ESR
Science for Communities

Experiences of the forensic medical exam after sexual assault: Qualitative thematic synthesis

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1.1 BACKGROUND AND OBJECTIVES

ESR is the leading forensic science provider in Aotearoa New Zealand ('Aotearoa') and provides laboratory testing for the evidential sexual assault kits that are produced during the forensic medical examination (FME) conducted by medical practitioners after sexual assault. As a key organisation in the FME 'system', ESR collaborated in a research project to support improvement in FMEs through identifying and prototyping innovations to the system.

The first stage of the project was to map the FME system, including who is involved, their perspectives of the system, and the multiple goals sought from the system. This qualitative thematic synthesis (Thomas & Harden, 2008) reviewed existing literature in order to map the system.

The objectives were to review what was known about experiences of patients and medical practitioners with the FME, both in Aotearoa and internationally, and to:

- Highlight the gaps in knowledge, especially for the Aotearoa context
- Identify the aspects that have the most impact on the FME experience, particularly for patients
- Identify target areas for innovation, which would have significant impact on the FME experience for patients while meeting the health and legal information requirements

1.2 METHODS

The search was undertaken between January and March 2021, and the search criteria had a focus on the experiences of the FME after sexual assault, with adult patients. Both academic and non-academic literature was included, both internationally and from Aotearoa, with priority given to finding literature from Aotearoa. A variety of search methods were used, including key search terms within databases, following specific authors to find other literature from them and their collaborators, and using the 'similar articles' features of many journal websites and literature-sharing databases. The 109 pieces of literature found were examined by the researchers for relevance to the topic and the method, with 33 pieces of literature being selected for the review. The selected literature originated predominantly from Aotearoa, the US and Canada, and the UK.

Following the qualitative thematic synthesis method, the findings of each study were extracted as the data for the review. The method called for a re-interpretation of the findings across the

study, as opposed to comparing the themes from each report or study. The extracted findings prioritised original data quotes from patients and practitioners which described their experiences of the FME. The qualitative software Dedoose was used by the researchers to code the data, using inductive codes arising from the data. These descriptive themes are presented in the results section. The process of coding and then writing the descriptive themes included multiple discussions between the researchers and became the analysis that generated the interpretive themes presented in the discussion section. The second step of generating interpretive themes from the descriptive themes is an essential element in the thematic synthesis method.

1.3 RESULTS

The descriptive themes from the review were arranged into roughly chronological order, from before, during and after the FME.

Deciding whether to have an FME was a complex decision involving the reasons that an FME was being sought, the time elapsed since the sexual assault, and the processes of gaining informed consent. The tension between the dual roles of the FME to meet both the immediate healthcare needs of patient and the requirements for legal evidence was highlighted. Most patients chose to have an FME for healthcare reasons, and some also for the forensic evidence. Yet systems often appeared to prioritise the legal purpose of the FME over the healthcare. The process of informed consent was problematic, given the generally distressed state of the patient, but also systems that did not separate consent for an FME from consent to release the results for legal purposes.

The FME was generally experienced as invasive, traumatic and a source of revictimisation for the patient. The practitioner's behaviour made the biggest single difference to how a patient experienced the FME. Numerous positive characteristics of the practitioner were identified, including: sympathetic and reassuring, could explain procedures carefully and calmly, was quick, efficient and skilled at the tests, who knew which tests were important for what reasons and which could be overlooked, and above all, attended to the therapeutic needs of the patients. These characteristics meant that the patient felt respected, informed and supported, and the competence of the practitioner meant that the overall time taken for the FME was minimised.

There was a strong theme of control and empowerment, which was important to sexual assault victims who had been in a traumatic situation that they had not been able to control. Not only was the act of undergoing an FME seen as a way of taking control of the situation, but also

practitioners could empower patients by explaining things carefully and giving choices wherever feasible.

Characteristics such as the gender, culture and training of the practitioner had some impact on the FME experience for patients, but this was secondary to the knowledge, competence and behaviour of the practitioner. Similarly, the warmth and welcoming aspects of the physical environment positively impacted on the FME experience, in a small but significant way.

Healthcare following the sexual assault and FME was variable, did not appear to be well integrated with the healthcare system and was affected by under-resourcing of longer-term services.

The processes after the FME varied depending on whether the patients decided to proceed with prosecution. Many of the kits are not tested for various reasons, and of those tested, it was not clear which parts of the evidence made a difference to legal outcomes. The use of the evidence in the legal process and in court proceedings was highly affected by the attitudes of people in the system, and the prevalence of entrenched 'myths' about causes of rape.

1.4 DISCUSSION

The review highlighted three areas where there could be changes within the system that would positively impact the experiences of the FME. These were concerning the FME documentation, the connection between FME evidence and legal outcomes, and practitioner training and support.

Currently the documentation for the FME covers the dual healthcare and legal evidence roles, yet the rules for information storage, use and disclosure are different for the two systems. Separating the healthcare information from the legal evidence information could allow the healthcare information to be treated in the same way as other health records, without compromising the legal evidence.

Any innovation which minimises the FME would improve the experience for patients and practitioners. To do this it would be necessary to know which aspects of the FME are essential or discretionary, which contributes to positive legal outcomes, and which can be left out without affecting legal outcomes.

In view of the significant impact of practitioner behaviour, systemic ways should be found to support continuing improvement. Aspects of training, documentation, resourcing, feedback and formalised processes for review and ongoing adjustments to the system would all support the positive practitioner behaviour that makes such a difference for patients.

2. BACKGROUND

ESR is the leading forensic science provider in Aotearoa New Zealand ('Aotearoa'), alongside roles in public and environmental health. The sexual assault forensic medical examination (FME[1]), apart from having therapeutic healthcare benefits for the patient, gathers forensic evidence using Medical Examination Kits (MEKs[2]). ESR processes the MEKs produced at the FME. As a key organisation in the FME 'system', ESR is looking to support ongoing improvement in FMEs through a project to identify and prototype innovations to the system.

'System' is understood as a collection of things (people, processes, organisations, information) interacting in such a way that they produce an outcome over time. To understand a system, we need to identify the things that make up the system, and the interaction between these things. We also need to understand decisions that have influence over interaction between things, such as funding, administrative processes and what outcomes are prioritised by people with power within the system.

The first stage of the project is to map the FME system, including who is involved, their perspectives of the system, and the multiple goals sought from the system. This review maps the system using a qualitative thematic synthesis approach (Thomas & Harden, 2008) to review existing literature, both from Aotearoa and internationally.

Sexual assault is an intensely traumatic experience for the person being assaulted. The FME is designed to help patients who present after a sexual assault, both by offering medical assistance and by collecting forensic evidence for use within the justice system. Informing this research is a principle that a key consideration in design of improvements to the FME is improvement in the experience of the patients undergoing the FME. At the same time the FME should continue to provide medical and therapeutic benefit and meet requirements for producing legal evidence. The starting point of this review, therefore, was the perspectives and experiences of the participants in the FME, that is, patients and medical practitioners (doctors or nurses).

In this review, we chose to use the term 'patient'. The literature uses many terms, depending on the focus of the studies or the perspectives of the researchers, for example, victim or survivor or client or complainant. Noting that the FME has dual therapeutic and legal objectives, we chose to privilege the therapeutic aspect by conceptualising the relationship as that of medical practitioner with a patient seeking care.

[1] In international literature this is sometimes called MFE or medical forensic examination
[2] Also called sexual assault kits or in international literature, 'rape kits'

3. OBJECTIVES

The objectives of this qualitative thematic synthesis are to review what is known about experiences of patients and practitioners with the FME, both in Aotearoa and internationally and to:

- Highlight the gaps in knowledge, especially for the Aotearoa context
- Identify the aspects that have the most impact on the FME experience, particularly for patients
- Identify target areas for innovation, which would have significant impact on the FME experience for patients while meeting the health and legal information requirements

The results of this review will input into the larger project which will map the FME system, then identify and prototype innovations to improve the system.

4. METHODS

4.1 SELECTION CRITERIA

4.1.1 Topic of interest

The topic of 'sexual assault' included not only rape, but also other types of unwanted sexual violence of a physical nature. The FME for sexual assault is carried out for a number of related offences. The review focused primarily on sexual assault as an isolated event, with offenders both known and unknown to the victim, because the majority of FMEs are carried out for this type of case. Further, working with child victims of sexual assault is covered by different guidelines within Aotearoa legislation. Therefore, the topic deliberately excluded child patients of the FME, and while not excluding FMEs in the situations of ongoing or historic sexual violence, the focus was more on single events of sexual assault.

This review was intended to inform research into improving the FME process in Aotearoa, and included international literature to gather wider perspectives and innovations.

4.1.2 Types of studies

To investigate ways of improving the process of the FME, the focus of this review was on the *experience* of all the participants. Therefore, we searched for full-text qualitative research studies and reviews which had some findings related to patients' and practitioners' experiences of an FME ('academic literature'). We also included non-academic literature from government agencies, hospitals, health and medical associations, non-government agencies and international online media, to support the academic literature findings by providing different types of information and different perspectives.

Recent studies were preferred, but the paucity of literature meant that relevant studies were included irrespective of publication date. Only English-language articles were searched for, due to the language capabilities of the researchers.

4.2 SEARCH METHODS

4.2.1 Initial searches

The initial search covered these electronic databases and sites:

- Web of Science Core Collection, Clarivate Analytics
- Science Direct
- ResearchGate
- Academia.edu

- Google Scholar
- Microsoft Academic, Entity Analytics
- JSTOR

Search terms included combinations of ‘sexual assault’, ‘forensic’, ‘medical examination’, and ‘experience’, and were changed based on the key words and titles of relevant literature that were found. Literature from those who were identified as key authors in the field were searched for, particularly Rebecca Campbell, Janice Du Mont, Deborah White, Denise Lievore and Oona Brooks, including from their profiles in ResearchGate and Academic.edu. Use was made of the ‘similar articles’ feature of journal websites, ResearchGate and Academic.edu.

4.2.2 Expanding the search

As we were seeking literature on FME participants’ experiences (both patients and medical practitioners), we broadened our search beyond academic research papers. We searched for community-based reports, international media articles, technical reports, and information booklets. We targeted electronic databases, with an emphasis on Aotearoa New Zealand literature.

- New Zealand Family Violence Clearinghouse
- Community Research Foundation
- New Zealand Ministry of Justice
- Networked Digital Library of Theses and Dissertations
- Google

The searching reached data saturation with 109 pieces of literature, when no new information was being found. The dates ranged from 1977 to 2020, 43 years in total.

4.3 FINAL SELECTION OF STUDIES

There were 33 studies which matched our search criteria, especially related to representing the patient or practitioner FME experience, with a date range of 1997 to 2020, 23 years in total. Two studies, one related to sexual assault of men and the other working with transgender patients, were deliberately included for diverse perspectives.

Of the 33 studies, 22 studies (59%) were classified as academic literature and 11 studies (41%) were non-academic literature, as shown in Appendix **Error! Reference source not found.**The countries of origin for the academic literature comprised United States (79%), multi-national (11%) and Aotearoa (10%). Countries of origin for non-academic literature were Aotearoa (33%), United Kingdom (27%), United States (13%), Australia (13%), Austria (7%), and multi-national (7%).

4.4 DATA ANALYSIS

The thematic synthesis method of Thomas and Harden (2008) focuses on integrating the findings of multiple qualitative studies. Therefore, the data that was extracted for inclusion into Dedoose software for coding was specifically the *findings* from the selected studies. In this way the review gathered a larger sample of primary data, that is, the experiences of patients and practitioners with the FME, often in the form of direct quotes. The methodological limitations of the studies were not a factor in the data extraction, as direct quotes and similar primary data were being re-analysed through this review.

The extracted findings were coded by two researchers using inductive codes that arose from reading the data. The codes were initially divided into patient or practitioner perspectives, although as coding progressed the separation between the two categories become minimal. Development of descriptive themes from the data (Thomas & Harden, 2008) therefore abandoned this separation in favour of a more integrated approach.

The key difference with a thematic synthesis is that while the initial descriptive themes that are generated remain close to the primary studies, the next step is interpreting these descriptive themes through the lens of the review's objectives to produce new interpretative findings. These analytical themes take a meta-view of the descriptive themes. While the coding process led to the development of descriptive themes, the act of writing up the results became the analysis process for the analytical themes. The researchers discussed and analysed the descriptive themes as they were being written, their interrelationships and their impact on the FME experience, and this led to further investigation of the current context of the system in Aotearoa New Zealand. This included gathering more information on the current FME documentation and the legislation before Parliament[3] that seeks to make changes to the evidence admissible for sexual violence court proceedings.

[3] https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_93010/sexual-violence-legislation-bill

5. RESULTS

The themes are arranged in chronological order of before, during and after the FME, although there is some overlap. In this section, quotes from the literature are block-indented, and the wording and grammar of the quote have been retained. All names included in the quotes have been previously published, and are generally pseudonyms. Note that because the literature originates in a variety of different countries, many of the terms and processes referred to are different to that of Aotearoa New Zealand. They are included here to illustrate the general points being made in the text of this report.

5.1 DECIDING TO HAVE AN FME

The first stage of a patient's experience of the FME was deciding or consenting to have one. People undergoing an FME were usually seeking healthcare or evidence for the justice system, or both. This was based on the specific circumstances of the offence, such as whether the identity of the offender was known and the relationship with the patient, if the patient was unsure of whether a sexual assault had occurred (e.g., because the effects of drugs or alcohol), and the length of time since the sexual assault occurred.

5.1.1 Purpose of the FME

Healthcare was a primary reason for undertaking an FME, whether or not the patient was intending to report the assault. From the patients' point of view, this was a higher priority than gaining evidence for prosecution.

> A clear pattern that emerged from the interviews was the significance of the healthcare dimension of the SADVTC [Sexual Assault/Domestic Violence Treatment Centre] experience for women. Fewer than half (n=8) went to a centre with the intention of undergoing an MFE, the possibility of which was generally raised with them by the police or nurse examiner. Most women were seeking medical attention and/or counselling. … When women were questioned about the relative weight they placed on different aspects of their experiences at a centre, the collection of evidence was considered less important than the provision of health care by many (n=10). Du Mont, White, and McGregor (2009, p. 690)

> Catherine, a 24-year-old White[4] rape victim advocate with 15 months' experience, explained, "The first thing I would say is they need to get health care. I tell them even

[4] In this study by Maier, the participants' race was identified using terms such as 'White' and 'Black'.

> if they don't want to report it they have to get checked for pregnancy, STDs [Sexually Transmissible Diseases], and make sure they are OK and have no abrasions. I don't want you walking around with gonorrhea and you don't know it. I don't want you walking around pregnant and you don't know it until 4 months later. I'm adamant about that. I think that is the most crucial piece." (Maier, 2008, p. 795)

In some cases, issues arose when the FME was seen by people other than the patient as solely a means for gathering evidence for prosecution:

> I had to sit around and wait for the GMO (Government Medical Officer) to arrive, then I was refused medical help because I'd decided not to make an official complaint. I shouldn't be refused because of this. (Lievore, 2005, p. 58)

However, for some women choosing to undergo an FME was an act of empowerment with a focus on achieving justice or credibility:

> A 36-year-old unemployed woman explained, ''I was gonna' do whatever it takes to get evidence to get a conviction and to identify the assailant'' (Interviewee 12). (Du Mont et al., 2009, p. 778)

> And her hope is that other survivors feel encouraged by her story to contact police and look past how uncomfortable a forensic exam is. Taking that step, she says, can help you feel like you're back in control "As confronting as it is, it can be one of the most crucial things to catching that person and preventing it from happening again". (Aubrey, 2019, p. 1)

> Some women also believed that the evidence collected from the MFE would serve as objective proof for family and friends that they had been sexually assaulted. This need to prove to others that a sexual violation has occurred may not be surprising in view of the disbelief rape victims often face in our society. (Du Mont et al., 2009, p. 778)

For the patient, the usefulness of the FME evidence was often in establishing proof that the violation happened, which made their complaint more credible. The patients were very aware that many cases were word-against-word, so physical proof that something happened was welcomed.

> That's part of the reason [that I continued] … because I had evidence towards it... Because that will just show that he did things to me, and I have proof. *Interviewer*: *Why is proof important?* Because that's what people need in the world is proof. (18-year old assaulted by a co-worker) (Fehler-Cabral, Campbell, & Patterson, 2011, p. 3625)

> Can you explain to me like how you felt, like what did you think about it as proof? I just was happy that she had found something, she had found the stains and put towards as evidence. Something that could help with the case. (26-year-old survivor raped by a stranger) (Fehler-Cabral et al., 2011)

In cases which revolved around establishing whether there was consent, the physical proof was often equivocal, absent or not useful. There is a lot of emphasis placed on physical injuries – the presence or absence, documenting the location and severity – yet this was seen as problematic as it reinforced the rape myth that without visible injuries a 'real rape' could not have occurred.

> It's taken the police seven months to investigate the case and no one's been charged… Forensic tests found his DNA on my clothes and in me. They've proved that everyone was in the room, but even with this amount of evidence they can't prove consent. I've got no bruises or scratches because you have no strength to fight back when you've been drugged. (Kendra). (Lievore, 2005, p. 43).

> [I]t's how they decide … The bigger the physical injuries, the greater the crime... I mean someone could be terrorized, there for three days, but if they don't have a bruise that goes along with this, then you know, it's [going to be perceived as] a minimal offence (Focus Group 1, Participant 3). (White & Du Mont, 2009, p. 4)

> It is rare for a forensic medical examination to discover physical findings which are relevant to consent (or the lack of consent) – more usually any injuries are equivocal in this regard. The summing-up in Schuette on the expert evidence of the examining doctor reflects the usual approach to genital injuries (emphasis added): Now I do need to discuss with you the evidence of Dr [ ]. In summary, she told you of three observed injuries on the complainant that you will need to think about. A laceration and an abrasion in her genital area and the abrasion on her left arm. The two vaginal injuries need to be considered very carefully. Dr [ ] acknowledged that such injuries can arise during both consensual and non-consensual activity **so you should regard this evidence as neutral and not taking you anywhere at all.** (McDonald, Benton-Greig, Dickson, & Souness, 2020, p. 293, emphasis in the original)

5.1.2 Timeframe for having an FME

The length of time between the sexual assault and presenting for an FME affected what could be achieved. If a longer time had elapsed, some of the tests were no longer able to be carried out. The healthcare aspects were then the predominant reason for the FME.

There were also women in this study who, although their reporting of the rape had been delayed, nonetheless felt a medical examination would still have been advisable. For example, in Lisa's case, although it was too late for a forensic examination, she felt angry that she had not been referred for a medical examination, especially since the man who raped her had raped numerous other individuals in his care. Her partner suggested she should have an HIV AIDS test, something she thought the police should have advised. (Jordan, 1998, p. 65)

In cases of delayed or historical reporting, which accounted for 18 per cent of the cases in the sample (N = 9), the passage of time usually renders a forensic examination unnecessary, although it may often be advisable for sexual assault victims to have a general medical examination and be tested for possible infections and/or pregnancy. One woman, for example, said she did not report the rape to the police and left town instead, hoping to forget the incident. She began to feel terrible and, on returning to her hometown, visited the family doctor, only to be told she was pregnant, at which point she was referred for an abortion. (Jordan, 2001, p. 689)

Examinations are conducted as swiftly as possible for two paramount reasons: to limit the victim-patient's discomfort and to collect forensic evidence with a limited life. (Mulla, 2014, p. 284)

5.1.3 Informed consent

There were multiple factors influencing a decision to consent to an FME, and the full implications of consenting were not always apparent to the patient. Immediately after the sexual assault, some patients are not able to fully absorb or comprehend information that was given; and yet, for some forms of evidence, time was of the essence so some FMEs were done "just in case" they were needed. This suggested that consent for use of the results as evidence should ideally be separated from the consent to undergo an FME and be a decision for a later time.

For those who did undergo a forensic examination, being treated with respect and dignity often equated to being talked through procedures and given explanations of what was going on. Such things were stated as highly important, merging with principles of consent and the need for medical staff to remain attentive to the altered and variable states of victim-survivors at the time of examinations. (Brooks-Hay, Burman, & Bradley, 2019, p. 6)

The great thing about the sexual assault protocol is that it has two signed consents: one is consent to a forensic medical examination; the second is consent to release it

> to police; and victims can make a separate and independent decision about this. Most don't sign the second consent until later. If they believed that having the examination committed them to further legal action, they probably wouldn't have it done. The ability to delay consent to release the kit gives them time to think about their options, about what they want to do, and still have forensic evidence in the event that they decide they want to make a formal complaint… (Lievore, 2005, p. 145)

Bridging the gap between consent and informed consent for FME was important to avoid misunderstandings with lines of enquiry. The example below highlighted the confusion between questioning for the purpose of identifying evidence and questioning for other purposes.

> EMILY: So, I went in for my medical exam and it was a male doctor. They asked me questions … but I'm thinking, why are you asking me these silly questions? Like when was the last time I had sex with my husband, like when was the last time I'd went for a shower. All I wanted to do was brush my teeth because, obviously I'd been drinking all night. And they're like, no, you can't do anything, you need to just be the way you are. So, done that test and then they took me to the police station. (Burman, Bradley, & Brooks-Hay, 2019, p. 1)

There was little awareness of what an FME might involve, and for some patients, having this knowledge would have changed their attitude to consent.

> A young college student said, ''it was horrible. just awful'' (Interviewee 1) and two women born overseas described it explicitly as ''traumatizing'' (Interviewee 15,9). Five women found procedures such as the drawing of blood, swabbing internally for semen, particularly in the anus, and the photographing of injuries so potentially distressing that they ''refused'' to have them done. Additionally, four women commented that in hindsight they wished that they had refused to undergo certain components of the Kit. For some of those women, it was ''needles'' and the internal examination that were particularly upsetting (Du Mont et al., 2009, p. 777).

5.2 THE FME EXPERIENCE

The experience of an FME was a shared interaction between patient and medical practitioner, and sometimes also with a witness or advocate. The nature of the FME was described in the literature, and the tension between the dual purposes of healthcare and evidence collection for prosecution was very apparent.

> As the book has argued thus far, the sexual assault intervention is not a simple legal intervention. Rather, it is compound, characterized as both legal and therapeutic, and the nurse examiner is charged with both collecting evidence from and caring for the victim of sexual violence. (Mulla, 2014, p. 154)

> Forensic evidence may be crucial for a successful legal case (Frazier & Haney, 1996; Spohnet et al., 2001), but even more important is the fact that there are significant long-term health consequences for untreated injuries and STIs/HIV (Aral, 2001). (Campbell, 2008, p. 4)

5.2.1 Healthcare

Healthcare provided during FMEs included documenting and treating obvious injuries, advice and/or provision of contraception, and testing and/or treatment for infections. The quality and extent of the healthcare provided appeared to vary widely.

> Most survivors also received information about the risk of pregnancy and STDs from the assault (63% and 53%, respectively). However, only 35% received information specifically about the risk of HIV, and only 28% were given emergency oral contraception to prevent pregnancy. (Campbell, 2005, p. 63)

> Several studies have found that women treated for sexual assault are not given adequate information from healthcare providers about the health consequences of sexual assault, such as STDs or how to get the morning-after birth control pill. One key study, for example, found that while 70% of rape survivors received a forensic medical exam, less than half the women seeking medical help received pregnancy information (49%), the morning-after pill (43%), information on STDs (39%) or information on HIV (32%). (University of Kentucky Center for Research on Violence against Women, 2010, p. 3)

Caring for patients was a familiar practice to medical practitioners, but sometimes the nervousness around the unfamiliar practices of collecting forensic evidence resulted in an emphasis on the legal nature of the FME, overriding the healthcare. This was especially the case where the FME was conducted by nurses, and one training programme focused on reassuring the nurses that the healthcare aspects were as important as the evidence collection:

> I don't know how to explain it; they gave me more of a purpose for being there for the person, not just collecting evidence for the police. I'm there for the patient and that made me feel better . . . (Patterson, Pennefather, & Donoghue, 2020, p. 4769)

Sometimes there were additional health benefits even when the focus was on retrieving evidence. In this example, the vaginal exam confirmed for the patient that a rape had actually occurred with the tampon itself providing legal evidence, and the additional health benefit was that removing it would have prevented the development of toxic shock syndrome:

> Originally I thought I'd just been sexually assaulted. Really I think I knew I'd been raped but wasn't ready to come to terms with it. I was feeding myself information as I felt I could manage it and in the middle of the examination they found the tampon. It was still in me in a little pocket way at the back….At the time that they found it, I lost it, because that indicated to me that he had raped me – it just didn't get there by itself, it had to be forced there. (Jordan, 1998, p. 73)

5.2.2 Collecting evidence

The FME experiences for women included similar medical procedures, such as:

> The collection of evidence through a rape kit is a very invasive and lengthy procedure that includes a pelvic exam, scraping under fingernails, pubic hair combing, and oral swabs, among other procedures. (Maier, 2008, p. 795)

Figure 1 uses data adapted from Du Mont at al.'s 2017 study, highlighting the significant services that Canadian women received following sexual violence. Services for 948 women included forensic evaluation (85.6%), risk and safety planning (54%), health care (90.3%), and referral for ongoing support (78.1%). Significantly, three quarters of the provided services were therapeutic based, and focused on providing short and long-term wellbeing and care.

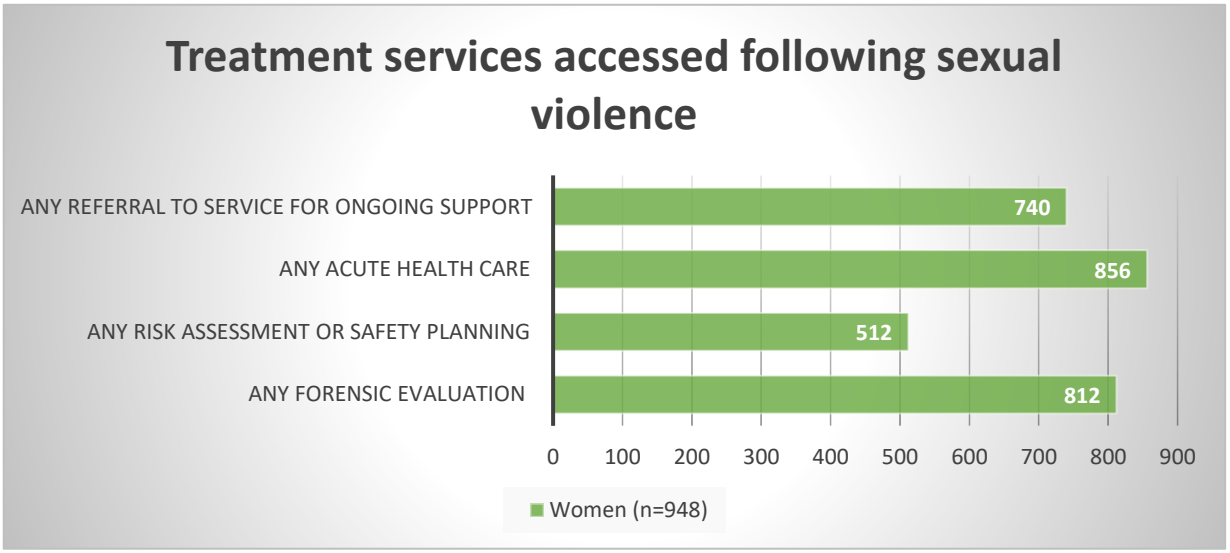

Figure 1: Treatment services accessed following sexual violence, adapted from Du Mont, Kosa, Macdonald, Benoit, & Forte (2017, p. 9).

Figure 2, from the same study by Du Mont et al., shows the services accessed in more detail. The administration of an FME (coloured orange) most commonly included the assessment, photographing and documentation of injuries, followed by completing a sexual assault evidence kit and having a vaginal examination. More than half of the women needed to use acute healthcare, a high number of whom were medicated for the prevention of sexually transmitted infections. Just under half of the women needed risk and safety planning, while almost three quarters received onsite care.

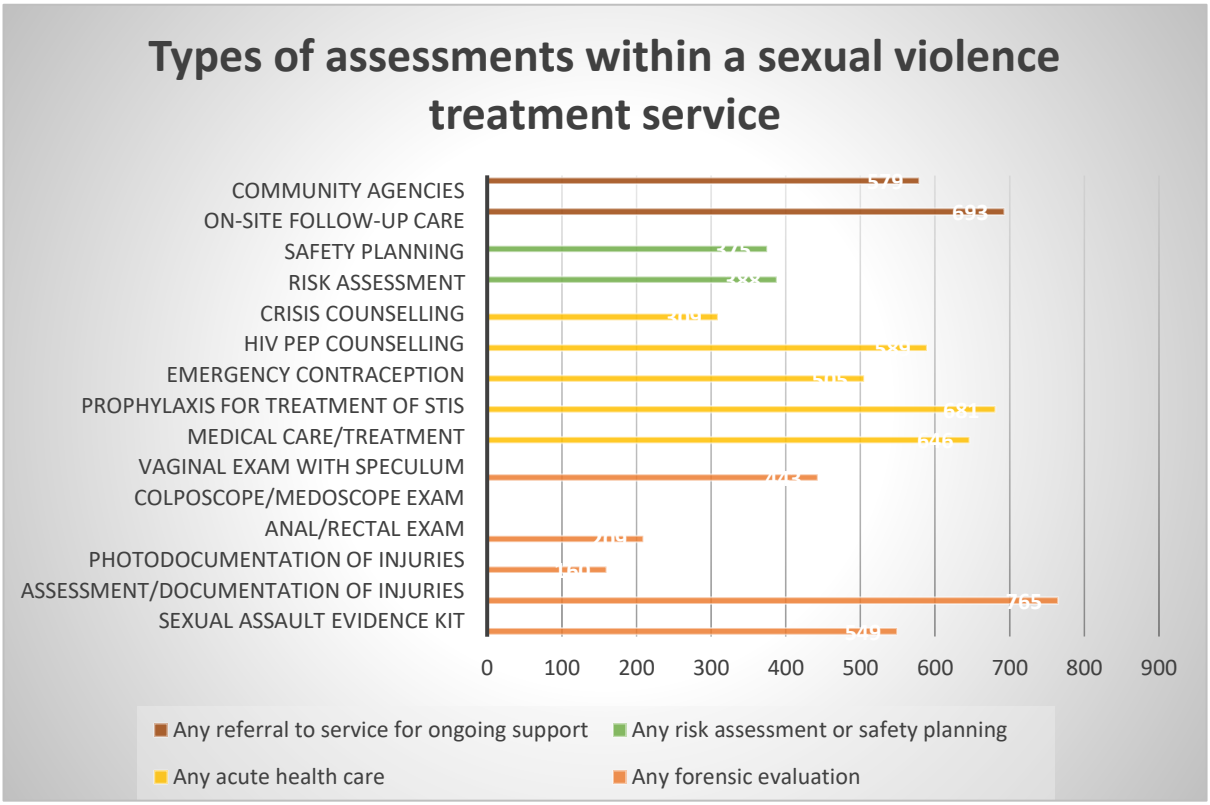

Figure 2: Types of assessments within a sexual violence treatment service, adapted from Du Mont, Kosa, Macdonald, Benoit, & Forte (2017, p. 9).

In the process of administering the FME, the patient's blood, urine and saliva were collected. The whole process could take an extended length of time:

> The task of gathering evidence involves items such as clothing, jewellery, mobile phones, and laptops being retained by the police. For recent assaults, there are also arrangements for the victim-survivor to undergo forensic examinations. Out of the 17 victim-survivors interviewed, six underwent forensic examination at, or close to, the point of reporting. Some commented on the ways in which this had the effect of protracting the proceedings even more; how it left them waiting around for extended periods, unable to eat, drink or wash, unable to return home in some cases, which all added considerably to the trauma. (Brooks-Hay et al., 2019, p. 6)

> EVE: After giving a brief statement, I was taken to the local police station where I sat for a long time and swabs were taken. I called my eldest son to come to be with me. A paramedic examined me for possible stab injuries and gave me a blanket as I was very shaky. A SOLO [Sexual Offences Liaison Officer] arrived, and I was told she would be with me for the rest of the day. We were driven to the sexual offences unit some distance away. A forensic examination and questioning took place. Further swabs were taken from my mouth, but by this time, I'd had coffee. (Burman et al., 2019, p. 1)

At times patients felt mistakes were made during the FME, which impacted negatively on the patients.

> Olive:…While I was up there [forensic examination room] I noticed I had bruises on the inside of my legs; and they said that didn't matter; so they never actually took any photographs of that, so I felt that they lost that evidence, because that was like finger prints on the side of my legs. (Brooks-Hay et al., 2019, p. 7)

> Pippa: …one of the things to start with, is stuff was missed at the very beginning. Because I was intoxicated, where was the toxicology report, do you know what I mean? They actually said later on […] I should have went for a toxicology report straightaway and like the blood work or whatever, because […] that's a piece of evidence that could help in the prosecution in the case […] as a sort of indicator that [I was] not able to consent. (Brooks-Hay et al., 2019, p. 7)

Invasiveness and secondary victimisation

Across the literature, most women found the FME emotionally and physically distressing. During face-to-face interviews with 19 Canadian women, exploring their medical forensic experiences, Du Mont (2009) found that 12 of the women felt that the FME was "very difficult" (p. 777), and further described a range of emotional distresses such as feeling exposed, vulnerable, scared, upset, stressed, embarrassed, angry, uncomfortable or angry.

Throughout the literature, it was well established that FME was experienced as extremely invasive, compounded by the fact that it needed to occur as soon as possible after the assault.

> 'I WAS SO RELIEVED I WENT THROUGH IT' Parsons, now 24, admits the examination was extremely confronting. She had swabs for semen in all three parts of her body where the assault happened. Her fingernails were scraped for dirt. Her body was searched internally and externally for injuries and abrasions. Leaves were picked off her. All this was happening mere hours after she had been sexually assaulted – an unfortunate inevitability to ensure the best possible DNA outcome. (Aubrey, 2019, p. 13)

For many patients, the FME was experienced as a secondary victimisation. The literature presented large numbers of quotes that made this and similar points, which made for difficult reading by the researchers.

> A 38-year-old White rape victim advocate with 2.5 years' experience, agreed: I have had victims actually look at me [during the rape kit] and say, "I'm not sure which is worse, this or what happened to me earlier today." (Maier, 2008, p. 795)

> During an invasive and extensive medical examination, the victim's body becomes a crime scene and nurses spend two to six hours gathering evidence. "I remember them swabbing every place possible that he could have even touched. And that was basically my entire body," Anna said. Saliva, pubic hair, fingernail scrapings, underwear and vaginal swabs were all collected and carefully stored in envelopes. "Just to feel that, not to be vulgar or anything, but inside of you right after being raped is not pleasant by any means," Beck said. "When you're talking about being vulnerable and being uncomfortable in that situation, that is pretty much everything that I felt in the hospital," Madison said. Victims recall pain and discomfort. They remember crying and screaming (Kummerer, 2019, p. 1).

> Maureen: …going through the rape suite, and the examination, that was, it was probably one of the worst times of my life. […] you've just been brutally raped and beaten, and then it's such a gruelling examination. And you don't want anyone going down to where you've just been hurt badly. And it's so in-depth, and so painful, and so, they're taking photographs, they're swabbing you, under nails, hair, mouth […] to the point where I thought, someone just kill me. I wished, in the end, I wished he would kill me, because my body and mind had been through so much. I was just praying to go. It had been through too much, and too much trauma, and heartache, and hurt. So I just thought, I wish he had just finished me. (Brooks-Hay et al., 2019, p. 6)

Despite the invasiveness and the difficulty of submitting to an FME, many women bore this with stoic resignation.

> It was like another invasion but it was different – she (doctor) was helping and it was necessary. (Jordan, 1998, p. 72)

> I had to chew chewing gum. . .she took fingernail scrapings, she took everything, it was really gung-ho. It was degrading, but it was no more degrading than a cancer smear, I suppose. (Jordan, 2001, p. 689)

Empowerment and control

While the FME was invasive and emotionally distressing, some women felt that undergoing an FME partly contributed to regaining a sense of empowerment and control following the brutality of rape. This process could include the longer process of criminal justice, which could take years. Brooks-Hay et al. (2019) found in a study of 17 women's progress through the Scottish criminal justice system that while three cases were "not proven verdicts…there was some sense that it had still been worthwhile in that the assault had been publicly recorded" (p. 3).

In one Canadian study, the women found the FME improved their sense of wellbeing, such as feeling empowerment with respect to the desire to see an assailant brought to justice, feeling more in control, more powerful, actively doing something, something she had to do for herself (Du Mont et al., 2009). In this study, despite the women's distress and confusion during an FME, 2 of the 19 women said they would recommend an FME:

> "in a heartbeat'', ''right away'' (Interviewees 8, 19). (Du Mont et al., 2009, p. 778)

Being given control during the FME was also highlighted as beneficial, sometimes shown by examples where there was a lack of control offered to the patient.

> The issue of control also featured repeatedly in the women's accounts. During the examination itself, control arose as an issue for some women in relation to who was present, with it clearly being important that the women be offered a choice in this matter. Not every woman wanted a support person in the room with her during this intimate procedure. Some preferred more anonymous professional support and did not want close family members to be present during the examination, while others thought they would have found it extremely difficult to manage such a procedure without close support. Such opposing views reinforce the need for the woman to be consulted as to her wishes so that her choice in these matters is able to prevail. (Jordan, 2001, p. 690)

> Firstly, the importance of communication prioritising the patient and encompassing trauma-informed care; secondly, patients prioritised care that enhanced their power and control. (Caswell, Ross, & Lorimer, 2019, p. 12)

> They just said they were gonna perform a rape kit. They took pictures of my bruises, and then, it was just like a regular exam at the doctor's, kind of. I just wish they would have explained everything that they were doing, and what they were doing it for . . . They didn't even tell me what was going on. I don't know if it was 'cause she was tired…(19-year-old survivor raped by her male friend). (Fehler-Cabral et al., 2011, p. 3630)

The issue of control was also noted from a practitioner point of view.

> Just how vulnerable patients are in so many situations, but particularly in one where there's been trauma or assault and how important it is to help them feel safe and give them as much control as possible. (Patterson et al., 2020, p. 4767)

Rape myths

Rape myths, such as rape being carried out by a stranger or that men cannot be raped by women, were responsible for generating processes (e.g. Documentation) based on stereotypes. This was hurtful for those people who did not fit the stereotypes:

> The [auditing] physician is outraged and contacts the forensic nurse examiners to berate them. The forensic nurse examiners then refer him to the forms he is auditing in order to demonstrate that the male-male victim-perpetrator dyad that he expected to underlie the attack was, in fact, a male-female dyad. ... In a world in which only men harm while women proffer care, the realities of a female assailant are veiled. Women, in their "caring capacity," filter into the paperwork predominantly as victims or family/caregivers of victims. (Mulla, 2014, p. 167)

> Furthermore, our social systems do not treat all rapes equally. Persistent, stubborn myths remain about what constitutes "real rape"—stranger assaults committed with a weapon, resulting in visible physical injuries to victims (Estrich, 1987). Social systems respond to these assaults with the highest attention. Yet, prevalence studies consistently demonstrate that non-stranger rape is far more typical (approximately 80% are committed by someone known to the victim) and that assailants use a variety of tactics—not just weapons—to gain control over their victims (Koss et al., 1987, 2007). Our social systems are least likely to respond to the most common kinds of assaults. (Campbell, 2008, p. 703)

Practitioners were sometimes guided by rape myths which lead to inappropriate questions being asked and contributed to a sense of secondary victimisation where the patient felt they were being blamed for the rape.

> In the process of administering the forensic exam, STI [Sexually Transmissible Infection] services, and pregnancy-related care, doctors and nurses ask victims many of the same kinds of questions as do legal personnel regarding their prior sexual histories, sexual responses during the assault, what they were wearing, and what they did to "cause" the assault. Medical professionals may view these questions as necessary and appropriate, but rape survivors find them upsetting. (Campbell, 2008, p. 707)

5.2.3 The medical practitioner

Gender

The experience of undertaking a forensic medical examination (FME) was very personal, intimate and invasive. Enduring an FME was made easier (or not) by the characteristics and behaviour of the medical practitioner conducting the examination.

As sexual assault is a gendered crime where the majority of victims are women and the majority of offenders are men, it was no surprise that the gender of the practitioner made a difference to the FME experiences for the patients. Many patients were simply more comfortable with a female:

> Since the [FME] procedure itself is, by its very nature, invasive and distressing, virtually all of the women said they were pleased and relieved to be examined by a woman doctor. (Jordan, 1998, p. 689, p. 68)

There were interrelated reasons for preferring a woman practitioner. A primary reason was being a different gender to the attacker, especially as the FME in many ways mimics the invasiveness of the original attack:

> Because the examination is so intimate—after having had a man do that to me I didn't want another staring at me. (Jordan, 2001, p. 289)

There was a belief, and sometimes the experience, that women practitioners would be more empathetic or understand the patients better. This was partly from a general attitude that women possess these traits in greater degrees to men, and partly because the shared gender between patient and practitioner was thought to allow greater understanding:

> I thought she'd be able to be more in tune with how I was feeling. (Jordan, 2001, p. 289)

> She said he [the police surgeon] made her feel like: I was just an object. Come in – measure this, measure that … It seemed I just had to do what the police wanted me to do. (Jordan, 1998, p. 68)

> Forensic services are very good with women; they're approachable and good to talk to. The staff are women, the service is women-centred and informed by a feminist analysis of violence against women, whereas the police force is a patriarchal culture and a male dominated organisation, where gender still operates in traditional ways. (Lievore, 2005, p. 139)

However, it was often noted that there was a shortage of FME practitioners in general, leading to a lack of availability of women practitioners for those women patients who would prefer

them. This was due to the unattractiveness of the work, such as being on call, having to give evidence in court, follow up appointments, and a lack of compensation for the extra work. FME work was seen as underfunded by the health authorities. This led to a lack of choice for the patients.

> There's a difficulty with doctors not wanting to do the [forensic] work. They're poorly recompensed, especially when they're giving evidence, and they refuse to do the work, because general practice is more lucrative. There's also a gender problem: the forensic examiners around here are all males and we need females. (Lievore, 2005, p. 148)

> Across the state, sexual assault services and the health system are under-funded, which affects decisions to do forensic examinations. … There are insufficient female workers in forensic and police services. Victim/survivors are not given the choice of seeing a female and this is problematic, or female workers have not had training in sexual assault. (Lievore, 2005, p. 142)

> Typically, the women were not able to exercise any choice as to who would examine them. Only two women said they felt that they had some choice over this, plus one young woman's parents requested that a female doctor be found. The remaining 32 women (91%) felt they had no choice in this regard. Of these, most (87%; N=27) said that this did not make any difference to them. (This finding needs to be considered within the context of the women's earlier stated preference for women doctors to conduct the examination). (Jordan, 1998, p. 69)

While the experience of the FME was generally improved by having a woman practitioner, having a practitioner trained in the FME process and in dealing sensitively with patients of sexual assault took precedence over a gender preference:

> Support by women for women: Numerous research studies show that in the aftermath of violence, women and girls feel more trusting towards other females and have a strong preference for female staff – especially with respect to medical interventions and forensic examinations, the provision of shelter and longer-term support. A preference for female service providers must not be understood, however, as 'any woman will do': survivors want and have the right to be supported by sensitive and skilled professionals. (Kelly, 2005, p. 25)

> Views about a male doctor conducting the forensic examination were mixed. For some this was very traumatic, for others the respectful and dignified approach of the doctor mitigated the initial shock of not having a female doctor. (Brooks-Hay et al., 2019, p. ii)

Nurse or doctor

As with the gender of the practitioner, from a patient point of view, the difference between a nurse or doctor being the examiner was secondary to the practitioner's behaviour. Secondary victimisation through the FME was a major concern and was shown to be mitigated by empathetic practitioners who believed and validated the patient's story, explained carefully and thoroughly, and gave as much choice as the patient could cope with at the time.

> [The forensic nurse] said she was on my side. It was terrible what he did to me . . . Because I was happy when people actually believed me. (Fehler-Cabral et al., 2011, p. 3627)

> The doctors generally received high praise from the women for the understanding and professionalism they displayed. Nearly three-quarters of the women (73%; N=25) described the doctor who examined them as showing sympathy and understanding, and 38% (N=13) said the doctor was professional in attitude. (Jordan, 1998, p. 70)

> The first thing she [the doctor] said was 'Hi, I'm…' and she made me feel really good. She explained things to me, she was really good to me. She knew what she was doing and she made me feel OK. (Jordan, 1998, p. 70)

> Subsequent research in England found that 86% of 14 women examined by a (former) general practitioner were wholly, mainly or partly negative about [the experience] (Temkin, 1996). These feelings were tied largely to the sex and manner of the attending physician, although four women found the examination itself traumatic. (Du Mont et al., 2009, p. 775)

In many European and North American countries, FMEs are conducted by specialist nurses known by acronyms such as 'Sexual Assault Nurse Examiners' (SANEs). These specialist nurses were generally associated with positive experiences, often because of their training and knowledge.

> According to advocates, SANE nurses tend to be more knowledgeable than emergency room doctors and non-SANE nurses about rape kits and tend to show greater sensitivity and compassion toward victims. A 33-year-old White rape victim advocate with 5 years' experience explained "With the way the SANE program is designed, it is not as humiliating as it once was, and I think they are as comfortable as a rape victim can be in that situation." (Maier, 2008, p. 796)

> Survivors find services the most helpful and least distressing when aided by a Sexual Assault Nurse Examiner. (University of Kentucky Center for Research on Violence against Women, 2010, p. 2)

Where there was a noted difference between nurses and doctors, the nurses were seen as more caring and empowering, taking time, and being more careful with evidence collection and paperwork (Toon & Gurusamy, 2014).

> A 37-year-old White medical rape victim advocate with almost 2 years' experience commented "The medical professions want to get the bed back so they tend to be a little bit faster and more business-like. Not SANE, though." (Maier, 2008, p. 797)

> If victims stated that they felt blamed or depressed after interacting with legal or medical system personnel, more often than not police officers or doctors did not think the survivors were feeling such distress. This effect was not found for the nurses, as they had significant inter-rater agreement with the survivors. (Campbell, 2005, p. 65)

One study that focused on training nurses for FME work noted the anxiety that nurses felt around having to produce adequate evidence for legal purposes, and this could override their basic nurse training which was to care holistically for their patients. The training showed the nurses that they could put the 'care' into their FME work as with any other nursing task they might undertake:

> I thought that my most important job was to collect the evidence so that I could serve the patient better. After the course, I realize that my first job was to take care of the patient and then worry about collecting the evidence, I mean the evidence collection is important, but serving that patient's emotional needs and taking care of them as a patient is the most important thing I could ever do for them. (Patterson et al., 2020, p. 47)

In Aotearoa New Zealand, the sexual assault assessment and treatment services (SAATS) use trained doctors. The use of trained nurses is possible with regulation and system change, and has been considered - as noted in this recent review of SAATS services:

> Both the qualitative interviews and the international views (literature and interviews) demonstrated the high importance of the skilled nurse role in SAATS services. New Zealand does not yet have a development pathway for nurses, however DSAC / the SAATS network is considering how this can occur as an area of special practice. (Esplin, Smith, Blick, & Moore, 2016, p. 24)

Culture or ethnicity

In contrast to comments on the impact of the gender of the practitioner, there were only a few references in the literature to patients' preference for a practitioner from their own culture:

> Because she was New Zealand European/European it felt close to home. There was no culture shock to get over or anything to get used to. (Jordan, 1998, p. 69)
>
> *From an Alaskan Native who herself is a survivor:* I think that it is really important, because we do know that people generally have better outcomes if they see a provider that they can identify [with], that looks similar to them. If you have someone who is, or at least seems to be, of the same culture as you or the same background as you, there is more likelihood that you're going to share things with that provider than you would with someone who is different, because there are some things — say, beliefs or ideas or thoughts — that are commonly shared in that culture. … I don't think people really understand how important that is." (Gallardo, Sussman, Chang, Hopkins, & Theriault Boots, 2020)

This limited commentary could be because of the lack of choice available to patients, as noted in the section on gender. The comments showed, however, that cultural and ethnicity differences did affect the patients' experiences of the FME. This was especially the case for non-White patients, where it contributed to the FME being a source of revictimisation:

> African American women were more likely to view both medical professionals and police as the primary sources of revictimization. Of African American respondents, 80% named both medical professionals and the police as being primary sources of revictimization, whereas 38% of Whites and no one from other racial or ethnic groups discussed this combination. (Maier, 2008, p. 793)

Given the scarcity of choice amongst FME practitioners, emphasis was placed on the practitioner being culturally sensitive to those different from themselves. Specific training for this resulted in better outcomes.

> Getting that sort of on my radar from the training and getting information on how to be more aware and culturally sensitive to different groups and more comfortable asking . . . just asking questions to kind of clarify where people are in life and where they're coming from and not assume. (Patterson et al., 2020, p. 4767)
>
> *What were the most helpful aspects of the training module on trans-affirming care?* Background and terminology. I've been unsure of the proper terms, which makes it hard to be comfortable and supportive. (Du Mont, Saad, Kosa, Kia, & Macdonald, 2020, p. 5)

This cultural sensitivity was strongly linked with the role of advocate for the patient, which in some local systems fell to the practitioner and in other systems there was another person present as a specific advocate.

Knowledge

The experience of an FME for a patient was improved by having a practitioner who was familiar with the FME process and therefore was able to conduct the examination competently and quickly, without mistakes or overlooking important aspects, while at the same time being able to deal empathetically with a traumatised patient. The role of training in supporting such a practitioner to develop was highlighted, as discussed in previous sections. The consequences of not having an adequately trained practitioner was often revictimisation of the patient through the FME.

> We, like Regan et al. (2004), and others (Jordan,2001), found that most women felt overwhelmingly positive about their interactions with examiners, strengthening the case for approaches to care that are founded on sensitive victim-centred practices, and intensively trained medico-legal staff (Campbell, Patterson, & Lichty, 2005; Sievers, Murphy, & Miller, 2003; Stermac & Stirpe, 2002). (Du Mont et al., 2009, p. 779)

> A 27-year-old White medical rape victim advocate with 12 months' experience, explained: I have gone through some horrific experiences at the hospital when I was in [state] because they did not have a SANE nurse program state-wide so it was just random nurses who were doing evidence collection kits. Nurses who have never had any type of training on working with survivors and what their reactions are and what the effects are when you are doing a GYN [Gynaecological] exam and they have just been assaulted. They [victims] feel like they are being assaulted all over again. (Maier, 2008, p. 796)

Knowledge of specific groups of people's needs was also highlighted. While it might be good to have an advocate present during the FME who had such specialist knowledge, the reality was that the practitioner was the one who was dealing with the patients and therefore needed training in specialist areas such as people with disabilities or trans people.

> It should be mandatory to have a disability counsellor or ongoing education for all sexual assault counsellors, so they at least respond appropriately before referring to a specialist. There's also a need to raise awareness of sexual assault and disability among other agencies. Doctors also need training in taking forensic evidence from people with disabilities. (Lievore, 2005, p. 102)

> The key concerns and opportunities for improvements for SAATS services in New Zealand, when measured alongside international good practice criteria are: … Address accessibility and appropriateness for other vulnerable groups e.g. transgender, sex workers, disabled people and recent migrants. (Esplin et al., 2016, p. ix)

> Medical Care (e.g. I know how to ask a trans client sensitively about their history of transition-related medical interventions [e.g. hormones and/or surgeries], if relevant to the care being provided; I know that if a trans man/transmasculine client is taking hormones, certain types of hormonal contraceptives may be limited in their efficacy); (Du Mont et al., 2020)

Training had another effect, that of challenging 'knowledge' generated by rape myths, i.e. erroneous and preconceived ideas of what constitutes rape and how a victim and/or offender should behave. Such 'knowledge' is a barrier to a positive FME experience. The literature indicated that rape myths were more prevalent with police and legal personnel than with medical practitioners, although there were some practitioners who did hold such views.

> Disbelief was particularly prominent for those who disclosed their abuse was perpetrated by a woman: I left her office startled, confused, hurt and very angry to have a person who is supposed to be a healing professional, who cannot afford to be naive, express shock that a woman is capable of sexual abuse ... I found that attitude repeated again and again" (Female #1). (Caswell et al., 2019, p. 12)

5.2.4 The physical environment

While the largest impact on how a patient experienced the FME was directly related to the practitioner and their behaviour, the physical environment was also noted as having positive or negative impacts on the overall experience.

> Barros et al. (2015) provided a woman's account of how it felt to have no privacy within the reception area of a maternity service: My husband had to speak near another person, she heard it all. (...) She turned her face to look at me. If there was a hole I could've hidden in, I would have stuck my head there and never gotten out of it. (...) [3: 196] (Caswell et al., 2019, p. 12)

> Only a few women commented specifically about the physical environment in which they waited. Two said they felt safe and comfortable in the support agency's rooms and another commented: "The room was nice and I could look out the window if I wanted to. There was heaps to look at. I think you need that to take your mind off things." By way of contrast, one woman said she found it hard to walk into a doctor's ordinary waiting room before the medical: "It's difficult because you feel everyone knows why you're there. I felt all the receptionists knew as they all looked at me when I came in." In Alice's case, she was not impressed with the rooms she had to wait in at a Family Planning clinic. As she saw it: "I think because you're going there for these sorts of tests the environment contributes a lot to making you feel at ease. It was so

> cold looking – it reminds you of going for an abortion – cold, stone rooms." She also found it difficult having to share the waiting room with other people. (Jordan, 1998, p. 66)

5.3 AFTER THE FME

5.3.1 Post-assault care and recovery

Given the shock response of rape, followed by the flurry of activity with both the criminal justice system and medical care, an FME could contribute to a woman's sense of wellbeing, healing, and recovery:

> At the same time, getting the rape kit done … and being able to have time to think about how you want to move forward ... made a big difference for me in the way that I was able to heal after the assault. (Gallardo et al., 2020)

> Rather than serving purely as a legal tool, the documents also become a way in which the victim's narrative of his or her domestic world and relationship to kin, intimates, and network of care becomes articulated for purposes of making sense of the event of rape, as well as its aftermath and a return to the everyday. (Mulla, 2014, p. 172)

Providing care for patients after the initial FME was considered important and was noted as "part of international best practice" (Esplin et al., 2016, p. 23), but this care was often patchy due to logistical and resourcing difficulties. Some patients sought extra help after the FME:

> Of the five women who did seek professional help, three sought counseling immediately after the rape, while two later sought help for other issues in addition to the rape. The three that sought counseling right away did so because their parents encouraged them, they were referred to a counselor by a police officer, or their employer insisted that they seek help through the company's employee assistance program. (Guerette & Caron, 2007, p. 38)

Police investigation and court proceedings impacted on the overall recovery and long-term wellbeing of the patients and was heavily influenced by the actions of the policing and legal personnel involved. The process was generally stressful with an adverse effect on health, but conversely a legal outcome that validated the patient's experience was beneficial for recovery.

> Following the initial reporting period, victim-survivors enter a pivotal moment in their justice journey, though it is one that is largely overlooked. Transitioning between reporting to investigation is a defining part of the overall experience. Some felt that the process 'snowballed' after the point of deciding to report (Eleanor, Gavin, Helen, Lottie, Nat), and described feeling 'out of control' when the police investigation commenced

(Lottie, Helen). Following reporting, some were unable to continue with their prior life and work commitments for at least some time; others propelled themselves back into their normal routines only to find themselves having to take sick leave from work in the months that followed. Communication from the police appeared to be highly significant to victim-survivors' overall wellbeing in this period and yet experiences of this varied dramatically. (Brooks-Hay et al., 2019, p. 7)

Taking legal action, and was, "the best feeling in the entire world when I looked him in the eyes [at the trial] and pointed at him . . . I showed. And I was going to win. And I was going to win for the rest of my life." (Guerette & Caron, 2007, p. 38)

In the two cases where a guilty verdict was returned on sexual offences, there was a sense of having received some justice since the verdict signals belief or that the 'justice process worked' (Brooks-Hay et al., 2019, p. 6).

5.3.2 The justice system

Deciding to report

Not only do sexual assault survivors have to decide whether or not to undergo an FME, they must also decide whether or not to report the assault, and whether to then proceed with investigation and prosecution. These are separate decisions, yet sometimes these decisions were assumed by the way the system has set up.

> Misgivings about the legal system can in turn discourage women from seeking medical care, mental health treatment, and other services due to concern that these other service professionals will be required to report their rape to the police without the survivor's permission. (University of Kentucky Center for Research on Violence against Women, 2010, p. 2)

Some sexual assault survivors made up their minds about reporting at a very early stage in the process.

> Of the 15 cases examined, five survivors did not want to pursue prosecution, three were unsure about pursuing prosecution, and seven were willing to engage with law enforcement and pursue the prosecution of their perpetrators. (Feeney, Campbell, & Cain, 2018, p. 658)

> Some victims say no to the forensic examination immediately, deciding early on that they will not ever wish to report to police or provide a statement. They just wish to be "checked out" medically only, and perhaps be given the morning-after pill, or advice about STDs only. Their reluctance to proceed criminally is almost immediately apparent. (Lievore, 2005, p. 90)

Many patients wanted information from the FME so that they could decide whether to proceed with prosecution. This information needed to be provided in a way that patients could understand, and often so that they could decide at a later date when they had had time to recover from the immediate trauma and to consider the options. In such cases, an FME was carried out to preserve evidence so that the patient could have a choice at a later time as to whether to continue with prosecution.

> After the exam I apologize. … I say I'm sorry they have to be here, I'm sorry they have to feel like this. … I explain the process. It's not going to be overnight. It's not going to be in a week. … It's not like in the movies where if you go and report it, they're going to get thrown into jail and they throw the key away. I'm able to tell them things that I wish someone had told me (Gallardo et al., 2020, p. 1)

> The doctors took forensic evidence and advised me they'd keep it for a few months while I made up my mind. (Lievore, 2005, p. 58).

> She said the forensic exam and interview were "awful". But giving a statement to a forensic nurse and undergoing the exam, her evidence was preserved for the future. (Gallardo et al., 2020, p. 1)

What happened to the evidence?

The legal evidence aspect of an FME was guided by the sexual assault kit, the pre-prepared kit with documentation that sets out what is expected to be covered in the examination. Sexual assault kits were considered best practice internationally and were used extensively albeit with regional variations. The sexual assault kit covered the full range of tests and samples that could be done, and the practitioner selects as appropriate for the patient and their narrative. The completed sexual assault kit therefore comprised personal and health information about the patient, and samples that could generate legal evidence when tested. For the evidence to be admissible in court, legal rules regarding chain of evidence must be applied. This appeared to predominate over the usual protocols for handling patient medical records.

> I wasn't given the results of the medical examination because this is evidence and the hospital couldn't disclose them to me. It affected me a lot because I needed to go to my own doctor to have another medical examination to be cleared of STIs (sexually transmitted infections), but I didn't want anyone to touch me. (Amanda) (Lievore, 2005, p. 58)

Many sexual assault kits were completed but never analysed. There were many reasons for this, including the patient being unwilling to proceed with prosecution, or the lack of resources

to conduct or pay for the testing. There has been a movement internationally, particularly in the USA, to clear the backlog of untested sexual assault kits.

> In response to both public outcry and increased government attention, many cities with large numbers of unsubmitted SAKs [Sexual Assault Kits] (e.g., Detroit, Houston, New York) are now submitting them for testing, some choosing to test all SAKs and effectively clear their backlogs. (Feeney et al., 2018, p. 651)

Court proceedings

The literature showed that there was a high rate of attrition for sexual assault cases, with large numbers of sexual assaults never resulting in a trial, much less a conviction. The forensic evidence tended to be used to identify the suspect or establish the credibility of the complainant (Menaker, Campbell, & Wells, 2017). This was most useful when the assailant was a stranger, which is the minority of cases.

> Solid DNA was picked up, and following a lengthy investigation, a man in his 30s was arrested. His DNA matched. Two years later, after a guilty plea, he was handed a 10-year jail sentence. "I was so relieved I went through the exam. It was a big revelation for me [that] if I hadn't have done this, he wouldn't have been caught," she says. "The DNA solidified everything. It tied everything together, it was bulletproof. "Seven years on, she believes coming forward and undergoing the forensic exam was the "smartest thing I ever did in my life" (Aubrey, 2019, p. 15)

However, there was discussion in the literature about the contribution of the FME evidence to court proceedings and conviction.

> In just under half (44%) of those that examined the presence of general physical injury, a significant association with legal outcome such as charge filing and conviction was found. Less than a third of pertinent studies reported that the occurrence of anogenital trauma (29%) or collection of biological and/or nonbiological samples (31%) was related to a positive legal result. None of the relevant research demonstrated a relationship between the identification of sperm or semen and the successful outcome of a case. (Du Mont et al., 2009, p. 775)

Much of the evidence gained from the FME, while successfully showing what the test set out to show (e.g., presence of sperm in the vagina or drugs in the bloodstream), the meaning of this evidence was debated in court by lawyers, especially when the central legal issue was consent. This debate often appeared to be presented through the lens of rape myths, and the target was often the credibility of the complainant (more than the alleged offender).

While the fact that the complainant washed or showered after the alleged rape may well have relevance to explain the absence of certain forensic evidence, questions about showering tended to be asked for other purposes. Some defence counsel suggested that the complainant should have known to avoid showering if she really was raped (Edwards). However, in other cases the fact that the complainant did not shower was (also) used to suggest she was not raped (Moss). (McDonald et al., 2020, p. 210)

The evidence was equivocal as to whether the medication would have actually had the effects suggested, which would have given the evidence sufficient relevance. Instead, in this case as in the majority of others, the jury are given information about the complainant's mental health that has insufficient relevance to the matters in issue, and only contributes to crafting an unfairly prejudicial picture. We consider that evidence about the complainant being on ***any*** medication, but particularly treatment for anxiety or depression, needs to be carefully assessed for relevance. (McDonald et al., 2020, p. 210)

6. DISCUSSION

This thematic synthesis has reviewed literature relating to patients' experiences of the forensic medical examination following sexual assault. Bringing the patient experience into design and innovations within the FME process is important to minimise re-victimisation and maximise both therapeutic and judicial outcomes as far as possible. The synthesis was based on 33 selected papers predominantly from US, Canada, UK, Australia and Aotearoa. There was very little literature specific to the context of Aotearoa, particularly in terms of primary research studies.

The results have been presented in roughly chronological order as experienced by the patient, that is, before/during/after the FME. The thematic synthesis focused on analysing the data from the literature, looking for insights which reach beyond the original conclusions. Generally, the themes identified closely reflected the findings of the reviewed papers, however this synthesis added context through a perspective on the complete FME process and added weight to themes that were found across the studies. Even though the literature spanned 22 years across multiple countries, there were some consistencies in the experiences of patients. Undergoing the FME was uncomfortable for patients, at the worst it was seen to be as bad as the sexual assault itself, and anything that could be done to minimise the invasiveness of the FME was welcomed. Further, the practitioner and their behaviour made the single biggest difference to how the FME was experienced by patients.

In Aotearoa, there are a number of factors in place which support a positive experience for FME patients. The MEDSAC system provides specialist training for medical practitioners involved with FMEs, and there is a high proportion of women practitioners. There is a standard sexual assault kit which is widely available, and ongoing work to improve the kit and the accompanying documentation, including investigating moving towards use of online documentation. The NZ Police, too, have had training around dealing with victims of sexual assault, and there are specialist support services for victims. Legislation related to court and legal processes for sexual assault cases has been reviewed and changes are currently being passed through Parliament.

All of these factors are positive signs of a continually improving system. This review adds to the culture of improvement by highlighting the patient voice in the improvement process and suggesting three issues for further consideration: the treatment of FME documentation as health records or legal evidence, a critical assessment of the value of evidence collected at

the FME, and the importance of ongoing professional development for practitioners. These issues are discussed below.

6.1 FME DOCUMENTATION

The dual therapeutic and judicial purposes of the FME was well illustrated in the review. It is conducted by medical practitioners both for the patients' healthcare and wellbeing, and for collecting evidence for police investigations and court proceedings. From the patients' point of view both are important, yet the health aspect dominates their motivation for undergoing what is a very traumatic experience. The documentation that accompanies the sexual assault kit addresses both these purposes, and the practitioner asks about and documents information such as recent sexual activity and preferred contraception, or even general health status, which is best practice for healthcare for a person who has been sexually assaulted. McDonald et al. (2020) point out that this information is often admitted to court and forms the basis of questioning the complainant in contravention of other evidence admission rules. Such information is not relevant to the issue of whether a sexual assault occurred yet has persuasive power because of the prevalence of rape myths in society. Changing attitudes of the population is a difficult and complex thing to achieve. A more straightforward approach is to change the way FME documentation is produced, handled and conceptualised. A move towards online documentation and record storage would facilitate this.

If FME documentation is considered a health record, then it should be treated as such. The Code of Health and Disability Services Consumers' Rights[5] sets out patients' rights to be fully informed, to have the option of giving consent, to receive the results of the examination, and the right to privacy. Requirements of the legal system would then be a secondary consideration, and specific rules would need to be put in place to release the required information for court proceedings. This might mean that the FME documentation should be redesigned to separate 'court admissible' records from 'health-only records'. We would also support the recommendation from McDonald et al. to carry out further research in this area:

> We are of the view that there is a pressing need for a dedicated piece of research to be undertaken which will focus on the disclosure, use and admissibility of information gathered by the Medical Sexual Assault Clinicians Aotearoa (MEDSAC) experts who talk to and examine most adults who allege they have been sexually assaulted or violated. (McDonald et al., 2020, p. 238)

There is a Sexual Violence Legislation Bill 185 currently before the Parliament of Aotearoa, with the main aim of amending rules around evidence, victim's rights and criminal procedures,

[5] https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

to reduce the re-traumatisation experienced by many victims of sexual violence when they attend court and give evidence (New Zealand Parliament, 2019). This Bill proposes that no evidence may be presented, or questions asked about the complainant's sexual experience with the defendant, other people, or the complainant's sexual disposition, unless permission is expressly given by the Judge because this evidence is deemed relevant and essential to the case. Further, the legislation section on misconceptions that a Judge must direct the Jury to be aware of is proposed to be extended. Among other things, the Judge would have to direct the Jury not to consider a complainant less credible, or more likely to have consented, if they had been drinking alcohol or taking drugs. This means that information taken at the FME for therapeutic purposes, around the patient's recent sexual history and consumption of alcohol and drugs, would not be admissible as evidence in court. It seems reasonable, therefore, that this type of information is separated from the information that is (or will be admissible), so that legal personnel do not have access to personal health details.

6.2 CONNECTING FME EVIDENCE AND LEGAL OUTCOMES

Given that the FME experience is traumatic for patients, is intensive for practitioners, and has a financial cost attached, it makes sense to reduce the number of tests and examinations within the FME to the minimum required for effective healthcare and legal outcomes. For example, Du Mont and White (2007) found that genital trauma or the presence of sperm was not found to be associated with conviction. On the other hand, from investigators' points of view, one study found the FME evidence was useful for identifying or confirming suspects, establishing victim credibility and proving that sexual contact occurred (Menaker et al., 2017). We suggest that understanding the uses of tests and examinations and the purposes for which they are most relevant should support practitioners in keeping tests to the minimum perceived to be useful for each patient's situation.

FMEs being useful for establishing complainant credibility came through as a major issue within the literature, given that much of the legal argument in courts for sexual assault centres on the credibility of the complainant and to some extent on the alleged offender (Du Mont et al., 2009; McDonald et al., 2020; Menaker et al., 2017). Yet often the credibility of the complainant is based on juries' and judges' misguided views about rape and sexual assault, and the evidence is gathered to support rather than challenge those myths. For example, physical injury is correlated with charging and conviction, especially in the international literature, but this also works against the many complainants where physical force is not used, and mild bruising or trauma can be viewed as 'normal' and therefore not an indication of forced rape (Du Mont & White, 2007; McDonald et al., 2020). Would the examination be conducted differently if injuries were examined more for healthcare purposes than for convincing a jury

that the rape was ‘bad’ or ‘real’? Such questions could, and should, be asked about each test contained in the sexual assault kit. We would support the recommendations of Du Mont et al. (2009) who call for more research to establish the correlation between medico-legal evidence gathered at the FME, and legal outcomes such as charging and conviction.

6.3 SUPPORTING POSITIVE PRACTITIONER BEHAVIOUR

The literature showed repeatedly the impact of practitioner behaviour on the patient experience of the FME. Numerous positive characteristics of the practitioner were identified, including: sympathetic and reassuring, could explain procedures carefully and calmly, was quick, efficient and skilled at the tests, who knew which tests were important for what reasons and which could be overlooked, and above all, attended to the therapeutic needs of the patients. These practitioners were highly praised and credited with allowing the patient to cope with an extremely difficult situation, and their actions were able to be recalled in detail afterwards. Conversely, where the practitioner was lacking in any of these areas, this compounded the negativity of the whole situation. Unfortunately, these practitioners’ actions were also recalled in detail for a long time after the event. The literature indicated that practitioners should be supported to act as clinicians first and foremost, and that all the usual therapeutic practices apply. The forensic evidence gathering is secondary and should be done carefully so it only has to be done once, done quickly so as to minimise trauma, and only those tests necessary to the case should be carried out. The literature supports regular review and continual improvements processes for practitioner training and supervision is an area of activity that would have large benefits for patient experience.

6.4 LIMITATIONS AND FUTURE RESEARCH

An objective of this synthesis was to review what was known about the experiences of patients and practitioners with the FME, especially in the context of Aotearoa. There was very little literature found for the Aotearoa situation, although that literature tended to confirm findings from the international literature. However, there is still a gap of empirical, primary research studies which focus on the sexual assault response system in Aotearoa. The recent work by McDonald et al. (2020) is a good example of the types of studies that could inform future innovations and provides good evidence for changes such as the Sexual Violence Legislation Bill.

The literature reviewed provided little comment on the impact of the cultural background of the practitioner on the FME experience for the patient, but there were some indications that it could be important. Future research could investigate the perspectives of patients and

practitioners with respect to the impact of cultural similarity or difference on the experience of the FME, especially with respect to patients from Māori and Pasifika cultures.

Another research project that could provide useful information for improving the system of sexual assault response is to track the use of medico-forensic evidence through the legal process and the impact on the legal outcomes of cases. The extensive report of Du Mont and White (2007) on the use of medico-legal evidence in sexual assault cases showed international trends, but it is unknown how much of these findings are replicated in Aotearoa in the 2020s. Such information would support revising the sexual assault kit and its documentation as well as guiding the practitioner to make decisions around the relevance of the different forensic tests for the individual patient.

A process of continual improvement should be built into the system, and patients' perspectives and voice would be a valuable contribution to this process. Oranga Tamariki is an example of a government department who have formalised the process of hearing their clients' voices, through working with an independent charity[6]. Future research could investigate ways of incorporating the voices of patients who undergo an FME, in order to improve the system, not only in terms of the forensic evidence aspects, but also the therapeutic and health aspects.

The most effective way to improve the experience of an FME for a patient is to render it unnecessary, through creating a societal culture where sexual assault is unthinkable – instead of being commonplace as it is in Aotearoa New Zealand today, where almost a quarter of adults have experienced sexual violence at some point in their lives (New Zealand Ministry of Justice, 2019). While we advocate for and wait for this change, medical practitioners can glean ideas from research to improve the details of the FME, including separating health and legal documentation, revising what is considered as necessary and useful information for court proceedings, and ensuring thorough training and support for those medical practitioners who make all the difference to the sexually assaulted patient they are caring for.

[6] https://voyce.org.nz/about-voyce/

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Thank you to those women and men who have been brave enough to share their stories so that we might learn from them.

8. CONTRIBUTIONS OF AUTHORS

All authors contributed to the conception and design of the review, and the final edited report; HRTM, SM conducted and analysed the review and drafted the report; MW contributed to study design and provided critical review.

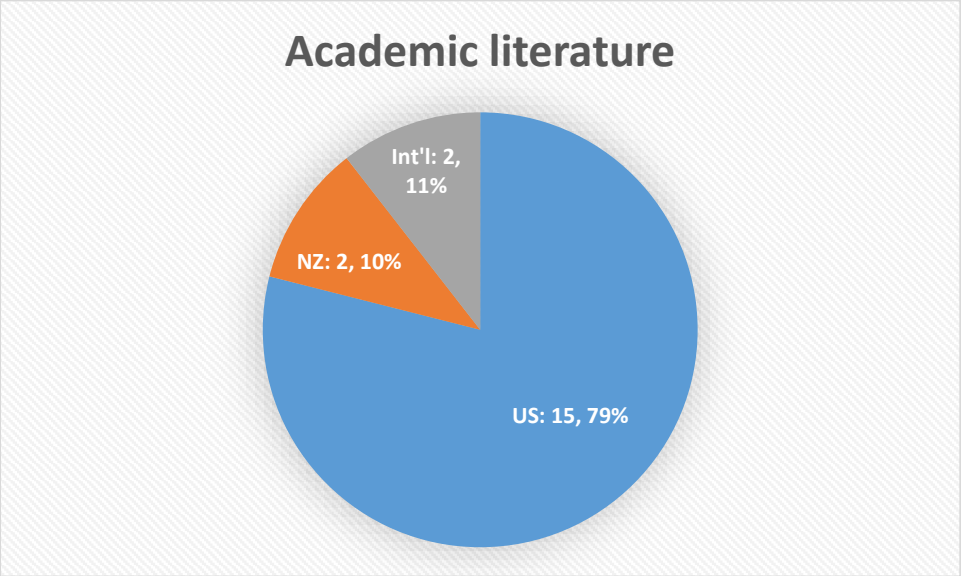
APPENDIX A: LITERATURE SELECTED FOR REVIEW

Source	No. of codes	Type of study
Menaker, T. A., Campbell, B. A., & Wells, W. (2017). The Use of Forensic Evidence in Sexual Assault Investigations: Perceptions of Sex Crimes Investigators. *Violence Against Women, 23*(4), 399-425.	2	FME evidence and justice outcomes. US.
Kelly, L. (2005). *Promising practices addressing sexual violence*.	3	Strategy development for in-depth study of all violence towards women. Vienna, Austria.
Shaw, J., R. Campbell, J. Hagstrom, L. O'Reilly, G. Kreiger, D. Cain and J. Nye (2016). "Bringing research into practice: An Evaluation of Michigan's Sexual Assault Kit." *Journal of Interpersonal Violence* 31(8): 1476-1500.	3	Review with practitioners and forensic scientists. US.
Du Mont, J., & White, D. (2007). *The uses and impacts of medico-legal evidence in sexual assault cases: A global review.* (ISBN 978 92 4 159604 6).	4	Review of FME evidence. International.
Burman, M., Bradley, L., & Brooks-Hay, O. (2019). Justice Journeys: Survivor Stories.	4	Female survivors' narratives. Scotland.
Kummerer, S. (2019, 20 May 2019). 'I felt like my body was numb:' Victims reflect on crucial decisions after being raped. *WMBF news*.	4	Female survivors' narratives. US.
Carswell, S., E. Donovan and H. Kaiwai (2019*). What is known about effective recovery services for men who have been sexually abused? An evidence review*.	7	Review of male recovery services. NZ.
Toon, C., & Gurusamy, K. (2014). Forensic Nurse Examiners versus Doctors for the Forensic Examination of Rape and Sexual Assault Complainants: A Systematic Review. *Campbell Systematic Reviews, 10*(1), 1-56.	8	Forensic nurses and doctors. UK
Gallardo, A., Sussman, N., Chang, A., Hopkins, K., & Theriault Boots, M. (2020). Have you experienced sexual violence in Alaska? Help us report these stories. *Anchorage Daily News*.	8	Female survivors' narratives. US.
Guerette, S. M., & Caron, S. L. (2007). Assessing the impact of acquaintance rape. *Journal of College Student Psychotherapy, 22*(2), 31-50.	9	Interviews with 12 female survivors of acquaintance rape. US.
McDonald, E., Benton-Greig, P., Dickson, S., & Souness, R. (2020). *Rape myths as barriers to fair trial process*: Canterbury University Press.	9	30 adults' rape cases from 2010 to 2015 (in which the defence at trial was consent) with 10 cases from the Sexual Violence Court Pilot heard in 2018. NZ
Du Mont, J., Saad, M., Kosa, D., Kia, H., & Macdonald, S. (2020). Providing trans-affirming care for sexual assault survivors: An evaluation of a novel curriculum for forensic nurses. *Nurse Educ Today, 93*, 104541.	11	Transgender survivor. Evaluation of forensic nurse practise. Canada and US.
Majeed-Ariss, R., T. Walker, P. Lee and C. White (2019). "The experiences of sexually assaulted people attending Saint Mary's Sexual Assault Referral Centre for a forensic medical examination." *Journal of forensic and legal medicine* 66: 33-37.	12	Female and male patients' FME experience. UK.
Du Mont, J., Kosa, D., Macdonald, S., Benoit, A., & Forte, T. (2017). A comparison of Indigenous and non-Indigenous survivors of sexual assault and their receipt of and satisfaction with specialized health care services. *PLOS ONE, 12*(11).	12	Compares indigenous and non-indigenous survivors of receipt of sexual assault healthcare. Canada and US.
Campbell, R. (2005). What really happened? A validation study of rape survivors' help-seeking experiences with the legal and medical systems. *Violence Vict, 20*(1), 55-68.	12	Advocates rape prevention & improving community response. US.
Jordan, J. (2001). Worlds apart? Women, rape and the police reporting process. *The British Journal of Criminology, 41*(4), 679-706.	14	Evaluation of victim complaints to Police. Qualitative interviews with 48 women. NZ.
University of Kentucky Center for Research on Violence against Women. (2010). *Needs of rape survivors*.	14	A survey with over 100 rape crisis and domestic violence advocates in Kentucky about what they needed to know from research to help them do their jobs. US.
Aubrey, S. (2019). After a rape, the forensic exam is 'extremely confronting' but crucial, says victim. *stuff.co.nz*.	16	Female survivor narrative. NZ.
Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: do rape victim advocates make a difference? *Violence Against Women, 12*(1), 30-45.	16	38 female rape survivors and FME. Michigan, US.

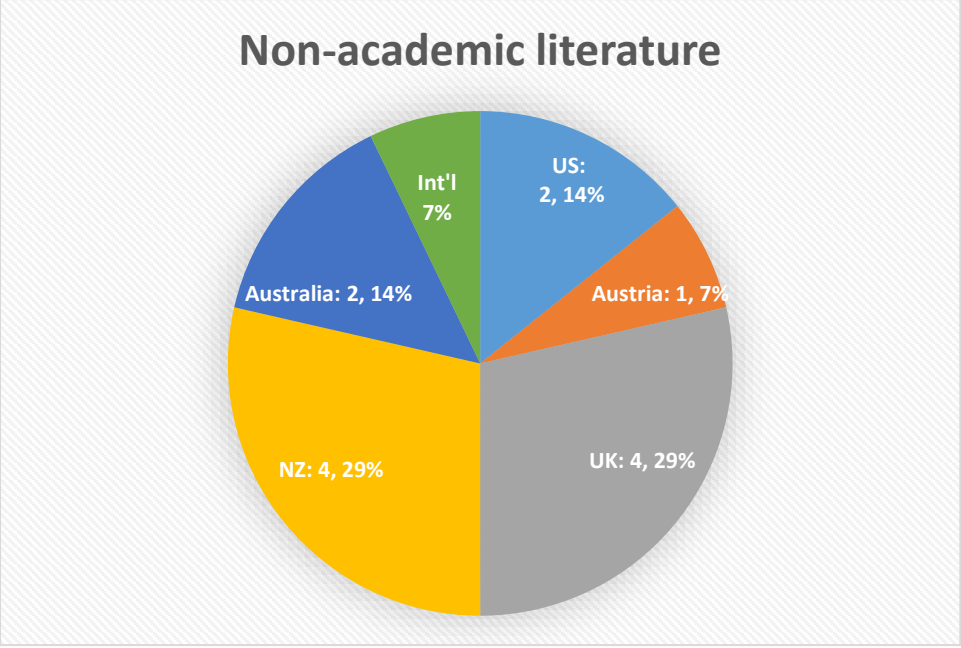
Caswell, R. J., Ross, J. D. C., & Lorimer, K. (2019). Measuring experience and outcomes in patients reporting sexual violence who attend a healthcare setting: A systematic review. *Sexually Transmitted Infections, 95*(6), 419-427.	16	Systematic review of patients' experiences of reporting sexual violence in the health care setting. International.
Feeney, H., Campbell, R., & Cain, D. (2018). Do you wish to prosecute the person who assaulted you?: Untested sexual assault kits and victim notification of rape survivors assaulted as adolescents. *Victims & Offenders, 13*(5), 651-674.	17	52 female rape survivors' evidence collection and outcomes. US.
Mulla, S. (2011). "Facing victims: forensics, visual technologies, and sexual assault examination." *Med Anthropol* 30(3): 271-294.	19	Medico-legal, photo documentation of females. US.
White, D., & Du Mont, J. (2009). Visualizing sexual assault: An exploration of the use of optical technologies in the medico-legal context. *Social Science & Medicine, 68*(1), 1-8.	19	Exploration of medico-legal evidence of women. Canada and US.
Campbell, R. (2008). The psychological impact of rape victims' experiences with the legal, medical, and mental health systems.	19	Review of female patients' experiences with medico-legal and mental health. International.
Fehler-Cabral, G., Campbell, R., & Patterson, D. (2011). Adult sexual assault survivors' experiences with sexual assault nurse examiners (SANEs). *Journal of Interpersonal Violence, 26*(18), 3618-3639.	22	20 females' experiences with Sexual Assault Nurse Examiners (SANE). US.
Mulla, S. (2014). *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention*: NYU Press.	23	FME review of female and male patients. US.
Maier, S. L. (2008). "I Have Heard Horrible Stories . . .": Rape Victim Advocates' Perceptions of the Revictimization of Rape Victims by the Police and Medical System. *Violence Against Women, 14*(7), 786-808.	25	Review of rape survivor advocates' perceptions of revictimisation by police and medical system. US.
Patterson, D., Pennefather, M., & Donoghue, K. (2020). Shifting Sexual Assault Forensic Examiners Orientation From Prosecutorial to Patient-Centered: The Role of Training. *Journal of Interpersonal Violence, 35*(21-22), 4757-4778.	26	Qualitative study of 64 health care professionals. US.
Esplin, J., Smith, J., Blick, G., & Moore, D. (2016). *Review of the Sexual Abuse Assessment and Treatment Services (SAATS) and the Organisation of Doctors for Sexual Abuse Care*.	31	Edited version of the full Sexual Abuse Assessment and Treatment Services (SAATS) and Doctors for Sexual Abuse Care (DSAC) review report. NZ and Australia.
Du Mont, J., White, D., & McGregor, M. (2009). Investigating the medical forensic examination from the perspectives of sexually assaulted women. *Social Science & Medicine, 68*(4), 774–780. doi:10.1016/j.socscimed.2008.11.010.	40	19 female patients' FME experiences. Canada.
Brooks-Hay, O., Burman, M., & Bradley, L. (2019). *Justice journeys: Informing policy and practice through lived experience of victim-survivors of rape and serious sexual assault* (No. 4/2019.	40	16 female & 1 male patients' narratives. Scotland.
Lievore, D. (2005). *No longer silent: A study of women's help-seeking decisions and service responses to sexual assault.*	53	36 female patients' and 55 sexual assault providers' FME narratives. Australia.
Jordan, J. (1998). *Reporting rape: Women's experiences with the police, doctors and support agencies*.[7]	69	48 females' FME experiences with police, doctors, and support agencies. NZ.

[7] Non-academic literature are shaded in grey

A.1.1 Academic literature breakdown analysis



A.1.2 Non-academic literature breakdown analysis



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