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SEXUAL VIOLENCE AGAINST WOMEN: ADHERENCE OF REFERENCE HOSPITALS AND SOCIODEMOGRAPHIC PROFILES

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ABSTRACT: The adhesion rate of reference hospitals to the Protocol of Attendance for women in situations of sexual violence in the state of Paraná, Brazil, between 2009 and 2015, is provided, associating it with sociodemographic profiles and adhesion categories. Current transversal observational study comprised an all-female population in situations of sexual violence attended by 28 hospitals in the state of Paraná. Ten items were analyzed, including reception of patient, prophylaxis and post-trauma referrals. All hospitals performed primary care for victims; 50% adhered to STIs, AIDS and hepatitis prophylaxis, secretion collection and blood tests; 63% offered emergency contraception; 69% forwarded them to outpatient follow-up. There was an association between age, ethnicity, education and marital status with better rates of adherence to the Protocol. Although reference hospitals are concerned with total care, they do not fully adhere to prophylactic, multidisciplinary and continuous measures.

KEY WORDS: Disease Notification; Gender-based violence; Rape; Violence against women.

VIOLÊNCIA SEXUAL CONTRA A MULHER: ADESÃO DE HOSPITAIS DE REFERÊNCIA E OS PERFIS SOCIODEMOGRÁFICOS

RESUMO: Buscou-se identificar o grau de adesão dos hospitais de referência ao Protocolo de atendimento às mulheres em situação de violência sexual no Paraná-Brasil, entre 2009 e 2015, associando aos perfis sociodemográficos e às categorias de adesão. Estudo observacional transversal, população composta por todas as mulheres em situação de violência sexual, atendidas por 28 Hospitais do Paraná. Analisaram-se dez itens sobre a taxa de adesão: desde o acolhimento, profilaxias, até encaminhamentos posteriores ao trauma. Encontrou-se que todos os Hospitais fizeram o atendimento agudo às mulheres; 50% aderiram às Profilaxias ISTs, AIDS e hepatites, coletas de secreção e exames sanguíneos; 63% ofereceram contracepção de emergência; 69% encaminharam para acompanhamento ambulatorial. Houve associação entre idade, etnia, escolaridade e estado civil com melhores taxas de adesão ao Protocolo. Entendeu-se que Hospitais de referência se preocupam com atendimentos agudos, mas não aderem integralmente às medidas profiláticas, multidisciplinares e continuadas.

PALAVRAS-CHAVE: Estupro; Notificação compulsória; Violência contra a mulher; Violência de gênero.

INTRODUCTION

Among the nuances of gender violence, sexual violence is one of the most perverse activity[1-3]. Sexual violence is a worldwide phenomenon, practiced particularly against women[2,3], with severe physical, psychic and moral damages[4-6]. Several studies insist that sociodemographic characteristics of vulnerability in females sexually assaulted may be identified, even though these studies are inconclusive due to their limits to specific places[2,7]. On the other hand, approximately 40% of females who undergo sexual violence are under fourteen-year old girls[8].

The state of Paraná, Brazil, ranks third among the states with the highest number of rapes in the country, with reports of 13 cases of sexual abuse per day[9]. However, studies published almost fifteen years ago[10] have already demonstrated that "medical services in general are not equipped for the diagnosis and treatment of women who are victims of sexual violence, due to the lack of specifically trained physicians and the relative 'invisibility' of the issue".

A holistic and multidisciplinary care to women in a situation of violence is an attempt to mitigate their suffering and that of their family through a systematic short- and long-term attendance from reception, acute attendance, tests and prophylaxes up to continuous ambulatory follow-up[11-13]. The Brazilian Ministry of Health recommends each item for the care of females in situation of violence through the "Technical Norm for the prevention and treatment of injuries resulting from sexual violence against women and adolescents"[14,15].

According to the recommended Protocol, the general norms for the care of females in situations of sexual violence enhanced by hospitals and reference units should systematically comprise: "interview, the narrative of the story, clinical and gynecological exams, complementary exams and psychological follow up", with "emergency interventions or hospitalization as special conditions"[16]. Updated knowledge of adhesion rates of reference hospitals to the Protocol for the care of females in situations of sexual violence is of paramount importance due to possible already existing and new difficulties in health services in employing an assistance routine for these women through a type of administration at worldwide levels. As far as it is known, there are no studies in Brazil that have established a systematic and categorical proposal for the evaluation of adhesion rates to care protocols by reference hospitals.

Further, for adequate health administration, besides characterizing the adhesion rate of reference hospitals to the care protocol for women in situations of violence, it should be observed whether there are months or three-month periods in which there would be an increase in notified cases of violence, with greater demand of reference hospitals. In the wake of originality of such investigations in Brazil, it has also been under scrutiny that some sociodemographic profiles of women would have better adhesion rates to the care protocol by hospitals to the detriment of others.

Current paper aims at identifying and systematizing adhesion rates by reference hospitals to the care protocol for women in situations of sexual violence in the state of Paraná, Brazil, between 2009 and 2015, by identifying whether there are any differences in the number of notifications in cases of sexual violence against women for three-month periods; to evaluate whether there are sociodemographic characteristics for women that would have better adhesion rates for care protocol to the detriment of others, according to adhesion categories (low, medium and high adhesion).

METHODOLOGY

Current transversal and observational study retrieved information from databases of the Health Secretary of the state of Paraná. The sample under analysis comprised all women in situations of sexual violence attended to by the 28 reference hospitals of the state of Paraná, notified by the Information System of Notification of Diseases (SINAN) between January 2009 and August 2015.

SINAN electronic data were used to survey sociodemographic data of women, the characterization of the types of aggressions and information on care provided in the reference hospitals. So that adhesion to care protocol to women in situations of violence by

reference hospital could be identified, the following items were evaluated: (1) reception; (2) clinical and gynecological exam in acute conditions; (3) collection of blood for tests; (4) collection of vaginal secretion; (5) prophylaxis for sexually transmitted infections (STIs), immunodeficiency syndrome (AIDS) and hepatitis; (6) collection of aggressor´s material/semen; (7) emergency contraception; (8) notifications (work accident); (9) forwarding of crime form; (10) forwarding to ambulatory follow-up (social, medical and psychological). In current paper, the ten-item set is given as "Integral Administration for Women in Situation of Sexual Violence", a tool provided by the authors after debates for the systematization of data.

Adhesion degree of reference hospitals to the Technical Norm for Care of Women in situations of sexual violence in the state of Paraná was calculated as the percentage of items complied with among those applicable for their respective situation for each attendance. Adhesion degree was divided into three categories: low (up to 50%), medium (between 51% and 75%) and high (between 76% and 100%). Further, the chi-square test was applied to verify significant relationships between adhesion categories and the sociodemographic characteristics of the women concerned.

Sociodemographic data of females in situation of violence were categorized according to the Brazilian Institute of Geography and Statistics (IBGE)[17], such as age, race/ethnicity, schooling, civil status and whether there was any type of deficiency or disorder. In the case of aggressions, types of aggressions, type of aggressor (parent or stranger, following classification of Notification Card of the Information System of Notification Diseases), times and place of aggression, recurrences, presence and type of intimidation and type of sexual violence (with or without vaginal penetration). To evaluate three-month-series trends for notifications and adhesion rates to the Protocol´s items, Mann-Kendall Seasonal test which assesses trends within a seasonal series, proposed by Hirsch et al. (1982) was applied. Mann-Kendall Tau statistical test for increasing ($Tau > 0$) or decreasing ($Tau < 0$) trends was also applied.

Collected data set was inserted into Excel Sheet and analyzed by descriptive statistics, evaluating the frequency of variables of interest. Other analyses were undertaken by statistical R Development Core Team. All tests were performed at 5% significance level.

Current study was approved by the Committee for Ethics and Research of the Universidade Estadual de Maringá, Maringá PR Brazil, protocol 2.969.836 of 18/10/2018.

RESULTS

Five (18%) out of the 28 reference hospitals analyzed in current study failed to send data on notifications for the 2009-2015 period and they were excluded from the sample. The other hospitals sent at least one notification of sexual violence against women. Total notifications amounted to 4,057 cases of sexual violence against females.

Within the description of items of Administration for Women in Situation of Sexual Violence, the items "Reception" and "Clinical and Gynecological Exam in acute condition" were performed in all reference hospitals (100%). The item "Collection of Blood for tests" was undertaken by 55% (2216) of the women attended at reference hospitals; the others failed to collect blood for tests. "Collection of vaginal secretion" was undertaken by 52% (1504), with inclusion criterion for the item comprising notification as "Rape" and/or "Vaginal, oral or anal penetration" (Table 1).

Prophylaxis for STIs, AIDS and hepatitis was performed only in 53% (1,555) of the cases attended to, with inclusion criterion for the item comprising notification as "Rape" and/or "Vaginal, oral or anal penetration" (Table 1).

Table 1. Adhesion rate of reference hospitals complying with Protocol of Attendance for women in situations of sexual violence in the state of Paraná

Item (step)	Description	Included Cases	Compliant Cases	%
1	Reception[1]	4057	4057	100
2	Clinical and gynecological exam[1]	4057	4057	100
3	Blood testing[1]	4057	2216	55
4	Collection of vaginal secretion[2]	2908	1504	52
5	IST, HIV and Hepatitis prophylaxis[2]	2908	1555	53
6	Agressor material and semen collection[2]	2908	851	29
7	Emergency Contraception[3]	2408	1509	63
8	Work Accident Notification[4]	183	36	20
9	Police asessment referral[1 5]	4057	2804	60
10	Outpatient follow-up referall (social worker, medical/nurse or psychologist)[1]	4057	3717	69

[1]All notifications made by the reference hospitals in Paraná

[2]Only victims that suffered "Rape" or any type of "Anal, Vaginal, Oral Penetration"

[3] Only victims that suffered "Rape" or any type of "Anal, Vaginal, Oral Penetration" and between 10 and 50 years of age

[4]Only victims that suffered work-related violence

[5]Considered any kind of refererall to police services.

[6]Only notifications between de 2009 a 2014

- Constant series that can't be tested

*Statistical significance ($p < 0,05$)

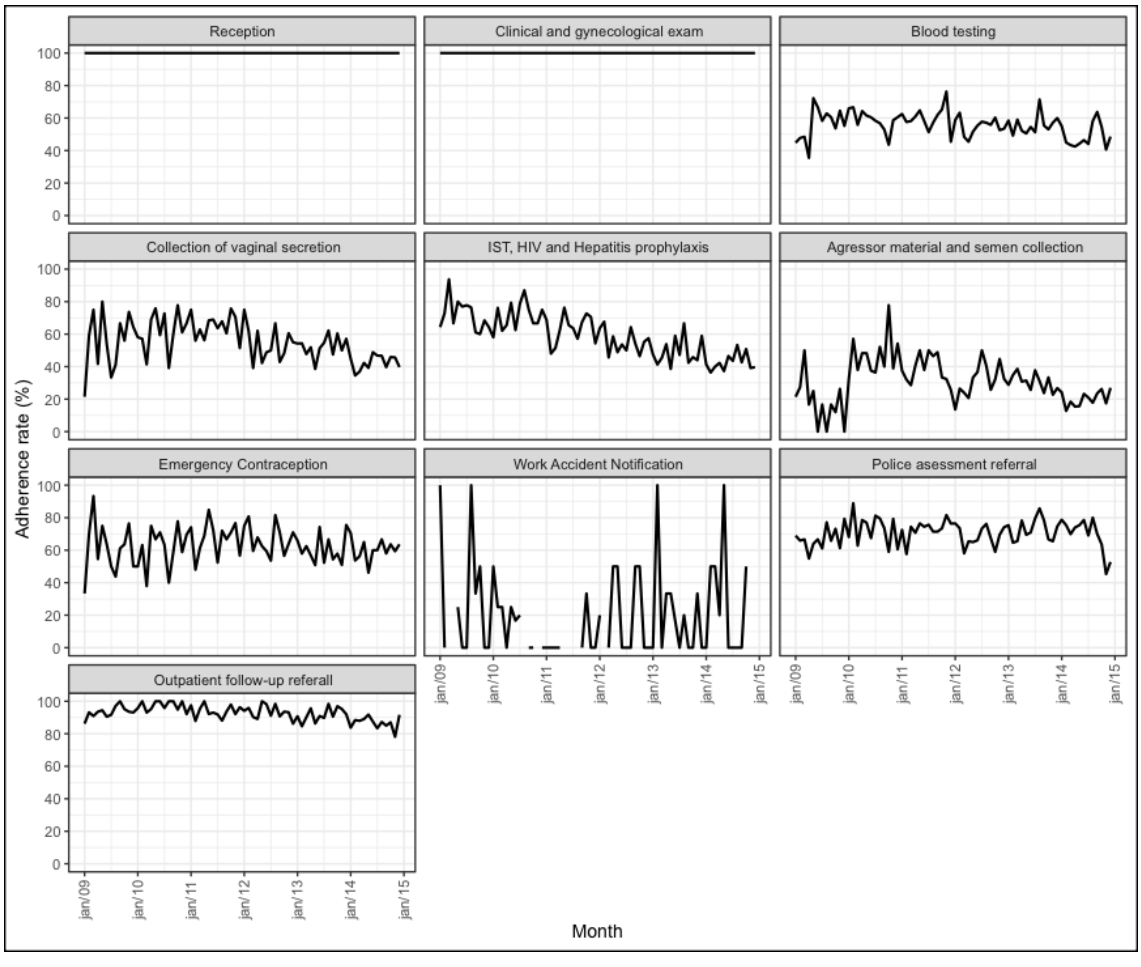
No reference hospital performed all the criteria of Administration for Women in Situations of Sexual Violence.

According to results of the Mann-Kendall seasonal test applied to the series of monthly adhesion of reference hospitals to the Protocol for the Care of Females in situations of sexual violence in the state of Paraná, between 2009 and 2014 (Graph 1), there are sufficient evidences that the series has a negative and significant trend for items 3, - Collection of Blood for tests (Tau = -0.324; p = 0.002); 4 – Collection of vaginal secretion (Tau = -0.440; p < 0.001); 5 – Prophylaxis for STIs, AIDS and hepatitis (Tau = -0.711; p < 0.001); 6 – Collection of aggressor´s material/semen (Tau = -0.212; p = 0.039) and 10 – Forwarding for ambulatory follow-up (social, medical and psychological) (Tau = -0.443; p < 0.001). The above shows a decrease in adhesion rates of these items throughout the period. There was no significant trend at 5% significance for the other items.

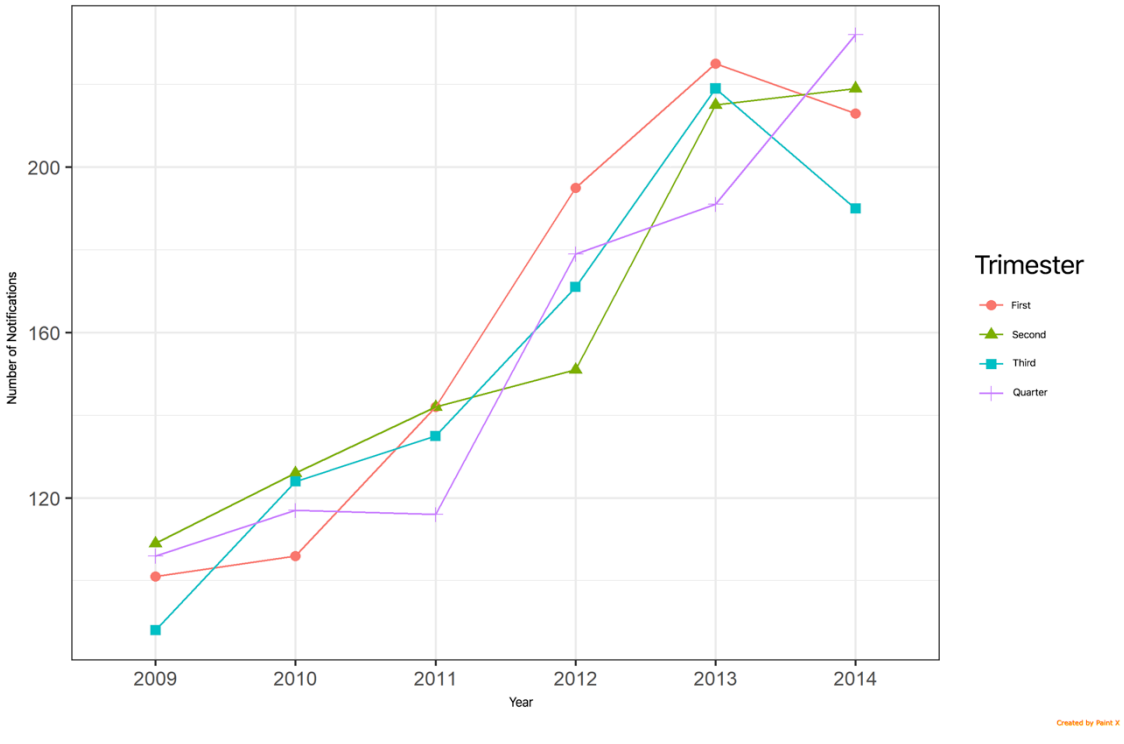
Notifications showed an ascending curve of cases between 2009 and 2014, with 404 cases in 2009 and 854 cases in 2014, notified by hospitals. Increasing monthly trend of cases throughout the period may be underscored. Results of Mann-Kendall Seasonal test showed there was evidence that series had a significant positive trend at 5% significance (Tau = 0.753; p < 0.001), corroborating increase of notification along the period.

No specific month with greater or lesser numbers of notifications has been underscored throughout the period, with a maximum of 88 cases in May 2013 and a minimum of 21 cases in June 2009.

The distribution of the number of cases between the three-month periods of the year was also investigated. The increasing number of cases throughout the years may be underlined with no sharp pattern between the trimesters. However, it should be highlighted that in three out of the six years evaluated and taking into groupings regardless of the year (982 notifications between October and December 2009 to 2014), the greatest amounts of notifications occurred in the fourth trimester (Graph 2).



Graph 1. Curve of adhesion arte of reference hospitals complying with the Protocol of Attendance for women in situations of sexual violence in the state of Paraná by item and month of occurrences and trend of change in rates between 2009 and 2015.



Graph 2. Graph on the number of notifications per trimester in the attendance of women in situations of sexual violence in the state of Paraná by years of occurrences.

Mean age of females attended to was 16 years, median 14 years. Females over 60 years old reached 1% (27) of cases, whereas the number of young female adults up to 19 years of age reached 72% (2920) of notified cases. It should be highlighted that 27% of these females were under 10 years old and more than 50% were under 15 years of age.

More than 90% of cases occurred in the urban area, with a total of 3,189 notifications. The rural and urban surrounding region accounted for just over 7% (269) of occurrences. More than 50% (2,013) of cases occurred in the 'home' of the females; 26% (983) in streets; 2.15% (81) on school premises (Table 2). Moreover, in 72.7% (2,530) of notified cases, it was the first time that the female suffered sexual aggression. Recurrence was reported in 27.3% (949) of notifications.

Table 2. Data related to aggression of females in situation of sexual violence attended in reference hospitals in the state of Paraná

(Continua)

ITEM	n (%)	Valor p
Age		< 0,001
0-16 years	2528 (62)	
17-59 yeas	1502 (37)	
60 years or more	27 (1)	
RACE/ETHINICITY		< 0,001
White	2784 (69)	
Black	191 (5)	
Asian	18 (0)	
Brown	821 (20)	
American Indian	9 (0)	
Ignored	214 (5)	
Not reported	20 (0)	
SCHOLARITY		< 0,001
Iliterate	25 (1)	
1st to 4th grade of elementary school	374 (9)	
Completed 4th grade of elementary school	144 (4)	
5th to 8th grade of elementary school	862 (21)	
Complete elementary school	214 (5)	
Incomplete high school	497 (12)	
Complete high school	327 (8)	
Incomplete college education	169 (4)	
College graduate	109 (3)	
Ignored	370 (9)	
Does not apply	834 (21)	
Not reported	132 (3)	
MARITAL/CONJGUAL STATUS		< 0,001
Single	2124 (52)	
Married/Consensual Union	380 (9)	
Widowed	32 (1)	
Divorced	168 (4)	
Does not apply	1210 (30)	
Ignored	48 (1)	
Not reported	95 (2)	
SEXUAL ORIENTATION (sexual relations)		< 0,001
Heterossexual / Only with men	210 (5)	
Homossexual / Only with women	2 (0)	
Bissexual / With men and women	2 (0)	
Does not apply	286 (7)	
Ignored	112 (3)	
Not rerported	3445 (85)	
GENDER IDENTITY		< 0,001
Transvestite	0 (0)	
Transexual woman	0 (0)	
Transexual man	0 (0)	
Does not apply	554 (14)	
Ignored	58 (1)	
Not reported	3445 (85)	
IMPAIRMENT/DISORDER		< 0,001
Yes	307 (8)	
No	3477 (86)	
Ignored	209 (5)	
Not reported	64 (2)	
TYPE OF IMPAIRMENT/ DISORDER		< 0,001
Physical Impairment	21 (5)	
Cognitive Impairment	136 (32)	
Visual Impairment	22 (5)	

(Conclusão)

ITEM	n (%)	Valor p
TYPE OF IMPAIRMENT/ DISORDER		< 0,001
Auditive Impairment	24 (6)	
Mental Disorder	94 (22)	
Behavour Disorder	77 (18)	
Others	49 (12)	

Taking into consideration adhesion degree in the treatment of each patient complying with the Protocol for the Care of Females in situation of sexual violence in the state of Paraná, provided by percentage of items attended to between those applied to their respective situation and those classified in the three categories, namely, low (up to 50%), medium (between 51% and 75%) and high (between 76% and 100%), it has been reported that slightly more than 51% of females were classified as high adhesion attendance; 25% as medium adhesion attendance and 23% as low adhesion attendance. Adhesion classification was significantly associated with all the sociodemographic characteristics of patients evaluated, at 5% significance (Table 2). In the case of high adhesion females, there was a predominance of characteristics related to white ethnicity, schooling between 4th year and high school, with no permanent partner. All percentages were high when compared to medium and low adhesion classification, at 5% significance level (Table 3).

Table 3. Association between sociodemographic characteristics of females in situations of sexual violence attended in reference hospitals of the state of Paraná and adhesion rates to Protocol

(Continua)

ITEM	n (%)	Valor p
OCCOURENCE AREA		< 0,001
Urban	3189 (79)	
Rural	163 (4)	
Peri-Urban	106 (3)	
Ignoraed	66 (2)	
Not reported	533 (13)	
TIME OF OCCOURENCE		< 0,001
Morning (6:00 - 11:59hs)	368 (9)	
Afternoon (12:00 - 17:59hs)	559 (14)	
Evening (18:00 - 23:59hs)	810 (20)	

(Conclusão)

ITEM	n (%)	Valor p
TIME OF OCCOURENCE		< 0,001
Night (0:00 - 5:59hs)	633 (16)	
Not reported	1687 (42)	
LOCATION OF OCCURRENCE		< 0,001
Residence	2013 (50)	
Collective habitation	22 (1)	
School	81 (2)	
Sports practice area	20 (0)	
Night venue or similar	30 (1)	
Public ways	983 (24)	
Commerce/Services	63 (2)	
Industries/construction yards	15 (0)	
Other	546 (13)	
Ignored	244 (6)	
Not Reported	40 (1)	
AGRESSION RECORRENCE		< 0,001
Yes	949 (23)	
No	2530 (62)	
Ignored	537 (13)	
Not Reported	41 (1)	
MEANS OF AGRESSION*		< 0,001
Physical Coercion/Beating	1606 (29)	
Choking	155 (3)	
Blunt Object	60 (1)	
Objeto Pérfuro Cortante	223 (4)	
Hot substance/object	11 (0)	
Poisoning	46 (1)	
Firearm	341 (6)	
Verbal Threat	1252 (23)	
Other	267 (5)	
Not Reported/Ignored	1518 (28)	
TYPE OF SEXUAL VIOLENCE*		
Sexual Harassment	1042 (23)	
Indecent Assault (2009-2014)	488 (11)	
Rape	2713 (59)	
Child Pornography	84 (2)	
Sexual Exploitation	106 (2)	
Other	137 (3)	
TYPE OF PENETRATION*		
Oral Penetration	594 (20)	
Anal Penetration	536 (18)	
Vaginal Penetration	1851 (62)	

**The form admits registering more than one option*

DISCUSSION

Current study used the Protocol for the Care of Females in situations of sexual violence to highlight the ten items or ten steps of attendance which are basic for the evaluation and follow-up of females, called in current study, as Integral Administration for Women in Situation of Sexual Violence. Adhesion to attendance items aim at decreasing damage and promote post-trauma care to patients. The authors of current research made sure that adhesion for each item would be pertinent to each case, namely, type of violence and age for clinical decisions and later follow-up.

Current analysis revealed that the adhesion degree of reference hospitals with regard to the Protocol for the Care of Females in situations of sexual violence in the state of Paraná between 2009 and 2015 was low in most items. Concern exists in the acute attendance to females and the clinical report. Other long- and short-term items, including prophylaxes and ambulatory follow-up, are precarious. This is especially true since almost half (47%) of the females did not receive any prophylaxis for STIs, HIV or hepatitis, whilst 37%, who were exposed to pregnancy risks, failed to receive any emergence contraceptives.

In spite of the existence of the Protocol for the Care of Females in situations of sexual violence, no reference hospital in the state of Paraná adhered to all the items. Patel et al[18] employed the concept of "Comprehensive Medical Care Management" to define the adhesion of US health establishments for the protocol for the care of females in situation of sexual violence in the USA by a telephone research. Low adhesion rates for stipulated items were reported.

The motives for low adhesion rates in reference hospitals comprised lack of health professionals in multidisciplinary areas to attend to females in situations of sexual violence, insecurity of professionals with regard to the applicability of the whole protocol, lack of structural and materials for full attendance and the lack of continuous capacitation of health professionals for the attendance of sexual violence in several regions[19,20].

Only 69% of attendances were forwarded for ambulatory follow-up (social, medical/nursing or psychological). The above datum is highly relevant since the long-term damage in the life quality of females requires ambulatory follow-up for the mitigation of harm done[4,11].

It has also been reported that females between 15 and 59 years old, with schooling ranging from 4th year to high school, white, with partners had the highest adhesion rates with regard to attendance items by reference hospitals. The above reveals an association between adhesion rates and the sociodemographic profiles of the victims, and thus differentiated attendance to these females, to the detriment of others. The datum was unexpected since the literature deals with the great vulnerability of children under 14[8], and thus the group with the highest adhesion rates to the protocol´s items. One hypothesis refers to the fact that, within this age group, there is a greater chance of chronic exposure to the aggressor, pinpointing, for instance, prophylaxis for non-viral STIs[16]. However, if the context is removed from analysis, there are still deficiencies in attendance items in the age group.

Although several Brazilian studies have analyzed sociodemographic data and undertaken attendance protocols for females in situation of sexual violence, sampling was restricted to specific regions (for instance, one single hospital[4,12]) or were based on the description of isolated items of the protocols or sociodemographic descriptions[21-23]. A sample with national representations employing the 1998 Ministry of Health´s Technical Norm and 2001-2006 data acquired by telephone and not by notifications was provided in one research work[24].

Garbin et al[19] highlighted that notification of violence is mandatory and associates adequate notification with more 'satisfactory' results, preventing greater harm to the victims. Current study identifies a rising curve of notifications of sexual violence against females in the state of Paraná during the 2009-2015 period, with similar data countrywide[25], and may be the result of the Protocol´s consolidation in the state of Paraná and an increase in the number of municipalities that have started to notify cases of sexual violence against females due to the notification mandatory stance. However, there was a monthly trend on adhesion decrease throughout the period, initially very low. In other words, attendance was notified, but some of the necessary items for the integral attendance were missing, with a worsening of the situation.

No trimester had a greater number of notifications in the years under analysis.

Current study is limited by employing sociodemographic data of notification cards which may not have been correctly filled. Certain answers, such as those on race/ethnicity, may have been generated by asking the women directly and thus causing differences. However, current research is valid with regard to the quality of attendance to females who underwent sexual violence in the state of Paraná during the period analyzed. It is also possible that other cases were not notified. However, since most hospitals depend on SUS resources for their maintenance, it is hard to imagine that several cases were not notified. Possible omissions do not invalidate results with regards to the components of attendance which were not complied with and even less with regard to the association between sociodemographic variables and adhesion degree to protocol.

CONCLUSION

Current study is a contribution towards the elucidation of adhesion rates of reference hospitals in the state of Paraná to the protocol of attendance to females in situations of sexual violence, marking deficit adhesion and a decreasing trend during the period. This fact may signalize greater harm to the vulnerable population at short and long terms. Further, better adhesion rates to the protocol have been detected in several sociodemographic profiles to the detriment of others. No trimester pattern was detected with greater or smaller number of notifications throughout the period. Besides promoting equal and integral adhesion by reference hospitals to attendance items, the necessary adequate support should exist to maintain adhesion for a long period.

Gynecologists, obstetrics and the entire multidisciplinary team for attendance of females in situations of violence have a basic role to correct the trend for a less integral care to women who suffer sexual violence. The problem is not limited to the state of Paraná. The authors insist that the Brazilian Federation of Gynecology and Obstetrics (FEBRASGO) and its National Committee specialized in Sexual Violence and Abortion have a fundamental role to change conditions reported in current study. A possible mechanism may be the promotion of discussion groups, alone or within the context of regional and national venues of the specialty. One cannot just pinpoint the problem without suggesting correction mechanisms in a moment in which the combat against gender violence has become a theme of global interest.

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