

ORIGINAL ARTICLE

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VIOLETA: A descriptive study on victims of sexual violence treated in a Peruvian hospital

VIOLETA: Estudio descriptivo sobre víctimas de violencia sexual atendidas en un hospital del Perú

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ABSTRACT

Objective: To identify the characteristics of the victims, features related to the violent event and the care provided by the VIOLETA (comprehensive care for women and members of the family group affected by sexual violence) center, from January to December 2022. **Methods:** The sample includes the total number of people attended (n=40). Information was collected from medical records and the VIOLETA team database. Socio-demographic information and information related to sexual violence and its care was collected. **Results:** All patients (n=40) attended were female, mostly adolescent students from Callao, Peru. Sexual violence occurred mainly in the home and was perpetrated by a person known to them. Only 37% of the victims had made a complaint. 17.5% of the victims came within 72 hours of the violence and were able to receive a complete kit for the prevention of unwanted pregnancies and sexually transmitted infections, including HIV. Forty-five percent of the cases (n=18) were associated with pregnancy, 11 of which were in children under 14 years of age. **Conclusion:** Adequate knowledge of victims, violent events and care provided during 2022 will help us to improve care for victims of sexual violence. **Key words:** Violence, Sex offenses, Violence against women, Intimate partner violence, Gender-based violence, Patient care team

RESUMEN

Objetivo. Identificar las características de la víctima, particularidades relacionadas al suceso violento y la atención brindada en el centro VIOLETA (atención integral a las mujeres e integrantes del grupo familiar afectados por violencia sexual), de enero a diciembre de 2022. **Métodos.** La muestra incluyó el total de personas atendidas (n=40). La información fue recolectada de historias clínicas y de la base de datos del equipo VIOLETA. Se recolectó información sociodemográfica y aquella relacionada a la violencia sexual y a su atención. **Resultados.** Todas las pacientes (n=40) atendidas fueron mujeres, en su mayoría adolescentes, estudiantes, procedentes del Callao, Perú. La violencia sexual ocurrió principalmente en la vivienda y fue ocasionada por una persona conocida. Solo un 37% de las víctimas realizó una denuncia. El 17,5% de las víctimas acudió dentro de las 72 horas de ocurrido el hecho violento y pudieron recibir kit completo para prevención de embarazos no deseados y de infecciones de transmisión sexual incluyendo VIH. Cuarenta y cinco por ciento de los casos (n=18) estuvieron asociados con embarazo, 11 de los cuales se dieron en menores de 14 años. **Conclusión.** Un conocimiento adecuado de las víctimas, de los hechos violentos y de la atención brindada durante el 2022 nos ayudará a mejorar la atención hacia las víctimas de violencia sexual. **Palabras clave.** Violencia, Delitos de género, Violencia contra la pareja, Violencia de género, Violencia contra la mujer, Equipo de atención al paciente

INTRODUCTION

The World Health Organization defines sexual violence as 'any sexual act, attempted sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person, regardless of that person's relationship to the victim, in any setting, including, but not limited to, home and work⁽¹⁾. Sexual violence is a global public health problem and a violation of human rights^(2,3). Although there are international agreements to prevent and eradicate all types of violence, especially sexual violence, the figures are alarming⁽¹⁾. Globally, about 35.6% of women have suffered sexual violence, with highly variable prevalence estimates. Men may



also be subject to sexual violence, although it may be impossible to provide overall prevalence rates, as they generally do not report⁽⁴⁾. In Peru, according to the National Institute of Statistics and Informatics (INEI), between January and June 2022, 5,093 cases of sexual violence were registered, of which 94.5% corresponded to women⁽⁵⁾. The Ministry of Women and Vulnerable Populations (MIMP), through the Aurora program registered, during 2020, 9,582 cases of violence, of which 66% (6,323) were for rape and of this figure 92.7% (5,861 cases) occurred against girls and adolescent women; that is, an average of 16 girls and adolescents were victims of rape daily⁽⁶⁾. From January to September 2022, 279 cases of sexual violence were reported in the Callao region, 228 of them for rape⁽⁷⁻⁹⁾.

The consequences of sexual violence seriously affect the victim, her family environment and even society. Victims of sexual violence are affected physically, mentally and socially. In terms of physical health, there is an increased risk of contracting sexually transmitted infections, including human immunodeficiency virus (HIV), unwanted pregnancies, abortions and gynecological problems^(3,10). In mental health, there is a high incidence of post-traumatic stress, anxiety, depression, suicidal behaviors, eating disorders, substance abuse, low self-esteem, fear of being judged and rejected by society^(3,11,12), which are higher if the sexual violence was perpetrated during childhood or adolescence, also showing a negative development of their sexuality. Sexual violence also has serious social consequences such as discrimination, the continuation of the cycle of poverty and violence. Sexual violence also has serious social consequences such as discrimination, the continuation of the cycle of poverty and violence, low participation of women, among others^(10,13).

In Peru, according to Law 30364 - Law to prevent, punish and eradicate violence against women and family members-, the Ministry of Health (MINSa) is responsible for providing comprehensive services for the recovery of the physical and mental health of victims of sexual violence. MINSa, through the Directorate of Sexual and Reproductive Health, promotes care for women and family members affected by sexual violence in health facilities, for which it developed in 2020 the Technical Health Standard N°164-MINSA/2020/DGIEPS 'Technical Health Standard for

the comprehensive care of women and family members affected by sexual violence⁽¹⁴⁾, offering comprehensive and multidisciplinary care to promote the physical, mental and social recovery of the victims. At the National Hospital Daniel A. Carrión (HNDAC), located in Callao, Peru, the implementation of the technical standard began with the creation of a multidisciplinary team (Directorial Resolution 274-2021-HNDAC-DG of November 9, 2021), which once organized promotes, with the support of MINSa and the British Embassy, the creation of the first differentiated clinic for comprehensive care of victims of sexual violence (VIOLETA), based on the model of the Sexual Assault Referral Center (SARC) of the United Kingdom, which focuses attention on the affected person, generating access to multiple institutions in one place⁽¹⁵⁾. Due to understaffing, the clinic is open from 8:00 am to 2:00 pm. The committee has been responsible for training all professional groups for the identification and timely referral of cases. The emergency teams have also been trained to provide immediate attention to the cases that arise, avoiding delay, postponement and re-victimization. This ensures 24-hour attention every day of the week, including holidays. The care package is classified according to the time elapsed since the violent event and the contact with health services (before or after 72 hours). In both cases, care is provided by a multidisciplinary team.

METHODS

The present descriptive, quantitative and retrospective study evaluated the sociodemographic profile, characteristics of aggression and care of victims of sexual violence attended at the Daniel A. Carrión National Hospital in Callao, Peru, from January to December 2022.

The data were collected from medical records and the committee's database, in a collection form designed for the study, including all the victims attended during 2022.

The following variables were considered:

- Sociodemographic: age, sex, education level, occupation, origin, nationality.
- Sexual violence-related variables: characteristics of the aggressor (known or unknown, single or multiple), place of the aggression and



whether the victim reported the aggression before going to the HNDAC.

- Related to care: time elapsed between the violent event and the first evaluation at the hospital (before or after 72 hours), clinical intervention (prescription of violence kit, complete or partial), multidisciplinary care, pregnancy associated with sexual violence, sexually transmitted infections caused by sexual violence, record of psychological or psychiatric disorder associated with sexual violence, activation of Code Violet (summoning the Public Ministry, Legal Medicine, Women's Emergency Center, Police, among others) for access to justice.

All the data obtained during the care provided were included and stored in a digital database to which only the researchers involved had access. The database was structured in Microsoft Excel. Data analysis was performed using SPSS version 29.

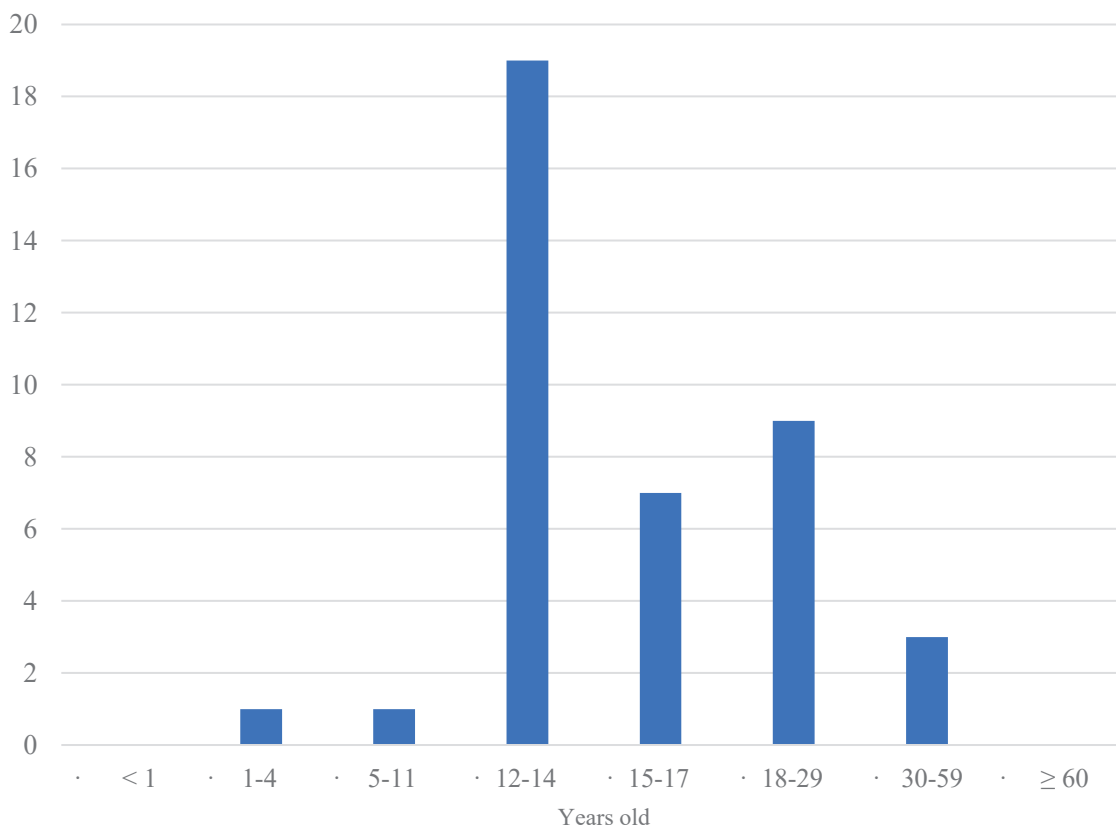
The research project was approved by the Research Ethics Committee of the Hospital Nacional Daniel A. Carrión (approval certificate: N°057-2023-CEI-HNDAC).

RESULTS

From January to December 2022, a total of 42 patients were attended, 2 of whom were excluded because the events did not constitute sexual violence.

We evaluated the data of 40 victims of sexual violence who attended the Daniel A. Carrión National Hospital in Callao (n=40), all of whom were female; 29 of the cases were treated in the emergency room and 13 as outpatients. The mean age was 17.3 years (minimum: 2 years; maximum 59 years); most of the victims were adolescents (65%), 73% between 12 and 14 years of age (Figure 1). When evaluating the level of education, it was found that, among the population aged 12-17 years, 7 of the victims dropped out of school (29%). Among those over 18 years of age, 54% of the victims had completed secondary school, 2 had incomplete secondary school and 1 had incomplete elementary school. Occupation data for victims aged 18 years and older (n=13), 38% were students and 24% were housewives. Regarding origin, 95% of the victims came from the Callao region (15% from the district of Ventanilla, the largest and poorest district in this region),

FIGURE 1. PATIENTS TREATED FOR SEXUAL VIOLENCE ACCORDING TO AGE GROUP VIOLETA – HNDAC 2022.





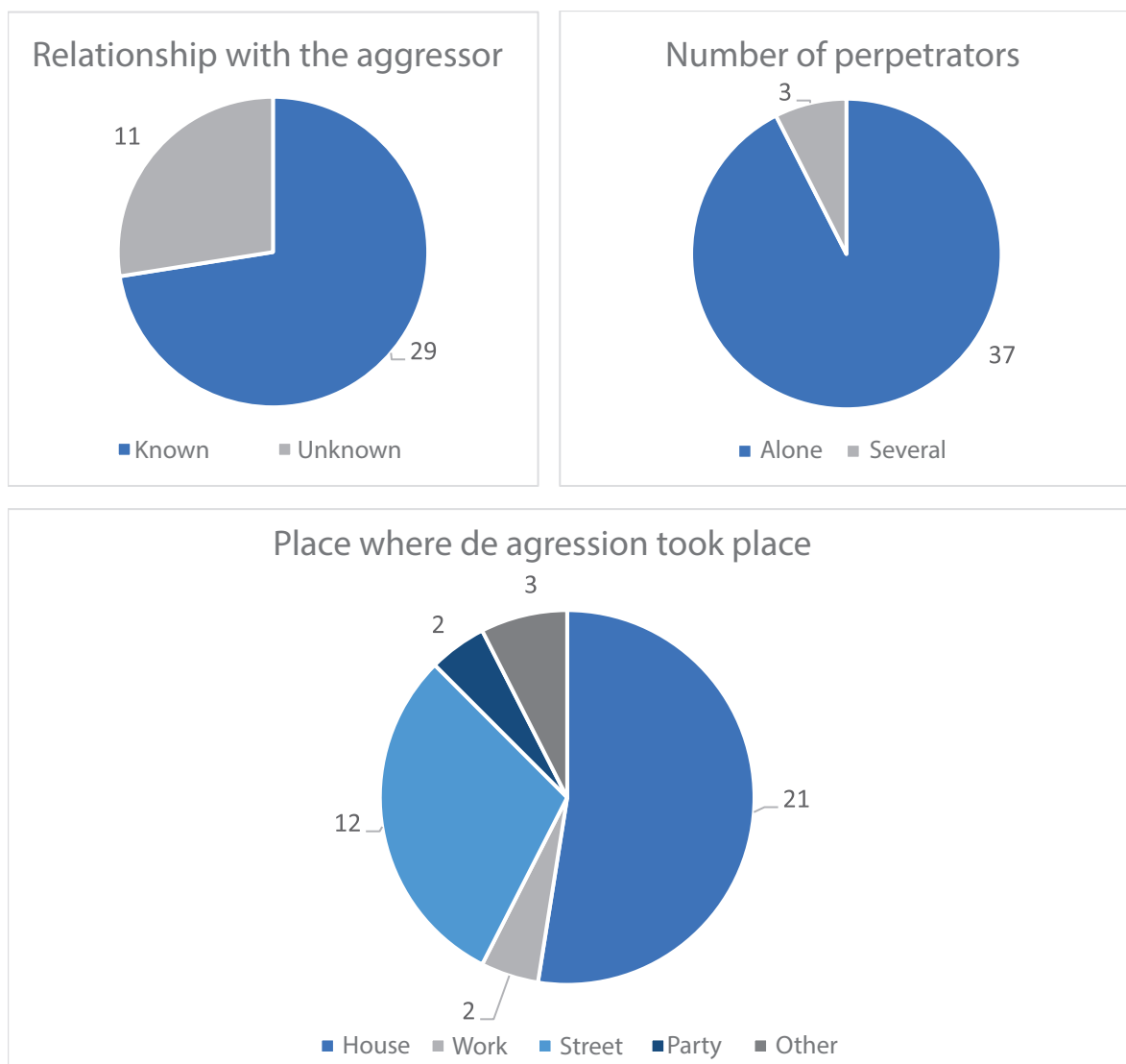
and 2 patients came from Lima and Chancay, respectively. In terms of nationality, the majority were Peruvian (92.5%) and 3 were foreigners (2 Venezuelan and 1 Colombian).

Regarding sexual violence, 72.5% of the victims knew their aggressor and in 92.5% it was a single aggressor. It was observed that most of the victims under 18 years of age were known aggressors, compared to those over 18 years of age. When the place where the violent events occurred was evaluated, 52.5% of the cases were in the victim's or aggressor's home and 30% in the street; the remaining 17.5% were in other places such as a party and at work (Figure 2).

When evaluating the characteristics related to care, only 17.5% of the victims attended with-

in the first 72 hours after the violent event occurred, of which only 2 of the 28 users under 18 years of age (7%) and 4 of 12 users over 18 years of age (17%) attended within the first 72 hours. When reviewing the administration of the complete violence kit (which includes rapid tests for HIV, syphilis, hepatitis B and chorionic gonadotropin, as well as treatment for sexually transmitted infections including HIV and to prevent unwanted pregnancy), it was received by 17.5% of the total number of patients (Figure 3); it was more frequent in patients over 18 years of age. Most of the victims received a partial kit (rapid tests for HIV/ syphilis, hepatitis B and in some cases human chorionic gonadotropin). When reviewing the diagnosis with which the patient was admitted, 45% of the victims were admitted for obstetric diagnosis (pregnancy or abortion),

FIGURE 2. DISTRIBUTION OF VICTIMS OF SEXUAL VIOLENCE ACCORDING TO CHARACTERISTICS RELATED TO SEXUAL VIOLENCE.





32.5% for sexual violence as such and 22.5% for other causes, such as suicidal gesture among others. In 45% of the cases attended, pregnancy was the result of sexual violence. When evaluating the presence of sexually transmitted infections, 5 patients had them and in all cases the patients attended after 72 hours (HIV, syphilis, chlamydia, trichomoniasis). All patients received care from a multidisciplinary team (medical, mental, social). In terms of mental health, 60% of the patients also had a psychological/psychiatric diagnosis.

When we evaluated access to justice, 37.5% of the patients came after having filed a complaint and undergone an evaluation by Forensic Medicine. In 57% of the cases the Violet Code was activated in the HNDAC (communication with external institutions such as the Public Prosecutor's Office, Legal Medicine, Women's Emergency Center, among others), of which only 7.5% of the cases indicated that they required evaluation by Legal Medicine to collect evidence because they were within the first 72 hours.

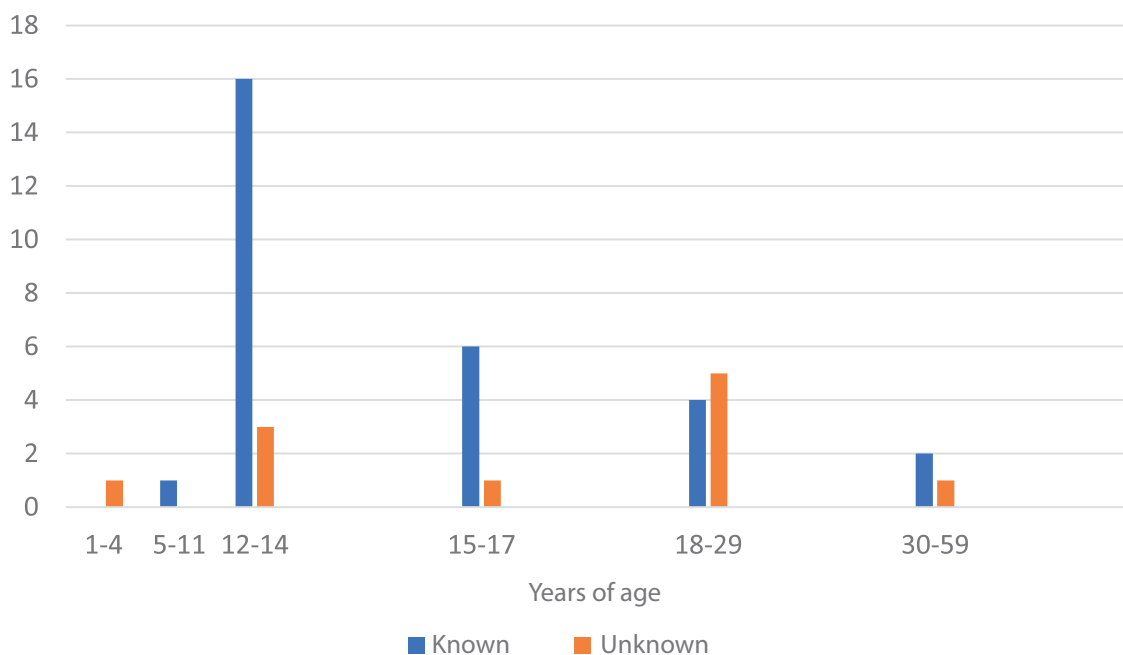
DISCUSSION

Sexual violence is a public health problem, not only because of its prevalence but also because of the serious consequences that it generates

in the affected person, such as psychological and behavioral problems, depression, alcohol abuse, anxiety and suicidal behavior, reproductive health problems -such as sexually transmitted diseases, unwanted pregnancies and sexual dysfunction-, as well as the major complications that it generates in their environment⁽¹⁶⁾. The demand for action against sexual violence has been increasing thanks to the greater recognition of rights, including sexual and reproductive health rights, generating records mainly on the side of the institutions involved in the administration of justice⁽¹⁷⁾. However, most of the data that have been collected on different forms of sexual violence are based on population surveys (demographic and health surveys, reproductive health surveys⁽¹⁸⁾), which show the existence of a large underreporting when comparing the number of people who report having suffered sexual violence with those who have made some kind of complaint or who have accessed health care for this reason.

Since 2019, MINSA has implemented the administration of sexual violence kits in health centers, and since 2020 it has been disseminating the Technical Standard for the care of victims of sexual violence, which commits health centers at all levels of care to provide timely and multidisciplinary care to victims of sexual violence.

FIGURE 3. RELATIONSHIP OF VICTIMS TO THE PERPETRATOR BY AGE GROUP.





From a sociodemographic point of view, all the victims attended to at HNDAC were women. According to INEI, of 5,093 cases registered from January to June 2023, 94.5% comprised women⁽⁵⁾. This corresponds with international figures, such as in a sexual assault referral center (SARC) in London where 93% of the cases were women⁽¹⁹⁾, the study by Ingemann-Hansen et al. in Denmark where 97% were women⁽²⁰⁾ and the study by Agustí et al. in Guatemala in 2011 where 86% of the cases of sexual violence were women⁽²¹⁾.

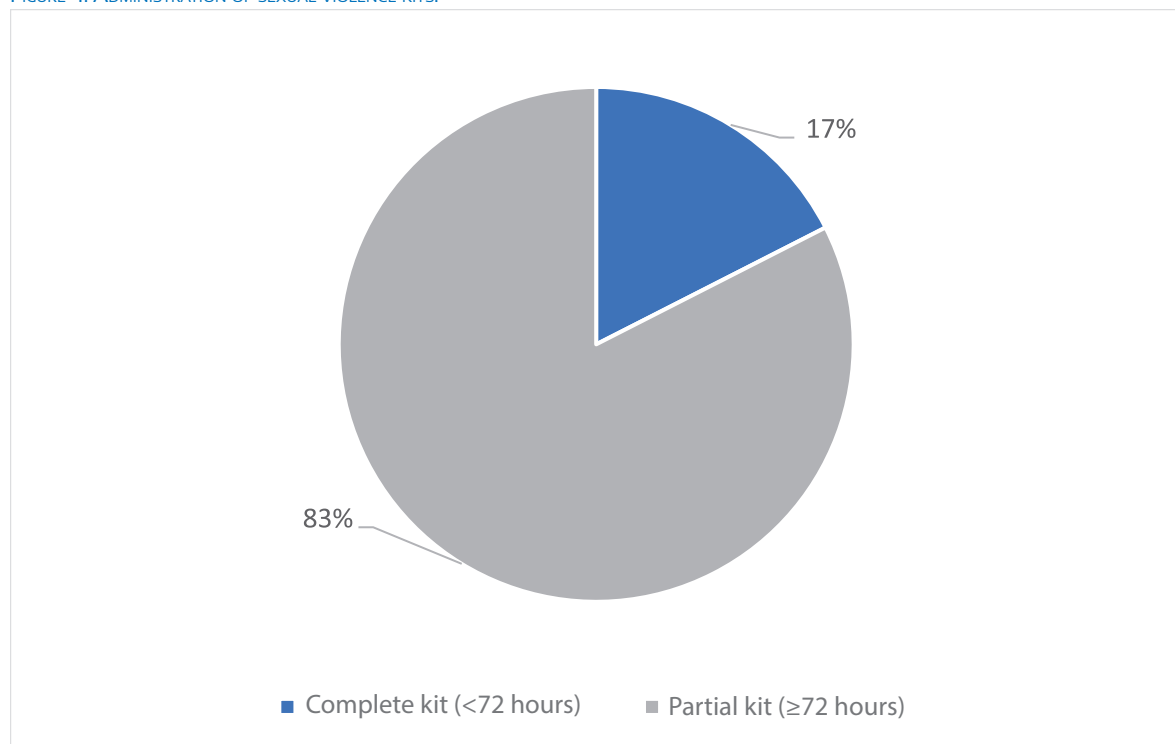
The absence of cases of men in situations of sexual aggression could be related to social stereotypes, myths, and prejudices where silence makes this problem invisible and makes it very difficult for them to file a complaint. Studies such as Krugman's showed a slight increase in the number of cases of sexually abused males in the 1980s⁽²²⁾. This fact is currently evidenced in neighboring countries such as Colombia through the statistics of attention of the National Institute of Legal Medicine and Forensic Sciences, where it is observed how between 2013 and 2016 complaints by the male gender increased⁽²³⁾. The study conducted in Guatemala also showed that 14% of males were treated for sexual violence⁽²¹⁾.

The finding that most victims were adolescents and young adults corresponds with international studies^(2,20,22,24-26), and mostly students, which also coincides with results found in multiple studies^(2,20,22,24,27).

When evaluating the variables related to sexual violence, we observed that 72.5% of the victims knew their aggressors, mostly adolescents, as shown in Figure 3, in contrast to the adult victims who showed more aggressions by unknown subjects. This coincides with the results obtained in a care center for victims of sexual violence in Campinas, Brazil⁽²⁾, and in the child and adolescent population as mentioned in a study in Colombia, where 37% of victims were between 10 and 14 years old and were assaulted mostly by an acquaintance⁽²⁸⁾. We can add as additional data that the adolescents assisted come from disintegrated homes, with dysfunctional family dynamics, mostly single parent under the care of the mother.

Regarding the place where the events occurred, more than half (22 cases) occurred in the victim's or the aggressor's home. When correlated with the age group, we observe that it is higher in girls and adolescents where the aggressors are generally known by the victims and in their

FIGURE 4. ADMINISTRATION OF SEXUAL VIOLENCE KITS.





close environment⁽¹⁸⁾. These data are similar in Latin America and the Caribbean⁽²⁷⁾. In older age groups (over 18 years of age), it can be observed that the incidents occur more frequently in the street and at work, similar to national and international statistics.

In Peru, the minimum age of sexual consent is 14 years⁽²⁹⁾; sexual relations with minors under 14 years of age are classified as sexual violence and are punishable (Art. 173 of the Penal Code)⁽³⁰⁾. Therefore, a girl or adolescent with obstetric pathology should be presumed to be the result of sexual violence. For this reason, comprehensive sexual violence care has been provided to all patients under 14 years of age who attended the HNDAC for obstetric pathology, with a total of 11 cases, 82% of which were third trimester pregnancies. Of this group of patients, only 2 came with a previous complaint and Code Violet had to be activated in 9 cases. These cases were reported at the first contact with the patient both in the emergency gynecology-obstetrics department and in the obstetrics office by the health personnel.

When reviewing the variables associated with care, only 17.5% attended within 72 hours of the occurrence of sexual violence. Therefore, the same percentage received a complete emergency kit for victims of sexual violence, most of whom were over 18 years of age. This figure is lower in comparison with neighboring countries such as Brazil, which have had these programs for victims of sexual violence in place for more than 20 years, as shown in the study by Oliveira et al. in 2013, where 87% of victims of sexual violence over 12 years of age attended before the first 72 hours to receive care⁽²³⁾. In Denmark, 85% of victims aged 12 or older attended within 72 hours for care⁽²⁰⁾. Similarly, in Guatemala, in a 2011 study, after 4 years of implementing comprehensive care for victims of sexual violence, 34% of patients attended within 72 hours⁽²¹⁾.

As for sexually transmitted infections, 5 cases were detected during victim care (12.5%). In the study by Hagemann et al. in 412 victims, they found an incidence of 8.5% of cases of sexually transmitted infections⁽³¹⁾. It is important to consider that 2 of the victims, both 13 years old, had STIs, one of them with advanced HIV, which shows the risk to which children and adolescents are exposed.

An important fact that should be mentioned is the patient's admission diagnosis. Specifically, 32% of patients are admitted for sexual violence, 45% for obstetric diagnoses and 22% for suicide attempts. It is necessary to highlight the effort and training of the multidisciplinary teams to detect sexual violence in these patients.

One of the limitations of the present study is that being a new project with no specific budget, there is no staff dedicated to this work, which makes it difficult to follow up the cases.

CONCLUSIONS

During 2022, 40 patients were treated as victims of sexual violence, all of them female, mostly adolescents. Most of the victims knew their aggressor and these aggressions occurred mostly in the victim's or aggressor's home. Only 17.5% of the victims attended within 72 hours for care and administration of the sexual violence kit.

Adequate knowledge of the victims, the violent events and the care provided during 2022 helps us to improve our care for victims of sexual violence.

As expectations, we hope that after this first year, with trained and committed health personnel, we will be able to increase the dissemination of the care provided by the Violeta program, as well as greater coordination with other institutions to shorten times and provide timely care, with humanized treatment, always focusing on the victim.

May the information that originates in this space serve to continue generating knowledge and research to identify good practices in the care of victims of sexual violence, which can improve our care and in turn be replicated in other hospitals in the country with similar characteristics.

It is necessary to have resources to strengthen the comprehensive and individualized treatment plan for victims of sexual violence, with permanent staff, as well as to follow up on the victims until they recover and reintegrate into society.

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