Response to sexual assault in Bogotá, Colombia: a qualitative evaluation of health providers' readiness and role in policy implementation

Introduction

Violence against women (VAW) is a global public health, human rights, and clinical problem (Devries et al., 2013). "Violence against women" is defined by the United Nations (UN) as, "any act of gender based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (World Health Organization, 2017). Sexual violence includes unwanted sexual advances or sexual harassment, sexual abuse of children, mentally or physically disabled people, forced marriage, wife inheritance, sexual slavery, forced impregnation and attempted rape or rape within marriage or dating relationships, by strangers or acquaintances, or of children (Garcia-Moreno et al., 2012; Velzeboer, Ellsberg, Arcas, & García-Moreno, 2003). Sexual violence (SV) puts women at risk for adverse sexual and reproductive health outcomes including unwanted pregnancy, high risk sexual behavior, unsafe abortion, and sexually transmitted infections (STIs) (García-Moreno, 2013; Krug, Mercy, Dahlberg, & Zwi, 2002; United Nations Population Fund y Ministerio de Protección Social, 2011). Girls who experience sexual abuse both in childhood and later in life may be at higher risk for sexual risk behavior, and subsequent unintended pregnancies or STIs including HIV (Guedes, Bott, & Cuca, 2002; Krug et al., 2002; Reyes, Billings, Paredes-Gaitan, & Zuniga, 2012). These consequences relate to women having limited control over the circumstances and timing of sexual intercourse, including condom use negotiation (García-Moreno, 2013).

Health systems are recommended to ensure that health care providers ("health providers") are prepared to meet the needs of victims[1] who seek care, because appropriate early intervention can minimize psychological and physical consequences (García-Moreno et al., 2015; Ward, 2011). Beyond providing medical care, psychosocial support and referrals for additional support for sexual assault cases, health care workers also can play an important role in collecting medical and legal evidence as indicated to support the justice process (Krug et al., 2002; World Health Organization, 2013). Health providers play a key role in the health system response to SV, but the barriers they face in delivering quality care are often understudied by researchers and overlooked by policymakers.

The Convention of Belém do Pará—which is the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women—was adopted in 1994 and by 2016, 32 of 33 countries in Latin America and the Caribbean (LAC) had adopted it (UNDP, 2017). In addition to the regional and international agreements, there is a growing body of policy level commitments that are based on the notion that governments should address VAW as a human right (Ward, 2011). In LAC, approximately one third of countries have a national plan to address VAW, but the implementation status of such plans and other policies is unknown in many settings (Montaño, 2009; PNUD-ONU Mujeres, 2013). This region has high levels of violence; up to 40% of women have experienced violence at some point in their lives. A report by the Sexual Violence Research Initiative (SVRI) analyzing secondary data from LAC contends that the health care sectors in various countries tend to have serious deficiencies such as lack of infrastructure, lack of basic privacy, and confidentiality, discriminatory and patriarchal attitudes

[1] The term "victim" is used throughout this paper in accordance with the key World Health Organization documents utilized for the analysis.

on behalf of the health care workers which justify the violence and blame the victims, and a lack of both trained staff and adequate policies and protocols (Ellsberg et al., 2015).

The needs in Colombia are particularly striking. This country of 48 million has a Gender Inequality Index of .429, ranking 92 out of 155 countries in the index (The World Bank, 2016; United Nations Development Program, 2015). Colombian gender norms are patriarchal and masculinity is based on the notion that men are dominant and aggressive (Central Intelligence Agency, 2016). For example, the 2015 Demographic Health Survey (DHS) revealed that 50% of women and 36% of men agree that, "a good wife always obeys her husband" (Central Intelligence Agency, 2016; Profamilia, 2015). These rigid gender norms can lead to victim blaming (Human Rights Watch, 2012). Moreover, a six decade armed conflict between antigovernment insurgent groups and government forces enabled SV and created unique challenges around policy implementation and provision of care for victims (Amnesty International, 2011; Central Intelligence Agency, 2016).

According to the DHS, 12% of Colombian women of reproductive age have experienced SV (Profamilia, 2015). Colombia has a universal health care system and 98% of the population has access to health services (Class, 2014; World Health Organization, 2014). However, of the 85% of women who suffered an injury from physical or sexual violence in 2010, only 21% reported accessing a health care center (Profamilia, 2010). In 2016, only 16.1% of women who experienced some form of VAW reported accessing health care (Profamilia, 2015), nevertheless, in 2013, 20,739 medico legal exams were performed for sexual assault (SA) (Instituto Nacional de Medicina Legal y Ciencias Forenses, 2013). Data from the 2000 DHS showed that women who had been sexually or physically abused had 1.4 times higher odds of having an unintended

pregnancy, illustrating some of the potential consequences in this context (Pallitto & O'Campo, 2004).

Over the past decade, Colombia has developed an extensive policy framework to address VAW (Table 1). The Colombian *Ministerio de Salud y Protección Social* (*MinSalud*) is responsible for adopting measures to address the physical and psychological health of victims of VAW through strategic institutional policies, plans, and programs (Cabrera Cifuentes et al., 2013). However, gaps exist in implementation of policies that support SA victims, resulting in poor quality post sexual assault care (Cabrera Cifuentes et al., 2013; Human Rights Watch, 2012; United Nations Population Fund, 2008). While the presence of national and international policy guidance should inform Colombia's health system response to SV, little is known about the extent of policy implementation (Cabrera Cifuentes et al., 2013). Few studies have looked specifically at the health provider role in the response to SA (Cabrera Cifuentes et al., 2013; Human Rights Watch, 2012), and in Colombia only one study included primary data from health providers (Human Rights Watch, 2012). The aforementioned Human Rights Watch (HRW) report revealed that providers in Bogotá had not received training on how to treat victims of VAW and were unaware of existing protocols (Human Rights Watch, 2012).

The health system plays a crucial role in the response to SV, and the 2013 Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines ("WHO guidelines") help outline the ideal role a health system can play in responding to SV. This study seeks to understand whether health providers—actors who work within the broader health system and policy climate—are prepared to treat sexual violence victims in accordance with policies and protocols at different levels (García-Moreno et al., 2015). It also

examines how the policies compare to the WHO guidelines with a focus on where better alignment could improve care.

Table 1. Policy Timeline	
2008	Law 1257 passes, dictating norms for prevention and punishment of all forms of violence and discrimination against women and reinforces that women have a right to live a dignified life free of discrimination and violence (El Congreso de Colombia, 2008).
2008	The Bogotá Secretary of Health releases the *Protocolo para el abordaje integral de la violencia sexual desde el sector salud* created with UNFPA and the Institute of Legal Medicine and Forensic Science (United Nations Population Fund, 2008).
2011	The *Modelo de Atención Integral en Salud para Víctimas de Violencia Sexual* is released by UNFPA and the Ministry of Social Protection (UNFPA y Ministerio de Protección Social, 2011; Ministerio de Salud y Protección Social, 2012).
2012	Resolution 459 is passed and the 2011 *Protocolo y Modelo de Atención Integral en Salud para Víctimas de Violencia Sexual* is adopted (Ministerio de Salud y Protección Social, 2012).
2013	Former President Juan Manual Santos approves the *Política Pública Nacional de Equidad de género para las Mujeres en Colombia*, which includes the *Plan integral para garantizar a las mujeres una vida libre de violencias* 2012-2022 (Alta Consejería Presidencial para la Equidad de la Mujer y Presidencia de la República, 2012).
2013	The World Health Organization releases Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (World Health Organization, 2013).
2014	Law 1719 guarantees access to justice for victims of sexual violence. The health system is tasked with implementing the 2011 *Modelo de Atención Integral en Salud para Víctimas de Violencia Sexual* (Congress of the Republic of Colombia, 2014).
2014	The World Health Organization releases Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook (World Health Organization, 2014b).
2015	The World Health Organization announces that it will, "create training curricula that aim to strengthen the knowledge, skills and attitudes of health-care professionals and improve their response" (World Health Organization, 2015).

Materials and Methods

We chose to conduct our research in Bogotá, a city of 9.8 million, because working in the capital allowed for access to policymakers at different levels (Central Intelligence Agency, 2016). Qualitative methods allowed us to understand the provider perspectives on the system

response to SA cases (O'Brien, Harris, Beckman, Reed, & Cook, 2014). Participants were purposively sampled from five public hospitals in Bogotá and were eligible for the study if they were doctors, nurses, or social workers 18 years of age or older. Our study sought to obtain the health provider perspective because of their crucial role in the implementation of policies addressing SV. The hospitals were selected to represent different levels of care (I, II, III) because SA cases are received at all levels. Level I hospitals have general practitioners (GPs) providing basic care, level II hospitals have GPs referring patients, and level III hospitals have GPs working with specialists (Sarmiento Limas). Semi structured interviews were conducted with providers (n=46) in spring of 2015 (Table 2) and recorded digitally. Interviews took place in Spanish at private locations within the hospitals, and steps were taken to protect the confidentiality of the participants and the data.

The interviews were transcribed and analyzed in Spanish for thematic content through a two phase coding process (Saldaña, 2015). The codes were developed using both a priori and emergent techniques (Weber, 1990). Themes were developed based on the codes, a codebook was developed, and representative quotes were identified and translated by the researcher who is bilingual. We present the themes most directly related to elements of policy guidance from district (*Protocolo para el abordaje integral de la violencia sexual desde el sector salud*, 2008**)** (United Nations Population Fund, 2008), national (*Modelo de Atención Integral en Salud para Víctimas de Violencia Sexual*, 2011) (Ministerio de Salud y Protección Social, 2012; United Nations Population Fund y Ministerio de Protección Social, 2011) and international documents (Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines, 2013) (World Health Organization, 2013).

Table 2. Participant characteristics	
Profession	**n**
Doctor	20
General practitioner	15
Gynecologist	5
Nurse	22
Head nurse	15
Auxiliary nurse	7
Social worker	4
Level of hospital	
Level I	15
Level II	7
Level III	24
Age	
21-30	19
31-40	11
41-50	10
51+	6
Gender	
Men	14
Women	32
Total	46

Results

Results are organized by thematic area: woman centered care, emergency contraception and abortion, provider sensitivity towards victims, and training. Within a table, we summarize results that relate directly to the district, national, and international policy guidance. Subsequently, for each thematic area, we provide greater detail on current implementation status, and barriers and facilitators of specific policy elements.

Table 3. Qualitative results by domains of policy guidance from WHO, national, and district policies				
	Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines, 2013 (24)	***Modelo de Atención Integral en Salud para Víctimas de Violencia Sexual*, 2011 (21, 22)**	***Protocolo para el abordaje integral de la violencia sexual desde el sector salud*, 2008 (19)**	**Study Findings, 2015**
Women-Centered Care	• Offer immediate support to women who disclose any form of violence. • Provide care and support responding to survivors' concerns intruding on autonomy. •Ensure confidentiality and privacy for the consultation, while informing women of the limits of confidentiality.	•Sexual assault victims have the right to receive comprehensive care through high quality services with sufficient coverage. •Sexual violence is always an emergency, regardless of how much time has transpired, and immediate health and mental care should be provided. •The health care team should provide a private space for medical care.	•When a victim of sexual assault is detected or seeks help, it is an emergency and the person should be attended to immediately. •Actions taken should promote restitution of individual autonomy by listening to the victim. •Care should be provided confidentially in appropriate, private spaces.	•When a case of sexual violence presents, all providers reported that care is always offered free of charge, but it is not necessarily provided immediately. *"[This type of case] is immediately considered an emergency and one should stop working and treat the patient with the utmost respect and privacy because this is a patient comes with a lot of fears and anguish due to the situation that happened so other activities are suspended immediately and one of the specialists who is here takes care of the patient."[24-year-old male gynecologist, level III hospital]* •Some providers reported that the consultation is conducted in private and that confidentiality is guaranteed, while others mentioned that there may be other patients present during the exam or consultation or that the victim is gossiped about. *"Private, of course, away from everyone else nobody is going to call the patient 'the girl who was raped', none of that. She is called by her name and everything here is very reserved." [38-year-old female general practitioner, level I hospital]* *"Confidentiality is not guaranteed because the cleaning woman knows, the guard, the entire world knows and so rumors begin…" [56-year-old female auxiliary nurse, level I hospital]*

Emergency Contraception and Abortion	•Emergency contraception should be offered to women who seek care within five days of an assault.	•Emergency contraception should be given if the patient presents within 72 hours of the occurrence of sexual violence.	•A consultation should be provided about emergency contraception outlining all of the benefit and potential side effects, and it should be administered within 12 hours if possible or if not up to 72 hours after the incident. It should not be dependent on the results of a pregnancy test.	•Most healthcare providers responded that emergency contraception is provided if the assault has occurred within 72 hours, although only a few mentioned that the woman is given a choice while many said it is not up to her. Some explained that the results of a pregnancy test are analyzed before emergency contraception is provided. *"Yes [emergency contraception is given]…What I can tell you is that these are young people, women who are trying to get ahead in life and it would not be easy to have a baby so it's also because of that." [27 year-old female GP, level I hospital]* *"No, no, no, emergency contraception is not provided here. First, it has to be determined if the little mama is pregnant, which you cannot know after just two days" [52-year-old female auxiliary nurse, level III hospital].*
	•Women should have the option of having a safe abortion, if stipulated by national law.	•In accordance with Supreme Court Ruling C-355, the voluntary interruption of pregnancy is a right of all sexual violence victims and complete information should be provided and informed consent received.	•Access to abortion should exist all over the country for these cases (irrespective of ability to pay or health insurance coverage) in accordance with Supreme Court Ruling C-355.	•The majority of healthcare providers understood that abortion was available in the case of sexual violence, but they had differing levels of knowledge about the process. *"Although now we have VIP, no? The program for Voluntary Interruption of Pregnancy, to which she can get access" [44-year-old male GP, level II hospital]* •A few providers did not know that victims can get an abortion, or said it is not happening. *"No, here the law left that door open. It says that pregnancy can be interrupted, period. But no…" [42-year-old male gynecologist, level III hospital]*

Provider sensitivity towards victims	•Listen without pressuring her to respond or disclose information, and offer comfort to help alleviate or reduce anxiety.	•Victims should be treated with dignity, privacy, and respect during any interview or any act related to health, legal, or social services. •Ask the victim about her needs, worries, and anxieties to facilitate expression of emotions.	•Listen and write down the ideas that the person has about how she wants her care to be.	•An overwhelming majority of providers described that sensitivity towards victims is shown, and made comments indicating sensitivity. *"I think that definitely the most important thing in the handling of these types of patients is that we work without prior biases, without prior personal biases, without prior social biases and that we always trust the person's word." [39-year-old male gynecologist, level III hospital]* •On the other hand, a few providers indicated that something their co-worker has said or done bothered them while others exhibited insensitive or victim-blaming attitudes during the interview. *"Sometimes I think, my God but what is this girl doing in the street at two in the morning. It's such a violent area with such a low cultural level." [53-year-old female head nurse, level III hospital]*
Training	•Health-care providers offering care should receive in-service training.	•All staff at health institutions including administrators, security staff, and management should be trained on care pathways, victims' rights, and psychological first aid.	•Providers should establish processes of training in Human Rights, Sexual and Reproductive Health Rights, and Victims' rights, and about how to provide quality sexual violence care, and do crisis intervention.	•The majority of doctors, nurses, and social workers had not received training through the hospital where they currently work or during their medical training. •Providers were willing to and interested in receiving future training and presented various themes. *"The protocol may be very very clear, but on our behalf there might be a lack of knowledge in the medical-legal area so maybe forensic training, not medical training because we know that, but from the forensic perspective, that is important. There are a lot of gaps in the knowledge*

	•A health-care provider (nurse, doctor or equivalent) who is trained in gender-sensitive sexual assault care and examination should be available at all times of the day or night (on location or on-call) at a district/area level.	•An institutional team consisting of medical professionals, nurses, a social worker, a mental health professional, and an administrative person should be formed.	•Every institution should have an interdisciplinary team for the care of sexual assault victims.	*on the part of the doctors. We don't really like the topic and it is important to connect the medical part with the current legislation, I mean the legal environment we operate in." [39-year-old male gynecologist, level III hospital]* •None of the providers interviewed said that their hospitals have interdisciplinary teams. One social worker responded: *"[A team] hasn't been created because being a first level [hospital] we don't see a lot of cases." [23-year-old social worker, level I hospital]* •None of the hospitals where participants work seem to have on-call providers specifically trained in sensitive sexual assault care and examination.

Women Centered Care

The WHO guidelines state that sexual assault (SA) victims require immediate first line care and district and national policies align with this recommendation (Ministerio de Salud y Protección Social, 2012; United Nations Population Fund, 2008; United Nations Population Fund y Ministerio de Protección Social, 2011; World Health Organization, 2013). The majority of providers classified cases of SA as emergencies and acknowledged the importance of timely care. One nurse explained:

> *"If [the victim] is not affiliated anywhere, care is still provided but in that case we call the social worker so she can create a socio-economic record where [the person] will be evaluated and with that record we can treat her here in the hospital." [42-year-old female head nurse, level III hospital]*

However, some providers did not realize that district and national policies state that cases of SA that have occurred within the last 72 hours require immediate medical attention regardless of the severity of the physical injuries (Ministerio de Salud y Protección Social, 2012; United Nations Population Fund, 2008; United Nations Population Fund y Ministerio de Protección Social, 2011). Some highlighted the challenges in responding to SA cases immediately given the high flow of patients and limited resources. There were differing opinions in how urgent the SV response should be. One doctor stated:

> *"If we know that after being abused the person has, more or less, well I am not sure, 24 hours for an evaluation to be done and if the person doesn't bathe, doesn't change or at least keeps her clothing and doesn't bathe then it can wait, right?" [42-year-old male GP, level III hospital]*.

Some providers felt the patient should be attended to immediately due to the psychological distress or because of the time sensitive nature of forensic evidence collection. District policy considers SA an emergency because the victim needs to feel physically safe in order to regain control of her life (United Nations Population Fund, 2008). National policy states that immediate

care is necessary because SA triggers situations that may put life in imminent danger and affects the stability of the victims (Ministerio de Salud y Protección Social, 2012).

The district and national level policies emphasize the importance of privacy and confidentiality, aligning with the WHO guidelines (Ministerio de Salud y Protección Social, 2012; United Nations Population Fund, 2008; United Nations Population Fund y Ministerio de Protección Social, 2011; World Health Organization, 2013). Most providers said that the examination is conducted in private, however, hospitalization generally occurs with other patients. A few providers mentioned that if the patient is hospitalized, they try to give that person a separate room, but this seemed to be the exception. At one teaching hospital, some providers said that when medical rounds occur, the case is discussed in front of other patients and all the medical students implying confidentiality is violated.

> *"When the students do rounds it's a bit embarrassing because during them there are no limitations." [34-year-old female head nurse, level III hospital]*

Overall, providers indicated that care is being provided free, although not always immediately. It is evident that although the policies state that privacy and confidentiality are crucial components to the response to sexual violence, they are not always guaranteed.

Emergency Contraception and Abortion

There are both similarities and discrepancies between the WHO clinical and policy guidelines and the local and national policy documents. The WHO Guidelines stipulate that emergency contraception can be offered for up to five days after the assault, whereas both the local and national policy indicates a timeframe of 72 hours. The local policy emphasizes the importance of providing a consultation, which neither the WHO guidelines nor the national policy does (UNFPA, 2008; United Nations Population Fund y Ministerio de Protección Social,

2011; World Health Organization, 2013). While most providers understood that emergency contraception should be provided, few mentioned whether a consultation is provided and some said it is not a victim's choice.

> *"Do you understand? It is a ton of medication, I give levonorgestrel to prevent pregnancy which is one of those pills…" [26-year-old female GP, level III hospital]*

> *"Everything is offered, and then she might say no, but then that is her decision." [27-year-old female GP, level I hospital]*

Most healthcare providers responded that emergency contraception is provided, although only a few mentioned that the woman is given a choice while many said it is not up to her, emphasizing that it is part of the protocol. Some explained that the results of a pregnancy test are analyzed before emergency contraception is provided:

> *"When there is a possible pregnancy, first a pregnancy test must be given and then after emergency contraception is provided." [30-year-old auxiliary nurse, level I hospital]*

This contradicts the local level policy stipulating that the results of the pregnancy should are considered separately from emergency contraception (UNFPA, 2008).

In Colombia, abortion was legalized in 2006 through Supreme Court Ruling C-355 under three circumstances, and one of them is sexual violence (Ministerio de Salud, 2016). Therefore, women should have the option of having a safe abortion, which is called "Voluntary Interruption of Pregnancy." The WHO guidelines say that safe abortions should be provided based on national law, and the local and national policy agree with this based on C-355 (UNFPA, 2008; United Nations Population Fund y Ministerio de Protección Social, 2011; World Health Organization, 2013). Many providers had knowledge of this sentence and right.

> *"Although now we have VIP, no? The program for Voluntary Interruption of Pregnancy, to which she can get access" [44-year-old male GP, level II hospital]*

However, a few providers did not know that victims can get an abortion, or said it is not happening.

> *"No, here the law left that door open. It says that pregnancy can be interrupted, period. But no…" [42-year-old male gynecologist, level III hospital]*

According to the Supreme Court Ruling C-355, a woman is required to bring a copy of the criminal complaint unless she is under 14 years of age or unless she was a victim of the armed conflict (Ministerio de Salud, 2016). Only few providers mentioned this, and some said that women are referred to a social worker and/or psychologist to help determine if they should have an abortion or whether they are eligible. A few other providers mentioned that they are conscientious objectors and do no provide abortions, but they will refer women.

> *"I am an objector so I don't operate, under Sentence 355…" [32-year-old male gynecologist, level III hospital]*

A few providers said that is it more likely for pregnant women to come due to the pregnancy and then say that they were sexually assaulted during the consultation, as opposed to women coming due to sexual assault and then being pregnant. This might have implications for their access to VIP, especially if they did not file a report when it happened or depending on how many weeks pregnant they are.

Provider sensitivity towards victims

Most providers demonstrated sensitivity to the issue of SV. Some made victim blaming comments and had observed troublesome attitudes among their colleagues:

> *"It bothers me that my peers they make comments about the [victim], because that's a patient's privacy between her and the doctor and the auxiliary nurses." [23-year-old female auxiliary nurse, level III hospital]*

However, the vast majority recognized the seriousness of SA. Many expressed concern at the trauma that victims face in the aftermath of a SA. The policies at all three levels emphasized that listening actively to the victim is fundamental to responding sensitively, although few participants referred to active listening specifically. Some providers said that there is no justification for rape. One gynecologist said that he generally spends two to three hours with this patient instead of the routine twenty minutes. He explained why:

> *"Because it's a patient who is at high risk, who needs a lot of care, who ones knows arrives destroyed with a lot of intimate problems, crying, desperate, In many cases the patient doesn't know if she wants to tell her husband, how her husband will respond in this situation because this society is a little machista...*" *[24-year-old male gynecologist, level III hospital]*

The district and international policy guidance emphasizes restitution of autonomy of the victim, but this was missing in the national policy. The participants mentioned various ways that autonomy could be restored during care; for example, by allowing women to choose between a male and female doctor, to choose whether she wants family members present, and to choose whether to report to the police. Gynecologists seem to have the best understanding of how to handle SA cases. Overall, the participants demonstrated an understanding of the seriousness of SA and demonstrated sensitivity towards both the issue and the victims.

Training on sexual violence

We found that the policies at all levels emphasized the importance of training. The WHO guidelines specify that in-service training should be provided, while the national policy stipulates that all health care workers should be trained (with no mention of when or how training should occur). However, most providers had not received training through hospitals where they currently work or during their education. A few participants reported received training on SV, yet upon probing further it became clear that trainings were not exclusively about SV, lasted a

day or less, and had taken place between five and eight years ago. A nurse spoke of how she taught herself:

> *"[I learned] doing it. Nobody taught me, I arrived and my first case came and I took the kit out and figured out how to do it and how to preserve the samples and the clinical experience is all someone has to be able to attend to this type of case." [25-year-old female head nurse, level I hospital]*

One GP felt he had not received "real tools" to handle these cases:

> *"Of course, they give us a ton of paperwork, a ton of things, right? But they don't give us the real tools, they don't train us like you mention, right?" [42-year-old male GP, level III]*

In spite of a lack of training, the desire to receive training was pervasive. Participants were asked what topics they would like to see in future trainings on sexual violence, and four salient topics emerged: case management, how to treat the person, forensics, and the protocol. Two different social workers responded:

> *"The chain of custody, that would be like the initial handling of the case. I consider that maybe at least strengthening the group's management of the information, a proper handling of the information would prevent the patient from being asked questions over and over…Good management of the information and the protocol would help avoid these processes and these setbacks." [23-year-old female social worker, level I hospital]*

> *"They have not trained me in sexual violence, but it is very important they bring us up to date on legislation and on the handling of cases." [46-year-old female social worker, level III hospital]*

Other participants were interested in learning how to interact with the women:

> *"Well it would be important to always emphasize that the treatment of an abused patient should always be comprehensive, with a lot of humanism while trying to always put oneself in the other's shoes. Not talking in public, or in front of other patients, or when changing shifts, or anything like that." [25-year-old male GP, level I hospital]*

The district and national policies mandate that all hospitals have an interdisciplinary SV response team to coordinate care more effectively. However, none of the providers reported their hospitals having teams.

Discussion

Our findings illustrate that in Colombia, the district and national policies align fairly closely with the WHO guidelines in the areas of women-centered care, emergency contraception and abortion, sensitivity, and training. This indicates that the policies are well formulated, but findings from our qualitative study with health providers in Colombia demonstrate both strengths and gaps in the response to SV. Overall, providers recognized SV as a problem, but did not appear to always have the capacity or skills to provide quality care to victims. The confluence of high rates of violence and past gaps in policy implementation (Bott, Guedes, Goodwin, & Mendoza, 2012) makes LAC a critical region to study policy implementation. Many Latin American governments have created policies to address VAW, but the feasibility and effectiveness of implementation is yet to be seen.

Implementation research operates under real world conditions (Peters, Adam, Alonge, Agyepong, & Tran, 2013). Understanding policy implementation is crucial because many policies based on seemingly sound ideas are difficult when translated to practical application, and the employment of theoretical approaches can help explain how and why implementation fails or succeeds (Nilsen, Ståhl, Roback, & Cairney, 2013; Pressman & Wildavsky, 1973). Although we consider WHO Guidelines, this study is based on a bottom up approach, which views local bureaucrats as the main actors in policy delivery (Pülzl & Treib, 2007). Bottom-up

approaches argue that policy formulation and policy implementation are inextricably linked (Pülzl & Treib, 2007). According to political scientist Michael Lipsky, "street level bureaucrats" are public servants who become the public policies they implement through their decisions, the routines they establish, and the devices they invent to cope with uncertainties and work pressures (Lipsky, 2010). Only upon implementation are policies fully realized, and as street level bureaucrats, health providers play an important role in this process (Lipsky, 2010).

However, there is a lack of implementation-focused research on VAW policies in low and middle-income countries (LMICs) and in other health policy areas. A 2014 mapping study conducted by Erasmus, Orgill, Schneider, and Gilson (2014) of the literature on health policy implementation in lower income settings revealed that, "the LMIC health policy analysis field as a whole is small, fragmented and of somewhat limited depth" (p. iii47). Our study contributes to the gap in studies of health policy implementation in LMICs.

In 2013 *MinSalud* published a report that various training initiatives were underway about care for SA victims and about the implementation of the *Modelo de Atención Integral en Salud para Víctimas de Violencia Sexual* (Cabrera Cifuentes et al., 2013). However, our findings suggest that training had not been implemented at the five participating public hospitals in the two years following that report. Although information dissemination and training alone are not proven to create sustainable systems level changes (García-Moreno et al., 2015), they are necessary steps in that process, and training has been shown to impact knowledge and behaviors of providers (World Health Organization, 2013). Health providers work within bureaucracies that mirror the society in which they develop (Lipsky, 2010), and our results indicate gaps in knowledge in various areas including what privacy and confidentiality mean and how to treat patients sensitively. Training may increase knowledge in these areas.

The WHO guidelines recommend having a health provider trained in gender sensitive sexual assault care and examination available at all times (World Health Organization, 2013). District and national policies require hospitals to have an interdisciplinary team to respond to these cases (Ministerio de Salud y Protección Social, 2012; United Nations Population Fund, 2008; World Health Organization, 2013), and although this is not included in the WHO guidelines, teams could strengthen the response through improved coordination and referrals (García-Moreno et al., 2015). This might also help improve the knowledge of health care providers around emergency contraception and abortion, in particular the protocols and processes. *MinSalud* could work with hospital administrators to ensure that hospitals have teams designated and that those teams are prepared through training.

Moreover, training of a subset of providers specifically in sexual assault care to be available 24 hours to conduct rape exams would align with the WHO guidelines (World Health Organization, 2013). For example, in high-income settings Sexual Assault Nurse Examiner programs are an effective option to ensure quality care, because "…trained forensic nurses provide 24-hour-a-day, first-response medical care and crisis intervention to rape victims in either hospitals or clinic settings" (Campbell, Patterson, & Lichty, 2005), which improves the provision of medical services, emotional support and collection of forensic evidence (Maier, 2011; McLaughlin, Monahan, Doezema, & Crandall, 2007). The evidence comes from high-income countries, so a pilot study may be necessary to test the feasibility in Colombia, a middle-income country, especially given that the skill level of nurses varies by country. Our findings indicate that both having teams and specially trained survivors may be effective in this setting.

The WHO guidelines recommend training at the pre qualification level for those who are most likely to see victims including emergency service providers (García-Moreno, 2013). This

pre qualification (or pre service) level training was not mentioned in the Colombian policies analyzed, indicating a policy gap. Training should start during medical education to create a foundation in providers' knowledge, to be built upon during in-service training. Our findings suggest that training would likely be well received by health providers. *MinSalud* could adapt the WHO VAW curricula scheduled for release in 2018 to create standard curricula for professional education on VAW for medical, nursing, and social work schools across Colombia and then support implementation (World Health Organization, 2015).

Based on the WHO guidelines and our findings, in-service training of providers on SV is also advisable (World Health Organization, 2013). The WHO guidelines on in-service training align closely with what participants stated they wanted, including case management, how to treat the patient sensitively and appropriately, how to conduct forensic evidence collection, and knowledge of laws and protocols (World Health Organization, 2013). As street level bureaucrats, providers play a critical role in interpreting and implementing policy and their suggestions should be taken into consideration around implementation decisions (Lipsky, 2010)

MinSalud could work with hospitals to ensure that each institution has a training plan, prioritizing the members of the SA response teams and the providers most likely to receive these patients. Given the variety of topics that participants wanted covered and the available evidence (García-Moreno et al., 2015), a one day or half day in-service training would not suffice to change behavior and increase capacity. Rather, training needs to be ongoing and accompanied by system wide changes (García-Moreno et al., 2015).

Our findings are timely in light of recent reports focused on the care of SA victims in Colombia. A 2013 report on the implementation of *Ley 1257* indicates that there had been no evidence indicating implementation or application of the *Protocolo y Modelo de Atención*

Integral en Salud para Víctimas de Violencia Sexual (Cabrera Cifuentes et al., 2013). The HRW report found, "failure of health facilities to properly implement the relevant laws and policies, resulting in inadequate screening for signs of gender based violence, mistreatment of victims, and arbitrary denial or delays in providing essential services" (Human Rights Watch, 2012). Our findings reiterate that health facilities are failing to properly implement the relevant laws and policies.

There are opportunities for health system changes and improved policy implementation in Colombia. Our findings indicate that the high levels of health provider awareness of SV as a problem could be leveraged by giving providers and hospitals the resources they need to provide quality care for victims. A stronger system response would "enable providers to address violence against women, including protocols, capacity building, effective coordination between agencies, and referral networks" (García-Moreno et al., 2015). Based on these findings, recommendations to improve the response to sexual assault cases in hospitals include health system strengthening through the creation of hospital teams, improved in-service and pre service training, and the training of specific providers to handle cases.

The limitations of this study include its focuses on health providers excluding the perspectives of policymakers and victims. The study was conducted in an urban area, which has relatively higher standards of care and access in comparison with rural areas (Class, 2014). Furthermore, due to the qualitative nature of this study, findings are not generalizable.

The health workforce is a health system building block (World Health Organization, 2016), and our results speak to the systems model approaches found effective in improving intimate partner violence screening, identification, and intervention (McCaw, Berman, Syme, & Hunkeler, 2001; Young-Wolff, Kotz, & McCaw, 2016). Training health workers is central to any

strategy to address SV at the health system level (García-Moreno et al., 2015). Our results illustrate specific areas for strengthening the Colombian health system response to sexual violence, specifically in the area of training. There also needs to be adequate allocation of national budgets, senior level commitment, appropriate monitoring of services, improved health infrastructure, and research on effective practices (García-Moreno et al., 2015). Strengthening the response is critical to support the health and well being of victims; providers who respond supportively can help pave the way towards safety and healing, while providers who react poorly can put women at further risk (Bott, Guedes, Claramunt, & Guezmes, 2004; Ward, 2011). The findings suggest that, efforts to provide training would be timely, effective, and well received because there is investment and recognition of the problem by providers. Impact evaluations could also be helpful in a setting like Colombia, because there is limited evidence on effective response interventions in low and middle-income countries in LAC (García-Moreno et al., 2015; World Health Organization, 2013). While there is no simple solution to improve the quality of care for SA victims, preparing providers to properly implement well-formulated policies aligned with WHO Guidelines, in a supportive health system environment, can mitigate negative health outcomes, prevent fatal outcomes, and minimize potential psychological trauma.

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