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WOMEN VICTIMS OF SEXUAL VIOLENCE: ADHERENCE TO CHEMOPREVENTION OF HIV[1]

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This study aimed to investigate the adherence of women victims of sexual violence, to AIDS chemoprevention treatment. A quantitative study was carried out at a care service to victims of sexual violence in Salvador (Bahia, Brazil). Study participants were 172 women. Data were collected through interviews with forms and consultation of patient files. The results showed that 45.4% of the abused women were teenagers and 40.7% of the attended women were raped. Only 54% of the women were advised to use antiretrovirals to prevent HIV. Adherence to treatment occurred in 57.4% of cases and discontinuity corresponded to 42.6%. Non-adherence to treatment was attributed to psychological or emotional disorders and non-understanding of the established treatment. Therefore, it is important that professionals pay careful attention in order to perceive the conditions that might increase women's vulnerability to the infection.

DESCRIPTORS: women; violence; chemoprevention

MUJERES VÍCTIMAS DE LA VIOLÊNCIA SEXUAL: ADHESIÓN A LA QUIMIOPROFILAXIA DEL HIV

La finalidad de este estudio fue investigar si las mujeres víctimas de violencia sexual adhieren o no al uso de medicamentos para prevención del HIV. Fue realizado un estudio cuantitativo en un servicio de atención a personas sexualmente violentadas, ubicado en Salvador (Bahía, Brasil). Participaron del estudio 172 mujeres. Los datos fueron recopilados a través de entrevistas dirigidas y consulta a los archivos. Los resultados demostraron que el 45.4% de las mujeres víctimas de violencia eran adolescentes y que el 40.7% de las mujeres asistidas fueron violadas. Sólo el 54% de las mujeres fue aconsejado a usar medicamentos antiretrovirales para prevención del VIH, El 57.4% de ellas adhirió al tratamiento y el 42.6% no lo continuó. Aquellas que no adhirieron al tratamiento alegaron disturbios psicológico y/o emocional o no comprensión del tratamiento instituido. Por lo tanto, es necesaria una mirada atenta de los profesionales para percibir las condiciones que implican un aumento en la vulnerabilidad de las mujeres a la infección.

DESCRIPTORES: mujeres; violencia; quimioprevención

MULHERES VÍTIMAS DE VIOLÊNCIA SEXUAL: ADESÃO À QUIMIOPROFILAXIA DO HIV

O estudo teve como objetivo avaliar a adesão de mulheres vítimas de violência sexual ao tratamento de quimioprofilaxia do HIV. É um estudo quantitativo que teve como lócus o Serviço de Atenção a Pessoas em Situação de Violência Sexual em Salvador (Bahia). Participaram do estudo 172 mulheres. A coleta de dados foi realizada através de entrevista com formulário e consulta aos prontuários. Os resultados mostraram que 45,4% das mulheres violentadas eram adolescentes e o estupro acometeu 40,7% das atendidas. Apenas 54% das mulheres tinham indicação para o uso de anti-retrovirais para a prevenção do HIV. Houve adesão ao tratamento de 57,4% e a taxa de descontinuidade correspondeu a 42,6%. A não-adesão foi atribuída aos transtornos psíquicos e/ou emocionais e à não compreensão do tratamento instituído. Portanto, há necessidade de um olhar atento dos profissionais a fim de perceber as condições que implicarão no aumento da vulnerabilidade das mulheres à infecção.

DESCRITORES: mulheres; violência; quimioprevenção

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INTRODUCTION

Sexual violence ignores cultural barriers, social classes, socioeconomic levels and individual limitations. It can occur in the private as well as in the public sphere and affects men and women of all ages, with women being the greatest victims.

Violence against women, called gender violence, represents a severe violation of human rights and is capable of creating countless health problems, among which: fear, lack of credibility in the legal system and silence, turning victims into accomplices of their aggressors.

It should be highlighted that violence records do not reveal the reality as, in Brazil, there are no global data about this phenomenon: it is estimated that complaints are filed in less than 10% of cases[1].

For a long time, violence was considered a police matter. Nowadays, due to the dimensions it has assumed, it has also turned into a public health problem. Women in violence situations face severe health problems. Psychological disorders, for example, include repeated nightmares, anguish, flight, avoiding memories about the traumatic event, whether in talks or by avoiding to remember thoughts, places, people; increased emotional excitation, anger, lack of concentration, state of alert, getting scared easily and nervousness[2].

With respect to physical aspects, we can mention skin injuries, pregnancy, abortion, sexual infection, tears and contamination by HIV. Other effects of aggression are chronic diseases and drugs use.

Thus, as a result of the trauma, sexual violence is capable of provoking psychological disorders, physical diseases (such as body injuries for example), sexually transmissible diseases and Aids.

In response to the problems and repercussions of sexual violence to people's health, in 1999, the Brazilian Health Ministry launched a manual aimed at care standardization. Conducts standardized by the Ministry include the use of antiretrovirals to prevent HIV infection.

Dissemination and knowledge about this practice is still incipient in health services and in the population. However, since 2001, a referral center exists in Salvador which delivers care to victims of sexual violence and offers chemoprevention.

This study is justified by its epidemiological and social importance, as it puts forward questions that have received little attention until now and need further reflection, revealing or, better, unveiling the space of violence in the field of family relations, i.e. the home environment, which is generally considered as a place of affection and love, but which actually hosts atrocities and aggressions.

In this context, this study's general aim was to assess female victims of sexual violence's adherence to HIV chemoprevention treatment, and its specific objective was to identify factors influencing female sexual violence victims' non-adherence to HIV chemoprevention treatment.

METHODOLOGY

This descriptive, exploratory and quantitative study was carried out at a Care Service for People living in Sexual Violence Situations, located in Salvador (BA), Brazil, between October and December 2003. A systematic sample was selected. Our corpus was constituted by all female children, adolescents and adults who received care during this period, totaling 172 women (children, adolescents and adults) victims of sexual violence attended at the service, 60 of whom were victims of Violent Indecent Assault (VIA) and 112 of rape, either associated with VIA or not.

Sexual violence is considered as an act that obliges a person to have sexual, physical or verbal contact or to participate in other sexual relations by force, intimidation or any other mechanisms that annuls or limits personal will[3].

According to the Brazilian Penal Code, this coercion can be expressed in different ways, including rape, attempted rape, seduction, violent indecent assault and obscene act[3].

Data were collected through documentary analysis and interviews. The latter were only held with women who did not adhere to treatment.

Data were obtained from institutional records, which made it possible to identify the patient files and verify data, through the identification of victims, sexual violence, aggressors and HIV chemoprevention treatment adherence.

All ethical and legal aspects determined by National Health Council resolution 196/96[4] were taken into consideration and the project was approved by the Ethics Committee at the Professor Edgar Santos University Hospital.

Sexual violence, adherence and non-adherence to chemoprevention were chosen as

dependent variables, and sociodemographic data and gynecological history as independent ones.

RESULTS AND DISCUSSION

Studying violence requires integration among sectors, as the complexity involved does not allow treatment by one single discipline. Violence is, above all, a social issue and, as such, it is not only studied in health, but also in other areas, due to its disastrous consequences for women's quality of life.

In this study, the sample characterization revealed certain particularities, such as the large number of sexual violence cases among female children and adolescents and occurrence in the home environment.

The non-private aspect of the domestic sphere lies in the fact that it shelters things that should be hidden from human eyes: the distinction between what should be public or private is established through the difference between what should be exhibited and what should remain hidden[5].

Many children, adolescents and adults are victims of violence, but the data below do not reveal all cases of violence that occurred in family nuclei in Salvador. Thus, we infer that these data do not show the actual range of violence, although they suggest a preoccupying scene.

Intrafamily violence is rooted in the culture and history of civilizations and has become increasingly unveiled. It has received greater attention since the 1990's and, hence, constitutes a theoretical and practical knowledge area under construction[6].

Sample characterization

We used the age range division criterion established by the Statute of the Child and Adolescent, considering people under 12 as children, between 12 and 18 as adolescents and 19 or older as adults.

The results evidenced that the age group most affected by sexual violence is between 12 and 18 years old (45.4%), followed by child (32.6%) and adult victims (22%).

Other studies have already mentioned the relation between violence experiences and young age. According to the same age classification criteria, sexual violence affected 37.7% of children, 31.3% of adolescents and 31% of adults[7]. These data confirm that some groups are more vulnerable to violence, including young women[7-8].

This vulnerability is justified by relations that could be characterized by confidence and protection but which, however, are used as a subterfuge for violence. Thus, in the home environment, in most cases, these children and adolescents going through violence situations construct a social identity that is reproduced across different generations.

Violence is discussed as a phenomenon that appears in different social layers, that is, there exists an equality level among sexual violence victims, which is repeated across difference generations in the same family, and can be called intergenerationality[6].

What skin color is concerned, we believe this is a relevant variable when discussing violence as, although we have distinguished between the colors black and mulatto, in line with the institutional classification criterion, the Brazilian Institute of Geography and Statistics (IBGE) establishes that the term "black population" covers both the black and mulatto populations together, according to the terms adopted to name races and ethnic groups in the Brazilian population[9]. Based on this criterion, we found that 77.3% (39.5% black; 37.8% mulatto) of the violence victims were blacks.

However, these data do not prevent us from affirming that sexual violence was more frequent among black women, as these are not only women but also black, thus suffering because they are more discriminated against, devaluated, living in unequal gender conditions and violence situations.

A study carried out in Salvador (BA) found that 46.5% of women who suffered some kind of violence considered they were black[10]. However, in a study realized in São Paulo, 47.8% of women declared they were white. This difference can be justified by regional ethnic characteristics[11].

As to the gynecological variable, we found that the service clients used contraceptive methods and were already sexually active before the sexual violence.

It should be highlighted that 18.7% of the women were virgins and had their first sexual contact during the violent act, which raises the possibility of skin tears and lacerations, increasing HIV infection risks and the need to implement risk minimization conducts. This fact justifies the non-use of contraceptive agents, as these women had not started sexual life yet.

When virgin women are victims of sexual violence, this entails, among other problems, a higher risk of HIV contamination, as the perforation of the hymen injures genital mucosa integrity[12].

Seventy percent of violence victims were not using any contraceptive method: this evidences their vulnerability to pregnancy.

Even if some women used emergency contraception, in line with Health Ministry recommendations, some of them got pregnant after they were violated, as the medication is not 100% effective and many women attended the service more than 72 hours after the event, i.e. after the deadline determined to administer the medication.

In case of pregnancy, the women have two possible options: either they accept the pregnancy resulting from the rape and live with the suffering this can entail, or they choose to have an abortion, which is offered in health services but is not well-structured yet and can also cause suffering.

Sexual violence

With respect to the sexual violence variable, at certain times, we found an association with other forms, such as Violent Indecent Assault with Oral coitus (VIAO); Violent Indecent Assault with Anal coitus (VIAA) and both combined with rape.

Table 1 - Distribution of sexual violence cases according to age groups

Sexual Crime	Child		Adolescent		Woman		Total	
	n	%	n	%	n	%	n	%
Rape	7	12,5	41	60,3	22	45,8	70	40,7
Rape + VIAA	3	5,4	5	7,3	4	8,4	12	7,0
Rape + VIAO	-	-	4	5,9	11	22,9	15	8,7
Rape + VIAA + VIAO	-	-	4	5,9	11	22,9	15	8,7
VIA	46	82,1	14	20,6	-	-	60	34,9
Total	**56**	**100**	**68**	**100**	**48**	**100**	**172**	**100**

Table 1 shows that 40.7% of women in different age groups were victims of rape, i.e. 60.3% of adolescents, 45.8% of women and 12.5% of children. In some cases, this aggression was associated with other forms, such as VIAO in 22.9% of women over 18; VIAA in 8.4% of women in the same group and the three forms together in 22.9% of these women.

VIA was most frequent among children (82.1%) and affected 20.6% of adolescents. No cases of VIA were found among adults. This study confirms the predominance of rape among adults and adolescents, while VIA prevails among children.

The study by Drezett evidenced the prevalence of VIA among child victims of sexual violence, corresponding to 70.4% in this stage of life[13]. As to the distribution of aggressors according to the victims' different age ranges, we found that sexual aggression against children was most frequently committed by neighbors (32.1%), acquaintances (17.9%), fathers (14.4%) and stepfathers (12.5%).

Among adolescents, 27.9% of violence cases are practices by acquaintances, 19.1% by unknown persons and 13.2% by stepfathers. Among adult women, 60.4% of sexual violence cases were committed by unknown men. This shows that children and adolescents are more vulnerable to family violence.

Thus, it should be highlighted that, in the identified rape cases, the assaulted women are exposed to high HIV infection risks, considering that a study carried out at the outpatient clinic of a teaching hospital in São Paulo evidenced heterosexual relations as the main form of HIV/AIDS exposure, representing 83.5% of cases[14].

As to the number of aggressors, the study showed that, in 89% of cases, the sexual violence was committed by one single aggressor. Data indicate that psychological sequelae are more severe when sexual abuse is perpetrated by multiple aggressors and also that, the larger the number of aggressors, the higher the risk of catching STD and HIV[13].

Sexual violence involving children and adolescents occurred in the physical and symbolic territory of the family structure, where men are almost totally dominant. The distribution of sexual violence according to the place of occurrence demonstrated that the aggressor's house was the preferred site (29.6%), followed by the victim's house (16.2%) and bushes, among other public places (13.4%); in other words, violence can happen anywhere, whether public or private.

In the domestic sphere, aggressors with blood or parenthood bonds perpetrate sexual violence through a process of dominion and power, established by social rules. This can be called intrafamily violence[15]. The security of the home allows the aggressive to exercise power in well-known territory, where dominion and delimitation of space are characteristics that authorize violence, which turns

filing a complaint into a difficult decision. We found that most aggressors were between 20 and 40 years old. This qualifies adult individuals as perpetrators of sexual violence.

Few cases of alcohol use occurred among the aggressors in comparison with other studies on this theme. We found that 57.3% of them had not consumed alcoholic beverages when they committed the violence. However, it is common for victims to associate sexual violence with drugs use: hence, alcohol, as a legal drug, is also inserted in this context. A study of 150 female college students who had been victims of rape showed that 84% affirmed they knew the aggressor and 73% that he was under the influence of drugs or alcohol(16).

Adherence to chemoprevention

What the adherence to HIV prevention variable is concerned, we found that antiretrovirals had been indicated to only 54% of women who attended the service in order to prevent HIV[17]. The analyzed criteria include type and risk degree of the aggression; whether it was a rape or a violent indecent assault; whether genital injuries and fissures occurred; if piercing and cutting material or syringes, etc. were used; type of sex (oral with ejaculation, anal or vaginal); if the victim reacted to the violence or not, as some of these factors can potentializes the risk of infection.

Hence, 46% of the women used neither chemoprevention, because they did not attend to the above mentioned criteria, nor emergency contraception.

Among women who started treatment, adherence levels corresponded to 57.4%, i.e. 42.6% of women who initiated treatment did not continue.

Table 2 - Distribution according to adherence to chemoprevention use per age group

Treatment	Child		Adolescent		Woman		Total	
	n	%	n	%	n	%	n	%
Adherence	-	-	6	46,1	25	64,1	31	57,4
Non-adherence	2	100	07	53,9	14	35,9	23	42,6
Total	**2**	**100**	**13**	**100**	**39**	**100**	**54**	**100**

* Six cases of treatment were suspended on the doctor's order

In comparison with the study by Drezett, in which 75.8% of women adhered to treatment and discontinuity rates amounted to 24.2%[13], data in Table 2 show low adherence levels in our study. Reasons leading to non adherence include mental and/or emotional disorders (40%), lack of understanding about correct medication use (30%), secondary collateral effects (20%) and lack of financial resources to return to the service to receive the medication (10%). We did not manage to contact 56.5% of the women who stopped treatment to find out about the reason that made them give up.

Tightening the relation between professionals and patients is an excellent alternative to improve treatment adherence, as the team could have worked on all of the motives these women alleged to abandon treatment.

Public policies should be held accountable, so as to contribute with financial resources that can guarantee the adequate realization of treatment, providing at the very least transport tickets to allow the women to return to the service to pick up the medication.

Drezett's study indicated gastric intolerance as the main cause of treatment discontinuity (80%). Only one case of lack of understanding about treatment (6.7%)[12] was reported.

Thus, interaction between health professionals and victims of sexual violence is essential to increase adherence to HIV chemoprevention. This requires the continuous assessment of care with a view to the periodical identification of cases of abandonment, in the search for viable alternatives to reduce HIV infection risks.

FINAL CONSIDERATIONS

The results evidenced that sexual violence affects women in different age groups, with high incidence levels among adolescents.

Violence studies show the black race as the main target of aggressions. Black women played a significant role in the sample. Ethnic, socioeconomic, cultural and gender factors cannot be suppressed in discussions about violence.

Using force to intimidate was common practice: hence, sexual violence appeared as rape, violent indecent assault, violent indecent assault with oral coitus and violent indecent assault with anal coitus. The act generally involved one adult aggressor. In some cases, this person was an acquaintance or relative (father, stepfather, uncle or brother) of the victim, which characterizes intrafamily violence.

Adherence to HIV chemoprevention treatment was low, as all women should adhere to the therapeutic schedule with a view to reducing HIV infection risks.

Treatment abandonment can be justified by countless situations: taking a pill to prevent HIV is accompanied by a series of things, such as remembering the violence and making public something that would be private. Other reasons include economic difficulties to go to the service to pick up the pill and lack of understanding about treatment.

The team should work with and periodically assess these motives, with a view to improving adherence levels.

This study contributes to the education process for working with families, to the extent that it shows intrafamily violence as a naturalized part of socially construction intergenerational relations. Thus, professionals from different areas can have a differentiated look with a view to care delivery to subjects and families in violence situations.

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