



Division for the Advancement of Women



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***"Violence against women: Good practices in  
combating and eliminating violence against women"***

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**Promising Practices addressing sexual violence**

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## Introduction

*Commitment to preventing or controlling sexual violence is also reflected in an emphasis on police training and an appropriate allocation of police resources to the problem, in the priority given to investigating cases of sexual assault, and in the resources made available to support victims and provide medico-legal services (World Health Organisation, 2002, p161).*

*... the best evidence which is essential to successful prosecution can only be gleaned from the best treated complainant (i.e. the victim). Intelligent and enlightened treatment of the complainant from the human perspective thus becomes the critical key in the success of the police function of law enforcement (Gilmore and Pittman, 1993, p45).*

*Virtually every clinical health and mental health care provider treats victims of sexual assault and domestic violence, although most are unaware that their patients have formerly or recently been abused (National Advisory Council on Violence Against Women and the Violence Against Women Office, 2001, Chapter 2, p3).*

The simple truth is that despite three decades of research, advocacy and campaigning, even the most basic issues matters, such as ensuring that women reporting sexual violence are treated with respect and dignity, cannot be guaranteed even in high resource contexts. For much of the 1990s two forms of violence against women (VAW) dominated awareness and policy development: domestic violence (now often referred to as 'intimate partner violence') and sexual exploitation through trafficking in women and girls. Other forms of sexual violence - rape and sexual assault, sexual harassment - have been described as 'forgotten issues' (Regan and Kelly, 2003), except where they occurred in the context of conflict or involved high-profile/celebrity defendants. The relative neglect of sexual violence is also evident in research, including the documentation and evaluation of service provision, hence the preference for 'promising' practices in the title, although there is considerable agreement about basic good practice parameters with respect to procedural justice.

Previous research and the accumulated knowledge of women's organisations revealed that many survivors<sup>1</sup> viewed the responses of institutions, and especially the criminal justice system, as a 'second assault'. The immediate outcomes in many countries were statute reforms, the development of protocols and forensic examination kits. Attention was also paid to the environment in which forensic examinations were conducted. The models outlined in paper are second and third generation developments, building on the first wave of reforms. At the same time data from across Europe (Regan and Kelly, 2003), North America, Australia and New Zealand (Kelly et al, 2005) suggests that conviction rates have fallen or remained static for at least a decade, creating a context of virtual impunity for perpetrators: a reality recently recognised by the UN through the appointment of a Special Rapporteur on the Difficulties of Establishing Guilt to Crimes of Sexual Violence. The two graphs in Appendix 2 illustrate these trends for England and Wales and Sweden – countries with different definitions of rape and one with an adversarial and one an investigative legal system.

There are a number of limitations to this paper, it is primarily based on material published in English, and cannot compare legal systems (adversarial and investigative) or responses to adults and children. Issues covered by other experts – such as counselling and hotlines – have not been emphasised, although they are key elements of provision in this field, especially when provided by experienced women's NGOs. The sections which follow address statute law, the process of reporting, provision of appropriate support and

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<sup>1</sup> Throughout this paper the terms survivor and victim are used, victim is chosen primarily in relation to the process of reporting and legal cases, since this – like complainant - designates a legal status.

investigative responses and prevention of sexual violence. A table (in Appendix 1) summarises the most obvious promising practices known to the author and the research/evaluative data underpinning this.

### **What is sexual violence and what do we know about it?**

What counts as 'sexual violence' is also not immediately obvious, although at minimum it will include: rape and sexual assault; sexual abuse of girls; trafficking and sexual exploitation and sexual harassment. There is also an argument for including other forms of VAW such as FGM, acid throwing, forced/early marriage and crimes in the name of honour, either because they amount to legitimised rape or because they are attempts to deny women sexual autonomy. For reasons of space, however, this paper is limited to rape and sexual assault of women and girls, with some references to sexual harassment and FGM. Trafficking and sexual exploitation are dealt with in another paper.

Sexual violence occurs in a range of contexts, but as with all forms of VAW the majority of perpetrators are known men – current and ex-intimates, family/community members and professionals/those in a relationship of trust feature strongly – although sexual violence can also be perpetrated by strangers and recent acquaintances (Kelly et al, 2005; WHO, 2002). The overlaps between rape and domestic violence, childhood sexual abuse and trafficking are both significant and insufficiently acknowledged (op cit). Moreover, the fact that much sexual violence involves repeated assaults by the same (and sometimes different) perpetrators is rarely acknowledged, nor is the fact that repeat and re-victimisation has cumulative impacts. Much policy and practice still operates with an implicit notion of 'real rape' – committed by a stranger, involving weapons and injury – and the implied 'real victims' and 'real rapists'. The contexts in which most rapes take place are in some instances not even recognised in law – rape in marriage is not criminalised in many countries – and others are trivialised through inaccurate and unhelpful descriptions such as 'date rape'.

Specific contexts appear to exacerbate levels of sexual violence, such as conflict and economic transition, and certain groups of women and girls are more vulnerable to sexual assault, including those involved in the sex industry, homeless/runaways, women with learning disabilities and mental health problems and those living in institutions that they cannot leave, like prisons. This vulnerability has tended to be understood in terms of women's locations, lifestyles and/or abilities, but much more emphasis needs to be placed on the targeting strategies of sexually coercive men – that they choose to victimise women and children who have less resources to resist and who are less likely to be believed or taken seriously should they report. This applies to contexts in western societies where alcohol is far more significant than the use of drugs to facilitate rape, and where predatory men appear to target women who are drunk/getting drunk (Kelly et al, 2005).

### **The letter of the law**

Historically, law on sexual violence has functioned to protect women's honour and their value as the property of fathers and husbands. Legacies of this remain in many legal codes and have been the target of campaigns for reform. Initial reform efforts focused on defining rape as a form of physical assault – hence the term 'sexual assault' in many national laws (see, for example, Canada and Australia), although more recent discussions and legal reforms have accentuated the principle of 'sexual autonomy' (see the Sexual Offences Act 2003 in the UK and Schulhofer, 1998). As already noted, marital rape remains legal in many countries, and legal ages of consent as low as 12 limit the protections available to girls and young women. Moreover, efforts to ensure that the credibility and 'worth' of victims is not played out through stereotypes of acceptable femininity have not been successful, perhaps most graphically illustrated by the limited impact of efforts to limit sexual history evidence, especially in adversarial legal systems.

The question of anonymity for victims is a critical one, especially in countries where this does not exist as a right. Here, even at the initial investigation stage a woman's name, picture and workplace may be used in salacious media coverage. This undoubtedly discourages reporting and may create a context in which women withdraw their complaint. At the same time, one can also argue that creating this right reinforces the notion that there is something shaming and stigmatising about suffering sexual violence, and in a number of jurisdictions has led to men's rights groups to agitate for an equivalent right for defendants.

The issue of how to define rape in law remains a contested issue, with recognition that the shift to sexual assault did not achieve the hoped for benefits of a) increasing convictions and b) shifting the focus in trials to the behaviour of the defendant (Schulhofer, 1998). Definitions requiring the presence of force amount to a resistance requirement, even for minors. The two approaches being explored at the end of the twentieth century involve:

- introducing positive consent standards (UK, Australia)
- using 'sex in coercive circumstances' (ICC, South Africa).

There is little research to date that enables assessment of the relative merits of these recent reforms. The promising practices listed below are proposed not because they have 'proved' effective, but in so far as they reflect UN and human rights baselines with respect to bodily integrity, childhood and what we now know about sexual crime.

### ***Promising practices in legal reform***

- Criminalising rape in marriage and making it a state offence.
- Creating specific offences for sexual crimes against children, some of which can be defined as 'strict liability' ie if you can prove it happened there is no defence. So, for example it would not be necessary to show resistance where rape was defined in terms of force, and where it was defined in terms of an absence of consent, a consent defence would not be available where the victim was a child.
- Setting 18 as the age of consent to be involved in the sex industry – reflecting the UN Convention on the Rights of the Child and that this is a different decision to having sex with a partner.
- Addressing capacity to consent for people with major disabilities and breach of trust offences committed by professionals and those in positions of authority and care.

### **The decision and opportunity to report**

The decision to report is a difficult one, made more complex by the fact that sexual violence carries forms of stigma/dishonour in most societies. Women, therefore, weigh up factors such as their own circumstances (including cultural issues) and how they expect to be treated by professionals (see Box 1). Often friends or family members are the first to be told, and how they respond may encourage or discourage a formal report. The increased reporting figures in many countries show that some of the taboo and stigma has been removed, but sexual violence still carries more negative meanings than domestic violence, since it is four times less likely to be reported (Statistics Canada, 1993). Reporting increases access to health care - over half of those who report accessed medical treatment, compared to under a fifth of those who did not (Rennison, 2002).

There is broad agreement that police stations are not the best place to address sexual violence, and certainly not to collect forensic evidence. One route to addressing this has been the women's police stations initially established in Brazil and replicated in other Latin American countries and more recently in Asia (see Appendix 1). Unfortunately, there have been no detailed evaluations, although commentaries note that whilst reporting increased, very few cases are prosecuted. Other less absolute

responses include the training of women police officers as 'first responders' who take initial statements and act as a liaison point throughout the investigation.

**Box 1: Factors influencing the official reporting of rape**

| <b>Factors motivating reporting</b> | <b>Factors preventing reporting</b>             |
|-------------------------------------|---|
| To prevent further attacks          | Not naming as rape/defining as a private matter |
| For personal protection             | Fear of being disbelieved/blamed                |
| Access to justice                   | Fear of perpetrator                             |
| Encouraged by others                | Fear of public exposure/lack of anonymity       |
| Belief in the justice system        | Lack of faith in police/courts                  |

**Support and investigative responses**

In the immediate aftermath of rape the needs of the victim for health care/support and the collection of evidence for any subsequent case need to be addressed. Several promising practices address this issue including forensic nursing, Sexual Assault Centres (SARCs in the UK) and the 'One Stop Shop' in Malaysia (see Appendix 1).

Undergoing internal (and also external) examinations following sexual assault is a daunting prospect, and research shows they can be experienced as 'another assault' at worst, and uncomfortable and invasive at best. At the same time, a forensic examination may provide vital evidence that identifies the assailant, and/or supports the complainant's account should the case come to court. However, there has been relatively little reassessment of the process of gathering forensic evidence in light of the recognition that most rapes are committed by known assailants, and there has been limited investment in the training of forensic examiners and ensuring access to the most up-to-date tools for gathering evidence. Studies on reporting rape offer crucial insights into what makes the experience of a forensic examination less traumatic. These include: a female examiner; privacy; a non-institutional setting; being talked through the process; a caring but professional manner (Kelly, 2002). Negative experiences are associated with: long waits; no choice about the sex of the examiner; the examiner appearing to disbelieve; and 'heavy handed' examination (Jordan, 2004; Temkin, 1996). Early evidence kits (a mouth swab and bottle for urine sample) can be used by any trained professional and mean that if there is a wait for an examiner victims may drink/smoke/go to the toilet without contaminating evidence.

Forensic examinations have some unique features: a medical practitioner acting as an agent of law enforcement with a dual purpose - to address the immediate needs and concerns of the woman and to ensure rigorous evidence collection (see Box 2). Good practice involves understanding these dual functions and endeavouring to combine them relatively seamlessly. It is possible to gather some physical evidence up to 72 hours after an assault, and beyond, if there has been physical assault and/or internal damage. Developments in DNA technology and other forensic science techniques are continually extending what is possible (Dept of Justice, 2003).

**Box 2: The needs of victims and justice system**

| <b>Victim</b>  | <b>Justice system</b>   |
|--|---|
| Treatment of injuries                                  | Accurate history of assault   |
| Prompt examination                                     | Documentation of physical findings  |
| Crisis intervention and support                        | Collection and preservation of evidence   |
| Testing for HIV/use of prophylactics                   | Interpretation and presentation of findings and expert opinion in legal proceedings |
| Prevention of STIs                                     |   |
| Assessment and, where desired prevention of, pregnancy |   |

An approach to forensic examinations which places the rights and dignity of the victim at the centre will ensure the following elements, drawn from a combination of research findings and protocols across a number of societies (see Kelly and Regan, 2003).

- Victims are accorded priority in any triage system.
- Injuries are immediately assessed and where necessary treated.
- Facilities offer privacy and security.
- Support workers/advocates who explain the process/procedures.
- Female examiners as the default position.
- Good practice in some parts of North America and New Zealand involves the initial statement being taken in a context where the police, medical examiner and victim advocate are all present, thus decreasing the need to have to repeat the account.
- Informed consent is sought at the outset<sup>2</sup>, and for each procedure, providing as much control as possible to the victim throughout.
- Skilled examiners, not just in the collection of evidence, but also in the meanings of sexual assault, and how to adapt procedures to the facts of a case and the local legal context.
- Provision for additional needs (such as interpreting or communication).
- Integration, as far as possible, of medical and forensic procedures.
- Facilities to wash, change clothes, have a drink and make phone calls after the examination.
- Support workers/advocates who will debrief and, where necessary, develop a safety plan.
- Routine mechanisms for follow up and advocacy.

The dual functions also raise critical questions about the need to separate the information recorded as part of forensic examinations and that undertaken for health and medical screening purposes. This care is needed to ensure that information on, for example, contraceptive use is not used as a 'backdoor' route for the introduction of sexual history evidence at trial (Temkin, 1996).

Many jurisdictions have developed Rape Examination Kits, which contain all the necessary resources for forensic examiners to conduct the examination, collect samples and record findings (on body charts, and in some cases, a report form). A series of studies in Canada question a 'one size fits all' kit and protocol, since it presumes an implicit stranger rape scenario. Their research demonstrates the critical importance of documenting external injuries (since they predict prosecution) and that protocols should be more complex, with different routes adapted to the facts of the case – i.e. is it a known offender and likely consent defence (Du Mont, & Parnis, 2001). This in turn suggests a need for skilled practitioners who understand the relevance of evidence to legal processes.

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<sup>2</sup> Obtaining this requires a process before examination in which the purpose and procedures are explained, and the extent of confidentiality and the options women have are outlined. Depending on the local procedure, this might include the right to have the examination and evidence stored before making a report to the police, and the right to refuse certain procedures and/or to discontinue the examination at any point.

Practice varies internationally as to whether routine HIV screening is part of the medical protocol, and on whether prophylactics are routinely prescribed. The current recommendation is that medication should be given where it is known/suspected that the perpetrator is HIV positive, and in order to be effective prescribing needs to begin within 72 hours of the assault. A key global issue is affordability, particularly for poorer countries where rates of HIV infection in the general population are high. Rape crisis centres, for example, Cape Town Rape Crisis in South Africa, have campaigned, and even taken legal action, to establish a right for this treatment.

### *Forensic nursing*

There is a growing literature documenting forensic nursing and a professional organisation for practitioners (see, for example, [www.forensicnurse.org](http://www.forensicnurse.org)). Forensic nurse examiners now conduct the majority of sexual assault forensic examinations in the USA (where they are called SANEs – Sexual Assault Nurse Examiners), and are also strongly established within Canada. An evaluated pilot has just been completed in the UK (Regan et al, 2004). The nurses in the US and the UK have longer and more in-depth training than most forensic doctors, and have also been at the forefront in integrating use of colposcopes. As Appendix 1 notes forensic nurses are often cheaper than doctors and ensure the provision of 24/7 cover and the availability of female examiners. Models in the US have also established ways to extend this to remote areas, and even to cover a number of urban hospitals, using a peripatetic model.

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

There are a number of models of SACs/SARCs, with many countries having hospital-based provision, and Australia also having a community-based option, but located close to a partner hospital. Some countries, such as Canada, have extensive networks (although uneven across the states), whilst others, such as Germany, Switzerland and the UK, have a number of centres, often in major cities or locations where either women's groups or committed medical staff have campaigned to improve local provision. Still others have single 'centres of excellence' (Iceland, Ireland, Denmark).

SACs/SARCs aim to provide a high standard of comprehensive care to anyone who has experienced recent sexual assault. In Canada their mandate is 'to attend to the medical, emotional, social and medico-legal needs of clients in a prompt, professional, and compassionate manner and to provide leadership in the prevention of sexual assault' (Du Mont and Parnis, 2002). This broader framework (in contrast to a more limited medico-legal model) is attributed to their foundation within a feminist perspective that emphasised the principles of choice, respect, empowerment and honouring differences, alongside provision of crisis intervention, longer-term support and prevention. SACs/SARCs tend to be limited to responding to recent sexual assaults, i.e. within the last two weeks, and are available to women, men and in some instances children<sup>3</sup>. Access is usually through the hospital emergency room, where any necessary emergency medical care will be undertaken. Where this is not required, the Centre comprises a private suite of rooms, one of which is equipped for forensic examinations. Some are limited to two rooms - one for examination and another for support/follow-up - and a shower room; others have more extensive provision; still others have the two rooms plus shower (often close to the Emergency Department) and an additional suite located elsewhere in the hospital where any follow-up and counselling takes place. In North America and New Zealand there are strong victim advocacy programmes - based in the prosecutors office or community rape crisis/sexual assault service - with advocates expected to be linked in at the earliest point. A recent evaluation of SARCs in the UK (Lovett et al, 2004) found that advocacy and proactive follow-up were more relevant services than counselling in the immediate aftermath of sexual violence.

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<sup>3</sup> In contrast to Rape Crisis Centres, which are often services by women for women, and the majority of whose service users are dealing the legacies of assaults that happened some time previously.

One aspect of good practice is that services are provided regardless of whether a report will be made to the police, and offer the possibility of taking samples, and having them stored for a period of time, so that the decision about reporting can be taken at a later date. Funding of SACs/SARCs varies, with some in North America being supported through federal or state funding for victim services or health care budgets. In the UK, funding for staff and services has come from police budgets, with health covering the accommodation costs. The Australian model (termed Sexual Assault Services - SAS) emphasises longer-term continuity of care and advocacy, and has developed national standards (National Association of Services Against Sexual Violence, 1998). They have much in common with well-funded rape crisis centres, undertaking longer-term support of adult survivors of child sexual abuse<sup>4</sup>. The community location means that some services are for women only, but a number also work with men and children, services for men may have separate locations and their own staff, but are institutionally linked to the women's service, whereas others are co-located.

### *'One Stop Shops'*

Integrated models refers to provision that, as an organising principle, respond to adults and children and/or across sexual and domestic violence or even all forms of VAW. This kind of response is much more common in resource poor countries, not only because it maximises scarce resources but also because lessons have been learnt from other countries, often meaning that separate sectors did not develop in the same way. The most well known and promoted good practice example is the 'One Stop' model developed in Malaysia<sup>5</sup>, currently being replicated in much of Asia. Whilst many practitioners support such ideas in principle, recognising the connections between forms of violence at both the conceptual level and in the lives of women and girls, in practice they fear forms of prioritising – of children before women, of domestic violence before sexual violence.

An evaluation by Siti Hawa (2000) found in Malaysia was that the implementation of the model outside the metropolitan areas of Penang and Kuala Lumpur often lacked vital components and was frequently done 'on the cheap'. The most vital missing component was the partnership with women's NGOs to provide the support and counselling elements, policy makers had simply presumed they would be there. Almost all good/promising practices require substantial capacity building before they can be mainstreamed, but this investment is rarely forthcoming.

### ***Promising practices in initial responses***

- Ensuring the availability of female examiners and police officers
- Adapting forensic examination to the facts of the case
- Institutions outside police stations, preferably linked to hospitals, where examinations and initial support can be undertaken.
- Involvement of advocates/women's NGOs throughout, including proactive follow-up.

### **Prosecuting cases**

As the charts from the UK and Sweden demonstrate obtaining a conviction is the least likely outcome in a sexual assault case, although prosecution rates in Europe vary between 75 and 10 percent, and the proportion of cases resulting in a conviction span 70 to less than 30 per cent. All adversarial systems had a conviction rate of less than 10 per cent, but so did Sweden with an investigative system. The only exception to this depressing picture is Germany, where a sustained increase in prosecutions and convictions is evident over five years from 1997 (Regan and Kelly, 2003). More detailed research would be needed to account for these variations and anomalies.

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<sup>4</sup> Recent changes in funding regimes have decreased services to this group in some states.

<sup>5</sup> One inspiration for this model was a study visit to the UK funded by the British Council, which included visiting the St Mary's Sexual Assault Centre.

Whilst there are many valid reasons for cases not proceeding, in-depth research across many jurisdictions reveals that extra-legal factors influence much decision-making in rape cases (see Department of Women, 1996 for Australia; Jordan, 2004 for New Zealand; Kelly et al, 2005 for UK; McGregor et al, 2002 for Canada). The most significant appear to be the legacies of the notion of 'real rape' which in turn creates stereotypes of who are 'real'/legitimate victims and 'real'/culpable rapists. As a consequence the chances of prosecuting cases where the parties are known to one another and the rape takes place in the complexity and messiness of everyday lives have not been adequately addressed. The careful investigation of non-consent in non stranger rape (Archambault et al, 200?) , for example, would document any form of resistance, how submission took place, anything said to try and dissuade the rapists, fears in relation to the context/environment and any other constraints on action. In presenting cases prosecutors should be seeking to enhance the believability/credibility of the complainants narrative – but not through relying on stereotypes and myths about women and female sexuality. Specialisation by prosecutors means that they will not only be more alert to these pitfalls, but can develop skill and expertise in presenting such cases. This argument could also apply to investigative judges/magistrates. Only South Africa has created specialist sexual violence courts. Some practices also enable judges/magistrates to be held to account, such as the possibility of appealing acquittals and low sentencing by the prosecution/state. The latter has been done very effectively by the Solicitor General in England and Wales, with the submissions to the Court of Appeal addressing key issues, such as the discount often made for the fact that the rapist was known/a family member rather than this being seen as an aggravating factor given the breach of trust involved and the frequent presence of multiple assaults.

### ***Promising prosecutorial practices***

- Specialisation – police investigative teams (USA and London, UK) and special/sex crime prosecutors (USA) and investigative judges (South Africa?).
- Creating protocols and training on investigation of acquaintance rape.
- Combined investigative/prosecuting teams covering violence against women and children (Namibia)
- Sexual violence courts (South Africa)
- Protections whilst giving evidence – screens, video, video link, defendant cannot cross examine
- The possibility of appealing acquittals (Denmark)
- Justice ministers being able to appeal inappropriate sentences (England and Wales)

### **Prevention**

Unlike domestic violence where there are some indications of falling levels of homicide in North America, there is no data suggesting falls in sexual violence. Rather less effort has been invested in preventing sexual violence, although some integrated approaches to VAW – such as Scotlands Zero Tolerance Campaign have included it. HIV/AIDS prevention in Southern Africa reveals that one of the barriers to safe sex is the prevalence and acceptance of coercive heterosexual sex, with women lacking the power and resources to refuse sex. Recent research with young people in the UK and Ireland also reveals that they have very uncertain ideas about what 'consensual sex' means, suggesting that public health/safe sex messages across the globe should begin from a principle that safe sex requires consent.

A practice which was part of early women's movement responses to sexual violence, and women's fear of rape – self-defence – has not been promoted as strongly in the 1990s. That said, however, it has strong proponents in Europe, especially in the Netherlands and Germany (Seith and Kelly, 2003). Philosophy professor Susan Brison's (2002) reflection on her own experience of rape echoes Judith Herman (1986) in noting the critical importance of the simultaneous disconnections from one's body, place in world and relationships to others. For her, reconnecting to others and the embodied practice of women's self defence were critical in her re-making of her self.

*I develop and defend a view of the self as fundamentally relational – capable of being undone by violence. But also of being remade in connection to others... Learning to fight back is a crucial part of this process, not only because it enables us to experience justified, healing rage... the confidence I gained from learning to fight back not only enabled me to walk down the street again, it gave me back my life... a changed life, a paradoxical life. (Brison, 2002, pxi, p14-15)*

Self-defence is one of the few interventions that directly addresses the way in which the threat of rape limits and constrains women's space for action.

A practice worth exploring more widely is the pledging used by the NGO Tostan with respect to FGM in Senegal. They claim to have over 1200 villages which have pledged through public and local declarations not to use the practice on their daughters<sup>6</sup>. Are there equivalent collective/community-based preventative possibilities about other forms of sexual violence? Should the 'Making a Difference' Project in the USA be seen as a variant of this, since it involves eight communities (at the professional level) committing themselves to transformmg the way they respond to sexual assault. A key tool is data collection and evaluation, including organised 'court watching'.

### **Issues not addressed**

The provision of support and safety – in the form of hotlines, self-help groups, shelters – is not covered here, but all are relevant to sexual violence and are used in various forms and combinations in relation to it. Also, no discussion has been developed on inter-agency/co-ordination work, which whilst it exists, is far less developed than in the fields of domestic violence and trafficking. Again, the question of whether an additional structure should be created (such as the Sexual Assault Response Teams [SARTS] in the US), and whether more integrated models are possible, emerges.

Little attention has been paid to the context in which sexual violence occurs – be it conflict, post-conflict, refugee/IDP camps or in the aftermath of disasters such as the tsunami. The latest report on Darfur (Medecins sans Frontieres, 2005) suggests that little has really changed in awareness and intervention, and that women and girls are most at risk when undertaking daily tasks. Another gap is in relation to the sex industry, where some countries are attempting to address sex tourism and other forms of sexual exploitation. Hawaii (Dunford, 2004) has just passed a law directed at travel agents, and also made it illegal to transmit explicit sexual images in any digital or other media without the consent of the person in the picture.

An upcoming debate that has not been addressed is the application of restorative justice approaches, whereby cases are screened of the criminal justice system into a more communitarian model, where a) the victim opts for this b) the offender admits to the offence and c) the case fits various other criteria. Experiments are currently taking place in South Australia and Arizona, USA, but are in early stages and the practice is contested with respect to sexual violence.

### **Separate or Integrated?**

The needs of survivors of sexual assault, sexual exploitation and domestic violence may turn out to be more similar than different, if we approach this with an open mind, and good practice may be similar across the boundaries. A clear commonality are the both the needs for safety and support and the

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<sup>6</sup> In Kenya another alternative has been to link public education to an alternative Coming of Age process (the NGO working on the project is MYWO).

<sup>7</sup> In Benin 170 village committees are monitoring children in order to both prevent trafficking and support reintegration (Innocenti Insight, 2003, p44).

importance of procedural justice. Here even though the outcome may not be what one hoped for, being taken seriously, treated in professional and respectful manner, provided with information and options, creates a sense of having been treated fairly, and can even restore social connection.

Across all forms of VAW the issue of violence by known men continues to confound accepted models and approaches. Whilst many professionals no longer discount rapes by known assailants, they do treat them as less credible (Jordan, 2004; Kelly et al, 2005) and work with implicit models of 'real rape'. In fact, only a minority of rape cases fit this stereotype, but they are still the most likely to be reported, investigated and prosecuted. Real reform of the criminal justice system will have begun when reports of sexual crime by known offenders, in contexts where the complainant could be seen as 'taking risks' (such as accepting a lift, an invitation for a cup of coffee, or having consumed alcohol voluntarily), are not dealt with as an 'exercise in scepticism' (Yancey Martin, 2005) but rather as a report of serious crime which requires dedicated investigation and evidence gathering. We will also know that reform has taken deep roots when defence barristers act more ethically and choose not to invoke sexist stereotypes, however effective they might be, in their advocacy (Temkin, 2000). What is needed to address impunity is a change in culture – not just in the justice system, but across societies, such that 'the word of a woman', as Jan Jordan (2004) refers to it, is no longer treated as less worthy of belief when what she speaks about is sexual victimisation.

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Home Office Violence Against Women Programme [www.homeoffice.gov.uk/rds/violencewomen.html](http://www.homeoffice.gov.uk/rds/violencewomen.html)

### Appendix 1: Promising practices in sexual violence and the evidence base supporting them

| <i>Practice</i>                    | <b>Promising elements</b>   | <b>Evaluation</b>  | <b>Iifs &amp; Buts</b>  | <b>Other relevant literature</b>                            |
|------------------------------------|---|--|---|---|
| Female examiners/<br>investigators | <ul style="list-style-type: none"> <li>• Vast majority of female and male victims prefer female examiners</li> <li>• Most prefer female police officer</li> <li>• If complainants feel more at ease, are more likely to give clearer account/facilitate evidence gathering</li> </ul> | <ul style="list-style-type: none"> <li>• 83 per cent of female and male victims prefer female examiners</li> <li>• Around half (52%) would prefer female police officer for first response, and a third (65%) female officer to take statement</li> </ul> <p>From Lovett et al. (2004) and Kelly et al. (2005)</p>   | <ul style="list-style-type: none"> <li>• Still need to ensure adequate training – cannot assume ‘any woman will do’ (Jordan, 2002)</li> </ul>   | Ledray (1996)   |
| SARCs/SACs                         | <ul style="list-style-type: none"> <li>• Integrated, coordinated services</li> <li>• Female practitioners</li> <li>• Expertise in responding to sexual assault</li> <li>• Treat victims with dignity and respect, seek to restore control</li> </ul>                                  | <ul style="list-style-type: none"> <li>• Rated highly by majority of service users</li> <li>• Integrated SARCs were rated highest</li> <li>• Elements particularly appreciated were access to female practitioners, proactive follow-up, case tracking, advocacy, access to information by telephone</li> <li>• More forensic examinations conducted where SARC</li> <li>• Extend access to support and medical attention through self-referral option</li> </ul> <p>From Lovett et al. (2004)</p> | <ul style="list-style-type: none"> <li>• Informal/practical support and advocacy more relevant post-assault (Du Mont &amp; Parnis, 2002; Lovett et al., 2004)</li> <li>• Still issues around out-of-hours access (Lovett et al., 2004)</li> <li>• Need resources to do proactive follow-up</li> </ul> | Du Mont & Parnis (2002)                                     |
| One Stop Shops                     | <ul style="list-style-type: none"> <li>• Address overlap between child/adult cases and sexual/domestic violence</li> </ul>  |  | <ul style="list-style-type: none"> <li>• Replication is often ‘on the cheap’</li> </ul>   | Siti  |
| Forensic nursing                   | <ul style="list-style-type: none"> <li>• Access to female examiner</li> <li>• Availability, especially during daytime</li> </ul>  | <ul style="list-style-type: none"> <li>• Increased daytime availability, and number of daytime examinations conducted</li> </ul>   | <ul style="list-style-type: none"> <li>• Need to ensure adequate court training</li> <li>• In UK still issue of whether</li> </ul>  | Campbell (2004)<br>Du Mont & Parnis (2003)<br>Littel (2001) |

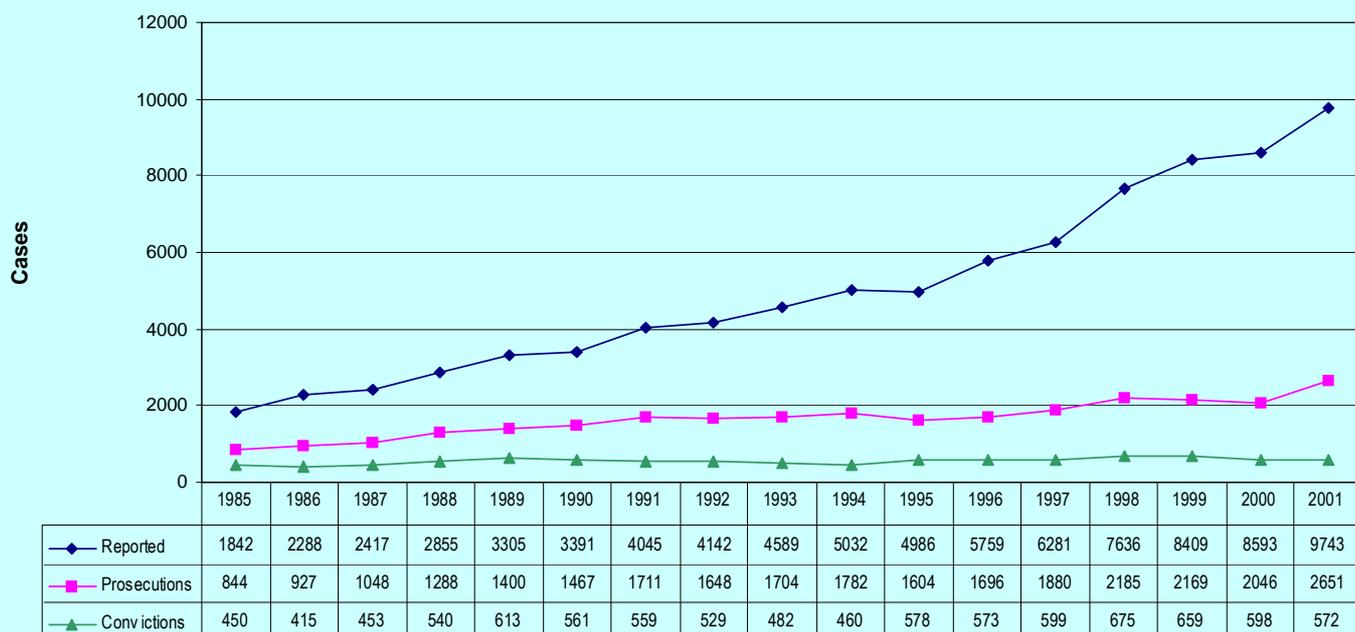
|   |  |   |   |  |
|---|--|---|---|--|
|   | <ul style="list-style-type: none"> <li>• Expertise in forensic and sexual assault issues</li> <li>• Improved evidence gathering</li> <li>• Possible increase in prosecutions and convictions</li> </ul>  | <p>increased by nearly half (Regan et al., 2004a; 2004b)</p> <ul style="list-style-type: none"> <li>• Forensic nurse underwent more detailed training and conducted more examinations than doctors (Regan et al., 2004a; 2004b)</li> <li>• Forensic nurse rated highly by examinees on all measures (Regan et al., 2004a; 2004b)</li> <li>• Overall cost of examinations by forensic nurse was lower compared to doctor (Regan et al., 2004a; 2004b)</li> <li>• SANE evidence kits more thorough than non-SANE on 10 quality control criteria (Sievers et al., 2003)</li> <li>• Conviction rate (guilty plea or verdict) higher among SANE than pre-SANE cases (Crandall &amp; Helitzer, 2003)</li> </ul> | <p>forensic nurse should be interpreter as well as gatherer of evidence</p> <ul style="list-style-type: none"> <li>• Increased convictions only where documented serious injury (Du Mont &amp; Myhr, 2000)</li> </ul> | <p>Ledray &amp; Simmelink (1997)<br/>Ledray (2001)</p> |
| Special prosecutors                     | <ul style="list-style-type: none"> <li>• Development of expertise in prosecuting sexual offence cases</li> <li>• Potential to challenge rape myths by taking on 'unprosecutable' cases</li> <li>• More active role in building cases and contact with complainant</li> <li>• More likely to provide continuity of personnel</li> </ul> | No known evaluation   | •   | Fairstein (1995)<br>Vacchs (1994)                      |
| Women's police stations (Brazil, India) | <ul style="list-style-type: none"> <li>• Increased reporting</li> <li>• Women feel more comfortable reporting to other women</li> <li>• Better treatment of women reporting violent offences</li> </ul>  | No known evaluation   | <ul style="list-style-type: none"> <li>• Are not consistently available – uneven access depending on location</li> <li>• Not matched by increase in prosecutions</li> <li>• Marginalisation of female</li> </ul>      | MacDowell Santos (2005)                                |

|   |   |  |   |   |
|---|---|--|---|---|
|   | <ul style="list-style-type: none"> <li>Better environment</li> <li>Potential to expand women's access to justice</li> <li>Collaboration between women's rights organisations, NGOs, state and police</li> </ul>   |  | <ul style="list-style-type: none"> <li>officers</li> <li>More recent inclusion of male officers in WPS as investigators – gendered division of labour</li> </ul>  |   |
| Linked investigative/prosecuting teams (Namibia)                  | <ul style="list-style-type: none"> <li></li> </ul>  |  | <ul style="list-style-type: none"> <li></li> </ul>  |   |
| Sexual violence courts (South Africa)                             | <ul style="list-style-type: none"> <li>Development of legal and judicial expertise through specialisation</li> <li>Aim to increase convictions and enhance procedural justice</li> <li>Potential for more focus on marginalised/problematic types of cases</li> <li>Continuity of court personnel</li> <li>Greater administrative efficiency</li> <li>Greater coordination with support services</li> </ul> | <p>No formal evaluation but a research study/assessment conducted</p> <ul style="list-style-type: none"> <li>Some procedural improvements – courts equipped with video-link equipment, separate waiting rooms for offenders and victims but no interview with victims</li> <li>Claims that have increased convictions, but little evidence (no pre-SOC rates and no comparison with generalist courts current rates). May be more in child cases</li> </ul> <p>From (Sadan et al., 2001)</p> | <ul style="list-style-type: none"> <li>Implementation is uneven</li> <li>Easier to establish in urban areas as already more centralised – lack of equal access</li> <li>Resources/support services need to be in place</li> <li>Have become more focused on child cases</li> <li>Need adequate data systems to assess impact</li> </ul> | <p>Walker &amp; Louw (2003)<br/>Moult (2000)<br/>Rasool (2000)</p>  |
| Focusing on known offenders in investigative processes/guidelines | <ul style="list-style-type: none"> <li>Majority of offenders are known</li> <li>Stranger assault evidence collection different to non-stranger (need to demonstrate lack of consent rather than identity/force)</li> <li>Addresses difficulties of consent defence</li> </ul>   |  | <ul style="list-style-type: none"> <li></li> </ul>  | <p>Archambault &amp; Faugno (2001)<br/>Archambault &amp; Lindsay (2001)<br/>National Center for Women and Policing (2001)</p> |
| Protections giving evidence – screens,                            | <ul style="list-style-type: none"> <li>Protects witness from being confronted by defendant in</li> </ul>  | <ul style="list-style-type: none"> <li>44% of sexual offence victims said special measures enabled</li> </ul>  | <ul style="list-style-type: none"> <li>Inconsistent availability of provision</li> </ul>  | <p>Reid Howie Associates (2002)</p>   |

|  |  |  |   |  |
|--|--|--|---|--|
| <p>video, video link, defendant cannot cross-examine</p> | <p>court</p> <ul style="list-style-type: none"> <li>• Lessens distress/trauma for complainant during evidence giving</li> <li>• More likely to ensure cooperation of complainant with CJS</li> </ul> | <p>them to give evidence they would not otherwise have been able to give</p> <ul style="list-style-type: none"> <li>• Anxiety about the court experience fell from 22% pre-special measures to 12% post for sexual offence victims</li> </ul> <p>From Hamlyn et al. (2004)</p> | <ul style="list-style-type: none"> <li>• Some complainants prefer to give evidence in open court</li> <li>• Debate about impact on juries – some argues makes witnesses less sympathetic; others that by highlighting their vulnerability, they reflect negatively on the defendant</li> <li>• No change in rates of satisfaction with CJS as a whole among sexual offence victims granted use of special measures (Hamlyn et al., 2004)</li> </ul> |  |
|--|--|--|---|--|

## Appendix 2: Illustrations of the attrition process in the prosecution of rape cases

### Attrition in England & Wales (Cases include Minors)



### Attrition in Sweden (Cases include Minors)

