Policy briefing:

Comparing Sexual Assault Interventions across Europe

This project has received financial support from the European Union Directorate-General Justice DAPHNE III Programme 2007-2013: *Combating violence towards children, adolescents and women* (Just/2010/DAP3/AG/1395)

This publication has been produced with financial support from the European Union DAPHNE III Programme 2007-2013.

This programme is managed by the European Commission Directorate-General for Justice. The Daphne III programme aims to contribute to the protection of children, young people and women against all forms of violence and attain a high level of health protection, well-being and social cohesion. Its specific objective is to contribute to the prevention of, and the fight against all forms of violence occurring in the public or the private domain, including sexual exploitation and trafficking of human beings. It aims to take preventive measures and provide support and protection for victims and groups at risk.

For more information see:
http://ec.europa.eu/justice/grants/programmes/daphne/index_en.htm

Published by the Comparing Sexual Assault Interventions (COSAI) project, May 2012

This document is also available online at **www.cosai.eu**

Comparing Sexual Assault Interventions (COSAI) project partners:
East European Institute for Reproductive Health (Romania)
Educational Institute for Child Protection (Czech Republic)
Latvian Association of Gynaecologists and Obstetricians (Latvia)
Liverpool John Moores University (UK)
Victim Support (Malta)

Associate project partners:
Department of Health (England)
European Regional Office of the World Health Organization (WHO-EURO)

This project is coordinated by
National Heart Forum/ Health Action Partnership International (HAPI)

This project has received financial support from the European Union Directorate-General Justice DAPHNE III Programme 2007-2013: *Combating violence towards children, adolescents and women* (Just/2010/DAP3/AG/1395)

CONTENTS

Acknowledgements

Health Action Partnership International gratefully acknowledges the support of all those who contributed to the research that informed this policy briefing. They include the individuals who gave their time to be interviewed as part of the telephone interview process, those who completed a questionnaire as part of the mapping survey and those who contributed information in other ways. In addition, we would like to thank the project partners and associate partners who provided advice on the methodology for the research, comments on the draft research reports and comments on the draft policy briefing.

Explanatory note

This policy briefing is based on research including a literature review, a mapping survey and telephone interviews. As such, it summarises and synthesises the information and perspectives from a range of stakeholders from different countries and sectors, as well as findings from academic and grey literature. It does not claim to provide a comprehensive description of all services available. Full references for written evidence that informs this briefing are included in the report of the literature review. References are only provided here for reports directly cited.

The views in this briefing do not represent those of the European Commission, HAPI, the project partners and associate partners or any single individual or organisation who participated in the research.

Executive summary

About the policy briefing

- This policy briefing has been produced as part of the *Comparing Sexual Assault Interventions* project. It is funded by the European Union as part of the DAPHNE III programme.
- The policy briefing draws on a literature review, a mapping survey and telephone interviews undertaken by the project.
- The scope of this policy briefing and the Comparing Sexual Assault Interventions project is limited to women aged over 16.

Prevalence of sexual assault

- There is widespread under-reporting of sexual assault.
- Prevalence rates for sexual assault are very difficult to estimate accurately and all methodologies are likely to underestimate the real numbers.
- Methodologies for calculating prevalence that use self-reporting surveys give a more reliable picture of the real extent of the problem than official crime statistics.

The impact of sexual assault

- Research shows that sexual assault survivors can suffer from a number of mental and physical health problems. The most frequently reported psychological consequence for victims is Post Traumatic Stress Disorder. Physical health consequences include gynaecological complications, sexually transmitted infections, HIV/AIDS and unwanted pregnancies. The fear of sexually transmitted infections, HIV/AIDS and unwanted pregnancies can also be severe.
- Coping with the aftermath of sexual assault can cause significant stress for the family, friends, and significant others of sexual assault survivors.
- Sexual assault also has implications and costs for a society as a whole. These include direct costs such as health care and criminal justice system and other costs, indirect costs caused by sick leave or imprisonment, intangible costs such as psychological costs and morbidity and multiplier effects including the the intergenerational transmission of violence.

Strategies to address sexual assault

- It is to be welcomed that many countries have adopted strategies that address sexual violence as this shows political recognition of the problem.
- Strategies themselves are not enough. They need to be implemented through specific actions.

Services for women who have been sexually assaulted

- Women who have experienced sexual assault have three main care needs: medical care; psychosocial care and assistance; and support from the criminal justice system.
- Countries have different models for delivering services. These include: coordinated services that provide psychological, health, forensic and legal

services in a single location; non-coordinated services whereby services are provided separately as part of mainstream service provision; integrated services whereby services for women who have been sexually assaulted are integrated within other services dealing with a range of other forms of violence against women and children; information and advice telephone helplines; and support services provided by NGOs.

Meeting the needs of vulnerable groups

- There is evidence that some groups of women are more vulnerable to sexual assault. These include adolescents, young women, those with disabilities, homeless women, sex workers, women on low incomes, women who were previously victims of sexual abuse or assaults and lesbian, gay, bisexual, transgender and intersex people.
- Evidence around ethnicity as a factor increasing vulnerability is inconclusive.
- Some groups of women are less likely to access services and have particular service needs. Service design needs to take account of these needs.

Evaluation of services

- There is a lack of systematic evaluation of sexual assault services in Europe.
- There are no commonly agreed indicators for measuring the effectiveness and accessibility of sexual assault services.
- Systematic evaluation of services for women who have been sexually assaulted is necessary to improve the effectiveness of services.
- Service effectiveness can be measured by two types of indicators: those that measure the wellbeing and health outcomes of the victim; and those that measure services such as user satisfaction.

Improving services

- Evidence shows a number of features of good practice that policy makers and service providers should build in to service design and provision to improve the effectiveness and accessibility of services. These include:
    - Providing comprehensive care and support for the medical, psycho-social and legal needs of victims;
    - Providing co-ordinated, specialised services in sexual assault;
    - Challenging taboos around sexual assault among providers, perpetrators and victims;
    - Providing staff training on technical aspects of service provision and crisis intervention;
    - Encouraging staff specialization in sexual assault;
    - Providing cognitive behavioural therapies to treat symptoms of post-traumatic stress disorder;
    - Ensuring sexual assault is not missed by integrated services;
    - Providing services without time limits, i.e. independently of when the assault occurred, and accessible 7 days a week and 24 hours;
    - Reducing variability in service quality and accessibility;
    - Providing language support;
    - Providing childcare and other social services (e.g. shelter, refuge);

- Providing self-referral pathways to access services;
- Providing information on the course of action and obtaining victim's consent;
- Ensuring that services are, and are perceived to be, independent and confidential.

Recommendations

Based on evidence from research undertaken as part of the *Comparing Sexual Assault Interventions* project, this policy briefing makes a number of recommendations that build on identified good practice and address common challenges. These recommendations are aimed at policy makers within regional and national governments, service providers and professional associations at the national level. International organisations and initiatives, such as DAPHNE III and the *Comparing Sexual Assault Interventions* project, also have an important role to play in enabling good practice to be shared between countries.

- Policy makers should recognise governments need to take the lead in addressing sexual assault. Sexual assault is a social, public health and economic problem and while NGOs have an important role to play, meeting the needs of victims of sexual assault is the responsibility of governments.
- Policy makers and service providers should incorporate the aspects of good practice described in this policy briefing in the design and delivery of services for victims of sexual assault.
- Professional associations need to develop and share modules for training staff. This is key to the transferability of specialised services. Training must include technical aspects of service provision, crisis intervention and awareness raising to change attitudes that blame or victimise women. International professional associations can support the sharing of training modules between countries.
- Policy makers need to ensure government led or endorsed major public awareness campaigns are undertaken that challenge rape myths, reduce the stigma of sexual assault and encourage women to seek help. Such campaigns need to build on the experience and activities of NGOs. International organisations and initiatives can support this by sharing information between countries on these campaigns.
- Policy makers and service providers should share learning on new coordinated models of services currently being developed by some countries (including England and Denmark) which are less resource intensive and enable improvements in the uniformity of service quality.
- Professional associations and service providers need to share national protocols on examination, treatment, follow-up and other aspects of case management.
- Policy makers should commission further research to improve understanding of the needs of groups who have particular difficulties in accessing services. These include women who have been trafficked for sexual exploitation, sex workers, Muslim women, women from the Roma community and migrant women. National governments and international organisations and initiatives, including DAPHNE III, need to support such research.
- Policy makers, service providers and other organisations need to recognise that prevalence studies underestimate the real extent of sexual assault and that further research is needed to improve understanding of prevalence. Methodologies using population-based surveys that count self-reporting

should be used as these more accurately reflect victimisation levels than crime statistics based on reports to the police. Sexual assault is one of the most under-reported crimes.

- International organisations and initiatives, including DAPHNE III and the *Comparing Sexual Assault Interventions* project, need to develop and support networks of organisations and policy makers with responsibility for sexual assault to share experiences with others, both within and between countries and regions.
- Policy makers need to ensure that criminal codes move from traditional rape laws that define rape based on force to those which define it based on consent in those countries where traditional rape laws are still in place.
- Policy makers, international organisations and initiatives, including the *Comparing Sexual Assault Interventions* project, need to develop tools for evaluating service effectiveness and accessibility, including those that include sensitive follow-up of victims. This is important because there is currently a lack of evaluation and evidence on the impact and effectiveness of services.
- Policy makers need to ensure that evaluations and research are also conducted in lower resource settings to test the effectiveness of interventions and also identify new evidence in these contexts. National governments and international organisations and initiatives, including DAPHNE III, need to support such research.
- Professional associations and international organisations and initiatives, including DAPHNE III and the *Comparing Sexual Assault Interventions* project, need to support networks for collaboration on evaluation and sharing skills for evaluation of sexual assault services.

Intended audiences for this policy briefing

This policy briefing is aimed at national and regional policy makers, service providers, professional bodies, non-governmental organisations (NGOs) and other individuals and agencies who are involved developing and delivering strategies and services that address sexual assault and rape, including prevention, medical and psychological treatment of victims, social services and criminal justice. The policy briefing is primarily aimed at a European audience and is based on research undertaken in Europe. However, as many of the issues discussed are also relevant to other regions, it may be of interest to stakeholders from other parts of the world.

1 About this policy briefing

1.1 Background and purpose

This briefing has been produced as part of the *Comparing Sexual Assault Interventions* project. It has been funded by the European Union (EU) through the DAPHNE III Programme 2007-2013. More information about the project is provided in appendix 1.

The purpose of the policy briefing is to support policy makers, service providers and other organisations who work with or for women who have been sexually assaulted by describing:

- The extent of sexual assault in Europe;
- The range of strategies and services that are in place to address the problem and support survivors;
- Good practice to improve the effectiveness of strategies and services based on evidence identified; and
- Recommendations for further action.

1.2 How the policy briefing was developed

This policy briefing draws on three research exercises that were undertaken as part of the *Comparing Sexual Assault Interventions* project. These are:

1. A literature review of peer reviewed articles in academic and scientific journals and grey literature to identify models of intervention for women who have experienced sexual assault across European Union (EU) Member States, EFTA, EEA & ascension countries.
2. A mapping survey based on a written structured questionnaire to gather information on current policy and programming on services for sexual assault from 30 European countries (EU Member States and EFTA/EEA countries[*]). In

[*] Liechtenstein was excluded because of its small size.

total 22 survey responses were received. These were supplemented by information provided through stakeholders and desk research to complete the mapping for those countries where no survey response was received.

3. Telephone interviews using a semi-structured questionnaire with 20 stakeholders from seven EU Member States. The seven countries were Latvia, England and Wales, Denmark, Romania, Austria, Spain and Bulgaria. These countries were selected to ensure a geographical spread from across the EU. The telephone interviews focused on what types of services are in place for women who have experienced sexual assault in different countries and what makes services effective.

This research was undertaken between September 2011 and February 2012. A separate detailed research report is available for each of these on the project website.

1.3 The scope of the policy briefing

The scope of this policy briefing and the *Comparing Sexual Assault Interventions* 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.

Definitions

The *Comparing Sexual Assault Interventions* project uses the WHO's definition of **sexual violence** as: *any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object*.[1]

The expressions *sexual assault, rape, sexual abuse* and *sexual violence* are often used interchangeably. This policy briefing uses the term *sexual assault* to describe all forms of sexual violence including rape.

Definitions have an impact on whether women who have been sexually assaulted report the crime and, therefore, on prevalence rates. There is a distinction between what is sometimes called traditional rape legislation, which is based on coercion and the use of violence to assault a woman, and modern rape laws, which are based on victim's non-consent and do not assume that a woman gives her consent because she has not physically resisted the unwanted sexual conduct[2].

2 The prevalence of sexual assault in Europe

Under-reporting

There is widespread under-reporting of sexual assault as many women do not report their experience. Because of under-reporting the extent of unmet need is not known and there is inadequate awareness of the real scale of the problem. Reasons why women do not report their experience of sexual assault include: strong taboos about sexual assault; common rape myths, such as those that blame the victim's behaviour for the assault, which result in secondary victimisation of the victim by professionals; restrictive legal definitions of sexual assault; lack of trust in professionals and systems by victims; psychological trauma of victims; some forms of sexual violence may be not be perceived by victims as an offence; and misinformation and lack of information among professionals and victims.

Prevalence refers to the percentage of people who have experienced a sexual assault. Prevalence rates for sexual assault are very difficult to estimate accurately as all methodologies are likely to underestimate the real numbers. Furthermore, countries do not use the same standard definitions and methodologies in estimating prevalence which makes it difficult to compare data between countries.

Some methodologies for calculating prevalence use self-reporting surveys that ask interviewees if they have experienced a sexual assault in a given period. While these are also considered likely to underestimate prevalence for some of the same reasons as official crime statistics, they are more reliable in that they do not only count victims who have reported their experience to the police. They use different time periods and definitions which means it is difficult to compare figures between countries.

The International Crime Victims Survey is a population-based survey that asks interviewees the following question: "People sometimes grab, touch or assault others for sexual reasons in a really offensive way. This can happen either at home, or elsewhere, for instance in a pub, the street, at school, on public transportation, in cinemas, on the beach, or at one's work-place. Over the past five years, has anyone done this to you?" For the period 1995-2004 results for Europe varied between Austria which had the highest rate of yes response at 12% and Spain which had the lowest at less than 2%.[3] However, by way of illustrating the variations in findings by different studies, another study examined by the literature review found that of the 223 female students in a Spanish university surveyed, 33.2% had experienced some form of unwanted sexual activity, of which 7.7% reported an attempted or completed rape at one point of their life.[4]

3 The impact of sexual assault

For many victims, the impact of sexual assault can be significant and long lasting. Research shows that sexual assault survivors can suffer from a number of mental

and physical health problems. The most frequently reported psychological consequence for victims is Post Traumatic Stress Disorder (PTSD). For example, one study found a quarter (25 per cent) of women reported having experienced some symptoms or had a full diagnosis of PTSD at some time in their lives following, and as a consequence of, their experience of sexual violence. The study also found that those who had experienced sexual violence were significantly more likely to have used medication for anxiety or depression or to have been a psychiatric hospital inpatient than those without such experiences. For instance, those who had experienced attempted or actual penetrative sexual abuse were eight times more likely to have been an inpatient in a psychiatric hospital than those who had not been abused (16% vs. 2%).[5]

Physical health consequences include gynaecological complications, sexually transmitted infections, HIV/AIDS and unwanted pregnancies. Physical injuries can be severe, sometimes even life-threatening, but this is rare and most physical injuries resolve within several days. The fear of sexually transmitted infections, HIV/AIDS and unwanted pregnancies are common reasons for seeking help at different medical settings immediately after being sexually assaulted.

Furthermore, sexual assaults are violations of human rights in themselves. They also impair the victim's enjoyment of a range of other human rights such as the rights to physical and mental health, personal security, equality within the family and equal protection for men and women under the law.

The effects of sexual assault do not stop with the survivors' health and well-being. Research indicates that coping with the aftermath of rape can cause significant stress for the family, friends, and significant others of sexual assault survivors.

Sexual assault also has implications and costs for a society as a whole. The economic impact can be broken down into: i) direct costs (to the health care sector, social sector, criminal justice system and other costs); ii) indirect costs (production loss caused by sick leave or imprisonment); iii) intangible costs (psychological costs and morbidity); and iv) multiplier effects (the intergenerational transmission of violence). More evaluations are available that look at the costs of gender-based and intimate partner violence than sexual assault. For example, in Sweden direct costs of gender-based violence were estimated at 947.4 million SEK (close to 104 million Euro) and the sum of other costs more than doubled direct costs.[6]

In terms of sexual assault, the Department of Health in the UK reports that each adult rape has been estimated to cost over £76,000 (around €91,000) in its emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health services and costs incurred in the criminal justice system. The overall cost to society of sexual offences in 2003-04 was estimated at £8.5 billion (around €9.5 billion).[7]

4 Protocols and strategies that address sexual assault

Many national and regional governments have developed strategies that aim to

prevent sexual assault and improve support for victims. A mapping of national strategies across 34 European countries is given in appendix 2. This mapping indicates that:

- Out of the 34 countries, 11 (33%) have protocols and strategies that address sexual violence explicitly either in dedicated sexual violence strategies or in strategies for violence against women.
- Out of the 34 countries, 16 (46.5%) have protocols and strategies on gender equality or intimate partner violence. Not all of these addressed sexual violence.
- Out of the 34 countries, 7 (20.5%) have no protocols and strategies in place that address sexual violence against women aged over 16.

More detailed information about 22 strategies collected through a recent survey shows:

- 89% refer to the role of the health sector. The emergency services are the health actor referred to by the greatest number of strategies/policies at 79%. The roles described most frequently are providing emergency care and collecting evidence.
- 95% refer to the role of the non-health sector. The police is the non-health actor referred to by the greatest number of strategies at 95%[8].

It is welcome that many countries have adopted strategies as this provides an indication that governments recognise the problem and are committed to addressing it. However, it is not possible to draw conclusions about whether strategies are being implemented based on the information available. In addition, a significant number of countries either do not have a strategy in place or do not have one that explicitly addresses sexual violence as distinct from intimate partner violence.

Intimate partner violence and sexual violence

Sexual assault does not exist in isolation, but within a larger societal problem of violence against women. One manifestation of violence against women is intimate partner violence, which is often referred to as domestic violence. The WHO defines intimate partner violence as: *behaviour in an intimate relationship that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, and psychological abuse and controlling behaviours.* [9]

Anecdotal evidence from telephone interviews carried out as part of the *Comparing Sexual Assault Interventions* project suggests that a large number of women who suffer intimate partner violence also experience sexual assault, but they rarely report the sexual violence. Some women may not recognise sexual assault within an intimate relationship as a crime. In addition, sexual assault is much more stigmatised that intimate partner violence so women may feel unable to raise it when seeking help.

However, the terms intimate partner violence and sexual violence are not synonymous. Women who suffer intimate partner violence are not necessarily victims of sexual violence as part of that experience. Additionally, many women suffer sexual violence outside a relationship with an intimate partner.

5 Services for women who have been sexually assaulted

Women who have experienced sexual assault have three main care needs: medical care to treat physical injury, prevent unwanted pregnancy and diagnose and treat sexually transmitted infections; psychosocial care to help deal with psychological trauma caused by the assault and assistance to ensure their safety and protection; and support from the criminal justice system to investigate the assault, including collecting evidence, ensure prosecution and punishment of the offender. These needs require input from different services including health providers, psychosocial support, forensic services, the police and the courts. Various models are used to meet these care needs in different countries and regions within countries. Appendix 3 summarises a mapping of these services for 34 European countries. The types of service identified can be grouped into five models as described below.

1. **Coordinated services,** which are also sometimes referred to as dedicated or specialist services bring together police, prosecutors, doctors, nurses, social workers, and rape victim advocates to provide psychological, health and forensic services in a single location, usually a centre in a hospital setting. Typically women can access these services by presenting to the police or a health care provider or by self-referral. An important feature is that the examination for medical and forensic purposes is done as a single examination, all services are accessed in a single location and a multidisciplinary teamwork together to meet the victims needs. Out of the 34 countries looked at by the project mapping, 14 countries (41%) have centres offering coordinated and specialist services for sexual assault victims. However, in some of these countries the services do not cover every region.
   In addition to coordination in one location, coordination can involve methods of collaborating and making referrals among and between services. Referral networks focus on providing prompt, confidential, and appropriate services to women.
2. **Non-coordinated services** whereby services are provided separately and in different locations as part of mainstream service provision. Services that women who have been sexually assaulted can use include emergency departments in hospitals, sexual health clinics, forensic medical services, counselling and psychiatric services, the police and the courts. Sometimes service providers may refer women to other services, but they are provided in different locations, medical and forensic examinations are done separately and the degree of liaison between service providers is usually minimal. Out

of the 34 countries looked at by the project mapping, 16 countries (47%) provide services in this way.

3. **Integrated services** whereby services for women who have been sexually assaulted are integrated within other services for women. While coordinated models have aspects of integration in that they provide multidisciplinary services, they are dedicated to the needs of women who have experienced sexual violence. Integrated service models also cover a range of other forms of violence against women and children. Out of the 34 countries looked at the project mapping, two countries (6%) provide services in this way.
4. **Information and advice telephone helplines** are services that offer women a range of support including advice on how to access services, legal information and psychological support. They are anonymous. Some are exclusively aimed at women who have experienced sexual assault and others are aimed at women experiencing any type of violence. Some are provided by government agencies and some are provided by NGOs and funded through government, charitable and/or private funding. Such services were identified in 12 countries as part of the project's mapping.
5. **Support services provided by NGOs.** In addition, to the services described above, most of the 34 countries included in the mapping have NGOs that provide support to women who have experienced sexual assault. These NGOs include those that focus on sexual assault and those that focus on women experiencing all forms of violence and discrimination. They often focus on providing advice and counseling for women. Many are also engaged in advocating for improved services and awareness. In some instances, these NGOs have close links with coordinated services and there are pathways or referral between them.

In addition to services for women who have experienced sexual assault, prevention programmes aim to reduce the incidence of sexual assault. Between 61% and 75% of respondents to a survey covering 22 European countries said prevention programmes such as school-based programmes to prevent violence in dating relationships, changing cultural norms to gender inequality, changing cultural norms that support intimate partner violence and changing cultural norms that support sexual violence were in place in their country.[10]

6 Meeting the needs of vulnerable groups

Anyone can experience a sexual assault at any point in their life but there is evidence that some groups of women are more vulnerable. These groups include adolescents, young women, those with disabilities, homeless women, sex workers, women on low incomes, women who were previously victims of sexual abuse or assaults and lesbian, gay, bisexual, transgender and intersex people.

There is some evidence that ethnicity may increase vulnerability to sexual assault. However, this is not conclusive.

There is evidence of an over representation of women from low social status groups in those accessing services. However, it is unclear whether this reflects a higher

incidence of sexual assault in these groups or is because women from higher social status groups are less likely to access services.

Whether or not they have increased vulnerability to sexual assault, some groups of women are less likely to access services and have particular service needs. Service design needs to take account of these needs. These groups include:

- Women who have been trafficked for sexual exploitation and may have a range of additional service requirements and need protection from people traffickers;
- Sex workers who are likely to be particularly mistrustful of the police and healthcare providers and be concerned that making a complaint could result in their own prosecution;
- Muslim women who may be particularly concerned about family members finding out;
- Roma women who may find it especially difficult to seek help outside their own community because of the mistrust of outsiders;
- Migrant women who may also have concerns about their immigration status and so be wary about coming to the attention of the authorities;
- Women from ethnic minorities who do not speak local languages and need independent interpretation, culturally aware staff and staff from outside their own communities to ensure confidentiality;
- Older women who may find it more difficult to talk about sexual violence and prefer not to talk to a young woman;
- Lesbian and bisexual women who may be concerned about their sexuality being used as a factor to justify the assault.

7 Evaluating the effectiveness and accessibility of services

There is a lack of systematic evaluation of sexual assault services in Europe. Evaluation of such services is not straightforward for several reasons. Firstly, sexual assault entails a multifaceted response to medical, psycho-social and legal needs, which requires effectiveness to be measured against multiple domains. Secondly, different types of studies provide evidence of varying quality which information and data are not directly comparable and cannot be reliably aggregated. Thirdly, incorporating user follow-up such as service satisfaction questionnaires is complex because of concerns that follow-up may cause some women distress. Finally, many women have concerns about confidentiality so may use services anonymously and/or be lost to follow-up and evaluation.

In addition, there are no commonly agreed indicators for measuring the effectiveness and accessibility of sexual assault services. Many countries have focused on improving reporting rates, increasing prosecution and conviction rates and reducing attrition rates (the numbers of reported cases that are lost during the legal process and thus do not result in a criminal conviction) as a measure of the effectiveness of their services.

However, these are not considered the best indicators of service effectiveness for two broad reasons. Firstly, many women experience reporting the sexual assault to the police and going through with a prosecution as traumatic in itself and this is sometimes referred to as a "second rape" or "secondary victimisation". Secondly, conviction rates are largely arbitrary in that they are dependent on judges' and juries' attitudes that are not dependent on service effectiveness. Nevertheless while not considered effective service indicators, the victims' sense of being believed and taken seriously by police that comes with a proper investigation and the healing power of justice that comes with the conviction and punishment of a perpetrator are important.

Despite the complexity, systematic evaluation of services for women who have been sexually assaulted is clearly necessary and must be improved. Overall sexual assault service provision in any given area has to ensure all the domains of care and support can be met, which includes both the availability of services and collaboration and referral between the services. Service effectiveness can then be measured by two types of indicators. Firstly, indicators that measure the wellbeing and health of the victim including: sexual and reproductive health; post-traumatic stress disorder symptoms; feeling informed and empowered to make decisions; feeling safe and secure; and ability to return to work. Secondly, service indicators including: how satisfied women are with the service; whether women attend follow-up; and the number of women who turn to services for support.

8 Improving the effectiveness and accessibility of services

Given the lack of systematic evaluations, it is not possible to develop a methodologically sound hierarchy or framework that directly compares the effectiveness of different interventions and services for women who have been sexually assaulted. However, the evidence shows a number of features of good practice that policy makers and service providers should build in to service design and provision to improve the effectiveness and accessibility of services.

- ***Providing comprehensive care and support for the medical, psycho-social and legal needs of victims:*** The evidence shows that responding to sexual assault requires addressing multiple dimensions of care, which should be guaranteed through coordination and referral mechanisms within and between services.
- ***Providing co-ordinated, specialised services:*** There is evidence that having service providers in one location decreases the risk of secondary victimisation of women by professionals when reporting sexual assault. Other advantages include:
    - 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 service, forensics, research and psychology;
    - Pro-actively offering psychological help;

    - Offering a range services from a single centre makes them more accessible;
    - Specialist staff who are respectful towards women.

- ***Challenging taboos:*** Evidence shows that rape myths that blame and stigmatise the victim are prevalent and that these have an impact on the behaviour of perpetrators, victims and professionals. There are also strong taboos about sexual assault and a prevalent tendency for women to be blamed and victimised. This means there is huge under-reporting of the problem and women often do not seek services. Intimate partner violence is less stigmatised than sexual assault and, therefore, receives more attention from service providers.
- ***Providing staff training:*** There is evidence that training and specialisation in sexual assault contribute to raising awareness of victim's emotional distress and challenging assumptions, thus reducing the risk of secondary victimisation of women by professionals when reporting sexual assault. In addition, evidence supports specialisation and training in forensic examinations for sexual assault cases. Victim blaming attitudes of many professionals are a significant factor in why many women do not report.
- ***Encouraging staff specialisation:*** There is evidence that victims seen by specialised sexual assault nurse examiners receive more consistent and broad based medical care. Training and specialisation in sexual assault, either in the form of specialised service provision or by specialised professionals, will be more likely to offer victims thorough medical care.
- ***Changing staff attitudes:*** There is evidence that how service providers respond to women has significant impacts on their accessing appropriate services and recovery. Long waits for the examination and the examiner appearing to disbelief have strongly negative impacts. Services delivered by compassionate staff who are aware of the trauma caused by sexual assault can support healing.
- ***Providing cognitive behavioural therapies:*** There is evidence of the benefits of cognitive behavioural therapies, especially in terms of PTSD outcomes. However, some studies also suggest that PTSD symptoms remain even after treatment.
- ***Ensuring sexual assault is not missed by integrated services:*** Integrated services that deal with all forms of violence need to specifically address sexual violence otherwise there is a danger women will not seek help and will instead focus on other problems. Sexual assault remains much more stigmatised than other forms of violence such as intimate partner violence.
- ***Providing services without time limits:*** It is important of avoid placing time limits on accessing support. Many women will try to cope alone first and only contact services some time after the assault. Additionally, some women may require psychosocial support for some time after the attack. Twenty-four hour, seven days a week provision of support is preferable as many women have limited private time and space to seek help and the decision to do so is often a difficult one. If there is no response or an answer message when they do try to access services, they may not try again at a later point.

- ***Reducing variability in service quality and accessibility:*** Sexual assault is not a phenomenon unique to urban settings. It also occurs in rural and more secluded areas with different or limited legal, medical and social infrastructures and resources. Most of the existing evidence focuses on understanding urban patterns of sexual assault and services. In addition, where co-ordinated services are available in urban areas, they are not always accessible to those living outside large cities. There is often a large variation in the quality of services available in large urban areas and the rest of the country which leads to inequities in care and outcomes.
- ***Providing language support***: The quick and easy availability of independent language interpreters, including for deaf women, is important.
- ***Providing childcare:*** Many women need to have childcare in order to access services.
- ***Providing self-referral:*** The ability to self-refer to services so women who do not want to report to the authorities can still receive treatment services is important.
- ***Providing information on the course of action and obtaining victim's consent:*** Women want to know what to expect from different services and have the ability to make informed decisions during the process of care, such as getting a forensic exam, choosing female examiners.
- ***Ensuring that services are, and are perceived to be, independent and confidential:*** Legal requirements on doctors to report cases of sexual assault to the police can prevent women accessing health services for fear the police will become involved. Whether this requirement actually exists or not, the perception it exists amongst professionals and victims is enough to reduce service take-up. In addition, the fear of a lack of confidentiality by service providers is a factor limiting the uptake of services, especially in rural areas and close-knit communities where everyone is perceived to know everyone else.

9 Overcoming common challenges: recommendations

Evidence shows that countries share common challenges in addressing sexual assault, whatever models of service provision and strategies are in place. These include:

- High levels of under-reporting by women who have experienced sexual assault;
- Low public awareness of the problem;
- Strong taboos and rape myths;
- Victim blaming attitudes prevalent amongst some professionals;
- High levels of non-reported sexual violence amongst women experiencing intimate partner violence;
- The need to provide services of consistent quality and accessibility to urban areas, where demand is higher due to population density, and rural areas where demand, is lower;
- Resource intensiveness of specialist services that are open permanently;

- Different levels of service infrastructure between regions;
- Ensuring systems and protocols are uniformly implemented;
- A lack of specially trained professionals;
- The need to ensure confidentiality and independence of service, including in close-knit communities;
- Population groups that require additional support such as ethnic minorities and trafficked women;
- Constraints on funding for public services; and
- Difficulty in ensuring the criminal justice system deals with cases consistently and fairly.

Based on evidence from research undertaken as part of the *Comparing Sexual Assault Interventions* project, this policy briefing makes a number of recommendations that build on identified good practice to overcome these common challenges. These recommendations are aimed at policy makers within regional and national governments, service providers and professional associations at the national level. International organisations and initiatives, such as DAPHNE III and the *Comparing Sexual Assault Interventions* project, also have an important role to play in enabling good practice to be shared between countries.

- Policy makers should recognise governments need to take the lead in addressing sexual assault. Sexual assault is a social, public health and economic problem and while NGOs have an important role to play, meeting the needs of victims of sexual assault is the responsibility of governments.
- Policy makers and service providers should incorporate the aspects of good practice described in this policy briefing in the design and delivery of services for victims of sexual assault.
- Professional associations need to develop and share modules for training staff. This is key to the transferability of specialised services. Training must include technical aspects of service provision, crisis intervention and awareness raising to change attitudes that blame or victimise women. International professional associations can support the sharing of training modules between countries.
- Policy makers need to ensure government led or endorsed major public awareness campaigns are undertaken that challenge rape myths, reduce the stigma of sexual assault and encourage women to seek help. Such campaigns need to build on the experience and activities of NGOs. International organisations and initiatives can support this by sharing information between countries on these campaigns.
- Policy makers and service providers should share learning on new coordinated models of services currently being developed by some countries (including England and Denmark) which are less resource intensive and enable improvements in the uniformity of service quality.
- Professional associations and service providers need to share national protocols on examination, treatment, follow-up and other aspects of case management.

- Policy makers should commission further research to improve understanding of the needs of groups who have particular difficulties in accessing services. These include women who have been trafficked for sexual exploitation, sex workers, Muslim women, women from the Roma community and migrant women. National governments and international organisations and initiatives, including DAPHNE III, need to support such research.
- Policy makers, service providers and other organisations need to recognise that prevalence studies underestimate the real extent of sexual assault and that further research is needed to improve understanding of prevalence. Methodologies using population-based surveys that count self-reporting should be used as these more accurately reflect victimisation levels than crime statistics based on reports to the police. Sexual assault is one of the most under-reported crimes.
- International organisations and initiatives, including DAPHNE III and the *Comparing Sexual Assault Interventions* project, need to develop and support networks of organisations and policy makers with responsibility for sexual assault to share experiences with others, both within and between countries and regions.
- Policy makers need to ensure that criminal codes move from traditional rape laws that define rape based on force to those which define it based on consent in those countries where traditional rape laws are still in place.
- Policy makers, international organisations and initiatives, including the *Comparing Sexual Assault Interventions* project, need to develop tools for evaluating service effectiveness and accessibility, including those that include sensitive follow-up of victims. This is important because there is currently a lack of evaluation and evidence on the impact and effectiveness of services.
- Policy makers need to ensure that evaluations and research are also conducted in lower resource settings to test the effectiveness of interventions and also identify new evidence in these contexts. National governments and international organisations and initiatives, including DAPHNE III, need to support such research.
- Professional associations and international organisations and initiatives, including DAPHNE III and the *Comparing Sexual Assault Interventions* project, need to support networks for collaboration on evaluation and sharing skills for evaluation of sexual assault services.

Case studies

Four case studies have been included in this policy briefing. These are intended to provide a brief snapshot of the types of strategic and service delivery approaches in place in different countries and to describe some of the current challenges they face. The case studies do not provide a comprehensive description of services and issues and do not suggest some countries are performing better than others.

Case study 1: England and Wales

Specific objectives on rape and sexual assault are included in the *Call to End Violence against Women and Girls,* a cross-Government strategy published by the Home Office in November 2010. It is accompanied by an action plan.

Coordinated specialist services sexual assault referral centres (SARCs) are in place covering most areas. Where these exist, women who report rape to the police will be brought to the SARC. Women can also present directly to the SARC or be referred through another service or NGO. There is no mandatory requirement to have a forensic examination or to prosecute. Evaluation suggests client/victim centered approach of SARCs is valued by women and even if they have to travel some distance to get to them, this is considered worth it. 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 forensic services for these women.

Additionally, rape crisis centres run by NGOs also offer support for women. Rape crisis centres take self-referrals, referrals from the GPs and hospitals and the police. SARCs also sometimes refer women to rape crisis centres for on-going support. Rape crisis centres do not cover all areas, though funding for 15 new centres has recently been agreed.

The quality of rape suites where there are no SARCs is very variable. Broadly speaking there is a rural/urban divide in service quality. There is a really good gold standard in some areas, mainly those with well established SARCs. But in other areas the quality of services is poor. There is a high variation in workload, referral rate, funding per case. In some areas there are delays in getting seen by a doctor. Also because there are so few women doctors, there can be a time delay before a woman can get to see a woman doctor. In practice these means that women sometimes have to chose between seeing a male doctor quickly or waiting hours or even days to see a woman doctor. In addition, the SARC service model is expensive because staff need to be on hand in case there is a client. New models that are less resource intensive and will improve the uniformity of service quality are currently being

explored. These include models whereby large centres that are permanently open can support smaller satellite ones.

Case study 2: Spain

Spain has a federal system of government with responsibility for healthcare resting with regional governments. This means that different strategies and models of service delivery are used in different regions. Some regions, such as Catalonia, have centres offering coordinated and specialist services for sexual assault victims. In other areas women can access medical treatment through health care services and the criminal justice system through police services. Hospitals deal with the immediate and urgent care. Primary care centres are responsible for prevention/detection and post-hospital follow-up, including STD tests results, HIV, psychological care.

In many regions NGOs and associations play a major role in supporting victims, especially in providing long-term psychological support. However, funding for these services is inadequate and they cannot deal with the number of clients.

Some regional governments have a coordinated strategy to deal with victims of gender violence and sexual assault. La Rioja is one example. This strategy identifies the roles and responsibilities of the health and legal sectors, social services and regional penitentiary.

At the national level, there is no separate strategy on sexual violence exclusively. Sexual violence is addressed in the law and strategy on gender based violence. In 2007 the Ministry of Health published a protocol with recommended actions for victims of sexual violence and sexual assault.

Case study 3: Latvia

There are no coordinated specialist units for women who have experienced sexual assault. The emergency department of a hospital offers emergency medical treatment free of charge. There were different perceptions among participants in the telephone interviews about whether it was compulsory for medical establishments to report to the police 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. Several interviewees said that the perception doctors would tell the police prevented some women seeking treatment.

The legal definition of rape is based on force and vaginal penetration. This means the police will expect some evidence of force, for example torn clothes or other injuries. Forensic work is done by a separate forensic medical department that is open 24

hours a day, seven days a week. The victim of a sexual assault has to initiate the case by writing an application. In other criminal cases the police initiate cases. This is to ensure criminal action only starts in those cases where the victim wants to take action.

An initiative by the Latvian Association of Gynaecologists and Obstetricians has recently started providing training in sexual violence for gynaecologists.

The trafficking of women for sexual exploitation from Latvia to other countries is a significant problem. While this gets some media and political attention, there is very little public understanding of the problem. Women are blamed for allowing themselves to be trafficked. More public education is needed to increase awareness of the nature of the problem. Women who are young, unemployed, uneducated and from social risk families are most at risk. There is currently a major inter-departmental government project on this that involves police, health, welfare, education and other depts.

There is no separate strategy on sexual violence exclusively. The programme on prevention of family violence 2008-2011 includes sexual violence within the context of intimate partner violence.

Case study 4: Denmark

There are co-ordinated specialist centres for rape victims based in hospitals. The biggest is in Copenhagen that sees around 300 clients a year. There are other centres in Aarhus and other towns that 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 but women can also come directly. Data analysis quoted from services suggested that client numbers and reporting levels are fairly stable, with around 30% of clients not reporting the sexual assault to the police.

A major restriction is that there is a time limit on accessing these centres whereby clients have to come within a week of the sexual assault. This means women who do not report within this time cannot use the services. There is also a wide variation in the quality of services between urban and rural areas. Women who do not report to the police are often not getting help because they cannot get transport to the specialist centres (if they report to the police the police take them). There is a new national working group looking at this. They are exploring models where larger specialist centres will support smaller centres.

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. It is concerned about the lack of services for women who cannot use the co-ordinated

specialist centres, either because the do not live near one or because the time limits exclude them, and is advocating for free psychological support for victims.

There is no national government strategy in place that addresses sexual assault.

Appendix 1: About the Comparing Sexual Assault Interventions project

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:

- Define the evidence base of policies and programmes for dealing with sexual assault by reviewing the international literature.
- Explore what models of intervention for victims of sexual assault exist in EU Member States and EFTA/EEA countries.
- 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.
- Compare the acceptability, transferability, effectiveness and efficacy in achieving their outcomes, including by seeking women's views of services provided.
- 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. It 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.

Appendix 2: Mapping of national strategies that include sexual assault

Country	***National strategies to address sexual violence***
Cyprus	No separate strategy on sexual violence exclusively. The National Action Plan on Gender Equality 2007-2013, includes measures on violence against women in general.
Finland	No separate strategy on sexual violence exclusively. The Action Plan to Reduce Violence against Women includes sexual violence.
Greece	No separate strategy on sexual violence exclusively. The National Programme for Substantive Gender Equality 2010-2013 the National programme on preventing and combating violence against women 2009 – 2013 include sexual violence.
France	No separate strategy on sexual violence exclusively. The three Year Plan of Action Ministry of Social Cohesion 2011-2013 includes a section on violence against women.
Ireland	No separate strategy on sexual violence exclusively. The National Women's Strategy 2007-2016 includes an objective on violence against women.
Lithuania	No separate strategy on sexual violence exclusively. The National Strategy for Combating Violence against Women is more focused on intimate partner violence.
Luxembourg	No separate strategy on sexual violence exclusively. There is a strategy on intimate partner violence.
Netherlands	No separate strategy on sexual violence exclusively. The LGBT and Gender Equality Policy Plan of the Netherlands 2011 – 2015 includes a target on target reducing insecurity amongst women and girls.
Spain	No separate strategy on sexual violence exclusively. Sexual violence addressed in the law and strategy on gender based violence.
Portugal	No separate strategy on sexual violence exclusively. The IV National Plan for Equality, Gender, Citizenship and Non-Discrimination, 2011-2013 includes gender based violence.
Poland	No separate strategy on sexual violence exclusively. There is a strategy on intimate partner violence.
Romania	None identified.
Slovenia	No separate strategy on sexual violence exclusively. The National Programme for Equal Opportunities for Women and Men, 2005-2013, includes sexual violence.
Italy	There is a National Action Plan against Sexual and Gender-based Violence.
Czech Republic	No separate strategy on sexual violence exclusively. There is a strategy on intimate partner violence.
Northern Ireland	Tackling Sexual Violence and Abuse - A Regional Strategy 2008 – 2013.
England & Wales	No separate strategy on sexual violence exclusively. However, specific objectives on rape and sexual assault are included in the Call to End Violence against Women and Girls.

Scotland	No separate strategy on sexual violence exclusively. Specific objectives on rape and sexual assault are included in Safer Lives: Changed Lives. A Shared Approach to Tackling Violence Against Women in Scotland.
Sweden	No separate strategy on sexual violence exclusively. Sexual violence is included in the National Action Plan to combat men's violence against women.
Slovakia	No separate strategy on sexual violence exclusively. The National Action Plan to prevent and eliminate violence against women and update of tasks 2009 – 2012 includes action on sexual violence.
Latvia	No separate strategy on sexual violence exclusively. There is a strategy on intimate partner violence.
Hungary	None identified.
Estonia	None identified.
Germany	No separate strategy on sexual violence exclusively. Sexual assault is covered in the National Action Plan II to combat violence against women.
Malta	None identified.
Belgium	No separate strategy on sexual violence exclusively. There is a strategy on intimate partner violence.
Bulgaria	No separate strategy on sexual violence exclusively. There are particular laws and provisions relating to intimate partner violence.
Austria	No separate strategy on sexual violence exclusively. Aspects of it are included in several other strategies.
Denmark	None identified.
Switzerland	None identified.
Norway	No separate strategy on sexual violence exclusively. The Action Plan for Women's Rights and Gender Equality in Development Cooperation (2007–2009, extended to 2010-2013) includes gender based violence.
Iceland	The National Action Plan against gender based violence and sexual violence for 2007-2011.
Macedonia	None for adult women. The Action Plan for prevention and protection of sexual abuse and pedophilia 2009 – 2012 deals with children.
Montenegro	No separate strategy on sexual violence exclusively. There is a strategy on intimate partner violence.

Appendix 3: Mapping of interventions for women who have experienced sexual assault

Country	***Services for women who have experienced sexual assault***
Cyprus	Women can access medical treatment through health care services and the criminal justice system through police services.
Finland	Women can access medical treatment through health care services and the criminal justice system through police services. There are also NGOs that provide support.
Greece	There is a 24 hour phone line for victims of violence against women. There are 12 regional consultation centres offering support to abused women and their children. They can be described as integrated services in that they deal with sexual violence with the context of gender violence.
France	There is a free national rape helpline. In each region there is also a hospital based service known as *les pôles régionaux d'accueil et de prise en charge des victimes de violences sexuelles.* These are centres offering coordinated and specialist services for sexual assault victims.
Ireland	There is a network of 18 Rape Crisis Centres and there are also six dedicated sexual assault treatment units (SATU). These are centres offering coordinated and specialist services for sexual assault victims.
Lithuania	Women can access medical treatment through health care services and the criminal justice system through police services There is a free telephone helpline for women who have experienced violence.
Luxembourg	There is a telephone hotline service that provides 24h assistance for victims of rape and sexual assault. Women can access medical treatment through health care services and the criminal justice system through police services. There is also a standard rape kit for forensic examinations which are performed by court-appointed forensic doctors.
Netherlands	No information identified.
Spain	Some regions have centres offering coordinated and specialist services for sexual assault victims. In other areas women can access medical treatment through health care services and the criminal justice system through police services.
Portugal	No information identified.
Poland	Women can access medical treatment through health care services and the criminal justice system through police services. There are operational procedures for assisting victims of sexual violence which cover medical and psychological support and forensic examination but these are not obligatory.
Romania	Women can access medical treatment through health care services and the criminal justice system through police services.
Slovenia	There is an SOS Help-line, for victims of sexual violence. Women

	can access medical treatment through health care services and the criminal justice system through police services.
Italy	Women can access medical treatment through health care services and the criminal justice system through police services. There are also anti-Violence Centres are socio-welfare services provided by NGOs. They can be described as integrated services in that they deal with sexual violence with the context of gender violence.
Czech Republic	Women can access medical treatment through health care services and the criminal justice system through police services.
Northern Ireland	There are three rape crime units. These are centres offering coordinated and specialist services for sexual assault victims. There are also a variety of other specialist services including rape crisis centres and helplines provided by government and NGO.
England & Wales	In England there are a range of service providers offering facilities and care for victims of sexual violence which include sexual assault referral centres (SARCs). These are centres offering coordinated and specialist services for sexual assault victims. In addition there is a network of Rape Crisis Centres provided by NGOs.
Scotland	There is a dedicated Sexual Assault Service. This is a centre offering coordinated and specialist services for sexual assault victims. There is also a national helpline and 14 rape crisis centres provided by NGOs.
Sweden	There are dedicated sexual assault centres. These are centres offering coordinated and specialist services for sexual assault victims. These are also a range of support services provided by NGOs.
Slovakia	Health care services for women at risk of violence, or women experiencing violence are provided through inpatient care, outpatient care, emergency medical and health services across the Slovak Republic.
Latvia	Health care services are provided in health care settings. A separate forensic service undertakes forensic examinations. NGOs provide counselling.
Hungary	Women can access medical treatment through health care services and the criminal justice system through police services. The police commission forensic examinations from experts. A foundation provides counselling.
Estonia	Women can access medical treatment through health care services and the criminal justice system through police services.
Germany	There are dedicated sexual assault centres. These are centres offering coordinated and specialist services for sexual assault victims. There is also a range of non-governmental organisations providing services.
Malta	Women can access medical treatment through health care services and the criminal justice system through police services.

Belgium	Specialist services exist in some regions but not others. There are also services for police assistance to victims at the local police zones.
Bulgaria	Women can access medical treatment through health care services and the criminal justice system through police services. There is a forensic department. A number of NGOs offer support.
Austria	There are range of specialised services including rape crisis centres. These are coordinated services specialising in sexual assault victims. There is also a 24 hour helpline.
Denmark	There are specialised sexual assault centres based in hospitals. These are centres offering coordinated and specialist services for sexual assault victims.
Switzerland	Medical and sexual health care is provided by health care providers. There are victim support centres in every canton.
Norway	Centres for victims of sexual assault are in place in major towns and cities. These are centres offering coordinated and specialist services for sexual assault victims.
Iceland	There is a specialist Rape Trauma Service. This is a centre offering coordinated and specialist services for sexual assault victims.
Macedonia	Women can access medical treatment through health care services and the criminal justice system through police services. There is an Institute for forensic medicine.
Montenegro	Women can access medical treatment through health care services and the criminal justice system through police services.

[1] http://www.who.int/mediacentre/factsheets/fs239/en/

[2] Diesen, C. & Diesen, E.F., 2010. Sex crime legislation: Proactive and anti-therapeutic effects. *International Journal of Law and Psychiatry*.

[3] Aebi, M.F. et al., 2010. European Sourcebook of Crime and Criminal Justice Statistic2010, WODC. Available at: http://europeansourcebook.org/ob285_full.pdf [Accessed February 23, 2012].

[4] Montorio Cerrato, I. et al., 2000. Sexual aggression against women by men acquaintances: Attitudes and experiences among Spanish university students. *The Spanish journal of psychology*, 3, pp.14–27.

[5] Hannah M McGee, Rebecca Garavan, Mairead de Barra, Joanne Byrne & Ronan Conroy, 2002. The SAVI Report Sexual Abuse and Violence in Ireland: A national study of Irish experiences, beliefs and attitudes concerning sexual violence, Royal College of Surgeons in Ireland.

[6] Gemzell, T., Asp, I. & Lindvall, J., 2005. *The Cost of Gender-Based Violence in Sweden*. Linköping: Linköping Universitet.

[7] Department of Health, Home Office & Association of Chief Police Officers, 2009. *A Resource for Developing Sexual Assault Referral Centres (SARCs)*, Department of Health. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107570 [Accessed December 17, 2011].

[8] Health Action Partnership International. 2012. Comparing Sexual Assault Interventions: Mapping of national strategies and services and analysis of survey responses. Health Action Partnership International.

[9] http://www.who.int/mediacentre/factsheets/fs239/en/

[10] Health Action Partnership International. 2012. Comparing Sexual Assault Interventions: Mapping of national strategies and services and analysis of survey responses. Health Action Partnership International.