault victims.
- The emergency department of a hospital is the most common provider of services to women who have been sexually assaulted. Services are free.
- There were different perceptions among interviewees about whether it was compulsory for medical establishments to report to police within 12 hours when providing medical treatment to a patient there is a reason to believe that the patient has suffered from sexual violence or whether this is dependent on what the patient wants.
- One interviewee said women are unlikely to go to hospital because they do not trust the services and believe professionals will blame them.
- Some women may also see their family doctors.
- Training has just started in sexual violence for gynaecologists under the professional association for gynaecologists. Gynaecologists who have been trained are in insufficient supply because the training has only just started.
- Forensic work is done by a separate forensic medical department which is open 24 hours a day, seven days a week.
- The definition of rape is based on force and vaginal penetration. The police will expect some evidence of force, for example torn clothes or other injuries.

- The victim of a sexual assault has to initiate a criminal case by writing an application. In other criminal cases the police do this. This is to ensure criminal action only starts in those cases where the victim wants to take action.
- There are some "crisis centres" in municipalities that provide residential accommodation and support for women and children but they are usually full so not an option in an emergency. This service is integrated within services provided for victims of domestic violence.
- Women who have been trafficked for sexual exploitation receive support for social rehabilitation paid for by the State.

Issues raised by interviewees:

- There was a request from several interviewees for practical exchanges with countries that have good services in place to see how other countries do it. Norway is known to be very good.
- One interviewee considered that a change has occurred in recent years in how sexual assault and violence is seen. It is now much more discussed and there is more attention on the needs of victims.
- NGOs have been very active in this area, especially family violence.
- The law has been changed very recently to include family violence in the criminal code.
- One interviewee said the police are not effective, for example they gave a traumatised woman a copy of the law on social rehabilitation to read.
- Family doctors are now much more aware of sexual violence and have been asking for more support and services.
- Women sometimes do not get health support because they are worried about confidentiality as doctors have to tell the police. This is particularly so in rural areas with low density.
- Trafficking of women for prostitution is a big problem. This gets a lot of public and media attention. But there is very little understanding of the problem. Women are blamed for being stupid. What is really needed around trafficking is more public education to increase awareness of the nature of the problem. At the moment the courts give harsh sentences but this will not stop the problem. Women who are young, unemployed and uneducated and from social risk families are most exposed. They are recruited through social networks. Some are already working as sex workers. There is currently a major inter-departmental project on violence prevention that involves police, health, welfare, education and other depts. It includes education, work with high risk groups, sharing data.
- The Law on Social Services and Social Assistance obliges the state to provide social rehabilitation services for adult persons who have suffered from violence. However it has not been possible to implement this yet due to severe cuts in the budget. It is planned that the state financed rehabilitation will be provided beginning with 1 January 2015 and that victims of sexual violence will be one of the priority groups to receive state financed rehabilitation.

- There is no single NGO in Latvia that specialises in victims of sexual assault and sexual violence.
- Sexual violence is often considered to be the woman's fault. A year ago a national newspaper published a feature where professionals such as psychologists said it was the victims fault which started a debate in the media.
- One interviewee said that training in victim care for staff involved in forensics was urgently needed.
- There are very strong gender stereotypes. This was considered by one interviewee to be a legacy of soviet society. Women had labour market equality but very strong traditional roles for women in the home.
- Latvia is a very small society (2 million people). Especially in the countryside, there is no confidentiality, for example the police are likely to personally know a victim's family. People want anonymous services in Riga.
- In general sexual violence was not considered to be a political priority. Other victim groups, for example children and trafficked people, get more attention.

4.5 Romania

Overview of services described by interviewees:

- Interviewees had different perceptions of the role of forensic medicine. One interviewee said that it was obligatory for a hospital to refer a woman patient reporting sexual assault to the forensic medical department for examination before treating her. Another interviewee said this was not obligatory.
- Although some forensic centres are open 24 hours a day, some are not open at night or at the weekend so women may have to wait without washing or changing their clothes. One interviewee said this means they cannot be given the necessary medical treatment such as emergency contraception or prophylaxis immediately because they have to wait for a forensic examination.
- There are variations in the services available and their quality between doctors and hospitals.
- For the last 5 years several emergency departments have been recruiting social workers. A woman who has been sexually assaulted will first of all see the social worker. The social worker will call the police, accompany the woman for her gynaecological examination and go with her for the forensic examination.
- There is a national programme whereby women who have been sexually assaulted can be tested for sexually transmitted diseases. They also get free antibiotics for prevention.
- There is a national programme that provides free counselling for women younger than 24.

Issues raised by interviewees:

- A major problem is under-reporting. The services are only available to the women who come to the hospital, police or forensic department.
- There is a lot of stigma around sexual assault. One interviewee said that women do not have confidence in the police or the system. They think they will be treated with disrespect.
- Very low levels of education amongst the groups most at risk contributes to under-reporting.
- There are no national protocols so it is up to individual hospitals to design their own services. This means there is no national data and there is a large variation in the quality of service between different areas.
- One of the most important priorities is to raise awareness of the available services.
- Training for staff is needed. There is not enough personnel. Social work is still a developing discipline in Romania.
- There is no DNA testing available outside Bucharest so this service is only available in specific cases.
- One interviewee reported that there are many false complaints from young women practicing prostitution who do not get paid as agreed and from young girls who engaged in agreed intercourse but their parents are unhappy when finding out about it.
- Sexual assault gets very little media attention.
- There is ethnic pressure in the Roma community. Domestic violence rates are very high in that community. Domestic violence and sexual violence often go together but it is very difficult when people live together and have children together to understand if sexual violence has taken place.
- A particularly Romanian issue is that there are sizeable numbers of young people who are HIV positive who are now just getting to the age where they are becoming sexually active. These are from poor, uneducated communities which are more likely to be affected by rape. This is a public health issue.
- Sexual violence does not seem to be a political priority. Domestic violence gets a lot more attention from the media and politicians than sexual violence.

4.6 Spain

Overview of services described by interviewees:

- Spain is a federal type government where each regional government has responsibility for health care within their region. Therefore, different strategies and models of service delivery are used in different regions. Interviews were carried out with stakeholders in Catalonia, the Canary Islands and La Rioja.
- At the national level, the Ministry of Health published in 2007 a Protocol with recommended actions for victims of sexual violence and sexual assault. The Protocol introduced a guideline to reduce the psychological impact on victims by having the forensic and medical examination done at the same time. The forensic doctor performs the first and the gynaecologist the latter. It stipulates that women who have been assaulted either report directly or are

taken to the hospital for the immediate medical, forensic and psychological care. Whether the woman decides to go through or not with the criminal prosecution, the judicial system is notified about the assault, but the forensic examination is only performed if the victim decides to report.

- There are a number of NGO/women's associations that work to help and support women who are victims of gender violence more generally. Some women attend these services without referral, but for the most part, they are referred to these centres by the hospital or primary care centres. In particular they deal with psychological support in both the short- and longer-term.
- Hospitals deal with immediate and urgent care. Primary care centres are responsible for prevention/detection and post-hospital follow-up, including STD and HIV tests results and treatment, and psychological care. There are protocols for action for both primary care centres and for hospitals.
- NGOs and specialised services provide mental health and judicial support but these operate within the broader context of violence against women.
- Some of the hospitals in Catalonia have created specialised units for victims of sexual assault. In all cases, the specialised unit is part of the psychiatric department of the hospital and it includes doctors, gynaecologists, forensic doctors, doctors specialised in STDs and HIV, and psychiatrists.
- Some regional governments have a coordinated strategy to deal with victims of gender violence and sexual assault. La Rioja is one example. The regional strategy was designed by all the institutions and third sector organisations that play in role in dealing with victims. It was coordinated by the Regional Government and it identifies the roles and responsibilities of the health and legal sectors, social services and regional penitentiary.

Issues raised by interviewees:

- NGOs and associations currently carry the largest burden dealing with women who are victims of gender violence. The public sector funds these, but consistent and long-term funding has not been "institutionalised". In addition, there is little communication and collaboration between the NGOs and the health sector.
- One interviewee thought the specialised units were effective in terms of dealing with the immediate care for the victim and for putting in place the follow-up mechanisms in terms of medical and psychological care. However, the interviewee criticised the approach of psychological treatment for victims of sexual assault as too medical, that is, not enough support and counselling and too much reliance on medication, such as antidepressants.
- Victims can also be referred to NGOs for long-term psychological support. However, these services are saturated and lack human and financial resources to deal with the number of clients.
- Many NGOs deal with gender violence more broadly and the personnel do not have specific training on sexual assault and dealing with these victims.
- At the national level, there are regional inequities in terms of service availability, quality and implementation of the national protocol.

- Criminal cases are to be treated equally and on a systematic basis. Judges and forensic doctors have not been trained in gender violence issues and crisis intervention.
- There is not enough awareness of the extent that gender violence is a health problem, in addition to a social problem. Professionals from the health sector need to treat this with the same importance that they do with other health protocols, such as those for cardiovascular disease, diabetes, etc.
- Gender violence and sexual violence are not a political priority, although there is recognition about the problem. More is needed in the areas of professional training and demystification among professionals and the general population.
- One of the shortcomings of the way services are delivered is that they are not evaluated based on quality indicators. Instead, the evaluations are done in quantitative terms in relation to the number of patients seen and whether the protocol was followed.
- One problem is the lack of appropriate training of professionals. There is more training needed not only in terms of prevention, treatment and follow-up as part of their profession, but also in terms of what and how they communicate with women prevention measures and what to do once they have been assaulted.
- Protocols and policies on sexual violence are integrated within the broader context of gender violence, which diminishes the importance of sexual violence as a unique phenomenon.
- Sexual assaults are seen as "semi-public" offences by which a woman is within her rights to not report the assault to the police and criminal justice system and the latter cannot pursue it on their own despite having all the evidence to prosecute the assailant.

4.7 UK

Overview of services described by interviewees:

- In many areas Sexual Assault Referral Centres (SARCs) bring together medical, forensic and other services for women in a single site. Where these exist, women who report rape to the police will be brought to the SARC. There is no mandatory requirement to have a forensic examination or prosecute. SARCs are considered to provide a better service by women. Even if they have to travel some distance to get to them, this is considered worth it. The client-/victim-centred approach is valued.
- If there is no SARC in the area the woman will be seen at the police station in the rape suite. In these areas the police will commission services for these women.
- NGOs such as rape crisis centres also offer support for women. Rape crisis centres take self-referrals and referrals from the NHS (General Practitioners and hospitals) and the police. Rape crisis centres do not cover all areas, though funding for 15 new centres has recently been agreed.

- Usually referral to a SARC is through the police. But not all victims go to the police first. Some contact a rape crisis centre or another NGO. Therefore, the SARCs and NGOs have different pathways.
- SARCs have a limited cut off point so they refer on to NGOs and other services for on-going care and support.

Issues raised by interviewees:

- The quality of rape suites where there are no SARCs is very variable. Research has found a huge range of quality of service available. Broadly speaking this follows a rural/urban divide. There is a really good gold standard in some areas, mainly those with well-established SARCs. But in other areas the quality of service was poor. There is a high variation in workload, referral rate, funding per case.
- The commitment and attitude of staff is key. There is a need to recruit for attitude as well as skill.
- One major issue is around rotas for doctors. Where there are joint rotas (which means that the doctor on call is responsible for all issues in the police station) the doctors are often very busy. Also because there are so few women doctors, there is often a long time delay before a woman can get to see a female doctor. In practice this means that women sometimes have to choose between seeing a male doctor quickly or waiting hours or even days to see a woman doctor. Evidence shows that once a girl reaches puberty she wants to see a woman doctor.
- The perception amongst police that false allegations are common among women aged 25 to 35 is strong. Younger and older women and men are more likely to be believed.
- Relationships between SARCs and NGO providers are key and services are most effective where these are good.
- The longest established SARCs are most effective, as they have had time to learn lessons and improve.
- The SARC service model is expensive because staff is needed on hand just in case there is a client. A hub and spoke model is being explored now.
- The UK is multi-cultural so there are many different factors for different communities.
- SARCs are very important but there are problems. One interviewee said SARCs are supposed to accept self-referrals but some are not open to these in practice. This means the many women who do not report to the police do not access SARCs. Also in some areas SARCs have created a hierarchy of care because rape crisis centres are expected to deal with SARC referrals first.
- One interviewee said there is a real need for services for women who have been raped on holiday.
- Women want long term counselling. One interviewee said because SARCs are often perceived as part of the criminal justice system women may not want to go to the SARC to receive this.
- Sexual violence is getting political attention now. For example, funding for 15 new rape crisis centres has been agreed. However, this is vulnerable as it is

based on the commitment of an individual politician. If she moves, the next person might not be supportive.

- One interviewee said service providers do not understand gender. They think they have to treat everybody the same. They do not understand the difference between formal and substantive equality.

5 Key messages about services

5.1 The types of services described

Specialist services provided by statutory or public service providers to meet the needs of women who have been sexually assaulted were described by interviewees in three of the seven countries. These are:

- In England Sexual Assault Referral Centres (SARCs) bring together medical, forensic and other services for women in a single site. These exist in most areas of England and there is a commitment to expand them so all areas are covered.
- In Austria there are six regional rape crisis centres that provide counselling and support. One is open round the clock.
- In Denmark there are specialist centres for rape victims. The biggest is in Copenhagen which sees around 300 clients a year. They see men and women, though the vast majority are women. There are also centres in Aarhus and other towns which see smaller numbers.

Spain is a federal type government where each regional government has responsibility for health care within their region. Therefore, different strategies and models of service delivery are used in different regions. Interviews were carried out with stakeholders in Catalonia, the Canary Islands and La Rioja. Some of the hospitals in Catalonia have created specialised units for victims of sexual assault.

Additionally, in several countries including England, Denmark and Austria, interviewees described specialist NGOs that provide services for women who have been sexually assaulted. These were reported by interviewees to supplement and complement the services provided by public providers. In most cases pathways of care are complementary, with referrals between public providers and NGOs. This was considered to be important by many interviewees as some victims will seek help from an NGO but will not be prepared to approach public service providers.

In the other countries included in the interviews a variety of services were described. These include:

- Services for women experiencing domestic violence and discrimination that also deal with children and families;
- NGOs that provide services including psychological support for women experiencing gender violence;
- Treatment in emergency departments in hospitals;
- Social workers in emergency departments in hospitals;

- Family doctors and primary health centres;
- Gynaecologists;
- Forensic medical departments;
- Crisis centres provide residential accommodation and support for women and children fleeing violence;
- Police services;
- National programmes providing free testing for sexually transmitted diseases and prevention;
- National programme that provides free counselling for women younger than 24;
- Medical services, for example emergency contraception.

5.2 Services considered effective and what is effective about them

Specialised services for women who have been sexually assaulted were considered by most interviewees to be an effective form of service delivery in those countries that had these services. Several interviewees from countries that did not have specialised services also believed they were the most effective form of service delivery. Factors that were considered to make these services effective were:

- This approach minimises the exposure of the victim to different professionals at different times. In particular the forensic and medical examination can be done together which is reported to be less traumatic for women.
- Women are more likely to disclose and seek help for sexual assault in a specialised centre than a general women's support service. Because it is much more stigmatised than other forms of violence, women tend not to disclose sexual assault in more general services.
- This form of service provision supported collaboration between the police, the medical service, forensics, research and psychology. This helps each player to understand the different roles each play.
- These services pro-actively offer psychological help that many women would not ask for themselves if it was not offered.
- The fact that all the services are offered together from one centre. This means it is easier for women to access these services.
- Because some of victims also have multiple problems, a single service centre enables them to access a range of services.
- The staff of specialised services are more likely to have received specialist training and be respectful towards women who have experienced sexual violence because their roles are exclusively focused on this client group.

Other factors that were considered by interviewees to support effective services that are often associated with specialised services but not necessarily restricted to them were:

- 24 hour service provision, seven days a week. If a woman decides to call a service and then gets an answer machine, sometimes she will not call back. Many services stop at 6pm just when a woman is most likely to call.

- Specially trained staff. In particular several interviewees cited the importance of changing professional attitudes of blaming or disbelieving women.
- Language interpreters, preferably from in-house staff or from confidential, independent interpreters.
- The client/victim centred approach with compassionate staff. The commitment and attitude of staff was cited by several interviewees as key.
- Childcare for clients.
- The ability to self-refer to services. Many women do not want to report to the police because of a fear they will be victimised or blamed.

Interviewees also described other factors that were considered to be key in ensuring services are effective. These include:

- The availability of independent psychological support for as long as the women needed it.
- Follow-up services that are provided in accessible locations so women do not have to travel too far.
- The need for services to be anonymous.
- Professional guidelines and protocols.

5.3 Factors that limit the effectiveness of services

One of the factors cited most frequently by interviewees as limiting the effectiveness of services was the fact that so many women do not report the assault to anyone so cannot get help and support. This issue of under-reporting was identified as an issue in every country included in the interviews. Many of the interviewees cited strong victim blaming attitudes amongst professionals as a major factor contributing to under-reporting.

Several interviewees cited the lack of long term support for victims, in particular long term psychological support provided free of charge. In most of the countries included in the interviews NGOs were considered to be the main provider of long-term psychological care of victims in the absence of state provision, but funding for these services was inadequate.

Another issue raised by interviewees in the majority of countries included in the interviews was that the judicial process is often ineffective and arbitrary. Professionals involved in the court process and juries were seen as insufficiently aware of and sensitive to issues of sexual violence and emotional distress. Several interviewees also said that certain types of victims were less likely to be believed; including women aged 24 to 35 and sex workers.

Another issue cited by several interviewees in different countries was the variability of service quality between different areas. In particular, interviewees described a rural/urban divide. In some countries interviewees said there existed a “gold standard” in some areas, mainly urban areas with well-established specialised

service models, but in other areas of the same countries the quality of service was comparatively poor.

Several interviewees from different countries raised the fact that specialist services that are permanently open can be very resource-intensive. Given that specialist services require trained staff, it can be difficult to ensure they are properly staffed. Interviewees from two countries, England and Denmark, said that models based on central services supported by satellites (sometimes known as a hub and spoke model) were being explored to improve service accessibility and efficiency. Approaches to staff management to ensure staff were available which were cited included:

- Using nurse practitioners instead of doctors;
- Ensuring the need for professionals to be released to cover duties is included in performance management and contractual arrangements;
- Ensuring the relevant professional bodies are involved.

In Denmark the time limit placed on accessing the specialised rape centre was cited as impacting on their effectiveness. At the moment women need to come within three days of the sexual assault or they cannot use the service. This is not long enough. Many women try to cope alone and only later realize they need help.

Another problem cited was the lack of research on the acute psychological needs of women who have been raped. This means it can be difficult to design services that meet their needs. Following on from this, many women have broader problems so it is difficult to disentangle symptoms of the rape from symptoms of other problems.

Several interviewees said they believed systems in place to support women who had experienced sexual violence in their countries were effective. However, these systems were not always implemented by staff. Systems were reliant on trained and committed staff for their efficacy.

Getting women to attend follow up was considered challenging by several interviewees. Some victims also have other problems. Sexual assault may be one part of a bigger picture. Follow-up is an important opportunity to help these women. But this is a real challenge because it is difficult to get them to see the follow-up as important.

Forensic services being unavailable at night or within a short time frame was cited by several interviewees as an important issue. Where these are not open at night or at the weekend women have to wait without washing or changing their clothes. This is likely to substantially exacerbate psychological distress and prevent immediate medical treatment such as emergency contraception or prophylaxis for sexually transmitted infections.

There were different views as to the necessity of women being able to choose whether to have a woman doctor. However, there was agreement that medical

examination had to be carried out as soon as possible. This is linked to the issue of staff availability and staff working patterns.

One interviewee suggested women may prefer not to use a service associated with sexual violence and instead may turn to general services such as family doctors.

Other factors that limit the effectiveness of services were:

- Lack of independent interpretation being immediately or quickly available, including for deaf women.
- Lack of childcare.
- Lack of recognition that the closer the relationship the perpetrator has to the victim the more difficult it is to talk about the assault.
- Failure to understand gender amongst service providers. One interviewee said that they tend to think they have to treat everybody the same. They do not understand the difference between formal and substantive equality.
- Perceived lack of independence of services from the criminal justice system meaning that women are reluctant to access services or follow-up support.

5.4 Indicators of effectiveness and appropriateness of services

There was broad agreement that indicators based on women reporting to the police, going through with cases and conviction rates are not appropriate because they are largely arbitrary in that they are dependent on judges and juries. Reporting to the police is not always a good measure as it can lead to more trauma for the woman. However, several interviewees made the point that it was important not to lose sight of the need for justice for victims and that a sense of justice can contribute to healing for women.

Most interviewees stressed the importance of wellbeing and health indicators. Rape was seen by interviewees not just a criminal act. It also impacts on the woman's health. For example, many women are very scared about HIV and other infections and this has a real impact (even though the risk is very small). These include:

- Post-traumatic stress disorder symptoms. These are linked to wellbeing, confidence, control, ability to work and feeling safe;
- Sexual health;
- Happiness and well-being;
- Confidence levels;
- Feeling informed about their case and empowered to make decisions;
- Feeling safe;
- Self-esteem.

Service indicators were also considered important by many interviewees. These include:

- The quality of care to victims and, in particular, avoiding secondary victimisation. This involves training professionals.
- How satisfied women are with the service.

- Whether women attend follow-up.
- The number of women who turn to services for support. This shows services exist and women trust them.
- The number of clients using each service. However, one interviewee acknowledged this is difficult to measure as many women prefer to use another service not associated with sexual violence.
- Time available per client.
- Duration of service.
- How easy it is to get information.
- Accessibility of services in rural areas.
- Availability of childcare.
- Language support.
- Availability of a range of services.

5.5 Evaluation

There were few formal service evaluations cited by interviewees.

In Denmark the sexual assault centres do user-evaluation. In general this was reported to be quite positive. Some women do not return the questionnaire and it is not possible to chase these in case it is traumatic for the woman. The Aarhus Centre does a 6 month follow-up of women to see if they are experiencing PTSD symptoms. The Centre is now doing research into whether this follow up causes trauma for the women. In most cases this does not seem to be so. However, some women do get upset. The Copenhagen Centre has a detailed database with 3,000 client details including follow-up. Studies are on-going to analyse this, including 5 year follow-up.

Formal evaluation has been undertaken in the UK. However, one interviewee said that data was difficult to get and where this was accessible it related to service inputs rather than client outcomes. There were also reported to be differences between data provided by the police and that provided by SARCs. The Home Office used to collect data every month but it is not really clear if this was analysed.

In Austria there is no formal recent evaluation of the telephone advice service. Data is analysed regularly. Client numbers are quite stable.

5.6 Obstacles to service development

Where interviewees said that services in their countries either did not exist or were inadequate, they were asked whether there were any particular factors that blocked or hindered the development of services. Interviewees suggested factors including:

- The level of under-reporting was perceived to be key by many interviewees. This means that the level of unmet need is not recognised or measured and that there is inadequate awareness of the real scale of the problem.

- Because women do not trust the service providers, including healthcare and the criminal justice system, they do not report. A major factor in this lack of trust is the victim- blaming attitudes of professionals.
- There is a lack of appropriate training of professionals. More training is needed not only in terms of prevention, treatment and follow-up as part of their profession. Training needs to be a core part of professional preparation, rather than occasional workshops.
- The failure by professionals to recognise sexual assault and believe the victim unless there were obvious signs of struggle or violence.
- Sexual violence is hidden in more integrated services for women and the broader context of gender violence, which diminishes the importance of sexual violence as a unique phenomenon requiring specific services.
- Strong gender stereotypes that blame women for sexual violence, for example by suggesting they seduced the perpetrator or are promiscuous.
- Poor trust of institutions.
- A lack of recognition that the state needs to provide services in this area.
- Funding constraints. One interviewee said that there is a particular lack of money at the municipal level with all funds held by central government.
- A lack of national protocols which means it is up to individual hospitals to design their own services and means there is no national data.
- A lack of specialised NGOs was cited in one country.
- A lack of a service infrastructure with providers.
- The lack of political prioritisation and political support.

5.7 Support required to develop and improve services

Where interviewees said that services in their countries either did not exist or were inadequate, they were asked what types of support would be helpful and whether examples from other countries could be useful. Interviewees described a range of support as being potentially useful including:

- More staff training;
- More funding;
- More support through networks with organisations that provide similar services to share experiences;
- Community education programmes;
- Measures to raise awareness of the available services;
- Support to design services from the beginning, including mapping existing services, developing new services, training professionals, developing service providers;
- Government funding for NGOs which often have more experience than public services;
- Government needing to be faster and more responsive;
- Government need to develop and pilot service models to see if they work in practice;
- Changing the attitudes of professionals that blame women;

- Exchanges with countries that have good services in place to see very practically how other countries do it.

6 Key messages about contexts

6.1 Particular cultural and social factors which influence service take-up and outcomes

The majority of interviewees talked about the strong stigma attached to sexual violence. Powerful gender stereotypes mean that women are often blamed for sexual violence. From a service design and delivery perspective this has a number of implications.

- There is huge under-reporting of the problem and women often do not seek services.
- Women may be ashamed to be seen entering/existing specialised centres for women.
- Staff training to counter strong perceptions and social conditioning about women and sexual behaviour is needed.
- Women may not talk about sexual assault when seeking services from general service providers. Instead they may focus on other problems such as domestic violence.
- There is a lack of awareness of the scale of the problem and, therefore, services are not sufficiently prioritised.

Some groups were considered to have particular needs in accessing services:

- Muslim women are less likely to seek help and, when they do, have particular issues about family members not finding out.
- Sex workers are unlikely to seek services.
- There are more blaming attitudes towards women in the Roma community. Girls start having sex younger – often aged 12 or 13. It is very difficult for Roma women to get help. Roma communities are very suspicious of outsiders.
- Older women find it more difficult to talk about sexual violence. There is a lot of taboo. Service providers also tend to ignore this because of social conditioning that sexual violence happens to young, attractive women who are behaving in a risky way. This needs to be challenged.
- It is very hard to encourage younger women to come for on-going counselling. They often don't come back and are lost to follow-up.

Several interviewees said that women from low socio-economic groups experience more sexual violence. Some interviewees also said that low educational status of victims may contribute to low reporting. However, other interviewees said that maybe higher social status women are not accessing the services because they are less likely to report the attack and/or because the experience is more contradictory to their views of themselves. Several interviewees also suggested that there may be a stigma attached to using a public service in some countries.

One of the themes most frequently raised by interviewees was that sexual violence is still much more difficult for women to talk about than domestic violence, and there are more taboos. The fact that many women who experience domestic violence also suffer sexual violence was also stressed by a number of interviewees as an important issue. Many women who experience domestic violence accept sexual assault as an inevitable part of this, do not seek help and do not recognise that sexual assault is in and of itself a crime.

Several interviewees raised the perception among some professionals that there are many false complaints of rape from young women. This was seen to be part of the victim blaming attitudes common amongst professionals.

Human trafficking was seen by several interviewees as getting a lot of public and media attention. However, there was seen to be very little understanding of the problem. Women are blamed for allowing themselves to be trafficked.

For women who come from minority ethnic communities, interviewees cited some particular issues:

- Cultural differences – woman may prefer to be supported by someone from their own culture.
- Some women do not want to be seen by a professional from the same community they come from because they are worried they will have acquaintances in common or will be judged according to their community's social rules.
- Language is important. The community gets to know if there is a counsellor that speaks that language.
- Interpreters take time to organise. If an interpreter is not available when a woman first tries to access a service, sometimes they will not return for a future appointment.
- If the community is small, the woman might know the interpreter.
- Migrant women prefer services for migrant women.
- Outside inner city areas cultural awareness is very poor.
- Low understanding of female genital mutilation (FGM).
- One interviewee said statutory services tend to use men to act as community representatives.

6.2 Particular legal or political contextual factors

In Spain the national health protocol against gender violence was seen as an important step in the right direction in terms of providing indicators and plans of actions. However, interviewees reported there is not enough understanding about the extent that gender violence is a health problem in addition to a social problem. Professionals from the health sector need to treat this protocol with the same importance that they do with other health protocols, such as those for illnesses like cardiovascular disease and diabetes. In terms of raising awareness, there is more

relevance given in the media to abuse and murders at the hands of partners/ex-partners than to cases of sexual assault or sexual violence, so it remains a hidden problem within the larger context of gender violence.

In Denmark there seems to be political support. However, one interviewee said this is mainly passive in that politicians are not opposed to services, as opposed to actively supportive. One interviewee said it looks likely that more resources to enable the time limit in which the service must be accessed to be removed will soon be available.

In Bulgaria interviewees said that sexual violence was not considered to be a priority. There are some media reports of sexual violence but no specific campaigns. Domestic violence and sexual violence as it affects children were considered to be more of a political priority and given more media attention.

In Romania several interviewees said that sexual violence was not a political priority and received little media attention. Domestic violence was seen to get more attention.

Interviewees from Latvia said that the problem of human trafficking is a political priority. Domestic violence is also seen as a priority. One interviewee said sexual violence is now becoming more of a priority but it is still very highly stigmatised. In addition, there are limited resources.

In England sexual violence was considered to be a political priority by two interviewees. However, funding is limited due to broader financial constraints on public services. One interviewee said that while they are positive about the political climate now with funding for 15 new rape crisis centres agreed, this support is vulnerable as it is based on the commitment of an individual politician. If the person moves, the next person might not be supportive. There are also concerns about funding for rape crisis centres being used as a political football, that is, there is debate around the issue, but there are no decisions made.

Interviewees from Austria said that context domestic violence got more media and political attention. However, a recent conference on sexual violence was well supported by both politicians and media.

Common themes that emerged from interviewees from different countries included:

- Sexual violence remains more stigmatised that other forms of violence against women and this means getting the personal support of leading figures can be difficult.
- Domestic violence gets more media and political attention. There is less taboo attached to domestic violence.
- Political and high level support is important.
- Greater awareness-raising is needed on sexual violence. This needs to include public campaigns about the existence of services/centres to help women.

- Legal definitions of rape requiring coercion are too restrictive. Definitions should be based on consent.
- One interviewee said language used in service provision should reflect legal definitions to avoid confusion. For example, if the legal term used in a particular context is “rape”, services should be for women who have been “raped”.

7 Summary of key findings

Services models:

- Specialist services provided by statutory or public service providers to meet the needs of women who have been sexually assaulted were described by interviewees in three of the seven countries.
- These were complemented by services provided by NGOs.
- In three countries there were no specialised services for women who had been sexually assaulted. Instead women can seek help from hospitals, other health providers, the police, forensic medical departments, welfare services and NGOs.
- In Spain where regional governments are responsible for service delivery, different models including specialist services exist.

Factors contributing to the effectiveness of particular service models:

- Specialised services for women who have been sexually assaulted were considered by most interviewees to be an effective form of service delivery in those countries that had these services. Several interviewees from countries that did not have specialised services also believed they were the most effective form of service delivery. Advantages cited by interviewees included:
    - Combining medical and forensic examinations;
    - An exclusive focus on sexual assault means women are more likely to disclose and seek help;
    - Supporting collaboration between the police, the medical services, forensics, research and psychology;
    - Pro-actively offering psychological help;
    - Offering a range of services from a single centre makes them more accessible;
    - Specialist staff who are respectful towards women.
- Other features that were considered by interviewees to make services effective included:
    - 24 hour service provision, seven days a week;
    - Specially trained staff;
    - Independent and easily accessible language interpreters;
    - The client/victim centred approach with compassionate staff;
    - Childcare for clients;
    - The ability to self-refer to services.

Factors that limit the effectiveness of services:

- Interviewees identified a range of factors that could compromise the effectiveness of services, including specialist services. These included:
    - High rates of non-reporting mean many women do not get help;
    - Lack of trust in systems amongst women:
    - Victim blaming attitudes of professionals;
    - Lack of long term support, in particular psychological support;
    - Time limits requiring the sexual assault to be reporting within a particular time frame;
    - Inadequate resources for services;
    - Ineffective and arbitrary judicial systems;
    - Women having to wait long periods for medical and/or forensic examination;
    - Variability in the quality and accessibility of services within different regions of the same country;
    - Difficulties in staffing services round the clock;
    - Perceived lack of independence of services from the criminal justice system;
    - Lack of childcare;
    - Lack of language support;
    - Inadequate staff training.

Indicators of effectiveness and appropriateness of services:

- There was broad agreement that indicators based on women reporting to the police, going through with cases and conviction rates are not appropriate because they are largely arbitrary in that they are dependent on judges and juries.
- Wellbeing and health indicators were considered important for example, sexual health, post-traumatic stress disorder symptoms, feeling informed and empowered to make decisions, ability to return to work.
- Service indicators were also considered important. These include: how satisfied women are with the service; whether women attend follow-up; the number of women who turn to services for support.

Evaluation:

- Some services undertake user satisfaction questionnaires. However, these are not always returned and there are concerns that follow-up may cause some women distress.
- Data analysis quoted from services in Denmark and Austria suggested that client numbers and reporting levels are fairly stable.

Obstacles to service development:

- Interviewees who said that services in their countries were inadequate cited a variety of factors that blocked or hindered the development of services. These included:
    - The level of under-reporting means that the extent of unmet need is not known and that there is inadequate awareness of the real scale of the problem;

- Professional attitudes that blame victims;
- A lack of appropriate training of professionals;
- Expectations among professionals that sexual assault always involves obvious signs of struggle or violence;
- Lack of national protocols;
- Lack of recognition that the state needs to provide services in this area;
- Funding constraints;
- Lack of service infrastructure.

Contextual factors:

- There were shared contextual cultural and social actors described by interviewees from different countries. These include:
  - Strong taboos about sexual assault and a tendency for victims to be blamed;
  - Domestic violence is considered less stigmatised than sexual assault and, therefore, receives more attention from service providers;
  - Many women who suffer domestic violence also suffer sexual assault but this is under-reported;
  - Over representation of women from low social status groups in those accessing services, although there were different perceptions about whether this reflected a higher incidence of sexual assault in these groups or was because women from higher social status groups are less likely to access services;
  - Recognition that some groups are less likely to access services so need special support to do so. These include sex workers, Muslim women, older women, Roma women and migrant woman;
  - Women who have been trafficked for sexual exploitation required particular support;
  - Recognition that women from ethnic minorities need particular support including independent interpretation, culturally aware staff and staff from outside their own communities to ensure confidentiality.
- Other contextual factors cited by interviewees included:
  - Measures to raise awareness of sexual assault are needed;
  - Legal definitions should be based on consent;
  - Language needs to be consistent.

Transferability of services:

- The fact that many contextual factors are shared between different countries, suggests that service models are likely to be transferable.
- Specialist services that are permanently open can be resource-intensive which is likely to limit their transferability to contexts where service infrastructure is less developed.

- Models based on having central services supported by satellites (sometimes known as a hub and spoke model) may be less resource intensive and, therefore, more transferable.
- The availability of specially trained staff is key to the transferability of specialised services.
- The ethnic make-up of the local population needs to be taken into account in considering service transferability to ensure the needs of particular hard to reach groups are taken into account, for example Roma women.
- The confidentially and anonymity of services is essential. Measures to ensure this need to be built into services for small, close-knit communities.

Types of support needed:

- Interviewees who said that services in their countries were inadequate described a range of support measures as being potentially useful. The types of support included:
    - Staff training on technical aspects of service provision and awareness raising to change the attitudes of professionals that blame women;
    - Additional funding;
    - Support through networks with organisations that provide similar services to share experiences and exchanges with other countries;
    - Technical support to design services.

Appendix 1: List of interviewees

Country	***Name***	***Organisation***
Austria	Barbara Michalek	Viennese Women's Helpline
	Marie-Theres Prantner	Chancellery for Women, Federal Government of Austria
Bulgaria	Borislava Metcheva	Pulse Foundation
	Genoveva Tisheva	The Bulgarian Gender Research Foundation
Denmark	Anja Hareskov Jensen	The Centre for Sexual Assault, Arhus University Hospital
	Dr Malene Hilden	Centre for Rape Victims, University Hospital Copenhagen
	Jeanette	Joan-Søstrene
Latvia	Viktorija Bolsakova	Ministry of Welfare
	Iluta Lace	Marta (NGO for women)
	Indra Gratkovska*	Ministry of Justice
	Jana Feldmane	Ministry of Health
	Lāsma Stabiņa	Ministry of Interior
	Dr. Grigory Vabels*	State Forensic Medicine Centre, Riga
Spain	Rosa Del Valle Alvarez	Regional Health Service of the Canary Islands
	Montserrat Pineda	Creación Positiva
	Jorge Gonzalez Fernandez	Institute of Legal Medicine of La Rioja
Romania	Dr Cristian Boeriu	SMURD (Mobile Emergency Service for Resuscitation and Extrication), Mureş County Clinical Hospital
	Dr Harald Jung	Institute of Legal Medicine, Tirgu Mures, Mures County
	Dr Lucian Puscasiu	University of Medicine and Pharmacy of Târgu Mures,
Spain	Rosa Del Valle Alvarez	Regional Health Service of the Canary Islands
	Montserrat Pineda	Creación Positiva
	Jorge Gonzalez Fernandez	Institute of Legal Medicine of La Rioja
UK	Androulla Michael	Department of Health
	Deborah Davidson	Health Services Management Centre at the University of Birmingham
	Sheila Coates	South Essex Rape & Incest Crisis Centre

* Provided information by e-mail

Appendix 2: Draft initial interview request e-mail

Dear (title, name)
I am writing to you about a European Union funded project *Comparing Sexual Assault Interventions*. The goal of this project is to improve the effectiveness, appropriateness and humanity of sexual assault services. I am attaching a short summary of the project for your information.

You have been proposed as a key stakeholder with experience and knowledge of sexual assault services in your country. As such, I would like to request a short telephone interview with you. This would take around 30 minutes. During the interview I would like to discuss your views on several questions that I have given at the bottom of this e-mail. Your views will be used to help develop tools to support improved services and professional training.

I would be very grateful if you could let me know a convenient date and time at which I can contact you between 12th December 2011 and 13th January 2012. Please also let me know the telephone number I should use to call you and whether you are comfortable to use English for our discussion. You can contact me by replying to this e-mail or on the telephone number below.

Thank you in advance for your time and assistance.

Best wishes

Name
Health Action Partnership International

Questions for discussion

1. Can you please describe your organisation and your role?
2. Could you describe the models of service delivery for women who have been sexual assaulted that are available in your country?
3. What is or would be a measure of the effectiveness and appropriateness of services for women who have been sexual assaulted in your country?
4. Are there any particular social, cultural or other factors that impact on how women use sexual assault services in your country?
5. Are their any particular legal or political issues that influence sexual assault services in your country?
6. Do you have any suggestions for others it might be useful for us to interview?