SITUATION ANALYSIS OF MEDICO-LEGAL AND HEALTH SERVICES FOR VICTIMS OF SEXUAL VIOLENCE IN CENTRAL AMERICA

Subregional Report
Belice, Costa Rica, El Salvador, Guatemala, Honduras y Nicaragua

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The "Gender and Public Health Series" is produced by the Gender and Health Unit of the Pan American Health Organization / World Health Organization in the sub-region of Central America with the purpose of disseminating different topics of interest which are promoted by the Unit. Its goal is to stimulate reflection, analysis and actions from an interdisciplinary gender perspective on public health matters.

Documents are published in these Notebook Series to help consolidate the processes that are currently underway in the Central American countries to incorporate gender considerations into policies and actions in the Health Sector. The content of the Series may be conclusions from workshops, contributions by individual authors and results of research.

The content of the works published and the manner in which data is presented do not necessarily imply the position of PAHO/WHO’s Gender and Health Unit on a particular topic.
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EXECUTIVE SUMMARY

Sexual violence is increasingly being recognized as a matter of concern for the security and public health of the sub-region. The Health Sector plays an important role in providing health care services and collecting forensic evidence for victims of sexual violence. Notwithstanding, the regional recognition of this reality is not derived from any study on the national or regional prevalence of sexual violence. The problem of sexual violence in the Central American context in can be summarized as follows:

- Sexual violence is recognized as a public health problem, a violation of rights and an obstacle to development.
- Despite this recognition, sexual violence is rarely recorded by institutions.
- Central American information regarding this problem centers mostly on child sexual abuse, incest and commercial sexual exploitation.
- A high level of impunity exists for perpetrators of sexual offenses, which is mainly derived from the gap between legal procedures and their application.
- The institutional response for the care of the victims is practically non-existent or inefficient.
- The response of the health sector is uneven, and is interpreted as the result of the individual actions of well-intentioned service providers.

The situation analysis of the medico-legal and health services available to victims of sexual violence can be better understood when linked to the characteristics of Central America, particularly three basic facets: the socioeconomic situation of the region; the situation of women; and the response of the health sector to gender-based violence.

This sub-regional report is the result of a joint initiative of the World Health Organization and the Pan American Health Organization – through its Gender and Health Unit- to contribute to the development of policies and integrated care strategies for the victims of sexual violence. To this end, in the year 2002 it was decided that a regional diagnosis would be carried out, starting with a situation analysis of each of the Central American countries. The purpose of these analyses was to generate a description of the status of the response to sexual violence on the part of both the health sector, and Legal Medicine in the sub-region. In total, six studies were carried out in Guatemala, Honduras, Belize, El Salvador, Nicaragua and Costa Rica using common objectives, methodology and instruments.

The studies compiled data on medical and medico-legal services available to victims of sexual violence in each country. To this end, the structure and resources of the health and legal sectors that offer a systematic response to sexual violence, and pertinent aspects of the service-delivery process were documented.
In the fulfillment of this purpose, a descriptive methodology developed by the World Health Organization was used to describe the situation starting with the information offered by key actors from the health and medico-legal sectors. The selection of informants was made according to their positions and the work they performed, and two types of instruments were used: questionnaire and check list. Essentially, the report is qualitative, and the statistical data are presented without an eye to generalization. The studies of each country were assessed and feedback was incorporated throughout the process, and each of the final reports was reviewed. To that end, technical coordination was established from the Gender and Health Unit and an expert advisory consultant was hired.

The Report emphasizes general findings and some specificities worth pointing out, with the aim of highlighting both strengths and pending challenges to the provision of integrated care for victims of sexual violence within the Region.

Among the general strengths were the following:

- A demonstrated interest in working on the subject from suppliers, administrators and managers;
- Free services;
- Significant advances in addressing gender-based violence: policies, norms and procedures. Although these have not been delineated for sexual violence, they constitute a first step towards specifying guidelines.
- Presence of non-governmental organizations that fight for the rights of women, and that are giving support to victims of sexual violence.
- The presence in public debates of related subjects: violence against women, commercial sexual exploitation and child sexual abuse.
- The presence in the region of several international cooperation agencies that support and stimulate work on sexual violence (PAHO; IPEC/ILO; IPAS, UNICEF, among others).
- The existence of ministerial-level agreements within the health sector to declare gender-based violence, including sexual victimization, a public health problem, thus creating a governmental commitment to work on the issue.
- A greater number of reports on sexual violence over the last decade, which points to a higher level of social and institutional awareness of the problem.
- The methodology used in national studies has permitted the generation not only of expected results, but also of commitments to action.
Among the sub-regional challenges to addressing sexual violence, three basic ones were identified: limited access to services, basically in rural areas; absence of specific policies on the subject of sexual violence in the health sector; and limited multi-sectoral cooperation in offering cohesive and integrated responses to victims. Overcoming these challenges requires a strong regional commitment. Additionally, the following stand out:

- Absence of information and standardized recording systems.
- Absence of standardized protocols for detection and care.
- The care process is cumbersome; care is not provided in one specific place, which makes it necessary to refer victims to different institutions. This is aggravated by a lack of transportation and an absence of a true platform of cohesive services with a good follow-up system. All this results in the victims' being lost in the process.
- There is no specialized training on sexual violence for service-providers. Efforts are isolated, without follow-up and without complete coverage.
- In medico-legal services, integrated care for the health of victims, including emotional support and prescription of necessary medication, is not always available.
- Services do not have national coverage and are generally concentrated in metropolitan areas.
- There is a lack of administrative resources to support work on the care of sexual violence; which is evident in rural areas.
- Many providers still consider violence a private issue, and and do not act with legal and professional responsibility, leaving action to the families of the victims.
- Existence of few forensic examiners in proportion to the population to be attended.

The main result of the investigative process will be the building of a sub-regional vision for the care of victims of sexual violence in Central America. Simultaneously, the results from each country can inform the strengthening of national responses to situations of sexual violence.
LIST OF ACRONYMS

BACKGROUND INFORMATION:
ILO/IPEC: International Program for the eradication of the worse forms of child work of the International Labor Organization
WHO: World Health Organization
NGOs: Non-governmental Organizations
PAHO: Pan American Health Organization
UNICEF: United Nations Children’s Fund

BELIZE:
KHMH: Karl Heusner Memorial Hospital.

COSTA RICA:
CCSS: Caja Costarricense del Seguro Social.
EBAIS: Basic Teams for Integral Health Attention.
ATAP: Technical Assistants for Primary Attention.
ECOS: Community Health Educators.
PROCAL: Fundación Promoción, Capacitación y Acción de Alternativas (Foundation for the Promotion, Training and Alternative Action).

EL SALVADOR:
IML: Institute of Legal Medicine.
SIBASI: Integral Basic System for Total Health Attention

GUATEMALA:
IGSS: Instituto Guatemalteco de Seguridad Social
MP: Public Ministry
MSPAS: Ministry of Public Health and Social Assistance
OJ: Judicial Organism.

HONDURAS:
CESAMO: Health Centers
CESAR: Rural Health Centers
CLIPER: Peripheral Emergency Clinics.

NICARAGUA:
INSS: Instituto Nicaragüense de Seguridad Social.
MINSA: Ministry of Health.
SILAISS: Local Systems of Integral Health Attention
INTRODUCTION

This document analyzes the medico-legal and health services available to victims of sexual violence in Central America through six diagnostic studies carried out in Costa Rica, Nicaragua, El Salvador, Honduras, Belize and Guatemala. This is a joint initiative of the World Health Organization and the Pan American Health Organization (through its Gender and Health Unit) to contribute to the development of policies and strategies for the integrated care of victims of sexual violence.

Among the antecedents that led to the preparation of a regional diagnostic on the health sector’s care of victims were:

The interest of the World Health Organization is in promoting actions, based on a participatory methodology, whose purpose is to define policies on sexual violence, and in developing a protocol for the care of adult/child victims of sexual violence. This interest is outlined in a document that grew out of a meeting of experts on the subject held in Geneva in 2001. The document specifically points out that health centers can provide services from a gender-sensitive perspective to care for people who have experienced sexual violence, while at the same time collecting and documenting the necessary evidence to establish the circumstances in which the violent act occurred. They can perform an important referential role for other services that the victim might need.

The World Health Organization recognizes the existence of a gap between the needs of victims of sexual violence, and the response of health services in most of the countries for such cases. Thus, WHO asserts, there is a need to offer a normative guide to strengthening the response capacity of the health sector to people who have been victims of sexual violence.

The Gender and Health Unit of the Pan American Health Organization in concluding its Project on intrafamily violence –carried out in Central America over the last eight years– decided to continue responding to the problem of gender-based violence and thus initiated a Project with an emphasis on sexual violence in 2002.

During the Gender and Health Unit’s annual evaluation and planning meeting for Central America, held in Costa Rica in June 2002, the Unit’s strategy for collaborating with the response to sexual violence in the region was analyzed. As part of the meeting, the World Health Organization presented their work on addressing Sexual violence.

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1 Proposal to Include Central America in WHO’s global initiative to spearhead a health response to sexual violence.
Within this context, the Pan American Health Organization’s Gender and Health Unit agreed to perform the “Situation Analysis of the Care of Victims of Sexual Violence in Central America”, not only as a response to the initiative of the World Health Organization but also because it considered that the project coincided with its own strategic plan. To complete it, a work plan was prepared, following the normative methodology of the WHO, for a diagnostic study in six countries of the region. The integration and synthesis of these studies is the main objective of this review. In each country, the studies were headed by Abigail McKay (Belize); Ligia Hurtado (Guatemala); Emilia Alduvín (Honduras); Sofía Villalta Delgado (El Salvador); Carmen María Lang (Nicaragua), and Alicia Zamora (Costa Rica).

This document therefore describes the structure of medical and legal services, and the process of service-delivery for sexual violence in Central America. It also identifies the main gaps and strengths with the aim of defining priority strategies for strengthening existing services and proposes objectives for future practices.

The report is divided into four large sections, which are in turn divided into interrelated subsections. The first part presents a general background of Central America; including its geographic location, some economic, demographic and health indicators, the status of women, and a brief review of existing studies and data on sexual violence in the region. The second part presents the conceptual premises, objectives and the methodology used in the study. The third part presents the results of the diagnostic study and the final part offers conclusions and recommendations.

Finally, it is hoped that this study will serve as a baseline in Central America to develop standardized procedures for ensuring the good quality of health and medical-legal services to people who have experienced sexual violence.

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4 Situation analysis of medico-legal services for survivors of sexual violence. World Health Organization. Sexual Violence Research Initiative. Questionnaires one, two, three a-b, four. 2002
CHAPTER 1
THE CENTRAL AMERICAN CONTEXT

General Characteristics

Studies and Informational Data on Sexual Violence in Central America
1.1 General Characteristics of the Region

Geographically, the Central American region is a long strip of land located between North America and South America, bordered by the Caribbean Sea on the East and by the Pacific Ocean on the West. It is made up of seven countries: Guatemala, Belize, Honduras, El Salvador, Nicaragua, Costa Rica and Panama. As a result of the Spanish conquest and colonization, six of them share the Spanish language. With the exception of Belize therefore, the region has both similar organizational and productive structures, and analogous cultural traditions. Belize, although geographically located within Central America, shares the English language and a large part of its cultural traditions with countries located in the Caribbean region; however it also presents socioeconomic characteristics similar to the rest of the Central American countries. The countries of the region are small, with big challenges to satisfying the survival needs and welfare of the population.
## Chart #1
General socio-demographic characteristics of the Central American region

<table>
<thead>
<tr>
<th></th>
<th>Guatemala</th>
<th>Honduras</th>
<th>El Salvador</th>
<th>Nicaragua</th>
<th>Costa Rica</th>
<th>Panama</th>
<th>Belize</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Extension in Km²</strong></td>
<td>108.890</td>
<td>112.090</td>
<td>21.040</td>
<td>129.494</td>
<td>51.100</td>
<td>78.200</td>
<td>22.965</td>
</tr>
<tr>
<td><strong># of Inhabitants</strong></td>
<td>12,335,580</td>
<td>5,997,327</td>
<td>5,839,079</td>
<td>3,674,490</td>
<td>3,674,490</td>
<td>2,778,526</td>
<td>228,000</td>
</tr>
<tr>
<td><strong>Population Growth Rate %</strong></td>
<td>2.68</td>
<td>2.24</td>
<td>1.53</td>
<td>2.84</td>
<td>1.9</td>
<td>1.8</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Life expectancy at birth</strong></td>
<td>66 years, 64 years, 63 years</td>
<td>65 years, 63 years, 66 years</td>
<td>70 years, 67 years, 73 years</td>
<td>67 years, 65 years, 70 years</td>
<td>76 years, 74 years, 79 years</td>
<td>75 years, 72 years, 78 years</td>
<td>75 years</td>
</tr>
<tr>
<td><strong>GNP (millions)</strong></td>
<td>45,700</td>
<td>14,400</td>
<td>17,500</td>
<td>11,600</td>
<td>24,000</td>
<td>19,900</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Per capita Income</strong></td>
<td>3,800</td>
<td>2,400</td>
<td>3,000</td>
<td>2,500</td>
<td>6,700</td>
<td>7,300</td>
<td>2,730</td>
</tr>
</tbody>
</table>


In order to provide a more profound picture of the general situation in Central America, specific data from Guatemala and Nicaragua are discussed below.

**Nicaragua** is the largest of the Central American countries and the second poorest in Latin America, with a GNP per capita that does not exceed $500/year (the Poverty Study pointed out that 74.8% of Nicaraguan homes are poor and of these 43.6% are in a condition of extreme poverty). 57% of the Nicaraguan population is urban and 42.9% is rural. Of this, 53% are children and adolescents under 18 years of age; 49.2% are male and 50.7% are female.

Presently, this country is undergoing a political and economical crisis with severe consequences such as high unemployment and poverty rates, factors that have been associated with a general increase in social violence.

En la actualidad este país se encuentra en período de crisis política y económica, con graves consecuencias como altas tasas de desempleo y pobreza, factores que se han asociado con un aumento generalizado de la violencia social.

Source: Diagnosis of the situation of attention to victims of sexual violence. Nicaragua.
Guatemala, is one of the poorest countries of the continent and the third most inequitable in the world. It is a multi ethnic, pluricultural and multilingual country. 51% of the population is female, approximately 45% of the population is under 15 years of age, at least 5% are older than 65 years, and women of reproductive age constitute 22% of the population.

In this country, 21% of the population is concentrated in the metropolitan region, and of this half a million inhabitants live in marginal conditions. Indigenous people represent 42.28% of the population, distributed across 24 ethnicities and languages.

Source: Situational diagnosis of attention to victims of sexual violence. Guatemala

The situation of women, who constitute the main victims of sexual violence and therefore the basic target group for medico-legal and health care services can be seen in charts #2 and #3. Chart #2 uses participation in political decision-making as a basis for reflecting gender discrimination, and Chart #3 provides some basic health indicators.

### Chart #2
Proportion of women participating in formal political decision-making (1994)

<table>
<thead>
<tr>
<th>Country</th>
<th>Parliament</th>
<th>Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>Guatemala</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>El Salvador</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Honduras</td>
<td>8%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: UNDP. Human Development Report, 1995
In relation to gender-based violence, Central America does not escape global statistical trends with regard to its prevalence. Violence that occurs within the family has been the most studied, and it has occupied the largest place in public debate.

Between 1997 and 1999, the Gender and Health Unit sponsored a study on the critical path that women take to find care for and a solution to violence. The investigation included all the Central American countries, also extending to Bolivia, Ecuador and Peru. Among other results, this report showed that:

- In spite of the recognition of violence as a public health problem, a violation of rights, and an obstacle to development, it is rarely recorded by institutions.
- The response of the health sector is uneven and responses are interpreted as the result of individual actions by well-intentioned service providers.

The recommendations arising from this study and specifically related to the health sector include:

- Incorporation of the problem in sector plans with allocation of resources and budget
- Development of a protocols of care
- Creation of specialized services
- Mandatory recording in causes of morbidity/mortality
- Revision of models, practices and approaches that encourage repeat victimization
- Promotion of healthy lifestyles
- Inter-institutional collaboration

In summary, it can be stated that the situation of medico-legal and health services for victims of sexual violence is better understood when linked to the Central American context, particularly the socioeconomic situation of the region, the situation of women, and the response of the health sector to gender-based violence.

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**Chart #3**

<table>
<thead>
<tr>
<th>Situation of Women - Health Indicators (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guatemala</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Prevalence of birth control 1995-2001</td>
</tr>
<tr>
<td>Coverage of prenatal attention 1995-2001</td>
</tr>
<tr>
<td>Births attended by specialized personnel 1995-2001</td>
</tr>
<tr>
<td>Maternal mortality rate recorded 1985-1999</td>
</tr>
</tbody>
</table>

1.2. **Studies and General Data on Sexual Violence in Central America**

The regional recognition of the existence of sexual violence is not derived from any study on the national or regional prevalence of the problem. The existence of sexual violence can be determined from:

- The increase in the demand for institutional services on the part of the victims.
- Classification of sexual crimes in national penal codes, and the presence of individuals sentenced for the commission of these crimes.
- The existence of data from private and public institutions dedicated or related to the care of victims.
- Recording of complaints.
- Newspaper reports and news.
- University or institutional studies focused on the investigation of certain variables or types of abuse.
- National and regional research regarding traffic of women for sexual purposes and commercial sexual exploitation of minors.

Central American information regarding sexual violence focuses primarily on the victimization of children. More recently, concern has also extended to the problem of commercial sexual exploitation, broadening the scope to include adolescents. Sexual violence against adult women has not been, comparatively, a matter of priority concern for the generation of research processes, with the exception of the trafficking of women, about which a subregional study was conducted in 2002.

It must be pointed out that sexual commerce has been the only problem to generate regional research:

In 1994, as the result of an initiative sponsored by UNICEF, a regional study was prepared, based on research from several of the countries of the region, to learn more about the processes of victimization of girls and adolescent females.

The most evident results of this study are its constitution as a starting point for later research, and the advances in the conceptualization of commercial sexual exploitation of under-aged persons. **That is to say, the study became the point of reference for passing from the consideration of child and adolescent prostitution as a way of life, to a manifestation of sexual violence and a severe violation of human rights.**
In 2002, Casa Alianza published the **Regional Investigation of Trafficking, Prostitution, Child Pornography, and Sexual Tourism in Mexico and Central America**\(^6\). This study is the result of an institutional alliance between several private organizations whose purpose is to study facts related to the commission of crimes: middlemen nets, sexual exploiters, promotion of commercial sex and its presence on the Internet. The application of legislation and the capacity and quality of the institutional response was also researched.

The most important results were:

- The presence of networks of direct and indirect exploiters within a plurality of actors and organizations.
- The personal experiences of the victims in conditions of poverty and social exclusion.
- Serious distance between legislation and its application for the punishment of crimes.
- Absence of effective policies and strategies for institutional intervention.

Other studies by IPEC/ILO\(^7\) have found disturbing information on the issue of commercial sexual exploitation:

- It was not possible to quantify the problem of sexual trafficking
- No Central American country has included the subject on the national agenda
- Government representatives recognize the problem and its increase
- All the countries, with the exception of El Salvador consider international trafficking for sexual purposes a criminal offense, but the law is rarely applied.
- Government response mechanisms are non-existent or inadequate.

In general, research on sexual violence has agreed on the following:

- Women are the main victims of sexual violence. This data is relevant for the preparation of national and sectoral policies about the problem, as well as for the planning of services directed towards the care of victims by the health sector.
- Existence of high levels of impunity towards sexual crimes due to gaps in the classification of crimes, procedural norms regarding proof, and the gap between judicial norms and their application.
- Assistance to victims is poor and not well integrated.

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\(^6\) Casa Alianza Internacional. Regional research on traffic, prostitution, child pornography and sexual traffic in Mexico and Central America: Regional Summary. San Jose, Costa Rica: Gustavo Leal, editor. 2002

\(^7\) ILO/IPEC. Commercial sexual exploitation of underage persons in Central America, Panama and the Dominican Republic. Regional Summary. 2003
CHAPTER 2
WHAT IS THE BASIS FOR THE REPORT AND HOW WAS IT DONE?

Conceptual Premises

Objectives and Methodology
2. 1. Conceptual Premises

Gender-based violence is a concept that includes several manifestations of abuse against women, and female children and adolescents. The term reflects the gendered reality of a common and socially legitimized form of violence; meaning it recognizes that this violence, or the risk of experiencing it, is associated with being female (Claramunt, 2002). In 1993, the United Nations approved the Declaration on the Elimination of Violence against Women, stipulating that gender-based violence is a violation of women’s human rights. In Article I of this Declaration, violence against women is defined as:

“Every act of gender-based violence which results or has the possibility of resulting in physical, sexual or psychological damage or suffering of the woman and includes the threat of committing such acts, repression and arbitrary deprivation of liberty whether in public or private life”

Sexual violence is a violation of fundamental human rights and constitutes a common manifestation of gender-based violence with multi-factoral roots and social and individual repercussions. In this regard, it must be approached in an integrated manner, including the dimensions of prevention, punishment of aggressors and care for the victims, with the aim of eradicating it. It has been pointed out that since the great majority of the countries in the region incorporate various types of sexual violence in their penal codes, the work to eradicate it must integrate the active participation of the health sector in institutional networks, where a preferential place is currently occupied by: integrated State services of protection for minors; specialized centers for crises caused by rape; offices for the reception and handling of complaints; and in the countries that require it, judicial departments in charge of carrying out forensic examinations.

Data managed by WHO reveal that sexual violence significantly affects the health and security of victims. Research has found that more than 36% girls and 29% boys have suffered sexual abuse during their childhood, which has physical as well as emotional and social consequences, including suicide, HIV/AIDS and other sexually transmitted diseases, post traumatic stress and other mental disorders, adoption of high-risk behaviours such as having multiple sexual partners and the use of drugs.

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The following definitions are part of the operational platform offered by WHO for the execution of the diagnostic study. All operational definitions are presented in Annex 4.

**SEXUAL VIOLENCE:**

Any sexual act, intent to perform a sexual act, comments or unwanted sexual advances, trafficking of women for sex, using repression, threats with arms or physical force by one person in relation to the victim, in any environment, including the home and place of work, without limitation to these environments.

The concept encompasses physical force or sexual repression, the intent of sexual repression, attacks to a sexual organ, sexual harassment, sexual humiliation, forced matrimony or concubine, forced prostitution, traffic of women, forced abortion, denial of the right to use birth control methods or to protect oneself from a sexually transmitted disease, and acts of violence against women such as feminine genital mutilation genital and virginity control.

In accordance with WHO, the definition of sexual violence should also include the parameters presented by Saltzman, Fenlow, McMahon and Shelley (1999):

- The use of physical or psychological violence to force a person to participate in a sexual act, whether or not the sexual act is actually consummated.
- A sexual act (whether consummated or intended) against a person incapable of understanding the nature or meaning of the act or to refuse it, or to be able to indicate that he/she refuses to participate in the act, whether due to disability, effects of alcohol or other substances or due to intimidation and pressure.
- Abusive sexual contact.

It is also recognized that sexual violence can take place among family members or intimate partners (marriage or concubine), among familiar persons and strangers, and it can happen at any time during the lives of men and women.

The purpose of the diagnostic study was to determine the effectiveness of services, which were evaluated using the following indicators:

- the establishment of a system to report cases of sexual violence
- the creation, application and implementation of protocols of care
- the creation of security measures for service-users
- establishment of conciliation among multi-sectoral bodies
- the possibility of adequate situations and follow-up
- number and type of equipment and activities intended for service-provision
- gathering and distribution of information representative of all population groups
- increase in the accuracy of case-reporting and changes in the structural organization. 10

2. 2. **OBJECTIVES AND METHODOLOGY**

2. 2. 1 **THE OBJECTIVES THAT LED TO THIS REPORT ARE:**

**General Objective**

To provide comparative data on the medical and legal services available to victims of sexual violence in the Central American region.

**Specific Objectives**

- To document the structure and resources of the health and legal sectors that offer a systematic response to sexual violence (at the macro and micro levels);
- To document pertinent aspects of the service-delivery process

2. 2. 2 **OUTLINE OF THE METHODOLOGY USED**

The studies were conducted between November 2002 and May 2003 and used the descriptive methodology suggested by WHO to fulfill the proposed objectives; namely to describe the situation according to the information provided by key health sector informants, including management and service-providers, using two types of instruments: questionnaires and checklists.

Given the Gender and Health Unit’s interest in using the study as an input for the implementation of its strategies, national teams who have access to decision making were organized to validate and complement the collected information.

As a starting point, a coordinating team was formed in order to a) develop a methodological proposal that would permit the adaptation of the WHO procedures to each of the Central American countries; b) coordinate efforts; c) follow-up on the studies; and d) carry out an analytical summary of national efforts for the purpose of preparing a sub-regional report. Additionally, people were selected by country to carry out the study under the supervision of the Gender and Health Unit’s national focal points.

Of the Central American countries; Guatemala, Belize, Honduras, El Salvador, Nicaragua and Costa Rica took part in the initiative. Based on the findings in each of them, similarities, differences, and common and specific challenges and strengths were presented.
The research took place in five phases:

**First Phase:** Planning of the study and formation of the work team
**Second Phase:** Collection of information in each country
**Third Phase:** Systematization and analysis of information
**Fourth Phase:** Validation of results by country
**Fifth Phase:** Writing of reports (national and sub-regional)

### 2. 2. 3 Participating Population

A total of 162 key informants were consulted, distributed by position in the following manner: 13 people in positions of national directorship, 11 in regional directorship, 24 service managers, 71 health service-providers, including forensic medicine, and 43 providers of related services (police and non-governmental organizations).

### 2. 2. 4 Instruments

**Questionnaires:** There were five questionnaires that differed according to the type of informant to whom they were addressed. Therefore, each one included different questions designed to elicit the necessary information from each informant. The same questionnaires were applied at the level of national directors of health and legal medicine sectors, at the level of regional or provincial directors, at the level of service managers and direct service-providers (forensic examiners, nurses, doctors, practitioners, doctors with forensic training, nurses with forensic training and gynecologists), and to service-providers that did not belong to the health and medico-legal sectors: police and representatives of non-governmental organizations. The information requested covered issue such as: training, attitudes, structure and content of services, collection of evidence, and procedures, among others. The thematic issues are presented in Annex #4.

**Checklists:** These were applied in the places or institutions in which victims of sexual violence were attended. They were destined for the observation and corroboration of the availability of equipment and materials, the existence of protocols, and access facilities, among other things. The variables included in the list are presented in Annex #4.
2. 2. 5 Selection of the places of study for the confrontation of results at the central and local levels

Chart #4
Places selected by country

<table>
<thead>
<tr>
<th>Country</th>
<th>Central level</th>
<th>Location studied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guatemala</td>
<td>Guatemala</td>
<td>Escuintla</td>
</tr>
<tr>
<td>Belize</td>
<td>Belize</td>
<td>Cayo</td>
</tr>
<tr>
<td>Honduras</td>
<td>San Jose</td>
<td>Alajuela</td>
</tr>
<tr>
<td>El Salvador</td>
<td>San Salvador</td>
<td>Apopa</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>Managua</td>
<td>Carazo</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>San Jose</td>
<td>Heredia</td>
</tr>
</tbody>
</table>

Key informants were selected in accordance with inclusion and exclusion criteria, and the questionnaires and checklists were applied. This process and those performed in each of the phases are detailed in Annex #5. Amendments and methodological adjustments are presented in Annex #6.
CHAPTER 3
PRESENTATION OF RESULTS

General Outlook of Findings
Characterization of services
Examinations and collection of evidence
Contents of the attention
Equipment for the attention
Policies and protocols
Security
Attitudes
Training
Multi-sectoral Cooperation
3. 1. **GENERAL OVERVIEW OF FINDINGS**

**STRENGTHS FOUND IN THE REGION:**

- There is interest in the issue on the part of service-providers, administrators and managers;
- The need for standardized protocols of attention is apparent;
- The regional experience of work in intrafamily violence permits the visualization and understanding of the problem of sexual violence;
- A significant number of health providers have specialized training in gender, intrafamily violence and sexual violence against children of both sexes;
- Reporting on sexual crimes and the demand for care on the part of the victims are increasing;
- Most services are free of charge for the population.

**REGIONAL CHALLENGES:**

- There is little priority given to the problem of sexual violence. This is reflected in the absence of institutional systems of registration of information, few studies on prevalence and incidence and the absence of standardized protocols for detection and care in most of the institutions studied.
- The care process is cumbersome; care is not given in one centralized place, which makes it necessary to refer victims to several institutions. This is aggravated by limited transportation and the absence of a true platform of integrated services, with a good follow-up system. Thus, victims are lost in the process and the right to justice cannot be exercised.
- There is little specialized capacity on sexual violence as part of the institutional policies. Efforts are isolated, without follow-up and without complete coverage.
- There is no integrated health care in legal medicine services, for example, emotional support and prescription of necessary medication.
- Prophylactic medicines in situations of sexual violence (prevention of sexually transmitted diseases, including HIV/AIDS, pregnancy and hepatitis) are not routinely offered in most services.
- Services do not have national coverage and are usually concentrated in the metropolitan areas.
3. 2. CHARACTERIZATION OF SERVICES OFFERED IN RESPONSE TO SEXUAL VIOLENCE IN CENTRAL AMERICA

3. 2. 1. STRUCTURE OF HEALTH SERVICES

The characterization and structure of services in the Central American Health Sectors vary in each of the countries, although in general they are divided into two sub-sectors: public and private. There is little information about the private sector. The Ministries of Health act as regulatory agencies for these services, although there are some normative public institutions, such as the Caja Costarricense del Seguro Social in Costa Rica and at the Central Level the National Management of Integral Care for the Health of Women in El Salvador.

Services are basically rendered at three levels of care:

- **Primary level** - is interdisciplinary in nature and directed towards the work in and with communities, including promotion, prevention and basic care.

- **Secondary level** - houses the services that have an infrastructure and specialized health professionals (medicine, general surgery, gynecology-obstetrics, pediatrics and some sub-specialties). It also houses, for example, clinics that offer external health services, emergencies, and diagnostic and follow-up services.

- **Tertiary level** - is made up of the network of general and specialized national hospitals, and regional and peripheral general hospitals, which offer external health services as well as hospitalization services.

These levels of attention are distributed throughout the capital as well as in many of the provinces or departments, though in most of the countries there is a clear concentration in urban and metropolitan areas.

The private sector is composed of private doctors, clinics and hospitals, and non-governmental organizations focused on health care. It also includes pharmacies, optics, laboratories for analysis, and diagnostic centers.

No specialized services for the care of victims of sexual violence were identified within the private and public health sectors of the region (all three levels).
3. 2. 2. Structure of Services in Legal Medicine

Contrary to the structure of general health services, there are more differences among the countries in the services dedicated to legal medicine, since they are governed by the policies of the Judicial System. In general in Central America, it was been found that there were no medico-legal services exclusively dedicated to or specialized in the care of victims of sexual violence. The victims access them once the complaint has been lodged with the offices that receive complaints. From there, they are referred to legal medicine services for the collection of evidence. These can be offered directly within the legal organs (Costa Rica), or else in a health center (Honduras and Belize).

3. 2. 3. Services Offered and Type of Personnel

Specialized services for boys and girls: According to the majority of people interviewed in all the countries, there are specialized services for boys and girls, as demonstrated in the graphic:

![Graphic #1](source)

Existence of specialized services for boys and girls in the sub-region according to key informers (%)

- Yes: 88%
- No: 8%
- No Response: 4%

Source: Questionnaires applied to key s at the national and local levels 2003. N=162
Medico-legal services: In all the countries the main duty of forensic medicine services is the collection of evidence, which will be discussed later on.

Specific services
(not present in all services or in all countries):

- Immediate medical attention.
- Intervention services and emotional support during times of crisis.
- Individual and/or family therapy.
- Long term health care.
- Some social assistance services.
- Support groups within the hospitals of certain countries.
- Prophylactic measures.
- Support for complaints on the part of the institution or the professional.

Associated services: Committees for assaulted children and adolescents of both sexes, committees for intrafamily violence and violence against senior citizens in Costa Rica.

In the sub region, no national plans for the care of sexual violence have been developed, which is evidenced by the difficulties that affected persons face when looking for an integrated approach. Thus, for example, health care without prior presentation of a complaint can be limited. Close to one third of providers in health and medico-legal services interviewed indicate that there is no possibility of receiving health care without prior presentation of a complaint.

Type of personnel: Within Central American health sector institutions there are professionals with academic degrees in: general medicine, gynecology, nursing, psychiatry, psychology and social worker. Moreover, there are support personnel. In some countries, these people are authorized to perform forensic exams; however, they do not always have the necessary training or are not always prepared to perform them. In others, only forensic doctors (Costa Rica), or legally authorized professionals can perform them (Nicaragua).

Regarding the type of personnel that offer care services to victims of sexual violence in the sub-region, most of the individuals interviewed pointed out that it is mainly gynecologists (31% of the individuals interviewed) who offer care to the victims. 29% indicated that this is done by doctors, male or female, and 24% mentioned nurses of both sexes, while 11% indicated that the exams are done by forensic examiners and 5% mentioned general practitioners of both sexes.

Within the health sector some specific situations were pointed out regarding the services offered and the type of personnel within institutions. The following chart indicates the situation in Honduras.
3. 2. 4.  **MEDICO-LEGAL SECTOR**

A central component of the care of victims of sexual violence takes place within the **Legal Medicine Sector**, and although this exists in all the countries, the services offered vary in each of them.

**Forensic Medicine:** Among the services offered are: examination of the victims and accused, evaluation in cases of sexual crimes, intrafamily violence, traffic accidents, aggressions and injuries, drug addiction, medical malpractice, abortions, determination of age, pregnancy diagnosis; health exams and physical examinations to those in detention or in jail; referral of doctors and hospital certificates and preparation of certificates on the physical state of individuals.

**Forensic Psychiatry and/or Psychology:** The main services provided are: performance of psychiatric and psychological evaluations requested by legal authorities; diagnoses of the existence of an altered mental state; psychiatric and psychological evaluation; evaluation of drug dependence; domestic violence; sexual offenses and traumatic after effects; participation in jurisdictional progress and attendance to debates; and evaluation of how dangerous an accused individual may be.

---

**Chart #5**

**Existence of Professional by Type of Institution**

**HONDURAS**

<table>
<thead>
<tr>
<th>Type of Organization</th>
<th>Professional rendering the service</th>
<th>Existence in the capital city Tegucigalpa</th>
<th>Existence at the regional level Danlí</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary of Health: Health Center and hospital levels</td>
<td>Doctors</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Nurses</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Secretary of Health: Counseling Clinic</td>
<td>Psychologist</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Legal Advisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NGO “Center of Women Rights CDM”</td>
<td>Psychologist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Legal Advisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Ministry: Forensic Clinic</td>
<td>Qualified Forensic Doctor on call (15 hours of training)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Trained forensic doctor (60 hours)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Source: Honduras: Diagnosis of the situation regarding health attention to victims of sexual violence. 2003.
Health services are not usually performed in the medico-legal sector beyond the collection of evidence, as demonstrated in the graphic:

**Graphic #2**

Percentage of possibilities, according to service providers, of receiving basic health care within the legal system, other than the collection of evidence

- Yes 28%
- No 36%
- Does not know 12%
- No Response 24%

Source: Questionnaires applied to service providers. 2003. N=114

It was possible to identify the following professionals working in the medico-legal sector with various specializations: forensic doctors, pathologists, forensic dentists, social workers, attorney, laboratory technicians, secretaries, forensic nurses, X-Ray technicians, forensic photographers, autopsy assistants, motorists, warehouse workers and ordinances.

### 3. 2. 5. OTHER INSTITUTIONS

Besides the services offered by the health and medico-legal sectors, the region has other institutions that are also involved with people affected by sexual violence, such as the police and non-governmental organizations directed to women and the under-aged population.

**Police** offer support services such as: police presence, counselling, prevention and immediate attention to the victims. In some cases, police transfer the victims to legal institutions or health centers. In Nicaragua, for example, there are the Commissaries for Women and Children, the result of a joint effort between the National Police, the Instituto Nicaragüense de la Mujer (Nicaraguan Institute for Women) and various non-governmental organizations, which specialize in the reception of complaints and counselling of victims of various forms of abuse.
Non-Governmental Organizations  In the various countries there are several different organizations that offer support in different problematic situations, including sexual violence. They usually offer support and accompaniment services, including: individual psychological care; social and individual accompaniment; development of socio-educational and promotional activities; technical training in various areas; education; support groups; legal information and advice; accompaniment during the presentation of complaints and legal procedures; and direct health care or coordination of services. In the face of violence, these organizations can act on their own or as a network. According to existing reports on their experiences, most women victims are taken care of within the organization, but do not follow-up or denounce their abusers to legal authorities.

3. 2. 6. PHYSICAL SPACE

No specific physical space has been identified in Central America for the care of victims of sexual violence.

According to the people interviewed, private spaces do exist for the purposes of performing physical and forensic exams and collecting evidence. However, since it is not a space dedicated exclusively to the care of victims of sexual violence, before and after the exams victims must share the space with other users of the medical or forensic services, in some cases waiting in hallways, corridors or the reception area. In the specific case of Nicaragua, there are no physical installations within the departments to perform forensic exams, which must be performed in the private clinics of authorized doctors, or in the hospitals of the Ministry of Health (agreement entered into by both organisms).

Those psychology and psychiatric services offered are not specifically directed to victims of sexual violence, so once again the physical space must be shared with other types of service-users.

A similar situation exists with regard to the spaces destined for the receipt of denunciations and for emergency medical care in hospitals and health centers.

3. 2. 7. NUMBER OF MONTHLY VICTIMS ATTENDED

In the Central American sub-region the number of monthly victims seen in the various institutions cannot be ascertained, as figures vary depending on the type of services and the recording systems used. In no country or sector are there recording policies or specific information systems on sexual violence. As a result, although there is statistical information available, it does not necessarily reflect the true magnitude of the demand for services, and the care provided. Generally, results showed the registry of non-standardized variables, often manually, and with important variations between key informants regarding the place where the recording must be done. Thus, data and its interpretation vary. As an example, the range of variation in the estimation of the number of victims attended per month is demonstrated in the next graphic.
The absence of national information systems is evidenced by the following examples.

**Chart #6**
Average monthly cases attended/denounced for sexual violence in relation to national population. Costa Rica 2002

<table>
<thead>
<tr>
<th>Institutional Reports</th>
<th>Nat Pop.</th>
<th>Forensic Medical Clinic Capital</th>
<th>Sexual Offenses Attorney’s Office Capital</th>
<th>Forensic Psychiatric and Psychology Section Capital</th>
<th>San Juan de Dios Hospital Capital</th>
<th>Alajuela Hospital Social Work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.674.490</td>
<td>118</td>
<td>90</td>
<td>294</td>
<td>3</td>
<td>15</td>
</tr>
</tbody>
</table>


**Chart #7**
Average monthly cases attended for sexual violence in Legal Medicine, in relation to the national population. El Salvador 2002

<table>
<thead>
<tr>
<th>Institutional Reports</th>
<th>Nat Pop.</th>
<th>Central Region of Legal Medicine</th>
<th>Metropolitan Region of Legal Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12.335.580</td>
<td>26</td>
<td>98</td>
</tr>
</tbody>
</table>

3.2.8. Distribution of the victims by sex and age

It has been established that in the Sub-region sexual violence affects mainly under-aged women.

Distribution by sex:

In Central America there is a general recognition among providers, administrators and directors that sexual violence affects mainly women. For example, the Institute of Legal Medicine of El Salvador indicates in its report on recognition of victims of sexual violence, that in 2000 in the Occidental Region, 476 victims were detected, of which 88.23% were women. It is also worth pointing out that in 1999 in the Metropolitan Region the same percentage of women victims of sexual violence was reported.

There is also a recognition that among male victims of sexual violence, the majority are children, men suffering from mental retardation, or prisoners.

Distribution by age:

According to national reports, under-aged individuals are the most vulnerable to sexual abuse. However, such an assertion was not backed by the majority of service-providers, who do not know the age distribution of the population that attends their services. This contradiction can be interpreted as the result of a lack of a registration and information system, or the lack of focus on age by the people interviewed.

---

**Graphic #4**

Percentage of victims attended for sexual violence according to age groups

- Females under 15 years: 25%
- Females 15 years old and over: 8%
- No answer: 67%

Source: Questionnaires applied to providers of services. 2003 N=114
3.2.9. **Busiest Days at Services**

Although there is no record of daily attendance, service-providers selected Monday as the day of greatest demand; which is attributable to the accumulation of cases during the weekend. There is no consensus on days of lesser attendance.

**Chart #8**

*Days of greater and lesser attention, according to service-providers (%)*

<table>
<thead>
<tr>
<th>Days of greater attention</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>42%</td>
</tr>
<tr>
<td>Saturday</td>
<td>4%</td>
</tr>
<tr>
<td>No answer/Does not know</td>
<td>54%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Days of lesser attention</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday</td>
<td>17%</td>
</tr>
<tr>
<td>Wednesday</td>
<td>8%</td>
</tr>
<tr>
<td>Friday</td>
<td>8%</td>
</tr>
<tr>
<td>Sunday</td>
<td>4%</td>
</tr>
<tr>
<td>Others</td>
<td>4%</td>
</tr>
<tr>
<td>No answer/Does not know</td>
<td>59%</td>
</tr>
</tbody>
</table>

Source: Questionnaires applied to service providers. 2003. N= 114

3.2.10 **Where do the victims go the first time and why?**

According to the informants, many victims of sexual violence do not immediately go to services after the sexual aggression. Among the reasons interpreted by them are: shame, fear of reprisals, economic dependence, fear of being blamed or ridiculed, or simply assuming that denunciation is a long and difficult process, and the response is not in accordance with their needs.

However, when the victims do access some support resource, the first contact according to the informants is with informal systems, for example family members, friends or religious organizations. The formal attention services that may be accessed for the first time after the violent act takes place are set out in the chart below:
Chart #9
Formal Institutions first accessed by the victims, according to key informants (%)

<table>
<thead>
<tr>
<th>Institution</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>27.5%</td>
</tr>
<tr>
<td>Regional Hospital</td>
<td>8.5%</td>
</tr>
<tr>
<td>Primary Health Attention Clinic</td>
<td>11%</td>
</tr>
<tr>
<td>Medico-Legal Institute</td>
<td>10%</td>
</tr>
<tr>
<td>Tertiary Hospital</td>
<td>7%</td>
</tr>
<tr>
<td>District Hospital</td>
<td>6%</td>
</tr>
<tr>
<td>Office of General Practitioner</td>
<td>4%</td>
</tr>
<tr>
<td>Non-governmental Organizations</td>
<td>3.5%</td>
</tr>
<tr>
<td>Social Work Services</td>
<td>6%</td>
</tr>
<tr>
<td>Health Center designated for victims of sexual violence</td>
<td>2%</td>
</tr>
<tr>
<td>Other*</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

Source: Questionnaires applied to key informants. 2003. N=162
*Examples: 911 service for Costa Rica and private mental health professionals.

Chart #9 reveals the variability of places identified by the key informants as the places first accessed by the victims. Although there is a lack of information from the victims themselves, it could be argued that this data implies a coming and going to various institutions, as well as the cumbersome route faced by women who experience sexual violence from their partner.

In relation to the criteria used by the victim to decide where to go the first time, service-providers interpretations are listed in Chart #10.

Chart #10
Criteria used by the victim to decide where to go the first time, according to service-providers (%)

<table>
<thead>
<tr>
<th>Criteria for decision</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximity</td>
<td>36.5%</td>
</tr>
<tr>
<td>Service specialization</td>
<td>31.5%</td>
</tr>
<tr>
<td>Legal requirements for cases of sexual violence</td>
<td>13%</td>
</tr>
<tr>
<td>Others</td>
<td>12%</td>
</tr>
<tr>
<td>Reputation of the service</td>
<td>3.5%</td>
</tr>
<tr>
<td>Do not know</td>
<td>3%</td>
</tr>
<tr>
<td>No answer</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Questionnaires applied to service providers 2003 N = 114
Regarding the people accompanying victims of sexual violence on their first approach, providers identify the following:

- they arrive alone
- accompanied by relatives or friends
- teachers of both sexes, professors of both sexes
- members of the community
- mental health professionals and social workers
- in some cases, the victims have arrived with the assailant.

The manner of accessing the services, according to the people interviewed, do not differ for women, men, and children and adolescents of both sexes.

### 3. 2. 11 Process

The process followed by the victims of sexual violence depends on:

**The time elapsed after the incident of sexual violence:** Some informants stated that affected people do not always go to institutions of care immediately after the abuse has occurred. Rather, they abstain from accessing care, and then find themselves in need of these services due to consequences not immediately present after the violent act such as sexually transmitted diseases or emotional trauma. The legal process is thus not applied in the same manner as when the victim enters the services immediately after the sexual abuse.

**The victim’s first point of access:** The place or agency accessed will influence or determine the subsequent process. For example, if the victim accesses the health sector or a non-governmental organization and s/he wishes to file a complaint (or there is an obligation on the part of the service-provider to file a complaint - as in the case of minors), then the person must be referred to the district attorney or the judicial system. The reverse is true if the victim’s point of entry is a police station, and s/he needs medical attention.

**Age of the victim:** In the case of a minor, the service-provider is under an obligation to denounce the abuse. Denouncement procedures vary from country to country and from sector to sector, however the presence of a third person at the time of the examination and collection of evidence is common.

**National legal norms:** Although there are a number of laws in the region that codify sexual violence, normative moralistic interpretations of these offenses persist. For example, the vision that sexual offenses are a violation of sexual morality (e.g. immoral abuse) and not of sexual integrity requires that the sexual morality of the victim be demonstrated, otherwise there is no crime (rape). Aside from the legal code, procedural codes directly influence the steps that the victim must follow, as they determine the type and value of the evidence that s/he will have to present.
The following graphic illustrates the process followed by victims of sexual violence according to the information gathered from the national studies.

**Illustration #1**

*Process followed by victims of sexual violence*

Among the common challenges identified in the process, it is worth highlighting the need to implement regional and national actions directed to the reduction of:

- **Separation**: The health, legal and medico-legal sectors are separated, and victims have to come and go to the various institutions to receive health services and follow legal processes, whether they are children, adolescents, or adults. This also represents a transportation cost that people cannot always afford.
- **Re-victimization**: The abusive incident must be told repeatedly on several occasions in different institutions, in order to access different services.
- **Partial responses on the part of the institutions**
- **Lack of monitoring of services**: Institutional procedures are not applied in a regularized manner.

### 3. 2. 12. ACCESS

According to national studies, the access to services attending sexual violence in the region is limited due to the following reasons:

- **Concentration** of services in the metropolitan areas
- **Insufficient number** of forensic examiners in relation to the population
- **Language** (difficult access for ethnic populations that speak a language other than the official language)
- **Hours of operation** (no 24 hour attendance, except medical or legal emergency services, which are not necessarily available in all regions of every country)
- **No access to transportation** - free or otherwise - in all the countries
- **Very long waiting times** between procedures. For example, between presenting a denunciation and the trial; between a request for forensic evaluation and performance of same.
Number of institutions in the countries

For the number of institutions and forensic medical personnel, as well as the proportion of them per 100,000 inhabitants, the most outstanding datum in the region is the lack of knowledge of this information on the part of people with directorial or management positions.

**Chart #11**

**Number of institutions per country**

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Sector</th>
<th>Legal Medicine</th>
<th>Others</th>
</tr>
</thead>
</table>
| Belize    | 8 public hospitals  
3 private hospitals  
26 public clinics  
57 private clinics | Data not available               | Data not available            |
| Costa Rica| Data not available                                                             | 1 complex of Forensic Sciences  
10 Medico Legal Units   | Data not available            |
| El Salvador| 34 health units                                                              | Data not available            |                             |
| Guatemala | Instituto Guatemalteco de Seguridad Social  
24 hospitals  
30 doctors’ offices,  
18 first aid posts,  
5 annex rooms in Hospitals  
350 clinics for outside consultation | Data not available               | 1,100 NGOs                  |
| Honduras  | 32 hospitals  
9 sanitary regions  
41 health areas  
23 Maternal-infantile clinics  
249 health centers  
964 Rural Health Centers  
3 Peripheral Emergency Clinics | 33 institutions of medico-legal services | Data not available               |
| Nicaragua | 849 health posts  
176 health centers  
28 acute hospitals  
4 chronic hospitals. | 7 judicial complexes  
6 forensic doctors Managua. | Data not available            |

Source: National Reports of each of the countries. 2003

**Number of institutions per 100,000 inhabitants:**

76% of the key informants do not know, and the rest provided contradictory data in response to this question. 12% indicated an average below one; 4% indicated the existence of two institutions; another 4% indicated 3 institutions and the rest, 17 institutions per 100,000 inhabitants.

An exceptional case is Belize, as can be observed in the following chart, where the number of institutions per every 100,000 inhabitants is accurately known.
In spite of the absence of data, access to care for violence can be extrapolated starting with existing data on women’s access to health services in the Central American region, starting with the variables “care of childbirth by qualified personnel” and “women who receive prenatal attention”.

Chart #13 reflects the difficulty in accessing basic health services for a significant part of the female population. Access to specialized care for sexual violence can be even more difficult to access, particularly considering that in comparison to health services, many countries have even less judicial infrastructure, and therefore less medico-legal services and facilities for the receipt of denunciations.
Number of forensic examiners per 100,000 inhabitants:

As with the number of institutions per 100,000 inhabitants, it was not possible to collect, from the information given by key informants, data regarding forensic examiners (the exception was Costa Rica). However, some countries report an average of 1 forensic examiner per 100,000 inhabitants. For example:

- **Costa Rica:** is the country with the greatest health services coverage in the region, and with 70 forensic doctors for the whole population, which results in 1.9 doctors per 100,000 inhabitants.

- **Nicaragua:** in Managua there are 6 forensic doctors for a population of almost 1.5 million inhabitants, a ratio of 250,000 inhabitants for each forensic doctor. Exact data was not available for the number of forensic examiners in the country.

Range and average hours of attention:

With regard to the range or average hours of operation of institutions related to the care of victims of sexual violence, many of them keep regular office hours; Monday to Friday from 7 or 8 in the morning until 4 or 5 in the afternoon. However, some institutions offer 24 hour services, such as hospital emergency services or the so-called guard services of judicial institutions. Informants indicated that agreements exist to offer such services outside established hours, though not all the services are available in all regions of the country; rather they are found in the national capital and the capital cities of departments or provinces. Thus there are regions, particularly in rural areas, that are totally lacking any kind of service.

Cost of the Services:

Most of the health services offered by the government are free of charge, financed with state funds, and managed by the institutions. However, due to the lack of forensic examiners in the public institutions, in some cases (Nicaragua and Belize, for example) victims must resort to private services. There are great differences among the cost of forensic examinations in the region, estimated at between 20 and 200 dollars.

Waiting Time:

The waiting time in each of the institutions varies, but at the sub-regional level and according to service providers, the maximum time is 24 hours. Chart #14 specifies the times by country:
## Chart #14
Minimum and maximum waiting time for services by country

<table>
<thead>
<tr>
<th>Country</th>
<th>Waiting time for services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimum</td>
</tr>
<tr>
<td>Belize</td>
<td>5 to 15 min.</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>30 min.</td>
</tr>
<tr>
<td>El Salvador</td>
<td>5 to 15 min.</td>
</tr>
<tr>
<td>Guatemala</td>
<td>1 hour</td>
</tr>
<tr>
<td>Honduras</td>
<td>5 min.</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>10 min.</td>
</tr>
</tbody>
</table>

Source: Questionnaires applied to key informants. 2003 N=162
3. 3. EXAMINATIONS AND COLLECTION OF FORENSIC EVIDENCE

3. 3.1. PERFORMANCE OF EXAMINATIONS

In most of the Central American countries due to the lack of specialists and the increase in demand, medical and nursing personnel without university-level specialization have been authorized to perform forensic examinations after passing a course and fulfilling other administrative prerequisites. However, legal authorization must also be obtained.

Authorized professionals include, according to service-providers: doctors with forensic training (36%), gynecologists (24%), general practitioners (18%), emergency room doctors (11%), and nurses with forensic training or emergency department nurses (3%).

There is no consensus surrounding the process of accreditation (with the exception of Costa Rica). 36% of the service-directors interviewed from the health and legal medicine sectors indicated the existence of mechanisms for the accreditation of forensic examiners, 20% stated that they did not exist, and 44% did not respond or indicated lack of knowledge.

There is considerable lack of knowledge of the number of forensic examinations handled in one year, as well as other types of information required for a diagnostic; therefore the average number of examinations in one country or service varies from 100 to 3000 cases.

Close of 80% of the service-providers indicated that psychological evaluations do exist, and are performed in parallel to medical evaluations. This high percentage of positive replies, in comparison with other types of information, can be interpreted in different ways. The purpose behind the performance of the psychological evaluation of a victim of a sexual crime is the starting point for all these interpretations:

- Is the evaluation being done to determine the effects of sexual violence and to refer the victims to support services?
- Is the evaluation being done to find out if the person is distorting the facts and therefore presenting a false accusation?
- Is the evaluation being done to further a psychological/psychiatric report on the mental health effects and their correlation with the victimization process?

The existing consensus surrounding the evaluation of the psychological status of victims can be interpreted as a manifestation of the predominantly patriarchal culture, where the trend is to re-victimize those who have experienced situations of sexual violence based on the beliefs that children of both sexes fantasize about sexual contact with adults, and that many “invent” a rape crime in order to cover up a coital relationship. These beliefs have been discussed in several studies of the region.
An investigation carried out in Costa Rica in the early 90s for example determined that most complaints were found to be lacking sufficient evidence (less than 5% of accusations presented resulted in sentencing). The challenge of overcoming re-victimization is already being addressed among the child population. The Costa Rican Supreme Court of Justice has prepared a series of mandatory guidelines for all its personnel, with the aim of eliminating the re-victimization of boys and girls through judicial procedures.

3. 3. 2.  **MINIMUM PROCEDURES**

Minimum procedures differ according to the type of institution. A series of procedures identified as minimum were detected in the health and legal medicine sectors, however it has been established that these procedures are not always applied or are not actually performed.

**Health Sector**

- **Take samples** (smear and cultures) to present as possible evidence in situations of sexual violence (in cases where forensic examinations are performed by this sector);

- **Have a clinical file at the disposal of judicial authorities.**

- **Refer the results of examinations to the medico-legal sector.**

- **Intervene during crisis and follow-up.**

**Medico-legal Sector**

- **Verify the judicial requisites**
  the backing of a request for medical examination by a forensic doctor is necessary and must be signed by a judge, or in the case of Nicaragua it is necessary to verify if the person presented a denunciation to the police (either of the two alternatives)

- **Complete the identification data for the victim.**

- **Perform a medical evaluation:**
  Medico-legal history using a protocol, in the countries where available (as discussed in a later section);

  Complete physical examination - from head to toe;

  Complementary examinations: semen, DNA, saliva, blood, sexually transmitted diseases, X-rays and others, in the countries where available;

  Psychological/Psychiatric evaluation of the victim;
Children and adolescents must be accompanied by an adult or responsible person, or by a nurse during the performance of the examinations; this is also true for adult women when the examination is being performed by a male doctor. However, providers also stated that although there is a regulated procedure it is not always possible to enforce it.

Register clinical reports and keep them safe
Reports must be available as evidence whenever there is an appearance before judicial institutions, although this is not always complied with.

Referral to other follow-up institutions
mainly the health sector and non-governmental organizations for the follow-up of the situation.

Other procedures
Among other procedures is the function performed by nursing personnel (who are not authorized to perform forensic examinations, except in Belize), whose role is of great importance, especially the emotional support they offer to victims. Nurses contribute to preparing victims for the type of examination they will undergo, as well as the rights they have over their bodies if they do not wish to be examined. They also assist doctors during examinations and are responsible for transporting samples to the various sections in the laboratory for their respective analyses. They may also accompany patients to the laboratory to undergo complementary examinations.

64% of informants indicated that the same procedures are followed for both men and women, 20% indicated that there are sex-based differences, and 16% indicated lack of knowledge or did not answer.

3. Training for forensic examiners

Forensic examiners require university-level specialization, which is generally obtained after having acquired a medical degree. There is no training on sexual violence within the forensic speciality, since this depends on the personal interest of each professional, or on the needs of some medico-legal departments. Due to the scarcity of this type of personnel however, agreements have been established that allow forensic specialists to perform examinations as long as they comply with certain requirements (Nicaragua), or have the legal authorization to do so (Belize).
Generally, the responsibility for training in collection of evidence rests with the universities themselves, during both graduate and post-graduate courses. When training is received during service (after school), it is usually offered by external consultants or, as is the case in Costa Rica, by the Judicial School (a Judicial agency in charge of the training all personnel involved in the administration of justice). In general, there are no mechanisms to monitor the training.

The situations of Belize and Costa Rica, in particular, stand out. In Belize, for example, doctors are not trained to perform forensic examinations, although they have the legal authority to do so. At the other extreme is Costa Rica, where the doctors of forensic medicine, aside from their university specialization, are offered in-service training and are permanently supervised during their 3 years of post-graduate work. To be accredited, they must perform forensic examinations under the continuous presence of an assigned tutor. The institution uses a mechanism of re-certification and professional points as incentives for the specialists to train—in a continuous manner—to offer better services to victims of sexual violence.

3. 3. 4 Evidence

It is important to highlight the collection and analysis of evidence, the chain of custody, and the conditions for and threats to guarding evidence.

At the moment in which a referral is made for forensic evaluation as the result of a denunciation, and the wish of an adult victim to continue with the judicial case, forensic evidence is automatically analyzed. It must be clear however that those defining what must be collected are the forensic examiners themselves.

The analysis of forensic evidence is mediated by the criteria of the person performing the forensic evaluation. After the evidence has been collected, it is classified and labeled, which begins the chain of custody.

The chain of custody is the route that forensic evidence takes until it reaches the Court. This chain starts with the transportation of evidence collected by nurses or forensic examiners. On some occasions, besides carrying the samples nurses also accompany the victims to additional exams that may be required to amplify the evidence.

Among the conditions established to preserve evidence before it reaches its destination is to keep it frozen; especially in cases where there has been no previous request from the judicial system. In general, evidence is kept for approximately six months, depending on what the sample is, or the origin of the sample.
Common threats identified within the chain of custody:

- Not having the necessary equipment or the relevant inputs to gather the evidence;
- Not having the adequate infrastructure or equipment to safeguard the evidence, mainly in the rural areas;
- Lack of laboratory services in the evenings or nights, as well as during holidays and weekends;
- Lack of services in the rural areas.
3. 4 COMPONENTS OF CARE

3. 4. 1 SUMMARY

- None of the services offered is specific to the care of victims of sexual violence, either at the level of the national capitals or in the provinces or departmental zones;
- Care is partial and, as a rule, minimum procedures are not carried out in accordance with international norms for cases of sexual violence.
- Although procedures are indicated, they are not applied in a standardized manner.

3. 4. 2 DNA TESTS

According to the key informants, DNA tests to facilitate the victims’ access to justice are an almost non-existent service in the region, as reflected in the next graphic.

![Graphic #5: Percentage of key informants with knowledge of systematic DNA testing in sexual violence cases]

Source: Questionnaires applied to key informants. 2003. N= 162

3. 4. 3 TESTING AND CARE FOR HIV/AIDS

Most of the countries offer HIV/AIDS counseling, and in a descending manner, the texts and anti-retroviral for this infection.
3.4.4 TESTING AND CARE FOR PREGNANCY, ABORTION AND EMERGENCY CONTRACEPTION

In the sub-region it was possible to identify a low percentage of services that offer emergency contraception to victims of sexual violence, as well as little or no access to abortion in the public health services.

3.4.5 TESTING AND CARE OF SEXUALLY TRANSMITTED INFECTIONS

As can be seen in Chart #16, 21% of the service-providers interviewed do not test for sexually transmitted infections and 34% do not treat them.
3. 4. 6 Psychological Assessment/Counseling or Referral to Counseling

Psychological assessment and referral to counseling services do not follow a norm within the sub-region; rather they depend on the disposition of each professional and how they perceive the victim. When it is done, providers indicate that they refer them to non-governmental organizations and the departments of social work of health institutions.

<table>
<thead>
<tr>
<th>Percentage of services providers that indicate the existence of counseling for victims of sexual violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes: 69%</td>
</tr>
<tr>
<td>N/A: 1%</td>
</tr>
<tr>
<td>No: 27%</td>
</tr>
<tr>
<td>3% No Response</td>
</tr>
</tbody>
</table>

Source: questionnaires apply to service providers, 2003
N=114

3. 4. 7 Country-Specific Examples of the Content of Care

El Salvador. The Instituto Salvadoreño de Seguro Social offers medication for STIs, emergency contraception, hepatitis and anti-retroviral therapy; nevertheless, not all of them are available at the primary and secondary levels of care.

Guatemala. Only the Hospital de Accidentes del IGSS (Capital) offers emergency contraception and prophylactic treatment of STIs.

Costa Rica. Among the procedures of the health sector, counseling, tests, examinations, treatments and referrals to other sectors are given when necessary for HIV, STIs and pregnancy in victims of sexual violence; although emergency contraception and abortion counseling are excluded. The quality and importance that health professionals attach to this aspect of care depends on the individuals' attitude towards the case, for which no procedures can be expected, and which can not be regularized or rigorous.

In relation to psychological support:

Belize. 62.5% of the people interviewed indicated offering psychological support, and 60.0% indicated that they make referrals to these types of services.

Honduras. For these types of services, providers generally identify the counselors from the Ministry of Health to fulfill the role. Some NGOs were also mentioned as working for women rights. This last option is only available in the capital city.
3. 5. **Equipment for Care**

3. 5. 1 **Summary**

- The availability of equipment and materials for the care of sexual violence is determined by type of institution: medico-legal or health sector.
- There are kits, but mainly in the medico-legal sector.
- Medication to treat STIs is available in the health sector but not the medico-legal sector.
- Urban zones possess more complete and modern equipment.

3. 5. 2 **“Kits” or Equipment for Testing of Sexual Violence Exam**

Medico-legal services have most of the equipment that, according to providers, allows them to operate freely in each of the services offered. In the Health Sector, however, providers indicated they do not have the necessary equipment, beyond what is needed to take samples or cultures.

![Graphic #7](source)

*Source: Questionnaires applied to providers and service directors. 2003*

The equipment when complete and available allows the gathering and examination of forensic evidence in:

- Biological material (hair, grass, other);
- Samples (semen, saliva, fluids);
- Cultures (in sexually transmitted infections);
- Blood (pregnancy, DNA, HIV);
- Refrigeration.
In spite of the above, only 11% of providers pointed out the problem.

**Graphic #8**

*Do you find any problem with the equipment for collection of evidence?*

- No Answer: 10%
- Yes: 11%
- No: 24%
- I do not know: 4%
- Does not Apply: 51%

*Source: Questionnaire applied to service providers. 2003*

### 3. 5. 3 Medicines

Regarding the medicines used by institutions, it was possible to collect the following sub-regional data:

- Within the health sector, informants indicated that they have most necessary medication, without them being specifically for victims of sexual violence.
- Within the medico-legal sector, due to its focus on forensic medical or forensic psychiatric expertise, they do not have any type of medicines, nor do they offer medical prescriptions.

### 3. 5. 4 Administrative material

Regarding administrative material or office resources related to forensic examinations, it was established that:

- Administrative material is shared with all the services given by the institutions, and which within these countries, according to providers, is very scarce and obsolete.
- Clinical reports are kept in general files.
- Most files are not locked up; the only security measure is restriction of entrance to the location.
- Some institutions have consent forms for the victims to sign before being examined, but some providers admitted not using them on a regular basis.
- There is a lack of informative materials available to service-users, such as brochures or posters that give information about sexual violence situations.
- There are no reference guides to make follow-up possible.
- A substantial difference in available administrative resources was identified between urban and rural regions, to the detriment of the latter.
3. 6 Policies and Protocols

Within the framework of this study, it was made evident that services need norms for the provision of services to victims of sexual violence in a comprehensive and gender-sensitive way, including two basic components:

Policies of care for victims of sexual violence
Protocols for care

Following is the information gathered about standardized policies and procedures for the care of sexual violence within the Sub-region. A gap in policies, norms and protocols represents a challenge for the countries under study.

3. 6. 1 Policies

A surprising finding was the non-existence in almost all of Central America of a policy on sexual violence, and if one existed, it was unknown by those who provide or administer services for the people affected by sexual violence. The above chart demonstrates that only 7% of informants confirmed the existence of policies.

![Graphic #9](image)

Source: Questionnaires applied to key informants. 2003. N=162

Also, providers remarked on the absence of guidance or guidelines for working with victims of sexual violence:
The fact that some professionals indicate the existence of policies and others do not, demonstrates that in the event that policies do exist, they are not suitably disseminated or implemented. This situation is exemplified by the fact that 32% of the directors to whom the questionnaire was applied pointed out that policies exist and are widespread, and 41% of service-administrators interviewed expressed that personnel had been trained in the use of those policies. By contrast, only 18% of service-providers indicated that they had been trained in the use of these policies.

A possible explanation for these contradictions may be the extrapolation of the concept of intra-family violence and its instruments to sexual violence, as many informants indicated that they were equal. In this sense, it is important to emphasize most of the countries have a policy, norms and health sector protocols for intra-family violence.

### 3. 6. 2 Protocols

When investigating the existence of protocols that serve as a guide for providing services to victims of sexual violence, 39% of key informants indicated that they existed, as demonstrated in the next graphic.
It is important to indicate that, according to the national studies conducted, existing protocols are within the medico-legal services, though they are generally technical in nature, for the gathering of evidence, and not necessarily for the integrated care of sexual violence.

The minimum contents include:

- Personal information about the victim;
- Description of violent event: place, date, time;
- Who is or are the presumed offenders/link to the aggressor;
- Abusive sexual practices sustained, to determine which places to collect biological or human material;
- Complete physical examination in order to document evidence;
- Information about the family situation, physical and mental condition of the victim; if she is pregnant, births, condition of the hymen and anus and hymenogram and anoscopy;
- Medical handling;
- Referral systems;

Within this context, training was identified by 73% of informants as the primary mechanism for the use and dissemination of protocols. Nevertheless, only 28% of health sector and medico-legal providers indicated having been trained in the use of a protocol for the care of sexual violence.
3. 6. 3 Other mechanisms

The presence of other administrative-type mechanisms for the appropriate care of victims of sexual violence, such as reporting, promulgation, training and application of policies and protocols was considered necessary. The majority of people interviewed indicated that although these exist, they have not had an impact.

Specifically, in relation to the procedures for the reporting of cases of sexual violence within the health sector, they are in the process of being institutionalized within the sub-region. Thus, although reporting is regulated in some countries, barriers still exist to its real application. Among them, a lot of the informants indicated that they do not report cases in order to avoid being involved in possible legal proceedings at a later date. In addition, providers considered that reporting was low because they are not in the habit of filling in the data correctly, presenting it or attaching it to victims' files. Reasons like lack of time, interest, qualification, and sensitivity to detecting and treating cases were also cited.

The existence of the norm and by consequence the obligation of reporting was recognized by most of the providers (79%), as demonstrated in the next chart.

![Graphic #12: Percentage of service providers that indicate the existence of regular reporting of basic information on people affected by sexual violence]

Source: Questionnaires applied to key informants. 2003. N=162
However, the existence of the reporting system is contradicted by the statistical reports of cases attended, which was discussed in previous sections. This discrepancy can be explained by the absence of a protocol for detection in the health sector, of standardized reporting mechanisms, and of institutional processes for monitoring these procedures.

Graphic #13
Format in which service providers report cases (%)

Source: questionnaire applied to service providers. 2003. N=114

In the health sector, the reporting norm indicates that information about victims of sexual violence must be considered within the medical file and includes: personal information, reported symptoms, examinations administered, types of treatments, and all information complementary to the health care process such as the presence of support networks. These data, however, do not always reach a system of institutional reporting that permits the keeping of an account of the incidence of sexual violence.

On the other hand, the reporting systems of the medico-legal services can be used to:

- Present the information requested by the Office of the Public Prosecutor.
- Compile the annual work report of the Section.
- Conduct thesis investigations.
- Present issues of importance at talks, seminars, conferences, or other events.

Another type of mechanism used is accountability, which is in many institutions through the use of suggestion boxes. Feedback is collected through research and once the conclusions are made available, the necessary measures are taken. Nevertheless, there are institutions that do not possess the resources to keep track of their services, especially those located in rural zones.
3. 7 Security

With regard to the security conditions of the services; providers recognized the existence of sporadic incidents of violence within the institutions (there is no record of these), such as fights, arguments, damage or destruction of objects, verbal mistreatment, and use of weapons. However, the majority of informants indicated that there are no standard procedures for responding to these types of incidents, and in the event of a situation like this, they generally call the security personnel of the building.

Among the security measures that have been implemented in an informal manner are:

- When a patient arrives - regardless of age - the presence of a nurse is required throughout the examination.
- Monitoring the entrance to the institutions.
- Chain of custody for the gathering of evidence.
- Evidence kept in files under lock or in inaccessible refrigerators.
- Restricted access to specific sections.

Source: Questionnaire applied to service providers. 2003. N=114
3. 8 Attitudes

Regarding the attitudes of some service-providers towards the care of sexual violence cases, the national studies are fairly coincident:

- **A person that has suffered sexual violence is a serious case.** It is recognized that in addition to physical consequences, victims confront important psychological consequences. In questions on the category to which sexual violence belongs, 31% of informants indicated that it was a social problem, 7% said it was a criminal problem, 4% said it was a health problem, 56% indicated two or all of the above, and 2% indicated other or no answer.

- The situation of greater vulnerability to the crime, and the level of impact of sexual violence on physical and emotional health are both recognized.

- Prevention of the problem is regarded as a job that can be done through strategic institutional alliances to increase healthy life-styles and develop actions for promoting violence-free lives.

- It was indicated that the role of health professionals in caring for victims should include warmth, humanity, and should facilitate expedited, integrated care that offers ways for the affected person to continue with support, and technical and legal consultation.

- The health service-providers generally perceived the justice system as a power of the State that leaves aggressors free and that in some cases – due to existing impunity - the victim is revictimized and left to the mercy of his/her aggressor.

- The role that the health sector and its directors at the national and departmental levels must play is related to the fact that the existence of sexual violence must be recognized, and a quick response offered, and it must be a permanent subject within the health sector’s agenda.

Some other negative attitudes were identified in some providers, such as: interpretation of violence as a **private matter, lack of interest, placing blame on the family (mainly the mothers), and blaming the victims themselves.**
3. 9 Training

In relation to the training received by the sectors involved in the care of people affected by sexual violence, it was possible to identify some central points:

- In general, personnel indicated not being trained specifically for the care of sexual violence. Exceptions are interpreted as the result of the personal interest of employees in the subject. Training in sexual violence has been basically oriented to sexual violence against children or intra-family violence.

- Most of the professionals in the health sector consider themselves insufficiently knowledgeable to effectively diagnose and treat victims of sexual violence.

- There is a discrepancy between directors/authorities and direct providers. The former indicate that training exists and most of the latter complain about the lack of training.

- According to the informants, specialized training in sexual violence is not part of the study plan in universities (except for forensic examiners), but courses, seminars, and conferences have been offered by governmental and non-governmental institutions, or international cooperation institutions.

- Due to the diversity of the trainings, the contents or emphasis of these were also different.

- Generally, there are no incentives/rewards for those who complete the training.

- Employees that have received some type of training, specifically in intra-family violence, indicated that it has been useful in their jobs.

- Less than 30% of the directors indicate having a monitoring system to determine if the trainings are adequate.

- The duration of the courses or trainings vary according to the institution or the program of which they are a part, for example they range from two days, mostly in the health sector, to the training of specialists in Forensic Medicine that can last up to 3 years.
Within the sub-region, inter-institutional collaboration is seen as an ideal option rather than a reality being applied at the present time. It was highlighted that in spite of the intention and some initiatives, there has been great difficulty in unifying institutional efforts, largely due to the absence of national policies and action plans. Thus, care is offered in an isolated manner by the institutions and not as part of a platform of integrated services.

Some basic points can be made about collaboration between institutions and related sectors:

- Initiatives for multi-sectoral collaboration vary, and many are mediated by the personal attitudes of service-providers. In the majority of cases, each professional or institution fulfills its role only, without taking into consideration the general process that a victim of sexual violence must follow. Coordination between the institutions does not exist; rather what is done in most cases (83% of the providers) is to refer the victims to or inform them of the next step or institution so they can receive other necessary services.

- Inter-institutional coordination is not regulated and there are no known inter-institutional agreements, so standardized mechanisms of referral and counter-referral do not exist.

- The perception of the quality of multi-sectoral relations varies considerably from one professional to another, according to the institution where s/he is located, the position s/he occupies, their specialty, the job s/he performs, and their sensitivity and interest.

- The coordination that currently exists is mainly between the health, medico-legal, and judicial sectors, for the handling of evidence or the chain of custody.

- The key informants recognized the necessity for coordination with an agency that monitors the well-being of minors and supports them in this process.

- The existence of networks as the body that facilitates multi-sectoral collaboration was identified in the case of Nicaragua.

- Informants indicated that inadequate inter-sectoral coordination, accompanied by the cumbersome process which the victims must follow makes them repeat examinations, with heightens the risk of re-victimization.
CHAPTER 4
CONCLUSIONS

Discussion of Results

Recommendations
4. 1 DISCUSSION OF RESULTS

Strengths Identified

- In the course of information gathering, an attitude of openness towards the subject of sexual violence, and training in subjects compatible with sexual violence, was reflected by service-providers from the health, medico-legal and other sectors.

- Services are free in most countries.

- The health sector has made progress in addressing intra-family violence, including policies, norms, procedures and reporting systems. Although these are still in the process of being institutionalized, and are not specific to sexual violence, they constitute a first step towards the specification of guidelines. The lessons learned about the care of sexual violence are of great usefulness in the implementation of models of integrated care of sexual aggression and all manifestations of gender-based violence.

- Non-governmental organizations that fight for women rights have been identified as also giving support to victims of sexual violence, including children and adolescents. These constitute an important resource in the implementation of a platform of services that can be integrated or fortified by the health system.

- In relation to the contents of care, the existence of counseling about related subjects such as HIV/AIDS, pregnancy and sexual transmitted infections, was almost observed in the institutions of the health sector.

- The centers specialized in forensic medicine comprise qualified personnel and the necessary equipment, which allows the transfer of successful experiences and lessons learned to other services and to the rest of the country.

- The presence of related subjects in public debate, including violence against women, commercial sexual exploitation, and child sexual abuse.

- The presence in the region of different institutions of international cooperation that support and stimulate work on sexual violence (PAHO; IPEC/ ILO; UNICEF; IPPF; IPAS; among others).
The existence of ministerial and international agreements within the health sector that declare gender-based violence, including sexual victimization, to be a public health problem, and that therefore commit governments to work on the subject.

A greater number of sexual violence complaints in the last decade, which reflects a greater level of social and institutional awareness of the problem. The response of the health sector, though still incipient, is also a recognition of the necessity to offer better services that are appropriate to the victims needs.

In addition, the investigative process:

- Has allowed the generation not only of expectations, but also commitments for action, particularly through the formation of national teams to validate the results.
- Has generated a diagnostic that allows us to visualize not only the problems but also the construction of viable solutions.
- Allows the comparison of results to find, design, share and collect feedback on regional actions.

### Challenges identified:

- Three fundamental barriers were identified: lack of access to services, particularly in rural areas; the absence of specific policies about sexual violence in the health sector; and the lack of multi-sectoral collaboration to offer integrated responses to victims, all of which contribute to the existence of a cumbersome and discouraging route to justice and integrated care.

- Services are not available to the whole population, not only in relation to the health sector but also the justice sector. This constitutes an important limitation both to the possibility of presenting a complaint, and to the possibility of gathering evidence, since there are no suitable institutions, personnel, resources or necessary equipment to collect and forensic evidence and keep it safe.

- Generally, the personnel that work with victims of sexual violence do not possess specialized training, which can lead inadequate care and re-victimization.

- There are no protocols for integrated care that transcend the gathering of evidence.

- There is no national reporting system for institutional inputs that keeps track of the demand for services due to sexual violence. This is accompanied by a lack of computers and standardized reporting mechanisms.
There is a lack of functional administrative resources to support the care of sexual violence, which is most evident in rural areas.

Health services lack a standardized system of detection and reporting of sexual violence. This is aggravated when people access services a long time after the violent act has occurred, showing consequences that may go undetected as the results of sexual violence (STIs and pregnancy, among others).

Similarly, the lack of integration of sexual violence into sexual and reproductive health services can increase the lack of detection.

Some service-providers still consider sexual violence a private subject, which causes them to stop acting with professional responsibility.

The absence of mechanisms of control and monitoring of the institutional norms related to the care and reporting of sexual violence.

The existence of few forensic examiners in relation to the population that requires their services.

Medico-legal services are generally concentrated in the metropolitan areas. Thus, qualified personnel, rape kits and other types of inputs and resources are not available to the largest proportion of the Central American population: the rural, indigenous populations that speak a language other than the official language, illegal immigrants, and others.

Lack of follow up with the victims.

Dispersion of institutional resources for addressing the issue itself.

Lack of material resources and a budget specifically assigned to address the issue in most governmental institutions.

Problems in the quality of care, arising specifically from:

- Lack of knowledge of the treatment to be given to victims of sexual violence;
- Little training of health personnel in the legal aspects of violence;
- Lack of privacy during the receipt of complaints, and during care;
- Lack of care resources and an adequate infrastructure;
- Lack of protocols that offer the necessary guidelines to care for victims and follow up on their cases;
- Lack of knowledge of the type of legal aid that must be provided to the victims and/or places to refer them.
The socio-economic and cultural contexts of the region present problems that have direct repercussions on the integrated care of sexual violence: a gender gap that promotes not only aggression and masculine sexual control over the sexuality of women, but the social legitimization of the same; a lack of equity among large population groups; high incidences of crime; extreme poverty and social exclusion; and a great disparity between urban and rural areas regarding access to material and institutional resources.

Additionally, the problem of integrated care for victims in Central America is aggravated by the existence of high levels of impunity for sexual crimes.

4.2 Recommendations

The following recommendations are grouped in accordance with the expected time it will take to achieve them. Thus, those stipulated as short term because of their priority nature constitute recommendations that must be immediately attended to in order to obtain results in a period of six months to one year. The medium term recommendations are those that, once the previous products are obtained, should be implemented within a term not to exceed three years. Long term recommendations, the results of which would be observed over the next five years, are not included in this document due to the urgent nature of the existing recommendations. Recommendations directed at the research processes surrounding the subject of sexual violence are included.

Short term

At the Political Level

- Develop universal policies for the care of sexual violence;
- Develop a national plan for the care of sexual violence with an adequate budget. The plan should include general and annual goals, objectives and strategies, as well as the designation of sectoral and institutional responsibilities;
- Establish institutional responsibilities under the premise of constructing a platform of integrated services;
- Design a model to monitor the plan, with respective indicators of success that will allow for institutional accountability, and the modification and implementation of corrective actions. An institution responsible for the model’s execution should be designated;
- Develop a plan to facilitate progressive access to resources for the care of sexual violence in the region for populations without coverage;
- Promote the participation of all sectors in the promotion, prevention and eradication of sexual violence;
- Look for strategies for coordination between the judicial and medical sectors in an effort to make available to all victims the services of collection of evidence and all other resources necessary to access justice.
In the Health Sector

- Develop sectoral policies and strategies that allow the care of sexual violence at all levels of incidence, and the integration of the problem into services (for example, emergency services, sexual and reproductive health services, and primary care services, among others);
- Develop a sectoral plan of care in accordance with national plans and coordination with other sectors, to reach an integrated response system;
- Incorporate a gender and generational perspective in the sectoral work plan;
- Develop standardized norms, protocols, and procedures for detection, care, reporting, and follow-up;
- Prepare a plan to progressively transfer more resources (for example, kits) to improve care and access to care services, specifically in the areas and among the populations identified as having more limitations;
- Prepare a budget that makes available more resources for obtaining necessary equipment for the care of sexual violence;
- Develop a sectoral plan of continued education that includes sensitizing, capacity-building, and training;
- Develop a monitoring and follow-up system for policies, norms, and care procedures, with designation of responsibilities, criteria for success, and responsible individuals;
- Request that universities incorporate the subject of sexual violence at the graduate and postgraduate levels;
- Develop a work plan for intervention during crisis.

In the Forensic Medicine Sector

- Develop policies and strategies for the continuing education of personnel that goes beyond the collection of forensic evidence;
- Establish systems to monitor the adequate use of expert appraisal;
- Develop a specific proposal to widen the coverage of forensic medical services to areas where they do not exist, through creative strategies and the maximization of the sector’s own resources, and those of the Health Sector;
- Look for mechanisms to reduce waiting time for collection of evidence, increase hours of operation (including laboratory hours);
- Promote the participation of the sector in networks against sexual violence;
- Propose mechanisms of care that do not re-victimize. Implement a standardized security model for the chain of custody for evidence, especially in distant areas;
- Develop a model of care with a gender and generational focus;
- Include within standardized procedures:
  - Issues related to emotional support or contention;
  - Aspects related to the time and manner of safekeeping evidence;
  - The route of the evidence;
  - Coordinate medical work with social and psychological/psychiatric work.
In the justice sector

- Develop a sectoral policy that will permit the diminishing of impunity for sexual offenses, and that may contain: a process for the elaboration of law projects and their presentation and lobbying among legislative bodies; the strengthening of public ministries and the institutions for the receipt and investigation of complaints of sexual crimes; as well as the promulgation of institutional orders on the issue;
- Develop an institutional work plan that includes policies and orders to reduce victimization (a sole declaration, Gessell chamber, among others);
- In coordination with forensic medical departments and representatives of the health sector, look for mechanisms to broaden coverage of medico-legal services;
- Assign the necessary material resources to increase the access to justice for victims of sexual violence, including investigation of the crimes and proper collection of evidence in the largest number of institutions and across the whole country;
- Look for mechanisms to increase the number of positions for forensic examiners.

Medium term

At the political level

- Implement policies, strategies and national plans;
- Initiate a process of monitoring and sectoral and institutional accountability;
- Look for and apply corrective solutions.

In the Health Sector

- Develop and implement a standardized system of reporting with the minimum resources necessary for its implementation;
- Implement policies, strategies and sectoral plans;
- Initiate monitoring and accountability processes to identify voids in non-compliance with agreements or implementation of corrective actions;
- Develop a plan for training and continuing education; as well as the coordination of the same with universities and national institutions that are training professionals;
- Promote sectoral and institutional research on sexual violence and to initiate its development.
In the forensic medicine sector

- Implement policies, strategies and plans;
- Implement monitoring processes;
- Develop a directory of referrals and make it available to all direct care personnel;
- Promote and develop research on the subject of sexual violence that will permit the illustration of successful experiences and that may function as a model for other places, services and countries.

In the justice sector

- Implement policies, strategies, orders and plans;
- Develop and implement monitoring processes and pertinent adjustments;
- Put into effect the plans to enlarge coverage.

4. 2. 1 Recommendations for future research on the subject of sexual violence

- Incorporate the voices of victims to develop an approach that does not re-victimize, and that links resources;
- Follow-up on findings related to national and sectoral actions;
- Prepare situational diagnoses on legal norms and the application of justice;
- Develop proposals and research plans, and incorporate them into services;
- Develop, within methodological strategies, proposals for the validation, discussion and dissemination of results;
- Incorporate a human rights approach into all research on the subject of sexual and gender-based violence;
- Apply pertinent international human rights norms to proposals of research with humans;
- Develop research proposals with methodologies that are fast, creative and in accordance with the reduced national budgets that exist for such purposes.


WHO. (s. f.) “Proposal to Include Central America in WHO’s global initiative to spearhead a health response to sexual violence”.


National studies (unpublished):

ANNEX

Questionnaires

Occupational profiles of key informants

Contents of national reports

Axes of information of the questionnaires and check list

Methodological procedures

Methodological Modifications
## ANNEX 1

### Questionnaires

#### Questionnaire One - National Level

<table>
<thead>
<tr>
<th>Section</th>
<th>Subject</th>
<th>Items</th>
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<tbody>
<tr>
<td>A</td>
<td>Information on the person interviewed</td>
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<tr>
<td>B</td>
<td>Medico-legal facilities for survivors of sexual violence</td>
<td>1 - 14</td>
</tr>
<tr>
<td>C</td>
<td>Forensic examiners</td>
<td>15 - 21</td>
</tr>
<tr>
<td>D</td>
<td>Curriculum training for forensic examiners</td>
<td>22 - 47</td>
</tr>
<tr>
<td>E</td>
<td>Policies on sexual violence</td>
<td>48 - 51</td>
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<tr>
<td>F</td>
<td>Protocols on sexual violence</td>
<td>52 - 56</td>
</tr>
<tr>
<td>G</td>
<td>Structure of medical and legal services</td>
<td>57 - 66</td>
</tr>
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<td>H</td>
<td>Forensic evidence</td>
<td>67 - 80</td>
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<tr>
<td>I</td>
<td>Attitudes</td>
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#### Questionnaire Two - Provincial or regional level

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<td>B</td>
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<tr>
<td>C</td>
<td>Forensic examiners</td>
<td>15 - 21</td>
</tr>
<tr>
<td>D</td>
<td>Curriculum training on forensic examinations and gender-based violence</td>
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<td>E</td>
<td>Policies on sexual violence</td>
<td>49 - 54</td>
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<tr>
<td>F</td>
<td>Protocols on sexual violence</td>
<td>55 - 59</td>
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<td>G</td>
<td>Structure of medical and legal services</td>
<td>60 - 69</td>
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<td>H</td>
<td>Forensic evidence</td>
<td>70 - 83</td>
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<td>I</td>
<td>Attitudes</td>
<td>84 - 88</td>
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#### Questionnaire Three A - Service Administrators

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<td>B</td>
<td>Structure of services</td>
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<td>C</td>
<td>Security</td>
<td>7 - 14</td>
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<tr>
<td>D</td>
<td>Provision of services</td>
<td>17 - 43</td>
</tr>
<tr>
<td>E</td>
<td>Structures of responsibility</td>
<td>44 - 46</td>
</tr>
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<td>F</td>
<td>Protocols</td>
<td>47 - 51</td>
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<td>G</td>
<td>Training</td>
<td>52 - 57</td>
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<td>H</td>
<td>Multi-sectoral collaboration</td>
<td>58 - 68</td>
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<td>I</td>
<td>Other comments</td>
<td>69</td>
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#### Questionnaire Three B - Service Providers

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<tr>
<td>B</td>
<td>Provision of services</td>
<td>1 - 64</td>
</tr>
<tr>
<td>C</td>
<td>Policies and Protocols</td>
<td>65 - 70</td>
</tr>
<tr>
<td>D</td>
<td>Training</td>
<td>71 - 80</td>
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<td>E</td>
<td>Multi-sectoral collaboration</td>
<td>81 - 90</td>
</tr>
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<td>F</td>
<td>Other comments</td>
<td>91 - 93</td>
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#### Questionnaire Four - Other related organizations

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<tr>
<td>B</td>
<td>Provision of services</td>
<td>1 - 12</td>
</tr>
<tr>
<td>C</td>
<td>Multi-sectoral collaboration</td>
<td>13 - 27</td>
</tr>
<tr>
<td>D</td>
<td>Forensic and health services for victims of sexual violence</td>
<td>28 - 36</td>
</tr>
</tbody>
</table>
# ANNEX 2

## Occupational profiles of key informants

<table>
<thead>
<tr>
<th>Type of Questionnaire</th>
<th>Key Informants</th>
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</thead>
<tbody>
<tr>
<td>One</td>
<td>1 National Director of the health sector</td>
</tr>
<tr>
<td></td>
<td>2 National Director of the forensic medicine services</td>
</tr>
<tr>
<td>Two</td>
<td>3 Regional or provincial director of the health sector</td>
</tr>
<tr>
<td></td>
<td>4 Regional or provincial director of the forensic medicine services</td>
</tr>
<tr>
<td>Three A</td>
<td>5 Administrator of health sector services in the capital</td>
</tr>
<tr>
<td></td>
<td>6 Administrator of health sector services in the provinces</td>
</tr>
<tr>
<td></td>
<td>7 Administrator of forensic medicine services in the capital</td>
</tr>
<tr>
<td></td>
<td>8 Administrator of forensic medicine services in the provinces</td>
</tr>
<tr>
<td>Three B</td>
<td>9 Forensic examiner in the capital</td>
</tr>
<tr>
<td></td>
<td>10 Forensic examiner in the provinces</td>
</tr>
<tr>
<td></td>
<td>11 Nurse in the capital</td>
</tr>
<tr>
<td></td>
<td>12 Nurse in the provinces</td>
</tr>
<tr>
<td></td>
<td>13 Doctor in the capital</td>
</tr>
<tr>
<td></td>
<td>14 Doctor in the provinces</td>
</tr>
<tr>
<td></td>
<td>15 Practitioner in the capital</td>
</tr>
<tr>
<td></td>
<td>16 Practitioner in the provinces</td>
</tr>
<tr>
<td></td>
<td>17 Doctor with forensic training in the capital</td>
</tr>
<tr>
<td></td>
<td>18 Doctor with forensic training in the provinces</td>
</tr>
<tr>
<td></td>
<td>19 Nurse with forensic training in the capital</td>
</tr>
<tr>
<td></td>
<td>20 Nurse with forensic training in the provinces</td>
</tr>
<tr>
<td></td>
<td>21 Gynecologist in the capital</td>
</tr>
<tr>
<td></td>
<td>22 Gynecologist in the provinces</td>
</tr>
<tr>
<td>Four</td>
<td>23 Member of the police in the capital</td>
</tr>
<tr>
<td></td>
<td>24 Member of the police in the provinces</td>
</tr>
<tr>
<td></td>
<td>25 Social worker in the capital</td>
</tr>
<tr>
<td></td>
<td>26 Social worker in the provinces</td>
</tr>
<tr>
<td></td>
<td>27 Representative of a rape care center in the capital</td>
</tr>
<tr>
<td></td>
<td>28 Representative of a rape care center in the provinces</td>
</tr>
<tr>
<td></td>
<td>29 Representative of a related NGO in the capital</td>
</tr>
<tr>
<td></td>
<td>30 Representative of a related NGO in the provinces</td>
</tr>
<tr>
<td>Check list</td>
<td>31 Personnel or direct provider of a service in forensic medicine, in the capital</td>
</tr>
<tr>
<td></td>
<td>32 Personnel or direct provider of a service in forensic medicine, in the province</td>
</tr>
<tr>
<td></td>
<td>33 Personnel or direct provider of the Health Sector, in the capital</td>
</tr>
<tr>
<td></td>
<td>34 Personnel or direct provider of the Health Sector, in the provinces</td>
</tr>
</tbody>
</table>
ANNEX 3
Contents of national reports

Executive Summary - a one page synopsis of the study and its key findings.

Introduction - summary of the research protocol or methodological document.

Context and background
- Information and data about sexual violence in the country;
- Organization and provision of general services in health;
- Objectives of the study – of the research protocol or methodological document.

Methodology
- Summary of the methodology – types of questionnaires, key informants, or what appears on the research protocol or methodological document;
- How was the sample chosen? – give details;
- Process shifting – is it necessary to explain some transfer?

Results:
- Structure of services – at the national level, in the capital and in the provinces, at the level of the questionnaire, macro. middle-level and administrators of the institutions;
- Total sample size;
- Types of institutions examined: - seen in the questionnaire for administrators or managers of institutions or services;
- Types of services offered, type of personnel - include information on NGOs;
- Number of victims attended per month – total for all the institutions – meaning and rank by institution;
- Distribution by sex and age of the victims;
- Days when there is more or less demand for services;
- Ratio of examiners and/or needed personnel for the care of victims, based on the monthly number of victims;
- Where do victims go the first time and why?
- Process – how do victims come and go from the institutions;
- Access – on chart or text
  Number of institutions in the country, the capital and provinces;
  Number of institutions per 100,000 inhabitants;
  Results of the distribution of services in relation to the population;
  Number of forensic examiners per 100,000 inhabitants;
  Range and average number of hours functioning;
  Cost of the services (average – range);
  Waiting times: average and range for short and long wait.

Examinations and forensic evidence:
- Minimum procedures;
- Training for forensic examiners / who can do them;
- Evidence.

Contents of care:
- Chart of responses of the administrators or managers of institutions or services;
- Percentage of providers who have kept records of HIV, pregnancy and other sexually transmitted diseases (include differences between the capital and the rural area);
- Chart of medical care;
- Percentage of providers who are conducting psychological advisory services, giving counseling or referring for counseling.
Equipment (actual and reported) – differences between the types of responses and the people who respond;
- “Kits or equipment for examination of attack or rape”;
- Other equipment for the collection of evidence;
- Chart of the institution’s checklists.
- Policies and protocols – existence, implementation, training. Differences for men, women and children;
- Security;
- Doubts of administrators or managers of institutions or services;
- Security chart of the checklists;
- Attitudes;
- Training (Disparity between reports given and administrative or ministerial reports of the training received);
- Multi-sectoral collaboration.

Discussion:
Strengths and things to be improved;

Quality of care, in relation or comparison with objectives identified within the research (details of these were listed in the research protocol or methodological document; rules to improve health, security of the appropriate documentation of the evidence, insure satisfaction of the expectations of the client, insure community development);

Barriers identified to care:
- Geographical distribution of services in relation to the inhabitants;
- Service hours and waiting times;
- Transportation;
- Other.

Problems identified by providers and administrators or managers of services or institutions; Problems identified by NGOs or other related institutions;

Other problems;

Comments regarding the research process of the study, such as the use of instruments (what was your experience in doing the study?).

Conclusions:
Recommendations – imagine that the core of the recommendations will serve as terms of references for meetings or national and provincial interviews, to discuss how the training in this area must be done.
ANNEX 4
Axes of information of the questionnaires and check list

a. Questionnaires

- Medical - legal facilities for survivors of sexual violence
- Forensic examiners
- Curricular training for forensic examiners
- Policies on sexual violence
- Protocols on sexual violence
- Structure of the medical and legal services
- Forensic evidence
- Attitudes
- Security
- Provision of service
- Structures of responsibility
- Multi-sectoral collaboration
- Forensic and health services for victims of sexual violence
- Other comments

b. Check list

- Existence of protocols
- Access facilities
- Security measures
- Room for examinations
- Equipment
- Medicines
- Administrative supplements
First phase: Planning of the research

Included the following basic procedures:

- Preparation of the methodological guide and chronogram of work;
- Preparation of a different database for each questionnaire and check list;
- Preparation of matrices and categories of analysis for the presentation of qualitative information collected;
- Preparation of criteria for the selection of national researchers (See annex I);
- Process of communication and dissemination in each country to the ministerial and institutional agencies that take part in the problem - to advertise the research proposal and its objectives and expectations.

Second Phase: Information Gathering

Basic procedures:

- Selection of the department or province where the discussion of results at the central and local levels will take place.

The basic criteria for the selection of the departmental level were coincidence with the area where actions were developed – or are planned - by the Gender and Health Unit. However, some countries selected departments or provinces where there was a particular interest in developing strategies against sexual violence.

- Selection of institutions and key informants at the central and local levels, in accordance with inclusion and exclusion criteria.

The study took as a basis two levels of research which are directly related to the individuals interviewed:

Macro: central and provincial governments;
Micro: direct service-providers;

- For the application of the diagnostic instruments in the countries, the following criteria were considered for selection of sources of information:

  Forensic medicine center (mandatory in any country where only that agency can collect forensic evidence of sexual violence);
  Health centers in countries where the legal collection is not confined to the judicial sector. In these countries, therefore, forensic medicine institutions and public and private health centers are included;
  Inclusion of institutions from the capital and one province, region or department where there is a PAHO focal point or project;
  The national level is included through the national health directors and the directors of forensic medicine.
Inclusion criteria to select key informants for the various questionnaires were basically related to the type of information that a person could provide, according to their position in the health sector. If the person was unable to answer the questions s/he could refer the researcher to someone who would, or to the place where the required information could be found. Thus, the following people were interviewed: providers at the national and departmental levels with management functions; service administrators; providers who have contact with direct users; and other types of officials outside the health sector but related to the care of sexual violence, such as policemen and NGOs workers. The profile of positions requested by the World Health Organization is listed in in Annex I.

Whether the informant working in the institution had direct contact with the people attended there was also considered in the completion of the checklist.

Key locations and informants:
A total of 168 key informants at the different levels of care were interviewed in the six countries studied.

The places and institutions selected by country were:

**Honduras.** The study was done simultaneously in Tegucigalpa, the capital city, and Danlí in the western part of the country. A total of 25 officials were interviewed from various organizations and levels: Secretary of Health (local, regional and central levels); the Forensic clinic (regional and local director's level); the National Preventive Police; and one NGO working with women's rights. The choice of key informants took into consideration the existing criteria, and two key meetings were held for their definition with the Head of the Metropolitan Sanitary Region and the Head of the Sanitary Region #1. At the same time, information was recorded regarding equipment and inputs of the medical and forensic clinics on the checklists, one at the capital level and the other in Region #1 (Danlí). A total of 25 people were interviewed in the cities of Tegucigalpa and Danlí, and 2 checklists were applied.

**Belize.** The capital city and the district of Cayo were selected. The capital is important for this study since it includes a large proportion of the population and is the commercial heart of the country; in this area only one tertiary hospital was located and it houses a large part of health personnel at the national level. The District of Cayo, in the western region, has 3 hospitals (2 public and 1 private) and attends more of the population living in rural communities. The Belmopan Hospital is a secondary referral hospital of the Western Health Region, with one regional director of health services. In this country all hospitals of the capital and the Cayo District were taken into consideration in the selection of informants, 3 for each of the institutions: one administrator, one doctor and one nurse from the emergency unit. The administrator was asked to collaborate in the application of the checklist. A primary care health center, Matron Roberts in the capital, was also chosen. The urban center of Benque Viejo in Cayo was chosen to represent the western zone of the district; this institution belongs to an urban community but delivers services to all surrounding areas. This study considered some 20 institutions and a total sample of key informants was proposed; 27 in the Capital City and 18 in the Cayo District, however for the methodological amendments previously specified, the study was concluded with a total of 25 completed questionnaires.

**Costa Rica.** For this study the public health institutions chosen were: San Juan de Dios Hospital in the capital, and San Rafael Hospital at the provincial level. The prevailing criteria for this selection were the geographical location, the type of services offered, the wide population coverage, and its relation and coordination with existing medico-legal services in the country. With respect to medico-legal services, since they are centralized, the study was done at the Department of Legal Medicine of the Judicial Power, in the Forensic Medical Clinic and the Forensic Psychiatric and Psychology Clinic. 34 officials from various governmental and non-governmental institutions were interviewed in this country, resulting in the participation of 9 institutions. Interviews were applied to 34 key informants and 3 checklists were completed.
El Salvador. For the selection of informants in the capital, the following places were chosen: Legal Medicine Directorship, Technical Normative Forensic Clinic Directorship, the Maternity Hospital and Primero de Mayo Hospital. The provincial geographical area, Apopa, was chosen in the Northern SIBASI and the Health Unit of Apopa, belonging to said SIBASI. This selection was done based on previous experiences of PAHO in that area and the related training in intrafamily violence. The Medico-legal coverage in Apopa is done from the capital; therefore, the Medico-legal part was selected in the province of the Central Region and was also included within that same area the San Rafael Hospital, second level of attention of the Ministry of Health and Social Assistance. The key informants were chosen in accordance to their offices at the Macro level: General and Provincial Directorship and at the micro level: direct providers of the service such as gynecologists, social service doctors, forensic doctors, nurses in health and forensic social workers, attorneys from NGOs and the office of the Attorney General of the Republic. Three levels of attention were considered for the selection of the sample and the administrative levels of the Ministry of Public Health and Social Services. Regarding the total number of persons interviewed and the instruments applied we have that 29 questionnaires and 4 checklists were completed.

Guatemala. The capital city and the district of Escuintla were chosen for this study. In the capital, the following institutions were selected: Roosevelt Hospital of the Ministry of Public Health and Social Assistance, the Office of Care for Victims; the Department of Forensic Medicine of the Public Ministry; the Ministry of the Interior; the Hospital General de Accidentes of the Instituto Guatemalteco de Seguridad Social; and as an NGO El Grupo Guatemalteco de Mujeres. In the province, the institutions selected for study were: the Judicial Organism; the Hospital Nacional; the Area Chief and the Health Center of the Ministry of Public Health and Social Assistance; the National Police Commission; and the Hospital del Instituto Guatemalteco de Seguridad Social of Escuintla. Questionnaires were also applied to a sample chosen from personnel available in said institutions: forensic examiners, doctors, nurses, social workers, psychologists and the National Police Commissioner. 12 institutions participated and a total of 32 questionnaires and 5 check lists were applied.

Nicaragua. The Department of Care for Women, located at the primary level of care of the Ministry of Health was selected since it has been a historically important counterpart in the work in Gender and Health Unit, particularly regarding intra-family violence. At the provincial or municipal level SILAIS Carazo was chosen since they attend a mainly rural population. The other location chosen was Managua since it is the capital of the country. Initially SILAIS Masaya in the municipality of Tisma was chosen at the municipal level; however the director of the primary level of care considered that Carazo was more suitable due to the experienced accumulated in the care of intra-family violence; a strong experience supported by and present at the local level of the SAREM project (with Finish cooperation). Once these two locations were chosen, the services and key informants in Carazo and in Managua were located. 12 institutions took part in the application of questionnaires to informants. In total, 23 questionnaires and 5 checklists were applied in this country.

Application of questionnaires and checklists.

Questionnaires were applied to a group of 32 key informants in the Health Sector - at the central and local levels - as well as to others linked with the care of victims in each country.

The observation guide or checklist was applied at the central and local level and at the level of the health sector.

The instructions for the application of the instruments were first to provide information about what the purpose of the study, where it was being applied, what it was to determine, why and what for. Once the information had been offered, any doubts cleared, and the observations and comments gathered, the completion of the instruments followed.
Main limitation of this phase:

The application of the questionnaires had to be done, in many cases, by previous appointment. Thus, the time elapsed between the request and the application meant that in some cases, a significant delay occurred within the proposed chronogram. This was due to various reasons, among them: the period of data collection coincided with the presidential elections, strikes in the health sector or availability of time on the part of managers.

Third Phase: Systematization and analysis of the information gathered

To carry out the analysis of the data gathered in the questionnaires and checklists two forms were proposed; one quantitative and the other qualitative. Closed questions in the questionnaires and points of the checklists were entered into an Excel database for the national reports and in SPSS for the sub-regional report, and with this information a quantitative database was established which has also served to complement the qualitative analysis. The qualitative analysis was completed through interpretation of the quantitative data, from the open-ended questions or sections in the questionnaires, and from other observations of the researchers.

Fourth phase: Validation

The sub-regional coordination of the Gender and Health Unit requested the preparation of a workshop for the validation of each national report, with the participation of authorities on the subject, in order to complement the information gathered during the research process and supply an input for decision-making that favors the adequate care of victims of sexual violence in Central America.

At the general level, workshops were attended by officials of the various departments associated with the issue, among them:

- Ministry of the Condition of Women
- Ministry of Health
- Caja Costarricense de Seguro Social (Department of Health Prevention)
- Department of Legal Medicine
- Department of Nursing of the Escuintla Hospital
- Administrative Department of Legal Medicine and Evaluation of Disabilities Hospital General de Accidentes of the Instituto Guatemalteco de Seguridad Social
- Mental Health Program of the Public and Social Assistance Ministry.

Some countries have made a formal presentation of the results of the final national reports, and others are about to do so, with the participation of the sectors involved in the first validation workshop, with the purpose of reaching agreements for decision-making.
The methodology proposed was not altered in substance. Some countries made small changes based on the reality of their context.

The most important change was the incorporation of the validating element on the part of the national authorities in the care of sexual violence, and of the results of the study with the aim that they be incorporated in decision-making. This modification arises from the sub-regional initiative to incorporate the process of research into the policies and objectives of the project of attention to victims of sexual violence in Central America.

Specifically, the changes per country were:

**Belize:** Small changes were made to parts of the instruments taking into consideration the national context of this country. These were made to the 3 to 5 instruments intended to facilitate the interview. Among the changes made were widening the response options, adding “I do not know” or “other,” and changing the manner in which the question was presented to make two questions from it (done with questionnaires at the national and regional level, where item 21 was enlarged to items 21 and 22). The questionnaire intended for service administrators (3A) underwent more changes, with the enlargement of 3 questions, to ensure that the interviewer and the respondent could be capable of answering adequately. Two changes were made within the questionnaire to be applied to the service-providers, where items were enlarged to two questions. It must be taken into consideration that these changes have an effect on the qualitative report, but not on the database for the regional quantitative analysis.

Also in Belize, there was a change regarding the selection of people to be interviewed, since the position of National Director of Health Services was substituted for Delegated Director of Health Services and the Technical Supervisor of Health for Domestic Violence. Equally, there is no director of forensic services but rather a Chief Forensic Analyst as the key informant for forensic services. The Director of the Family Court was also identified as a national level informant.

**Honduras** stated that it was not easy to locate some of the suggested people or people that were performing the duties of some of the mentioned offices, in order to carry out the interviews. In the concrete case of the nurse with forensic training and representatives of NGOs and of the Center for Intervention during Crisis for Victims of Rape, which do not exist as such in Danlí, the administrators of forensic services and forensic examiners are positions that do not exist in the country. This resulted in the need to substitute these informants with people who are not necessarily specialists on the subject.

**Nicaragua:** The SILAIS Masaya, in the Municipality of Tisma had initially been chosen for the application of the questionnaires and checklists at the municipal level; however, the director of the primary level of care considered that Carazo was more suitable due to its accumulated experience in the care of intra-family violence; a strong background supported by and present at the local level of the SAREM project (with Finish cooperation).