

SEXUAL VIOLENCE AND THE RESPONSE OF THE HEALTH SECTOR IN BRAZIL

**Jorge Andalaft and
Anibal Faúndes**

Rape is an extreme form of violence against women not representing a great concern until recently. It was only in 1992 that the United Nations Economic and Social Council defined violence against women as "any act of violence resulting in physical , sexual or psychological harm". It also adds that "... (violence against women) includes threat ...and coercion" and can occur "... in the public or private sphere" (United Nations Economic and Social Council, 1992). The most perverse form of violence, and also the one with the worst consequences, is sexual assault. Sexual violence should be a matter of concern for everyone, particularly for health services in charge of providing care for women, because of its high level of occurrence, which is higher than suspected, and also because of the dramatic consequences it can have for women victims of aggression.

Prevalence

Due to its criminal nature, it is very difficult to get actual figures on the prevalence of sexual violence. Population-based studies conducted in several countries show prevalence rates ranging from 5.1 to 29.0% (Heise et al, 1994; Goldind et al, 1998). The significant variation observed may be influenced by the research method and the definition of sexual violence used, as well as the cultural differences between the various countries or regions.

A study conducted in the city of Campinas, in Sao Paulo, Brazil, showed that 62% of over 1,800 women aged 15-49 interviewed at their homes reported having had sexual relations against their will at some point in time in the past. Upon inquiring the reason why they were forced to do so, 7% of them stated they had been subjected to physical violence; 23% experienced some form of coercion and 32% stated they had believed it was their obligation to accept their partners' imposition (Faúndes et al, 2000). If we accept the definition of violence of the United Nations, which includes coercion, at least 30% of these women had a history of sexual violence.

Consequences

The immediate consequences of sexual violence are physical and psychological traumas, the possible contagion of sexually transmitted diseases (STDs) and the risk of unwanted pregnancies. The main long-term consequences are STDs/AIDS sequels, induced abortion or unwanted babies, mental health problems and gynecological somatization, which is expressed in various forms.

Some authors found that 10% or more of the victims of violence contracted an STD. Furthermore, forced intercourse in the middle of the menstrual cycle can result in unwanted pregnancies, which in Latin American countries often end up in illegal abortions with high risks of hemorrhage or

infection that can evolve into a pelvic inflammatory disease which, in turn, can lead to tubal obstruction, sterility, ectopic pregnancy and chronic pelvic pain.

As regards psychological sequels, the ones most commonly found as a result of violence against women are depression, sleep and eating disorders, concentration problems and alcoholism.

Finally, the consequences least recognized, although not less important, have to do with what we call the gynecological somatization of sexual assault, which includes menstrual disorders, chronic pelvic pain, dyspareunia and sexual dysfunctions such as the lack of libido and anorgasmia (Faúndes et al, 2000) .

The Response of the Health Sector

Over the last two decades, the Brazilian women's movement has fought for a better recognition of this problem and, particularly, for the enforcement of the article of the Penal Code depenalizing abortion for women victims of rape who get pregnant and wish to terminate pregnancy. The response of the health sector was slow and partial.

In 1988, a municipal law in Rio de Janeiro established the obligation to fulfill requests of abortion provided for the law, and designated specific hospitals to meet this demand. The municipality of Sao Paulo joined soon after, with the difference that the service in Sao Paulo, at the Jabaquara Hospital, had a much better performance. However, progress was fairly slow until 1996, when an NGO, the *Centro de Pesquisas Materno-Infantis de Campinas* (the "Campinas Mother-Child Research Center") (CEMICAMP), which had links with one of the three hospitals providing these services, organized the "First Interprofessional Forum on the Implementation of Abortion Provided for by the Law" in November 1996 in the city of Campinas, in the state of Sao Paulo. This forum was attended by fifteen of the most recognized professors of gynecology and obstetrics in Brazil, along with professors of bioethics, legal medicine, criminal law, and judges, promoters, feminist leaders and social scientists working in the field. Among them was the Chairman of the Federation of Brazilian Gynecology and Obstetrics Societies (FEBRASGO). At this first forum the conclusion was reached that it was no longer possible to only care about raped women getting pregnant; all women victims of sexual violence need and deserve care immediately after the episode of violence and also in the long term, which includes the termination of pregnancy where it is the result of an act of violence.

All the professors and heads of gyn-obs services attending the First Forum made a commitment to establish care services for women victims of sexual violence.

After the Forum, FEBRASGO created the "National Specialized Commission on Sexual Violence and Abortion Provided for in the Law". Soon after its creation, this Commission started participating in the joint organization, along with CEMICAMP, of the subsequent interprofessional forums on sexual violence against women, which were held in 1997, 1998 and 1999. The forum held in year 2000 took place on December 1-2 in Rio de Janeiro .

Each forum served to evaluate progress in the creation of new services and discuss the strategies followed by each hospital to initiate the implementation of services through specific programs. From the discussions at these forums proposals were made on the procedures to establish comprehensive care services for women victims of sexual violence. These proposals emerging from the first forums were taken into consideration by the Ministry of the Health to issue the "Standards for the prevention and treatment of the consequences of sexual violence against adult and adolescent women ", published in late 1998.

CEMICAMP and FEBRASGO later conducted a survey on abortion provided for by the law among gynecologists-obstetricians, and soon after among state health secretariats, large

municipalities and Regional Medicine Councils, consulting on activities carried out and the interest in carrying out actions in connection with sexual violence and access to abortion provided for by the law.

More than 90% of the doctors surveyed agreed with pregnancy termination in cases of risk of death of the mother and more than 85% in the case of rape. Only one of the Regional Medicine Councils stated they had no interest in the issue. All the others already had activities or expressed an interest in having a dialog on this issue with other organized groups and local authorities.

Over 50% of the state secretariats and 75% of the municipal health secretariats responded. Very few of them had programs providing care for women victims of sexual violence, but all those responding expressed their interest in having such programs.

Interventions

Armed with the recommendations of the forums and the standard of the Ministry of Health, professionals of CEMICAMP and the commission created by FEBRASGO traveled throughout the country to identify individuals, public institutions and NGOs interested in mobilizing local societies for the creation of services. These individuals and institutions were from the health, social, justice and human rights sectors.

Once the hospitals with professionals interested and a socially and politically favorable local environment were identified, CEMICAMP and FEBRASGO held local meetings to discuss the creation of services. They also provided professionals interested with technical assistance and training. Some of the oldest services with the largest number of clients and already having experiences to share were used for training purposes. In some of the cities the health secretariats of the state municipality took a leadership role, but it was not always the case.

The protocol of immediate care for women victims of sexual violence mainly focuses on women's needs and, secondarily, on identifying the aggressor. It is based on the principle that women victims of sexual violence need psychological support; protection against pregnancy, sexually transmitted diseases and AIDS; legal counseling and welfare. Therefore, it focuses on providing psychological counseling, emergency contraception, prophylactic antibiotics against syphilis, gonorrhea and chlamydia, active and/or passive immunization against hepatitis B and, in some cases, antiviral cocktails to prevent the transmission of the AIDS virus. Furthermore, welfare services are focused on counseling women and their relatives on the need of reporting violence at police posts (mainly those specialized in crimes against women). Women are also advised to get medical and legal services to facilitate the collection of evidence allowing the identification of the aggressor.

In addition to immediate care, follow-up is done on women to confirm they are not infected or to give them treatment if an infection could not be avoided. These services must also fulfill requests of termination of pregnancy, in case this occurs as a result of rape.

In the beginning, the establishment of services was difficult, but starting in 1999 there was a more rapid increase in the creation of services for women victims of violence in new hospitals. The number of service locations increased from 3 in two states in June 1997, to 22 in 7 states by June 1999 and 33 in 12 states by June 2000. At the last forum held in Rio de Janeiro in December 2000, 53 hospitals with care services for women victims of sexual violence were identified in 20 Brazilian states. Considering the number of hospitals in the process of establishing services, an objective estimate is that by the end of 2001 more than 71 hospitals will provide this service in all the Brazilian states.

Lessons Learned

1. A key element to get the health sector committed to the provision of care for women victims of sexual violence is the interaction among different social actors, where organized women's groups play a key role. However, the only way of achieving progress is through constructive dialogue. It was necessary to overcome a period of distrust and mutual attacks between women's groups and physicians to start building a new reality characterized by willingness to listen and learn from each other .
2. Another lesson learned from experience is that violence care services should not depend on the goodwill of a few professionals; rather, they should be institutionalized in order to have a protocol of care for these women, just like the protocols to address gravidic toxemia, placenta praevia or any other pregnancy complication.
3. Care for women victims of sexual violence must be comprehensive, and it should not be merely limited to immediate care following the aggression or pregnancy termination. All women sexually assaulted need assistance and, in case of pregnancy, they are entitled to pregnancy termination in an appropriate risk-free environment.