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**Citation:** Walby, S., Olive, P., Towers, J., Francis, B., Strid, S., Krizsan, A., Lombardo, E., May-Chahal, C., Franzway, S., Sugarman, D. & et al (2013). Overview of the worldwide best practices for rape prevention and for assisting women victims of rape (10.2861/37950). European Parliament.

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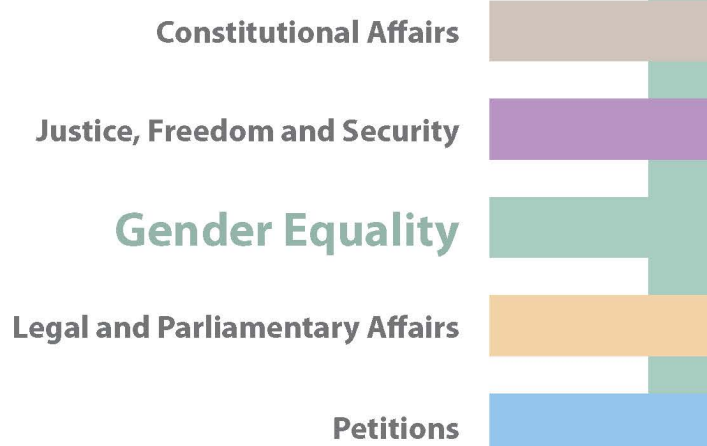
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DIRECTORATE-GENERAL FOR INTERNAL POLICIES

# POLICY DEPARTMENT

CITIZENS' RIGHTS AND CONSTITUTIONAL AFFAIRS



## Overview of the worldwide best practices for rape prevention and for assisting women victims of rape

STUDY







**DIRECTORATE GENERAL FOR INTERNAL POLICIES**

**POLICY DEPARTMENT C: CITIZENS' RIGHTS AND  
CONSTITUTIONAL AFFAIRS**

**GENDER EQUALITY**

# **Overview of the worldwide best practices for rape prevention and for assisting women victims of rape**

## **Study**

### **Abstract**

The study provides an overview of the worldwide best practices for rape prevention and for assisting women victims of rape. It reviews the international literature and offers selected examples of promising practices. It addresses the comprehensive range of policies in the fields of gender equality; law and justice; economy, development and social inclusion; culture, education and media; and health. It presents a wide-ranging set of examples of best practice. It concludes with a series of recommendations, based on the social scientific evidence presented in the study.

This document was requested by the European Parliament's Committee on Women's Rights and Gender Equality.

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## **LINGUISTIC VERSIONS**

Original: EN

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European Parliament, manuscript completed in October 2013.  
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## ACKNOWLEDGEMENTS

We would like to thank the following people for their help and contributions:

Health case studies: Rachel Belk, Research Officer, St. Mary's Sexual Assault Referral Centre, Manchester. Jennifer Holly, Stella Project Mental Health Initiative Coordinator, AVA (Against Violence and Abuse), London. Jackie Patiniotis, reVision (formerly The Joint Forum), Liverpool, England. Bill Roberts, Locate Investigations Ltd. Bernie Ryan, Service Manager, St. Mary's Sexual Assault Referral Centre, Manchester. Dr. Kylee Trevillion, Visiting Postdoctoral Research Fellow, Section of Women's Mental Health, Health Service and Population Research Department, Institute of Psychiatry, King's College, London. Dr Cath White, Clinical Director, St. Mary's Sexual Assault Referral Centre, Manchester. Liz Willows, Specialist Mental Health Independent Sexual Violence Advisor, The Haven, Paddington Sexual Assault Referral Centre, London.

Australia case study: Bec Neill

Comprehensive rape crisis services case study: Bobbi Grange (SACT) and Michelle Barry (Southampton Rape Crisis Centre)

Cyber-rape case study: Awais Rashid

Mexican law case study: Deysi Cheyne, Ana de Mendoza, Ana María Moreno, Lorena Pajares, Guadalupe Portillo, Charo Rubio

#talkaboutit case study: Gustav Almestad

Commenting on the draft report: Liz Kelly (CWASU, London Metropolitan University)

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## LIST OF ABBREVIATIONS

<b>A&amp;E</b>	Accidents and Emergencies
<b>ANCOR</b>	Australian National Child Offender Register
<b>BME</b>	Black Ethnic Minority
<b>CVTV</b>	Closed Circuit Television
<b>CJS</b>	Criminal Justice System
<b>CORE</b>	Counselling Outcomes Research Evaluation
<b>DFID</b>	Department for International Development
<b>DoH</b>	Department of Health
<b>DoJ</b>	Department of Justice
<b>DSD</b>	Department of Social Development
<b>ECP</b>	Emergency Contraception
<b>EIGE</b>	European Institute for Gender Equality
<b>EP</b>	European Parliament
<b>ESF</b>	European Structural Fund
<b>EWL</b>	European Women's Lobby
<b>FIJAIS</b>	Fichier Judiciaire Automatisé des Auteurs D'Infractions Sexuelles
<b>FOI</b>	Freedom of Information
<b>FRA</b>	European Union Fundamental Rights Agency
<b>GRIP</b>	Greater Rape Intervention Programme
<b>IAFN</b>	Checklist for Disaster Planning
<b>IAPT</b>	Improving Access to Psychological Therapies
<b>IASC</b>	Inter-Agency Standing Committee
<b>IAWG</b>	Inter-Agency Working Group
<b>ICL</b>	International Criminal Law



<b>ICTR</b>	International Criminal Tribunal for Rwanda
<b>ICTY</b>	International Criminal Tribunal for the Former Yugoslavia
<b>IHL</b>	International Humanitarian Law
<b>IHRL</b>	International Human Rights Law
<b>IMAGE</b>	Micro-Finance for AIDS and Gender Equality
<b>IRC</b>	International Rescue Committee
<b>ISVA</b>	Independent Sexual Violence Advocate
<b>MARAC</b>	Multi-Agency Risk Assessment Conference
<b>MHPSS</b>	Minimum Mental Health and Psychosocial Support
<b>MISP</b>	Minimum Initial Service Package
<b>MHISVA</b>	Specialist Mental Health Independent Sexual Violence Advisor
<b>NDPP</b>	National Director of Public Prosecutions
<b>NGO</b>	Non-governmental Organisation
<b>NPA</b>	National Prosecuting Authority
<b>NSOR</b>	National Sex Offender Registry
<b>OHCHR</b>	Office of the United Nations High Commissioner for Human Rights
<b>PATH</b>	Psychological Advocacy Towards Healing
<b>PFA</b>	Psychological First Aid
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>RCNE</b>	Rape Crisis Network Europe
<b>RCC</b>	Rape Crisis Centre
<b>ROKS</b>	Riksorganisationen För Kvinnojourer och Tjejjourer i Sverige
<b>SACT</b>	Sexual Assault Crisis Team
<b>SAME</b>	Sexual Assault Medical Examiner
<b>SANE</b>	Sexual Assault Nurse Examiner

<b>SAPS</b>	South African Police Service
<b>SARC</b>	Sexual Assault Referral Centre
<b>SART</b>	Sexual Assault Response Team
<b>SDVC</b>	Specialist Domestic Violence Court
<b>SOC</b>	Sexual Offences Court
<b>SOCs</b>	South African Sexual Offence Courts
<b>SOCA</b>	Sexual Offences and Community Affairs Department
<b>SOIR</b>	Sex Offender Information Registration Act
<b>SORN</b>	Sex Offender Registration and Notification
<b>SMSG</b>	Special Representative of the Secretary-General
<b>STAR</b>	Southampton Talking About Relationships
<b>STI</b>	Sexually Transmitted Infections
<b>TCC</b>	Thuthuzela Care Centres
<b>UN</b>	United Nations
<b>UNESCO</b>	United Nations Educational, Scientific and Culutral Organization
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNSG</b>	United Nations Secretary-General
<b>UNSCR</b>	United Nations Security Council Resolution
<b>ViSOR</b>	Violent and Sexual Offender Register
<b>VAWG</b>	Violence Against Women and Girls
<b>WWC</b>	Working Women's Centre
<b>WWC SA</b>	Working Women's Centre South Australia
<b>WHO</b>	World Health Organization

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## EXECUTIVE SUMMARY

### Introduction

Rape matters. It destroys lives, as its traumatizing effects can linger long after the immediate pain and suffering. It is a form of gender inequality, an injury to health, a crime, a violation of women's human rights and is costly to economy and society.

Rape is one of the most serious forms of violence. It is the unwanted penetration of the body; with variations in definitions that concern whether absence of consent or use or threat of use of force is central, the object doing the penetration, and the orifice of the body being penetrated. The UN has a recommended **definition for legislation**, but there are currently some variations in the definition used in different legal regimes. There are further variations in the meaning in social science research and in popular understandings.

There are many ingenious ways to address rape, to prevent it, to support victims. These practices are under development, constantly being tested and improved. This report is an overview of the worldwide best practices for rape prevention and for assisting women victims of rape. It is based on a review of the international literature on developments, together with a series of case studies of best practices.

There is a range of **practices** to prevent rape and to assist victim-survivors of rape. These may be classified according to: function of the practice; setting of the rape; target of the intervention; and the policy field. Distinctions can be made between: prevention, protection, prosecution, provision and partnership. There is need for a gender equality perspective and gender sensitive programming throughout these practices. The main policy fields include:

- Planning and coordination;
- Specialised services for victims-survivors;
- Health;
- Law and justice;
- Economy and social inclusion;
- Culture, education and media.

The evaluation of the practices requires the identification of the causes of rape and of the intended and actual contribution of each of the interventions to prevent rape and to assist victims. The detailed evaluation of specific practices and the exact scale of their contribution are on-going rather than complete. In broad outline, the **set of policies** needed to prevent rape and to assist victims is well-established. This includes both the development of specialised areas of expertise and also the diffusion of this expertise through normal policy actors, as is usual in the practice of gender mainstreaming.

However, the full set of policies that has been identified as necessary in the literature and by practitioners has **never been fully implemented** in any society.

### Planning and coordination

Strategic planning is needed at the different levels of governance, including the highest level. This works best when work on rape is integrated within a wider **framework** of

combating gender-based violence against women. The UN, Council of Europe and other international bodies have made significant contributions to the development of **strategic planning** across Europe and around the world. At a national level, the establishment of National Plans of Action has been a significant development. The instigators have often been feminist NGOs, whose **expert contributions** continue to be important, requiring that consultation procedures include them fully.

Local **coordination** mechanisms are intended to ensure that services on the ground are effectively coordinated and also focused on the needs of victim-survivors. This coordination is most effective when services on rape are integrated into a wider framework of services on gender based violence against women more broadly. There are some examples of coordination of both specialised provision of services centred on victim-survivors and of the prevention of rape across the full policy spectrum of law and justice, economic growth and social inclusion, education and media, and health.

## Specialised services for victim-survivors

The provision of a comprehensive set of services focused on the victim-survivor is important and centring their provision in one location, or some other form of coordination, can improve their effectiveness. The Council of Europe's list of **minimum services** for preventing violence against women and assisting victims includes: free 24 hour help lines; support and advocacy services; accessible services for socially excluded women, especially recent migrants, refugees, women from ethnic minority groups and those with disabilities; access to financial support, housing, residence rights, education and training; networking between specialist NGOs; multi-agency co-ordination; training curricula for professionals addressing the continuum of violence against women within a human rights framework; work with perpetrators rooted in women's safety and prevention; and safe shelters. The development of **special packages** of services to assist victim-survivors of rape in humanitarian emergencies, often led from a health perspective, has been an important development (discussed further, under health). Specialised rape crisis centres have developed that offer expert provision to victim-survivors and offer expert engagement in policy development.

## Health

The health consequences of sexual violence and rape are known to include: sexual and reproductive health problems including unwanted pregnancy, HIV and sexually transmitted diseases; mental health problems and health risk coping strategies; physical injuries; and social ostracization. Health sector based intervention for rape and sexual violence has been developing for over thirty years. Today, the overarching definition of best practice for services for victim-survivors of rape is a **health led, multi-sectoral 'one-stop shop' unit**, housed in a hospital or primary health care facility with a separate entrance and providing health interventions, forensic evidence collection, advocacy and counselling. Practice standards for this health-led intervention are differentiated into six domains: Capable and Care Conducive Environment; Health and Medical Care; Forensic Examination and Evidence Collection; Community and Social Support; Specialist Referral and Follow-up Care; Quality and Monitoring. These are relevant to both non-conflict zones and conflict zones.

## Law and justice

There have been significant changes to the law on rape, so that it is today almost **universally criminalized**. Rape is increasingly designated a serious crime not condoned

by the authorities and for which perpetrators should not expect to act with impunity; however, the legal definition of rape differs between legal regimes. Best practice includes: a **definition of rape** in which the presence of a coercive context or the absence of consent is considered sufficient, without the need to additionally demonstrate physical force; the range of body parts is inclusive rather than narrow; there should be no marital exception; and respect for victim-survivors is institutionalised within the legal and criminal justice system. The UN Handbook for Legislation on Violence against Women and the Council of Europe Istanbul Convention presents **internationally respected standards** for legislation.

The best practices in the Criminal Justice System (CJS) to prevent rape and assist women victim-survivors of rape are those that deliver **increasing conviction rates** for perpetrators of rape whilst **preventing secondary trauma** for victim-survivors. This includes: provision of support and advocates for victims throughout the CJS process; development of expert knowledge and skills among police, prosecutors, judiciary and other CJS personnel through training; specialist courts; embedding inter-agency working practices; and adequately funded and evidence-based practises that feed back into further improvement. Increasing conviction rates for perpetrators of rape contribute to rape prevention by making clear statements to the wider society that rape is a serious crime which is not condoned by the state and that perpetrators of rape cannot act with impunity. Preventing secondary trauma for victim-survivors contributes to assisting women victims of rape by enabling them to obtain justice whilst regaining a sense of dignity, autonomy and control.

There are a number of medical and therapeutic **treatments** of convicted rapists, ranging from surgical and chemical castration to cognitive behaviour therapy; but the more severe treatments can be regarded as violating human rights and the less severe to be lacking in proven effectiveness.

The inclusion of rape as a **war crime** and **crime against humanity** in the Rome Statute of the International Criminal Court was an important symbolic development, though there has been **little effective implementation**, since there have been few prosecutions or convictions. Efforts to reduce the very high rates of sexual violence in conflict and post-conflict zones by increasing the presence of women in peace-keeping forces and processes have been important recent developments, authorised by a series of resolutions from the UN Security Council.

## Economy and social inclusion

The extent of women's economic independence is linked to the level of violence against women, including rape. Some economic interventions aim to provide women with greater ability to resist by exiting relationships, locations or contexts which make them particularly vulnerable to rape. Robust **access to the means for livelihood** is necessary for effective recuperation from rape (in both domestic and other contexts), so the package of support to women victim-survivors of rape needs to address such economic issues by providing economic advocacy addressing issues of immediate income support followed by access to education, training and employment. Full social inclusion of women mitigates the likelihood and consequences of rape. Thus, policies for economic growth and social inclusion are relevant to policies to prevent rape, though this is rarely officially acknowledged.

## Culture, media and education

Interventions to prevent rape in the sphere of culture, media and education include programmes to raise **awareness** and to **change individual behaviour**, as well as to regulate the media. Media **regulation** has been tried to offer anonymity to rape victims in court cases and to restrict the circulation of some forms of pornography, for example involving children. The new **social media** have been used as a site for the discussion of the meaning of rape in both positive and negative ways. Individual programmes are used to **encourage positive attitudes** and behaviour in children and young people and to change the behaviour of individuals who have already become violent. Relationship approaches are used to influence interactions inside families and negative influences from peers. Awareness raising campaigns have provided information to inform people as to the rights of women and the wrongs of sexual violence. Targets include the school curriculum and educational institutions. There are some promising practices in the field of education.

## CASE STUDY EXAMPLES OF BEST PRACTICE

### Introduction

The case studies were selected as examples of the best practice that could be found. These are innovative, make a difference, and are models for replication. But the field is still developing, and there are many more examples of 'promising practices' than of 'best' practices.

### Comprehensive rape services: Sexual Assault Crisis Team: US

Sexual Assault Crisis Team (SACT) in the US provides **comprehensive services** to victims-survivors of sexual violence, including emergency shelter and transitional housing. SACT is a rape crisis shelter intervention that provides residential based support for victim-survivors of rape and sexual assault, including those in the immediate aftermath of a rape; those coming to terms with historic rape experiences, including as a child; and those who have returned to the area to testify at trial. SACT has been identified as an example of best practice by a 2011 resource sharing project for the National Sexual Assault Coalition (reshāp). It offers not only safe and secure **shelter** in the aftermath of a rape but is multifunction, also providing access to a comprehensive range of **education, training and support programmes** designed to enable residents to identify, work toward and achieve goals in order to move on from the shelter accommodation. SACT is victim-centred and needs-led, while utilising expert, evidence-based, knowledge and collaborating with a range of other agencies, including domestic violence shelters, health, criminal justice, housing, and local government.

### Development of coordinated and integrated services: Australia, including Yarrow Place

Australia offers an example of the development of **nationally coordinated services**, while the Yarrow Place Rape and Sexual Assault Service is an example of locally integrated provision. More than thirty years of feminist campaigning led to improved legislation, greater respect for victim-survivors of rape, established gender-sensitive support services and developed education programs for professionals working in the field (for example, police, legal services, health workers). There is increased prioritisation of better integration of services so that victims' experience of the diverse relevant services is smooth and timely. However, there remain issues concerning public perception and community attitudes towards rape.

## Coordinated community responses: US

The coordination of community responses to address rape and other forms of violence against women attempts to **integrate the activities** of the relevant state and non-state actors at the community level. A major objective of coordination is to avoid fragmentation and to keep the interests of the victim-survivors at the centre of all the responses. Coordination takes various forms, some more formalized and with more implications for policy development, others less formalized and geared towards a more efficient engagement with individual victim-survivors. There are examples in both the US and in Europe. Significant US examples include the Sexual Assault Interagency Council in Minnesota, the Sexual Assault Response Team (SART) in Fresno, California, and the SART in Montgomery, Alabama.

## Health-based programme in a conflict zone: the International Rescue Committee

The programmes of the International Rescue Committee (IRC) are **comprehensive, holistic, immediate and long term programmes** of intervention that address rape and sexual violence against women in conflict and post-conflict zones. They are health led, multi-sectoral 'one-stop shop' units, providing health interventions, forensic evidence collection, advocacy and counselling. They i) provide immediate responses for the prevention of rape and sexual violence against women and services for victim-survivors of rape and sexual violence in newly emerging humanitarian crises, ii) establish long term community prevention initiatives and victim-survivor support and services in conflict and post-conflict zones, and iii) promote women's re-integration and full **democratic participation** in social life in conflict and post-conflict zones.

## Health-based Sexual Assault Referral Centre: UK

St. Mary's Sexual Assault Referral Centre (SARC) in the UK provides an integrated and comprehensive, health-led service to victim-survivors of rape and sexual violence under one roof. It is a multi-sectoral '**one-stop shop' unit**, providing health interventions, forensic evidence collection, advocacy and counselling. Central to 'best practice' at St. Mary's SARC are options for service users to develop a personalized programme of intervention. St. Mary's SARC measures its success on reported service user experience and on a comprehensive programme of audit and service monitoring from which directions for service improvements and research are developed. St. Mary's SARC is an internationally recognized site of excellence and offers a suite of education and training programmes accessible to practitioners locally and from around the globe.

## Integrating a better understanding of rape within law: Mexico

'Ley General de Acceso de las Mujeres a Una Vida Libre de Violencia' ('General Law to guarantee Women Access to a Life Free from Violence') is a Mexican Law on violence against women including rape that conceptualizes 'feminicide' violence as gender-based and systemic. It thus promotes an understanding of rape as rooted in a **culture of male domination** over women that needs to be addressed to prevent rape and assist victims. It addresses state responsibility for reducing the impunity of perpetrators. However, the implementation of the law is still problematic. It is thus a best practice of integrating relevant gender concepts into law, rather than in its implementation.



## Identifying potential perpetrators of rape in cyber-space

This intervention seeks to identify potential rapists before they act, hence contributing to the prevention of rape. **Innovative software** is created to enable the identification of deception in the process of attempting to recruit (or groom) potential victims in cyber-space, such as on-line children's chat-rooms. The new software is currently focused on **child protection** and is being trialled by law enforcement in several European countries. The toolkits can be applied in any country to aid the identification of potential perpetrators of rape if accompanied by the right training and resources. Rape may be prevented by acknowledging that people across the world are increasingly living in a digital world. Further research and improved awareness and legislation could extend this approach to rape prevention to adult women.

## Special courts: Sexual Offences Court: South Africa

Sexual Offences Courts in South Africa assist victim-survivors of rape by reducing their trauma, including the potential secondary trauma of the criminal justice process, and help to prevent rape by making it more likely that rapists will be convicted and held to account. It is part of the South African '**anti-rape strategy**' to reduce secondary trauma for victims and improve conviction rates. Sexual Offences Courts (SOCs) are specialised courts hearing only sexual offence cases. They are staffed by specially trained individuals from a number of agencies in the criminal justice system and beyond. Evaluation studies have found significantly higher conviction rates for cases of rape and sexual violence compared to those delivered by non-specialist courts in addition to further benefits.

## Relationship change: Southampton Talking About Relationships: UK

Southampton Talking About Relationships (STAR) is a rape prevention intervention run by Southampton Rape Crisis Centre (England) that targets young people, using interactive workshops tackling a wide range of issues relating to sexual violence and relationships. STAR aims to prevent rape by educating and empowering young women and young men to choose **gendered cooperative relationship models** which are respect-based and comply with principles of consent. Evaluation of young people participating in STAR found over 85% had improved their understanding of healthy relationships; sexual assault and sexual exploitation; managing risky situations; and knowing where to go for help. STAR has also enabled **schools** and youth initiatives to develop their in-house policies and procedures to address rape and sexual violence more effectively: thus STAR's impact cascades well beyond the boundaries of the project itself.

## #talkaboutit: talking about consent and coercion: Sweden

#talkaboutit is a grassroots collective, network, social movement and public campaign in Sweden. It connects to the prevention of rape by raising awareness, by **creating public debates** about the boundaries between consensual sex and rape, by highlighting the difficulties in naming and establishing those boundaries, by making visible how rape is often committed by a perpetrator known to the victim and how rape is a consequence of gender inequality. It highlights how, what may be regarded as, private issues are public and political issues and attempts to alleviate some of the stigma attached to talking about experiences of sexual violence. It shows the existence of many hidden and unreported cases of events that are legally rape, but which women and men find hard to name as rape.

## RECOMMENDATIONS

A series of recommendations are made that follow on from the review of the international literature and the case studies of best practices.

### EU-level:

The EU could play a critical role in boosting prevention of rape and the provision of assistance to victims of rape. As the study shows, rape occurs in a complex environment. Legislation in the Member States (MS) does not always meet international standards. In the context of the Istanbul Convention that aims at a harmonised approach to tackle violence against women for the better protection of all women in Europe, the Member States might avail themselves of more effective tools to prevent rape, assist victim-survivors and stop the impunity of offenders. Consequently, a comprehensive package of law and policy is recommended at the EU level.

**EU legislative action.** While some instances of violence against women are already targeted by EU legal action, including trafficking, sexual harassment at the workplace and child pornography, the most serious form of violence against women, rape, has not been tackled. The **severity of the issue** justifies a careful examination of the possibility of legislative action on the EU level. In order to facilitate judicial cooperation in cases where alleged rapists cross borders, there is a case for a directive under the authority of **Article 82** of the Treaty on the Functioning of the European Union (TFEU) for a directive to establish **minimum rules for the definition of rape** that are consistent with international law. Since many aspects of policy to combat rape are shared with other aspects of gender-based violence against women and there are significant overlaps with other forms of violence, a comprehensive approach would be desirable on many aspects. Since violence against women is also a form of **gender discrimination**, EU legislative action is justified under **Articles 19 and 157** of the TFEU and should aim at the establishment of institutions that coordinate and monitor policy development and implementation; create an **administrative framework** ensuring that the relevant personnel, including the police, are adequately trained; that courts have adequate expertise; and that resources are made available to fund specialised services to support victims-survivors. This is not only relevant to EU internal relations and Member States but also for EU external relations.

**EU strategy and action Plan.** Based on the priority of combating violence against women and the relevant funding under the citizenship programme 2014-2020, the respective provisions of the strategy for gender equality should be further developed and their implementation accompanied by an action plan. The action plan should tackle violence against women as a whole and rape in particular. Member States should be assisted in **identifying the detailed policy measures** needed to implement the strategy effectively; and advice should be offered to EU entities engaged in external affairs. This should be subject to regular review, evaluation and improvement. An **EU office and coordinator** should be established to oversee the EU Action Plan, which might be similar to that established in the case of trafficking (a Coordinator with an office and budget). There should be a **consultation platform** that includes the women's organisations that provide services to victims of rape as well as Women Against Violence Europe and the European Women's Lobby (EWL). The strategy and the plan should be subject to regular review, evaluation and improvement of EU level action.

**Ratification of the Council of Europe Istanbul Convention on Combating Violence Against Women and Domestic Violence.** EU Member States are recommended to sign and ratify the Istanbul Convention. In its external relations, the EU institutions should work towards third countries either adopting the standards of the Istanbul Convention or signing and ratifying the most appropriate regional Conventions, such as the Inter-American Convention of Belem do Para for states in the Americas.

**Economic growth and social inclusion.** The effects of widespread violence against women, including rape, on the economic and social situation of individual women should be recognised. Concretely, in the framework of a fully inclusive EU2020 strategy, ESF funded actions could establish better access of victim-survivors to the **labour market** and help to prevent (further) incidents of rape. Further, rape and other forms of violence against women are a detriment to women's employment as a whole and reduce prospects for economic growth. Combating rape and other forms of violence against women should therefore be recognised as essential tools to realise the objectives of the EU 2020 strategy for inclusive growth. In EU external actions, the detrimental effects of violence against women should be further highlighted and, accordingly, rape prevention be acknowledged as an indispensable component of **economic development**.

**EU structural and social funds.** The above mentioned strategy should receive sufficient funds to be implemented. At the EU level, this should include access to the **ESF** and the **citizenship programme** for projects to prevent rape and assist women victims of rape, in recognition of the damaging consequences of this violence to an individual's capacity for employment and livelihood and thereby the cost of rape to business and society. Programmes to prevent rape and assist victims of rape contribute to the social inclusion and integration of **vulnerable groups** so should be funded by programmes that aim to assist social inclusion. The citizenship programme should ensure that the activities formerly deployed under the Daphne I-III programmes, for example the exchange of expertise and best practice on the wider topic of gender based violence, developed by non-governmental organisations across EU Member States, should continue.

**EU humanitarian assistance to third countries.** The inclusion of assistance to victims of rape should be a routine part of policies and packages of humanitarian assistance. The EU should assist in the delivery of justice in conflict zones, including through cooperation with international tribunals and courts, so that perpetrators cannot act with impunity. In addition, the EU should continue to assist in improving the gender-balance in peace negotiators and peace keepers in conflict zones, since this can reduce the extent to which conflict zones are conducive to rape.

**EU research.** There should be **better data gathering and analysis** on the extent of rape and its consequences, and the effectiveness of the various forms of intervention in diverse policy fields. This should include a **programme of research** funded under the EU Research Framework Programme. The Commission should initiate an EU-wide survey that has a sample size large enough to identify variations in the extent of rape in each EU Member State since the on-going pioneering FRA study on violence against women is too small to achieve this. The European Institute for Gender Equality, EIGE, should continue developing tools to assist Member States in the collection of data and its analysis, so as to ensure comparability where this is appropriate.

**Framework for development of services to assist victims.** The EU should assist Member States in providing assistance to victim-survivors of rape through its actions to develop and share best practice. EIGE could be called upon, with the relevant funding, to

provide guidance based on best practice and drawing on the Istanbul Convention of the Council of Europe. The EU should monitor the provision of these services, using the indicators developed by EIGE. The Open Method of Coordination should be considered as a possible model to assist the development of best practice. In accordance with Article 14 TFEU, services for victim-survivors of rape should be regarded as services of general economic interest and consequently excluded from EU competition rules, thereby allowing MS to support them financially without resort to competitive tendering.

### Member State level:

**Legislation.** Legislation on rape in each country should reach the minimum level recommended by the UN (2010a) and the Council of Europe Istanbul Convention (2011). Legislation on rape should: **eliminate the 'marital exemption'** that means that men can rape the women they are married to with impunity; use the threshold of **'absence of consent'** rather than that of physical force (and in conflict zones recognise the context of coercion); make illegal, either as rape or as an equivalently serious offence, the penetration of the body by objects or other body parts without consent.

**National plans of action.** Each Member State should develop a national plan of action based on an integrated strategy to reduce and eliminate violence against women with a particular section tackling the different issues related to rape prevention and assistance to victims of rape. The national plans should be **aligned** to the EU strategy and action plan to ensure synergies. The above mentioned regular review process might be similar to that used for the National Strategic Plans on Social Protection and Social Inclusion, involving the **Open Method of Coordination**. Each (Member) State should create a body (Commission) that oversees the national strategic plan, which might be similar to that established to oversee equal treatment for the protected equality strands. There should be a consultation platform that includes women's organisations that provide services to victims of rape and input into the national strategic plan and to the relevant body. There should be adequate **financial support** from national budgets to implement the plans, including both specialised and mainstream services, and monitored through gender sensitive budgeting techniques.

**Comprehensive services for victim-survivors.** The national plan should ensure the establishment of specialised services providing **universally accessible assistance** for victims of rape, including advice available by phone, expert advisers, centres and shelters, health-care, and legal advice. As shown by the good practice examples of this study, these services should be **victim-centred**, and delivered by experts in a gender-sensitive manner. Minimum standards should be established and maintained following the guidelines in the Istanbul Convention and of the World Health Organization (WHO). The **funding** of these services should be monitored and adjusted to real needs. There should be coordination of the provision of the comprehensive services at both national and local levels.

**Health care.** Rape causes injuries to mental health as well as to physical health. Member States should therefore ensure the availability of specialised services for victims of rape within health care systems that address both types of injuries and which are sensitive to their needs. In order to achieve this, **training** of personnel needs to be increased and improved, including of all those who might come into contact with victims of rape. Specialised programmes need to be developed which include forensics to collect evidence to assist the criminal justice system if the victims want this. Furthermore, best practice services should be **context specific**, including those provided in conflict and disaster

zones; they should be coordinated with non-health-care services for victims-survivors, for example, with the rape crisis centres that tend to address historic rapes more than recent rapes; and new research into the most appropriate pathways of care for victims of rape should be undertaken.

**Criminal justice system.** Justice should be easily accessible for all victims of rape. There should be improvement of the treatment of victims of rape so as to avoid secondary victimisation and to reduce the very high attrition of cases through the criminal justice system, thereby ensuring that perpetrators are held to account and **reducing the impunity of rapists**. These actions include: **training** of police, prosecutors, judges, and other relevant officials; the provision of **special courts** to pioneer improved standards; and the provision of **special advisers and advocates** to victims including during criminal proceedings. There should be the development of innovative methods of catching perpetrators of rape, including those that are using **social media** to lure potential victims into vulnerable positions, while mindful of the need to protect human rights and civil liberties. There should be monitoring of the conviction rate for cases of rape reported to the justice system.

**Economic growth and social inclusion.** As is the case at the EU-level, Member States should recognise the relation between economic status and the risk of falling victim to rape. Economic growth strategies that are inclusive of women can therefore be regarded as measures to fight violence against women. With guidance from the Commission and with ESF funding, Member States should implement measures which ensure **women's participation in economic growth** and avail themselves of measures directed at **increasing women's access to a livelihood**; by narrowing gender gaps in employment and the likelihood of access to property; and the social inclusion of victims of rape. Further, the rehabilitation of victims and the reduction of the economic costs of rape will only be possible if measures take into account the relation between violence against women and economic growth. Programmes to combat rape and other forms of violence against women should therefore be **mainstreamed** into Member State programmes that promote economic growth and social inclusion.

**Culture, education and media.** Educational programmes should **promote healthy forms of sexual relationships** that avoid violence and are based on consent. The media should be challenged to avoid reproducing myths about rape, where this practice exists. Regulations should ensure the **anonymity of rape victims**. In addition, as shown by the good practice examples, media, including social media, if used in an innovative way, could promote better public understanding of the issues involved in rape.

# 1 INTRODUCTION

## KEY FINDINGS

- Rape is one of the most serious forms of violence.
- Rape is both a form of gender-based discrimination and a violation of women's human rights, according to the UN. It is a detriment to health and to the economy; and it is a serious crime.
- Practices to prevent rape and assist victims exist in many policy fields including planning and coordination; specialised services for victim-survivors; health; law and justice; economy and social inclusion; and culture, education and media.
- There are links between actions to prevent rape and services to support victim-survivors.

## 1.1 The purpose of the study

Rape matters. It destroys lives, as its traumatizing effects can linger for many years after the immediate pain and suffering. It is a form of gender inequality, an injury to health, a crime, a violation of women's human rights and costly to economy and society. There are many ingenious ways to address rape, to prevent it, to support victims and survivors. These practices are under development, constantly being tested and improved. This report is an overview of the worldwide best practices for rape prevention and for assisting women victims of rape. Its purpose is to review developments in policy practices that aim to prevent rape and to assist victims-survivors of rape in order to identify best practices. It reviews the international literature and provides case studies of best practice.

## 1.2 Policy developments in the European Union and in international bodies

The study is shaped by the work of major governmental bodies, including reports and policy declarations by the European Parliament (EP), European Commission, European Institute for Gender Equality (EIGE), European Union Fundamental Rights Agency (FRA), Council of Europe, United Nations (UN) Beijing Platform for Action, UN Secretary-General, UNiTE to End Violence against Women (UNiTE), UN Women, and the World Health Organisation (WHO). These developments have drawn on the work of **Third Sector** or **Non-Governmental Organisations** (NGO), mainly women's groups and groups representing victims-survivors, which have long been at the heart of innovative ways of addressing this long-standing issue.

Within the EU, there have been several recent developments. The European Union has **Directives** on the prevention of trafficking (EU, 2011a), on the European Protection Order (for use, for example, in cases of domestic violence) (EU, 2011b), and on victims' rights (EU, 2012) which refer to forms of violence that can include rape.

The **European Parliament** (2011a) called in a Resolution for a new and strengthened EU policy framework to fight violence against women, and, in a series of Resolutions in 2008,



2009 and 2011, called on the EU to provide support to victims of sexual abuse in the Congo, where rape was being used as a weapon of war (2011b).

The **European Commission** (2010a) has included 'Violence Against Women' as one of its five priorities in the Strategy for gender equality (2010-2015), and reiterates this commitment for action in the Women's Charter (2010b), while the Advisory Equal Opportunities Committee of the European Commission (2010c) offered an opinion in favour of developing an EU strategy on violence against women and girls.

The General Affairs **Council** of the European Union issued EU Guidelines on Violence Against Women (European Union, 2008) for use in external relations.

The **European Institute for Gender Equality** (EIGE, 2012a) has published a study on sexual violence that offers resources on ways forward. The **European Union Fundamental Rights Agency** (FRA, 2011) is conducting an EU-wide survey on violence against women that includes rape.

Other international bodies, with which the EU is connected, in particular the **Council of Europe** and UN have also seen relevant developments. The Istanbul Convention of the Council of Europe on Combating Violence Against Women and Domestic Violence (Council of Europe, 2011) names rape as an important form of violence against women. The **United Nations** named violence against women as one of the twelve critical areas for action in the Beijing Platform for Action (UN, 1995), followed by the in-depth report on violence against women, including rape, by the Secretary-General to the General Assembly (United Nations Secretary-General, 2006), and the United Nations campaign, UNiTE, to end violence against women including rape (UNiTE, 2011a). The World Health Organization (WHO, 2007) offers further guidance on responses to rape.

The report is a review of practices worldwide. However, it is also mindful of the EU policy context and offers interpretations of the implications of worldwide developments for the EU policy framework. This entails awareness of the nature of law at the EU-level and issues of subsidiarity and proportionality that structure relations with EU Member States.

### 1.3 Methodology

This study is based on a review of the international **literature** on policy developments to prevent rape and to assist victims of rape, together with a series of **case studies** of best practices. The review of literature was conducted by experts in each of the relevant policy fields, using both systematic approaches to review and the experts' own knowledge of developments in these fields. The case studies used a variety of methods, including interviews with key actors, original data analysis, and review of documents and literature.

### 1.4 Definition of rape

Rape is a very serious form of violence. It is an important form of gender-based violence against women. While all forms of gender-based violence against women are serious, rape is especially hurtful and damaging, and can have long-lasting consequences. Some men are victims of rape, though this is much less common than among women. There are several aspects to identifying rape. The first is to report on the approach taken by international

bodies, in particular the UN and the World Health Organization (WHO). A second approach is to examine the detailed definitions in different legal regimes, both those at a national level, and those of international regimes, such as that of the Rome Statute of the International Criminal Court. A third approach is to note the usage of the term in popular culture. A fourth approach is that of social scientific research that investigates a range of concepts of rape and their operationalization. Fifth, to note that responses to rape may vary by context, for example, depending on whether it takes place in a conflict zone or not. Sixth, is to locate it within the range of forms of violence against women.

The **UN** (2010a) states that violence against women, of which rape is a component, is a form of 'gender-based discrimination' and 'a violation of women's human rights':

Over the past two decades, violence against women has come to be understood as a violation of women's human rights and as a form of gender-based discrimination. Legislation on violence against women should be in conformity with the United Nations General Assembly *Declaration on the Elimination of Violence Against Women* (resolution 48/104 of 1993), read together with article 1 of the *Convention on the Elimination of All Forms of Discrimination against Women*, and general recommendations No. 12 (1989) and 19 (1992) of the Committee on the Elimination of Discrimination against Women (UN, 2010a: 13).

The **World Health Organisation** (WHO 2002) treats rape, other forms of sexual violence and violence in general as issues of public health. WHO Resolution WHA49.25 in 1996 'declares that violence is a leading worldwide public health problem'. Rape is defined as:

Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object (WHO 2002: 149).

#### **Box 1: Absence of consent instead of the use of force**

The legal definition of rape varies slightly between legal regimes. At its core, rape is coerced violation or penetration of the body. The nature of the coercion is variously understood as the **absence of consent**, the use of force, the threat of use of force, or a wider context of generalised coercion. There are variations in whether the penetration can be with any object or is restricted to the penis; whether the part of the body penetrated can include mouth or anus or is restricted to the vagina. Variations in the object and orifice determine whether rape is only ever an offence by a man against a woman, or if men can also be victims, or women can also be perpetrators, in legal terms. Legal developments are discussed in more detail in the review of law below.

The '**popular**' definition of rape is often **more restricted** than the legal definition, in that survivors are reluctant to use the term rape unless the circumstances are more extreme than the law requires (Walby and Myhill, 2001). This is probably related to the stigmatisation of rape victims in popular culture (Soothill and Walby, 1991). This discrepancy between popular and legal definitions of rape has consequences for the treatment of victims of rape and for the conviction of rapists by courts that use juries.

**Social scientific research** has investigated the range of meanings attached to the term rape and explored the implications of the different ways in which rape is defined in both law and popular culture. The findings from this research means that some recent surveys offer



behavioural descriptions rather than the summary term 'rape' to respondents, gaining better understanding of the meaning of the act to the survivor (Walby and Allen 2004). Further research has developed the concept of a 'continuum of sexual violence' so as to capture the way in which small events are connected so as to create a context that is more threatening than the sum of the parts (Kelly, 1988).

The terms 'victim' and 'survivor' are used inter-changeably in this study, although there are different connotations attached to these terms. The use of the more conventional term, 'victim', has been subject to the criticism that it denies agency to the raped woman and hence that the term 'survivor' should be used instead to take account of her actions (Kelly, 1988). However, it is also argued that to attribute agency to the person who has been raped is misleading since it might imply that actions by this person could have made a difference and thus be consistent with victim blaming. Thus, the study follows the practice that has developed in the field of using both terms, 'victim-survivor', but when this is overly complex, to use the term 'victim', while cognisant of its limitations.

Rape occurs in a range of different **settings** which affect the possibilities for prevention and assisting victim-survivors, since they entail different levels of power and vulnerability of perpetrator and victim as well as of potential witnesses and other actors. These situations vary across: domestic; stranger/acquaintance; institutions (hospitals, prisons); and conflict zones (during and after militarised conflict). Of particular importance in this report is the distinction between rape in non-conflict zones, such as EU Member States, and rape in conflict zones, which might be of particular interest to EU External Affairs in matters such as the development of humanitarian aid packages.

Rape is adjacent to and overlaps with **other forms of violence**, including sexual violence, domestic violence, sexual abuse of children, forced marriage, and trafficking. Practices of pornography and prostitution can also be seen to be linked, though this is subject to debate. The extent and nature of the overlap between rape and other forms of abuse and violence is complex, not least when these are considered as legal categories.

The term '**sexual violence**' is more frequently used in the literature than that of 'rape', which is the focus of this study. 'Sexual violence' is broader in meaning than 'rape'. For example, sexual violence is defined by the WHO (2002: 149) 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, including but not limited to home and work.

A significant proportion of rapes are committed by partners and former partners. The British Crime Survey finds that nearly half (45%) of the rapes disclosed to the survey are perpetrated by a current or former intimate partner (Walby and Allen, 2004), though other national surveys find lower proportions. This means that the context and policies concerning domestic violence are of direct relevance to rape, since domestic violence can include rape.

The **sexual abuse of children** may include rape, but the term rape is rarely used in this context, even though sex with children is considered to be without consent since a child cannot in law consent to sex.

### 1.4.1 Limitations of the definition of rape

'**Forced marriage**' might be considered to include rape, since the sex is without consent because the marriage was 'forced'. However, since the coercion into the marriage may be from the family and kin of the woman, rather than from the man she marries, it is not clear that the man, who did not coerce the marriage, is, in law, a rapist. A similar issue arises in the case of **trafficking of women for purposes of sexual exploitation**, where the sex is without consent since the victim was trafficked, but where the man may be unaware that this is the case and believes the woman to have consented. It is not clear that the man who buys the (coerced) sex is, in law, a rapist. In law, the rapist is a person who knows that he is coercing the woman as he rapes her, but in the cases of forced marriage and trafficking the coercion is being done by someone other than the person engaging in the sex. Hence, while the man doing the sex in both of these cases is not usually considered in law to be a rapist, from the point of view of the woman this is nevertheless **sex without consent** because of the **coercive context created by others**.

The implication of these complex overlapping categories and concepts is that policies to address one field of gender violence will be relevant for others. This is consistent with the argument that the field of **gender-based violence against women should be addressed as a whole**, in addition to detailed attention to its specific forms.

## 1.5 Causes of rape

The prevention of rape entails the development of practices that intervene in the causal pathways leading to rape. In order to build the most effective strategy to prevent rape and assist victims of rape, it is thus necessary to identify the causes of rape. There are a variety of approaches. The UN (2010a) treats violence against women, including rape, as a form of '**gender-based discrimination**' as well as '**a violation of women's human rights**'. The WHO (2002: 12) uses an 'ecological model' that distinguishes nested levels of societal, community, relationship and individual. Brown and Walklate (2012) find that rape is a consequence of both gender inequalities in **power** and also of an absence of effective state power to sanction offenders.

The purpose of the criminal justice system is to deter people from committing crime by deterrence, punishment and rehabilitation. But **most rapists are not convicted**. The deterrent effect of potential punishment is only likely to occur if rapists were to be convicted in the courts. This would require reforms of the criminal justice system so that rapists were more usually convicted than not. The prevention of rape also requires the **changing of the minds of men** so that they do not want to rape. For this purpose, education, media and culture are an appropriate focus of preventative action. An important priority is looking after the victims-survivors. The hurt and harms from rape are very considerable and often long-lasting. It is possible to substantially mitigate the effects of rape by good practices, speeding healing, recovery and regaining a place in society. This is potentially offered by specialised **support services**, by specialised practices within health services, and by special attention to (re)gaining economic livelihood. How are appropriate changes to policies to be made? This requires the mobilisation of relevant actors. But does it also require gender-balance in each of the relevant domains of **decision-making**, from police to peace-keepers to parliamentarians? The approach taken here is that all of these sites of intervention are potentially significant. In almost all policy fields, there have been initiatives to address an issue that is relevant to reducing rape and mitigating its

consequences. This adds a further dimension to policy development and implementation, that of **strategic planning** and **coordination** at international, national and local levels.

There is consensus in the field that violence against women, of which rape is a particularly serious form, is a consequence of gender inequality, as well as itself contributing to that inequality. The **structural context** (Galtung, 1996) is part of the cause of harms that are named as violence. This means that most if not all social institutions contribute in some way to rape by actions or inactions. Actions and inactions contribute to an environment that is conducive of rape. Thus a full programme of policy actions to address rape would address each of these gendered institutions that are conducive to rape. Typically, researchers and practitioners have specialised in different aspects of the “rape system”; but it is best to think of these as interconnected. The range of institutions includes the state, as the source of law and justice and the source of strategic planning, coordination and funding of services; the economy, which is complexly entwined with vulnerabilities to rape; culture, education and media, where myths about rape are propagated or challenged; the health system that may or may not support victims’ recuperation; and the research system, usually based in universities, which may or may not offer scientifically based advice on which practices work to prevent rape and mitigate its consequences.

The absence of **effective sanctioning** of offenders in law and the criminal justice system, so that rapists can act with greater or lesser degrees of impunity, is an important concern. This absence can be especially significant in conflict zones, where informal interventions to sanction offenders may also be absent. This is not just an issue of a strong or punitive state (Galtung, 1996; Bumiller, 2008) but of a gender-sensitive state that responds to the concerns articulated by victim-survivors of rape and by relevant expert groups.

Gender inequalities in the **economy** are relevant, since it is hard to recuperate from rape without a stable source of livelihood. In the case of domestic rape, where sexual abuse may be part of a pattern of coercive control by an intimate partner, economic inequalities are complexly entwined with vulnerabilities to rape and other violence. Rape has consequences for the economy, since the physical and mental injuries have detrimental effects on the victim’s capacity for employment. The gender imbalance in decision-making means that women’s experiences and interests are under-represented when crucial decisions are made in professional bodies, parliaments and conflict zones. Gender inequalities in the **governance** and practice of culture, education and media have implications for the likelihood that these institutions propagate rather than contest rape myths, which affect juries making verdicts of guilt and innocence in trials. The health system is a potentially important source of assistance to victims of rape, assisting them to recover, but if poorly organised may contribute to the problem.

## 1.6 Links between preventing rape and assisting the victims of rape

Preventing rape and assisting victims of rape can be distinguished in some approaches to policy, but there are many links which means that they are actually highly interconnected. There are at least three reasons for this. First, if the criminal justice system is to reduce the impunity that some men feel, then victims need to be treated with care and respect so that they are willing to proceed with legal cases. **Assisting victims** can increase the chances of cases being prosecuted through to successful completion, rather than, as is so often the case, dropping out at one of the many ‘attrition points’ in the criminal justice system. **Reducing impunity** increases deterrence and thus helps to prevent rape. Second, since a substantial number of rapes are in the context of intimate partner violence, which is often a

repeat offence, then assisting victims can **stop repeated attacks**, thus helping to prevent rape. Third, survivors of rape who have been assisted can become important **advocates for change** in the wider system, drawing on their experiences to improve the system and thus helping to prevent rape. Their experience and advocacy, articulated through independent women's NGOs, makes a powerful difference to public education about the nature of rape and the importance of change, as well as detailed improvement of services and policies. This is part of the process of building the capacity for improving the system so as to reduce and eliminate rape.

## 1.7 Introduction to an integrated approach to prevent rape and to assist victims of rape

This section offers a summary of the **main dimensions** of the policy fields to prevent rape and to assist victims of rape. There is more than one way of clustering policies and practices for analysis. These include: function of the practice; context of the rape; target of the intervention; and the policy field. In this report the practices will be clustered according to policy field. The typology (categorisation) selected allows for the distinction between prevention and assistance as well as linkages between them. It allows for a consideration of the extent to which policies to address rape have similarities to and differences from those that address other forms of gender-based violence.

**Function of practice/policy:** The practice may be seen to be related to one of six p's: perspective (of gender equality), policy (integrated strategy and partnership between the agencies involved), prevention (of rape), provision (of services to assist victim-survivors), protection (of the victim), and prosecution (of the perpetrator).

**Context of rape:** Interventions vary by setting: including domestic, stranger, acquaintance, institutions, and conflict zones; and across diverse intersecting social groupings. The most important of these distinctions for the purpose of this report is that between non-conflict and conflict zone. This distinction is relevant to and thus will be made in most of the policy fields.

**Agency carrying out the practice:** Interventions are produced and implemented by diverse types of agencies: governmental - international, national or local; private/public service provider; and civil society/NGO/Third Sector.

**Target of the intervention:** Policies vary in their focus on different actors and institutions, including:

- victims (e.g. advocacy, practical and emotional support, counselling, centres and shelters);
- perpetrators (e.g. identifying perpetrators, prosecution, treatment programmes);
- situational (e.g. monitoring and structuring space as in CCTV and city design);
- professionals (e.g. training, improving the criminal justice system, improving health services, gender composition of decision-makers, coordination of agencies); and
- wider society (e.g. education and awareness arising, scientific knowledge base, engagement with media, women's empowerment).

**Policy field:** Policies vary according to the institutional field within which they are developed. In addition, **two policy fields cross-cut each of these** fields: 'gender equality'; and research and evaluation. The major fields include:

- strategic planning and coordination;
- law and justice;
- health;
- economy and social inclusion;
- culture, media and education.

Policies to address rape have similarities to policies to address other forms of gender based violence against women. However, there are some significant differences in detail, for example, in the nature of emergency services.

## 1.8 Evaluating practices

The evaluation of the practices requires the identification of the causes of rape and of the intended and actual contribution of each of the interventions. The detailed evaluation of specific practices and the exact scale of their contribution are on-going rather than complete. In broad outline, the **set of policies** needed to prevent rape and to assist victims is well-established. This includes both the development of specialised areas of expertise and also the diffusion of this expertise through normal policy actors, as is usual in the practice of gender mainstreaming. However, the full set of policies that has been identified as necessary in the literature and by practitioners has **never been fully implemented**. In order to know what would prevent rape, it is necessary to know what causes rape. It is important to build a **map of the various causal pathways** leading to rape and establish the various points at which interventions might contribute to its prevention. Preventing rape and assisting victims of rape are not separate processes but inter-connected. The evaluation of innovative practices to prevent rape and assist victim-survivors requires a **programme of research**. Preventing rape depends upon developing capacity and mobilising a wide range of relevant actors.

A wide range of practices are reviewed in the international literature using a wide variety of different means of assessment. In some areas of policy, such as medicine, there are established evaluation methodologies, including 'systematic review', such as those developed by Cochrane and Campbell (Ashman and Duggan, 2004) and 'cost-effectiveness'. However, since rape policy is newly developing, a wider range of methodologies of assessment is appropriate.

There is a need for more research to improve the knowledge to evaluate policies. There is a need for **national surveys** of the extent of rape in the population, with methodologies sensitive to the special needs of the subject group (Walby and Myhill, 2001). Interventions are usually aimed at addressing one **small part** of the causal pathways to rape or mitigating one part of its effects, so they need to be assessed in relation to that intended step, rather than in relation to the larger aim of stopping rape. Measuring changes in intermediate policy outcomes (e.g. changing conviction rate or 'attrition' in the criminal justice system (Lovett and Kelly, 2009; Walby, Armstrong and Strid, 2012); and recidivism rates calculated from registers of offenders) are ways forward here. There is a need for further social scientific research in this field.

In order to secure policy development and implementation it is necessary to engage and mobilise all the relevant actors. The **motivation** for each is likely to be slightly different and dependent upon their context. It is relevant to consider the different motivations that are relevant to the actors that need to be mobilised in order to secure policy development and implementation. These include the goals of reducing gender inequality, reducing violations of human rights, reducing the cost to business and the economy, preventing impairments and injuries to victims, reducing crime, increasing security, or increasing well-being and health. They are each valid in their context. The relevant actors in this field are usually considered to be governmental bodies, but they also include the Third Sector and NGOS as well as private bodies and employers.

## 1.9 Criteria of best practice

The term 'best practices' is used in the way proposed by EIGE (2011) as practices that are innovative, proven to have made a difference, and models for development elsewhere. This is distinguished from those that are merely '**promising practices**', which are only partially successful. Many of the policy interventions investigated for potential inclusion in this study are more appropriately described as promising practices rather than best practices.

The **criteria** to identify best practice are derived from the international literature and reflections on it. They are pitched at different levels: both at a high level that is pertinent to many of the services; and at more detailed levels that are pertinent to specific policy practices.

General criteria include: victim-survivor-centred; gender expert and gender sensitive; participation of survivors; trained personnel; skilled specialised centres that act as beacons of good practice to the mainstream; built-in monitoring and evaluation so as to constantly improve practice; inter-agency working collaboratively with other agencies; part of a comprehensive package of policies to combat violence against women that is strategically coordinated.

## 1.10 Structure of the report

The report has ten chapters. The first chapter is this introduction; Chapters 2 to 8 review the international literature analysing seven main types of policy practices; Chapter 9 includes ten selected case studies of best practice; Chapter 10 contains a set of recommendations that follow from the evidence presented in the study.

Chapter 1: introduction;

Chapter 2: planning and coordination;

Chapter 3: specialised services for victim-survivors;

Chapter 4: health;

Chapter 5: law and the criminal justice system;

Chapter 6: peace and security in conflict zones;

Chapter 7: economy, economic growth and social inclusion;

Chapter 8: culture, media and education;

Chapter 9: ten case studies of selected best practices;

Chapter 10: recommendations.

## 2 Planning and coordination

### KEY FINDINGS

- Strategic planning can make a significant difference to the effectiveness of interventions to prevent rape and assist victim-survivors.
- Strategic planning is needed at different levels of governance, including at the highest level available.
- The establishment of strategic plans of action at EU and Member State level is recommended.
- Local coordination mechanisms are important for the effective delivery of services and interventions by the multiple agencies involved.
- Consultation platforms at national and local levels that include gender experts and women's organisations in the development of plans and coordination mechanisms are recommended. Victim-survivors' interests should be at the centre of planning and coordination.

### 2.1 Introduction

Preventing rape requires policies that affect many aspects of society. No single intervention is sufficient. This is because many of the causes of rape lie deep in the structures and systems of **gender unequal societies**. Likewise, assisting victims of rape requires attention to many aspects of society, since the deleterious effects of rape permeate many aspects of their lives. The details of these various interventions are addressed in the following pages, but the focus here is on the strategic planning for a comprehensive **set of policy practices**. In the context of the EU, there are three major levels for strategic planning and coordination: the EU-level, the Member State national level, and the local level. Since gender inequality is a constant dimension of these issues, gender sensitive issues will be addressed throughout this study.

Planning and coordination are discussed at three levels:

- strategic planning;
- national plans of action; and
- local and community coordination of services.

### 2.2 Strategic planning

#### 2.2.1 Introduction

Strategic planning can be at the international, European/other region, national and local levels. These plans usually embed rape, or more broadly sexual violence, within a wider concern for violence against women.



A leading example of a strategic plan is that of UN Women (2011) '16 steps policy agenda'. A second example is that of the Council of Europe (2011) Istanbul Convention to Prevent and Combat Violence Against Women and Domestic Violence.

There is potential for the EU to develop strategic planning on rape in the context of policies to end violence against women, although there is a question as to the extent to which it has the legal remit to do so.

There are important developments in strategic planning at state level, often known as National Plans of Action.

### 2.2.2 UN Women 16 Steps

UN Women (2011) recommends a 16 Steps Policy Agenda, based on the three critical pillars of 'prevention, protection and provision'. The 16 steps are:

- (1) ratify international and regional treaties (e.g. CEDAW);
- (2) adopt and enforce laws;
- (3) develop national and local action plans;
- (4) make justice accessible to women and girls;
- (5) end impunity towards conflict-related sexual violence;
- (6) ensure universal access to critical services;
- (7) train providers of frontline services;
- (8) provide adequate public resources;
- (9) collect, analyse and disseminate national data;
- (10) invest in gender equality and women's empowerment;
- (11) enhance women's economic empowerment;
- (12) increase public awareness and social mobilization;
- (13) engage the mass media;
- (14) work for and with young people as champions of change;
- (15) mobilize men and boys; and
- (16) donate to the UN Trust Fund to End Violence Against Women.

### 2.2.3 Council of Europe

The Council of Europe (2011) Istanbul Convention constitutes a strategic plan to prevent and combat violence against women and domestic violence. Its many articles address a similar range of actions as recommended by UN Women. The similarity between the UN and Council of Europe strategies suggests that there is an **emerging consensus** on the best strategy for ending rape. In both cases, the focus is the broader one of violence against women, rather than the narrower one of rape.



All Member States of the European Union are members of the Council of Europe, so are parties to the Convention. Only some have yet signed and even fewer have yet ratified the Convention.

## 2.2.4 European Union

The European Union has some legal competence to act at EU-level in matters of policy on rape, but there are limits to this. This is discussed further in Chapter 5 on law. Existing EU-level actions include:

- Directives on trafficking (which includes an anti-trafficking coordinator), protection orders, and victim's rights include some matters that are relevant to rape;
- The European Arrest Warrant, which names rape as one of the serious crimes for which a person can be taken from one country to another for questioning by legal authorities;
- The Daphne programme, funded under the public health remit, which is a well-regarded programme that assists the exchange of information about best practice in the policy field of gender violence including rape across the EU;
- The European Institute for Gender Equality (EIGE) includes rape and sexual assault as one of the topics on which it conducts research and collects data;
- The EU-wide survey of violence against women, including rape, which is funded under the human rights remit by the EU Fundamental Rights Agency.

There is scope for greater action by the EU to develop strategic planning at EU-level and to assist Member States in developing policy which would add value to existing policy. Whether there is a legal basis for a directive concerning legislative action is under discussion.

## 2.3 National plans of action

National plans of action are examples of strategic planning at the level of specific countries. Discussion of the objectives and benefits of national action plans has been increasing in the last two decades. This has become particularly prominent in the context of the development of **international norms** in the field of violence against women and the shifting focus of international organizations from adoption of norms to their implementation. Literature analysing comparatively the implementation of norms on violence against women considers national action plans to be one of the crucial factors contributing to implementation (Kelly et al 2011; Weldon and Htun, 2012). National action plans and associated coordination mechanisms are considered **key elements in the implementation** of laws and policies in reports commissioned by the UN, Council of Europe and European Commission. The UN Handbook on Legislation on Violence against Women (2010) considers national action plans to be the main guarantee for a comprehensive and coordinated approach to implementation of relevant legislation. The Council of Europe Stocktaking Study notes the importance of a national level coordinating mechanism to which all stakeholder ministries, agencies, and criminal justice actors can join together with women's rights and victim's rights advocates (Hagemann-White, 2006). At the national level, national action plans and related national coordination mechanisms are potentially major instruments of efficient, victim centred implementation of anti-rape laws, which keep

victims and women's interests at the core of policies addressing rape also in the implementation stages. National coordination mechanisms can play a role in **monitoring and reviewing** laws and policy and improving the accountability of actors involved in the implementation process. One approach, considers that the **main objectives** of the national planning mechanisms are:

- To be a deliberative forum for a democratic and professional debate on violence against women. Placing coordination in ministries in charge for gender equality is one way to secure gender sensitivity of implementation processes (UNIFEM, 2010) and continued centrality of implementation processes on victim-survivors;
- To serve the identification of a common understanding of violence;
- To develop policies, protocols, referral systems, data collection systems and other implementation materials for working against violence in the spirit of the developed common understanding for all agencies and actors involved;
- To serve as accountability, monitoring and evaluation platform of the policy and law in place and aid review of policy if needed;
- To serve efficient policy coordination; and
- To provide a participatory policy mechanism for addressing gender violence including rape.

Kelly et al (2011: 23-4), in a report for the European Commission, consider that there has been a progressive development of **guidelines** for National Plans of Action, beginning with the Beijing Platform for Action and elaborated by UNIFEM, the Council of Europe and CEDAW. They consider that the guidelines now include:

- Developing an integrated, holistic approach to address the range of inter-related needs and the rights of women survivors;
- Ensuring that both responses to, and prevention of, VAW is encompassed in all relevant policies and programmes;
- Building multi-sectoral approaches, specifying the respective roles of state and non-state organisations;
- Setting out principles, costed concrete goals and the actions;
- Timelines and actors/agencies with responsibility and competence to carry out the actions; and
- Monitoring and accountability mechanisms.

The End Violence Against Women coalition in the UK set out six criteria that National Plans of Action should meet, which add perspective and policy to the previously established p's of prevention, provision, protection and prosecution (Kelly et al 2011: 24):

- 'Perspective', by which is meant underpinning principles of gender equality, human rights, due diligence and non-discrimination;
- 'policy' refers to an integrated strategy that addresses all forms of VAW and intersections between them; an agreed definition; research and disaggregated statistics; analysis of causes of VAW; and mainstreaming VAW into all policy areas;

- 'prevention' which encompasses education, work with perpetrators, public awareness and self-defence for women and girls;
- 'provision' includes the specialised women's sector, women's centres, rural women, black and minority ethnic women, and the statutory sector;
- 'protection' which likewise includes provision but also encompasses support networks, civil law, safety in public places, and non-discrimination;
- 'prosecution', holding perpetrators accountable, European models of good practice, procedural justice for victim-survivors, and, again, non-discrimination.

**Australia** considers itself to have a 'prevention-focused, longer-term and adequately-resourced NAP' (Australian Government, 2009) which focuses on strategies and actions for prevention, early intervention, enhanced service delivery, and the justice system' (see best practice case study at 9.3 later in report). National Plans of Action have been developing recently across the member states of the **European Union** and **Council of Europe**. Reviews of these plans find weaknesses, such as: not being comprehensive enough, for example, an undue emphasis on domestic violence at the expense of rape and other forms of sexual assault; vague general statements; absence of indicators, monitoring and follow up is often noted; lack of allocated budgets (Hagemann-White, 2006; Kelly et al, 2011). This means that further developments are needed to improve the quality of these national plans of action.

## 2.4 Local coordination

Coordination emerges as a key component of good practices in policy responses addressing rape. At the local level, the best coordinated community responses have as their main objective the provision of efficient, victim centred services. In the framework of coordinated community responses all the different stakeholders, including women's and victim's rights advocates are supposed to work together towards a mutual understanding of the problem of rape and develop and implement policies along its lines; and these are most effective when led from **gender expertise** and the **experiences of survivors**. The importance of coordination across multi-sector agencies to help service providers better address legal, medical, mental health needs and other needs of the victim-survivor is often noted (Campbell et al, 2001; Campbell and Ahrens, 1998; Hagemann-White, 2006; Morrison et al, 2007). Coordinated community responses have been devised, implemented and evaluated particularly in the **US** context for the last three decades. They have been most frequently developed in relation to domestic violence, as in the famous 'Duluth model', and to a lesser extent to sexual assault and rape. Coordinated community responses have been piloted in a few countries in Europe but have not yet become a widespread practice (Hagemann-White, 2006). Coordinated community responses have been favourably compared with fragmented interventions. It is widely argued that coordinated community responses should include all relevant service providers, criminal justice system agents and victim's rights advocates (Yancey Martin, 2007, Mallios and Markowitz, 2011), while noting that serious problems can arise if there is **imbalance** between the participating services, as has sometimes occurred with a disproportionately strong criminal justice lead.

The main stated **objectives** of coordinated community responses are:

- improving the efficiency of responses to victim's needs and preventing the risk of further secondary victimization;

- contextualizing rape and thus improving the community understanding and response to rape; and
- continuous monitoring and evaluation and improvement of the functioning of rape intervention schemes.

#### 2.4.1 Advantages of coordination

There are several modes of operation for coordinated community (or local) responses. Some are more formalised than others. Potentially, they provide the following advantages:

- One entry point for victims to the system: **one contact point** often means one contact person for the victim to avoid re-victimization. Referrals from the contact point will secure the possibility of multidisciplinary responses, flow of information and coordination of response. Sustained interagency consultation allows for the identification of a shared philosophical framework on sexual violence, a shared understanding of the roles played by the different actors, an up-to-date understanding of gaps in the system.
- Interagency consultation may concern more general matters, but most often discusses specific cases, such as the US Sexual Assault Response Teams (SARTs). This potentially allows for **openness to the (cultural) context** of rape and opportunities to include specific attention for victims coming from particular subgroups (ethnic minorities, disabled).
- Development of **standardized victim centred** policies, procedures and protocols for intervention across all actors.
- **Training** and professional development of all involved.

Interaction between different actors and inclusion of women victim's rights advocates can secure on-going deliberation of objectives and ensure that the victim-survivor as an individual and the group level problem of violence against women remains at the centre of the intervention. However, there is **criticism** from women's rights groups in the US that cooperation between women's autonomous groups and states carries the risks of entrenching them within a punitive justice and service model, leading to deleterious changes in the initial objectives (Bumiller, 2008), and in the UK where the focus in MARACs has been on the women to stop the violence themselves and concerns about the way that their cases are discussed without their consent or presence, thus turning them into 'an object of concern' (Coy, 2011). Some hope that the deliberative potential of coordinated community response models may overcome these drawbacks by conscious and organised efforts to transform state intervention modes.

#### 2.4.2 Criteria for best practice for coordination

The criteria for best practice for coordination practices found in the literature include:

- inclusiveness vis-a-vis relevant agencies, criminal justice actors and women's or victim's rights advocates;
- spelled out common understanding of gender violence including rape;
- working cooperatively towards development of policies, guidelines, referral and data collection mechanisms;

- led from gender expertise and the experiences of survivors; and
- accountability mechanisms and some independence from the state.

The analysis of the literature leads to the recommendation to develop on the one hand **guidelines** and publicise **good practice** cases for national action plans and national level coordination mechanisms in place in Europe and beyond. On the other hand, Europe specific guidelines should be developed and available European good practices of coordinated community response instances should be publicised.

Addressing rape through protective and preventive measures implies a wide range of disparate interventions involving several state and non-state, public and private actors: police, courts, prosecutors, health care and mental health providers, crises centres and help lines. A recurring experience of rape policies is the absence of coordination between the different actors involved resulting in inefficient interventions, interventions mistaking the interests of the victim or aggravating the harm suffered by the victim through re-victimization (Pence, 1999; Yancey Martin, 2005, 2007; Stark 2009). The need for coordination and cooperation between actors is a crucial element of victim centred implementation of legislation and policies addressing gender violence including rape.

#### 2.4.3 Victims and women's rights at the centre of interventions

In addition, cooperation is also a key in keeping the interests of women's rights in the centre of gender violence and rape interventions. Bumiller (2008) argues that too much emphasis on criminalization has been eroding the original objective of the women's movement, leading to a loss of focus on women victims' interests. Protecting women, she argues, means **enabling and empowering women**, sustaining fundamental rights and dignity, since this is the most efficient long-term approach to fight violence against women. Yet, routine forms of state control, by turning the issue into a 'treatable social problem', can lose sight of the victim's perspective (Bumiller, 2008). Coordination is a potential route to a solution to this problem, if it brings together grassroots organisations, victim's rights advocates, service providers and agents of the criminal justice system in a common platform.

Successful protection for women is dependent on improving victims' treatment within mainstream organizations. The objective is to **avoid re-victimization** at the hands of agencies working on addressing sexual violence. Yancey Martin on the basis of decades of rape work in the USA (2005, 2007) points to the failures of mainstream organisations and their personnel to 'own rape', that is, to see addressing rape and placing its victim in the centre as a primary objective of their organization. Rather than bad intentions, conflict between other work objectives (e.g. efficiency, transparency) and rape victim's priorities can result in weak and inefficient responses. Interagency cooperation and cooperation with victim's advocates is a route to spell out and address some of these conflicts, and to bring the victim's perspective back to the centre in the way that is necessary to ensure the intervention becomes truly supportive and empowering (Martin, 2007; Mallios and Markowitz, 2011).

In conclusion, local coordination of service provision is potentially important in avoiding fragmentation and enabling the victim-survivor to be at the centre of the provision of the necessarily multiple services. It is however a challenge to ensure that the victim-survivor remains at the centre of the process in the face of competing pressures from bureaucratic and other forces.

## 2.5 Conclusions

Strategic planning and coordination make important contributions to preventing rape and assisting victim-survivors of rape. These take varying forms at international, EU, national and local levels. There is scope for greater strategic planning and coordination at international, EU, national and local levels. Thus the study recommends for the EU and its Member States:

- the development of an EU strategy and action plan to combat rape, including a directive on either rape or violence against women;
- national plans of action by each Member State;
- the development of research to assist planning; and
- the signing, ratification and implementation of the Council of Europe Istanbul Convention.

### *Examples of best practice*

Two case studies that constitute examples of best practice at national and at local levels are provided in Chapter 11. The case study at 11.3 is of 'coordinated and integrated services in Australia', while case study 11.6 describes 'coordinated community responses'.

### 3 Specialised services for victim-survivors

#### KEY FINDINGS

- The provision of a comprehensive set of specialised services for victim-survivors is important in order to assist victims and can make a significant contribution to prevention.
- Specialised rape crisis centres have developed that offer expert provision to victim-survivors and offer expert engagement in policy development.
- The Council of Europe's list of minimum services for preventing violence against women and assisting victims includes: free 24 hour help lines; support and advocacy services; accessible services for socially excluded women, especially recent migrants, refugees, women from ethnic minority groups and those with disabilities; access to financial support, housing, residence rights, education and training; networking between specialist NGOs; multi-agency co-ordination; training curricula for professionals addressing the continuum of violence against women within a human rights framework; work with perpetrators rooted in women's safety and prevention; and safe shelters.
- The development of special packages of services to assist victim-survivors of rape in humanitarian emergencies, often led from a health perspective, has been an important development.

#### 3.1 Comprehensive service provision

The provision of a comprehensive set of specialised services for victims-survivors of rape is widely recognised as important. These specialist services have typically developed as specialist centres of support and expertise. There are also attempts to build specialist expertise into mainstream services that survivors might access. The mainstreaming (Walby, 2005) of efforts to end violence against women, including rape, into wider 'normal' policy arenas (Kelly, 2005) is developing but unevenly so.

The Council of Europe in 2008 announced a widely recognised list of **minimum standards** for support services to victims of violence against women, including sexual violence and rape (Kelly and Dubois, 2008). The minimum services recommended by the Council of Europe are:

- free 24 hour help lines;
- support and advocacy services;
- accessible services for socially excluded women, especially recent migrants, refugees, women from ethnic minority groups, and disabled women;
- access to financial support, housing, residence rights education, training;
- networking between specialist NGOs;
- multi-agency co-ordination;
- training curricula for professionals addressing the continuum of violence against women within a human rights framework;
- work with perpetrators rooted in women's safety and prevention; and
- safe shelters.



The Council of Europe (2001) Istanbul Convention makes specific reference to the services needed by victims of sexual violence in Article 25, which states:

Parties shall take the necessary legislative or other measures to provide for the setting up of appropriate, easily accessible rape crisis or sexual violence referral centres for victims in sufficient numbers to provide for medical and forensic examination, trauma support and counselling for victims.

In America, Mazy et al (2011) identify six areas of needed services: crisis services; legal advocacy; medical advocacy; support group; individual counselling; and shelters. Shelters are a specific form of service provision and separated from 'support and advocacy'; they are used by groups of women with particular needs.

There needs to be coordination between health-based and non-health based services for victims-survivors of rape: for example, responses to recent rape are most often addressed in SARCs, while rape crisis centres more often respond to historic rape.

In **conflict zones** there are further needs. The UN High Commissioner for Refugees (UNHCR) has developed a set of guiding principles for service provisions to refugee victims of rape (2003). They underline the importance of any service provision programme to: engage the refugee community fully; ensure equal participation by women and men, girls and boys in planning, implementing, monitoring and evaluating programmes; ensure co-ordinated, multi-sectoral action by all actors; strive to integrate and mainstream actions; and ensure accountability at all levels. On the individual level, all actions and interactions with individuals should: ensure the physical safety of the victim; guarantee confidentiality; and respect the wishes, the rights, and the dignity of the victim; and consider the best interests of the child (UNHCR, 2003: 28).

Health services are developing significant services. These are addressed in the following section on health.

## 3.2 Centres

The development of specialist centres of expertise to provide services to victims-survivors of rape has been central within this policy field. These centres sometimes take a **physical form**, though sometimes they offer services **by phone**. There are different needs for women who have recently experienced rape and those for whom it happened some year earlier. **Shelters** are important for victims of rape by an intimate partner, where the sexual violence is part of a wider pattern of coercive control made up of different kinds of violence and threat. Shelters are also important in locations where communities might reject women victims of rape, offering a route to alternative forms of livelihood.

### 3.2.1 Services offered by centres and shelters

**Rape crisis centres** provide a range of services including crisis hotlines, emergency contraception, abortion, victim advocacy, job-training, research, education and re-education, policy work, training of police, prosecutors and health staff, community outreach, housing, medical assistance, psychological assistance, legal assistance, pre-court training, and awareness raising. Rape crisis centres have been at the forefront of



challenging mistaken views about rape in the wider society. They are important institutions, sites through which women have been enabled to engage in transformative actions.

Most shelters provide for **emergency needs**, including food, clothing, medical and mental health referrals (e.g. Haven, USA), while others engage actively in wider issues of **gender equality and feminist politics** (e.g. Rape Crisis Network Europe (RCNE); Riksorganisationen för Kvinnojourer och Tjejjourer i Sverige (ROKS), Sweden). Other interventions focus on helping women through the criminal justice system (e.g. Greater Rape Intervention Programme (GRIP), South Africa).

Shelters offer a short term **refuge** for women and children from violent relationships. Shelters allow an abused woman to separate from the abuser and help the woman locate social services, find transitional and permanent housing, legal aid and access alternative means of livelihood. However, **lack of long-term funding** for shelters is a problem raised in much of the literature (Kulkarni et al, 2012; Macy et al, 2011).

In both non-conflict and (post)-conflict zones, shelters are especially needed by women who lack other means to find safety and security. Literature from the non-conflict zones of the global north often name the consideration of **intersecting inequalities** as conditions for good practice, whereas the literature on shelters in (post)-conflict zones of the global south more often name services that provide education and empowerment resulting in **reintegration into society** as good practice. There are a lot of different models, with varying degrees of quality.

### 3.2.2 Transformative effects of centres

Centres can be transformative. In many instances the vision underpinning the rape crisis movement is that, while they are intended to protect and assist women in moments of extreme duress, they are intended also to be the bases of practices of social transformation, to engage with the society which produced rape so that it is changed so that rape would not occur again. Centres sometimes have the goal of **transformation of the society** that produced the rape, rather than simply reintegrating women back into a rape-producing society (Critelli, 2012; Fantini and Hegarty, 2003; Kulkarni et al, 2012; Zaidi, 2002). By promoting women's independence and economic self-reliance, centres, shelters and service programme providers may help changing women's perceptions of themselves (UNHCR, 2003). Such interventions, particularly important in (post)-conflict zones, include offering literacy programmes; providing vocational training; developing income generating and micro-credit projects; and ensuring balanced representation of women on refugee management and assistance delivery committees (UNHCR, 2003).

RCNE suggests that best practice includes seeing the **interaction** between victim and service provider as one between equals who cooperate to remove the threat of violence. RCNE states that involving women who themselves have experienced sexual violence is an important element of good practice. RCNE argues for 'a flexible approach', that only the victim knows what she might need. However, it may take some time to discover these needs in the **trauma** following rape, including 'wartime rape' (Mertus, 2004). The goal is to enable and empower the victim to become aware of her own needs, and to meet those needs. In some cases, however, traumatising due to sexual abuse can leave some victims incapacitated for a period of time, as for example, Zimmerman found that in some cases of trafficking for sexual exploitation, a victim potentially needs 90 days to improve cognitive functioning to a level where informed decisions about her future and her role in the prosecutions of the perpetrators can be made (Zimmerman et al, 2006). The knowledge

and experience of the service provider enables them to offer alternatives and a range of possible interventions to the victim-survivor.

The RCNE offers a guide to best practice for services for rape survivors in Europe. Good practice includes educating, empowerment and awareness raising in the wider society. RCNE suggests that centre staff's expertise could be used to influence the **media** to carry out campaigns and to engage in coalitions and co-operation with other organisations, not only shelters. Some shelters publish **case studies** of some women victims and distribute them to other women victims, while others participate in TV and radio programs, press conferences and produce printed materials which are disseminated to governmental and nongovernmental organisations and institutions active within the policy domains of health, education, law, and immigration. To contribute to the development of effective social and political response to rape, service providers should have the resources to engage in education, awareness raising, advocacy work and lobbying.

In **South Africa**, GRIP offers victims of rape both immediate assistance and on-going support. GRIP's Court Intervention Program South Africa is an example of services extending beyond immediate care. There are Court Care Rooms, where GRIP staff provide support to victims throughout the trial (Neudorf et al, 2011). Established in the Nelspruit area in South Africa in 2000 as a response to the high levels of sexual violence and HIV, it is a **multi-sector program** with cooperation between the South African Police Service (SAPS), the Department of Health (DoH), the Department of Justice (DoJ), the National Prosecuting Authority (NPA), and the Department of Social Development (DSD). GRIPs provides 29 Care Rooms located in police stations, hospitals and courtrooms staffed by volunteers who are trained to provide victims with police and medical attention, emotional support, and courtroom assistance.

### 3.3 Conclusions

The study recommends for the EU and its Member States the development of a **framework** for the provision of a set of comprehensive specialised services for victim-survivors. Many of these services would be provided at Member State level, under practices of subsidiarity, but the EU has a contribution to make in assisting Member States as to best practice, as indeed it has been doing through the Daphne programme. The development of these services is a key component of recent international Conventions, including the Council of Europe (2011) Istanbul Convention.

#### *Best practice example*

An example of best practice is provided at 11.2. This is a study of 'comprehensive rape crisis services: Sexual assault crisis team (SACT)' in the US.

## 4 Health

### KEY FINDINGS

- Health care for victim-survivors of rape requires both specialised services and access to mainstream services.
- The health consequences of rape involve both physical and mental trauma and require a range of interventions.
- Best practice is a health led, multi-sectoral 'one-stop shop' unit, housed in a hospital or primary health care facility with a separate entrance and providing health interventions, forensic evidence collection, advocacy and counselling.
- Practice standards can be identified in six domains: Capable and Care Conducive Environment; Health and Medical Care; Forensic Examination and Evidence Collection; Community and Social Support; Specialist Referral and Follow-up Care; Quality and Monitoring.
- Health care for victim-survivors is important in both non-conflict zones and in conflict zones, where it can be part of humanitarian assistance packages.

### 4.1 Introduction

The improvement in access to and quality of health services for victims of rape includes mental, sexual and reproductive health services. There have been important **innovations** in addressing mental health issues and in the use of the diagnosis of post-traumatic stress disorder. These health services are differently organised in response to rape in different settings (Lovett, Regan and Kelly, 2004; WHO, 2007, 2013b).

This section is focused on establishing best practices for health sector led interventions for women who have been raped in disaster and non-disaster zones. The best practice standards and recommendations identified here should be adapted to reflect international and national standards, protocols and legal requirements where relevant and for general **minimum standards** for violence against women support services (see Kelly and Dubois 2008). This chapter first outlines the health consequences of sexual violence and rape, identifies how best practices have been established for this study, and then presents minimum and best practice standards for health interventions for victims of rape in non-conflict zones and humanitarian emergencies.

Best practice standards for health interventions for victims of rape and sexual violence in humanitarian emergencies can be regarded as the core minimum standards for health interventions for victims of rape in non-disaster zones. This core of standards is then supplemented with reference to further international literature to identify best practices for health interventions for victims of rape in non-disaster zones.

### 4.2 Health consequences of sexual violence and rape

The health consequences from sexual violence and rape are well documented. The first global synthesis of health and sexual violence literature (Jewkes et al, 2002) reported the

known **health complications** for women who have been raped as: i) sexual and reproductive health problems including unwanted pregnancy and sexually transmitted diseases; ii) mental health problems and health risk coping strategies; iii) physical injuries; and iv) social ostracization.

Rape may result in pregnancy and gynaecological consequences (bleeding, infection, pain, genital irritation, urinary tract infections, pelvic pain, painful intercourse, and decreased sexual desire) and victim-survivors of rape and sexual violence may have been exposed to HIV and other sexually transmitted diseases (Jewkes et al, 2002) including Hepatitis B.

#### **Box 2: PTSD as a consequence of rape**

In the immediate phase after rape, victim-survivors may express fear, anger, sadness or may control and subdue emotions (Wang and Rowley, 2007). Rape associated social fears and stigma may evoke experiences of social isolation (Jewkes et al, 2002). Victim-survivors of rape have reported enduring **psychological distress** and mental health sequelae and these are reported as sleep disturbances, anxiety, depression, post-traumatic stress disorder, panic and obsessive-compulsive disorders (Wang and Rowley, 2007). Many victim-survivors of rape and sexual violence experience nightmares, flashbacks, heightened arousal and/or numbness, all of which are symptoms associated with **post-traumatic stress disorder** (PTSD) (Wang and Rowley, 2007); indeed PTSD diagnosis is more likely for victim-survivors of sexual violence than other types of trauma (Regehr et al, 2013). One third of rape survivors will develop PTSD (SVRI, 2011). There is no clear evidence to suggest that there are distinctions in the severity of mental health sequelae based on the victim-perpetrator relationship but greater prevalence of PTSD has been associated with life-threat and severity of physical injury during the sexual assault (Wang and Rowley, 2007). Commonly, PTSD associated symptoms gradually increase in the first three weeks but then resolve within three months for approximately half of rape victim-survivors (SVRI, 2011). The SVRI (2011) has summarized indicators of likely development of chronic PTSD and lists these as: persistent dissociation, rumination, self-blame, disorganized memories of the trauma, maladaptive coping strategies, substance abuse, depression, physical reminders of the attack, and severity of symptoms. In addition to PTSD rape is also associated with greater risk of depression, suicidal thoughts, suicide attempts (Jewkes et al, 2002) and health risk coping strategies that are associated with poor health outcomes (Campbell, 2002).

In conflict and post-conflict zones, the **severity of violence** is often extreme (Kippenberg et al, 2009). Conversely, sexual assault and rape may result in minor wounds, soft-tissue and/or musculoskeletal trauma (Fehler-Cabral et al, 2011), or indeed, as the findings of Sugar et al (2003) indicate, there may be no physical injuries. Physical injuries from sexual violence are less often life threatening (Jewkes et al, 2002), however extreme violence (as recently exemplified in Delhi) may be used and assessment of and intervention for traumatic injuries will depend on the severity of violence perpetrated in the assault.

### **4.3 Establishing best practice in conflict and non-conflict zones**

The WHO report on violence and sexual health (WHO, 2002) detailed health interventions for victims of rape under the terms: 'psychological care and support', 'medico-legal services', 'prophylaxis for HIV infection', and 'comprehensive care centres' and 'training for health professionals'. The World Health Organisation (2010) stresses the importance of randomized controlled trials or quasi experimental designs through which comparisons for

**effectiveness** of an intervention can be made against a non-intervention control group. However, confidently associating intervention and outcome is often fraught with difficulty in real world complex social systems and there is very little research of this calibre in this field. That said, as Kelly et al (2006) point out, there are many effective systems developed locally in low, middle and high income countries. The recently published World Health Organization (2013b) clinical and policy guideline 'Responding to Intimate Partner Violence and Sexual Violence against Women' presents an appraisal of the evidence to date for the clinical care of sexual assault.

In the EU, Kelly and Dubois (2008) found that only the **UK** and **Ireland** had commenced developing minimum standards for sexual violence services as distinct from domestic violence services. The benefits of minimum standards, although by no means considered best practice, provide key information for service commissioners, leverage for service providers to secure resources from government, and a consistent, minimum set of service provision for service users (Kelly and Dubois, 2008). Best practice standards for health interventions for rape and sexual violence have been developed for this chapter from extracting minimum, desirable and comprehensive recommendations from systematic reviews where available, evaluation studies, expert recommendations and policy documents from international data repositories.

#### **4.3.1 Humanitarian Emergency situations**

The term 'Humanitarian Emergency' is used to encompass the range of types of 'disasters' globally associated with natural hazards, man-made hazards, or complex political emergencies (including armed conflict). '**Disaster**' is defined by the World Health Organization (2013a) as: 'a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources'. The terms 'disaster', 'emergency', 'crisis', and 'humanitarian emergency' are used interchangeably in this section.

Health services for survivors of rape and sexual violence are essential in disaster zones (WHO, 2004b, 2005, 2007; IASC, 2005; The Sphere Project, 2011; IAWG 2010). For them, the protection and safety of women must be central. This section will address health services for victims of rape and sexual violence in disaster contexts whether associated with natural or man-made hazards or complex political (armed conflict) emergencies. Where distinctions exist for best practice service provision in different disaster zone contexts the difference will be made clear. This report is for best practices for women survivors of rape and as such has not included specific considerations for child and adolescent rape services. However, humanitarian actors should be familiar with local legislation in relation to the **age of consent**, who can give legal consent for clinical care of minors and requirements and procedures for child protection.

##### **Natural hazards**

Disaster situations pose new and increased threats to women. Sexual violence in the midst of disasters arising from natural hazards has been reported worldwide in **Australia**, the **Philippines** and **Central and North America** (IASC, 2005). Levels of gender-based violence against women increase as women are displaced, separated from protective support systems and perpetrator distancing becomes less possible (WHO, 2005). In Klein's (2006) review of rape and sexual violence during **Hurricane Katrina**, women reported being raped whilst waiting for emergency rescue in life threatening situations, whilst seeking refuge in official evacuation shelters and non-official shelters, and incidents of

sexual violence and rape continued as women tried to rebuild their lives in new environments. An online survey identified more than one hundred reports of sexual violence made to agencies in the aftermath of Hurricane Katrina, 95% of which were disaster victims and 93.2% were women (Klein, 2006). In the aftermath of Hurricanes Katrina and Rita, a study of sexual assaults found that 30.8% of the sexual assaults were perpetrated at an evacuation site or other shelter (NSVRC, 2006). Displaced women in refugee camps have also reported sexual violence (WHO, 2005) and in official disaster shelters women are often unprotected.

### ***Rape as a weapon of war***

In complex emergencies, the risk of rape and sexual violence against women is significantly heightened and sexual violence is perpetrated as a weapon of war (IASC 2005). The Inter-Agency Standing Committee Task Force on Gender and Humanitarian Assistance (IASC, 2005) document the extent of reported rape and sexual violence experienced by women in the conflict zones of **Sierra Leone, Rwanda, Bosnia and Herzegovina** and, as reported by Human Rights Watch (Kippenberg et al, 2009), in the **Democratic Republic of Congo**. In the chaos of disasters, perpetration of sexual violence and rape against women increases and sexual violence services, if they existed, are often disrupted (IASC, 2005).

### ***Minimum standards***

From the review of international policy documents (WHO, 2004b; WHO, 2005; WHO, 2007; IASC, 2005; The Sphere Project, 2011; IAWG, 2010) minimum standards for primary health services for victim-survivors of rape and sexual violence in disaster zones were extracted (see Table 1), these minimum standards together with other practice recommendations have been differentiated into six domains for best practices for rape and sexual violence health care in disaster zones. The six domains are:

- Capable and Care Conducive Environment
- Health and Medical Care
- Forensic Examination and Evidence Collection
- Community and Social Support
- Specialist Referral and Follow-up Care
- Quality and Monitoring

#### **4.3.2 Health services for victims of rape in non-disaster zones**

In recognition, on the one hand, that in non-disaster zones, health-led services for victims-survivors of rape and sexual violence can be offered in a broader and more sustainable way and, on the other hand, that victims-survivors may present and disclose during a consultation at other health services, it is recommended that all health services have a service relevant **policy and protocol** to respond to such disclosures and refer victims-survivors to specialist services as required (WHO, 2003, 2013b). An example of such a non-specialist sexual violence and rape health service policy is the **United Kingdom** National Guideline for Genitourinary Medicine / Sexual Health clinics on the management of adult and adolescent complainants of sexual assault (Cybulska et al, 2012).

**UN Women** (2012) in their model framework for mandated National Action Plans recommend that health care systems are supported to provide integrated, multi-sectoral



services, to identify victim-survivors of gender-based violence against women and to provide services without charge. Lovett, Regan and Kelly (2004) propose that health-led integrated rape and sexual violence services should be **funded by statutory services**.

Health sector led rape and sexual violence services have been developing for over thirty years and have developed globally in non-disaster zones in largely similar ways differing only in the operational formation of standalone units versus mobile on call teams.

SARCs operate in the **UK**, the **US**, **Canada** and **Australia** commonly as **standalone units** providing onsite crisis intervention, forensic examinations, immediate medical care, follow-up tests, and short term counselling (Lovett, Regan and Kelly, 2004). These units are often close to or in hospital buildings. In **England**, SARCs can be accessed by contacting a police service, presenting at an emergency department, contacting a victim helpline or by self-referral. **On-call SARTs** operate in **North America** and **Australia**, and provide a similar service to SARCs but are activated through victim-survivor contact with police service or emergency department and may have designated units or provide mobile services. SARCs may also provide outreach services to victim-survivors who are medically unfit to attend the SARC.

## 4.4 Capable and care conducive environment

The domain 'Capable and Care Conducive Environment' is about creating the environment for women to be able to knowingly and safely access **integrated and competent health services** for care after rape and sexual violence that will make a positive difference to their health and wellbeing.

### 4.4.1 Situations of humanitarian emergencies

In some regions, health services designated as specifically for sexual violence may be stigmatizing for women (Wang and Rowley, 2007) and may pose risks of further violence for victim-survivors accessing services, communities hosting services and service providers (WHO, 2007). In light of the incidence of rape and sexual violence against women in disaster zones, health services for rape and sexual violence should be **available at all primary health facilities** and accessible to women in the immediate and acute phases of natural hazard and complex emergencies and included in emergency planning for humanitarian responses to disasters (The Sphere Project, 2011).

It is widely accepted that **multi-sectoral programs** are 'best practice' for gender-based violence services in disaster settings; multi-sectoral models entail full collaboration with the affected community and are interdisciplinary and inter-organisational, bringing together health, legal, psychological and security services (IAWG, 2010; The Sphere Project, 2011). **Emergency planning** should take account of the configuration of sexual violence health services in the event of disasters (IASC, 2005) in collaboration with local and indigenous populations (Peate and Mullins, 2008). However it is likely that in some territories emergency planning may be absent or the event was unforeseen. In the immediate first response in these situations, it is likely that no services will be available and first response relief teams will need to work with local women and women leaders to establish the extent of functioning services and work to restore and/or create services for women victim-survivors of sexual violence (WHO, 2007; The Sphere Project, 2011).

Basic care and support must be in place before any activities are instigated that may lead to individuals disclosing rape (WHO, 2007). As a minimum response in the midst of emergencies, **specific psychological and social considerations** should be included in the provision of general primary health care (IASC, 2007). Health service staff being prepared for disaster and emergency work should be trained in cultural and linguistic competency and culturally appropriate clinical care for survivors of gender-based violence (IASC, 2007). An example of **cultural competency training** is the online learning programme for first responders in disaster situations delivered through the U.S. Department of Health and Human Services, Office of Minority Health (no date).

The Inter-Agency Standing Committee (IASC) Global Health Cluster (2010) advocates removing user fees and assessing accessibility for primary health care services during humanitarian crises. This proposal is based on the humanitarian principle that intervention in crises should be '**based on needs alone**' and '**accessible without discrimination**'. The removal of user fees is intended to ensure that the poorest and most vulnerable disaster affected populations are not further disadvantaged or financially prevented from accessing health services. The IASC Global Health Cluster (2010) recognises that in parallel with possible increased demand for health services during humanitarian emergencies, any removal of existing fees will impose additional financial burden for services and, consequently, the implications of and solutions to such a move should be considered before removing user fees.

#### 4.4.2 Services for victims of rape in non-disaster zones

##### *Sexual Assault Referral Centres (SARCs)*

In the first **UK** evaluation of SARCs, Lovett, Regan and Kelly (2004) found that in comparison to non-SARC sites, SARCs more integrated services:

- Provided more consistent services;
- More effectively balanced the needs of the victim-survivor with the needs of the legal system;
- Increased access to health services for victim-survivors of rape who did not wish to report to the police;
- Provided greater access to female medical examiners;
- Facilitated greater victim-survivor control of the examination;
- Encouraged take up of support services;
- Had more embedded referral systems to a greater range of supports;
- Provided case-tracking services to support victim-survivors through the criminal justice system; and
- Provided procedural justice.

In response to victim-survivor service user evaluations, Lovett, Regan and Kelly (2004) concluded that SARCs should develop advocacy services and more flexible and practical support. For minimum standards for violence against women advocacy services see Kelly and Dubois (2008).



### ***Sexual Assault Response Team (SART)/Sexual Assault Nurse (SANE)/Sexual Assault Examiner (SAME)***

In the **US**, Sexual Assault Response Teams (SARTs) are on-call teams comprising of a police officer, a victim advocate, a sexual assault nurse (SANE) or sexual assault medical examiner (SAME) and a prosecutor. Victim-survivors of rape can mobilise a SART by contacting a police service, presenting at an emergency department, or calling the victim helpline.

#### ***Experiences***

Experiences of victim-survivors are overall positive (For SANE see Fehler-Cabral et al, 2011, for victim advocacy services see Campbell, 2006). However, victim-survivors presenting at an emergency department for health care often do not have life or limb threatening physical injuries and have reported **long waits** to be seen after being triaged as non-urgent (Wang and Rowley, 2007). While victims-survivors who accessed a SANE service valued being given thorough explanations, being able to make choices during their exam, and receiving compassionate care, some victim-survivors did have negative experiences in which they described experiences of not having enough explanation or choice or their examiner as cold and distant (Fehler-Cabral et al, 2009). Even though victim rather than legal system centred, both SARCs (Lovett et al, 2004) and SARTs (Campbell et al, 2008) **improve outcomes for victims-survivors of rape and sexual violence proceeding through criminal justice systems.**

The **disadvantage** with stand-alone SARCs is in terms of the potential to marginalise particular groups of rape, i.e. victims-survivors who do not associate their experience of rape and sexual violence with SARC services or who may be concerned about social stigma associated with rape and sexual violence. Mobile SARTs with a geographically spread service network may pose difficulties for victims-survivors to navigate.

#### **Box 3: Ethical principles**

Kelly et al (2006) identify ethical principles for services for gender-based violence against women reflecting human rights principles of dignity and bodily integrity and providing a welcoming environment and a climate of belief and validation. Services should offer privacy and confidentiality whilst openly acknowledging the limits of confidentiality, and communication and information should be at the victim-survivors pace (Kelly et al, 2006; WHO 2013b). Care should also include checking for risks to current safety, contacting a friend or family member if desired, providing information about the options available, and practical and emotional support (Kelly et al, 2006; WHO 2013b).

Minimum standards for SARCs have been extracted from a number of reports and these are presented in **Table 2**. On comparison, the minimum standards identified in the different reports are largely consistent.

#### ***Sex of the examiner***

One notable difference in the minimum standards is the recommendation for the sex of the examiner. Some advocate that the examiner should be female *wherever possible* (WHO, 2003; DH, 2009) whilst others request that examiners *should be female* 'unless the service user specifies otherwise' (Kelly and Dubois, 2008:51). A study of examiner gender preference by Chowdhury et al (2008) found that most victim-survivors of rape voiced a preference for a female examiner and perhaps more significantly that nearly fifty percent of the women respondents indicated that they would not have preceded with an examination if they had no choice but to see a male examiner. Chowdhury et al's (2008) assertion that

most victim-survivors prefer a female examiner is contested by Templeton et al (2010) on grounds that there were no respondents who had been examined by a male examiner. Based on the current best evidence, examiners for women victim-survivors should be female unless otherwise requested by the victim-survivor.

### ***Best practices***

Best practice health-led sexual violence services should be '**one-stop shop' units housed in hospitals** providing health interventions, forensic evidence collection, and advocacy and counselling (WHO, 2003, 2013b; Kelly et al, 2006). For the purposes of this study, the term SARC is used to denote this best practice concept of a one-stop, health-led rape and sexual violence service but this type of service may be known by other terms in other regions of the world. From the review of literature, hospital-based, one-stop shop SARCs have been identified as most effective in improving outcomes for victim-survivors. The best practices for rape and sexual violence health care in disaster zones form the core practice standards for services in non-disaster zones. The following best practice standards for health-led rape and sexual violence services in non-disaster zones are additional to the best practice standards for disaster zones; *together* they form the best practice standards for health-led rape and sexual violence services in non-disaster zones.

#### **4.4.3 Best practice standards of capable and care conducive environments**

##### ***In humanitarian emergencies***

- Treatment and interventions can be started without a medical examination if the victim-survivor prefers this.
- Service providers should communicate supportively at the victim-survivor's pace, listen actively, and provide accurate information and compassionate, non-judgmental care.
- providers are able to give psychological first aid (PFA) to victims-survivors of rape and sexual violence as part of their usual care. ('Psychological First Aid' (IASC, 2007) is explained in the following mental health best practice standards).

##### **The service**

- is delivered with respect to the core principles of The Sphere Project (2011) Humanitarian Charter;
- is established and developed through a multi-sectoral approach that strengthens established services in collaboration with local populations rather than developing new ones where possible;
- provides and distributes information (once the service is established) to women and communities about the service and why, when and where to access it;
- is accessible and available at a health care facility that is safe for women to access, travel to and free from user fees;
- has sufficient supplies and equipment;
- is delivered by workers skilled and trained in cultural competence and culturally appropriate care for survivors of sexual violence and rape;
- has male and female service providers (or chaperones if not possible) fluent in local languages;

- offers a private consultation area, is confidential and ensures victim-survivors safety and dignity; and
- has lockable files for records.

#### ***Additional Best Practice Standards possible in non-disaster zones***

- All health services (i.e., services that are not specifically for rape and sexual violence) should have a service relevant policy and protocol to respond to disclosures of rape and sexual violence and refer victim-survivors to specialist services as required.
- Services for rape and sexual violence should be health led, multi-sectoral 'one-stop shop' units, housed in hospitals but with a separate entrance and providing health interventions, forensic evidence collection, and advocacy and counselling.
- Rape and sexual violence health services in non-disaster zones should meet the best practice standards for health-led services for victim-survivors of rape and sexual violence in disaster zones.
- Referral pathways should avoid A&E departments unless fast-track mechanisms for victim-survivors of rape and sexual violence are in place.
- A skilled crisis support worker should greet the victim-survivor on arrival and stay with her at least until the forensic examiner arrives.
- Medical/forensic examiners should be female unless the victim-survivor specifies otherwise.

## **4.5 Health and medical care**

Health and medical care is concerned with attending to victim-survivors immediate health needs and planning for longer term care. For clarity, this section is not only structured regarding humanitarian emergency situations and non-conflict situations but also regarding physical health interventions and mental health interventions.

### **4.5.1 Situations of humanitarian emergencies**

There are a number of resources with information about necessary supplies for emergency health services. A **supplies checklist** for medical and forensic examination minimum standards of care can be found in the IASC's Guidelines for Gender-Based Violence Interventions in Humanitarian Settings (IASC, 2005:68). The Inter Agency Working Group (IAWG) on Reproductive Health Field Manual (2010) provides information on regimens for emergency contraception, sexually transmitted infection treatment and HIV post-exposure prophylaxis. The IAWG designed 'Inter-Agency Reproductive Health (RH) Kit Block 1' contains the medical supplies necessary for Minimum Initial Service Package (MISP) service delivery of clinical care to survivors of rape and sexual violence. The RH Kit complements the Interagency Emergency Health Kit (WHO, 2011). These kits collectively have the supplies needed to implement MISP and are designed to supply community and primary health care for a population of 10,000 for three months.

### ***Mental health interventions***

Standalone mental health services for rape survivors can create fragmented systems whereas integrated systems are likely to be accessed by more people, be more sustainable and be less stigmatizing (IASC, 2007). The IASC (2007) in its guidelines for minimum mental health and psychosocial support (MHPSS) advocates that mental health services in emergency settings are **integrated into wider systems** of general health services and community support networks.

For the IASC (2007) mental health support systems are overlapping, layered tiers of support. At the first level are **basic services and security** for mental and physical wellbeing. In the second tier people find **support** from family and community and social networks. The third tier provides focused but **non-specialized support services** facilitated by trained responders, for example psychological first aid and basic mental health care by primary health care workers. Psychological First Aid (PFA) rather than being a specific psychiatric intervention is 'a humane, supportive response to a fellow human being who is suffering' (IASC, 2007:119). Many of the components of PFA practice (IASC, 2007:119-120) are contained within the capable and conducive care context domain. In addition to those listed above, PFA expressly includes: protection from further harm, the right to refuse to discuss events, respect of the wish not to talk, identifying basic practical needs and ensuring these are met, asking about people's concerns and trying to address these, discourage negative and health-risk ways of coping, encourage participation in normal daily routines, encourage positive coping methods, encourage (but not forcing) company from family or friends, offer possibility of return for further support, and refer to local appropriate and available support. The final, fourth tier of mental health support systems comprises **specialized services** for people who are experiencing difficulty in day to day functioning; if such specialized services do not exist, primary health care practitioners should receive further training for the longer term support of this population.

#### **Box 4: Long-term effects of rape in intimate partnerships**

Some physical and mental health outcomes from sexual violence or rape are more easily directly attributed to an assault than others. For longer term health sequelae, the association is indirect and **more complex** related to long term stress responses and coping strategies (Campbell, 2002). Distinctiveness and causality of longer term health risks for victims of sexual violence and rape in isolation is unclear and much research on health consequences of gender-based sexual violence is focused on or combined with sexual violence in intimate partner violence and appropriately so as much sexual violence and rape takes place within intimate relationships. In a national, cross-sectional study of reported health outcomes and exposure to violence, Black et al (2011) found statistically significant ( $p < .001$ ) higher prevalence of **adverse physical and mental health outcomes** for nine out of the ten measured health outcomes in women with a history of rape, stalking, or physical violence by an intimate partner in comparison with women with no reported exposure to these forms of gender-based violence. The health outcomes measured in Black et al's (2011) study were: asthma, irritable bowel syndrome, diabetes, high blood pressure, frequent headaches, chronic pain, difficulty sleeping, activity limitations, poor physical health, and poor mental health; the only measured outcome with non-significant difference was high blood pressure.

Therefore, it is likely that **early intervention** to address both physical and psychological consequences from rape and sexual violence can limit if not prevent both immediate and longer term rape and sexual violence associated adverse mental and physical health sequelae.

#### 4.5.2 Services for victims of rape in non-disaster zones

Health care, crisis intervention and advocacy should be available at the initial consultation irrespective of the victim-survivors decision to pursue legal recourse (Lovett, Regan and Kelly, 2004; UN Women, 2012). A nurse-led integrated health service for rape health care developed in an existing health service in a rural **South African** community resulted in significantly increased rates of post-exposure prophylaxis and completion of treatment and a reduced time gap between assault and treatment (Kim et al, 2007). The literature indicates that sexual violence health (and forensic) services can be provided by nurses or medical practitioners with appropriate training.

##### **Mental health**

Most of the immediate mental health interventions for rape and sexual violence services are included in the core best practice interventions. In addition to these, service providers should provide mental health care by helping the victim-survivor to understand their reactions as normal, explaining what to expect, giving information so that the victim-survivor can take control and make informed choices, assessing suicidality and responding as needed, and addressing victim-survivor self-blame or guilt (SVRI, 2011).

Many mental health therapies have been used to address the mental health sequelae following rape (Wang and Rowley, 2007). For victim-survivors whose mental health symptoms endure, a **diagnosis** can sometimes help to validate and/or make sense of experiences (SVRI, 2011). Although still limited the current evidence base indicates that cognitive behaviour therapies are effective in reducing symptoms of PTSD, depression and anxiety for victim-survivors of rape and/or sexual violence (Regehr, 2013; WHO 2013b). Debriefing is no longer recommended, rather victim-survivors control what and when they disclose to whom (SVRI, 2011; WHO 2013b).

Emotional support and counselling are more often readily available to victim-survivors of rape and sexual violence through the networks of services globally modelled on Rape Crisis Centres (RCCs), SARCs, and SARTs.

Mental health **symptoms** arising from rape or sexual violence resolve for approximately half of victim-survivors within three months, and WHO (2013b) recommends 'watchful waiting' during this period 'Watchful waiting' *"involves explaining to the woman that she is likely to improve over time"* whilst offering regular follow-up appointments and support (WHO 2013b:32). RCCs and an increasing number of SARCs are able to provide emotional support and further counselling programmes to support victim-survivors with longer term needs for an indeterminate period of time. However, victim-survivors who experience incapacitating, enduring and/or severe mental health consequences may require **referral to specialist mental health services** for additional models of psychotherapy such as cognitive behaviour therapies (see WHO (2013b) for specific guidance for immediate, up to 3 months, and post 3 months psychological/mental health intervention).

There are mixed reports on **experiences** from service users about mental health services for victim-survivors of rape and sexual violence experiencing enduring and/or severe mental health problems. Whilst there are some reports of good local practices, women repeatedly express dissatisfaction with statutory mental health services. In the **UK**, commonly reported insensitivities include minimizing or not believing women's experiences, practitioner responses that illustrate a lack of comprehension of violence against women, poor access to female practitioners, and a lack of safe, women only services (WNC, 2010). Women in the WNC (2010) study also reported too much emphasis in statutory mental

health services on a model of care concerned with treating the symptom and pharmaceutical intervention rather than the underlying experiences of abuse and violence.

Holly et al (2012), reporting on the variation of availability of domestic violence support within mental health service provision across one territory (**England**), illustrate that despite national initiatives to address mental health sequelae of violence against women, embeddedness of **violence against women strategies in mental health organisations** and access to good services for victim-survivors of rape and sexual violence with enduring mental health problems remains **sparse and variable**. In this study of mental health services in England, Holly et al (2012) report that only three (7%) of the forty-two (75%) mental health trusts responding to a Freedom of Information (FOI) request offered specialist group therapy for victim-survivors of domestic violence and only nineteen (45%) can refer victim-survivors of domestic violence to specialist abuse trauma therapeutic services. Lack of specialist mental health support services is not isolated to this territory; Hager (2011) reports that women with mental health problems in **New Zealand** and **Australia** also have limited access to domestic violence services and in Canada where psychological support services are available, waiting lists are long and incur fees (Morris, 2008). Advances have been made in the provision of systematically available and accessible psychological talking therapies free at the point of delivery in some territories such as those supported by the Improving Access to Psychological Therapies (IAPT) programme in England (DH, 2012; DH, 2011). However how these generalist services link with specialist rape and sexual violence services or support victim-survivors of rape and sexual violence is unclear.

#### 4.5.3 Best practice standards of physical health interventions

- The service provides treatment and documentation of physical injuries, wound care and tetanus prevention.
- The service provides sexual and reproductive health care that includes:
  - Emergency contraception (ECP) and prevention of unwanted pregnancy with unbiased counselling;
  - Safe abortion care (where abortion is legal);
- Prevention of disease: treatment for sexually transmitted infections (STI's) including Hepatitis B and post-exposure prophylaxis for HIV;
- Treatment and interventions can be commenced without medical examination if the victim-survivor prefers this;
- The medical history and examination is undertaken with victim-survivor understanding and consent;
- Pre-printed forms are used to guide the process and thorough documentation; and
- 24 hour / 7 day referral mechanisms are in place for care which is beyond the scope of the primary facility.

#### 4.5.4 Best practice standards of mental health interventions

##### *In humanitarian emergencies*

- Service providers are able to give PFA to survivors of rape and sexual violence as part of their usual care.



- Victim-survivors should have access to immediate and follow-up emotional and psychological support and counselling. Minimum standards for counselling services addressing violence against women have been identified by Kelly and Dubois (2008).
- Mental health care is integrated into the sexual violence and rape health service.
- Sexual violence and rape health services should have 24 hour, 7 day a week referral systems to specialist mental health services beyond the scope of primary health care provision of psychological first aid and basic mental health care.
- Training for more complex mental health care management should be provided for primary sexual violence health care providers if fourth tier, specialized mental health services do not exist.

***Additional Best Practice Standards possible in non-disaster zones***

- During the initial consultation victim-survivors of rape and sexual violence should be assessed for suicidality and responses developed as appropriate.
- An assessment for PTSD should be included in the initial assessment for victim-survivors with a delayed first access.
- Victims-survivors should be supported to understand their responses to their experiences as normal. 'Watchful waiting' is advised for the first three months after an assault, unless the person is incapacitated by symptoms.
- Victim-survivors who experience incapacitating, enduring and/or severe mental health consequences should be referred to specialist mental health services for additional models of psychotherapy such as cognitive behaviour therapies.
- Mental health services should have systems in place so that services are provided by female practitioners if the victim-survivor chooses.
- Service providers should give information so that victim/survivors can take control and make informed decisions.
- Service providers should address victim-survivor expressions of self-blame or guilt.

**Mental health services**

- and practitioners should be sensitive to gender and gender-based violence and offer holistic, comprehensive advocacy services.
- and practitioners should be sensitive to gender and offer women only specialist group therapies.
- providing psychological therapies should have practitioners sub-specialising in rape and sexual violence.
- should have formalized referral pathways to and from rape and sexual violence services.
- should have formalized referral pathways to specialist violence and abuse trauma therapeutic services.
- should have a strategic vision (in addition to policies) for addressing and responding to victim-survivors of rape and sexual violence.
- should evaluate thresholds for access and referral pathways to services so that early intervention in terms of low and/or high intensity interventions and onward referral

as appropriate becomes formalized and standard for victim-survivors of rape and sexual violence.

#### **Box 5: Local best practices for mental health support**

In recognition of the lack of an identifiable comprehensive and formalized system of a territory-wide mental health service provision specifically focused for victim-survivors of rape and sexual violence experiencing enduring mental health problems, this study is not presenting an example of a site of *mental health service* best practice. However, there are a number of localized examples of best practices in the **UK** that are embedded in other statutory and voluntary sectors worthy of note and which could form part of an integrated system of interconnected primary and secondary mental health services for victims-survivors of rape and sexual violence and these are listed below.

- *Specialist Mental Health Independent Sexual Violence Advisor* (MH ISVA) (The Haven Paddington and Westminster Mind (no date)). This specialist Mental Health Independent Sexual Violence Advocacy service at the Havens Sexual Assault Referral Centre Paddington provides integrated mental health and sexual violence support and advocacy for people with severe and enduring mental health needs who have been victims of sexual violence in the preceding twelve months. This specialist role is the only one of its kind in **England**. The service provides 1:1 emotional support and advocacy and offers holistic assessment and support for all aspects of people's lives to support individuals to navigate and be fully linked with all services.
- *The PATH* (Psychological Advocacy Towards Healing) project (PROVIDE, no date). The PATH project is a pilot project in which Independent Domestic Violence Advocates are trained to become Specialist Psychological Advocates and provide weekly psychological advocacy intervention alongside usual advocate intervention for victim-survivors of domestic violence.
- *The Emma Project* (nia, no date). The Emma Project provides refuge services for women escaping gender violence who use substances problematically and who are commonly excluded from other forms of refuge service provision.
- *Missing Link: Mental health and housing services for women* (Missing Link, no date). Missing Link has three arms to its services (Missing Link, Next Link and Safe Link). Missing link provides floating, outreach mental health support and housing services for women, to help women with mental health problems maintain tenancy and develop skills to become independent. Next Link provides domestic violence advocacy services and Safe Link provides rape and violence services sexual crisis support and advocacy services. Configured in this way Missing Link facilitates women's access to a range of integrated and gender sensitive primary mental health, housing, domestic violence and sexual violence services.



## 4.6 Forensic examination and evidence collection

Forensic examination and evidence collection is secondary to the main purpose of a medical examination after rape and sexual violence which is to identify the health care needs of the rape victim-survivor (WHO, 2004b). However, rape is a crime in most countries (see Chapter Five) and forensic evidence can be helpful for the **prosecution** of perpetrators. The options available for forensic examination and evidence collection should be communicated to the victim-survivor and only undertaken with **consent** by a practitioner trained in sexual assault forensic examination (WHO, 2004b). Forensic examination and evidence collection involves the accurate **documentation** of injuries with the use of pre-printed forms with pictograms to guide thorough documentation. Materials such as clothes and samples such as hair, blood, saliva, or sperm should only be taken if they can be used and processed according to available laboratory and legal requirements; if this is not possible then samples should not be taken (WHO, 2004b; IASC, 2005).

### 4.6.1 Situations of humanitarian emergencies

In the provision of sexual violence and rape services in evacuation shelters, Klein (2006) recommends that each shelter is staffed with a **trained sexual assault crisis worker** (Kelly and Dubois (2008) provide information for minimum standards for advice and advocacy services) and a sexual assault forensic examiner with the necessary equipment to conduct a forensic examination. Forensic examinations should only be conducted in a private and safe space. Any materials and samples taken should be collected and stored in appropriate and locked storage pending transport in accordance with local legal and laboratory protocols (Klein, 2006). In addition to the standards and resources previously mentioned, the Sexual Assault Nurse Examiner (SANE) Checklist for Disaster Planning (IAFN) is an example available from VAWnet.org's (2011) 'Special Collection: Disaster and Emergency Preparedness and Response'.

### 4.6.2 Services for victims of rape in non-disaster zones

Forensic evidence collection should include colposcope examination and SARCs should support continuing professional development of forensic examiners to develop services in accordance with new technologies (Lovett, Regan and Kelly, 2004). Lovett, Regan and Kelly (2004) also advocate that in addition to **no-report storage** of forensic evidence, victim-survivors should have the option for **anonymised samples** to be passed on to police for intelligence purposes.

### 4.6.3 Best Practice Standards for Forensic Examination and Evidence Collection

#### *In humanitarian emergencies*

- In disaster zones where forensic examination services pre-existed emergency shelters must be prepared to be able to provide sexual violence health care services including forensic examination in accordance with local standards and local emergency protocols and be staffed with a trained sexual assault crisis worker and sexual assault forensic examiner.
- Forensic examination should only be undertaken with the full understanding and consent of the victim-survivor in a private and safe space by a trained sexual assault nurse examiner (SANE) or sexual assault medical examiner (SAME).

- Materials and samples should only be taken if they can be used, stored and processed in accordance with local protocols and legal requirements.
- The forensic examination and accurate documentation of injuries should be recorded on pre-printed forms with pictograms.
- The service provides replacement clothing where necessary and at victim-survivors request.

#### ***Additional Best Practice Standards possible in non-disaster zones***

- Sexual forensic examiners should meet national training and practice standards where they exist.
- Sexual forensic examiners should be supported to undertake continuing professional development to maintain and develop practice skills.
- SARC budgets should take account of replacement and new technology procurements.
- SARC service users should have the option to have forensic examination with collection and storage of samples without reporting to the police.
- SARC service users should have the option to have a forensic examination with collection and storage of samples without reporting to the police and have anonymised samples passed on to the police for intelligence purposes.

## **4.7 Community and social support**

The IASC (2007) identifies family and community and social networks as the second tier of mental health support systems. Women often experience **social stigma** associated with rape and sexual violence and may be ostracized by their family and community (Wang and Rowley, 2007). Poor social networks are associated with greater adverse mental health outcomes (Wang and Rowley, 2007). Therefore, as stated above, in some regions, standalone health services and support groups designated as specifically for sexual violence support groups may be stigmatizing for women in addition to potentially increasing risk for targeted re-victimization (WHO, 2007). By contrast, non-sexual violence specific women's networks and groups in safe spaces, for example activity centres and wellness centres, can provide longer term assistance and emotional and integrative social support for victim-survivors of rape (WHO, 2012).

In this context, it should be reminded that Kelly et al (2006) highlight that disadvantaged women and women detained in residential institutions are less likely to have access to rape and sexual violence services.

### **4.7.1 Best Practice Standards for Community and Social Support Intervention**

#### ***In humanitarian emergencies***

- Health services for victim-survivors of rape and sexual violence should collaborate with existing women's networks and groups to establish existing functioning services, referral mechanisms, safety of access, and offer to host if required.

- Health services should collaborate with existing local services to host and/or facilitate community-based general, culturally appropriate support activities for women that are staffed by trained sexual violence counsellors and social workers.

***Additional Best Practice Standards possible in non-disaster zones***

- SARCs in collaboration with other sector service providers should develop support groups for underserved populations and women in residential institutions such as prisons, detention centres and mental health hospitals.

## **4.8 Specialist referral and follow-up care**

### **4.8.1 Situations of humanitarian emergencies**

Victims-survivors with health care needs beyond the scope of the sexual violence health care facility should be referred and safely transported to an appropriate hospital facility with the necessary resources to provide care (IAWG, 2010). If a victim-survivor has no safe place to go, the health service should arrange necessary **shelter**, protection and social service support (IAWG, 2010). **Legal support** should be provided if requested (The sphere project, 2011).

Victims-survivors should receive counselling about on-going care for any injuries and how to take prescribed treatments (WHO, 2004b). Follow up arrangements to provide on-going physical, mental and sexual and reproductive health care should be arranged during the first consultation (WHO, 2004b).

### **4.8.2 Services for victims of rape in non-disaster zones**

Information and support should be available to victim/survivors out of office hours, and service users should have access to follow up counselling, support groups and gender-based violence sensitive self-defence classes if requested (Lovett et al, 2004).

### **4.8.3 Best Practice Standards for Specialist Referral and Follow-up Care**

***In Humanitarian emergencies***

- Formalized 24 hour, 7 day a week confidential referral protocols for secondary and tertiary health care service referrals for care which is beyond the scope of the facility should be in place.
- Health services should arrange for protection, shelter and/or social service support if the victim-survivor has no safe place to go.
- Legal support should be accessible to victim-survivors attending the sexual violence health service.
- Information for on-going care and arrangements for follow-up appointments should be clearly communicated during the health consultation.

***Additional Best Practices standards possible in non-disaster zones***

- SARCs in collaboration with other sector service providers should develop and formalize clear protocols for out of office hours support.

- SARCs in collaboration with other sector service providers should develop and formalize clear protocols for follow-up counselling services.
- SARCs in collaboration with other services should develop referral mechanisms to women centred and gender-based violence sensitive self-defence classes.

## 4.9 Quality and monitoring

### 4.9.1 Situations of humanitarian emergencies

Service providers should have access to clear protocols covering health interventions and referral mechanisms (The Sphere Project, 2011; IAWG, 2010). Information needs for developing a **local protocol** for rape and sexual violence health services can be found in the WHO (2004) Clinical Management of Rape Survivors. For the longer term, community recovery phase emergency planners must be mindful that in parallel with social disruption the increased risk of violence against women may continue for some time after the acute phase and pre-existing sexual violence services may be disrupted and / or experiencing demand beyond capacity (IASC, 2005).

Service providers should have access to refresher and further **training** and supportive **supervision** to support their practice and service development (IASC, 2007). Once the disaster zone is stabilized service providers should look to expanding rape and sexual violence health services (IASC, 2005). The quality of care provided to victim-survivors of rape should be regularly assessed (IASC, 2005), if standards have not been met services should explain why this is so, assess the potential harms to the affected population and where possible seek solutions to improve the service (The Sphere Project, 2011). That said, The Sphere Project (2011) acknowledges the difficulties posed by some emergency zones and as such recognizes that achievement of minimum standards may be outside the control of service providers and humanitarian effort.

The already low **reporting** of sexual violence and rape is likely to decrease in disaster contexts even though the incidence of sexual violence will likely increase (WHO, 2007). Reporting sexual violence in emergency zones may pose increased physical, psychological and social risks to victim-survivor's well-being and with this in mind WHO (2007) has produced ethical and safety recommendations for monitoring and recording sexual violence in emergencies which should be taken into account by service providers. Information gathering should be legitimate, such as for human rights documentation, for needs assessments, or for informing the provision of sexual violence and rape services. If it is safe and ethical to do so, anonymous aggregated data of incidents of rape and sexual violence should be collated to inform prevention and response services (WHO, 2007; The Sphere Project, 2011). Agencies/organisations can obtain support for best practice gender-based violence data management in humanitarian settings from the inter-agency 'Gender-Based Violence Information Management System' (GBVIMS Global Team, 2013).

### 4.9.2 Services for victims of rape in non-disaster zones

#### *Dilemma of specialised services*

Whilst many national action plans recognise the links between multiple forms of violence against women, specialised services for particular types of violence may obscure the links between them (UN Women, 2012). Models of specific services for sexual violence have an advantage of providing expert and focused sexual violence services (UN Women, 2012), yet

may **marginalise potential victims-survivors of sexual violence within intimate partner relations** from accessing sexual violence services. There is added complexity for victim-survivors naming sexual violence and rape in intimate partner relations (Kelly, 1988). A forensic nurse based in university health centres and **social media** marketing should be considered to **increase young women's access** to sexual violence and rape services (Lovett, Regan and Kelly, 2004) and to target under-served communities (Kelly and Dubois, 2008). Patterson (2009) indicated that victims-survivors of rape in intimate partner relations may fall between sexual assault services where sexual violence is prioritised and domestic violence services where non-sexual intimate partner violence is prioritised and advocate cross training of service providers. Some SARC's for example in **Malaysia, Canada and Central America** and SANE projects in **North America** are increasing the scope of rape and sexual violence services to incorporate domestic violence services (Lovett, Regan and Kelly 2004) and in the **UK** some advocates are dual Independent Domestic *and* Sexual Violence Advocates (Cox et al, forthcoming).

In their review of sexual assault services, Lovett, Regan and Kelly (2004) found that **black and minority ethnic women** attending sexual violence services were underrepresented and that adolescents and women with non-recent experiences of rape may fall between services. Whilst clearly breaking new ground in advancing health led sexual violence services, it is likely that some populations (young women, women of colour and minority groups, women with historic experiences of rape, and women experiencing rape in intimate relations) are underrepresented in current SARC/SART configurations.

#### 4.9.3 Best Practice Standards Quality and Monitoring

##### *In Humanitarian emergencies*

- Sexual violence and rape services should provide clear intervention, treatment and referral protocols available to service providers.
- Service providers should receive on-going training and supervision to support the expansion and improvement of the service including protocols for the establishment of forensic examination and evidence collection.
- Service managers should engage in a process of continuous, collaborative multi-sectoral service improvement.
- Health services for victim-survivors of rape should undertake regular audits to monitor the attainment of standards and agree a multi-sectoral developmental action plan.
- Health services should collate anonymous aggregated data of reported incidents of sexual violence and rape to inform prevention and response service if safe and ethical to do so.

##### *Additional Best Practices standards possible in non-disaster zones*

##### SARCS

- should have clear intervention, treatment and referral protocols developed in collaboration with other sectors.

- in collaboration with other sectors should develop social media to communicate information about the service to underrepresented communities including why, when and how to access.
- should be clear about the scope of their services and have in place clear and formalised referral mechanisms to service providers for other forms of gender-based violence outside their scope of service delivery.
- should collaborate with other sector service providers to extend and improve services for rape and sexual violence victim-survivors.

#### Health-led rape and sexual violence services

- should monitor the demographic of service users and collaborate with BME and minority women's groups to develop culturally competent and accessible services.
- should reflect the interrelation between multiple forms of gender-based violence.
- should monitor the prevalence of intimate partner sexual violence and rape in their caseload.
- should support cross training of sexual violence advocates in domestic violence advocacy.
- should provide services for victim-survivors of intimate partner sexual violence and communicate this service to communities and to service providers of other forms of gender-based violence.
- Victim-survivors of intimate partner sexual violence and rape attending health-led rape and sexual violence services should have access to dual trained (sexual and domestic violence) advocates.
- Service users should be integrated in audit and evaluation strategies.

## 4.10 Conclusions

The health consequences of sexual violence and rape are known to include: sexual and reproductive health problems including unwanted pregnancy, HIV and sexually transmitted diseases; mental health problems and health risk coping strategies; physical injuries; and social ostracization.

Health-led services for victim-survivors of rape and sexual violence in humanitarian emergencies are well served by international policy documents. Research that establishes the effectiveness of integrated rape services in disaster contexts is limited, yet there are many effective health-led rape service initiatives.

The overarching definition of best practice for services for victim-survivors of rape is a health led, multi-sectoral '**one-stop shop**' unit, housed in a hospital or primary health care facility with a separate entrance and providing health interventions, forensic evidence collection, advocacy and counselling. Practice standards for this health-led intervention are differentiated into six domains: Capable and Care Conducive Environment; Health and Medical Care; Forensic Examination and Evidence Collection; Community and Social Support; Specialist Referral and Follow-up Care; and Quality and Monitoring. These standards are relevant to both non-conflict zones and conflict zones.

The distinctions between best practices for victim-survivors of rape in disaster and non-disaster settings are not great; there are few non-essential best practices for rape. This chapter presents best practice standards for health-led rape and sexual violence services in disaster and non-disaster zones. These standards have been collated and are presented in **Table 3**.

The best practice standards identified for **disaster zones** formulate core minimum standards for non-disaster zones. Services for victim/survivors of rape and sexual violence are likely disrupted in disaster zones whilst sexual violence increases. However, all health-led rape services irrespective of location should work to implement the best practice standards for health-led rape and sexual violence services in disaster zones as a minimum.

**Non-disaster zone** health-led rape and sexual violence services should facilitate critical service evaluation and develop multi-sectoral action plans to work towards and develop, refine, monitor and evaluate the best practice standards for non-disaster zones. As a priority non-disaster zones must integrate health-led sexual violence services into routine emergency preparedness plans.

**Psychological First Aid (PFA)** (IASC, 2007) for mental health and psychosocial support in emergency settings is a succinct yet comprehensive framework to guide all providers of services for people in acute distress after a traumatic event such as rape and sexual violence. As a non-medical mental health intervention, PFA is a useful concept to guide practice in both disaster and non-disaster zones. PFA training would be advantageous for all service providers in disaster and non-disaster zones who encounter both current and historic victim/survivors of rape and sexual violence in their caseload and it is recommended that PFA or its equivalent should be incorporated into service provider training in all zones. There is a lack of identifiable comprehensive and formalized systems of territory-wide mental health service provision specifically focused for victim/survivors of rape and sexual violence experiencing severe and/or enduring mental health problems.

The development of **nurses' roles** to deliver health and medical interventions including forensic examination have been successful in terms of improving access, capacity and service outcomes and in other areas nurse-led cognitive behaviour therapy services have had similar results. In developing services the potential of nurses to deliver further health interventions and mental health support services should be explored.

The study recommends Member States develop health-based nation-wide interventions in relation to rape. The European institutions should examine who this effort could be supported, for example with the exchange of best practices.

### **Best practice examples**

Best practice examples in the health field are provided at 11.4 and 11.5: 'Health-based services in a conflict zone: the International Rescue Committee' and 'Health-based centre in a non-conflict zone: Sexual Assault Referral Centre (SARC), St Mary's, UK'.



**Table 1: Aggregate of Standards for Primary Health Services for Victims/survivors of Rape and Sexual Violence in Disaster Zones**

Minimum Standards	WHO (2004)	WHO (2005)	WHO (2007)	IASC (2005)	Sphere (2011)	IAWG (2010)
Women have access to health services, assistance and resources.	✓	✓	✓	✓	✓	✓
Services provide treatment of physical injuries.	✓	✓	✓	✓	✓	✓
Victim/survivor injuries are documented.	✓					✓
Services provide wound care & Tetanus prevention.					✓	✓
Health care includes prevention of unwanted pregnancy.	✓	✓	✓	✓	✓	✓
Health care includes access to unbiased pregnancy counselling.	✓				✓	✓
Health care includes safe abortion care (where abortion is legal).					✓	✓
Health care includes prevention of disease: Treatment for sexually transmitted diseases	✓	✓	✓	✓	✓	✓
Health care includes prevention of disease: HIV prophylaxis.	✓	✓	✓	✓	✓	✓
Victim/survivors have access to mental health & psychosocial support.	✓				✓	✓
All health care is provided in a private consultation area.						✓
Services provide compassionate and confidential treatment that can be started without examination if victim/survivor chooses.						✓
Services have clear protocols.						✓
Services have sufficient supplies and equipment.						✓
The service is delivered by male and female service providers fluent in local languages or if not available trained male and female chaperones and translators.						✓
24 hour, 7 day a week hospital referral mechanisms are in place.						✓
Once service are established, information about sexual violence services detailing why, where, and when to access rape services are distributed to the community.						✓
Communication is supportive (accurate, non-judgmental, active listening) and provided at survivors pace.						✓
The medical history and examination is undertaken with victim/survivor understanding and consent.						✓



Pre-printed forms are used to guide service provision and thorough documentation.						✓
Service providers are skilled and have access to refresher training.						✓
Forensic evidence is collected in accordance with local legal requirements and processing capacity.						✓
The service provides replacement clothing where necessary and at victim/survivors request.	✓			✓		
Victim/survivors can access legal support if requested.					✓	
The service provides protection and social services if the victim/survivor has no safe place to go.						✓
The service provides community-based psychological support and social support for victim survivors.				✓		
If safe and ethical to do so aggregate incidents of rape and sexual violence should be collected to inform prevention and response services.			✓		✓	
<b>Desired Standards</b>	<b>WHO (2004)</b>	<b>WHO (2005)</b>	<b>WHO (2007)</b>	<b>IASC (2005)</b>	<b>Sphere (2011)</b>	<b>IAWG (2010)</b>
Health workers are trained to identify victims of violence.	✓	✓				
Care ensures victim/survivors' safety, privacy, confidentiality, and dignity.	✓	✓				
Victim/survivors are referred for counselling and follow up services.	✓	✓				
Women are part of response services.	✓	✓				
Services provide confidential referral to follow up services.			✓			

**Table 2: Minimum Standards for Sexual Assault Referral Centres<sup>1</sup>**

Minimum Standards	WHO <sup>2</sup> (2003)	Kelly et al (2008)	DH (2009)
There should one SARC per 400,000 women.		✓	
SARCs should be accessible 24 hours a day, 7days a week.	✓	✓	✓
SARCs should operate from a rights-based and gendered perspective.	✓	✓	✓
SARC services should be safe, secure, clean, available, accessible, capable, and delivered with respect to privacy, confidentiality and dignity.	✓	✓	✓
SARCs should in collaboration with other sectors and service users.	✓	✓	✓
SARC standards and pathways are developed, agreed, monitored, audited and reviewed regularly through a coordinated interagency, multi-sectoral framework to ensure standards are met.	✓	✓	✓
All victim/survivors shall receive the same standard of care irrespective of the circumstances of the assault, their social or legal status.	✓	✓	✓
Only service providers who are necessary and people requested by the victim/survivor to support them should be present during any stage of service delivery.	✓	✓	
SARCs should provide an immediate and appropriately trained and skilled crisis support and advocacy service.	✓	✓	✓
SARC advocacy services should provide follow-up support including support throughout the criminal justice process (if the victim/survivor chooses that route).		✓	✓
SARCs should provide comprehensive health and medical care that includes emotional support, mental health care, physical health care that includes sexual and reproductive health care (emergency contraception, abortion support where legal and appropriate, and post-exposure prophylaxis for sexually transmitted diseases), and security and social care.	✓	✓	✓
SARCs should provide <i>immediate</i> access to the full range of health and medical care as listed in the above standard.	✓		✓
The medical examination should include a risk of harm/self harm assessment and an assessment of vulnerability.	✓	✓	✓
SARCs should provide forensic examination and evidence collection.	✓	✓	✓
Forensic examination and evidence collection should proceed with a process of continuous informed consent.	✓	✓	✓
Forensic practitioners should be appropriately qualified, trained and supported and experienced in sexual offences examinations.	✓	✓	✓
Forensic examiners should be supported to develop and advance skills and competencies.	✓	✓	✓
Forensic examiners should be female unless the victim/survivor chooses otherwise.		✓	
Choice of gender of physician, wherever possible.	✓		✓
Forensic examinations should take place in forensically approved locations with approved decontamination and chain of evidence protocols in place.	✓		✓
SARCs should only release evidence and medical reports with the victim/survivors consent.	✓	✓	✓
SARCs should provide medical certificates free of charge.		✓	
SARCs should provide follow-up service and arrangements for specialist services.	✓	✓	✓
SARCs should collect data in accordance with a prescribed dataset and data collection and protection procedures.	✓	✓	✓

<sup>1</sup> This table is developed from standards that are made explicit in these documents and does not exclude that local policies and standards may subsume an eclectic amalgamation of standards from these and other sources.

<sup>2</sup> The WHO (2003) guidelines are not specifically for SARCs however a health-led SARC-like configuration is expressed as the preferred model for rape and sexual violence services delivery.

Desired standards	WHO (2003)	Kelly et al (2008)	DH (2009)
SARCs should consider forensic nurse examiners to increase capacity and improve access.		✓	
Services should be provided in a first or other language the victim/survivor understands.		✓	
Interpreters if used should be female and skilled in dealing with victim/survivors of trauma.		✓	
SARCs should meet the WHO (2003) guidelines for treatment, forensic examination and documentation.		✓	

**Table 3: Best Practice Standards for Health-led Services for Victim/survivors of Rape and Sexual Violence in Disaster and Non-disaster Zones**

Domain	Best Practice Standards for Health-led Services for Victim/Survivors of Rape in Disaster Zones
<b>Capable and Care Conducive Environment</b>	The service is delivered with respect to the core principles of The Sphere Project (2011) Humanitarian Charter.
	The service is established and developed through a multi-sectoral approach that strengthens established services in collaboration with local populations rather than developing new ones where possible.
	The service provides and distributes information (once the service is established) about the service and why, when and where to access it to women and communities.
	The service is accessible and available at a health care facility that is safe for women to access, travel to and free from user fees.
	The service offers a private consultation area, is confidential and ensures victim/survivors safety and dignity.
	The service is delivered by workers skilled and trained in cultural competence and culturally appropriate care for victim/survivors of sexual violence and rape.
	The service has male and female service providers (or chaperones if not possible) fluent in local languages.
	The service has sufficient supplies and equipment.
	Service providers are able to give psychological first aid (PFA) to victim/survivors of rape and sexual violence as part of their usual care.
	Service providers communicate supportively at the victim/survivor's pace, listen actively, and provide accurate information and compassionate, non-judgmental care
	Treatment and interventions can be started without a medical examination if the victim/survivor chooses.
	The service has lockable files for records.
<b>Health and Medical Care</b>	The service provides treatment and documentation of physical injuries, wound care and tetanus prevention.
	24 hour / 7 day a week referral mechanisms are in place for care which is beyond the scope of the primary facility.
	The service provides sexual and reproductive health care that includes: unbiased counselling, emergency contraception and prevention of unwanted pregnancy, safe abortion care (where abortion is legal) and post-exposure prophylaxis and treatment for sexually transmitted diseases including Hepatitis B and HIV.
	The medical history and examination are conducted with victim/survivor understanding and consent and pre-printed forms are used to guide the process and thorough documentation.
	Service providers are able to give psychological first aid (PFA) to survivors of rape and sexual violence as part of their usual care.
	Mental health care is integrated into the sexual violence and rape health service.
	Victim/survivors should have access to immediate and follow-up emotional and psychological support and counselling.
	The service should have 24 hour, 7 day a week referral systems to specialist mental health services beyond the scope of primary health care provision of psychological first aid and basic mental health care.
	Training for more complex mental health care management should be provided for

	primary sexual violence health care providers if fourth tier, specialized mental health services do not exist.
<b>Forensic Examination/ Evidence Collection</b>	<p>In disaster zones where forensic examination services pre-existed emergency shelters must be prepared to be able to provide sexual violence health care services including forensic examination in accordance with local standards and local emergency protocols and be staffed with a trained sexual assault crisis worker and sexual assault forensic examiner.</p> <p>Forensic examination should only be undertaken with the full understanding and consent of the victim/survivor in a private and safe space by a trained sexual assault nurse examiner (SANE) or sexual assault medical examiner (SAME).</p> <p>Materials and samples should only be taken if they can be used, stored and processed in accordance with local protocols and legal requirements.</p> <p>The forensic examination and accurate documentation of injuries should be recorded on pre-printed forms with pictograms.</p> <p>The service provides replacement clothing where necessary and at victim/survivors request.</p>
<b>Community and Social Support</b>	<p>Health services for victim/survivors of rape and sexual violence should collaborate with existing women's networks and groups to establish existing, functioning services, referral mechanisms, safety of access and offer to host if required.</p> <p>Health services should collaborate with existing local service to host and/or facilitate community-based general, culturally appropriate support activities for women that are staffed by trained sexual violence counsellors and social workers.</p>
<b>Specialist Referral and Follow-up Care</b>	<p>Formalized 24 hour, 7 day a week confidential referral protocols for secondary and tertiary health care services referrals for care which is beyond the scope of the facility should be in place.</p> <p>Health services should arrange for protection, shelter and/or social service support if the victim/survivor has no safe place to go.</p> <p>Legal support should be accessible to victim/survivors attending the sexual violence health service.</p> <p>Information for ongoing care and arrangements for follow-up appointments should be clearly communicated during the health consultation.</p>
<b>Quality and Monitoring</b>	<p>Sexual violence and rape services should provide clear intervention, treatment and referral protocols available to service providers.</p> <p>Service providers should receive ongoing training and supervision to support the expansion and improvement of the service including protocols for the establishment of forensic examination and evidence collection.</p> <p>Service managers should engage in a process of continuous, collaborative multi-sectoral service improvement.</p> <p>Health services for victim/survivors of rape should undertake regular audits to monitor the attainment of standards and agree a multi-sectoral developmental action plan.</p> <p>Health services should collate anonymous aggregated data of reported incidents of sexual violence and rape to inform prevention and response service if safe and ethical to do so.</p>
<b>Domain</b>	<b>Additional Best Practice Standards for Health-led Services for Victim/Survivors of Rape in non-Disaster Zones</b>
<b>Capable and Care Conducive Environment</b>	<p>All health services (i.e., services that are not specifically for rape and sexual violence health should have a service relevant policy and protocol to respond to disclosures of rape and sexual violence and refer victim/survivors to rape and sexual violence services as required.</p> <p>Services for rape and sexual violence should be health led, multi-sectoral 'one-stop shop' units, housed in hospitals but with a separate entrance and providing health interventions, forensic evidence collection, and advocacy and counselling.</p> <p>Referral pathways should avoid A&amp;E departments unless fast-track mechanisms for victim/survivors of rape and sexual violence are in place.</p> <p>A skilled crisis support worker should greet the victim/survivor on arrival and stay with her at least until the forensic examiner arrives.</p> <p>Medical/forensic examiners should be female unless the victim/survivor specifies otherwise.</p>
<b>Health and Medical Care</b>	<p>During the initial consultation victim/survivors of rape should be assessed for suicidality and responses developed as appropriate.</p> <p>An assessment for PTSD should be included in the initial assessment for victim/survivors with a delayed first access.</p>



	<p>Victims/survivors should be supported to understand their experiences as normal. Watchful waiting' is advised for the first three months after an assault, unless the person is incapacitated by symptoms.</p> <p>Victim-survivors who experience incapacitating, enduring and/or severe mental health consequences should be referred to specialist mental health services for additional models of psychotherapy such as cognitive behaviour therapies.</p> <p>Mental health services should have systems in place so that services are provided by female practitioners if the victim/survivor chooses.</p> <p>Service providers should give information so that victim/survivors can take control and make informed decisions.</p> <p>Service providers should address victim/survivor expressions of self-blame or guilt.</p> <p>Mental health services and practitioners should be sensitive to gender and gender-based violence and offer holistic, comprehensive advocacy services.</p> <p>Mental health services and practitioners should be sensitive to gender and offer women only specialist group therapies.</p> <p>Mental health services providing psychological therapies should have practitioners sub-specialising in rape and sexual violence.</p> <p>Mental health services should have formalized referral pathways to and from rape and sexual violence services.</p> <p>Mental health services should have formalized referral pathways to specialist violence and abuse trauma therapeutic services.</p> <p>Mental health services should have a strategic vision (in addition to policies) for addressing and responding to victim/survivors of rape and sexual violence.</p> <p>Mental health services should evaluate thresholds for access and referral pathways to services so that early intervention in terms of low and/or high intensity interventions and onward referral as appropriate becomes formalized and standard for victim/survivors of rape and sexual violence.</p>
<b>Forensic Examination/ Evidence Collection</b>	<p>Sexual forensic examiners should meet national training and practice standards where they exist.</p> <p>Sexual forensic examiners should be supported to undertake continuing professional development to maintain and develop practice skills.</p> <p>SARC budgets should take account of replacement and new technology procurements.</p> <p>SARC service users should have the option to have a forensic examination with collection and storage of samples without reporting to the police.</p> <p>SARC service users should have the option to have a forensic examination with collection and storage of samples without reporting to the police and have anonymised sample passed on to the police for intelligence purposes.</p>
<b>Community and Social Support</b>	<p>SARCs in collaboration with other sector service providers should develop support groups for underserved populations and women in residential institutions such as prisons, detention centres and mental health hospitals.</p>
<b>Specialist Referral and Follow-up Care</b>	<p>SARCs in collaboration with other sector service providers should develop and formalize clear protocols for out of hours support.</p> <p>SARCs in collaboration with other sector service providers should develop and formalize clear protocols for follow-up counselling services.</p> <p>SARCs in collaboration with other services should develop referral mechanisms to women centred and gender-based violence sensitive self-defence classes.</p>
<b>Quality and Monitoring</b>	<p>SARCS should have clear intervention, treatment and referral protocols developed in collaboration with other sectors.</p> <p>Health-led rape and sexual violence services should monitor the demographic of service users and collaborate with BME and minority women's groups to develop culturally competent and accessible services.</p> <p>SARCs in collaboration with other sectors should develop social media to communicate information about the service to underrepresented communities including why, when and how to access.</p> <p>SARCs should be clear about scope of their services and have in place clear and formalised referral mechanisms to service providers for other forms of gender-based violence out with their scope of service delivery.</p> <p>Health-led rape and sexual violence services should reflect the interrelation between multiple forms of gender-based violence.</p> <p>SARCs should collaborate with other sector service providers to extend and improve services for rape and sexual violence victim/survivors.</p>

	Health-led rape and sexual violence services should monitor the prevalence of intimate partner sexual violence and rape in their caseload.
	Health-led rape and sexual violence services should provide services for victim/survivors of intimate partner sexual violence and communicate this service to communities and to service providers for other forms of gender-based violence.
	Victim/survivors of intimate partner sexual violence and rape attending health-led rape and sexual violence services should have access to dual trained (sexual and domestic violence) advocates.
	Health-led rape and sexual violence services should support cross training of sexual violence advocates in domestic violence advocacy.
	Service users should be integrated in audit and evaluation strategies.

## 5 Law

### KEY FINDINGS

- In some jurisdictions, rape is illegal in its own right, while in others rape is made illegal as a result of its conceptualisation as a violation of human rights, a form of gender discrimination, a form of torture, and as a war crime.
- Recent developments in the definition of rape include: lack of consent rather than use of force, an extension in the range of body parts, and removal of the marital exception.
- There are discussions on whether and the extent to which the EU has the legal competence to legislate and develop policy on rape. The conclusion drawn here is that there is competence, while acknowledging that this is not a settled issue.

### 5.1 Introduction

There have been important developments and promising practices in law and in the criminal justice system but challenges still remain. Law and the criminal justice system are intended to be processes that hold the perpetrators to account, **reducing impunity** and thereby helping to prevent crimes including rape. The way that victim-survivors are assisted and treated in law and the criminal justice system is relevant not only for the assistance they need but also because of its **impact on the effectiveness** of the system and the attrition of cases through the processes. Three issues are addressed in this chapter: the **legal definition of rape** and its underpinning legal principles; the **practices** of criminal justice systems; and the **treatment of convicted rapists**.

The underpinning legal principles have been developing, drawing on concepts of human rights and gender equality, but these are not uniformly applied in all countries. The definition of rape has also been developing, removing marital exceptions and moving towards a consent-based definition, but again these are not uniformly applied in all countries. While there are best practices within the criminal justice system that treat victim-survivors with respect and prevent secondary victimisation, there is still evidence of **considerable 'attrition'** in the criminal justice system, which means that many reports of rape to the police do not lead to a conviction of the perpetrator. The legal and criminal justice practices in **conflict zones** are further addressed in the next chapter since specialised instruments have developed to address rape in this context. The chapter concludes with a summary of best practice developments and recommendations for the EU.

### 5.2 Legal principles

#### 5.2.1 Introduction

In many national and some international legal regimes **rape is a crime**, without reference or justification to any other legal principle or standard.

In some **legal regimes**, rape is declared illegal as a result of its relation to other major legal principles. Rape has been conceptualised as:



- a form of violence against women that is a violation of human rights;
- a form of torture that violates human rights;
- a war crime and also a crime against humanity; and
- a form of violence against women that is a form of gender discrimination contrary to the equality between women and men.

Rape has also been conceptualised as: a violation of bodily integrity and sexual autonomy. Further legal principles that are used to underpin the illegality of rape but which are widely regarded as **inappropriate** and **in contradiction to best practice** in international principles include: a violation of a woman's honour; and a violation of the property of husbands, fathers.

There are several issues pertaining to the interpretation of the legal concepts and to the **definitions** of rape used in legal instruments, including: the concept of consent, the relevant range of body parts, and the (ir)relevance of the status of marriage.

There have been numerous **legal reforms** in recent years, including: criminalising rape in marriage; making rape a state offence; and creating specific offences for rape against children, which can be defined as '**strict liability**' i.e. if it can be proved to have happened then no defence can be entered (Kelly, 2005). A report published in the wake of the rape and murder of a young woman in Delhi, India, in 2012, by the Justice JS Verma Committee (DNAIndia, 2013), identifies strengthening the law as one part of the response in rape prevention and assisting women victims-survivors of rape.

There are on-going discussions as to the extent to which the EU has the legal competence to develop legislation, in addition to other forms of policy, at EU-level on rape.

### 5.2.2 Violence against women as a violation of women's human rights

The **United Nations** Universal Declaration of Human Rights underpins the legal principle that rape is a violation of human rights. It states that 'All human beings are born free and equal in dignity and rights', it continues in article 2 that everyone 'is entitled to the rights and freedoms set forth in [the UDHR], without distinction of any kind', including sex.

In 1993 the UN General Assembly passed Resolution 48/104 declaring that violence against women, including rape, was a violation of human rights and a manifestation of gender inequality:

Affirming that violence against women constitutes a violation of the rights and fundamental freedoms of women and impairs or nullifies their enjoyment of those rights and freedoms, and concerned about the long-standing failure to protect and promote those rights and freedoms in the case of violence against women,

Recognizing that violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men,

The resolution went on to define violence against women in Articles 1 and 2:

Article 1 For the purposes of this Declaration, the term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Article 2 Violence against women shall be understood to encompass, but not be limited to, the following:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

It further developed the concept of the responsibility of the state to exercise '**due diligence**' to ensure that women's human rights were protected. This provides the basis under which international courts hold states to account, not only the individual rapist.

The application of human rights law to women victims seeking asylum has been significant, if complex (Crawley, 2001).

In the **Inter-American system**, the 1994 Convention on the Prevention, Punishment and Eradication of Violence against Women, also known as the Convention of Belem do Para, is aimed at the 'prevention, punishment and eradication of violence against women' under the principles of human rights law (Organization of American States, 1994). This treaty defines violence against women as being 'any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere.'

The 2011 Istanbul Convention is the **Council of Europe** Convention on Preventing and Combating Violence against Women and Domestic Violence. It is in terms of scope the most advanced treaty in the world creating a comprehensive legal framework to prevent violence, to protect victims and to end the impunity of perpetrators. It defines and criminalises various forms of violence against women (including forced marriage, female genital mutilation, stalking, physical and psychological violence and sexual violence). It also foresees the establishment of an international group of **independent experts to monitor** its implementation at national level.

The requirement under international and European human rights law that states must perform due diligence in protecting women from rape is articulated in a judgement of the European Court of Human Rights, including in the cases of: *Aydin v Turkey* (Application no. 23178/94) E Ct HR Judgment, 25 September 1997; *Maslova & Nalbandov v Russia* (application no. 839/02) E Ct HR Judgment; *Salmanoglu & Polattas v Turkey* (application no.15828/03) E Ct HR Judgment.

### 5.2.3 Rape as a form of torture that violates human rights

In some legal regimes, rape is deemed illegal because it is torture, which is named as illegal in treaties. This has become the practice of the European Court of Human Rights (2010) in implementing the European Convention on Human Rights. While there are no specifically enumerated human rights violations relating to rape in the European Convention on Human Rights, the court has developed jurisprudence under the articles relating to torture, inhuman and degrading treatment. Article 3 of the European Convention on Human Rights states:

Prohibition of torture: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

The European Court of Human Rights has used Article 3 (prohibition of torture) in supporting complaints of victims of rape against the inaction of their own State in the cases of *Aydin v. Turkey* (no.23178/94) in 1997 and that of *Maslova and Nalbandov v. Russia* (no.839/02) in 2008; and Article 3 (prohibition of degrading treatment) in the case of *M.C. v Bulgaria* (no.39272/98) in 2003 and that of *I.G. v Republic of Moldova* (no. 53519/07) in 2012 (European Court of Human Rights, 2013).

### 5.2.4 Rape as a war crime

The prohibition of rape under international humanitarian law (IHL) was already recognized in the Lieber Code of April 24, 1863, also known as Instructions for the Government of Armies of the **United States** in the Field (art. 44). While Article 3 of the **Geneva Convention** does not explicitly mention rape or other forms of sexual violence, it prohibits 'violence to life and person' including cruel treatment and torture and 'outrages upon personal dignity'. The Third Geneva Convention provides further that prisoners of war are in all circumstances entitled to 'respect for their persons and their honour' (art.14, first paragraph.). The prohibition of 'outrages upon personal dignity' is recognised in Additional Protocols I and II as a fundamental guarantee for civilians and persons *hors de combat* (Additional Protocol I, Art. 75(2). Article 75 of Additional Protocol I specifies that this prohibition covers in particular 'humiliating and degrading treatment, enforced prostitution and any form of indecent assault', while Article 4 of Additional Protocol II specifically adds 'rape' to this list (Additional Protocol I, art. 75(2)). The Fourth Geneva Convention and Additional Protocol I require protection for women and children against rape, enforced prostitution or any other form of indecent assault (art. 27, second paragraph). Rape, enforced prostitution and any form of indecent assault are **war crimes** under the Statutes of the **International Criminal Tribunal for Rwanda** and of the **Special Court for Sierra Leone** (ICTR Statute, Article 4(e)). The expressions 'outrages upon personal dignity' and 'any form of indecent assault' refer to any form of sexual violence.

The **Rome Statute of the International Criminal Court** (2011a) recognises rape as a crime under international criminal law. Article 7(1) g classifies as crimes against humanity:

rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity [committed] as part of a widespread or systematic attack directed against any civilian population.

And in Article 8(2)(b)(xxii) classifies these same acts as war crimes.

The **UN Security Council** assisted in establishing rape as a violation of international human rights law in conflict zones. In addition to the Statutes of the International Criminal Tribunal for the Former Yugoslavia (ICTY/R, created by UN Security Council resolutions) it has issued several resolutions condemning acts of rape and sexual violence. In Resolution 1743 on **Haiti** the Security Council condemned 'the grave violations against children affected by armed violence, as well as the widespread rape and other sexual abuse of girls.' Resolution 1034, concerning **Bosnia**, expressed the Council's concern over evidence which demonstrated 'a consistent pattern of rape'. Similar condemnations can be seen in Resolution 1493 which referred to 'acts of violence systematically perpetrated against civilians' in the **Democratic Republic of Congo** including 'sexual violence against women and girls'; and in Resolution 1539 on children and armed conflict the Council condemned 'sexual violence mostly committed against girls'.

Sexual violence against women has been recognised as a human rights violation under customary law, treaty law and also in the jurisprudence of international human rights courts. The international criminal tribunals created by the United Nations to deal with war crimes that took place during conflicts since the 1990's have been important new actors in the development of law. Thus, it has become an increasingly prominent topic in international law since the creation of the ICTY in 1993. The creation of the UN international criminal tribunals, in particular the International Criminal Tribunal for Rwanda (ICTR) established in 1994, has reflected and sustained a greater concern with prosecuting individuals for violence against women.

Furthermore, sexual offences committed by armed forces and uniformed men in conflict areas should be brought under ordinary criminal law (UN Office of the **High Commissioner for Human Rights**, 2013).

#### 5.2.5 Violence against women as a form of gender discrimination

The UN Convention for the Elimination of Discrimination Against Women (CEDAW) addresses violence against women, including rape, as a form of discrimination against women following recommendation 19 in 1992 (CEDAW, 1979, 1992). At Article 1 the Convention states:

For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

UN (1992) (CEDAW) General Recommendation 19 states:

Gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men. . .

The Convention in article 1 defines discrimination against women. The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence.

Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of article 1 of the Convention.

The application of the concept of gender discrimination to violence against women is perhaps under-utilised, but there are examples, such as in the work of MacKinnon (1979) on sexual harassment in employment and that of Edwards (2008) on jurisprudence in UN human rights treaty bodies.

### 5.2.6 Violence against women as gender discrimination and a violation of human rights

The Council of Europe (2011) Istanbul Convention on Preventing and Combating Violence against Women and Domestic Violence treats violence against women as both a form of discrimination against women and a violation of human rights. Article 3a states:

“violence against women” is understood as a violation of human rights and a form of discrimination against women and shall mean acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.

The Convention creates a comprehensive legal framework that places a duty on states to prevent violence, to protect victims and to end the impunity of perpetrators.

It offers a **detailed listing** of the policies considered necessary to achieve this goal: comprehensive and co-ordinated policies, including financial resources to implement the policies, **support for the work of civil society organisations** in the field, establishment of national coordinating bodies, and the collection of data and research; measures to **ensure prevention**, including awareness-raising, education, training of professionals, preventive intervention and treatment programmes, participation of the private sector and the media; the **protection and support of victims**, including actions in the legal system, provision of information, general support services, assistance in complaints, specialist support services, shelters, telephone lines, support for victims of sexual violence, protection and support for child witnesses, encourage reporting including by professionals; the provision of remedies in **civil law**, compensation, safety in matters of custody of children, address the civil consequences of forced marriages; ensure the **criminalisation** of psychological violence, stalking, physical violence, sexual violence including rape (defined as lack of consent), forced marriage, female genital mutilation, forced abortion and forced sterilisation, sexual harassment, with effective, proportionate and dissuasive **sanctions**; take measures that ensure the **implementation of these laws** through investigation, prosecution, procedural law and protective measures, including, immediate response by law enforcement agencies, risk assessment and management, ensure the availability of emergency barring orders, restraining or protection orders, **protect victims during judicial processes**, provide legal aid; ensure that the residence status of victims does not preclude justice, and that gender-based asylum claims can be recognised; **states should cooperate** with each other in these matters; a group of **experts** should monitor the implementation of the Convention.

The Convention was adopted by the Council of Europe Committee of Ministers on 7 April 2011, but only some Member States of the EU had signed and ratified it by September 2013.

## 5.3 Definitions

In addition to the underpinning legal principles, there are detailed issues as to the definition of rape in law. The development of best practice has seen revision to the definition in respect to:

- Lack of consent rather than use of force;
- Extension in the range of body parts; and
- Removal of the marital exception.

### 5.3.1 Consent

The *UN Handbook for Legislation on Violence Against Women* (UNDAW 2010: 26) recommends that legislation should:

Remove any requirement that sexual assault be committed by force or violence, and any requirement of proof of penetration, and minimize secondary victimization of the complainant/survivor in proceedings by enacting a definition of sexual assault that either:

- Requires the existence of “unequivocal and voluntary agreement” and requiring proof by the accused of steps taken to ascertain whether the complainant/survivor was consenting; or
- Requires that the act must take place in ‘coercive circumstances’ and includes a broad range of coercive circumstances.

In **non-conflict zones**, the European Parliament (2011a), in Resolution 2010/2209(INI), and the Council of Europe recommend a consent-based standard in the legal definition of rape and sexual abuse (EIGE, 2012a), as does the European Court of Human Rights (in the case of *M.C. v. Bulgaria* 39272/98) (2013).

Several EU Member States do not reach the internationally recommended standard on rape legislation in relation to consent (European Commission 2010d). Several countries, including **Austria, Germany and Hungary**, were found to require the use of force before sexual coercion is legally defined as rape, in research funded by the European Commission under the Daphne programme (Lovett and Kelly, 2009).

Hence there is a significant gap between the standards of the European Convention of Human Rights and several EU Member states in the legal definition of rape. These States may be regarded as failing in their due diligence to prevent human rights abuses, as was found in the above mentioned case of Bulgaria before the European Court of Human Rights. When the EU accedes to the Convention as a consequence of the commitments made in the Treaty of Lisbon, responsibility for due diligence will continue to fall on the Member States but may also include the EU-level.

In relation to **conflict zones**, there is a debate over the meaning of consent in contexts of generalised coercion. MacKinnon (2006) argues that in times of war and conflict, the generalised context “of coercion provides sufficient grounds for unwanted sex to constitute rape, without the need to additionally demonstrate that the woman did not consent”. This is relevant to the EU in the conduct of its external relations especially in the context of



international criminal tribunals addressing war crimes that may include rape and when there is provision of humanitarian assistance to rape victim-survivors.

#### Box 6: Body parts

Laws on rape vary in their definition of body parts that are relevant. In reviewing the laws of a selection of EU Member States, Lovett and Kelly (2009) found that **Belgium, Germany, Portugal** and **Sweden** employ a wide definition of rape which covers all forms of penetration by body parts and objects, while **Hungary** employs a narrow definition restricted to penile-vaginal penetration. The range of body parts included within the law affects whether rape is exclusively **a crime by men towards women or not**. **Scotland**, in passing the Sexual Offences (Scotland) Act 2010, changed from a narrow definition of rape (Lovett and Kelly, 2009) to a much wider one where rape is defined as 'penetration of the vagina, anus or mouth by the penis without consent' (Rape Crisis Scotland, no date). The **Swedish** legal definition of rape is even wider and includes the penetration of the vagina, anus or mouth by the penis, fingers or any other object without consent, or in a situation where the victim was incapable of giving consent (Swedish Penal Code, 6:1). **South Africa**, in 2007 passed the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 which repealed the previous common law offence of rape and replaced it with an expanded statutory offence of rape which is applicable to all forms of sexual penetration without consent, irrespective of gender (Department of Justice, 2008). **Best practice** is to include penetration of any orifice by the penis as rape and to define penetration by other objects as a further form of serious sexual assault.

### 5.3.2 No marital exception

The international standards allow for no marital exception for rape. The UN *Handbook for Legislation on Violence Against Women* (UNDAW 2010: 26) recommends that legislation should:

Specifically criminalize sexual assault within a relationship (i.e. 'marital rape'), either by:

- Providing that sexual assault provisions apply 'irrespective of the nature of the relationship' between the perpetrator and complainant; or
- Stating that 'no marriage or other relationship shall constitute a defence to a charge of sexual assault under the legislation'.

There has been a reduction in the marital exception to rape being a crime but it remains legal in dozens of countries today. It was criminalized in the **Nordic** European countries in the 1960/70s but in other European countries, like the United Kingdom, or third countries like the **United States, Australia** and **New Zealand** only in the 1990s. A number of South Asian and African countries, including **Cambodia, Thailand, Rwanda** and **Ghana** criminalized marital rape after 2000. International women's and human rights movements (Global Voices, 2012) and international organisations (UN Declaration on the Elimination of Violence Against Women, 1993; Council of Europe, 2009b, 2009c) have called on states to reform the law on rape and marriage, and to recognise marital rape as a human rights violation.

In some countries such as **Afghanistan; Lebanon; Jordan; and Morocco** where rape in marriage has not been criminalized, additional legislation exists which means a rape victim-survivor can face **criminal charges for adultery or prostitution**. Women convicted of



adultery as a consequence of being raped can face severe sanctions including long prison sentences and the death penalty. In some countries, including under Morocco's Article 475 (Maghri, 2012), unmarried rape victims can be pressured to marry the alleged rapist to reduce the sanctions they face if convicted, to prevent their family being shamed and end the prosecution of the perpetrators. However, a campaign in 2013 has led to plans to change this in Morocco (Aljazeera, 2013).

### 5.3.3 Conclusions

The EU Member States do not reach international standards on laws on rape. Some States do not use the threshold of consent but rather encode in law the more restrictive threshold of force. The standard of 'consent' has been articulated in judgements of the European Court of Human Rights, which enforces the European Convention on Human Rights and in the UN Handbook for Legislation on Violence Against Women.

Many countries around the world do not yet reach the standards of legislation on rape articulated in the UN Handbook, although there has been considerable movement towards them in recent years.

## 5.4 The legal competence of the EU on rape law and policy

The extent to which the EU has legal competence to develop legislation and policy on rape and other forms of violence against women is complex and is currently under discussion. The issues include: the identification of relevant legal principles and judgement as to the extent to which there is capacity to act at EU-level rather than Member State level under the principle of conferral and subsidiarity.

### 5.4.1 Four ways in which rape is conceptualised

As shown in the previous section, in international legal regimes, there are **four ways in which rape is conceptualised**: as a violation of women's human rights (UN General Assembly Resolution 48/104 based on the UN Universal Declaration of Human Rights); as a form of torture (practice of the European Court of Human Rights, based on the European Convention on Human Rights); as a war crime (Rome Statute of the International Criminal Court); and as a form of gender discrimination (CEDAW General Recommendation 19).

#### *Human Rights*

The EU also upholds the legal principles of **human rights**, equality between women and men, and non-discrimination against women. They are included at a high level in the Treaty of Lisbon. Articles 2 and 3 of the Treaty on the European Union (TEU) state:

2. The Union is founded on the values of respect for human dignity, freedom, democracy, equality, the rule of law and respect for human rights, including the rights of persons belonging to minorities. These values are common to the Member States in a society in which pluralism, non-discrimination, tolerance, justice, solidarity and equality between women and men prevail.
3. The Union's aim is to promote peace, its values and the well-being of its peoples.  
It shall combat social exclusion and discrimination, and shall promote social justice and protection, equality between women and men, solidarity between generations and protection of the rights of the child.

The EU is currently (September 2103) preparing its accession to the European Convention on Human Rights, which is already individually ratified by all Member States, on the basis of Article 6.2 TEU.

Article 8 of the Treaty on the Functioning of the European Union (TFEU) states:

In all its activities, the Union shall aim to eliminate inequalities, and to promote equality, between men and women.

### ***Anti-discrimination policy***

Furthermore, Article 10 TFEU states the aim to **combat discrimination** on grounds of sex:

In defining and implementing its policies and activities, the Union shall aim to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.

More concretely, Article 19 TFEU allows for a special procedure for the development of directives to combat discrimination based on sex:

1. Without prejudice to other provisions of the Treaties and within the limits of the powers conferred by them upon the Union, the Council, acting unanimously in accordance with a special legislative procedure and after obtaining the consent of the European Parliament, may take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age, or sexual orientation.
2. By way of derogation from paragraph 1, the European Parliament and the Council, acting in accordance with the ordinary legislative procedure, may adopt the basic principles of Union incentive measures, excluding any harmonisation of the laws and regulations of the Member States, to support action taken by the Member States in order to contribute to the achievement of the objectives referred to in paragraph 1.

In various places, EU documents note that various forms of violence against women constitute gender inequality and gender discrimination that the EU should combat.

For example, the conclusions of the Council of the European Union (2010) state:

Declaration 19 on Article 8, whereby, in its general efforts to eliminate inequalities between women and men, the Union will aim in its different policies to combat all kinds of domestic violence, and the Member States should take all necessary measures to prevent and punish these criminal acts and to support and protect victims.

### **5.4.2 Gap between EU commitment and Member States' standards**

There is a **gap** between the commitment of the EU to principles of human rights and the equality between men and women in its Treaties on the one hand and the standard of the legislation and policy on rape in some Member States on the other hand. For example, some Member States have failed to meet the standard on consent articulated by the European Court of Human Rights implementing the European Convention on Human Rights (European Court of Human Rights, 2013).

While the development of legislative and non-legislative policy action in this field on the European level in recent years is recognised, there remains a case for European legislative action to assist the Member States in closing the gaps between the national and international standards.

### 5.4.3 Prevention and sanctioning of rape on EU level

In relation to the prevention of rape and the assistance to victims of rape, European legislation and other policy action as mentioned above might be developed in the areas of freedom, security and justice; economy and social inclusion; public health; external relations; or research and statistics. However, for the prevention and the sanctioning of rape, European legislation in the area of freedom, security and justice, which covers also the promotion of fundamental rights, could be of particular added value. To this end, legislative action to sanction rape could be developed on the basis of Article 82 TFEU which provides legal competence to the EU-level to ensure the **mutual recognition of legal judgements** on criminal matters, which includes the identification and enforcement of minimum standards so as to ensure that legislation can be harmonised sufficiently to meet this requirement of mutual recognition. Furthermore, Article 83 TFEU provides particular powers in the area of **serious crimes** which explicitly covers the 'sexual exploitation of women and children', which it is reasonable to interpret as including rape. While the competence to act in this field is restrained to issues that are 'serious' and 'cross-border', these conditions are met in the case of rape: there is no doubt that rape is a serious crime; and offenders may well be "active" cross borders or cross them in attempts to escape justice while female EU citizens moving across the EU might become victims of rape in another Member State than they live in with quite different judicial and social consequences.

In addition, Article 153 TFEU has proven to be suitable as a legal basis to prevent and to sanction harassment on grounds of gender and sexuality at the workplace, which could in the most serious scenario include rape. Building on these achievements, common approaches to sanctions and the support for victims of rape at the workplace could be subject of European legal action.

While the issue of the legal competence to act at EU rather than Member State level is subject to on-going discussions, a very strong case can be made that the request for legal action on the European level cannot be refused by arguing that there is no legal basis. In the meantime, developing actions in a common effort to prevent rape and to assist victim-survivors of rape should be a priority of all Member States.

## 5.5 Conclusions

### 5.5.1 Legal definition

Rape is everywhere a crime, including in all EU Member States, but the definition and legal principle vary between countries and do not yet everywhere reach the best practice standards developed by international bodies such as the **UN** and **Council of Europe**.

Best practice, as defined by in the UN Handbook on Legislation and the Council of Europe Istanbul Convention: includes a definition of rape as a **violation of bodily integrity** and **sexual autonomy**; specifies that it includes **penetration of all orifices** not only vagina; identifies **lack of consent** as a sufficient threshold not requiring the additional use of

physical force; and **refuses marital exemption**. However, not even all member states of the EU reach this standard, as shown in the cases before the European Court of Human Rights.

### 5.5.2 Legal principles

The underpinning legal principles have been developed by the UN in the Resolution of the General Assembly in 1993 and in the Convention on the Elimination of Discrimination against Women Recommendation 19. Based on these documents, best practice can be identified: rape is both a **violation of human rights** and also a form of **discrimination** against women. Some further international jurisdictions, including the European Convention on Human Rights criminalise rape through its conceptualisation as a form of torture, which is a violation of human rights.

An example of best practice in legal principles for the **criminalisation of rape** and other forms of violence against women can be found in **Mexico**, where this is specified as gender-based and systemic (even though its implementation in practice is not complete). The legal developments in Mexico are described as one of the examples of best practice in Chapter 9 of this study, at 9.7.

### 5.5.3 Recommendation for EU legislation

The study recommends that the European Union improves the laws on rape in the Member States by setting **minimum standards** that meet those of international bodies including the UN, the European Court of Human Rights and the Council of Europe Istanbul Convention, to support the **mutual recognition** by Member State judiciaries of the criminalisation of rape by the Member States. This could be realised through a Directive on all forms of violence against women, or specifically on rape, provided there is the political will of all Member States to tackle this serious form of discrimination of women. There is potential scope for a directive to introduce minimum standards for the definition of rape using Article 82 or 83 of the Treaty of the Functioning of the European Union. There is potential scope for a directive on all forms of violence against women, since these constitute gender discrimination in the same way as harassment, under Articles 19 or 157 TFEU (See Walby 2013).

### 5.5.4 Best practice example

A best practice example in the field of law is at 9.7: 'Integrating a better understanding of rape within law', in Mexico.

## 6 Criminal justice system

### KEY FINDINGS

- Most criminal justice systems perform poorly in holding perpetrators to account for rape, with high rates of attrition of cases through the system, and poor outcomes of programmes for offenders.
- There are many innovative developments to improve the effectiveness of the justice system in relation to rape, including training professionals, special advisers to victim-survivors, special courts, and victim-centred practices.

### 6.1 Conviction and avoiding recidivism

The CJS intervenes to prevent rape by holding perpetrators to account. This process includes detection, arrest, prosecution, conviction and sentencing. An indicator of the effectiveness of the CJS in relation to rape is the conviction rate of perpetrators. There are developments in policies to prevent recidivism among offenders including the use of registers to monitor their whereabouts. There have been innovations in the treatment of offenders ranging from punitive criminal sanctions to rehabilitative health programmes and buddy support. There have been improvements to the way that data is collected so as to monitor which policy developments are most effective.

Increasing conviction rates for perpetrators of rape contributes to rape prevention by reducing the impunity of rapists and by making clear statements to the wider society that rape is a serious crime that is not condoned by the state or society.

### 6.2 Apply a victim-centric principle to avoid secondary victimisation

There are important improvements in the quality of criminal justice systems (CJSs) in relation to rape, including training police and prosecutors, as part of a drive to improve the conviction rate of rape cases. One problem that is important to address is the tendency of the CJS process to create secondary trauma (also described as secondary victimisation) of rape victim-survivors, through ill-informed processes that are insensitive or victim-blaming (Vatten, 2001). Assisting victims of rape by preventing secondary trauma to victim-survivors has the added benefit that victim-centric interventions are **more effective at increasing conviction rates**. Thus CJS interventions that assist women victim-survivors of rape by reducing secondary trauma, enable improved access to justice, contribute to victim-survivor efforts to rebuild dignity and autonomy and help to prevent rape by increasing the likelihood that perpetrators would be held to account. The best practices avoid therefore the re-victimisation of women by these processes. There are attempts to reduce the attrition of cases of rape as they proceed through the criminal justice system (Kelly, Lovett and Regan, 2005), though not all changes are necessarily improvements (Bumiller, 2008).

Therefore, a common feature of the specialist unit interventions listed below is that they operate under a victim-centric principle: i.e. the needs of the victim are at the centre of the process. UN resolution 15/2010 (2010) adopts the guidelines in the updated Model Strategies and Practical Measures on the Elimination of Violence Against Women in the Field

of Crime Prevention and Criminal Justice which recognise, amongst other things, that crime prevention and criminal justice responses to violence against women must be focused on the needs of the victim and empower individual women who are victims of violence. The sense of control, autonomy, safety and support provided by a victim-centric principle governing the operationalisation of specialist unit interventions is significant:

- in retaining victim-survivor engagement in the CJS process (Skinner and Taylor, 2009);
- in enabling the collecting of more robust evidence (Sadan et al, 2001); and
- in making victim-survivors more credible witnesses in court (Sadan et al, 20001)

All of these increase conviction rates whilst reducing secondary trauma for victim-survivors.

#### **Box 7: Particularly vulnerable victim-survivors**

The best interventions further recognise that some victim-survivors are particularly vulnerable by virtue of their ethnicity, language, minority, refugee or indigenous status, their age, their location in remote or under-developed areas, or their disability status and ensure that special attention, intervention or protection required by these victims-survivors is met.

## **6.3 Develop expertise through specialist units, then mainstream**

The improvement of CJS practices is often led by the development of specialist units that develop expertise that can then be mainstreamed into routine practices. Specialist units have been important for the development of expert knowledge, skills, training practices and appropriate forms of interagency cooperation. After the identification and development of best practice in expert specialist units, this expertise can be mainstreamed into routine service provision.

### **6.3.1 Expert knowledge and skills through training**

The spreading of expert knowledge and skills in CJS personnel through training has been demonstrated to impact positively in a number of ways which contribute to increasing conviction rates and reducing secondary trauma for victim-survivors. For example, the International Association of Women Judges (2012) found that after training judges on instruments which protect women's human rights, those instruments were more likely to be cited in the judicial opinions of the trainees than those of judges who had not received the training. By contrast, prosecutors with little awareness of the needs of rape victim-survivors or the context in which these cases work have been found to delay processes and hamper victim-survivors access to justice when not appropriately trained (Robinson, 2003; Cossins, 2007; Thomas et al, 2011).

### **6.3.2 Interagency working practices**

One outcome of the development of specialist expert units has been the improvement of methods of inter-agency working. A common feature of these improved inter-agency practices involves personnel from a range of CJS agencies, and staff from relevant agencies outside the CJS being located together within the specialist unit. Inter-agency working

practices are recognised as good practice in a number of reports, for example, in Resolution 2010/15, the United Nations recognised that effective and integrated CJ responses to violence against women require close cooperation among all key stakeholders, including law enforcement officials, prosecutors, judges, victim advocates, health professionals and forensic scientists (UN Resolution 2010/15, 2010). DFID recognises that impact is more likely when all the various aspects of violence against women are dealt with coherently through targeted support (DFID, 2012), and UN Women (2012) calls for provision in national actions for the development and implementation of shared services or practice standards, guidelines or codes across the sectors that respond to violence against women and the development of information sharing protocols. It should be noted that the leadership of inter-agency working needs to be done from a victim-centric stance with the involvement of gender expertise.

### 6.3.3 The gender of specialist staff

The gender of specialist staff has been debated, with some calling for staff to be female by default (Kelly, 2005), or that examiners should be female 'unless the service user specifies otherwise' (Kelly and Dubois, 2008: 51), whilst others (Jordan, 2002) have found that enabling victim-survivor choice of the gender of key personnel was crucial. The importance of specially trained personnel and the embedding of training on rape and sexual violence is clearly recognised and promoted by a number of national and international bodies in their strategy documents (DFID, 2012; EIGE, 2012a 2012b; UN Women, 2012). Like specialist units (which is where most specialist personnel are currently found), the presence of specialist personnel have been found to positively impact on conviction rates in rape cases and in decreasing secondary trauma.

## 6.4 Advocates for victim-survivors

Providing advocates for victim-survivors, supports them throughout the CJS *process* has been found to be particularly effective at reducing secondary trauma for victim-survivors, especially keeping them well informed about the progress of their case (Jordan, 2002; Skinner and Taylor, 2009). By supporting victim-survivors through the CJS process, this intervention reduces drop-out and thus increases conviction rates (Robinson, 2009; Lovett, Regan and Kelly 2004; Sullivan and Bybee, 1999). A number of CJS employ special advocates including the Sexual Violence Advisor service (ISVAs) in **England and Wales** (Robinson, 2009); **South Africa's** victim advocate officers (Sadan et al, 2001); and **Austria** automatically entitles victim-survivors of sexual violence to free psycho-social and legal support via an advocate (Lovett and Kelly, 2009). Kelly (2005) cites the use of support workers/advocates as a promising practice whose role should include debriefing the victim-survivor and where necessary developing a safety plan with them. These advocates take a variety of forms in different countries, from general support to specialised legal advice.



#### **Box 8: Specialised legal advocates**

The use of specialised legal advocates to support victim-survivors through the legal and courtroom aspects of the CJS has been found to reduce secondary victimisation and improve conviction rates. The trial can be a harrowing experience for victims if their testimony and character are subjected to hostile questioning, and a person who is legally entitled to speak for the victim in this specific legal setting has been found to be of assistance in promoting justice (Londono 2007; Horvath and Brown, 2009). In the courtroom narrow stereotypes of 'real rape' (Temkin and Krahé, 2008) or the practices as to what constitutes a 'good case' (Smith and Skinner, 2012) can get in the way of the delivery of justice. Raitt (2010) argues convincingly that the provision of independent legal representatives for rape victims is the most effective way of supporting rape victims during trials, while Smith and Skinner (2012) note that this is a widespread but not universal practice in the European Union.

### **6.5 The role of civil society organisations**

Best practices for rape prevention and assisting women victims of rape in the CJS often develop where civil society movements, usually feminist-led, have articulated requests for:

- recognition by the state of rape as a serious crime;
- the right of victim-survivors of rape to justice and reparation; and
- the right of women to be protected against rape through its criminalization and prevention.

Such movements have been found worldwide in developed, transitional and developing nations, as well as in some post-conflict locations. The development of best practice depends upon the ability of women to express their views as to their priorities, and to revise policy practices accordingly via democratic political processes.

### **6.6 Limitations and problems**

Despite the very positive impacts delivered by these examples of best practice interventions in the CJS, research has highlighted a number of limitations and problems including:

- inadequate funding;
- inadequate training;
- lack of robust data collection and management systems; and
- lack of formal evaluation.

In addition, whilst specialist units and expert staff have been particularly successful interventions, there is not yet evidence that such expert knowledge, skill and working practices is being consistently mainstreamed throughout the CJS.

### 6.6.1 Funding

Inadequate funding for the on-going running and maintenance costs of interventions threatens their existence over time and the delivery of the service to the quality and principles set. Sadan et al (2001) found inadequate funding to be a major factor in preventing South African Sexual Offences Courts operating as effectively as they could and lack of funding meant resources such as transport and food for victim-survivors were limited and this had knock-on effects on their performance in court. Funding cuts to ISVA services in the UK have been demonstrated by Towers and Walby (2012), and Järvinen et al (2008) highlight the problem of funding for SDVCs.

### 6.6.2 Availability of data

There is a lack of robust data collection and management systems within countries and across-countries: this severely hampers efforts to build **evidence-based interventions**. Baños Smith (2011) argues that the key challenge in preventing violence against women is the limited evidence base of what is effective. This is reflected in the repeated call for better data collection and monitoring systems found in the strategy documents of numerous organisations, for example EIGE (2012a, 2012b) calls for the development of official statistics and data collection activities and methodology and multisectoral, interagency coordination of the development, implementation and evaluation of data collection. Further EIGE (2012a, 2012b) also calls for mechanisms to ensure that up-to-date research in the field of sexual violence is available for study. UN Women (2012) call for national action plans to harmonise police, prosecution, court and service delivery data collection and to establish systems to measure support, safety and satisfaction of victim-survivors. Research which has looked at current data and measurement regimes highlight the need to, at least, disaggregate data by gender and age (Walby et al, 2012; Sadan et al, 2001).

### 6.6.3 Evaluation of interventions

There is also a lack of comprehensive evaluation research on interventions to prevent rape and assist women victim-survivors of rape. A small number of evaluations, such as Sadan et al (2001), followed a methodology which set clear measurement criteria and compared the results for the specialist intervention against a non-specialist intervention within the same context. The evidence obtained from these studies is particularly valuable.

## 6.7 Recommendations

In this study, CJS best practices for rape prevent and for assisting women victim-survivors of rape have been derived from the review of the international literature on research findings, evaluation studies, expert recommendations and policy documents. The best practices in the CJS are those that increase the conviction rate of perpetrators of rape whilst preventing the secondary trauma of victim-survivors.

Best practices:

- need a conducive **context**, i.e. they are framed by the rule of law; a functioning and democratic CJS; clearly expressed political will to prevent rape and assist women

victims of rape; and a civil society able to hold government and statutory agencies to account;

- are **evidence-based**; best practice interventions should be designed and implemented with reference to what has been demonstrated to work and avoid what has been shown to be detrimental to achieving the outcomes and overall aims of/for the intervention;
- are subject to comprehensive **evaluations from the start**; drawing on dedicated data collection systems which enable the aims of evaluation to be comprehensively assessed whilst adhering to high standards of confidentiality and ensuring ethical principles for working with individuals within the CJS are met. 'Gold-standard' evaluation methodologies compare the target intervention with alternative interventions with the same/similar aims;
- use **standardised data collection** and **quality monitoring** tools that should be established across the full range of CJS interventions designed to prevent rape and assist women victim-survivors of rape to enable robust comparison;
- make a contribution back into the continued development of such by making available **lessons learnt** and highlighting **what works best** thus adding to the evidence-base in order that future development can be evidence-based;
- treat the victim-survivor with respect and sensitivity so as to **avoid secondary re-victimisation** and are **victim-centric**, placing the health, safety, dignity, privacy and autonomy needs of the victim-survivor at the centre of the practice;
- provide the victim-survivors with their own **advocate** who supports them throughout the CJS process, including legal advocates who can speak for the rape victim-survivor during the trial;
- provide **specialist units** including courts that accumulate expertise and good practices;
- engage appropriately led **inter-agency working**, which should be embedded within practice and include agencies across and beyond the CJS;
- are **adequately funded**; it is not enough to fund the establishment of interventions, on-going running and maintenance costs must be adequate to ensure that the other best practice criteria can be sustainably delivered and that the intervention can continue to evolve in ways which ensure their contribution to rape prevention and assisting women victim-survivors of rape;
- are **specialist**; this is an intermediate-term recommendation in order that expert skills and knowledge on rape prevention and assisting women victim-survivors of rape in CJS-led interventions can be developed through training for all relevant practitioners;
- are **mainstreamed** throughout the CJS. Specialist and expert facilities, training, knowledge and skills should be mainstreamed so that best practices for rape prevention and assisting women victim-survivors of rape become embedded, not isolated, within the CJS.

It has to be noted that examples of CJS best practices are **usually missing from conflict zone locations** where many of these conditions are absent.

CJS-led best practices for rape prevention and assisting women victim-survivors of rape discussed above should be embedded within wider social, political, economic and cultural practices which are guided by **principles of gender equality** and equal rights for men and women. This is well illustrated by Navanethem Pillay, the UN High Commissioner for Human Rights, response to the Justice JS Verma Committee's report and its recommendations for systemic change in India's response to rape and in developing India's practices for rape prevention and assisting women victims of rape, when she said:

The Committee's recommendations are grounded in a framework of rights, equality and non-discrimination, and represent a paradigm shift towards recognition of women as holders of rights, not just objects of protection. The report should serve as a beacon for many other countries struggling to respect the rights of women more comprehensively by addressing sexual violence through legislation, policies and programmes (OHCHR, 2013).

## 6.8 Implementing best practices – promising practices

Consequently, best practice CJS-led interventions that could be mentioned are context related, i.e. their operationalization in different locations and contexts contain features that make them more successful in increasing the conviction rate of rape and in preventing secondary trauma to victim-survivors.

In this respect, the establishment of specialist units has been demonstrated to be a very successful intervention for increasing conviction rates whilst reducing secondary trauma for victim-survivors. UN Women (2012) states that the creation and strengthening of well-funded specialised units should be provided for in national action plans. Specialist units deal with specific stages in the CJS process:

- The Sapphire project allows for a team of expert police detectives and connected staff in London, **England**, to focus on the *investigation of rape*. Despite problems, an evaluation of the project found a significant increase in the rate of charging suspects compared with non-specialist teams (Metropolitan Police, 2005).
- SARCs (see also above under health) are specialist units in the **UK** run jointly by health and the CJS designed to gather forensic evidence in the immediate aftermath of a rape in a safe and supportive environment whilst simultaneously providing physical and mental health services, assessing victim-survivor safety and providing support for victims-survivors to access justice (Lovett, Regan and Kelly, 2004). Kelly (2005) cites the use of health and forensic practitioners in specialists units which integrate, as far as possible, the medical and forensic procedures following a rape as a promising practice.
- Regarding *prosecution*, for example, in Kabul, **Afghanistan**, a specialist prosecutor unit for dealing with crimes of violence against women prosecuted nearly 300 cases in its first year, with the rate of prosecution doubling between the first month and the last. The success of this specialist unit led to the opening of a second in Herat in 2011 (Thomas et al, 2011).
- *Special units*: From 2008, **Austria** obliged prosecutor offices to set up special units to deal with cases of sexual and domestic violence (Lovett and Kelly, 2009), while the Department for International Development (DFID) in the UK promotes the establishment of specialised units, courts and/or court time where possible (2012);

- Specialist *court interventions* have also been established, for example, Specialist Domestic Violence Courts (SDVCs) in **England and Wales** operate with a dedicated court room, separate entrances and waiting areas for victim-survivors and expert, trained staff (Women's Resource Centre, 2008; Cook et al, 2004).
- *Specialist advocates for victim survivors* have been established in at least 14 EU countries, including **Austria, Belgium, Denmark, France, Germany, Ireland**, with activities ranging from legal representation at trials to more general support (Raitt 2010; Smith and Skinner 2012).
- **South Africa's** Sexual Offence Courts (SOCs) are also specialist courts which deal exclusively with rape and sexual violence prosecutions. They are separate from other court facilities and are designed to both protect the victim-survivor from secondary trauma through the use of expert, trained staff who work with the victim-survivor to prepare them for what they will face in court, and through the design of the facility itself, such as separate waiting areas for victims-survivors and separate 'camera rooms' with a CCTV link so that vulnerable victims-survivors, especially children, do not have to give their evidence in front of the perpetrator (Sadan et al, 2001). SOCs have been found to have conviction rates of between 70% and 95% (Thomas et al, 2011) compared to an average conviction rate of around 10% (South African Law Commission, 2001).

Whilst specialist units concentrate on one part of the CJS process, best practice interventions are found to have **strong inter-agency links across the whole CJS process**, sometimes to other specialist units further up/downstream.

- For example, in 2000, Thuthuzela Care Centres (TCCs) were added to the model of **South African** rape-prevention: these are also specialist facilities staffed by expert and trained personnel who work with the victim-survivor in the immediate aftermath of the rape to collect evidence and begin initial investigations. TCCs are attached to, or located close by SOCs and staff from SOCs and TCCs work in close collaboration across these two stages of the CJS in order to ensure that the evidence and outcomes from the investigation are as robust as possible for court, to make sure that victim-survivors are prepared for the court process, including having been referred to counselling before the court hearing, and so that information sharing about a case can be efficient and effective whilst maintaining confidentiality (Johnson, 2012; UNICEF, 2009). A study of the factors which are significant in getting a rape case to court found that where there was no medical history for the victim-survivor and no forensic evidence the odds of those cases getting to court were 90% lower and 80% lower respectively than those cases with a medical history or forensic evidence (Feist et al, 2007).
- **EIGE** calls for specialist interventions to recognise and apply minimum standards for sexual violence-specific services (2012a, 2012b).

## 6.9 Conclusions and a best practice in increasing conviction rates

There are high rates of **attrition** in cases of rape as they progress through the criminal justice system in many countries. However, there are examples of promising practices to increase the proportion of rapes reported to the police that end with the conviction of the rapist.

One of these best practices is the development of **specialist courts**, which use the expertise existing in the field to implement procedures that are sensitive to the needs of victim-survivors, thereby simultaneously addressing the goals of assisting victims and preventing rape by reducing the impunity experienced by rapists. An example of such best practice, in **South Africa**, is provided in Chapter 9 of this study, at 11.9.

A best practice example of prevention is at 11.8: 'Identifying potential perpetrators in cyber-space'.

## 7 Treatment of convicted rapists

### KEY FINDINGS

- There are serious legal and ethical issues with surgical castration as a treatment.
- Evidential efficacy is weak and therefore best practice is hard to define.
- Sex Offender Registration and Notification (SORN) is not a best practice, but a practice that is common among many jurisdictions. While there is little evidence of prevention of reoffending by sex offenders (and more specifically rapists) and of deterrence of new sexual offending, there is some evidence that the communities in which offenders live feel more secure, although preventative action is not likely to take place.

While prison is the standard sentence by courts for convicted rapists, there are several treatment programmes that are specific to sex offenders. These include surgical and chemical castration; the use of cognitive and other therapeutic psychological interventions; and the registration of sex offenders with police authorities. These are intended to prevent rape by reducing recidivism, that is, the repetition of the offence by the same perpetrator. The outcomes of these programmes are rarely promising.

### 7.1 Surgical castration of sex offenders

One of the most controversial treatments for sexual offending, surgical castration for sexual offenders, is currently practised only in **Germany** and in the **Czech Republic** within the EU, but in the past has been used widely across Europe, particularly in Denmark and Norway. **The South Korea** National Assembly however is considering the introduction of surgical castration to replace chemical castration, which is seen there as ineffective (Ji-hoon, 2012). In the US, both **Texas** and **California** mandate castration for repeat offenders before release for civil commitment. In other states, offenders may opt for surgical castration to reduce their sentence.

The procedure in the **USA** is that the most serious sexual offenders, who are civilly committed to state sex offender institutions after serving their criminal sentence, can opt for surgical removal of the testes (bilateral orchiectomy). The procedure is **voluntary** and options for chemical castration are also available in some jurisdictions. However, the civil commitment means that offenders are **unlikely to be released** without undergoing one such procedure.

#### 7.1.1 Objective

The intervention has the intention of **reducing interest** in sex and **removing motivation** for sexual attack. Proponents identify the treatment as alleviating the suffering tied to an abnormal sex drive. Studies of cancer patients having had such a procedure for medical reasons show a reduction in sex drive and sexual interest.



### 7.1.2 Weak methodological standard

Schmucker and Lösel (2008) identify eight studies on surgical castration that have an average odds ratio of 15.03 on subsequent recidivism – ( $p < 0.01$ ), meaning that those castrated are **15 times less likely** to rape again, providing evidence for reduction in recidivism (re-offending). However, they also identify the eight studies as **flawed** in that there are no suitably equivalent control groups. A recent widely quoted **German** study followed 104 offenders who were surgically castrated and found only **3% offended**, compared to a 46% reoffending rate for sexual offenders who desired the treatment but were not castrated (Wille and Beier, 1989).

Scientific evidence is based on a small **number of studies**, and many studies on which research has been based are historical. While **effect sizes are large**, human rights issues will undoubtedly play a large role in the future adoption of surgical castration as a treatment. The issue of whether offenders really **consent** to such a treatment will become critical to this debate.

### 7.1.3 Legal and ethical issues

There are serious legal and ethical issues with surgical castration as a treatment. The **American** Civil Liberties Union identifies it as cruel and unusual punishment. The **Council of Europe's** Committee for the Prevention of Torture has recently criticized both the **Czech Republic** (European Committee for the Prevention of Torture, 2009) and **Germany** (European Committee for the Prevention of Torture, 2012a), saying that

- offenders may feel **coerced** into agreeing to such treatment,
- it is **irreversible** and affects the offenders ability to procreate, and
- that the presumed reduction in reoffending is **not scientifically proven**.

Both the **Czech and German Governments** have responded saying that appropriate safeguards on consent means that the treatment is not degrading, and instead aids reintegration of offenders into society. The European Committee for the Prevention of Torture (2010, 2012b) and Weinberger et al (2005) have identified neurobiological and psychological factors which may also be associated with sexual drive, and offenders can obtain **exogenous testosterone treatment** to compensate for the loss of endogenously generated testosterone.

### 7.1.4 Biological drivers versus psychological, social or cultural drivers

The primary issue, however, lying behind this is whether sexual crimes against women are primarily motivated by biological drivers such as testosterone, or by psychological factors such as **lack of empathy**, or by sociological and cultural drivers encompassing **power**, **habituation** and **religious views** in society.

If sex crimes against women are not biologically driven, then the intervention is misplaced.

## 7.2 Hormonal medication of sex offenders

Hormonal medication, also referred to as **androgen deprivation therapy** (or ADT) and popularly referred to as 'chemical castration' covers a range of antiandrogenic drug treatments (or antiandrogens) designed to reduce male sexual desire and sexual performance to pre-puberty levels. **Effectiveness** in terms of recidivism is contested – while a range of studies have found a reduction in odds of recidivism of over three times, the quality of the studies is poor, and results could be explained by offenders **self-selecting** into treatment. There are medical **side effects** and some have identified legal and ethical issues.

### 7.2.1 Antiandrogenic drugs for high risk offenders

Grubin and Beech (2010) report that the main drugs used are cyproterone acetate or CPA (in the United Kingdom, Europe, and Canada); medroxyprogesterone or MPA (in the United States). They also report the increasing use of leuprolide, goserelin, and triptorelin. Such treatment is used in a **wide range of countries** for high risk offenders. In Europe, offenders mostly opt in to receive treatment with informed consent. Thus in the UK, Curtis, (2012) reports that 100 sex offenders have recently volunteered for such treatment. It is used in many states in the EU, particularly in **Scandinavia, Germany, Poland** and the **Czech Republic**. In some states in the **USA**, participation is often a **condition of release** for high risk offenders and selection of participants becomes a legal rather than a medical matter (Harrison, 2007).

Antiandrogenic drugs work by **blocking androgen receptors** and thus suppressing the effect of androgens in the male human body. Androgens are hormones which control the activity and development of male sexual development and performance. The most well-known androgen is testosterone. Grubin and Beech (2010) state that the reason that such drugs work is thought to be due to **reduced pressure** caused by sexual arousal, notwithstanding the '**strong psychological factors** that contribute to sexual offending'.

### 7.2.2 Weak methodological standards

A recent systematic review (Schmucker and Lösel, 2008) of sex offender treatments identified hormonal medication as the most effective treatment out of all non-surgical interventions. They examined six studies, and found a combined efficacy odds-ratio of 3.11 ( $p < 0.01$ ) when examining the risk of recidivism, meaning that those treated were **three times less** likely to re-offend. However, Schmucker and Lösel (2008) point out that the results are based on studies with a weak methodological standard. This point is reinforced by more recent research by Rice and Harris (2011), who take a more sceptical approach. They point out that there have been **no placebo studies**, and that **sample selection effects** (those choosing to have treatment may be those less likely to reoffend) may account for much of the difference.

### 7.2.3 Standards for best practice

Harrison (2007) suggests a number of proposals for best practice. Firstly, the drug used should be **CPA** rather than MPA, as there are far fewer side effects. The hormonal treatment should be **combined with psychological treatment** or counselling to improve efficacy. Finally, **informed consent** must be a priority, with offenders being informed of the effects and side-effects of the drug therapy and being able to withdraw such consent at

all times. Rice and Harris (2011) make a strong case for a **randomised control** trial of hormonal medication, with sex offender volunteers being randomly assigned either to a treatment group with early release or to a non-treatment group with standard release, with long term follow-up to both groups.

### 7.3 Cognitive behavioural sex offender treatment

A different approach to sex offender treatment from that of modifying their bodies is that of behavioural modification, which attempts to **reform their minds**. There are several models of sex offender treatment that attempt to **change the behaviour** of convicted sex offenders to reduce the likelihood that they will rape again. These include cognitive behavioural treatment classical behavioural treatment, insight oriented treatment, and therapeutic community treatments.

Schmucker and Lösel (2008) state that, out of these, only **cognitive behavioural therapy** (CBT) consistently demonstrated a **positive impact**. Their review of 35 studies showed a significant increase of 46% in the odds of not re-offending when CBT is used. They explain that “the usually less clearly structured insight-oriented and milieu-therapeutic approaches seem to be of little benefit while highly structured cognitive-behavioural treatment shows good effects” (ibid, p16). Recent authors have come to view specific variants of CBT as particularly effective. The Risk-Need-Responsivity model used in Canada is one example (Andrews et al 2011); the Good Lives Model is another (Ward et al 2012). They work by assessing risks, identifying needs and developing a programme to change the behaviour of the convicted offender.

#### 7.3.1 Good practice: The Good Lives Model

The Good Lives Model is a community based program aimed at sex offenders in the community but still being managed by offender management services. It was proposed by Tony Ward in a series of publications (Ward and Maruna, 2007; Ward and Stewart, 2003; Ward, 2002) and has been implemented in **Australia**, the **UK**, the **USA** and **Canada**.

The good lives treatment programme has been given in the form of a **module** as part of a sex offender group work programme. The module aims to develop positive acquisition of goals and skills, namely a healthy life, knowledge acquisition, achievements, excellence in agency, inner peace, friendship, community spirituality, happiness and creativity. Its aim is to instil **knowledge**, **skills** and **competence** to allow the offender to live a better life and so avoid reoffending. It is not intended to be a complete programme, and other modules on the programme address other issues such as **victim empathy** and **problem solving**.

The theoretical basis for the program is that sex offending arises because offenders try to obtain the **same goals** as other individuals (states of mind, personal experiences and personal characteristics) but in an inappropriate way. The inappropriateness may arise either from an imbalance in goals where some goals are inappropriately prioritised over others (sexual gratification over intimacy) or through frustration at being unable to achieve such goals. Treatment is carried out in the community on sex offenders who have either received a community sentence, or are serving part of their sentence on licence in the community.

A small scale trial was carried out in **Northumbria in the UK** (Harkins, Flak, Beech, and Woodhams, 2012). 77 male offenders received the good lives module and 701 received the

standard risk prevention module. Attrition rates on the program were the same in the two groups. From interview data, there was evidence of a more positive outlook towards future life amongst offenders in the Good Lives treatment programme.

There is currently dispute about the **added value** that the Good Lives Model provides over the Risk Needs Responsivity model. Andrews et al (2011) questions the added value of the Good Lives Model and points out that the programme needs **more systematic scientific evaluation** (Andrews, Bonta, and Wormith, 2011). Ward, Yates, and Willis, (2012) have defended this lack of evaluation, explaining that the focus of treatment programmes would be on their **underlying rehabilitation theories** rather than treatment utility.

While there is promise, there is **no current evidence** of treatment effectiveness over the current regime of the Risk Needs Responsivity model, which is used in many jurisdictions. Consequently, a study of what works in reoffending, marks the Good Lives programme as 'perhaps promising' but with 'no replicated empirical evidence in evaluations' (Lösel, 2010).

## 7.4 Sex offender registration and notification schemes

Sex offender registration and notification (SORN) is now common throughout the Western world to keep track of recently released or sentenced sex offenders, and allowing communities to be aware of sex offenders living in their neighbourhood.

There are two forms of registration scheme. The first form (registration only) requires **police registration** for a fixed period of time depending on the severity of the sexual offence; the second form has an additional **community notification** component. This can vary from the police supplying information about a named individual on request from a parent, to publicly available web registers of sex offenders with mapped locations.

### 7.4.1 Objectives

Sex offender registration and notification laws cover most sexual offences including rape and are common in many Western countries. They are intended to serve **four purposes**: – firstly to allow local law enforcement knowledge of the sex offenders who may reside in a specific area, – secondly to act as a disincentive for existing sex offenders to reoffend, – thirdly to act as a disincentive for potential new offenders to start offending, and – finally to improve public knowledge about potentially dangerous individuals living in their community and thus to improve safety.

### 7.4.2 Registration

The legislation is applied to convicted sex offenders from release from prison after conviction or after a non-custodial sentence is imposed. Registration is also sometimes required of sex offenders who accept a police caution and therefore accept guilt. Registration periods depend on the seriousness of the offence, with lifetime registration required for serious offences in some countries. Depending on the jurisdiction, **juveniles** might receive a shorter period of registration compared to adult offenders. There is usually a requirement on the offender to notify all changes of address, and sometimes to reconfirm their current address each year. Non-compliance attracts a criminal sanction.

### 7.4.3 Introduction of legislation on registration: examples from Member States and Third Countries

In the **USA**, registration legislation was first introduced in California in 1947 with federal legislation in 1994 (the Jacob Wetterling Act) being introduced to require all states to introduce SORN registries, following the kidnap of an 11 year old boy in 1989 in Minnesota. An extra requirement of community notification introduced in New Jersey in the 1990s, was consolidated into the Adam Walsh Child Protection and Safety Act of 2007. This act requires states to maintain a **public and free to access register** of the location of sex offenders anywhere in the USA. Registration periods depend on the seriousness of the offense – the most serious offenses (Tier 3) require lifetime registration, Tier 2 offenses require 25 years of notification from release, and Tier 1 offenses 15 years. The legislation allows a reduction of five years for Tier 1 offenses if the offender has not been convicted for ten years – with registration effectively stopping at ten years. A Tier 3 juvenile sexual offender can also have the registration term reduced to 25 years if they have no convictions in that time.

**Canada's** closed National Sex Offender Registry (NSOR) came into force at the end of 2004, with the passing of the Sex Offender Information Registration Act (SOIR Act). The registration period varies from 10 years to life according to the length of the sentence awarded, and there are no discounted periods for **juveniles**. There is **no public access** to the registry.

In **Australia**, the responsibility for sex offender registers lies with the individual states. More states have introduced **closed sex offender registration**. The Australian National Child Offender Register (ANCOR) also provides national information on child sex offenders and is used to co-ordinate state registration systems. Registration times of eight years, fifteen years and life again depends on the severity of offense. **Juvenile** offenders receive a 50% time reduction. The state of Western Australia has recently introduced an **open register**, and there are also **private registers** maintained by individuals.

Turning to **England and Wales**, a **closed sex offender register** was introduced in 1997, with its operation subsequently modified by the Sexual Offences Act 2003 – it now forms part of the Violent and Sexual Offender register (ViSOR). There is the ability for an enquiry about a named person to be made if there is just cause (the child sex offender disclosure scheme). The length of time to which such individuals are to be registered is determined by the length of sentence received, and ranges from 2 years for a caution, seven years for a sentence of 6 months or less, 10 years for a sentence between 6 months and 30 months and indefinite for longer prison sentences. Those **under 18** at the time of conviction are required to register for only half the registration time.

In **France**, the FIJAIS (Fichier judiciaire automatisé des auteurs d'infractions sexuelles) provides for automatic registration for serious child and adult sexual offences receiving a sentence of five years or more.

In **Ireland**, there is a requirement for convicted sex offenders to notify the police of their current address. This notification requirement can be indefinite for offences which have been sentenced to two years or more in custody.

**South Korea** is an exception in that the jurisdiction posts names and details of convicted sex offenders on the Internet for anyone to download. There is no requirement for the offender to register, and the procedure is more concerned with public shaming than with aiding law enforcement and detection.

#### 7.4.4 Problems associated with the evaluation of the effects of legislation

Assessment of whether such registration and notification work is effective, is fraught with difficulty as the majority of such assessments tend to be historical comparisons between a sample of offenders convicted before the legislation was in place with a sample convicted afterwards. These are often known as **before-after studies**. They have the risk that a beneficial effect of the legislation is balanced out by an increase in the number or nature of the sexual offending over time. An additional problem is that registration may or may not have been accompanied by community notification, and that other legislation to address sexual recidivism, such as civil commitment, or the abolition of discretionary parole has also been introduced in a similar timeframe and might blur the result. Some studies look at aggregate sexual offending rates and assess the disincentive for both new offenders and existing offenders; other studies have looked solely at recidivism rates.

Nearly all evaluation studies have been carried out in the **USA**. A group of studies have looked at the potential decrease in recidivism and timing of reoffending following SORN – most of this work has been US-based. One of the earliest studies (Schram and Milloy, 1995) assessed community notification, comparing on the one hand 90 sex offenders released from prison between 1990 and 1993 in **Washington State** and subject to registration in Washington state and the highest level of community notification with, on the other hand, a matched 90 sex offenders released after 1986 and not subject to notification. There was no difference in the rate of sexual recidivism measured by arrests in the two groups after three years, but there was some evidence that recidivists of the notification group were arrested faster.

Later work by staff at the same institute (Washington State Institute for Public Policy, 2005) looked at over 8,000 sex offenders released between 1986 and 1999 and covering the introduction of two pieces of registration and notification legislation the first in 1990, and an amended form in 1997. Once adjustment for offender characteristics had been made, there was a **significant difference** in sexual recidivism following the 1990 legislation and a further decline after 1997, however, as stated in the report, this may have been caused by general state wide decrease in reoffending. Similarly, a study in Minnesota (Duwe and Donnay, 2008) showed a significant reduction in sexual re-arrest and reconviction compared to a pre-notification group. However, other studies have come to **different conclusions**. A **New Jersey** study showed that community notification had no effect on sexual recidivism (Zgoba et al, 2008) and a **South Carolina** study came to similar conclusions (Letourneau et al, 2009). Most recently, a study in Arkansas (Maddan et al, 2011) also showed no effect of registration and notification on recidivism.

Other studies have focused on comparing rates of sexual crime in different states within the US. The earliest study was that of Vasquez, Maddan, and Walker (2007), who used a time series approach to examine the effect of the notification component of SORN schemes on rape in various states in the US. They found mixed results, with three states (Hawaii, Idaho and Nebraska) showing significant reductions in rape rates, but with California showing a significant increase. Some studies have focused on only one state. Thus, Sandler, Freeman and Socia (2008) examined before-after rates for rape and for other sexual offences in the state of New York and found no legislative effect; and Letourneau, et al (2010), looked at the effect of notification on **juvenile** sexual offending rates in North Carolina, and found no effect once other criminal justice changes were accounted for. Agan (2011) instead focused on the effect of registration rather than notification, and examined state level data for rape and sexual offending. She found **no evidence** that the legislation had an effect overall. Ackerman, Sacks, and Greenberg (2012) have recently re-examined US state level



data and focused specifically on **rape**, using a panel data approach and controlling for other legislative changes across all states. They conclude that the notification component of SORN schemes have **not brought about dramatic reductions** in the rates at which rapes occur.

#### 7.4.5 Reoffending trajectories

A second smaller strand of work has examined the reoffending trajectories for the number of convictions of sex offenders released before notification and after notification. In a study in **Iowa**, Tewksbury and Jennings (2010) examined the three distinct post-release trajectories of reconviction for a pre-SORN and a post SORN group and found them to be of similar shape with similar proportions of offenders; there was **no statistical evidence of any effect** of the SORN legislation. Similarly, a study in **New Jersey** (Ri et al, 2012) found no differences in either the shape or proportions of offenders in the two trajectory groups found.

#### 7.4.6 Negative effects for offenders

The negative effects of SORN policies on offenders also need to be considered. Letourneau et al (2010) summarise these effects in numerous studies which include impeding employment and housing, disruption of supportive relationships and subjection of the offender to harassment and rejection. These all **deter the reintegration** of the offender back into society and may increase the risk of recidivism. Finally, an additional criticism of registries is that they are too broad in scope, often capturing minor juvenile sexual offending, not only more dangerous adult forms.

#### 7.4.7 Evidence that fear of crime decreased without concrete actions being taken

Thus, although some studies have shown decreases in recidivism and changes in sexual offending rates, the consensus appears to be that in most states registration and notification laws have had **little effect**. Is there any evidence that public safety is increased and fear of crime is decreased? A study by Anderson and Sample (2008) provides some evidence. In a survey of Nebraska residents, they found that nearly 90% of respondents knew of the existence of a registry, and around 35% had accessed it. Of the third of respondents who answered questions on safety, over 89% said they felt safer knowing of the existence of a registry and 35% had taken action, such as talking to neighbours or their children. However action in providing **enhanced security provisions was unusual**. Recently, Bandy (2011) found that there was no evidence that individuals took increased self-protective measures against sexual offending, but community members did **increase protection for children**.

### 7.5 Conclusion

Evidential efficacy is weak, and so best practice is hard to define. If such a policy is considered, it seems to act best both as a **law enforcement** policy and as a way of **decreasing fear of crime**. Human rights issues for the offender have been considered in Europe but are considered less relevant in the US. Policies tend to be driven by well publicised extreme events and introduction of such a policy needs to consider why such a policy is being introduced, and the **human rights issues** and the effect on offenders who are attempting to desist.



### 7.5.1 Best practice

Sex Offender Registration and Notification (SORN) is not a best practice, but a practice that is common among many jurisdictions. While there is **little evidence of prevention** of reoffending by sex offenders (and more specifically rapists) and **of deterrence** of new sexual offending, there is some evidence that the communities in which offenders live **feel more secure**, although preventative action is not likely to take place.

Implementation of such a system would need an **integrated and comprehensive criminal records system** across the whole of the country to which a registration scheme can be added. In countries with strong regional autonomy with their own records, this may be hard to achieve. Secure access by professionals need to be designed, and data security issues need to be considered. Given these prerequisites, transfer of this methodology to many other countries would be feasible.

Future evaluation studies need to focus on a **variety of outcome measures**, including the views of the community, the changes in reported and convicted sex offender rates, changes in recidivism rates and negative effects of vigilantism on the offender. Research also needs to take place in other jurisdictions outside the USA as the high gun ownership of the US may be influencing issues related to public safety and protection.

## 8 Peace and security in conflict zones

### KEY FINDINGS

- Rape is sometimes used as a weapon of war.
- Rape and other forms of violence against women are higher in conflict zones in addition to its use as a weapon.
- Improving gender-balance in decision-making, including in peace-keeping, peace processes, and negotiations is a significant strategy to reduce the rate of sexual violence as well as contributing more generally to the likelihood of peace.
- Gender expertise is a necessary part of processes to reduce rape and to assist victims of rape in conflict zones, as elsewhere.
- The EU potentially has a significant role in addition to the UN in the provision of resources and expertise in humanitarian crises in order to reduce rape and sexual violence as well as to improve the prospects of peace.

### 8.1 International law provisions

With a shift of the meaning of **security to include the social and human dimension**, there has been an increased focus on civilians and women in peacekeeping operations (Hudson, 2000). Civilians stopped being victims only, and became 'actors' in the peacekeeping process.

Similarly, a series of **practices are emerging** to address the very high rates of rape and sexual violence in conflict zones, including the development of: special services for women victims of rape, including centres and shelters; research and documentation centres; **international criminal law and courts**; and the inclusion of women in decision-making, as mandated by UN Security Council Resolutions 1325 and 1820 (UN Security Council 2000, 2008; Jacobs, Jacobson and Marchbank, 2000; Farr, Myrtilinen and Schnabel, 2009; Shepherd, 2006).

Some of these practices have been set out in the chapter on health, while this chapter considers the wider context of conflict zones.

#### 8.1.1 UN Security Council Resolution 1325 (UNSRC, 2000) on women peace and security

UN Security Council Resolution 1325 calls on governments to **increase the representation of women** in all institutions that deal with the prevention, management and resolution of conflict. It includes women as military observers, civilian police, and humanitarian personnel. The implementation of 1325 requires gender equality at all levels of peace-keeping, peace-making, peace-building, and post-conflict reconstruction. It aims not only to ensure equality in representation, but the resolution calls for interventions that **address gender based violence** against women during conflict, to **train local security forces** in gender awareness, to **provide funding** to protect women during conflict, to **rebuild institutions** that provide services that are essential to women, and to support women's organisations working with peacekeeping and peace-making (UNSRC, 2000).

Worth noting though is that long before resolution 1325 the UN had committed to women's rights in the UN Charter, CEDAW (1979) and the Beijing Platform for Action (1995).

### 8.1.2 UN Security Council Resolution 1820 on Women and War and Peace (2008)

UN Security Council Resolution 1820 (UNSCR, 2008) confronts sexual violence in conflict and post-conflict situations. The key provisions recognise a direct relationship between the systematic use of **sexual violence as an instrument of conflict** and the **maintenance of international peace and security**. It requires the Security Council to consider appropriate steps to end the violence and interventions to penalise perpetrators.

More in detail, UN Resolution 1820 recognised that mass rape used in war, genocide, and ethnic cleansing was a '**weapon**'. The Resolution recognises that women and children can be targeted for rape and calls for: the **immediate cessation** of the use of sexual violence against civilians in armed conflict; the **exclusion of sexual violence crimes from amnesty provisions** in the context of conflict resolution processes; and an international acknowledgement of the importance of **ending impunity** for such acts.

### 8.1.3 Resolutions of other actors

The **Council of Europe** (2009a) issued a resolution condemning the use of rape as a weapon.

The **European Parliament** passed Resolutions in 2008, 2009, 2011 calling for action to support women who were victims of rape in war, especially the **Democratic Republic of Congo** (European Parliament, 2011b).

The **G8** has made a declaration on the importance of preventing sexual violence in conflict zones (G8, 2013).

### 8.1.4 Women's empowerment

Women's empowerment and increased participation in decision-making processes **reduce all forms of violence** against women, including rape, in (post)-conflict zones (Bridges and Horsfall, 2009; Hudson, 2000). Women's empowerment can be defined as 'a process of **awareness** and **capacity building** leading to **greater participation**, to **greater decision-making power** and **control**, and to **transformative action**' (Karl, 1995).

Understood this way, women's empowerment is crucial to obtain the goals of UN Security Council Resolutions 1325 (UNSCR, 2000) and 1820 (UNSCR, 2008). Scandinavian countries, where gender equality is a political priority, show a more **gender balanced composition** in their peace keeping troops (Olsson, 1999; Hudson, 2000). The conclusion here is that analysis, policy, mechanisms and best practice to achieve gender balance linked to the reduction of sexual violence and rape are more likely to be adequate and successful when a **gender equality framework** is utilised.

### 8.1.5 Lack of implementation

There have been important developments and practices coming out of UN resolution 1325 and 1820, and yet women are underrepresented at all levels of peacekeeping processes (UN 2007; UN Women, 2012a). How and why have gendered structures of power and knowledge persisted within peacekeeping operations despite Security Resolution 1325?

Tickner argues that **masculine values** underpin international politics and limits the possible interventions by policymakers; the state is not a neutral 'provider of security', but rather sustains and delivers policy primarily in the interests of men (Tickner, 1992).

## 8.2 Rape as tactic of war

### 8.2.1 Increased sexual violence against women by fighting forces and peace keeping troops

Already 10 years ago, the UNCHR (2003: 7) reported on evidence gathered about the increased rape and sexual violence used against women in times of war. From Sierra Leone to Rwanda, from Bosnia-Herzegovina to Afghanistan systematic rape has become a tactic of war. Sexual violence and rape as a warfare tactic are **increasing** and mass rape in war has been documented in Bosnia, Cambodia, Liberia, Peru, Somalia and Uganda. The UNCHR reports estimates of over 500,000 women in Rwanda being raped in 1994; 60,000 in Croatia and Bosnia-Herzegovina between 1991 and 2001; 64,000 in Sierra Leone, and 32,000 rapes in South Kivu province in the Democratic Republic of Congo in 2005.

The majority of sexual violence is conducted by the **fighting forces** during conflict, but perpetrators in post-conflict zones can also include **peace-keeping troops**, and community and family members. Not only is there sexual violence during conflict but the peace-keeping security forces may themselves become perpetrators of sexual violence against local women, albeit of different forms (Simić, 2012; Willet, 2010; UN, 2010b). In 2002 a UNIFEM report stated that one of the most disturbing observations was 'the association, in the vast majority of peace-keeping environments, between the **arrival of peacekeeping personnel and increased prostitution, sexual exploitation and HIV/AIDS infection**' (Rehn and Johnson Sirleaf, 2002: 61). Indeed, between 2008 and 2009, the overall number of allegations against sexual exploitation and abuse **against the UN Department of Peacekeeping Operations** increased, with the United Nations Organization Mission in the Democratic Republic of Congo accounting for the highest increase (UN, 2010b).

However, there should be some caution in treating rape in war in isolation from rape in other settings. In a study based on interviews with 200 soldiers in the Democratic Republic of the Congo, Eriksoon Baaz and Stern (2010) conclude that a one-sided focus on rape as a tactic of war **blurs the reasons for rape and disconnects rape from other forms of gender based violence**.

### 8.2.2 UN recommendations

#### *UN Special Representative of the Secretary-General on Sexual Violence in Conflict*

The UN Special Representative of the Secretary-General on Sexual Violence in Conflict, who chairs the network UN Action, underlines the importance of empowering women and awareness raising for the prevention of rape and the protection of victims. The Special Representative is mandated with five internally related priorities to address rape in conflict and post-conflict zones:

- (1) to **end impunity** for conflict-related sexual violence,
- (2) to **empower women** to seek redress,
- (3) to mobilise **political ownership**,

(4) to **increase recognition** of rape, and

(5) to **harmonise the UN's response** to rape in conflict and post-conflict zones.

### ***United Nations High Commissioner for Refugees (UNHCR)***

The United Nations High Commissioner for Refugees (UNHCR, 2003) has issued guidelines for prevention and response in order to address sexual and Gender-Based Violence against refugees, returnees and internally displaced persons. These include: involving and respecting the refugees themselves; ensuring a coordinated multi-sectoral approach; ensuring the safety and confidentiality of the victim; identifying points of especial vulnerability; transforming socio-cultural norms, with an emphasis on empowering women and girls; rebuilding family and community structures and support system; designing effective services and facilities; working with formal and traditional legal systems to ensure that their practices conform to international human rights standards; and monitoring and documenting incidents of sexual and gender-based violence.

## **8.3 The role of women in peace keeping to reduce rape and sexual violence**

One of the policy interventions to reduce violence against women in (post-)conflict situations has been to attempt to change the gender composition of decision-makers in conflict zones. The aim is to **narrow the gender gap** in composition of peacekeepers and negotiators to **assist in the vocalisation of women's perspectives** in the development of policies and programs to decrease sexual violence (Bridges and Horsfall, 2009; Carey, 2001). (Post)-conflict zones where local women, local women's NGOs and other civilians have been actively involved in the peacekeeping process and as political and legal advisors; election and human rights monitors; and as information specialists or administrators show a **more sustainable** and **long term peace** with fewer incidents of rape.

### **8.3.1 Increased representation of women in peacekeeping missions: the key role of the recruitment process**

In line with the two UNSC resolutions, UN interventions in post-conflict zones have been concentrated in three areas: (1) **increasing the number of women** in peace operations; (2) **appointing gender experts** within peace operations; and (3) **gender training**.

Although there are some existing gender experts and gender training within the UN system (Willet, 2010; Rehn and Johnson-Sirleaf, 2002), the representation of women in peacekeeping mission is **as low as 2-2.7%** (UN, 2007; UN, 2012).

The UN maintains the responsibility for gender mainstreaming and gender balance in decision-making in peacekeeping missions (WRC, 2007; UN, 2006a; UN, 2004; UN, 2001; UN, 2000) but ultimately, it is **member states that are accountable** for the number of women military peacekeepers: The UN has very little influence over the recruitment of peacekeeping troops at national level (Hudson, 2000). This suggests that interventions must be directed towards the **recruitment process** at the national level.

**Scandinavian** peacekeeping missions have traditionally had a higher representation of women peacekeepers than any other region. Helland and Kristensen find that although the high percentage of women is partly a **reflection of the economic, political and social**

**climate** with generally high levels of gender equality, it is also a **result of direct and practical interventions** into the recruitment process.

**Sweden** does not require military training as a pre-requisite for entry into peacekeeping missions; **life skills and education** are taken into consideration. Women and men who lack military training receive **basic military training** prior to any mission (Helland and Kristensen, 1999; Olsson, 1999). Hudson's (2000) research found how in **Norway** there is a '**holistic understanding**' of women's contributions during mission, not only to peacekeeping but to long-term reconstruction and post-conflict developments.

### 8.3.2 Positive effects of women in peacekeeping

Peace missions with high percentages of women, such as **Namibia** (40%) and **South Africa** (50%) have been successful (Carey, 2011). A higher proportion of women among the international peacekeeping missions has positive effects on the local level **representation and democracy**: when a 30% critical mass of mission personnel are female, local women **more quickly join peace committees** (Carey, 2001).

Further, local women confide more in female than in male peacekeepers; and find it easier to **report sexual violence** to other women. There are examples from **Somalia** where women experienced body searches by men as extremely humiliating, and reports from the peace missions in Bosnia and Rwanda, where women provided valuable assistance to victim-survivors of sexual violence (Carey, 2001). The presence of women in the case of peace keeping and negotiations in post-conflict zones is crucial for the development and implementation of **successful programs** and for women's empowerment, and linked to the elimination of violence against women (Carey, 2001).

By way of conclusion, it can be said that involving women in the peacekeeping process reduces the risk of sexual violence and rape and increases the likelihood of women accessing help. Moreover, women's presence assists in engendering trust, improving the reputation of peacekeepers, and in **facilitating the peace process** (Hudson, 2000; Bridges and Horsfall, 2009; Allred, 2006; Hagen, 2006; Carey, 2001; Skjelsbaek, 2001; DeGroot, 2002; Johanson and Cobley, 2007; Karame, 2001; Steim, 1997). It is also likely that the increased presence of women explains how and why sexual misconduct by military peacekeeping troops was placed on the agenda in the first place (the Namibia mission) (Hudson, 2000).

### 8.3.3 Effects of resolution 1325

The **UN 10 year impact study** of resolution 1325 shows that although there has been success in supporting the adoption of laws to combat sexual violence and in training the judiciary and police, violence remains widespread. The security of women has only been improved by missions which supported active protection measures, such as **joint protection teams** involving both international peacekeepers and local groups. The impact study concludes that a 'more concerted and robust response from national and international actors is required to fight against SGBV [sexual and gender based violence] as it remains highly prevalent' (UN, 2010b: 10).

The **Secretary General's strategic framework** to guide the UN's implementation of resolution 1325 focuses on four areas (UN 2011):

- **Prevention:** Prevention of conflict and all forms of violence against women and girls in conflict and post-conflict situations;
- **Participation:** Women participate equally with men and gender equality is promoted in peace and security decision-making processes at national, local, regional and international levels;
- **Protection:** Women's and girls' rights are protected and promoted in conflict-affected situations; and
- **Relief and Recovery:** Women and girls' specific relief needs are met and women's capacities to act as agents in relief and recovery are reinforced in conflict and post-conflict situations.

## 8.4 Women are missing from peace negotiations

In a review of 14 out of 35 major peace negotiations since the adoption of resolution 1325, UNIFEM found that only 1.2 % of the signatories of peace agreements were women; women accounted for 9.6% of negotiating delegations; and not a single woman served as a negotiator, mediator, signatory or witness in the peace negotiations in Indonesia, Nepal, Somalia, Cote d'Ivoire, the Philippines and the Central African Republic (UNIFEM, 2008; Goetz, 2008).

Women are not only missing from the formal peace processes, but negotiations and programs are too often externally imposed on local populations and lack strong local roots (UNIFEM, 2000). Consequently, the **voices of local women are excluded**, both by peacekeeping troops and local decision-makers.

It is argued that the inclusion of women in peace and security issues is crucial for the **sustainability** of the process and does not constitute only an abstract norm (Tryggestad, 2010). Undesirable 'elite brokered and dominated negotiations' often result in 'many countries fall back into conflict five or six years after a peace agreement' (Collier, 2007).

Positive examples, however, exist. For example, UNIFEM in Burundi worked on **capacity building** with local groups of women to enable them to participate in the peace talks. This intervention also showed the importance of using the 'time between the end of a conflict and the beginning of the reconstruction process in order to promote the participation of women in peace efforts.' (UNDP, no date).

### **Box 9: Changing the relationships between masculinised protectors and feminised protectors**

The challenge here lies in developing participatory processes of implementation (UNIFEM, 2000) to overcome what Enloe calls the idea of the socially constructed 'natural bond' between the protector and the protected (Enloe, 2007, in Willet, 2010) in national security issues. Willet applied this reasoning to peacekeeping forces, and concludes that the peacekeeper/protector can claim to speak on behalf of the protected, and therefore lacks incentive to include women as well as local women's groups in decision-making. Willet (2010: 147) writes 'gender mainstreaming in peacekeeping means **changing the relationships between masculinised protectors and feminised protected**. It means challenging the relation between military knowledge and being an expert on security. Participation in peace negotiations should be based on integrating different views of the society in question.



## 8.5 Conclusions

The EU has a significant role in disaster and conflict zones. In addition to formal compliance with UNSCR 1325, and following the guidelines of UNHCR (2003), further recommendations are made:

The EU is called upon to:

- Ensure that the intervention is **victim-centric and gender sensitive**;
- Establish **joint protection teams** and implement **codes of conduct** for peacekeeping forces;
- Ensure **co-ordinated multi-sectoral action** by all actors (community services, health, protection, security);
- Establish formal ways of **holding actors accountable**, including those involved in programmes targeting sexual and violence;
- **Prosecute** persons responsible for serious violations of international humanitarian law, including rape, sexual slavery, forced prostitution or any other form of sexual violence, by Special Courts;
- Offer tailored **training** for
  - senior managers, gender advisers and programme staff on how to integrate and mainstream a gender perspective in programs;
  - local security forces in gender awareness;
  - peace consolidation, female leadership and gender mainstreaming in peacekeeping missions;
- Practice **local community participation** as important for all stages of programming for prevention and responses to sexual and gender-based violence, including the planning stage;
- **Provide specialist gender expertise and also mainstream actions** to prevent and respond to sexual and gender-based violence into already existing programmes as special programs to prevent sexual abuse and rape are less likely to be sustainable over the long term.

Women's participation in peace negotiations and peace agreements should include:

- **Raising awareness** on SCR 1325 provisions through workshops and its translation into local languages;
- **Coaching and technical assistance** to women's groups and delegates to mainstream gender in peace agreements;
- **Training** women's organisations and potential representatives in negotiation skills, advocacy and in-depth understanding of SRC 1325 provisions; and
- Establish **gender units** in peacekeeping operations to ensure that women are not only represented in peace negotiations but are informed and able to articulate their concerns.

### ***Promising practices***

Women in the peace process are often organised on grassroots level to promote activities for peace, but remain excluded from the negotiations, which jeopardizes a sustainable peace. **UNIFEM in Burundi** worked on capacity building with local groups of women to enable them to participate in the peace talks.

**West Africa Network for Peace**, a local women's NGO that participated in a course on SCRC 1325, later conducted a seminar recommending gender committees within the security and defence forces, which today are a reality.

### ***Best practice example***

A best practice example is shared with health at 11.4: 'Health-based services in a conflict zone: The International Rescue Committee (IRC)'.

## 9 Economy, economic growth and social inclusion

### KEY FINDINGS

- Economic inequalities contribute to higher rates of rape and other forms of violence against women.
- Victim-survivors of rape have economic needs, including for income and housing, as well as for health care and other specialised services.
- Rape damages women's capacity for employment and is thus a detriment to the contribution of women to the economy and to economic growth.
- Rape contributes to the social exclusion of women.
- Improvements to the economic well-being of women can increase the resilience of women from rape and from some of the consequences of rape.
- The use of EU structural funds, such as the European Social Fund, for programmes that support women survivors of rape are recommended.

### 9.1 Introduction

The practice of empowering women through democratic involvement and economic independence is linked to the reduction of violence against women, including rape. Women's empowerment has a significant but **complicated relationship with economic development**, which is mediated by the form of the development (Moser and Shrader, 1999; Bedford, 2009; Walby, 2009). The practice of **measuring the economic cost** of sexual and domestic violence assists the mainstreaming of gender violence policy into economic policy (Walby, 2004).

Strengthening women's economic status delivers **decreasing rates of rape** and increases the range of options available to assist women to avoid situations in which they are particularly vulnerable to rape, including within intimate and family contexts. As such, best practice interventions operate at multiple levels, create systemic change and locate the strengthening of women's economic status at the core of policy and practice.

Identifying best practices for rape prevention in the field of economy and development is **more problematic** than in other fields, such as health or criminal justice, because specific interventions are **less likely to be formally designed** and implemented as part of a rape prevention strategy, unlike sexual offence courts designed to improve conviction rates in cases of rape and sexual assault, for example. In addition, there is currently a **lack of available and systematically collected data** referring specifically to sexual violence (EIGE, 2012a); the evidence-base so far has developed to a greater degree for other forms of gendered violence, specifically intimate partner violence, rather than rape.

Nevertheless, despite the evidence-base being weighted toward other forms of violence against women, there is a body of research which has identified **specific associations between rape and the economy and development**, which can be used to inform the criteria for best practice interventions in this field. In addition, research findings have suggested both that a high proportion of rapes and sexual assaults are carried out by a perpetrator known to the victim, including intimate partners and family members (Walby

and Allen, 2004) and, that a high proportion of assaults by intimate partners and family members include a sexual element (Kelly, 2000). Therefore, the evidence-base which is centred on intimate partner violence against women, if used carefully, can also contribute to identifying best practice criteria for rape prevention interventions in this field, seen the **prevalent economic dependency** of women. Both are explored in this chapter. Similarly, there are examples of **successful interventions for rape prevention which have targeted women's economic status**, the strengthening of which has been shown to reduce rates of rape and sexual violence: three such examples are explored in the body of the report.

## 9.2 Economic inequalities' impact on violence against women

### 9.2.1 The evidence-base concerning the relationship between economic status and violence against women

Despite the above mentioned limitations, the impact of gendered economic inequality on violence against women is **well recognised by a number of bodies**. For example, the **United Nations** (2006b) report on ending violence against women argues that **economic inequalities can be a causal factor** for violence against women both at the level of individual acts and at the level of broad-based economic trends that create or exacerbate such violence; and that policies such as structural adjustment, deregulation of economies and privatization of the public sector can reinforce women's economic and social inequality. Similarly the **WHO** has noted the **disruptive effects of globalization** on social structures and consequent increases in overall levels of violence in society, including gendered violence (WHO, 2005; Krug, 2002).

Cross-national comparative studies support these positions, for example, Asal and Brown (2010) found **countries with the greatest levels of economic inequality** reported the **highest rates of intimate partner violence**, while the WHO (2005) reports that countries scoring high on the gender development index are those with low rates of sexual violence against women.

This has led to the development of rape prevention strategies that target the associations between gendered economic inequality and rape (see below).

#### *Economic cost of sexual violence*

The recognition of the impact of rape and sexual violence on women's employment with its consequences for economic growth is a further aspect of the identification of the relationship between gendered economic inequality and rape. This has led to rape being recognised as a cost to the economy. For example Walby (2004) estimated the **cost of domestic violence** (which included sexual assaults) to the **UK** economy to be GBP £23billion per annum, and in the **United States** estimates range from US\$15billion to US\$260billion per annum (WHO, 2004a).

#### *Violence against women as a security issue*

Recently, the importance of the economic productivity of women and the links between gendered economic inequality and violence have moved beyond traditional economy and development issues into security concerns. Some security experts have argued that countries which nurture terrorists are disproportionately those where women are marginalised (Kristof and WuDunn, 2012). However, True (2012) argues that although rape and sexual violence are recently and increasingly the subject of national and international

security agendas, such **approaches have been poor at explicating the political-economic dimensions of sexual violence**; she points out that the UN Security Council's Resolution 1889 (2009) is the first to include language that encourages member states to address the socioeconomic needs of women in relation to security goals.

### 9.2.2 Economy and development interventions for victim-survivors of rape

Some forms of assistance for women victim-survivors of rape have been delivered as part of a package of **support programmes** in order to help them **strengthen their economic status** through access to education, training and/or employment. Such interventions aim to provide women with a tangible means **to resist and to exit** relationships, locations or contexts which make them particularly vulnerable to rape. They can provide support for income and for integration into the labour market.

Economic and development interventions designed to prevent rape are relatively infrequent, but are gaining ground. In particular the **potential impact** of interventions designed to strengthen the economic status of women, such as microfinance projects working with small groups of women in the developing world are being **increasingly recognised** and **formally incorporated** into the design of such interventions, whilst also providing an evidence-base from which more specialist interventions can be developed.

## 9.3 Rape prevention interventions: the evidence base

### 9.3.1 The relation between economic status and the risk of being raped

The European Institute for Gender Equality (EIGE) notes the lack of available and systematically collected data referring specifically to sexual violence (EIGE, 2012a). Despite this, there is evidence that demonstrates that women in weak economic positions are at increased risk of rape. A weak economic status is relative depending on the context and / or location, but women whose access to economic resources is severely limited are more vulnerable to rape because a lack of economic resources **restricts them from being able to avoid situations** in which they are more vulnerable to rape, for example being unable to afford to travel by private car or taxi or living in insecure housing.

There are a number of ways women can **access** economic resources, the most usual being through earned income from employment or welfare receipts, but may also include income from pensions or study grants or through ownership of material assets such as land or property.

In addition, a number of studies which have looked specifically at women's **ability to make choices** about exiting violent relationships show economic resources are a key factor in women's ability to leave (Short et al, 2000); whereas a lack of economic resources is a key reason women **return to violent relationships** (Anderson and Saunders, 2003; Agarwal and Panda, 2007).

### 9.3.2 The role of different forms of income

In one **UK** study of rape/attempted rape, Kelly, (2007) found that the odds of being raped/attempted rape by a stranger both outside and inside the home were **significantly lower for employed women** compared to those of unemployed women and Walby and Allen (2004) similarly found unemployed women's odds of sexual assault were almost

double those of employed women. In the same UK study, Walby and Allen (2004) also found **women in the poorest households** were **more likely** to have been sexually assaulted than women in richer households and the proportion of women with low personal earnings (less than £10,000 per annum) experiencing a sexual assault was double that of women with above average earnings (2.0% and 0.7% respectively). Perhaps most significantly, the study also revealed that the odds of women who would find it impossible to find £100 at short notice experiencing a sexual assault were more than double (2.3 times greater) those of women for whom finding £100 at short notice would be no problem.

If a wider evidence base is reviewed, studies which have focused on intimate partner, marital or **domestic violence** which have included rape and/or sexual assaults support the findings above: that a **weak economic status** correlates to **higher risks**. For example, Johnson et al (2008) found that women in **Denmark** with no income reported lifetime rates of intimate partner violence by a current partner to be **twice** that of women with earned or other sources of income. Tolman and Raphael (2000) in their review of U.S. studies of domestic violence concluded that the prevalence rate among **women on welfare** is consistently **higher** than that for women in the general population.

#### Box 10: Empowerment through quality employment

The findings from other studies on the effects of employment are more mixed than those found by Kelly (2007) and Walby and Allen (2004) and suggest that **employment *per se* may not be enough** to strengthen a woman's economic status. Rather the type of employment makes a difference to its potential for increasing a woman's resilience. Agarwal (2013) argues that in India 'employment' for women may mean unpaid labour for the family enterprise, or that women may not earn enough to widen their available choices, for example to afford to set up an independent household. Similarly, Riger et al (2004) found an inverse relationship between **work stability and recent intimate partner violence**, reporting that higher levels of violence were associated with fewer months' work, even when other factors, such as human capital, were taken into account. 'Precarious' (part-time; insecure; low-paid; low status; with little or no legal protection for workers) employment is associated differently to rape and sexual violence than employment that is stable, high pay and high status and provides legal protections for workers; i.e. the '**quality**' of employment, not just employment *per se* may be the pertinent factor. Work by Agarwal and Panda in India on marital violence (Agarwal and Panda, 2007; Panda and Agarwal, 2005), found more consistent results when women owned tangible economic resources (land and/or house). The **ownership of land and/or house** by women correlated to both **reduced risk of violence** in the first instance and with women's ability to exit and remain free from violent relationships.

### 9.3.3 The role of housing

Poor women are also more likely to live in **insecure** rented accommodation or to be marginally housed or homeless, all of which have been found to increase women's vulnerability to rape. Kelly (2007) found the odds of women in vulnerable housing experiencing rape/attempted rape by a known man were **significantly higher** than those of women living in non-vulnerable housing. Walby and Allen (2004) found the odds of women in **social rented housing** being sexually assaulted were **2.5 times higher** than those of women in owner/occupier housing. Kushel et al (2003) found significantly higher rates of rape and sexual violence for homeless and marginally housed women compared to women in the general population, with 32% of women living in such conditions reporting

either physical or sexual victimization in the previous year. Women in **refugee camps** or **temporary camps** set up in the wake of natural or humanitarian disasters are also vulnerable to rape; canvass is easily penetrable and does not provide a safe space for women (MADRE, 2012).

#### 9.3.4 'Survival sex'

A lack of economic resources can force women to have to engage in 'survival sex' in exchange for food, shelter or other essentials (Jewkes et al, 2002). Survival sex practices have been observed in disaster contexts, for example, following the earthquake in Haiti in 2010, it was found that women were **forced to exchange sex for food and medicines** in relief camps (MADRE, 2012). Survival sex is, however, a **routine feature** across contexts and locations, disaster and non-disaster and developed, transitional and developing nations, where women, young people and children are found to routinely be forced to exchange sex for food and shelter because they do not have the economic resources to gain the essential resources they need to survive in alternative ways (Greco and Dawgert, 2007). 'Survival sex' is a phenomenon very close to rape, with a fine line around consent potentially separating the two concepts.

### 9.4 The effects of rape on the economic status of women

It is not only that a weak economic status places women at greater risk of rape; rape and sexual violence impacts also adversely on the economic status of women. It can be a two-way relationship. For example, Estes and Weiner (2001) found **61% of homeless girls reported sexual abuse as the reason for leaving home**. Without access to adequate economic resources, these girls are forced to live on the streets or 'sofa surf' where they are more vulnerable to rape, sexual exploitation and 'survival sex' and Ellis et al (1993) in their study found 50% of sexual assault **victims lost their jobs** or were **forced to quit** after being raped.

Victim-survivors of rape incur **significant out-of-pocket expenses** they could not have foreseen or planned for. For many, this consequence is unaffordable. According to a report by the National Institute of Justice (Miller et al, 1996), the costs of rape and sexual assault for victims can **include**: out-of-pocket expenses such as medical bills and property losses; reduced productivity at work, home, and school; and non-monetary losses such as fear, pain, suffering, and lost quality of life. For someone living in poverty these **costs can be devastating**. For those on the edge of poverty, these costs can push them over the line. Whilst assistance may be available to victim-survivors of rape to cover some of these costs, if such support or **services require money 'up front'**, even if it is later reimbursed, this is simply unaffordable for many.

### 9.5 Best practices

Whilst the evidence for an association between the economic status of women and rape is strong, the **nature of the links is complex**, multi-directional and multi-layered.

Best practices for rape prevention in the context of economic and security policies include:



- The **recognition of the relation** between the economic situation of women and their vulnerability to sexual violence;
- enabling women to access the economic resources required in order to be able to avoid locations, contexts and relationships which place them at higher risk of rape;
- provide for funding for an adequate supply of stable, safe and affordable **housing** and shelter;
- provide for funding of an adequate supply of safe and affordable **transport**;
- ensuring that all necessary **services** to assist victims-survivors of rape are **free at the point of use**; and
- stable, safe employment.

In **emergency contexts**, accommodation in refugee camps for women must be secure and access to food, shelter, medicines and health care should be guaranteed in accordance with the guidelines of the UNHCR (2003).

There are a number of examples of interventions which demonstrate these best practice criteria and at the same time often also assist women victim-survivors of rape by strengthening their economic status enabling them to **avoid high risk contexts**, locations, and relationships thus preventing re-victimisation, and contributing to long-term rape prevention.

## 9.6 Examples of interventions

### 9.6.1 Microfinance

One of the outcomes of microfinance interventions for women is **decreasing rates of marital, family and community violence** as women raise their awareness, confidence, status and contribute material wealth to the household and community (Kristof and WuDunn, 2012). Microfinance interventions provide financial services to micro-entrepreneurs and small businesses which lack access to banking and related services due to the high transaction costs associated with serving these types of clients. There are two main mechanisms for the delivery of such financial services; relationship-based banking for individual entrepreneurs and small businesses; and group-based models, where several entrepreneurs come together to apply for loans and other services as a group.

Microfinance interventions with women, currently **predominately located in developing countries**, usually take the second form. In addition, a common feature of these interventions has been **group-based education and training** for the women in literacy and numeracy, business, health, and their legal and human rights.

#### *IMAGE intervention in South Africa*

Kim et al (2007) performed an evaluation of the 'Intervention with Micro-finance for Aids and Gender Equity' (IMAGE) in rural South Africa. Run by an NGO, the intervention has more than **40,000 active clients**. The intervention works with groups of five women who each serve as guarantors for the other's loans: all five must repay their loans in order to qualify to borrow more credit. Loan centres of approximately 40 women meet fortnightly to repay loans, apply for additional credit, and discuss business plans. The intervention also includes a participatory learning program called '**Sisters-for-Life**' which comprises two

stages: the first provides ten hours of training on; gender roles, cultural beliefs, relationships, communication, domestic violence, and HIV infection and is aimed at strengthen communication skills, critical thinking, and leadership. The second encourages wider **community mobilization** to engage both youths and men. In addition, women deemed 'natural leaders' by their peers are elected by loan centres to undertake a further week of training and subsequently work with their centre to address priority issues including HIV infection and intimate partner violence.

The evaluation study recruited both eligible loan recipients and control participants who were women aged 18 years and older living in the poorest households in each village for comparative purposes. The IMAGE intervention was found to **reduce the levels of past year physical and/or sexual intimate partner violence by more than half** and levels of intimate partner violence were found to consistently decrease in all four intervention villages at follow-up, whereas they either stayed the same or increased in the four control villages. After two years, the risk of past year physical and/or sexual intimate partner violence was still reduced by more than half among the intervention group.

Qualitative data gathered as part of the study supports anecdotal findings from other similar interventions. Reductions in violence appear to be the result of women feeling enabled to:

- **challenge the acceptability** of such violence;
- expect and receive **better treatment from partners**;
- **leave violent relationships**;
- give material and moral **support** to those experiencing abuse;
- **mobilize new and existing community groups**; and
- **raise public awareness** about the need to address both gender-based violence and HIV infection.

The development of such interventions as part of rape prevention strategies is **expanding**: a second evaluation study of a microfinance intervention **specifically design to prevent rape** and to support women victim-survivors of sexual violence by improving their economic well-being is currently underway in the **Democratic Republic of Congo** and is due to report in July 2013 (Bass, 2011).

### 9.6.2 Economic Advocacy

In a report for the Pennsylvania Coalition Against Rape, Greco and Dawgert (2007) identify economic advocacy as a **core requirement** for rape prevention practices and for assisting women victims-survivors of rape. They argue that economic advocacy is already a thread that runs through the fabric of rape crisis advocacy, but is rarely explicated as such and is not yet positioned as centrally in such work as it needs to be.

Economic advocacy is defined as the provision of: information, advocacy and support to expand economic resources and **reduce/eliminate economic-related risk factors** that contribute to sexual violence in the lives of victims-survivors and communities. In centralising the role of economic advocacy, the focus of research work, lobbying for **policy change**, and the range of partners collaborated with is expanded to deal directly with economic issues, such as:

- legal protection for victims-survivors, including early release from leases and **employment protection** if a victim-survivor cannot work in the aftermath of a rape;
- broadening **crime compensation** to cover rent and bills;
- prioritising victim-survivors on **public housing registers**;
- campaigning for affordable, high quality, accessible **childcare**;
- the expansion of safe and affordable housing, shelter and public transport;
- affordable and comprehensive **health care**;
- **minimum wage standards**;
- **training** on the impacts of rape and sexual violence for staff working in public and private assistance programmes and personnel staff in businesses and organisations; and
- designing systems to **take into account** women's and/or victim-survivors likely economic status in relation to accessing and affording important support and services.

### 9.6.3 Education, training and employment programmes

Many services working with victims-survivors of rape, particularly those in the voluntary sector, offer support programmes designed to strengthen women's economic status by increasing her ability to **access and retain quality employment** and thus to achieve a level of economic resources which enable her to **make choices about the context**, location and relationships she operates within. For example, Eaves Housing in the UK runs the Scarlet Centre in London, a 'one stop centre' for women who have experienced rape and sexual violence. As part of the support and recovery programme delivered by the Centre, women can access courses and workshops to **build skills** for 'independent living', including education and training opportunities and skill-building workshops on *Curriculum Vitae* writing, as well as **budgeting** skills and **advice on benefits and housing** (Eaves Housing, 2013).

### 9.6.4 Independent Sexual Violence Advisers

The English and Welsh intervention of Independent Sexual Violence Advisors (ISVAs) supports individual women who have experienced rape or sexual violence and offers, amongst other things, **advice on and help to women** to access, education, volunteering and employment opportunities and skill-building workshops to help improve victim-survivors economic status over the **long-term** (Robinson, 2009). Similarly in the U.S. the SACTs provides education and training programmes (Sexual Assault Crisis Team, 2013).

## 9.7 Conclusions

In this study, economy and development best practices for rape prevention and for assisting women victims-survivors of rape have been extracted from empirical research findings, evaluation studies, expert recommendations and policy documents used in the body of the report to identify interventions, their purposes and what works. Best practices for rape prevention and assisting women victims of rape are those which **strengthen**

**women's economic status** so that women have **adequate economic resources** in order to be able to avoid contexts, locations and relationships in which they are vulnerable to rape and sexual violence. Such practices thus result in decreasing rates of rape.

Best practices criteria include: gendered; systemic; multi-level; core/centralised; appropriately funded; comprehensive evaluation; make a contribution back into the continual development of economy and development practices by making available lessons learnt and highlighting what works best thus adding to the evidence-base.

### 9.7.1 Recommendations

Best practice interventions help to prevent rape and assist women victim-survivors of rape by improving the economic status of women to enable them to avoid contexts, locations and relationships in which they are vulnerable to rape.

A number of recommendations for best practices in rape prevention and assisting women victim-survivors of rape are made:

- **Gendered:** best practice interventions should **recognise and respond** to gendered economic inequality and poverty aiming to improve the economic status of women so that women are better able to avoid relationships, contexts and locations where they are vulnerable to rape. Best practice interventions additionally consider the wider relative economic positions of women and men in communities and societies and seek to **contribute to the overall development of the economic status of a society**.
- **Systemic:** best practice interventions change the wider social, cultural and political landscape to **reduce poverty and embed economic equality**, thus strengthening individual women's economic status and the status of women as a group within communities and the wider society.
- **Multi-level:** best practice interventions recognise that economic status is relative and that the strengthening of women's economic status must consider the links between individuals, their community and **wider society**, to ensure that improving the economic status of women in one sphere is not done in such a way that causes increasing risk to women in different contexts or locations. For example, women's economic status is not uniform, since **gender intersects with other factors** which are associated with poor access to adequate economic resources, such as race (Crenshaw, 1991) or development context (Radford and Tsutsumi, 2004).
- **Core:** best practice interventions should make **economic advocacy** a core function which plays a political role in working with local, national and international public and private service providers and policy makers to ensure that the links between rape and economy and development are understood and that rape prevention is **embedded within economic and development policy** and practices, such as employment and property ownership legislation, funding and provision of housing, transport and childcare, etc.
- **Appropriately funded:** best practice interventions acknowledge the substantial cost to victims-survivors caused by rape and recognise that the requirement to pay 'up front' for services and support is not a socially just model: best practice models for essential services and support programmes for victims-survivors of rape should be **free at the point of use**.

- **Evaluation:** Best practice interventions should build in comprehensive evaluations from the start, including dedicated data collection systems whilst adhering to high standards of confidentiality and ensuring ethical principles for working with vulnerable individuals are met, in order to address the current dearth of evidence-based practice in rape and sexual violence work. This will enable future interventions to be constructed on a robust evidence-based which demonstrates what works whilst highlighting lessons learnt.

These recommended interventions are relevant to both Member States and the EU-level. Additional recommended actions for the **EU-level** include:

- Recognition of the inter-connections between rape and gendered economic inequalities, so that the prevention of violence, in particular rape can be mainstreamed into EU economic policy developments;
- Use of EU structural and social funds to support projects to prevent rape;
- Inclusion of economic assistance to women victim-survivors of rape in the context of humanitarian aid packages.

## 10 Culture, media and education

### KEY FINDINGS

- The propagation of misleading myths about rape is damaging to victim-survivors in general and especially when they attempt to seek justice.
- There are innovative interventions in culture, media, and education to change public understandings of the nature of rape.
- Projects to change responses to rape include: the development of projects to get bystanders positively involved; the use of new media to engage counter-hegemonic meanings; and the development of educational programmes on healthy relationships in schools.

### 10.1 Introduction

Interventions in media, culture and education to prevent sexual violence range from individual programmes to **change individual behaviour** to **broad political interventions** into the social and economic domains to change societies. To challenge and address the causes of sexual violence, best practice interventions should be cross-cutting and organised across several different levels at the same time. The ecological method sets out interventions on four different levels (Krug et al, 2002; Loots et al, 2006): individual programmes tend to **encourage positive attitudes and behaviour** in children and young people and can change the behaviour of individuals who have already become violent; relationship approaches are used to **influence interactions inside families and negative influences from peers**; community-based efforts can stimulate community action or focus on the **care and support of victims**; finally, societal approaches focus on economic conditions, cultural norms, and broad social influences such as mass media (Krug et al, 2002). Interventions on sexual violence in media, culture and education have tended to focus on individual and relationship interventions and underemphasized community and social strategies (Krug et al, 2002).

### 10.2 Culture

#### 10.2.1 Increasing the visibility of sexual violence

A first step is to increase the visibility of sexual violence in society. Although rapes of women by gangs of men are committed in countries as diverse as **South Africa, Papua New Guinea** and in parts of the **USA** (Watts and Zimmerman 2002), publicity to such reports of rape are less common. However, recent high profile cases of sexual violence, such as the gang rape and subsequent death of a 23 year old woman in **India** and the exposure of sexual exploitation of girls by Muslim men in the **UK**, have **increased the visibility** of violence against women and provided an opportunity to explore how best to challenge the subject at a cultural level.

Indian activist Seema Karzi has welcomed the protests calling for institutional remedies but argues for the **need to challenge entrenched and pervasive cultures of sexual violence against women**: 'The denial of equality and dignity to women in an

inegalitarian, caste-ridden and patriarchal society, imbued with culturally dominant ideas of violent masculinity, together with a **wider culture of impunity** regarding sexual violence against women in general, cannot but translate into violations of women's bodily and sexual integrity' (Karzi, 2013). Changing given cultural and societal norms (be they at the state, community or individual level) is crucial for interventions to prevent sexual violence.

### 10.2.2 Interventions that challenge social and cultural norms

Some 'promising practices' are being developed and evaluated that challenge the social and cultural norms that help to perpetuate sexual violence. These focus on the **prevention** of rape.

They include social marketing campaigns to engage bystanders to challenge rape and other forms of violence against women; and to present alternative models of masculinity for men than that of machismo.

Other projects, such as the London based **EMPOWER**, work to raise awareness on specific forms of sexual violence. EMPOWER is a support programme addressing experiences of sexual violence and exploitation of **young women's** (aged 11-18), as a consequence of their involvement in gang activity. The young women receive support to address risks, improve their sense of identity, **confidence and self-esteem**, to **develop resilience** and the capacity for change.

### 10.2.3 Intervention on family level

There are interventions that target the family level to ensure family members and peers have **tools to intervene**. Projects devised to grow strong communities to prevent domestic violence recognise that this can only happen when people (neighbours, friends, family members) can deal with real life situations of sexual violence.

### 10.2.4 Intervention on community level for a culture of safety and respect

Community and culturally based approaches and interventions are less common than individual approaches (Locket et al, 2013). The latter form of intervention has the purpose of enabling/making individual perpetrators and victims **re-examine their attitudes** towards violence and awareness raising activities, rather than engaging whole communities around social norm change (Locket et al, 2013).

Alternatively, Krug et al argue it is crucial that interventions empower communities, because many of the most important solutions will have to be implemented locally (Krug et al, 2002). However, there remains a **significant challenge** to create a **sense of ownership** and **responsibility for addressing violence** at the community level.

A successful community mobilisation project to engage '**men as allies**' and encourage intervention is *The Bell Bajo* or **Ring the Bell** advert campaign developed by Breakthrough in **India** and the **USA**. It shows how bystanders can make **small interventions** when they suspect domestic violence. In one advert a man hears his neighbour shouting at his wife so rings the doorbell to ask for some milk. This intervention works on a number of levels that have been proven to be effective – it provides practical advice on how to intervene in situations that could escalate to sexual violence and also **strengthens the cultural norm of safety and respect**.



Research into the attitudes of college graduates in the **USA** suggested 'that an important first step may be to increase men's **accurate perceptions** of women's and, more so, other men's attitudes and behaviours toward sexual violence against women through the **social norms approach**. Then, in conjunction with other individual and environmental interventions, men may be empowered to act in congruence with their values' (Fabiano et al, no date). The contribution of 'bystanders' to the prevention of rape and other forms of violence could be significant.

## 10.3 Media

While most democracies uphold the **freedom of the press** as a value, **some forms of regulatory practice** have developed where excess has a detrimental effect on rape victims-survivors or in promoting sexual violence. Media regulation has been developed to try to offer anonymity to rape victims in court cases and to restrict the circulation of some forms of pornography, for example involving children.

### 10.3.1 The role of the media for perpetuating a rape culture

Some research suggests the media perpetuates a 'rape culture', a concept which describes a culture where rape and sexualised violence is normalised and sometimes condoned (Burt, 1980). Norms prevalent in rape cultures **blame and sexually objectify the victim rather than the perpetrator** (Suarez and Gadalla, 2010). Dominant cultural attitudes may facilitate a '**continued tolerance** of aggression toward women and thus the occurrence of sexual violence' (Iconis, 2008). Primary interventions in the forms of both **media regulation** and **educational programs** in schools have been suggested as a way to change attitudes, cultural norms and to empower young girls, with the ultimate goal to prevent and reduce sexual violence and rape (EVAW et al, 2012; EVAW, 2012).

### 10.3.2 Reproducing detrimental stereotypes of violence against women

Feminist research and advocacy have long been concerned with the media's role and responsibility in reproducing **gender stereotypes** (Gill, 2007) and the way in which the popular press seeks the sensational to keep or increase its readership (Soothill and Walby, 1991). Debates on preventing sexual violence through interventions in the media (Buiten and Salo, 2007; EVAW et al, 2012; Ferguson, 2012; Machisa and Van Roos, 2012) have focused around the role of the media in **sexual objectification**; its normalisation of **misogyny** and **violence against women** by **pathologising individual male perpetrators** or by **obscuring the role of perpetrators** (Buiten and Salo, 2007); its sensationalistic reporting which **trivialises the experiences of women** victims of violence (Machisa and Van Roos, 2012); and the **role of pornography** in men's attitudes towards violence against women (Hald, Malamuth and Yuen, 2009). The normalisation of the objectification of women and violence against women indicate that the media sector will not adapt to a gender equal or gender sensitive approach without **huge political or public intervention** (Larasi, 2012).

#### *Experiences in the UK*

In the UK, recent debates around **sexism in the media** were fuelled by the Leveson Inquiry, a judicial public inquiry into the culture and practices of British media, set up by the government after the News of the World phone hacking scandals in 2011 (Leveson, no date). During this Inquiry, women's organisations argued that **newspapers glamorise, sexualise and, occasionally, eroticise violent crimes** against women and girls, and

that this in turn normalise rape. A civil society study found **widespread sexual objectification of victims** and 'blame the victim' attitudes and 'consistent, systematic sexism' throughout British media (EVAW et al, 2012). Media reports on crimes of violence against women were found to not only be **directly inaccurate**, but they **uphold stereotypes** and **false attitudes towards violence** against women and girls. The study suggests interventions including a **new press code** with clear rules on sexist discrimination and the setting up of a **complaints body** which includes experts on equality. The setting up of a **new media watchdog** is also suggested, a watchdog able to intervene in discriminatory media reporting and which reflects the UK **equalities legislation**. The purpose of the intervention is to **prevent normalisation of rape**, and the spread of what women's organisations have labelled a 'rape culture'.

### 10.3.3 Anonymity for rape complainants

The experience of rape victims during trials of alleged perpetrators is affected by the images and information presented in the press. In order to reduce the impact of the process on the victim, there have been attempts to prevent her from being publicly revealed through regulation of the press. However, the issue of anonymity represents a tension between the competing rights of the individual to privacy and the freedom of the press. The regulation of the media to provide anonymity for complainants in rape cases is practiced in many countries, either through **legislation** (e.g. **Australia, Britain, India, New Zealand, Sweden**) or through **policy** (e.g. **Canada**, most of the **US**, with the exception of Florida and South Carolina) (Elliot, 2012), and research shows there is **strong public support** for non-disclosure of victims' names (Denno, 1993). Once a complaint has been made, the claimant is often automatically entitled to lifelong anonymity. The purpose of the intervention is to **avoid re-victimisation**; to remove the distress rape victims suffered when their names and the personal details of their lives were revealed in the press; and to **increase reporting rates**, since publicity is often understood to be a deterrent to women reporting rapes. Further, reporting rates increase with interventions that **shift the focus away from the victim-survivor and towards the behaviour of the defendant** (Clay-Warner and Harbin Burt, 2005).

## 10.4 Education

### 10.4.1 Men and boys as agents of change

Interventions to prevent sexual violence include educational programs for male children and youth. Boys' attitudes towards violence against girls have been identified as part of the problem of rape, and involving boys (and men) in educational programs and in schools to prevent rape is identified as part of the solution (see Flood, 2011). Boys and men are not only perpetrators of violence, but potentially 'agents of change, participants in reform, and potential allies in search of gender justice' (Connell, 2002).

Violence prevention education delivered in schools and universities in particular are evaluated as having **positive effects** on boys' attitudes towards violence against women (Whitaker et al, 2006) although more evaluations are called for (Lonsway et al, 2009). Male pupils and students who have attended rape education sessions are **less likely to uphold rape myths** than those who have not (Morrison et al, 2004). There is some evidence to suggest that various educational programs have not only reduced men's (self-reported) likelihood to commit rape (Lonsway et al, 2009) but men's actual sexual violence as well (Foshee et al, 2004; Foubert, Newberry, and Tatum, 2007). Despite this, **surprisingly few**

**educational rape prevention programs** are explicitly directed towards boys or men, only 8% in the US (Morrison et al, 2004).

### *Criticisms of educational programmes for boys*

Some critics of such educational programmes suggest that targeting **college or university students** does not constitute primary prevention since they target a population that is **likely to have already experienced forced sexual violence** in some form since sexual violence occurs in middle school and secondary school (Hickman, Jaycox and Aronoff, 2004). Educational programs targeting college and university students should be seen rather to focus on repeat rather than primary prevention.

Other forms of criticism against educational programs focusing on boys or men are based on the fact that economic resources are limited; **the focus on boys and men take away resources and focus from the women victim-survivors**, and the very effectiveness of such programs has been questioned (Day et al 2009).

### **10.4.2 Make sexual violence at school visible**

Empowering girls through enrolment in public education (as well as reducing or prohibiting early marriage and economic empowerment) (Barker, 2006), as prescribed by the Millennium Development Goals (2000) is seen as a vehicle for economic development. However, the **quality** of that schooling and **safety and security at school** are **rarely in focus** (see MDGs). **School grounds** and the **route to school** are two sites where **young girls are likely to become victims** of sexual violence and abuse (Barker and Ricardo, 2005; EVAW, 2012; Morrison, Ellsberg and Bott, 2007).

Violence against girls at school and on the way to school has only recently become recognised as a **widespread problem** (see Dunne, Humphreys and Leach 2006 for a worldwide literature review on gendered violence in schools). When it comes to intervention strategies, the main identified problem appears to be the **lack of recognition that the violence occurs** in the first place; it becomes invisible (Dunne, Humphreys and Leach, 2006).

Policy on school discipline or codes of conduct for teachers are not implemented; prosecutions of teachers who sexually assault or rape students are rare, and the main **punishment for teachers** found guilty of sexual abuse is being transferred to other schools. Here, the **lack of political will**, heavy and slow **bureaucratic and legal systems** explain the lack of change (Human Rights Watch, 2001; Leach et al, 2003).

### **10.4.3 Challenging rape myths**

Rape myth acceptance can be thought of as a **set of cultural views on rape and sexual relations that shift blame for rape from the rapist to the victim**. These include the myths that rapists are usually **solitary strangers**, that women cannot be raped if they did not **want it**, that women dressing in a culturally unacceptable way are 'asking for it' and that 'date rape' is not rape.

The beliefs are held by **both men and women** and relate to issues of denial of rape victims that they have been raped, as well as denial by the offenders that they are rapists. Numerous studies have shown a significant and **high correlation between rape myth acceptance and rape proclivity** (Check and Malamuth, 1983; Bohner et al, 1998; Bohner et al, 2005). The purpose of the intervention is therefore to reduce rape acceptance among

young people (secondary and tertiary education), with the intention of reducing real rape events.

Programmes are generally didactic, i.e. in the form of video and lecture presentations, although workshops and interactive theatre is sometimes used. Efficacy has been assessed by psychological attitude measures, such as the Illinois rape myth acceptance scale (Payne, 1999), the General attitudes towards rape scale (Larsen and Long, 1988) and the RAPE scale (Bumby, 1988). However, the effects of the programmes are debated. Based on the **US** experience, it can be said that school based programmes need more careful design, with measurement on attitudes akin to the college based work. There is evidence that **single sex programmes** work better than mixed sex programmes in a college setting. Education programmes can be effective in some circumstances in reaching their specific goals.

Flores and Hautlaub (1998) examined numerous previous studies on programs to reduce rape myth acceptance amongst males. The results showed that a variety of interventions, including human sexuality courses, workshops, video interventions all appear to be successful for reducing rape myth acceptance, but benefits are sometimes **short-term**. Brecklin and Forde (2001) carried out a meta-analysis of the characteristics of college rape education programs most likely to **increase effectiveness**. They found that men in mixed gender groups had less behavioural change than men in single sex groups. Anderson and Whiston (2005) carried out the most comprehensive meta analysis of **North American** college education programs examining 69 **US** studies. The meta analysis found that rape attitudes, rape-related attitudes, rape knowledge, behavioural intent and incidence of sexual assault all had significant effects. The largest effects were found for increases in rape knowledge and rape attitudes. No significant changes were found for rape empathy and awareness behaviour.

Longer interventions were found to be more effective than shorter interventions. Cornelius and Resseguie (2007) review the literature on education programs for the prevention of dating violence, which encompasses programs delivered mainly at high school and examining both primary programmes (stopping violence before it occurs) and secondary programmes (stopping/ exiting violence). They found that although numerous programmes had been introduced, in general they failed to assess participants on attitudinal scales, and many studies instead 'are simply assuming that changes are occurring' (Cornelius and Resseguie, 2007). Fay and Medway (2006), however, found that attitudes to rape myth decreased in their study of students transitioning to high school with the use of a specific activity program. Most recently, Malo-juvera (2012) found that use of a young adult fiction book 'Speak' (Anderson, 1999) reduced rape myth acceptance in a high school group compared to the controls.

## 10.5 Conclusions

There are significant interventions into culture, media and education in order to prevent rape. The intention of the interventions is to **reduce the acceptability of rape** found in 'rape myths' and 'rape culture', to **encourage bystanders** to challenge potential perpetrators, and to **reduce the additional harm** to victims that victim-blaming attitudes can produce. The role of 'bystanders' is newly emerging as important; it provides a focus of activity in addition to those on the perpetrators and victim-survivors.

### **10.5.1 Best practice examples**

There are two examples of best practices at 9.10 and 9.11: 'Sexual relations education: Southampton talking about relationships' in the UK; and '#talkaboutit: talking about consent and coercion' in Sweden.

## 11 CASE STUDY EXAMPLES OF BEST PRACTICES

### KEY FINDINGS

The following nine examples of best practice are reported.

- Comprehensive rape crisis services
- Coordination and shelter
- Coordinated community responses
- Health-based services in a conflict zone
- Health-based services in a non-conflict zone
- Changing the law
- Identifying potential perpetrators in cyber-space
- Special courts
- Sexual Relations education

### 11.1 Introduction

This chapter presents nine selected case study examples of best practice in particular types of intervention. None of these constitutes a comprehensive programme; rather they are particular interventions that contribute towards a comprehensive programme. Best practice in the sense of an overall programme to combat rape is discussed in Chapter 2, which is focused on planning and coordination, where the identification of the full range of necessary interventions is addressed.

Chapter 1 (sections 1.7, 1.8 and 1.9 above) discusses the methods used to evaluate the most effective ways of preventing rape and assisting victims, which are summarised here. The concept of 'best practice' is developed by EIGE (2011) to mean practices that are **innovative**, are proven to have **made a difference**, and are **models for development elsewhere**. The field of violence against women has adopted six points of intervention, the 6 p's:

- Perspective (of gender equality)
- Policy (integrated strategy and partnership between the agencies involved)
- Prevention (of rape)
- Provision (of services to assist women victim-survivors)
- Protection (of the victim)
- Prosecution (of the perpetrator)

The selected case studies illustrate the significance of these six points for best practice in preventing rape and assisting victim-survivors. The criteria for the quality of interventions can be further developed in relation to the following five points:

- **Victim-centred:** the intervention is focused on the needs of the victim, requiring professionals to adjust their practices to sustain this priority, ensuring that professional priorities do not lead to secondary victimisation.
- **Prevention and assistance overlap:** the prevention of rape involves reducing the impunity of the rapist, the effective prosecution of which requires supporting the victim-survivor.
- **Co-ordinated and collaborative:** a multiplicity of actions are required that are in need of coordination if they are to be most effective, though there is more than one way to ensure this coordination, including national strategic planning, local community coordination, inter-agency working, and victim-centred 'one stop shop' collaborative work-teams.
- **Gender-sensitive:** rape is gendered, and responses to victims need to be sensitive to this; the inclusion of gender experts, women's advocacy organisations, and victim groups in the devising of services is necessary to achieve this.
- **Expert:** the best interventions have been developed as a result of the accumulation of expertise, which requires: systematic collection of data and its evaluation; training of professionals; and the development of centres of expertise that can inform mainline practice.

The range of policy interventions includes:

- Planning and coordination, including gender balance in decision-making;
- Specialised services for victim-survivors, from counselling to health care to assistance with livelihood;
- Law and the criminal justice system to remove impunity from perpetrators;
- Economic inclusion, both to prevent, and to assist victim-survivors;
- Culture, media and education to engage with rape myths.

The practices reported in this chapter are illustrative of best practice across the range of policy domains and from around the world. They are as follows:

- Comprehensive rape crisis services;
- Coordinated and integrated services;
- Health-based services in a conflict zone;
- Health-based services in a non-conflict zone;
- Coordinated community responses;
- Integrating a better understanding of rape within law;
- Identifying potential perpetrators of rape;
- Specialised sexual offences courts;
- Sexual Relations education;
- Talking about consent and coercion.



## 11.2 Comprehensive Rape Crisis Services: Sexual Assault Crisis Team (SACT) (USA)

By Jude Towers

### 11.2.1 Background

Specialist services to support victim-survivors of rape are a necessary part of the best practice response, with the potential to mitigate the long-lasting harms inflicted. In supporting the victim-survivors these services also act to prevent rape, through supporting the victim in challenging the impunity of rapists through the criminal justice system.

There are a variety of components to these services and their coordination so that the victim-survivor receives the best support is a complex matter. The Sexual Assault Crisis Team (SACT) practice is an example of best practice in the provision of these services.

### 11.2.2 Characteristics

Sexual Assault Crisis Team (SACT) is a **rape crisis shelter intervention** in the US which provides residential based support **for victim-survivors of rape** and sexual assault, including those in the immediate aftermath of a rape; those coming to terms with historic rape experiences, including as a child; and those who have returned to the area to testify at trial. SACT has been identified as an example of best practice by a 2011 resource sharing project for the National Sexual Assault Coalition (reshāp).

The shelter was established in 2002 and serves around 20-30 victim-survivors in its shelter overnight every year. Unlike many domestic violence shelters, all residential accommodation is in solo rooms to accommodate the specific need for privacy of many rape victim-survivors. Clients of the shelter are also less likely to have young children with them compared to those staying in domestic violence shelters. Importantly, the **board which oversees SACT is made up of people from the communities** it serves.

The average stay in the shelter is 3–5 days, though individuals who are looking for new housing options or have other needs might stay longer. There is no limit to the time SACT permits a survivor to stay; as long as they are working towards their goals they can keep their residential place (Bein and Hurt, 2011).

As well as residential accommodation, SACT provides a **24hour sexual assault hotline** answered by **trained advocates**, and a range of advocacy services for both residential and non-residential clients, including: hospital advocacy; legal advocacy; attorney consultation through a specialist law project; education, training and support programmes; information and training on date rape, stranger rape, surviving incest, inner child workshops, ritualized abuse, different types of harassment, support groups, cults and criminal activity; and school and community safety programmes (SACT, 2013).

SACT is a **non-profit organisation** staffed by personnel expert in supporting victim-survivors of rape and sexual assault. Recipients are female victim-survivors of rape and sexual assault and male victim-survivors of rape and sexual and domestic assault. As well as serving the local community, referrals to SACT have also come from across the country, including; California, Connecticut, New York and Boston.

### 11.2.3 Objectives

The goal of SACT is to **provide comprehensive services** to victims-survivors of sexual violence, including emergency shelter and transitional housing for female victims of sexual violence and male victim-survivors of sexual or domestic violence, legal and medical advocacy, crisis services, support groups, and educational forums. To address the problem of sexual violence in the community, these services are designed to meet the needs of both female and male victims-survivors and services are also available to victims-survivor's non-offending family members and support networks (SACT, 2013). SACT's vision is that 'the **shelter serves every non-offending human being**' (SACT, 2013).

SACT is designed to provide immediate support to victim-survivors of rape, including **accessing health and legal services**; to **re-build victim-survivors self-esteem** and self-confidence; and to **come to terms with what has happened** to them no matter when the rape occurred (i.e. SACT works with victim-survivors in the immediate aftermath of a rape and with those who were raped longer ago, including those adults who experience rape or sexual abuse as children). In addition, SACT provides training to help prevent rape in the future by enabling victim-survivors to better understand the nature of sexual violence and to develop access to independent living through education and training.

### 11.2.4 Innovation

#### *Specialised expertise in assisting victims of rape*

Prior to the opening of the shelter, SACT was already providing outreach services, but was having difficulty finding appropriate shelter for victim-survivors of rape. Whilst the local domestic violence shelter would certainly take in female sexual assault victim-survivors, the shelter's massive workload prevented the development of **specific services to support rape and sexual assault victim-survivors in their recovery**. SACT already had this expertise from running the 24hour hotline and outreach services for victim-survivors of rape and therefore, the shelter was conceived of to fill **an identified need** utilising the knowledge and skills already available in the local rape and domestic and sexual assault support community (Bein and Hurt, 2011).

#### *Ensures privacy and personal safety*

The shelter ensures issues of privacy and personal safety are **taken very seriously**. For example, they recognized that the shelter would need to offer bathrooms and showers that individuals could use privately and that shelter residents would need to be able to lock their doors and be alone whenever they chose. All bedrooms are designed for solo occupation, unless there is a non-offending partner whom the survivor chooses to accompany them. Whilst many of these requirements are similar to those for domestic violence victim-survivors, other 'rules' which work well in these types of shelters need to be adapted to support victim-survivors of rape.

#### *Services offered to female and male victims as well as to family members*

In keeping with its vision (to serve every non-offending human being) SACT provides residential services to male victims of rape, sexual and domestic violence, as well female victims of rape and sexual violence. This enables SACT to **address a gap in local provision** because the local domestic violence shelter was not able to house men, so male clients were being housed in hotel rooms which did not enable a good model of support and recovery to be delivered and created additional concerns around client safety and client-advocate meetings (Bein and Hurt, 2011).

SACT also houses **family members** of victim-survivors who have come to town to provide support in the immediate aftermath of a rape, as well as victim/survivors who are returning to town to deal with legal processes and trials.

#### 11.2.5 Coordination and cooperation

SACT works collaboratively with organisations across the country, which enables it to meet the needs of diverse range of recipients. For example, through collaborative work SACT provides specialized services to the **transgender community** and **safe housing for bias/hate crime victims**; through collaboration with the local children's advocacy centre, for **child victims and non-offending parents or guardians** and receives referrals from, mental health agencies, therapist, other community programs such as the Council on Aging, as well as other shelters and network programmes when they have reached capacity.

SACT also provides shelter and services for victims-survivors and the professionals who are involved in the work of stopping **human sex trafficking** including law enforcement, attorneys, and both state and federal professionals.

#### 11.2.6 Good practice

In accordance with the EIGE criteria, SACT is not only **innovative** but also **transferable** to other setting where there is an identified need for expert rape-specific residential shelter interventions and where **coalitions** can be developed which incorporate expertise on shelter-based interventions and working with victim-survivors of rape.

SACT has been identified as an example of best practice in shelter-based interventions for victim-survivors of rape by the National Sexual Assault Coalition Resource Sharing Project (no date). Best practice criteria are the generic features found by scrutinising the SACT intervention which aims to assist victim-survivors of rape through the provision of **safe and supported residential accommodation** whilst also contributing to rape prevention by **educating and empowering women and men** to recognise and resist rape and sexual abuse<sup>3</sup>.

SACT can be considered a best practice case study for a number of reasons:

- Evidence shows that safe and secure shelter in the aftermath of a rape is essential for victim-survivors. SACT addresses this need by providing shelter which is **specifically designed** to meet the needs of victim-survivors of rape and sexual assault;
- SACT was developed and established to **respond to identified unmet need** for specialist residential shelter for victim-survivors of rape and sexual assault;
- SACT is **collaborative**, working with the local domestic violence shelter and draws on the knowledge and expertise of its outreach arm;

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<sup>3</sup> In this report, best practices for rape prevention and for assisting women victim-survivors of rape through shelter-based interventions like SACT have been extracted from a review of best practice shelter and sexual violence interventions (Bein and Hurt, 2011) for the National Sexual Assault Coalition Resource Sharing Project (National Sexual Violence Resource Centre (no date). The National Sexual Assault Coalition Resource Sharing project was created to help (US) state sexual assault coalitions across the country access the resources they need in order to develop and thrive. The project is designed to provide technical assistance, support, and to facilitate peer-driven resources for all state-wide sexual assault coalitions and is funded by the United States Department of Justice, Office on Violence Against Women (National Sexual Violence Resource Centre).

- SACT is **multifunction** providing safe shelter for victim/survivors but also providing access to a comprehensive range of education, training and support programmes designed to enable residents to identify, work toward, and achieve goals in order to move on from the shelter accommodation; and
- SACT utilises its **expert knowledge** in working with victim-survivors of rape and sexual assault in order to establish and run the residential shelter in such a way which specifically identifies and addresses the needs of victim-survivors of sexual violence.

### 11.2.7 Recommendations for future such projects

Based on this case study and the best practices criteria that have been extracted from the research, a number of recommendations are made for future development and implementation of shelter-based rape prevention projects:

- ⇒ Interventions should be led from the needs of the victim-survivor  
Projects should address an identified need for victim/survivors of rape which is not being met in that location or context.
- ⇒ Assistance should include a range of functions  
Interventions to assist rape victim-survivors should address crisis intervention, advocacy, support and accessing other services and/or agencies such as health and criminal justice.
- ⇒ Outreach  
Best practice interventions reach out beyond the immediate environment through inter-agency relationships to help develop or facilitate additional resources such as 'safe lists' or accreditation schemes for landlords and organisations/business who install locks and other security devices.
- ⇒ Interventions require expert knowledge  
Expertise is requested in dealing with the needs and supporting of victim-survivors of rape across a range of contexts, covering recent and historic experiences of rape; assistance for adults as well as children; dealing with individuals with chronic mental health or substance abuse or homelessness problems; rape within intimate partnerships, within the family, or in the course of working in the sex industry, including having been trafficked for work in the sex industry.  
  
This includes specialist expertise in the issues concerning rape; specialist professional knowledge; and gender expertise.
- ⇒ Cooperation and collaboration with other agencies  
Assistance to women victim-survivors of all forms of gendered violence should be ensured by collaboration across agencies with different objectives so that expertise is shared and joint services are, where appropriate, developed and delivered.

Best practice interventions should incorporate input and expertise from a range of agencies, including health, criminal justice, housing, local government, landlord-tenants, unions, and women's organisations. Inter-agency sharing and strengthening of expertise, knowledge and skills makes the search for help less burdensome for the victim-survivor.

⇒ Evidence-based

Best practice shelter-based interventions should be designed and implemented with reference to **what has been demonstrated to work** and avoid what has been shown to be detrimental to achieving the outcomes and overall aims of/for the intervention. Best practice interventions should therefore build in **comprehensive evaluations** from the start; this will require dedicated data collection systems which enable the aims of evaluation to be comprehensively assessed whilst adhering to high standards of **confidentiality** and ensuring **ethical principles** for working with individuals who have been subject to rape or sexual violence are met.

### 11.3 Coordinated and integrated services: the integrated rape crisis service in Yarrow Place, Australia

By Suzanne Franzway and Bec Neill

#### 11.3.1 Background

The coordination of responses to rape is an important part of the delivery of best practice services. The best practice example, the integrated rape crisis service in Yarrow Place, Rape and Sexual Assault Service, South Australia, is presented against the process of development of coordinated and integrated services.

More than thirty years of **feminist campaigning** (Carmody, 1992, 2009) has done much to improve legislation, respect for victim-survivors of rape, establish support services with feminist perspectives and develop education programs for professionals working in the field (for example, police, legal services, health workers).

A rape crisis group and a voluntary counselling phone service were first set up in Melbourne in 1973. Rape crisis centres and women's refuges were established in most large cities. They were supported by **some funding from state and federal governments**. More recently, services have been mostly funded through governments' health portfolios. A number of **specialist services** have been established to respond to sexual assault and family and domestic violence (Carmody, 1992; Olle, 2005). These services accumulated evidence for the development of campaigns and to inform the improvement of support practices.

Gains in policy and service provision came under attack with the election of a conservative federal government (1996-2007). Phillips (2008) argued that women's organizations and the politics of social policy were directly challenged by a hostile, anti-feminist context and a neo-conservatism that denied gender in its approaches to violence against women. Neo-liberal social policies **shifted focus to the individual and their responsibility for risk avoidance** (Culpitt, 1999; Hogg and Brown, 1998; O'Malley and Sutton, 1997). The capacity of Australian women's policy interventions was undermined as government agencies were restructured, resources severely cut and women's advocacy organizations

were excluded from policy governance at the national level (Chappell, 2002; Sawer, 2002; Summers, 2003; Hamilton and Maddison, 2007). The **UN Committee on the Elimination of Discrimination Against Women** reported an apparent reversal in Australian women's policy, particularly in relation to gender equity and human rights for women. In addition, the Howard federal government refused to sign the protocol to CEDAW.

The change of government at the federal level in 2008 to a less socially conservative leadership allowed for renewed effort at national level. **Sexual assault services and domestic violence services were extended**, working with other government and non-government agencies to provide flexible, innovative, inclusive and integrated services.

The *National Council to Reduce Violence against Women* produced the Report "Time for Action National Plan" based on extensive consultation (Australian Government, 2009). It recommends a series of strategies across six fields for improvement, described as 'outcome areas'. These include

- **safety** in the whole community;
- access to appropriate high quality **services**;
- the legal system to **treat women with dignity** and **hold the perpetrator accountable** for his behaviour;
- the perpetrator to accept **responsibility** for changing his behaviour and **preventative** measures to be available to ensure he does not repeat his violence;
- the success of the Plan of Action hinges on the success of the sixth outcome area, that the **entire system joins seamlessly and all its parts work together**.

The National Plan provides policy settings and standards for State and Territory agencies to establish their own programs and services.

However, despite these considerable efforts little **has changed in terms of public perception and community attitudes** towards violence against women and rape in particular. One reason for this is that the past exercises an intense pull on the law in a range of ways. Myths about sexual assault remain prevalent within Australian culture (Friedman and Golding, 1997; Xenos and Smith, 2001).

### **Data collection**

A strong knowledge base has been built. There have been **specific national surveys** of women's experiences of violence undertaken by the Australian Bureau of Statistics (ABS) and published in 1996 and 2006 (ABS, 1996; 2006). The two ABS safety surveys together with the survey conducted as Australian Component of the International Violence Against Women Survey (Mouzos and Makkai, 2004), inform significant aspects of research about sexual violence across a range of research disciplines.

Australian research suggests that **one in five women and one in twenty men** over the age of 18 have been '**forced or frightened into unwanted sexual activity**' across their lifetimes, many of them having experienced coercion when aged under 16 (de Visser et al, 2003: 200). A high proportion of sexual assaults against women are perpetrated by male intimate partners (Heenan, 2004).



The production of the **National Standards of Practice Manual for Services** Against Sexual Violence developed in consultation with over 80 services throughout the country was a milestone in 'represent[ing] the first Australian effort to **document the nature of the professional response** to which women, children and men are entitled following sexual violence' (Dean, Hardiman and Draper, 1998: i).

### *Aboriginal women*

Aboriginal women argue it is inappropriate and oppressive to universalize women's oppression and that the **complex conditions for all women** must be confronted if policy is to be relevant across the country (Pettman, 1992; Behrendt, 1993; Lake, 1999; Phillips, 2008; Moreton-Robinson, 2002). At the same time, evidence suggests that **sexual assault of Indigenous women** by both Aboriginal and non-Aboriginal men **is endemic** (Lievore, 2003).

Various task forces and inquiries commissioned by state, territory and federal governments have yielded qualitative information about **sexual and family violence** through consultation with Indigenous women and organisations involved in their welfare. In the last decade, attention has shifted to focus on **child sexual assault** with the Mullighan (2008) inquiry conducted on Anangu Pitjantjatjara Yankunytjatjara, a large Aboriginal local government area located in the remote north west of South Australia. The Wild and Anderson (2007) report was dramatically adopted in the last months of the Howard federal government to justify highly intrusive interventions into Aboriginal communities in the Northern Territory in the name of child protection which were retained by the incoming Labour federal government.

### *Changes in the law*

In the last thirty years, there have been major changes to the law concerning sexual offences in every state and territory. Australian law is founded in the English common law tradition. Campaigns to reform rape laws sought to **criminalise rape in marriage** (first in New South Wales in 1981) (Lake, 1999: 241) and to **redefine 'lack of consent'** claimed as a first in the common law world (Scutt, 1998). In 1981 the law on rape was extended to include rape in marriage.

The law relating to adult sexual offences has moved a long way from its history in a legal tradition that saw women as the property of their husbands or fathers, and treated rape as a violation of male property rights. The modern law of rape focuses much more strongly on sexual autonomy. As **definitions of rape** were expanded with rape law reform, the term sexual violence became more common in the research literature as well as in policy development (see Dean et al, 1998; Rowntree, 2010).

Legal changes to laws and judicial processes on rape and sexual assault in the state of **South Australia** were proclaimed in **December 2008** (South Australia 2013). These changes aim to **increase consideration for victims** during the judicial process. Sexual offences committed since this date will be prosecuted under the Criminal Law Consolidation (Rape and Sexual Offences) Amendment Act 2008. Offences committed prior to the legal changes will be prosecuted under the Criminal Law Consolidation Act (Sexual Offences) 1978. The laws have been strengthened to **provide a clearer definition of offences** and what constitutes consent. The reforms require a person's agreement to sexual activity to be free and voluntary. Rape is also defined as a situation in which a person withdraws their consent after initially agreeing to sexual intercourse and the other party continues regardless. Courts will also have to make special arrangements for victims of rape and sexual assault giving evidence.



### ***Low reporting and conviction rates***

However, convictions have **not risen above 3.1 per cent of reports** in any year in the last decade (Heath 2005). These figures are all the more disturbing since at least 85 per cent of sexual offences are never reported to the police (McLennan, 1996; Cook, David and Grant, 2001; de Visser et al, 2003; Lievore, 2003).

Low reporting and conviction rates indicate the **limits on the capacity of the law to address rape and sexual assault** (Daly et al, 2003). Alternative models have been proposed. In particular, '**restorative justice**' approaches are being examined for their applicability to sexual assault and domestic violence. These approaches bring together people who have been affected by criminal activity and aim to achieve a reintegration of the offender into the broader community. Restorative justice processes take a large number of forms with widely varying relationships to usual criminal justice processes (Stubbs, 2004).

Evaluation of **family conferencing** of sexual offences committed by young people in South Australia has shown that while a substantial proportion of offenders whose cases go to court are never held responsible for their conduct, family conferencing may produce better outcomes for victim-complainants (Daly, 2011). Family conferences resulted in more apologies to victim-complainants as well as more undertakings to do community service and more undertakings to participate in therapeutic counselling from offenders than court processes. By contrast, the few custodial sentences imposed in court were almost all suspended (Daly et al, 2003; Daly, 2004). However, critics question whether restorative justice approaches adequately address power imbalances and provide safety for victim-complainants (Stubbs, 2004). While appropriate restorative justice processes may provide a valuable alternative choice within the context of the criminal justice system, the current failures of the criminal law still need to be effectively addressed. (Heath, 2005: 6).

Every jurisdiction has created distinct legislation on sexual offences. As a result, Australia offers significant opportunities to consider which laws work most effectively and why (Heath 2005). Most Australian jurisdictions have also undertaken evaluation of this legislation (Heenan and McKelvie, 1997; Stubbs, 2003).

#### **11.3.2 Characteristics**

The Yarrow Place Rape and Sexual Assault Service (Yarrow Place, no date) was established in **1993** by merging the Sexual Assault Referral Centre, based in a city hospital with the community based, feminist Rape Crisis Centre.

The Yarrow Place service is designed to ensure that **women's forensic and longer-term health care** needs can adequately be met **on site**, regardless of when the assault occurred. Hence, women victim-survivors, who may, months or even years after the assault endeavour to seek medical support, especially in terms of gynaecological care, can **continue to access the service** and be assured of seeing a doctor who is both sensitive and aware of the effects of sexual violence. This is **in contrast to those services that focus on acute or crisis care** responses which can result in less attention being given to the potential for longer-term or life-span health effects of sexual violence for individuals (Olle, 2005). This shift in focus is only now beginning to recognise the need for **responses over time or over life-spans**. This is of particular value for those for whom no initial acute response was possible or desirable, or for those for whom no response was historically available.

In addition, Yarrow Place has Aboriginal Sexual Assault workers who provide counselling to Aboriginal people who have experienced sexual assault/abuse, and training and community education regarding issues of sexual violence in Aboriginal communities.

### 11.3.3 Objectives

Yarrow Place works with and **for victims of both sexes** who were **over the age of sixteen** at the time of the assault. Yarrow Place is the leading public health agency responding to rape and sexual assault in South Australia with a state-wide mandate. It has four main roles:

- providing direct services to people who have been raped or sexually assaulted;
- providing a lead agency role in South Australia; this includes advocacy in relation to key issues, public policy, planning and service delivery in the area of sexual violence against adults;
- resourcing other agencies and workers to provide services to victim-survivors; and
- working to prevent rape and sexual assault.

### 11.3.4 Innovation in co-ordination and co-operation

#### *Victim-centred*

Yarrow Place is victim centred, with a **long-term service provision** focus, designed to integrate medical and counselling services (with, for example health agencies such as Dale Street Women's Centre). The formal integration policy implemented through such services involves trialling and **implementing restorative and interrogative justice** approaches, as well as **feminist approaches** to sexual assault victim services. It is also important that service providers are able to work under supportive conditions with **high-level workplace standards**.

#### *Integrated services*

Yarrow Place is an exemplar of integrated service delivery models. The model has been most effective in **streamlining** the extent to which victim-survivors will be obliged to repeat the details of their abuse. These integrated health models offer forensic and counselling services on the same premises, either attached to, or close by hospitals where emergency departments can provide **medical treatment** for serious injury. Pregnancy and STI testing and the provision of prevention and amelioration measures such as emergency contraception counselling services, follow-up medical care, and short-term counselling for acute or recent sexual assault, are all provided in an environment of **relative security and comfort** (Olle, 2005).

#### *Time and cost effective for victims and providers*

Such a model provides a cost-effective means to **prevent delays** in forensic examinations, increase the availability of female forensic examiners, and has the potential to **enhance professional standards** (Regan et al, 2004:1). Nurses have previously been able to access specialist forensic training in Australia. Yarrow Place currently delivers training in forensics where some of the participants in the course have been nurses (some from remote areas).

### 11.3.5 Recommendations based on this best practice for future projects

- ⇒ Rape crisis services need to be founded in comprehensive legislation dealing with the diversity of sexual offences. This is necessary but not sufficient.
- ⇒ Services should be victim-centred.
- ⇒ Services need to incorporate cultural and ethnic awareness.
- ⇒ Funding for services needs to be adequate and predictable.
- ⇒ Formal integration of services (from legal, to health and counselling) overcomes obstacles such as legal delay.
- ⇒ Informal sustainable networks between and across services and agencies encourage flexibility and responsiveness to emerging issues, such as impact of economic insecurity and policy changes.

## 11.4 Health-based services in a conflict zone: The International Rescue Committee (IRC)

By Philippa Olive

### 11.4.1 Background

Conflict zones (zones of newly emerging or re-emerging conflict, on-going conflict and post-conflict) pose special problems for the provision of specialised services to support victim-survivors. Mobilising comprehensive services to respond locally in conflict zones is **logistically complex** with many programmes and international organisations reporting multi-sector, multi-agency working to prevent and respond to rape and sexual violence against women in conflict zones (UN, not dated). Health-based services are potentially sites of good practices in such context of humanitarian emergencies. This example of best practice is drawn from the work of the International Rescue Committee (IRC) which is an organisation delivering **tailored suites of practices** and **responding to the multi-faceted contexts of conflict zones**.

### 11.4.2 Characteristics

The IRC is an established organization that responds to humanitarian crises. In particular its focus is to offer aid to refugees. One of the cornerstones of the IRC's work is to develop and implement programmes to **prevent and respond to rape and sexual violence against women during and following humanitarian crises**. Working with local partners where possible, the IRC shapes programmes of intervention for rape and sexual violence in relation to the community's priorities and existing infrastructure.

The annual report on the impact of IRC programmes of intervention indicates that in 2012, IRC programmes provided **care and counselling for over 22.000 survivors of sexual violence** and provided **education about sexual violence to over 982.000 men, women and children** to enable them to lead sexual violence prevention initiatives in their communities. In their **Syrian** report (IRC, 2013) the IRC documents the accounts of **Syrian** women and girls who cite rape as the primary reason for their displacement and also documents the lack of health and psychosocial services available to victim-survivors.

However, the IRC (2013) clearly articulates **difficulties in the delivery of services** for victim-survivors of rape and sexual violence in conflict zones. Health care workers are often **targets of violence** themselves and international aid organisations may not be able to gain access to the conflict zone directly limiting service provision in conflict zones. In addition, many refugees are hard to reach, living not in refugee camps but dispersed in **very poor conditions** across urban and rural areas and are generally underserved. In their **Syrian** field report, the IRC (2013) found few services for sexual violence and rape in place for **Syrian** refugees displaced in **Jordan, Lebanon and Iraq**. To provide effective sexual violence and rape prevention and response services directly in conflict zones and in refugee camps in neighbouring non-conflict zones, organisations such as the IRC and countries hosting refugees are dependent on **financial aid** and donors must respond to humanitarian aid funding appeals.

#### 11.4.3 Objectives

The IRC's programmes of intervention are developed in collaboration with local partners where possible and are aimed to three distinct phases in conflict zones:

- **respond to the immediate needs** of victim-survivors of rape and sexual violence in conflict zones and prevent further violence;
- **establish local infrastructure** of integrated health, mental health and legal services for both the immediate and long term needs of victim-survivors of rape and sexual violence in conflict zones; and
- **build long term capacity** in rape and sexual violence services and community responses to end violence against women, promote women's economic independence and full democratic participation in social life.

#### 11.4.4 Innovation

##### *Range of specialist practitioners*

The IRC emergency response teams are made up of a range of specialist practitioners that assess and co-ordinate an appropriate response in acute and/or ongoing humanitarian crises. An **expert in the prevention and provision of services for victim-survivors of rape and sexual violence** forms part of this response team to establish a **programme of intervention** for victim-survivors of rape and sexual violence in collaboration with local and international partners.

Programmes of intervention for rape and sexual violence prevention and assistance programme are supported by the IRC's '**Gender Based Violence Technical Unit**'. The IRC maintains an **emergency response team** and pre-positioned emergency supplies that can be mobilized to anywhere in the world **within 72 hours**. The IRC is currently running programmes to prevent and respond to sexual violence and rape in many different conflict zones and post conflict zones around the world.

### ***A comprehensive and holistic approach***

The IRC programmes of intervention are comprehensive and holistic in respect of:

- providing **immediate responses** for the prevention of rape and sexual violence against women and services for victim-survivors of rape and sexual violence in newly emerging humanitarian crises;
- establishing **long term** community prevention initiatives and victim-survivor support and services in conflict and post-conflict zones;
- promoting **women's re-integration and full democratic participation in social life** in conflict and post-conflict zones; and
- providing programmes that address logistic complexity and provide **reports on the status of crises** and on the humanitarian aid needed to respond.

As a first responder to humanitarian crises in conflict zones IRC programmes have a history of providing comprehensive and **confidential health and psychosocial support** services to victim-survivors within health facilities and presently IRC teams are responding to recently increasing reports of sexual violence and rape in **North Kivu, DRC**. Once a service has been established **awareness raising** information about the rape and sexual violence services available to victim-survivors is distributed to communities often by IRC community workers.

### ***Local, safe spaces for women***

In developing long term services, the IRC works with local partners to build long term capacity and develop a community collective of a comprehensive range of health, mental health and legal services for the immediate and long term needs of victim-survivors of rape and sexual violence. The IRC recognizes the criticality of **local women's networks** and works collaboratively with local partners to develop services, community referral pathways for victim-survivors, and women's support systems. Central to IRC programmes of aid are the creation of local, safe spaces for women. These local Women's Centres provide access to sexual violence specific resources, support and referrals for victim-survivors. In addition, the Women's Centres offer **emotional support** and **social interaction**, and house **literacy** and **skills-building** classes and information about health.

Presently the IRC has opened women's centres for **Syrian** refugees in Lebanon. The centres have **trained caseworkers and counsellors**, offer support groups and provide confidential, specialised sexual violence and rape and referrals to other services.

In **Iraq** the IRC has provided workshops and awareness raising activities for Syrian refugees to address violence against women and girls and trained the Iraqi police about how to respond to sexual violence.

In **Jordan**, the IRC is providing primary health care, free medicine and essential items to **Syrian** refugees and for women refugees in particular the IRC is providing emotional support, reproductive health care and hygiene materials. Recognizing women and girls as a refugee group at high risk, the IRC in collaboration with other agencies principles the protection of women and girls at refugee camps.

### ***Promotion of gender equality and women's democratic participation***

In promoting gender equality and women's democratic participation the IRC long term intervention programmes focus on:

- women's access to violence response services;
- promoting community responses to end violence against women;
- increasing women's economic independence;
- increasing women's democratic participation in social life; and
- women's advocacy at national level. The IRC's Women's Centres' skills-building classes are linked with other income generation activities to promote women's economic independence. IRC teams work with local leaders to promote women's rights. Reflecting the interconnections of multiple forms of gender-based sexual violence the IRC has recently launched a campaign to address domestic violence in post-conflict zones.

#### **11.4.5 Co-ordination and co-operation**

##### ***International Campaign to Stop Rape and Gender Violence in Conflict***

The International Campaign to Stop Rape and Gender Violence in Conflict (no date) has three pillars: **Prevention, Protection and Prosecution**. These pillars **call on political leadership** to prevent rape in conflict, to protect victims-survivors of rape and to prosecute those responsible. Indeed, a high-level panel convened during the 67<sup>th</sup> UN General Assembly (2012) called '*on world leaders for stronger actions to secure justice for survivors of conflict-related sexual violence and gender-based crimes*' (UN Women 2012). Evident here is the political will to **move beyond prevention and protection to encompass justice**; justice is interpreted as including not only prosecution of those responsible but also justice for survivors.

Zainab Bangura (Special Representative of the Secretary-General (SRSG) on Sexual Violence in Conflict) explains that **justice for survivors** involves care and services for survivors, means for survivors to recover losses, and to fully participate as equal members in society (Bangura 2012, cited by UN Women 2012b).

#### **11.4.6 Good Practice**

##### ***Quality monitoring***

In terms of quality monitoring the IRC programmes for rape and sexual violence interventions are supported by the IRC's 'Gender Based Violence Technical Unit'. This unit is concerned with programme quality and is responsible for **developing policy and practice**, programmes of **staff learning and development, research** and for providing technical support. The IRC monitors its programmes activities and collects data on rape and sexual violence to produce **reports** and target responses and programme interventions appropriately.

#### **11.4.7 Recommendations for future projects**

Whilst the interventions identified in this best practice case study are clearly aimed at women's recovery and protection from rape and sexual violence and protection,

**difficulties in service provision** and **access** in conflict zones and refugee camps and for displaced populations remains widespread (IRC, 2013). In addition, **justice** in terms of holding those responsible to account is also limited. Therefore, it can be concluded that although developments have been forged in responding to rape and sexual violence in conflict and post conflict zones, **inadequacies** remain and services may take many years to become established.

**Pressing and difficult issues** for global communities in responding to rape and sexual violence in conflict zones are:

- access to conflict zones to provide supplies and services for victim-survivors of rape; and
- initiatives to promote the collection of evidence of rape and sexual violence so that those responsible can be called to account.

The international community **should develop strategic global contingency plans** including **funding initiatives** that places gender-based violence as a priority to provide for

- an immediate response to rape and sexual violence in the acute phases of emerging humanitarian crises;
- for long term rape and sexual violence prevention; and
- assistance capacity building for on-going conflict zones, displaced populations and post-conflict zones.

## **11.5 Health-based centre in a non-conflict zone: Sexual Assault Referral Centre (SARC), St Mary's, UK**

By Phillippa Olive

### **11.5.1 Background**

The provision of specialised services to support victim-survivors of rape takes different forms and is centred in varied organisational settings. There are challenges common to all service provision, which are addressed in varied ways. This example of best practice is a health-based centre.

### **11.5.2 Characteristics and co-ordination and co-operation**

St. Mary's SARC, in the **UK**, delivers an integrated, comprehensive service to victims-survivors of rape and sexual violence under one roof; it is centrally located and has its own private entrance that is security monitored. The SARC is housed in a bright, refurbished stand-alone unit within a hospital complex.

Initially, SARCs were principally concerned with **improving the medico-legal response** to rape (Lovett, Regan and Kelly, 2004) and as such the focus was on achieving good practice standards for **immediate health interventions** and **forensic evidence collection** (if desired).



Today, these core services have expanded to include also **sexual and reproductive health interventions** (unbiased counselling, emergency contraception, prevention of unwanted pregnancy, abortion support, and screening for sexually transmitted diseases), **crisis support, mental health examinations, counselling, and advocacy**.

Victims-survivors have access to a crisis worker and advocate from the time they first access the SARC until the time the victim-survivor 'self-discharges' from the service.

Furthermore, SARCs provide:

- unbiased information and counselling;
- partner violence screening, risk of harm assessment;
- risk of homicide assessment, vulnerability assessment;
- legal support, independent sexual violence advocacy;
- proactive follow-up: practical advice, social support, counselling, follow-up services and 24 hour telephone helpline; and
- Outreach services which are also provided for situations where it would not be possible or safe for the person to attend the SARC.

Research at St. Mary's SARC indicates **greater completion** of post-exposure prophylaxis and **follow-up** at genitourinary medicine appointments for service users with proactive support from ISVAs.

In the UK a SARC provides sexual violence and rape services to a **geographically defined area**. A SARC service should be easily and safely accessible. The service should be available 24 hours a day, seven days a week. It is preferable for SARCs to be **standalone units in established health service facilities**.

#### ***Steering group and annual conference***

The inter-disciplinary and multi-sectoral integrated service of St. Mary's SARC is **reflected in the centre's steering group** and the embedded collaborative working relationships with local, regional and national NGO, health, legal and social services.

St. Mary's SARC annual conference is attended by an **international audience**. St. Mary's as an **internationally recognized site of excellence and innovation** offers a suite of education and training programmes for forensic examiners, police and counsellors and the clinical director has written a clinician's guide to forensic practice. St. Mary's SARC has supported the development of integrated health-led rape and sexual violence service worldwide. In sharing good practices and innovations, St. Mary's SARC is visited by practitioners from around the globe, while staff from St. Mary's SARC have visited centres around the world providing alternative models of care. An on-going programme of research is supported by the SARC's Research Officer. Health-led, multi-sectoral SARCs are transferable (with adequate resources) to other settings.

#### ***Multi-sectoral, multi-disciplinary teams***

SARCs are made up of multi-sectoral, multi-disciplinary teams. Configurations of SARC teams may vary, this best practice site team is comprised of: a clinical director, a service manager, sexual violence advocates, crisis workers, counsellors, forensic physician (or nurse) examiners, a consultant paediatrician and police liaison officers. This **front line**

**service team** is supported by a **PR and communications officer, administration officers, a training and development officer, and a research officer.**

#### ***Local and international outreach activities***

The SARC monitors **diversity and group representation amongst service users**. In order to widen service access, St. Mary's SARC has worked with social care, the police service, children's services, education sector, Black and Minority Ethnic (BME) services and the voluntary sector. St. Mary's has recently secured funding for a young people's advocate for early intervention and engagement with **children at risk of sexual exploitation**. St. Mary's SARC has a **Facebook page** and **Twitter account** that distribute news and events information. Its **website** has service introductory information available in six languages. The SARC provides **services for historic as well as recent rape and sexual violence**. In recognition of the intersections of multiple forms of violence St. Mary's has introduced routine enquiry for partner violence. Sexual violence in the domestic setting is also the theme for St. Mary's SARC forthcoming annual conference.

#### **11.5.3 Objectives**

SARCs were developed to provide a '**one-stop shop**' for victim-survivors of rape and sexual violence.

The goals behind SARCs are

- to limit the physical and mental health consequences of rape and sexual violence,
- to provide a quality forensic service,
- to support victims-survivors through the criminal justice system if they choose to report, and
- to prevent any form of secondary victimisation.

#### **11.5.4 Innovation**

##### ***Integrated service model***

SARCs provide an integrated service model in the form of a one-stop shop approach; this approach precludes victims-survivors from having to navigate multiple services and also ensures that all victims-survivors have equitable access to good quality services.

SARCs work by providing victim-survivors with access to the full range of specialist and expert providers of medical, health, social and legal services for rape and sexual violence under one roof at the time of first attendance.

##### ***Victims-survivors' control their engagement with the criminal justice system***

Above and beyond the core of best practice at St. Mary's SARC is the **routine availability of service options** for service users (what, where, and when) for the development of a personalized programme of service interventions.

All services are provided irrespective of whether the victim-survivor chooses to report to the police or not. St. Mary's SARC offers the **full range of medical and forensic examination and evidence collection and storage options**. Service users can choose whether to have a forensic examination and evidence collection or not and any forensic

evidence can be stored for up to seven years, if desired anonymously. Furthermore, they can choose to have their anonymous forensic evidence sent to the **police** for police intelligence purposes.

In this way victims-survivors are in **full control of their engagement** with the criminal justice system. If a victim-survivor chooses to report to the police the **police interview** can also be undertaken at St. Mary's Centre if that is what the victim-survivor chooses. All service users have access to an Independent Sexual Violence Adviser (ISVA) service irrespective of whether the victim-survivor has chosen to report or not.

#### *Same scale of option choices for other services*

The same scale of option choices applies to the Centre's other service interventions, for example service users can choose to have follow-up services at the SARC or can choose to be referred to other service providers of sexual and reproductive health care, mental health care and counselling. Service users have access to an **interpreter service** that has a core of interpreters with experience in sexual violence and rape. In developing interpreter services St. Mary's has also worked with 'Freedom from Torture'. All of the services are **free to all at the point of delivery** and transport arrangements for services are made under National Health Service normal operating arrangements.

### **11.5.5 Good Practice**

#### *Quality evaluation*

Outcomes of SARC services are challenging to evaluate, often being a mix of many different interventions and services provided simultaneously to victims-survivors of rape and sexual violence each with individual experiences and service requirements. St. Mary's SARC measures its success on reported **service user experience** and on a **comprehensive programme of audit and service monitoring** from which directions for service improvements and future research are developed, which is in line with best practice benchmarks.

### **11.5.6 Recommendations for future projects**

- ⇒ In developing services for rape and sexual violence that reflect the range of service user experiences, SARCs should consider how best to respond to service users who experience **sexual violence and/or rape from an intimate partner**. This may involve greater integrated working with domestic violence services and/or cross training in domestic violence advocacy for SARC ISVAs.
- ⇒ **Cross training** could be in the form of a dual sexual violence / domestic violence advocacy qualification or could be in the form of primary and secondary advocacy training based on the practitioner's principal role.
- ⇒ SARCs should **monitor their service user demographic** and develop strategies to **increase underrepresented service user groups' access** to sexual violence and rape services.
- ⇒ In areas where there is low service uptake, **regional centres of excellence** with hub and spoke (centre and satellites) service support models could be used to ensure consistent delivery of and equitable access to quality SARC services. SARCs should have formalized referral pathways to and from mental health services, specialist violence and abuse trauma therapeutic services and general health services.

## 11.6 Coordinated community responses, USA and other countries

By Andrea Krizsan

### 11.6.1 Background

The planning and coordination of the wide range of services and interventions needed is a challenge in the field of rape policy. This has been addressed in a variety of ways. This example focuses on coordination at the community level.

Coordinated community responses (CCRs) first developed in the USA for domestic violence intervention. However similar **coordinated responses** were used for rape and sexual assault intervention from the 1970s, when rape crises centres first started to coordinate action with hospitals, including **developing common protocols for interventions** (Advocates for Human Rights, 2009). Other countries, including within the EU, have also developed coordination practices.

### 11.6.2 Characteristics

#### *Actors*

The variety of actors involved in addressing rape depends on local contexts and community needs and may include law enforcement, prosecution, judiciary, health care, as in Dodge, Fillmore and Olmsted County in **Minnesota**, but can also involve mental health providers, victim advocacy, crises centres, and social services.

For example, the sexual assault response teams in Fresno, **California** include sexual assault nurse examiners and their monthly meetings are extended with participants representing district attorney's office, hospitals, the Rape Counselling Centre and local child protection services. The Sexual Assault Response team in Montgomery, **Alabama**, has a multidisciplinary team involving also representatives from the local domestic violence program and the Alabama Crime Victim's Compensation Board.

**Site specific stakeholders** are often included. Accordingly, communities with substantive minority populations include minority women's crises centres in responding to rape; communities including large university campuses include university representatives in developing responses.

Independence of the organisation is an important aspect of their mode of working. Fresno Rape Counselling Centre is one such example of such independence.

#### *Activities*

US practice in using coordinated community responses highlights eight aspects of activities that make coordinated community intervention more efficient. Of primary importance is the work on the development of a **common philosophical framework**, a common way of understanding sexual assault, accepted by the various participant organizations in the CCRs.

Based on this understanding, the first step undertaken by CCRs is to **develop model protocols** that guide all further coordinated intervention to prevent and address sexual assault. A series of protocols developed in various communities across the USA is available from the website of the National Sexual Violence Resource Centre (2013).

A further task of importance for CCRs is to **monitor and track individual cases** and **ensure accountability of practitioners** in dealing with these cases.

Furthermore, CCRs play a major role in coordinating the **exchange of information** and inter-agency communications between those involved in responding to rape. CCRs make sure that the **provision of resources and services** to victims, of sanctions, restrictions and services for offenders are **smooth and efficient**.

Finally, a core role of CCRs is the **on-going evaluation** of the coordinated justice system response from the victims' perspective (Little et al, 1998).

### 11.6.3 Objectives

The main objective of coordination is to avoid fragmentation and to keep the interest of the victim at the centre of all responses (Allen, 2006). This takes various forms, some more formalized and with more implications for policy development, others less formalized and geared towards a more efficient engagement with individual victim-survivors.

The focus on the victim-survivor can also benefit from the cross-agency reflexivity and learning. An important objective is to include victim's advocates among the coordinating actors and to ensure that they have a role in shaping responses.

Furthermore, coordinated community responses can address the tendency to fragmentation among services while also adapting national policies to local contexts and changes in the environment.

### 11.6.4 Innovation

US practice shows that the best examples of coordinated community responses can bring benefits to addressing rape in four ways. First, they can enhance the **autonomy** of the individual victim-survivor. Second, they can place priority on the **safety** of the victim-survivors rather than focusing on the 'case'. Third, they can promote **institutional change** within systems (law enforcement, legal, medical or social services etc.) to improve response to victim-survivors. Finally, they can promote **community-wide response** to reduce violence against women, rather than sector specific responses (Little, 1998).

### 11.6.5 Co-ordination and co-operation: weaknesses can arise

Coordinated community responses in the US take **various forms**. Community partnering, community organizing, councils and task forces, community intervention and training are some of the forms (Little 1998). While community partnering and community organizing are more informal, councils and task forces and interventions are more formalized, with resources (both financial and human) allocated for facilitating coordination and taking initiative. At their core is '**meeting face-to-face, planning, developing policies and protocols, cross-training of staff**, appearing in educational panels, and **communicating** about victims' (Martin, 2007).

**Formal councils and task forces** are the most formalized kind: these are platforms which allow for all involved agencies and actors to meet on a regular basis, undertake common larger scale projects, monitor and amend policies according to flaws identified in the practice. They are often better resourced than other forms of coordination, but they may also **lack independence** for a genuinely critical voice. Councils develop model

protocols for responses to sexual assault. The Sexual Assault Interagency Council in Dodge Fillmore and Olmstead is a good example here.

Another form of a platform for coordination is provided by independent community based victim's advocacy organizations. In such cases there is a stronger emphasis on monitoring and critical evaluation and oversight of activity by stake-holders.

The generally positive experience with coordinated community responses is supported by numerous evaluations and pieces of analysis (reviewed in Martin, 2007). Martin argues, though, that while all coordination is good for addressing violence against women, some forms of coordination are nevertheless better than others.

Weaknesses that emerge can be linked to **resource problems** and particularly to the lack of staff dedicated specifically to running the coordination exercise.

The issue of **independence** of CCRs has also been raised as problematic. Independent monitoring along quality criteria supporting the victim's perspective had best been secured in CCRs that were **led by victim's advocacy organizations** or other autonomous platforms (for example the Fresno Rape Counselling Centre is a comprehensive sexual assault victim service program that is a major facilitator of CCRs in Fresno), rather than by hospitals, police or other stakeholders. Coordination led by victim's advocacy groups is also advantageous for developing a **common understanding of objectives** acceptable across different agencies that reflects a victim centred approach and facilitates all participants to 'own rape'. Interference by local politics has also been noted as problematic: convincing political actors as well as peer groups of the need to cooperate can prove difficult (Martin, 2007).

Finally, dilemmas around the co-optation of the objectives of women's rights and victims' advocacy groups flowing from the coordinating activity with different public actors have repeatedly been raised (Martin, 2007).

#### 11.6.6 Good Practice

Coordinated community responses are good practices because they provide channels for **integrating victim's advocates** into developing and monitoring policy responses to rape.

Another related aspect that makes CCRs a good practice is that by the integration of victim's rights advocates into coordination they facilitate the maintenance of the **primary focus of intervention on protecting the victim-survivor** and on responding to the perpetrator. Finally CCRs also improve the **efficiency** of the intervention and improve accountability of the numerous actors involved in responding to rape.

CCRs are **transferable**. Coordinated community responses are now common in Europe, especially in the realm of domestic violence interventions. Countries where this is taking place include: **Austria** (oral communication with Rosa Logar) and **Albania** (supported by UNDP, 2009, oral communication with Raluca Popa). However, no evaluation is available at this point about how these pilots work in practice. The example of MARACs in the **UK** points towards the difficulties that arise when the police are the coordinators of CCRs, rather than victim's advocates.



### 11.6.7 Recommendations for future projects

- ⇒ Encourage the creation of coordinated community responses;
- ⇒ Provide incentives to actors involved in responding to rape to take part in CCRs;
- ⇒ Develop protocols for the creation of coordinated community interventions, their operation and membership;
- ⇒ Ensure that the needs of the victim-survivor are at the centre of the practice; and
- ⇒ Stipulate the inclusion of women's rights advocates and rape crises centres into community coordination mechanisms.

## 11.7 Integrating a better understanding of rape within law, Mexico

By Emanuela Lombardo

### 11.7.1 Background

The law is an important instrument in preventing rape in **challenging the impunity** of rapists. It is central to the working of the criminal system and is also significant in its effects at the symbolic and cultural level in defining what is wrong. The best practice example here of developments in Mexican law concerns its integration of a better understanding of rape into law.

The General Law to guarantee Women Access to a Life Free from Violence was adopted in Mexico in 2007: 'Ley General de Acceso de las Mujeres a Una Vida Libre de Violencia' ('General Law to guarantee Women Access to a Life Free from Violence'). Preceding this law, a 2004 initiative of a General Law on femicide proposed the introduction of 'gender crimes' in the Penal Code (Borzacchiello, 2012). There was a later amendment in 2012 (Congress of the United Mexican States, 2012).

The law is in compliance with international obligations to promote women's Human Rights (CEDAW; Belém do Pará Convention; see UNWomen, InMujeres, Cámara de Diputados, 2011). The process of making the Law included the creation of a team of 60 researchers, experts in violence against women, who, under the guide of Marcela Lagarde, feminist academic and Member of the Congress, elaborated a diagnosis of femicide violence in Mexico (Lagarde, 2008). Feminist organizations participated in the elaboration of the law and contributed to its concept of violence (Borzacchiello, 2012).

The concept of '**femicide**', articulated by Lagarde (2005; 2006a; 2006b; 2008), suggests the **systemic character** of violence against women, **rooted in structural inequalities** between women and men, the violation of women's Human Rights in the public and private spheres, and the state responsibility in breaking the rule of law and favouring impunity, which moves Lagarde (2005: 155) to claim that 'femicide is a State crime'. Art 21 of the Law states: 'Femicide violence is the extreme form of gender violence against women, the product of violation of her Human Rights, in the public and private spheres, that is made of a variety of misogynous [hate against woman that is manifested through violent and cruel acts against her for the mere fact of being a woman (Art 5)] conducts that can imply **social and state impunity**, and can end up in homicide and other forms of violent death of



women'. In cases of feminicide, sanctions foreseen in Article 325 of the Penal Code will apply. The concept of 'feminicide' is different from 'femicide' in that the killing of women is seen as an **intentionally gendered act**.

### 11.7.2 Characteristics

#### *Definitions*

The law embeds a holistic and gender-based approach to sexual violence – including rape – and other types of gender violence. Article 5.4 defines **gender-based violence** as whatever action or omission, based on gender, causing harm or psychological, physical, patrimonial, economic, sexual damage or death, in either private or public spheres. **Sexual violence** is defined (Art 6.5) as 'whatever act that degrades or damages the body and/or sexuality of the victim' and that 'affects her freedom, dignity and physical integrity. It is an expression of the **abuse of power** that implies male supremacy over woman, denigrating and conceiving her as an object'.

The intended **beneficiaries** of the law are victims of violence who are women of any age who have been affected by the violence defined in the law (Arts 5-6), including rape (as part of sexual violence), and who thereby are given the right to receive medical, psychological and legal attention, as well as education and training.

**Perpetrators** of violence are defined as 'the person who inflicts any kind of violence against women' (Art 5.7). They incur administrative and/or penal sanctions for breaching the law, which vary according to the administrative civil and penal codes of the different Federal entities. 'In cases of feminicide, sanctions foreseen in Article 325 of the Penal Code will apply' (Art 21). Perpetrators are obliged to attend re-education programs, if competent authorities so establish.

#### *Instruments for the implementation of the Law*

The main mechanisms through which the Law is supposed to work are the following: institutional coordination through a National System (Arts 35-37) and a Comprehensive Programme (Art 38) to Prevent, Attend, Sanction and Eradicate Violence against Women, both of which have been assigned a **budget line** in the Federal Budgetary Law (Art 39); distribution of competencies among the Federation, the federal states, the Federal District and municipalities (Arts 40-50); attention to victim-survivors of violence, including shelters for raped women (Arts 51-59); and a Gender Violence Alert (Arts 22-26).

The **National System to Prevent, Attend, Sanction and Eradicate Violence against Women** establishes guidelines for coordinating the different governmental entities. For the prevention, attention, sanctioning and elimination of violence against women, the **Comprehensive Programme** includes education and research measures such as gender education and training of public personnel working in justice, police and other relevant areas as well as **statistical diagnosis** on the causes, frequency and consequences of violence to assess implemented measures. There is biannual publication of general and statistical information on cases of violence and their incorporation into the National Database on cases of violence, established in response to CEDAW (ratified by Mexico in 1981) and to the Belem do Parà Inter-American Convention to prevent, sanction and eradicate violence against women (ratified by Mexico in 1998).

The **authorities** are to provide legal, budgetary, and administrative measures to guarantee women's right to a life free from violence (Art 2). They have the obligation to create mechanisms to psychologically and legally support the victim-survivors, and avoid

secondary victimisation (Arts 13, 14, 15). Institutional actors that fail to comply with the law will incur into **administrative sanctions** (Art 60).

**Civil society organizations** concerned with women's rights are involved in the implementation of the law. Federal entities are asked to promote the participation of women's organizations in the implementation of state programmes, and to receive from these organizations proposals and recommendations to improve measures against violence (Art 49).

The introduction of gender education into schools and universities has begun, while gender training of the police is awaiting implementation (Borzacchiello, 2012; Corte Iberoamericana de Derechos Humanos, 2009).

### ***Sanctions and reparations***

The Mexican state is responsible for repairing the damage caused by femicide violence by providing, within the framework of International Human Rights, an investigation of violations of women's Human Rights and sanctioning of perpetrators; specialized and free legal, medical and psychological attention to victims; measures to prevent the violation of women's Human Rights; **acceptance by the state of its responsibility** in the caused damage and commitment to repair it, investigation and sanction of omitted or negligent actions by public authorities that led to impunity of the violation of victims' Human Rights, design of public policies that avoid committing crimes against women, and verification of the facts and information on the truth (Art 26).

The creation in 2006 of a **Special Public Prosecutor** to investigate crimes on violence against women is a step towards a **gender expert treatment of femicide cases**. Since 2008, the Prosecutor is also responsible for Trafficking, and since 2012, the office is placed with the Prosecutor on Human Rights, Attention to Victims and Community Service.

However, the Special Public Prosecutor's capacity for effectively investigating and sanctioning institutional violence depends both on the **harmonization of penal codes** of the Federal entities incorporating the Law and on adequate funding (EQUIS, 2012; Borzacchiello, 2012; for the Prosecutor's budget information see México Infórmate and Special Prosecutor budget webs; for the monitoring of judicial sentences see Articulación Regional Feminista web). The difficulties in implementing the Mexican law show that the formulation and implementation of anti-rape measures need to be carefully connected if the law is to be effective.

### **11.7.3 Objectives**

The 2007 Mexican Law on violence against women aims at establishing **coordination** between the Federation, the 31 Federal states, the Federal District and 2465 Municipalities **to prevent, sanction, and eradicate violence, and support women victim-survivors, including victims of rape** (Arts 1-3). These institutional actors are obliged to organize the governmental machinery in order to reach the objectives including by investigating, sanctioning and repairing the damage that this inflicts on women (Arts 19-20). Assistance to victims of rape and prevention of rape are included within the broad conceptualisation of 'femicide violence', which includes sexual violence.

#### 11.7.4 Innovation

For the first time, the General Law has given **visibility** to violence against women; women-murders and rape-murders; it has confronted public authorities with the problem; and has created instruments for making a diagnosis of violence, enabling reports, such as those jointly elaborated with UN Women, InMujeres (FD Women's Institute) and the Mexican Congress, which followed the increase in women-murders between 1985 and 2009 (ONU Mujeres et al, 2011). The Law promotes **preventive measures**, such as training for police and justice employees. The Law has created a framework for implementing actions to eliminate violence against women in the Federation, Federal entities and municipalities, and combat impunity. Its status of General Law creates **pressure on federal states** to implement it at the local level.

##### *Addresses institutional violence*

The law addresses institutional violence, conceived as institutional acts or omissions that **limit women's access to protection** from violence, thereby providing a legal basis to investigate and combat cases of impunity and institutional legitimisation of violence, including rape. 'Institutional violence' is defined (Art 18) as the '**acts or omissions of civil servants** of whatever government level that discriminate, or have the aim to delay, hinder, or impede the enjoyment and exercise of Human Rights of women and their access to public policies to prevent, attend, investigate, sanction, and eradicate different types of violence, including rape.'

##### *Emergency intervention*

The Mexican law pioneers a form of emergency intervention in specific areas known as the '**gender violence alert**', which national or federal Human Rights organizations, civil society or international organizations can request, and the Federal Government, through the Governance Secretary (Art. 25) can declare when crimes against life, freedom, integrity and security of women trouble social peace in a given territory and society claims it; when an unfair disadvantage hinders full exercise of women's Human Rights; and when Human Rights organizations at the national or federal levels, civil society or international organizations demand it (Art 24).

The Gender Violence Alert requires emergency government actions to tackle femicide violence in a given territory (Art 22). The aim of the Alert is to guarantee the security of women, the end of violence against them and the elimination of inequalities. It requires the **establishment of an inter-institutional and multidisciplinary gender expert group** that monitors the Alert, the implementation of preventive justice and security measures to combat femicide violence, the elaboration of reports on the affected area on the basis of indicators of violence against women, the necessary economic resources to face the situation (Art 23), as well as informing the population about the reasons for declaring the Alert.

##### *Education and training*

Competent public authorities must assist victim-survivors of violence – including rape – through protection actions and programs, provision of free, fast and specialized medical, psychological and legal attention to victims, shelters, interpreters to accompany indigenous women in the process, training programs and job opportunities for victim-survivors, and compulsory re-education programmes for perpetrators.

### 11.7.5 Lack of co-ordination and co-operation

To date, only 23 Federal entities out of 32 have adopted their own law on violence against women, which is the first step to implement the Law, and only 3 Federal entities (Aguascalientes, San Luis Potosí and Yucatán) have adopted the regulation that enables the implementation of the law. This shows that, despite the pioneer design of a law that addresses gender-based and institutional components of violence against women, and the progress that the 2007 General Law has promoted, the **implementation of the law is still problematic** (Borzacchiello, 2012).

The implementation gap is mainly due to **difficulties in the harmonization of laws** on violence, civil and penal codes, equality and of other legislative and institutional measures and policies between the Federation and the Federal entities that the implementation of the General Law requires (ONU Mujeres et al, 2011). Mexican NGOs and international institutions report that implementation works better at the Federal level than in the Federal states (Borzacchiello, 2012) but even at the Federal level, the implementation of the mechanisms that were established on the basis of the Law, such as the National System and the National Programme on violence against women, needs improvement (ONU Mujeres et al, 2011; Borzacchiello, 2012).

### 11.7.6 Good Practice

#### *Gender-based concept*

The strengths of the law lie in its conceptualisation of **violence as the result of gender inequality**, its use of gender equal language, and its attempts to **empower women victim-survivors**. The law embeds the holistic and systemic nature of 'femicide violence', which is not only (rape-)murder but a broader system of male domination, in legal institutions. The conceptualisation as gender-based promotes the understanding that this violence is rooted in a system of gender inequality and that promoting gender equality can help to prevent rape and improve assistance to victims.

#### *Strengths of the Law*

The main strengths of the 2007 Mexican law as a practice to prevent rape and assist victim-survivors of rape are:

- gender-sensitive analysis;
- comprehensive and systemic understanding of violence;
- making violence visible;
- addressing violence in both public and private arenas;
- addressing state legitimization of violence;
- addressing impunity of perpetrators;
- use of gender expertise in the diagnosis of the problem and its embedding in institutions;
- institutional coordination and identification of the responsibility of each level of government;
- specific funding;
- emergency instruments to address violence in specific contexts;
- inclusion of gender expert NGOs in policymaking;

- preventive approach;
- attention to victim-survivors; and
- periodical improvements of the law by incorporating feedback.

#### 11.7.7 Recommendations for future projects

- ⇒ The more **general aspects** of the law appear to be **transferable** to other settings. These include the holistic, gender-based and systemic conceptualisation of 'feminicide violence', the empowerment of feminist NGOs, the preventive approach, the use of gender expertise, the creation of specialised structures and mechanisms to coordinate institutions and to assign competencies to the different levels of government.
- ⇒ The more **specific aspects** of the Mexican law **require more adaptation** before they would be suitable for transfer elsewhere. These include: the emphasis on institutional violence by public authorities through omissions and negligence that led to impunity of feminicide crimes, and the establishment of a mechanism of gender violence alert.

The weakness of the law lies in its limited implementation.

### 11.8 Identifying potential perpetrators of rape in cyber-space: the ISIS and iCOP toolkit, EU

By Corinne May-Chahal and Awais Rashid

#### 11.8.1 Background

This case study focusses on the prevention of rape. One way to attempt this is to identify those who are intending to rape and stop them before they actually rape. The present best practice example concerns the identification of men who intend to rape as they engage with their intended or potential victims on-line, attempting to deceive **a child or a young person** into entering a vulnerable situation. It seeks to identify these men in on-line chat rooms. It is an intervention that seeks to prevent rape by identifying would-be rapists as they attempt to recruit victims on-line. Stopping rape before it happens is the challenge addressed by this intervention.

Potential perpetrators of rape, particularly **of children and young people**, can hide behind multiple identities online. Unravelling these multiple digital personas is a non-trivial problem owing to the large amounts of text communicated in online social media and the large numbers of digital personas involved. The cognitive load for cybercrime investigators is immense – **existing tools lack the sophisticated capabilities** required to analyse digital personas in order to provide investigators with clues to the identity of the individual or group hiding behind one or more of them.

There are three main ways in which computer mediated interaction connects with rape. The first and perhaps most frequently referred to is that of **cyber-rape** itself, where invented on-line characters engage in virtual rape in cyber-space (Dibbell, 1998; Powers, 2003; Nunes, 2006). Secondly, the Internet and social networks can be an important source of **education, information and awareness** both for the public and victims

(Burnett and Buerkle, 2004). A third connection is where **rape may be a consequence of interaction online**; such as where people meet on dating sites and go on to meet off line, grooming, cyber-stalking and cyber gender harassment where threats are made to rape offline (Citron, 2011; Rambaree no date.; Halder and Jaishankar, 2009).

### 11.8.2 Characteristics

Identifying potential perpetrators of rape in cyber-space is directed at this third level of preventing rape as a consequence of online interaction. The intervention involves **developing and applying software** to identify potential perpetrators of rape in order to prevent future attacks and also to help identify victims who may need support. The intervention has two pillars: the **UK funded ISIS project** is focused on detecting age and gender deception specifically for the purpose of identifying adults masquerading in social networking sites grooming children and young people (ISIS, 2013). A **follow on project, funded by the EU Safer Internet programme**, extends development to image analysis in order to assist law enforcement in the identification of new child abuse media circulating in peer to peer networks (iCOP, 2013).

#### *Focus on child protection*

The software is new and constantly in development and is **currently focused on child protection**. The two toolkits are currently being trialled by law enforcement in several European countries. The toolkits **can be applied in any country** to aid the identification of potential perpetrators of rape if accompanied by the right **training** and **resources**. An increasing number of rape cases may be both prevented and facilitated by acknowledging the role that this digital world plays for people across the world. Further research and improved awareness and legislation could **extend this approach to rape prevention to adult women**.

The text analysis toolkit has been tested in trials involving a masquerading adult and over 250 children in **England**. Across over 700 identifications, the ISIS toolkit had an **accuracy rating of 93%** for assessing age in contrast to the children who were correct in 15.6% of guesses (Accuracy varied across year groups and ranged between 10.3% in Year 7 and 21.6% in Year 11). The accuracy ratings using the toolkit were thus significantly more accurate than those of the children themselves.

For the purpose of **personal protection** rather than law enforcement, a free to download application, 'Child Defence', has been developed that **enables children** themselves to scan webchat through their mobile phones and quickly detect whether the person they are chatting to is trying to deceive them (ISIS Forensics, 2013).

### 11.8.3 Objectives

The primary purpose of this development intervention is to assist law enforcement and civic organisations (such as schools, health and social care services) to **identify potential perpetrators** of rape and sexual exploitation that originate in or are facilitated by computer mediated interaction.

### 11.8.4 Innovation

#### *The ISIS toolkit*

The ISIS toolkit supports **identification of patterns** typical to a person's online presence and its interaction with other participants. This is achieved through **structural analysis of**



**the text** (natural language analysis techniques), which extracts details such as the user names of those who are participating in the chat, or date and time information that can be used to model the conversation flow to identify patterns and trends over time.

The toolkit can quickly **analyse and present intelligence** about a particular participant including, for example, **stylistic characteristics** such as keywords, names, topics, etc. that are frequently used or identifying patterns of online/offline times. Use of semantic categorisation allows parts of a conversation to be classified based on their meaning (for example, whether sexual or aggressive in nature) (Rashid et al., forthcoming). By applying these techniques to the model of a participant's conversation, it is possible to **view any trends** that may occur over the duration of the conversation, for example, to help determine if a conversation is becoming increasingly sexualised. The iCOP toolkit applies similar matching and profiling methods and new techniques of image analysis to detect child abuse media.

### 11.8.5 Challenges to co-ordination and co-operation of law enforcement

Trials with law enforcement are still in the early stages but early results are promising. At this level, however, there are a number of **challenges**. Firstly, the extent of **technical expertise and priority** given within different law enforcement agencies to cyber-crime is variable across different countries. While the time needed to track through many false negatives will be considerably reduced, in most countries, the **rules concerning evidence** demand that data obtained through the toolkit is still verified by law enforcement representatives. Furthermore, the **protection of privacy rights** and the **ethics of routine monitoring** have been an underlying concern for the project. To what extent does the potential detection and prevention of rape and abuse authorise the routine monitoring of individual activity in cyberspace?

Therefore, careful application using country specific policing methods currently ensures that the toolkits aid law enforcement and do not transgress jurisdictional boundaries. This current practice restricts the potential of the toolkit but observes human rights. It also has the effect of limiting access by potential perpetrators who might subvert the toolkit by hacking into the design.

Furthermore, **divisions of on/offline law enforcement and civic interventions** may serve to weaken the prevention and response to rape. Practitioners may consider they do not possess sufficient **technical expertise** when mediated environments are introduced and also because victims may consider that behaviours in mediated environments are different from offline behaviours; for example, viewing a screen rather than a face to face relationship. This may be exacerbated in conflict zones and developing countries where offline lives can be devastated by the proximity of war, poverty and disease. For example, Cassim (2011: 123) notes:

The increase in broadband access has resulted in an increase in internet users. Thus, Africa has become a 'safe haven' for online fraudsters. African countries are pre-occupied with pressing issues such as poverty, the Aids crisis, the fuel crisis, political instability, ethnic instability and traditional crimes, such as murder, rape, and theft. As a result, the fight against cyber crime is lagging behind.



### 11.8.6 Good Practice

This good practice focusses on the prevention of rape.

The intervention is **transferrable** and could be adopted by law enforcement in many other countries with appropriate training and resources.

### 11.8.7 Recommendations for future projects

There are two key recommendations arising from this project:

- ⇒ Cyberspace should be included as one of the arenas in which actions contributing to rape occur. In order to make better use of existing resources, a key recommendation would be to begin to mobilise the competencies in civic actions **to be alert** to the role of cyberspace in rape and abuse. Offline responses such as shelters, rape crisis centres and health services focus support in the offline environment of victims and rarely become involved in **online prevention**, other than through education. The intervention providing the app to children accepts the **victim's positioning in the ontology of cyber space** and off line space as part of one digital world (May-Chahal et al, 2012).
- ⇒ The developing recognition of cyber-crimes should extend to the recruitment of women for the purposes of rape and for other forms of sexual exploitation. Some cyber-crimes are clearly recognised under EU law, international law and national jurisdictions but the emphasis in the area of rape has been primarily on children with **clear legislation around child abuse** images and grooming on line existing in many countries. However, **cyber-crimes against adult women** are still less defined in law and less researched (Halder and Jaishankar, 2009).

## 11.9 Specialised courts: sexual offences courts (SOC), South Africa

By Jude Towers

### 11.9.1 Background

The holding of perpetrators to account for their actions is a challenge to the criminal justice systems around the world that few successfully address. The rate of conviction of rapists for crimes reported to the police is very low everywhere. There have been many attempts to improve the functioning of the criminal justice system in relation to rape, with the goal of increasing the rate of conviction (reducing the attrition rate) while preventing the secondary traumatisation of the victim in the process. This best practice example of specialised sexual offences courts (SOC) in South Africa addresses this challenge.

The SOC intervention, as part of this wider strategic vision, should be understood within the **context of rape and sexual violence in South Africa**: population surveys suggest a prevalence rate of around 134 rapes/attempted rapes per 100,000 of the population; and an estimated prevalence rate of 68-72 per 100,000 of the adult population (Statistics South Africa, 2000). Police statistics find a lower prevalence rate (in South Africa, as elsewhere, not all victim-survivors report to the police: one estimate suggests that eight out of nine cases goes unreported (South African Law Commission, 2001)) of around 114 per 100,000

of the total population, with just over 55,000 rape cases being reported to the police in 2003/04 (South African Law Commission, 2001). An estimated 40% of rapes are of children (Statistics South Africa, 2000); in 2000 over 25,500 sexual offences against children were reported to the police (Sadan et al, 2001).

Findings from population surveys suggest an estimated 35% of rapes involve relatives and intimate partners compared to an estimated 25% involving a stranger, whilst 55% of rapes reported to the police are committed by strangers. Patterns of reporting in South Africa then are similar to those found elsewhere, but rates are amongst the highest in the world, including those of South Africa's neighbours (Statistics South Africa, 2000). A **survey that asked men** in South Africa if they had raped found that more than one quarter (27.6%) had raped a woman or girl, including 4.6% in the last year; and that nearly half (46.3%) of rapists had raped more than one woman or girl (Jewkes et al, 2009).

Against this backdrop, in 2007 the law on rape and sexual violence of South Africa was substantially amended in order to reflect the **commitment to criminalization**; reducing the impunity with which perpetrators can act; and to **support access to justice** for victim-survivors.

The Department of Justice highlight the new Act (Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007) as a key part of South Africa's efforts to fight sexual crimes (Department of Justice, 2008). Amongst other measures, the new Act repeals the previous common law offence of rape and replaces it with an **expanded statutory offence of rape** which is applicable to all forms of sexual penetration without consent, irrespective of gender. The Act also makes provisions for the sanctioning of perpetrators, including a National Register of Sex Offenders (Department of Justice, 2008).

The government of South Africa recognises that its "anti-rape strategy" must **address the wider social acceptance** of rape and sexual violence against women and children in order to make real impact. Strengthening the CJS response to rape and sexual violence is one strand in this strategy and is designed to demonstrate that rape and sexual violence against women are **serious criminal offences**, and to support victim-survivors to **obtain justice**. Violence against women and children is clearly identified as a key priority in the strategic visions of CJS agencies and has been designated a priority crime area (Sadan et al, 2001).

### 11.9.2 Characteristics

The idea of specialist courts is not new: the first 'SOC' in South Africa was established in 1993 in Wynberg by the attorney-general of the Western Cape in response to a public outcry over the way two rape cases were dealt with by the Cape Town Magistrates' court (Rasool, 2000). Evaluation of early courts found these to be **an effective way of dealing with cases of rape and sexual violence**, particularly those involving children. Since its establishment in 1999, SOC's come under the authority of the Sexual Offences and Community Affairs (SOCA) Department in the office of the National Director of Public Prosecutions (NDPP). The role of SOCA is to establish best practices and policies that seek to eradicate victimisation of women and children, while improving prosecution, particularly in the areas of sexual offences, maintenance, child justice and domestic violence (UNICEF, 2009).

Sexual Offences Courts (SOCs) are specialised courts hearing only sexual offence cases. They are staffed by **specially trained individuals** from a number of agencies in the

criminal justice system and beyond. Evaluation studies have found **significantly higher conviction rates** for cases of rape and sexual violence compared to those delivered by non-specialist courts as well as other benefits

SOCs are separate from regular courts and are staffed by specialist personnel from numerous criminal justice system (CJS) agencies and other relevant staff. A typical SOC would comprise: a **separate court room** devoted to sexual violence crimes; a **separate waiting room** for victim-survivors and witnesses for the prosecution; a **camera room** with Closed Circuit Television (CCTV) so vulnerable victim-survivors do not have to testify face-to-face in court; **two specialist prosecutors** (one who deals with the in-court procedures and the other who works with and prepares the victim-survivor for appearing in court); a **victim advisor officer**; and a **social worker** (Sadan et al, 2001).

There were 59 SOC in operation by 2007 around the country, with plans for additional SOC to be set up (Thomas et al, 2011). In addition, there were 25 Thuthuzela Care Centres (TCCs) in operation in 2010/11 with plans to expand the number to 55 by 2016/17, which offer a wide range of specialised services to victim-survivors (National Prosecuting Authority, 2012).

Despite the positive findings, a number of limitations and weaknesses with SOC have been highlighted. One major concern is the **high caseload** in the SOC and the **backlog of cases**; Sadan et al (2001) found that the backlog was clearing over time, but nevertheless, the caseload of SOC remains exceedingly high. The other is the **under-resourcing of SOC**; this prevents some SOC from meeting the best practice standards under which they are supposed to operate. For example, Sadan et al (2001) found that Cape Town SOC, which deals exclusively with cases involving **children**, relied on the police to transport both victims and the accused to court, this sometimes involved children having to travel long distances in the same bus as the person who had raped or abused them. A lack of resources also meant that Cape Town SOC could not provide lunch or refreshments for victim-survivors during the course of a very long day: this impacted on the **quality of evidence** children were able to give in court and thus on court outcomes.

Whilst the **training programmes** for staff were initially comprehensive (375 individuals being trained to coincide with the development of the SOC programme) (Vetten, 2001), little inter-sectoral training occurs and on-going training is problematic, not for the lack of availability, but because **staff are too busy to attend** (Sadan et al, 2001). A further consequence of the very high workload placed on staff in SOC, many of whom are on 24-hour call, plus dealing with very distressing and stressful cases without adequate counselling and supervision support, has been concomitantly **high rates of sickness and staff leaving**: training regimes are finding it difficult to keep up with the rate of staff replacement, thus new staff are not always fully trained (Sadan et al, 2001).

The infra-structure of some SOC is not ideal: SOC should include at least one **dedicated courtroom** for cases of rape and sexual violence and a separate waiting room for victim-survivors: whilst most SOC provide this, the waiting rooms have found to be of **insufficient size** to accommodate the number of people waiting for court hearings that day and access to the court and/or waiting room and other facilities is not usually adequately separated (Vetten, 2001). For example, the four SOC at Wynberg are on the fifth floor of the Magistrates court building but there is only one entrance and one lift; and in the Cape Town SOC the toilets are located at the opposite end of the building to the SOC waiting room (Sadan et al, 2001).

### 11.9.3 Objectives

SOCs are specialist courts designed to improve and streamline the handling and prosecuting cases of rape, sexual abuse and sexual violence (Qualst, 2008). Some SOC specialise in child victim-survivors, who are under 18 years of age (Sadan et al, 2001).

The SOC contribute to South Africa's **anti-rape strategy** by addressing three aims: **reducing secondary trauma** through ill-informed, insensitive, blaming treatment of rape victim-survivors by member of the CJS and wider society (Vetten, 2001); **improving conviction rates**; and **reducing the lead time** for finalizing cases (UNICEF, 2009).

This strategic vision seeks to achieve the '**holistic**' **management of sexual offence matters** by all role-players and to reorient the investigative process from being police-driven to being prosecutor-driven. This is reflected in the design of the Sexual Offences Courts (Vetten, 2001).

### 11.9.4 Innovation

SOCs are designed to improve and streamline the process of handling and prosecuting cases of sexual abuse (Qualst, 2008). Staff has been **specifically trained** in dealing with victim-survivors of rape and sexual violence in order to progress cases through the CJS.

**Special prosecutors** are the lynch-pin of the system and are on **24hour call** so that a victim-survivor meets with a prosecutor as soon as possible after reporting a rape so that they and their case can begin preparing for court. That special prosecutor should then remain with the case through to its conclusion providing **consistency for the victim-survivor** and **strengthening communication and information sharing** (Vetten, 2001).

The SOC process is designed to ensure the **most robust case is presented at court**. The use of specially trained staff has been found to **help keep victim-survivors within the system**, to extract **better quality evidence** (forensic, physical and witness) and to prepare victim-survivors to be **robust witnesses** in court, all of which contribute to increasing the conviction rate (Sadan et al, 2001; UNICEF, 2009; Cook et al, 2004). The use of specially trained staff also **reduces secondary trauma** to victim-survivors as they travel through the CJS process (Sadan et al, 2001; UNICEF, 2009); and the expert handling of cases in dedicated facilities **shortens the time** it takes for cases to travel from report to court outcome (Qualst, 2008; UNICEF). All three are clearly inter-connected and support each other.

### 11.9.5 Co-ordination and co-operation

SOCs are designed to be inter-agency; i.e. personnel from **different agencies** within the CJS, and other sectors, work in close collaboration. SOC include actors from across a number of government, and some welfare and voluntary sector agencies, including: special prosecutors, police, victim advisor officers, social worker, and staff from health. In 2000, '**one stop centres**' for the immediate aftermath of a rape and the initial evidence gathering and investigation stages were added to the model with the aim of improving the investigation and prosecution of rape cases (UNICEF, 2009). Thuthuzela Care Centres (TCCs) are attached, or located close, to SOC, open 24 hours and staffed by personnel trained to deal with victim-survivors of rape and sexual violence: medical professionals, social worker, police officer, victim assistant officer; prosecutor; and a dedicated case monitor who liaises between the victim-survivor and the court system (Johnson, 2012).

The TCCs have significantly contributed to the success of the model in increasing conviction rates and reducing secondary trauma for victims through efficient and effective evidence collection practices and good communication with police and prosecutors (Johnson, 2012).

When victim-survivors report to police stations, they are transferred to the nearest TCC where a forensic examination takes place and **physical evidence** gathered; an interview with a **specialist officer** is conducted and the victim-survivor's **statement is recorded**.

**Consultation with a specialist prosecutor** from the SOC is arranged as soon as possible after the initial report is made and the victim-survivor works with a victim assistance officer to prepare for the court process.

#### 11.9.6 Good Practice

The South African SOCs can be considered a best practice for several reasons. SOC:

- are a policy intervention to **prevent rape** which proved that rapists will be convicted and held to account, and to **assist victims** of rape by reducing their trauma;
- in South Africa are part of a comprehensive national 'anti-rape' **strategy** which identifies rape prevention and assisting women victim-survivors of rape as policy priorities across the CJS.
- are designed to be **victim-centric** through the specialist training of staff to work with women and children who have experienced rape and through the design of court infrastructure which enables victim-survivors to avoid unnecessary interaction with the perpetrator as far as possible.
- operate under a principle of **inter-agency cooperation** and are staffed by personnel from all the CJS agencies, as well as those relevant agencies from outside the CJS.

#### *Conviction rates*

Average conviction rates of between 70% and 95% have been reported for SOC (Thomas et al, 2011). Sadan et al's study (2001) found an average conviction rate for the Wynberg SOC (1995-2000 inclusive) of 68.5%, ranging from 65% to 76% over the course of the six years. In the same study, Cape Town SOC was found to have an average conviction rate of 55.5% over four years (1996-1999 inclusive), ranging from 41% to 66%. By contrast, the South African Law Commission (2001) reports an average conviction rate for rape (all ages) countrywide of 8.9% in 1998.

#### *Reduction of lead time*

Case resolution, prior to the establishment of the SOC and TCC, took an average of 18 months to two years, within the SOC/TCC system the typical case is resolved **within six months** from the date of the first report. This reduction in case time has **positive knock-on effects** for conviction rates (Qualst, 2008).

#### *Changing the culture*

There may also be some early signs of changing culture in South Africa, in part as a consequence of the work of the SOC: the National Prosecuting Authority's Strategic Plan 2012-2017 reports that **in 2012 sexual offences decreased by 3.1%** compared to

2009/10. This was due to a recorded decrease in all crimes against women and children, except the murder of adult females (which rose by 5.6%) and sexual offences against children under the age of 18 years (which rose by 2.6%).

### ***Contribute to the development of specialised court interventions***

SOCs contribute back into the continued development of specialist court interventions by making available lessons learnt and highlighting what works best thus adding to the evidence-base; embedded in a comprehensive national 'anti-rape' commitment by the authorities through strategy, law and policy priority status; holistic management of sexual offences through the CJS process (linking back to evidence gathering and investigation and forward to sanction and rehabilitation).

Evaluative data from expert studies and other sources, including government reviews, is publically available for use in the continual development of specialist court interventions in both South Africa and elsewhere: such data has been widely reported in international reviews of CJS interventions for rape prevention and assisting women victim-survivors of rape (see for example: Thomas et al, 2011; Mossman et al, 2009; Qualst, 2008).

- survivors; this enables them to develop specialist knowledge, skills and expertise in best practice for rape prevention and assisting women victim-survivors of rape.

### ***Transferable***

Specialist court interventions are **easily transferable** to other settings: in fact a number of other countries have or are in the process of developing specialist courts for rape and sexual violence cases, or for **domestic violence hearings**, many of which include an element of sexual abuse.

For example **England and Wales** have a system of 'Specialist Domestic Violence Courts' (SDVCs) which operate in a similar manner to SOC: A comprehensive evaluation of the SDVC intervention found they enhanced both the effectiveness of court and support systems for victim-survivors; made advocacy and information sharing easier to accomplish; and increased victim-survivor participation and satisfaction which led to improved public confidence in the CJS (Cook et al, 2004).

Mossman et al (2009), Vetten (2001) and Rasool (2000) argue that the South African experience with specialized courts provides lessons learnt about continual improvements that can **help increase the efficiency** of such specialized courts in other locations and contexts, though Johnson (2012) provides a note of caution warning that the replication of the South African model in other contexts and / or locations requires a number of **key criteria to be met**, including; a fundamental respect by all for the rule of law; a **functioning and democratic police service**; clear **political will** to stem the tide of sexual violence; and a **civil society** that is vibrant and supports accountability in all relevant sectors.

SOCs are also being championed as potential interventions in other contexts which are similarly dealing with what appears to be an **endemic 'rape culture'**. For example, in an opinion piece in *The Hindu* on 14<sup>th</sup> January 2013, Gopalan Balagopal positions South Africa's anti rape strategy with its SOC and connected TCCs as an exemplar of dealing with rape culture and calls for the model to be transplanted to **India**.



### 11.9.7 Recommendations for future projects

Based on this case study and the best practices criteria that have been extracted from the research, a number of recommendations are made for future development and implementation of specialist courts. SOC's should be:

- ⇒ **Victim-centric**; specialist courts should place the health, safety, dignity, privacy and autonomy needs of the victim-survivor at the centre of the practice.
- ⇒ **Inter-agency**; co-operation should be embedded within the practice and should include agencies across and beyond the CJS.
- ⇒ **Adequately funded**; it is not enough to fund the establishment of specialist courts, on-going running and maintenance costs must be adequate to ensure that the other best practice criteria can be sustainably delivered and that the intervention can continue to evolve in ways which ensure their contribution to rape prevention and assisting women victim-survivors of rape;
- ⇒ **Evaluated**; comprehensive **evaluations** should be built in from the start of specialist court programmes; this will require **dedicated data collection systems** which enable the aims of evaluation to be comprehensively assessed whilst adhering to high standards of confidentiality and ensuring ethical principles for working with individuals within the CJS are met. 'Gold-standard' evaluation methodologies compare the target intervention (specialist courts) with alternative interventions with the same/similar aims, in order to achieve this standardised data collection and quality monitoring tools should be established across the full range of CJS interventions designed to prevent rape and assist women victim-survivors of rape in order to enable robust comparison.
- ⇒ **Further developed**; SOC's should contribute back into the **continued development** of specialist court interventions by making available lessons learnt and highlighting what works best thus adding to the **evidence-base**; in order that future development, in the same and in other locations and contexts, can be evidence-based.
- ⇒ **Based on a strong political will**; SOC's should be embedded in a **comprehensive national 'anti-rape' commitment** by the authorities through strategy, law and policy priority status.
- ⇒ **Well managed; holistic management** of sexual offences through the CJS process should link back to evidence gathering and investigation and forward to sanction and rehabilitation. Interventions in other parts of the process should adhere to the same best practice criteria as specialist courts in order that the full impact of such intervention for the prevention of rape and assistance to women victim-survivors of rape can be realised.
- ⇒ **Specialist**; this is an intermediate-term recommendation in order that **expert skills and knowledge on rape prevention and assisting women victim-survivors of rape** in the CJS through interventions such as specialist courts can be developed. The long-term recommendation is that best practices for rape prevention and assisting women victim-survivors of rape are mainstreamed throughout the CJS.



## 11.10 Sexual relations education: Southampton talking about relationships (STAR), UK

By Jude Towers

### 11.10.1 Background

The confronting of 'rape myths' and 'rape culture' is part of the strategy to prevent rape. **Education** has been repeatedly identified as a **key pillar** in strategies to prevent rape and sexual violence against women and girls. A study in the UK found that 72% of sexually abused children did not tell anyone about the abuse at the time they were experiencing it (Cawson, 2000) whilst two separate polls of young people, also in the UK, found 77% felt that they did not have enough information and support to deal with physical or sexual violence (ICM, 2006) and 93% had no information about sexual abuse during their sex education classes in school (Baños Smith, 2011).

Interventions to tackle **rape prevention are far fewer** than those which focus on domestic violence: 'Southampton Talking About Relationships' (STAR) was the only project funded under the UK Home Office *Violence Against Women and Girls (VAWG)* programme in 2000 which focussed on rape prevention: four others covered rape and sexual violence more generally, the remaining forty-nine focused on domestic violence (Southampton Rape Crisis, 2011).

### 11.10.2 Characteristics

STAR is a rape prevention intervention run by Southampton Rape Crisis Centre (England) which is a **voluntary sector organisation**: the project employs specific staff to develop and deliver the project (Southampton Rape Crisis website).

The STAR project is a set of programmes which develop and deliver interactive workshops to **young people** (in 2010/11 54% of recipients were male), aged 10-24 years, in schools, colleges and other youth locations in the Southampton area. Workshops tackle a range of issues around **rape** and **sexual violence** and the development of '**healthy relationships**', including sexual exploitation; teenage pregnancy; Internet safety; cyber bullying; and substance use. STAR also enables young people who have/are experiencing rape or sexual violence to access Southampton Rape Crisis Centre Counselling Service.

Since STAR first began in 2000, the project has worked with over 70,000 young people in schools, colleges, housing projects, young offenders groups and Black and Minority Ethnic (BME) young women's groups. In 2010/11 there were 521 sessions delivered to 6,990 young people (Southampton Rape Crisis, 2011).

As part of the intervention young people **explore gender stereotypes** and the objectification of bodies in popular culture and the normalisation of violence within media including pornography so that they can explore how these influence the emerging sexualities of young people of both genders (Baños Smith, 2011). In this way STAR works to explore the **complexities of sexual violence** and how it affects young people directly with both young women and young men who work together and so develop an appreciation of the pressures and expectations each other experience whilst exploring alternative approaches to building 'healthy relationships' together.

**Interactive sessions** are facilitated by both female and male workers who demonstrate in practice collaborative alternative models of male and female behaviours and sexual identities as part of the delivery mechanism.

### **Funding and resources**

Funding is a key limitation for STAR as it is not guaranteed for the continuation of the work and the UK is currently experiencing increasing cuts to public sector spending budgets for projects like STAR and to reducing monies being available through private trust and grant funds (Towers and Walby, 2012). This may also be exacerbated in the future when schools in the UK move to hold their own budgets, instead of school budgeting for an area being help centrally in the Local Education Authority (LEA). To date, interventions like STAR have been commissioned by the LEA but once budgets move to individual schools, each will have to be **individually convinced** that investment in projects like STAR are worthwhile for their students by **recognising the impact** on children's behaviour and attainment caused by sexual violence and by contributing to the wider objective of rape prevention (Baños Smith, 2011).

#### **11.10.3 Objectives**

STAR aims to **reduce the incidence of rape and sexual abuse** and raise awareness of relevant support services (Southampton Rape Crisis, 2011).

STAR aims to prevent rape by **educating and empowering** young women and young men to choose gendered cooperative relationship models which are respect-based and comply with principles of consent. Evaluation of young people participating in STAR found over 85% had improved their understanding of healthy relationships; sexual assault and sexual exploitation; managing risky situations; and knowing where to go for help. STAR has also **enabled schools and youth initiatives** to develop their in-house policies and procedures to address rape and sexual violence more effectively.

The purpose of STAR is to **equip young people with the knowledge and skills** to: recognise rape, sexual violence and abuse; know where to go for help; understand what is and is not acceptable behaviour; and develop 'healthy relationships'. The programmes do this by: raising awareness of the issues surrounding rape and sexual abuse, promoting skills to negotiate respect and consent within relationships; improving knowledge about appropriate services and support; and by talking about the different (and gendered) pressures felt by girls and boys. Participants also explore the meaning of consent; the right to say 'no'; and how to recognise whether or not another person has given their consent (Baños Smith, 2011).

#### **11.10.4 Innovation**

STAR staff work with the youth providers to develop and implement their in-house policy and procedures on rape and sexual violence which **empowers staff** to confidently and effectively deal with disclosures by young people and ensures those young people are directed to the help and support they need to be safe, to recover their health and to regain their dignity, autonomy and sense of control.

The intervention works by **increasing awareness** of the links between **unequal relationships** and **unwanted sexual experiences**, whilst providing the tools young people need to develop more equal relationships with each other.

### 11.10.5 Co-ordination and co-operation

The impact of STAR is cascading beyond the boundaries of the project: for example, Southampton Rape Crisis, through STAR, works in collaboration with other agencies to deliver parts of the *Sex and Relationships Education Curriculum* concerning **rape, sexual violence and abuse in local schools**.

These had previously been neglected areas because teachers did not feel they had the skills or knowledge to deliver them (Baños Smith, 2011). Teachers in schools have been reluctant to engage with STAR for fear that talking about rape and sexual violence will cause a significant increase in disclosures from young people which teaching and other staff feel unprepared to deal with: linking STAR to the Southampton Rape Crisis Centre Counselling Service and working with staff to develop safeguarding policies and practices have been key to engaging staff.

This is why STAR has been able to support schools to work with their own in-house policies regarding the protection and safeguarding of children and school awareness of violence against women and girls (VAWG) issues has increased. This has enabled schools to **get to know its pupils better**, which has helped them to **deal with behavioural and attainment issues**: in one primary school, collaboration between STAR, the local domestic violence forum and the school itself found that across two classes 47% of pupils had been exposed to domestic violence (Baños Smith, 2011).

### 11.10.6 Good Practice

There has not been a specific independent evaluation of STAR. The most comprehensive assessment of STAR to date has been the EVAW (End Violence Against Women coalition) report on 'promising practices' to end violence against women and girls (VAWGs) (Baños Smith, 2011). This report identified STAR as one of five education-based interventions for rape prevention, which met the designated criteria for promising practice, from across the UK.

Despite the lack of formal evaluative evidence, there are a number of alternative measures which demonstrate to some degree the success of STAR. For example, a 2010/11 in-house poll of nearly 4,000 young people who had participated in STAR programmes found over 85% agreed that their understanding of healthy relationships; sexual assault and sexual exploitation; managing risky situations; and knowing where to go for help had improved (Southampton Rape Crisis, 2011). Since the beginnings of STAR, referrals of young people into Southampton Rape Crisis Centre Counselling Service have increased six-fold: **young people are now the largest client group** of the service (Baños Smith, 2011). STAR is award winning: the 'PEP Talk' programme (Peer Education Pack) for Year 10 students (launched in 2007) was awarded the 'Actions Speak Louder' national award from the DFES /National Youth Agency for excellence in innovative work with young people (Southampton Rape Crisis, 2011).

STAR can be considered a best practice case study for several reasons: Evidence shows that young people are at risk of rape and sexual violence and that they are poorly equipped with the knowledge and skills to develop and negotiate respectful and consensual relationships; STAR addresses this evidenced need. STAR uses an inclusive gendered approach to explore the complexities of sexual violence and how it affects young people by working with both young women and young men who collaboratively develop an

appreciation of the pressures and expectations each other experience whilst exploring alternative approaches to building 'healthy relationships'.

STAR is relatively easily transferable to other setting where there are youth-based organisations willing to work collaboratively with external organisations and back up support for young people (provided by Southampton Rape Crisis) for whom the issues are real and lived.

#### 11.10.7 Recommendations for future projects

Based on this case study and the best practices criteria that have been extracted from the research, a number of recommendations are made for future development and implementation of education-based rape prevention projects. They should be:

- ⇒ **Gendered;** best practice interventions should work with both young men and young women in order to recognise and explore the gendered pressures facing each concerning emerging sexualities and the realities of rape and sexual violence. They should also demonstrate through delivery mechanisms alternative gendered relationship models based on cooperation, respect and consent.
- ⇒ **Expert;** best practice education-based interventions should be designed by those with expert knowledge of rape prevention and should be located in, or have access to, expert support organisations in order to ensure that disclosures raised during prevention work are dealt with effectively so that the health, safety, and other needs of the victim-survivor are met.
- ⇒ **Systemic;** best practice interventions should produce a systemic impact beyond the boundaries (physical and temporal) of the project itself.
- ⇒ **Collaborative;** best practice interventions should work collaboratively with staff in the locations of programme delivery: this also increases systemic impact, including empowering staff to continue the work beyond the life of the project at that particular location.
- ⇒ **Adequate funding;** best practice interventions should have sustainable and secure funding to both continue and to develop best practices for rape prevention through education-based work.
- ⇒ **Evaluated; comprehensive evaluations** should be built in from the start of education-based rape prevention interventions; this will require dedicated data collection systems which enable the aims of evaluation to be comprehensively assessed whilst adhering to high standards of confidentiality and ensuring ethical principles for working with individuals are met. 'Gold-standard' evaluation methodologies compare the target intervention (education-based rape prevention) with alternative interventions with the same/similar aims. In order to achieve this standardised data collection and quality monitoring tools should be established across a range of similar such interventions designed to prevent rape by increasing awareness of the links between unequal relationships and unwanted sexual experiences, whilst providing the tools to develop more equal relationships, in order to enable robust comparisons of the success of interventions.
- ⇒ **Further developed;** make a contribution back into the **continued development** of education-based rape prevention interventions by making available lessons learnt and highlighting what works best thus adding to the evidence base in order that future development, in the same and in other locations and contexts, can be evidence-based.

## 11.11 #talkaboutit: talking about consent and coercion, Sweden

By Sofia Strid

### 11.11.1 Background

The intervention makes visible how the understanding of rape in popular and public Swedish discourse is more restricted than the actual legal definition. #talkaboutit makes visible the way that rape takes place in the **home**, and is committed by someone **known to the victim** and it enables women to **talk about it**: 'The law calls it a rape, but they /the women/ don't consider it a rape. Women believe they can't be raped by a boyfriend, friend, or husband, that it must a stranger attacking her outside for it to be considered a rape' (Dahlén, 2010). The intervention enables victims of rape to talk about their experiences and **name it as rape** since the act took place without their consent, even though many of the experiences described by victims were not violent (see Walby and Allen 2004; Walby and Myhill 2001).

The intervention was connected to the allegations against Julian Assange which constituted a possible tension and dilemma; #talkaboutit was quickly described as a conspiracy against Assange and WikiLeaks, which distorted the initial idea and aims. The network argued that #talkaboutit 'was not a campaign against Julian Assange, even though it could be interpreted as such', (JfA, no year), while one of the two main Swedish morning newspapers, Svenska Dagbladet, attributed #prataomdet to Assange's arrest.

### 11.11.2 Characteristics

#talaboutit could be understood as a **social media phenomenon** that started on Twitter on December 14, 2010 with a single Twitter hash tag in the wake of the allegations of rape, sexual molestation and unlawful coercion against Julian Assange (Almestad and Beijbom, 2012).

#talkaboutit (#prataomdet in the original Swedish) is a grassroots collective, network, social movement and public campaign which connects to the prevention of rape by raising awareness, by creating public debates **about the boundaries between consensual sex and rape**, by highlighting the difficulties in naming and establishing those boundaries, by making visible how rape is often committed by a perpetrator known to the victim (Walby and Allen, 2004) and how rape is a consequence of gender inequality (Brown and Walklate, 2012).

It highlights that, what may be regarded as private issues, are public and political issues, and attempts to alleviate some of the stigma attached to talking about experiences of sexual violence. It shows the existence of **many hidden and unreported cases of events that are legally defined as rape**, but which women and men find hard to name as rape. This case study is based on e-mail exchange with one of the core members of the original network and campaign, and who is the co-editor of the book *#talkbout it* (2012).

#talkaboutit started with one woman's tweet (Koljonen, 2010) which initiated a joint effort by a collective of around twenty (some well-established and well known) journalists and other writers to **enable synchronised publishing of self-lived experiences of sexual violence** and the difficulties associated with setting the boundaries between consent and coercion. Originally, the group of journalists wanted to use the combined media space they already had access to through their employment and networks. The idea was to create debate from this joined platform on the basis of synchronised publishing of their stories for

a bigger impact (Almestad and Beijbom, 2012). The articles about the boundary setting dilemma were published in the four major Swedish newspapers (Dagens Nyheter, Svenska Dagbladet, Expressen and Aftonbladet) and other well-known and well established newspapers and magazines and social media in Sweden (including ETC, Bang, City, City Skåne, Dagens Arena).

Television also quickly became involved in the campaign. One of Sweden's two key news programs, the Morning News on Channel Four (TV4 Nyhetsmorgon) with more than five million weekly viewers (Sweden's total population is approximately nine million) invited representatives from the network each day of the week leading up to Christmas 2010 where the campaign as such was discussed as well as the grey area between consent and coercion of sexual relations. Another well-known Swedish television programme, Debatt (Debate) also invited representatives from the network to discuss sexual violence and rape.

Consequently, geographically, #talkaboutit started in Stockholm, Sweden, but rapidly spread across the entire country and later on to Europe and internationally (Gentlemen, 2010; Gray, 2011; Escobedo Shepard, 2010; Valenti 2010). The campaign has had **widespread international reach**, with both the English hash tag and the setting up of websites in English. The actual location of the intervention is new social media and the internet, and is as such without geographical borders. After the first wave of publications, tweets, media reporting and television debates, a second wave of theatre plays, articles and more recently a book (Almestad and Beijbom, 2012) has created new spaces.

Currently, there are about fifty people actively involved in the core campaign group. The main involvement though, comes from the thousands of individual bloggers and social media users who started 'talking about it' through the spread of the twitter hash tag, and in addition to the Swedish hash tag, there is an English version.

### 11.11.3 Objectives

The purpose of the intervention is to **raise awareness** of sexual violence and rape, to make sexual violence and rape **visible in public discourse**, to **set a new agenda**, and to **'shake the boundaries of shame'** surrounding sexual relations and rape (Hadley-Kamptz, 2010). The intervention could be understood as part of the continuing feminist struggle to highlight the links between private and public, and how the private *is* public.

Koljonen's initial tweet was meant to highlight the difficulties involved when consenting adults (fail to) communicate sexual boundaries, and that **many cases of rape do not overlap with the way in which rape and sexual assault are described and discussed in contemporary public discourse and media**.

### 11.11.4 Innovation and co-ordination and co-operation

In the media, rape is often understood as the assault of an unknown perpetrator away from the home, whereas #talkaboutit tells the stories of how some people, predominantly women, experience sexual violence by a boyfriend, a partner or a husband. #talkaboutit **makes visible how rape and sexual assault is inaccurately described in public debate and discourse** as something that either is or isn't; #talkaboutit works by highlighting the difficulties many women experience in **struggling to accept that sexual coercion in their own home, with a partner or acquaintance, constitutes rape**. In this sense, the campaign also works as a reaction against the way in which Assange's solicitors criticised the allegations and claimed that what the women were describing did



not constitute 'real rape'. #talkaboutit as an intervention works by showing that women's experiences of rape are in alignment with the legal definition of rape.

The involvement of all major Swedish newspapers and the Channel Four news program means that the campaign reached quite possibly the majority of the Swedish population and a wide international audience. The intended initial recipients, according to Almestad, is best characterised as the Swedish people, involving them in a **public discourse**.

#### 11.11.5 Good Practice

The intervention worked well, in that it fulfilled its aims to raise awareness and make the grey areas of consent and coercion visible and the subject to public debate. In 2010 Koljonen, who posted the original tweet, and Sofia Mirjamsdotter, who were involved in the original campaign, were awarded the **Swedish Grand Journalism Award** – the most prestigious journalist award in Sweden, for 'making the private relevant to the public and for making an entire world talk about it.' Koljonen was awarded **several other prizes** for #talkaboutit, including: 'Women's Deed of the Year' by the Swedish National Shelter Movement (ROKS) in 2012; the Swedish Association for Sexuality Education (RFSU) Award in 2011; the Gyllene Haldan Journalism Award in 2011; and the Stockholm Award in the Media category in 2011.

Seen as a **media campaign and political strategy**, #talkaboutit was a success. Newspapers and media from across the entire world contacted the network and wrote articles about it and its aims and methods. Through the Swedish press, it spread beyond a Stockholm-centred media sphere or elite cultural debate.

#### 11.11.6 Recommendations for future projects

The methods and the social media used could be replicated elsewhere, but there are country specific considerations to be made.

- ⇒ The intervention uses the realisation that **traditional media no longer can control** what people talk about; #talkaboutit as a future project to be replicated elsewhere would have to **draw on the functions of new social media** to create a campaign and conversation which cut across all sectors of the media.
- ⇒ Although the intervention requires very little resources on the one hand in terms of **material, labour or money**, it requires large resources in terms of a **social and political climate** where gender equality is already a political priority on the other. Sweden is characterised by its high levels of gender equality and the journalists who started tweeting and publishing texts in the largest Swedish newspapers were to some extent already established as feminist writers, and were backed up by editors who were positive to the intervention as such and to gender equality in general.
- ⇒ However, there is no reason to believe that similar collective, grassroots campaigns using new social media and synchronised publishing methods would not connect to the prevention of rape by: raising awareness; creating public debates about the boundaries between consensual sex and rape; and by making visible how rape is often committed by a perpetrator known to the victim.



## 12 RECOMMENDATIONS

A series of recommendations are now made that follow on from the review of the international literature and the case studies of best practices.

### 12.1 EU-level

The EU could play a critical role in boosting prevention of rape and the provision of assistance to victims of rape. As the study shows, rape occurs in a complex environment. Legislation in the Member States (MS) does not always meet international standards. In the context of the Istanbul Convention that aims at a harmonised approach to tackle violence against women for the better protection of all women in Europe, the Member States might avail themselves of more effective tools to prevent rape, assist victim-survivors and stop the impunity of offenders. Consequently, a comprehensive package of law and policy is recommended at the EU level.

**EU legislative action.** While some instances of violence against women are already targeted by EU legal action, including trafficking, sexual harassment at the workplace and child pornography, the most serious form of violence against women, rape, has not been tackled. The **severity of the issue** justifies a careful examination of the possibility of legislative action on the EU level. In order to facilitate judicial cooperation in cases where alleged rapists cross borders, there is a case for a directive under the authority of **Article 82** of the Treaty on the Functioning of the European Union (TFEU) for a directive to establish **minimum rules for the definition of rape** that are consistent with international law. Since many aspects of policy to combat rape are shared with other aspects of gender-based violence against women and there are significant overlaps with other forms of violence, a comprehensive approach would be desirable on many aspects. Since violence against women is also a form of **gender discrimination**, EU legislative action is justified under **Articles 19 and 157** of the TFEU and should aim at the establishment of institutions that coordinate and monitor policy development and implementation; create an **administrative framework** ensuring that the relevant personnel, including the police, are adequately trained; that courts have adequate expertise; and that resources are made available to fund specialised services to support victims-survivors. This is not only relevant to EU internal relations and Member States but also for EU external relations.

**EU strategy and action plan.** Based on the priority of combating violence against women and the relevant funding under the citizenship programme 2014-2020, the respective provisions of the strategy for gender equality should be further developed and their implementation accompanied by an action plan. The action plan should tackle violence against women as a whole and rape in particular. Member States should be assisted in **identifying the detailed policy measures** needed to implement the strategy effectively; and advice should be offered to EU entities engaged in external affairs. This should be subject to regular review, evaluation and improvement. An **EU office and coordinator** should be established to oversee the EU Action Plan, which might be similar to that established in the case of trafficking (a Coordinator with an office and budget). There should be a **consultation platform** that includes the women's organisations that provide services to victims of rape as well as Women Against Violence Europe and the European Women's Lobby (EWL). The strategy and the plan should be subject to regular review, evaluation and improvement of EU level action.

**Ratification of the Council of Europe Istanbul Convention on Combating Violence Against Women and Domestic Violence.** EU Member States are recommended to sign and ratify the Istanbul Convention. In its external relations, the EU institutions should work towards third countries either adopting the standards of the Istanbul Convention or signing and ratifying the most appropriate regional Conventions, such as the Inter-American Convention of Belem do Para for states in the Americas.

**Economic growth and social inclusion.** The effects of widespread violence against women, including rape, on the economic and social situation of individual women should be recognised. Concretely, in the framework of a fully inclusive EU2020 strategy, ESF funded actions could establish better access of victim-survivors to the **labour market** and help to prevent (further) incidents of rape. Further, rape and other forms of violence against women are a detriment to women's employment as a whole and reduce prospects for economic growth. Combating rape and other forms of violence against women should therefore be recognised as essential tools to realise the objectives of the EU 2020 strategy for inclusive growth. In EU external actions, the detrimental effects of violence against women should be further highlighted and, accordingly, rape prevention be acknowledged as an indispensable component of **economic development**.

**EU structural and social funds.** The above mentioned strategy should receive sufficient funds to be implemented. At the EU level, this should include access to the **ESF** and the **citizenship programme** for projects to prevent rape and assist women victims of rape, in recognition of the damaging consequences of this violence to an individual's capacity for employment and livelihood and thereby the cost of rape to business and society. Programmes to prevent rape and assist victims of rape contribute to the social inclusion and integration of **vulnerable groups** so should be funded by programmes that aim to assist social inclusion. The citizenship programme should ensure that the activities formerly deployed under the Daphne I-III programmes, for example the exchange of expertise and best practice on the wider topic of gender based violence, developed by non-governmental organisations across EU Member States, should continue.

**EU humanitarian assistance to third countries.** The inclusion of assistance to victims of rape should be a routine part of policies and packages of humanitarian assistance. The EU should assist in the delivery of justice in conflict zones, including through cooperation with international tribunals and courts, so that perpetrators cannot act with impunity. In addition, the EU should continue to assist in improving the gender-balance in peace negotiators and peace keepers in conflict zones, since this can reduce the extent to which conflict zones are conducive to rape.

**EU research.** There should be **better data gathering and analysis** on the extent of rape and its consequences, and the effectiveness of the various forms of intervention in diverse policy fields. This should include a **programme of research** funded under the EU Research Framework Programme. The Commission should initiate an EU-wide survey that has a sample size large enough to identify variations in the extent of rape in each EU Member State since the on-going pioneering FRA study on violence against women is too small to achieve this. The European Institute for Gender Equality, EIGE, should continue developing tools to assist Member States in the collection of data and its analysis, so as to ensure comparability where this is appropriate.

**Framework for development of services to assist victims.** The EU should assist Member States in providing assistance to victim-survivors of rape through its actions to develop and share **best practice**. EIGE could be called upon, with the relevant funding, to

provide guidance based on best practice and drawing on the Istanbul Convention of the Council of Europe. The EU should monitor the provision of these services, using the indicators developed by EIGE. The Open Method of Coordination should be considered as a possible model to assist the development of best practice. In accordance with Article 14 TFEU, services for victim-survivors of rape should be regarded as services of general economic interest and consequently excluded from EU competition rules, thereby allowing MS to support them financially without resort to competitive tendering.

## 12.2 Member State level

**Legislation.** Legislation on rape in each country should reach the minimum level recommended by the UN (2010a) and the Council of Europe Istanbul Convention (2011). Legislation on rape should: **eliminate the 'marital exemption'** that means that men can rape the women they are married to with impunity; use the threshold of **'absence of consent'** rather than that of physical force (and in conflict zones recognise the context of coercion); make illegal, either as rape or as an equivalently serious offence, the penetration of the body by objects or other body parts without consent.

**National plans of action.** Each Member State should develop a national plan of action based on an integrated strategy to reduce and eliminate violence against women with a particular section tackling the different issues related to rape prevention and assistance to victims of rape. The national plans should be **aligned** to the EU strategy and action plan to ensure synergies. The above mentioned regular review process might be similar to that used for the National Strategic Plans on Social Protection and Social Inclusion, involving the **Open Method of Coordination**. Each (Member) State should create a body (Commission) that oversees the national strategic plan, which might be similar to that established to oversee equal treatment for the protected equality strands. There should be a consultation platform that includes women's organisations that provide services to victims of rape and input into the national strategic plan and to the relevant body. There should be adequate **financial support** from national budgets to implement the plans, including both specialised and mainstream services, and monitored through gender sensitive budgeting techniques.

**Comprehensive services for victim-survivors.** The national plan should ensure the establishment of specialised services providing **universally accessible assistance** for victims of rape, including advice available by phone, expert advisers, centres and shelters, health-care, and legal advice. As shown by the good practice examples of this study, these services should be **victim-centred**, and delivered by experts in a gender-sensitive manner. Minimum standards should be established and maintained following the guidelines in the Istanbul Convention and of the World Health Organization (WHO). The **funding** of these services should be monitored and adjusted to real needs. There should be coordination of the provision of the comprehensive services at both national and local levels.

**Health care.** Rape causes injuries to mental health as well as to physical health. Member States should therefore ensure the availability of specialised services for victims of rape within health care systems that address both types of injuries and which are sensitive to their needs. In order to achieve this, **training** of personnel needs to be increased and improved, including of all those who might come into contact with victims of rape. Specialised programmes need to be developed which include forensics to collect evidence to assist the criminal justice system if the victims want this. Furthermore, best practice

services should be **context specific**, including those provided in conflict and disaster zones; they should be coordinated with non-health-care services for victims-survivors, for example, with the rape crisis centres that tend to address historic rapes more than recent rapes; and new research into the most appropriate pathways of care for victims of rape should be undertaken.

**Criminal justice system.** Justice should be easily accessible for all victims of rape. There should be improvement of the treatment of victims of rape so as to avoid secondary victimisation and to reduce the very high attrition of cases through the criminal justice system, thereby ensuring that perpetrators are held to account and **reducing the impunity of rapists**. These actions include: **training** of police, prosecutors, judges, and other relevant officials; the provision of **special courts** to pioneer improved standards; and the provision of **special advisers and advocates** to victims including during criminal proceedings. There should be the development of innovative methods of catching perpetrators of rape, including those that are using **social media** to lure potential victims into vulnerable positions, while mindful of the need to protect human rights and civil liberties. There should be monitoring of the conviction rate for cases of rape reported to the justice system.

**Economic growth and social inclusion.** As is the case at the EU-level, Member States should recognise the relation between economic status and the risk of falling victim to rape. Economic growth strategies that are inclusive of women can therefore be regarded as measures to fight violence against women. With guidance from the Commission and with ESF funding, Member States should implement measures which ensure **women's participation in economic growth** and avail themselves of measures directed at **increasing women's access to a livelihood**; by narrowing gender gaps in employment and the likelihood of access to property; and the social inclusion of victims of rape. Further, the rehabilitation of victims and the reduction of the economic costs of rape will only be possible if measures take into account the relation between violence against women and economic growth. Programmes to combat rape and other forms of violence against women should therefore be **mainstreamed** into Member State programmes that promote economic growth and social inclusion.

**Culture, education and media.** Educational programmes should **promote healthy forms of sexual relationships** that avoid violence and are based on consent. The media should be challenged to avoid reproducing myths about rape, where this practice exists. Regulations should ensure the **anonymity of rape victims**. In addition, as shown by the good practice examples, media, including social media, if used in an innovative way, could promote better public understanding of the issues involved in rape.

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ISBN: 978-92-823-4865-9

DOI: 10.2861/37950