

Sexual violence against women in Brazil: achievements and challenges of the health sector in the 2000s

Violência sexual contra mulheres no Brasil: conquistas e desafios do setor saúde na década de 2000

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Abstract

The article brings a revision on the public politics for the confronting of the sexual violence against women developed along the decade of 2000s. It analyzes the collision on the progress, retreats and challenges of the theme to the light of the propositions of the section health. Institutional documents and articles were analyzed selected on the subject, pointing varied strategies for intervention proposed and accomplished by the Brazilian National Health System. The text still presents emblematic questions that send us to think on the challenges to be overcome by the managers of health in the current decade, such as the covering and continuity of the services of attention, the professionals' permanent training, as well as the service to the legal abortion.

Keywords: Public Health; Integral Care; Sexual Violence; Woman.

Resumo

O artigo traz uma revisão sobre as políticas públicas para o enfrentamento da violência sexual contra mulheres desenvolvidas ao longo da década de 2000. Analisa o embate sobre os avanços, retrocessos e desafios do tema à luz das proposições do setor saúde. Foram analisados documentos institucionais e artigos selecionados sobre o assunto, apontando variadas estratégias para intervenções propostas e realizadas pelo Sistema Único de Saúde. O texto apresenta ainda questões emblemáticas que nos fazem refletir sobre os desafios a serem superados pelos gestores de saúde na década atual, tais como a cobertura e continuidade dos serviços de atenção e capacitação permanente dos profissionais, bem como o atendimento para a interrupção da gravidez, prevista em lei.

Palavras-chave: Saúde Pública; Atenção Integral; Violência Sexual; Mulher.

Introduction

The trivialization of sexual violence against women has been denounced by feminist movements and Brazilian academics for almost thirty years (Grossi et al., 2006). Sexual violence “[...] is the most democratic of social phenomena” (Strey, 2001, p. 48), as it can be a trans-generational situation, that is, women from the same family or community can experience it over many generations.

The discussion of the woman as victim or accomplice in violence suffered in public or private spaces refers to the socio-cultural and historic context of gender in Brazil, in which women are educated to accept various forms of dominance and, sometimes, to naturalize the discrimination to which they are exposed (Saffioti, 1999; Abramo, 2004; Almeida, 2007).

Violence is not always the first priority on the health sector agenda, either in technical discussions or in implementing policies. From the 1990s onwards, with changes in the epidemiological situation in various countries, external causes of morbi-mortality came to be highlighted and the phenomenon of violence gained visibility; in 1993, the World Health Organization (WHO) recognized violence as a public health problem (Minayo and Souza, 1993).

The World Report on Violence and Health (WHO, 2002) recognized sexual violence and conceptualized it to cover its many forms, defining it as:

[...] any sexual act, attempt to obtain a 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 their relationship to the victim, in any setting, including but not limited to home and work (p. 148).

The description according to the Brazilian Ministry of Health (MH) (Brasil, 2012a), based on Law 12.015, of 2009, that altered the Brazilian Penal Code, details the procedural conditions that modulate such violence, obliging an individual to maintain sexual, physical or verbal contact or to participate in other sexual relations through the use of force, intimidation, coercion, blackmail, bribery, manipulation, threats or any other mechanism that nullifies or limits personal will. Sexual violence

also includes the aggressor obliging the victim to participate in any of these acts with third parties.

Sexually violent acts can occur in different circumstances and situations, affecting both sexes, although women of all ages are the biggest victims. This form of violence may have consequences ranging from sexually transmitted diseases, AIDS, and unwanted pregnancy to unsafe abortion, from psychological and psychiatric disorders to suicide (Brasil, 2005a; Faúndes et al., 2006).

Regarding the scale of the violence, the WHO (2002) stated that 10% of the world population (male and female) had suffered from some type of sexual violence at some time in their lives, of whom only 2% had sought health care services. Qualified preliminary data from the VIVA-Sinan-Net¹ (Brasil, 2009) indicate that, in mid-2010, sexual violence accounted 44.9% of the total of 2,825 recorded cases of girls aged 0 to 9 years old; 54% of the 2,690 cases among young girls and adolescents between 10 and 14 years old; 24.5% of the 1,351 records in the 15 to 19-year-old age group; 9.2% of the 2,089 cases among women aged 20 to 59; and 4.9% of the 79 records for women aged 60 and over.

The legal, technical and public policy responses related to sexual violence that have been developed over the last decade have resulted in the collective involvement and effort of civil society, government and professionals from a variety of sectors, such as health, public safety, the law, social care and human rights.

The topic of violence against women has made its presence felt in Brazilian public health care policy since the 1980s. The Integrated Women's Health Care Program (Paism) (Brasil, 1984), formed in partnership with the women's movement, the main focus of which was sexual rights and family planning. For Correa (1993), who evaluated the first ten years of Paism, the challenges faces reflected the difficulty with which the State was faced by society's conservatism and the impositions of the Catholic Church. Osis (1998), reflecting on the perspective

of the feminist movement, recognized how Brazil was pioneering in its position on women's sexual and reproductive rights, even before international discussion of the topic began.

The right to a life free from violence is also explained in the Universal declaration of Human Rights (ONU, 1948) and in international documents on women's rights: the Declaration of Cairo (ONU, 1994), Beijing (ONU, 1995), Convention of Belém do Pará (OEA, 1994), texts in which dealing with violence against women is repeatedly recommended in all countries. Brazil is a signatory to all international agreements repudiating violence against women, although the reality is contradictory, and even though the problem is underreported, the records that do exist show that it still so widespread as to constitute a public safety problems, as it is a crime and public health is affected as it affects individuals' mental and physical integrity, as well as compromising both families' and communities' capacity to develop.

In this article, we aim to analyze and reflect on the main public policies and actions produced or instituted in the Brazilian public health sector throughout the 2000s that contributed to dealing with sexual violence against women in Brazil, considering the advances made and the difficulties faced.

Methodology

This study consists of documental research (Gil, 2008). The difference between bibliographic and documental research lies in the nature of their sources. In the former, access can be increased, include analysis by the authors, thus enabling a meta-analysis of the reflections produced, often from the scientific area. Documental research, on the other hand, depends on active searching, on knowledge of the topic and sieving the data to select it, constituting material still to be interpreted (Oliveira, 2007).

The distinction also lies in the definition of what constitutes a document, as documental research

¹ The Violence and Accident Monitoring System (VIVA) was instituted by Ordinance GM/MS nº 1,356 of 23/06/2006 in 2011 it was incorporated into the Health Problem Notification System by Ordinance GM/MS nº 104, of 25/01/2011. Data from records from the Individual Notification/Investigation of Domestic, Sexual and other Violence are fed into the VIVA Sinan Net System and can be accesses at: <<http://dtr2004.saude.gov.br/sinanweb/>>.

deals with any sources that provide data on facts or human behavior. Thus, in addition to written sources, other material is also included, such as videos, films, photos etc. (Sá-Silva et al., 2009). In this reasoning, we can qualify the support of the recorded data, organizing a unit to serve for consultations, studies or structured elements recognized as documents (Appolinário, 2009).

We highlight three investigative questions with which to guide this study: what care was recommended to women in situations of violence in the ambit of the SUS in the 2000s? What advances have been made and what setbacks observed? What benefits have been instituted in Brazilian states and municipalities?

The analysis archive was made up of national health care policies, action plans and management reports dealing with the topic of sexual violence against women in the period 2000 to 2010. The main documents chosen to be analyzed were: the National Integrated Women's Health Care Program (Brasil, 2004a) and the National Plan of Women's Policies (Brasil, 2003b); Technical Norm for the Prevention and Treatment of Health Problems Resulting from Sexual Violence against Women and Adolescents (Brasil, 2005a, 2012a); Emergency Contraception (Brasil, 2005c); Humanized Abortion Care (Brasil, 2005b); Legal Aspects of Sexual Violence Care (Brasil, 2005d); Ordinance GM/MS 1.508 (Brasil, 2005e); National Agreement to Tackle Violence against Women (Brasil, 2007b); managerial technical reports produced by the Brazilian Ministry of Health; Management Report 2003 to 2006: National Policy of Integrated Health Care for Women, from the Technical Area of Women's Health (Brasil, 2007c); Integrated Plan for Tackling the Feminization of the AIDS Epidemic and other Sexually Transmitted Diseases (Brasil, 2007b); More Health Report (Brasil, 2008); federal laws, decrees and other MH ordinances and various reports from the Women's Policies Secretariat from 2005, 2006, 2008 and 2009; and the Report from the Tribunal of Federal Audits (Brasil, 2012b) portraying the implementation of the II National Plan of Women's Policies and notes actions in the area of public health.

The documents were catalogued by date and institutional author, with a total of 37 texts. Each

was categorized individually according to topics. National policies were read, searching for details on the topic of sexual violence against women and related directives or priorities were selected. The technical and management reports were organized based on the results presented, classified according to specific topic and categorized as "legal advances", "organizational advances", "technical advances", "limited results - inertia" and "non-execution of proposed actions". The material was dealt with following a script analyzing the context of their production, characteristics of the authors, nature of the text and their key concepts and logic (Sá-Silva et al., 2009; Cellard, 2008).

Conduction of the articles' texts was primarily of a descriptive character in order to map the proposals onto a time line. On a secondary level, critical analysis was carried out, presenting interpretative inferences constructed based on hermeneutic exercise and dialogue with the literature on the topic (Macedo, 2000).

Results and discussion

Throughout the 2000s, the policies drawn up, the legal changes and the plans developed focusing on sexual violence were undeniably positive in the area of legislation and launched directives for the future. They represented possibilities for expansion and institutionalization, constructed in previous decades, especially with the participation of feminist movements. They remain little recognized by society and within institutional environments (Villela and Lago, 2007). In the period analyzed, the intensity with which legislation on the topic was produced is noteworthy, reflecting a broader spectrum of national and international political commitments.

The National Policy to Reduce Morbi-mortality from Accidents and Violence (PNRMAV) (Brasil, 2002) inaugurated the 2000s, finally placing the topic of violence on the Brazilian public health policy agenda (Minayo and Souza, 2003). At that time, the PNRMAV did not directly prioritize vulnerable segments of the population, and violence against women was mentioned only briefly.

Between 2000 and 2003, the MH Women's Health Coordinator had a working group dealing with the

topic of violence and the National Health Council acted on the topic through the Inter-sectoral Women's Health Commission (Cismu). This commission monitored the drawing up of the directives for the National Policy of Integrated Health Care for Women (Brasil, 2004a), and continues to monitor the implementation of its directives as a deliberative body. Cismu is made up of members from civil society and federal government and favors topical discussions in pursuit of compliance with legal provisions for women's right to health in this country.

The decade began with ministerial recognition of violence as a public health problem (Brasil, 2002) and the institutionalization of the technical area of women's health into the MH organizational chart.

The 2002 Presidential elections encouraged broad technical and social discussions on the topic of violence against women. In this period, the debate by the Inter-professional Forum for Sexual Violence Care and Legal Abortion stands out. In the previous decade, it supported care strategies for women in situations of violence and legal issues. The forum is a space for technical-operational discussions involving academia, the Brazilian Federation of Gynecology and Obstetrics, women's movements, international organizations, non-governmental organizations, the Ministry of Health and state and municipal Health Secretariats, among others.

The president who came to power in 2003 publicly highlighted commitment, with the guideline of human rights, and created the Special Women's Policies Secretariat (SEPM), a relevant framework for promoting gender policies in this country. In the same year, the I National Conference on Women's Policies (I CNPM), took place, and emphatically recommended the government to discuss policies aimed at tackling sexual violence. Also in 2003, the National Plan for Women's Policies was launched, establishing directives, priorities and goals for women's health and sexual and reproductive rights; tackling violence against women; and organizing services, among other topics. The support of the President and the prioritization of SEPM demands led work conducted between 2003 and 2007. At the end of 2005, surprisingly, a report on activities concerning advances made in this short period was made available, showing the president's political

support. The report made technicians and academics reflect on policies and issues that had so far blocked the evolution of actions.

During the 2000s, the MH proved to be an important ally in supporting the National Plan for Women's Policies (Brasil, 2003b), developing technical norms and ordinances and discussing the implementation of care services for women in situations of sexual violence, as well as developing and including the Violence Notification Form (Brasil, 2004b) in SUS databases. Between 2003 and 2007, the Inter-professional Forum for Sexual Violence Care and Legal Abortion (Febrasgo) and the women's movement consolidated themselves as partners and Ministry of Health critics. The main criticism was (and continues to be) the ambiguity of the Brazilian State with regards its lay character and faced with religious pressure on women's sexual and reproductive rights (Adesse e Monteiro, 2007; Villela and Lago, 2007; Galli e Sydow, 2009; Menezes and Aquino, 2009; Drezett and Pedroso, 2012).

In 2004, the MH published the National Policy of Integrated Health Care for Women (Pnaism) (Brasil, 2004a), incorporating gender focus on men's and women's sexual and reproductive rights. This policy, which emphasizes dealing with domestic and sexual violence against women, began a technical and financial support program for state and municipal Health Secretariats.

At this time, the PNAISM was the only health policy that prioritized, in writing, the topic of sexual violence against women and adolescents, in articulation with other Ministry of Health areas, women's movements, FEBRASGO and the specialists from the Inter-professional Forum it supported normalizing and widening Unified Health Service care services for female victims of sexual violence. In the face of internal resistance from within the SUS itself, treating women in situations of sexual violence or legally permitted abortions gained greater visibility, through the actions and direct pressure of professionals with raised awareness (OMS, 2004).

Articulating the I National Plan for Women's Policies with the PNAISM and other ministerial plans was a process of institutionalizing actions of the Brazilian State, providing visibility in the context of gender inequalities and making actions to enforce

constitutional rights, including dealing with sexual violence against women, a priority.

During this same period, significant changes were also made on the topic of sexual violence. Laws 11.106/2005 and 12.015/2009 of the 1940 Brazilian Penal Code were altered, changing the concept of sexual violence to include both sexes and characterized as physical, psychological or threats, including rape, attempted rape, seduction and indecent assault, with or without carnal intercourse.

In the second half of the decade, in Brazil, institutional mechanisms to deal with sexual violence expanded. The Ministry of Justice, together with the Special Women's Policies Secretariat, increased the number of Specialized Women's Police Stations, while the Ministry of Health, in partnership with the Health Secretariats, increased health care. However, in addition to the coverage provided being insufficient to meet the needs of the national territory, this expansion was concentrated in state capitals and metropolitan regions (Cemicamp, 2006; Brasil, 2005b).

The re-issuing of the Technical Norm for the Prevention and Treatment of Health Problems Resulting from Sexual Violence against Women and Adolescents (Brasil, 2005a) consolidated the strategy of integrated health care for women and adolescents, a representative expression of the maturing of care services when dealing with sexual violence that began in the 1980s, and advances by the STD/AIDS program. The updated 2005 version corrected a significant institutional mistake from the original version, from 1998, enforcing the woman's right to care without having to present a police report in cases of pregnancy resulting from rape, a document which had never been necessary, as established in Art. 128 of the 1940 Brazilian Penal Code.

The Technical Area of Women's Health introduced the concept of forming Integrated Care Networks for Women and Adolescents in Situations of Violence, developed in a pedagogical matrix (Brasil, 2006). This matrix was pioneering in its guidelines and in organizing inter-sectoral care networks for States and municipalities. However, the document

was not well disseminated by the MH and was not widely integrated in the Health secretariats.

Also in 2005, Emergency Contraception (EC) and the Technical Norm for Humanized Abortion Care were launched as documents to demystify care approaches and processes in the services. A new and intense movement to raise awareness in health care professionals took place to introduce EC as routine and obligatory in caring for cases of sexual violence. The medication was received with reluctance and, in some cases, the batches of EC sent to municipalities were rejected and sent back to the Ministry of Health. Municipal laws prohibiting the use of EC were passed, without clarity as to the true function of the substance.

During this decade, the state of São Paulo was that with the highest number of municipal laws concerning the prohibition of emergency contraception, followed by Paraná, Santa Catarina, Goiás, Rondônia and Mato Grosso do Sul, where the same legal mistakes were also made. In some places, the laws were found to be unconstitutional, and revoked by State Tribunals; in others, the legal wrangling is still in progress (Comissão de Cidadania e Reprodução, 2012)².

Legal projects were shelved and in some places discussion of the topic remains heated (Pirassununga/SP, Jundiaí/SP, São José dos Campos/SP, Jacareí/SP, Porto Velho/RO, São José do Rio Preto/SP, Maringá/PR, Londrina/PR, Joinville/SC, Vargem Grande/SP, Campo Grande/MS, Cachoeira Paulista/SP, Jundiaí/SP, Ilhabela/SP and Pindamonhangaba/SP). This subject led to legal initiatives from the Ministry of Health, state governors, state Public Ministries and civil society organization in order to guarantee women's rights in Brazil as informed by the Citizenship and Reproduction Commission.

The publication of Ordinance GM/MS of nº. 1.508/2005, dealing with Justifying and Authorizing the Termination of Pregnancy in legally permitted cases within the SUS was another significant advance in defending women's rights. This ordinance has still not been fully implemented in the SUS. Health care professionals argue conscientious ob-

² The documents can be accessed on the Comissão de Cidadania e Reprodução website. Available: <<http://www.ccr.org.br/biblioteca-documentos.asp>>. Acesso em: 17 jun. 2014.

jection, the exclusive prerogative of doctors in their professional ethics, meaning the procedure cannot become routine care, which would avoid abortions and the deaths of many women. In the case of legally permitted abortion, the role of the health care professionals is confused with personal and religious convictions, so that the express wish of the woman who was raped are not the main focus of care.

The health sector needs to organize and provide the location of services for those seeking information about where to find help in cases of violence. However, during this decade, there was no form of registration or supervision, apart from small-scale, specific projects for local observations. The expansion of the number of services without financial stimulus and with little supervision from the Health secretariats have not been institutionalized.

In 2007, the Integrated Plan for Tackling the Feminization of the AIDS Epidemic and other Sexually Transmitted Diseases, drawn up by the MH and the SPM was launched. This action plan interfaced with issues related to sexual violence and sexually transmitted diseases. The initial development was representative, with movements discussing its implementation in the States and it received the support of women's groups. Unfortunately, its implementation was criticized in some States, and it failed to receive the necessary support. Structural difficulties and little governmental involvement hampered the strategy and its proposals.

The period between 2005 and 2009 can be identified as one of the major clashes in the field of tackling sexual violence against women. The guidelines for legally permitted abortions caused dissatisfaction in the more conservative sectors of society, which accused the Ministry of Health of working to legalize abortion. In 2007, the MH's position was exemplary, places as it was, in the position of a federal manager guiding the system in complying with the laws in force and explaining women's rights to the population. The Supreme Court audience, in 2008, in which the ministry and experts argued for anencephalic abortion, was representative and strengthened a positive decision.

Brazilian society has been arguing about the controversial topic of abortion for decades, without looking at the reasons and inequalities that lead women to it, without an in-depth look at the phenomenon in this country or counting the number of women who die each year as the result of unsafe abortion (Brasil, 2005a; Galli e Sydow, 2009). According to the Pnaism Management Report (Brasil, 2007c), at the beginning of the 2000s, in the SUS there were 82 services to care for sexual violence, climbing to 131 at the end of 2006. Of these services, 69 establishments performed legally permitted abortions. By the end of 2010, there were 552 services to care for sexual violence and the number that carried out legally permitted abortions had fallen to 60 according to the SISFACTO reports. This change in the number of hospital services performing legally recognized abortion may contribute to the increase in unsafe abortions and direct causes of maternal death (Souza and Adesse, 2005).

Between 2007 and 2008 there were positive changes in the country with regards training, workshops and increased access to public health care services for women suffering sexual violence, reflected in the increased number of cases dealt with recorded by SUS information systems. Even with difficulties in financial execution, some states managed to advance in strategies and internalize services. A relevant and negative issue is that of the stagnation that occurred in certain Brazilian state capitals as, even with federal support, there was no growth in care lines for female victims of sexual violence. Of all the States, by the end of the decade, five had made no expansion to municipal networks or made any use of the resources aimed at complying with the national goal³.

Research conducted by the Center for Women's Health Studies, Universidade de Campinas (Cemcamp, 2006) confirmed inadequate service coverage and dependence on the willingness of the hospital manager in order for care for situations of violence to be provided and that state and municipal Health secretariats have not yet made the issue a priority as one of the strategies or day-to-day actions. It also

3 Gescon Agreement Reports for 2007, 2008, 2009 by state. Available: www.fns.gov.br.

verified that the Ministry of Health technical norms were not widely disseminated and that many professionals reported refusing to care for cases due to lack of knowledge of legislation and women's rights.

Of the advances made in this period in tackling sexual violence against women, investments made in health information also stand out. Law 10.778 (Brasil, 2003a) established compulsory notification of violence against women and required the MH to develop an instrument to collect and systematize information. Decree 5,099/2004 required the Ministry of health to establish a compulsory service reporting violence against women. Also in 2004, Ordinance nº. 2,406 was published, establishing the Compulsory Notification of Violence against Women. Later, the VIVA SINAN System started to record all cases of accidents and violence cared for in the SUS, and qualified the information produced, detailing the type of violence suffered and possible perpetrator. In 2006 this broadened to include producing specific reports. The usual resistance to reporting violence was encountered, in a national sample, the VIVA showed that sexual violence represented 22% of cases of violence dealt with by the SUS (Brasil, 2009) and, therefore, that the capacity to offer integrated care was in urgent need of expansion and of sustainability mechanisms.

Agreements for tackling violence

The II National Conference on Women's Policies, conducted by the Special Women's Policies Secretariat and partner ministries in 2006, presented an assessment of the results of the first national plan. In 2007, the government launched the National Agreement to Tackle Violence against Women.

The agreement (Brasil, 2007a), signed by federal and state government, sets out responsibilities and financial execution, laying out the actions to be taken, goals to be achieved, strategies and monitoring and control to verify results. In this agreement, it fell to the Ministry of Health to empower SUS services and train health care professionals in dealing with women, in sexual and reproductive rights and in implementing the Integrated Plan for Tackling the Feminization of the AIDS Epidemic, with emphasis on increasing provision of non-permanent contra-

ceptive methods, including emergency contraception and the difficulty of establishing technical norms, protocols and care flows in the health care services to deal with women in situations of sexual violence.

The efforts of the Women's Policies Secretariat, now with ministerial status, was an advance in the management area, and deserves to be recognized. However, resistance on the part of state government in agreeing priorities for dealing with violence against women shows how difficult it is to establish policies proposing cultural, attitude and behavioral changes. Only in 2011, at the start of a new decade, did São Paulo agree to take part, becoming the last State to adhere to the agreement.

At the end of the decade, after extensive discussion on the direction the Unified Health System was to take, its management and operationalization lines and increased sustainability, the MH, National Councils of State and Municipal Health Secretariats produced a new proposal, the Management and Life Agreement (Brasil, 2008). In this agreement, integrated care for women in situations of violence, now part of the area of health, came to be a set of links available to receive and provide psycho-social follow-up. In practice, it would be the junction of various initiatives existing in a particular territory, providing complementary conditions to resolve the problem and avoid re-victimizing the women, as still happens.

At the end of the 2000s, with the expected re-organization of public health in Brazil, the MH discussed a document establishing directives to provide SUS health care networks. It was another attempt at the long awaited institutionalization of dealing with violence against women, as networks caring for sexual and domestic violence had already been set up for more than a decade and are still waiting to take effect.

Discussion: balance of impasses and breakthroughs

Advances have been observed, such as the expansion of care services which, compared with the start of the decade, have undeniably increased. The precariousness of provision observed in the early

years of the decade was denounced by academics (Andrade et al., 2001), and it was proposed that university hospitals be included in order to expand and qualify the network (Mattar et al., 2007). Coverage in some regions of Brazil is still a problem, the volume of women suffering violence and who do not have access to their rights is representative and the State has still not managed to provide care with the necessary rapidity to the extent needed (Oliveira et al., 2005).

On the topic of normalizing care for women in situations of sexual violence and the need to disseminate this strategy as a form of preventing health problems stemming from sexual violence, Faúndes et al. (2006), Oliveira (2009) and Drezett and Pedroso (2012) are unanimous in emphasizing the importance of training specialists in this type of care.

During the decade, financing by states and municipalities to organize their services was a point that stood out, as they still do not demonstrate adequate conditions for humanized attendance and qualified listening to women in situations of sexual violence. The changes in institutional culture that would sustain reception and care strategies and comply with legal mechanisms pose a greater challenge, going beyond the technical qualifications of the health care professionals (Cavalcanti et al., 2006; Souza and Adesse, 2005).

Another important development in the decade was the Violence and Accident Monitoring System. The information systems' capabilities need to be further extended to cover issues of gender, race and color as it pertains to violence against women (Okabe and Fonseca, 2009).

Inter-sectoriality was the exercise trialed in this decade. The topic of sexual violence against women was the focus of technical discussions, work plans and investment in different public sectors.

During the period in question, a variety of process of professional qualification and training were set in motion. According to the National Policy of Integrated Health Care for Women's Management Report 2003-2006, (Brasil, 2007c), 8,350 health care professionals benefitted from courses, workshops and awareness raising. In the following years, these numbers were described in Management and Life Agreement Reports and Sispecto Reports for 2008

and 2009, with 2,000 professionals trained yearly in applying technical norms for caring for sexual violence in States and municipalities.

The policy of strategic resources in caring for cases of sexual violence, developed by the Ministry of Health Department of STD/AIDS and Women's Health was a referential framework in the advances made in the 2000s. The effort was to increase access to antiretroviral medicines, to monitor patients and perform examinations during immunological window periods (Brasil, 2005b).

In the challenges faced in tackling sexual violence in Brazil during that decade, one cannot ignore the lack of political decision making in overcoming certain obstacles to sustainability and operationalization of services and strategies. The attitudes of management in States and municipalities, and also in the federal ambit, underwent setbacks due to religious influences and the willingness of universities to introduce sexual violence as a topic in health courses changed little (Cemicamp, 2006).

In 2005, the initiative to provide procedures to terminate pregnancies, permitted by law and regulated by the Ministry of Health faced major obstacles during the second half of the decade. Between 2005 and 2008, according to official statistics, there was an increase in the number of hospitals performing this procedure; however, in 2009, there was a significant decrease in the number of procedures recorded (SIH/SUS), the causes of which will be the object of future studies. During the entire decade, abortion was the fourth or fifth most common cause of maternal mortality. Studies show that the majority of deaths resulting from abortion were in women aged under 40, from disadvantaged segments of society, with little education and, in most cases, black (Menezes and Aquino, 2009; Adesse e Monteiro, 2007). These findings confirm the reality invisible to society and highlights the social and health inequalities existing in Brazil in their most critical form, that of preventable death.

It is worth highlighting that, at the end of the 2000s, the networks for tackling sexual violence against women were still fragile in terms of sustainability and collective actions.

Expanding care networks and guaranteed access to services remains at the mercy of local managers,

worried about votes at election times and concerned not to lose the support of the conservative sections of society. A revival of the Brazilian feminist movement is seen as important in the right for integrated care for women suffering from sexual violence, as is work to broaden preventative actions and those recognizing the serious social problem this violence poses.

Social control of public actions on the topic are also a challenge. Villela and Lago (2007) discuss the thesis that the women's movement in defense of tackling violence is dispersed, due to these frameworks migrating to government bodies, meaning that the energy necessary for social mobilization to apply pressure in implementing the policies has been limited.

In the analyses of the implementation of the Integrated Plan for Tackling the Feminization of the AIDS Epidemic and other Sexually Transmitted Diseases (Brasil, 2010), only eight states presented plans that included sexual violence as a priority, showing managers' lack of commitment to the issue.

In the ambit of social control of the PNAISM, it is necessary to discover, observe and monitor the role of management in sexual violence care in municipalities and States. Society can contribute to tackling violence when cases are reported, as well as when faced with neglect and by supporting actions to raise awareness and guide women.

Considering the total number of SUS health care professionals, questions regarding the coverage of qualifications in caring for sexual violence is inevitable. It has been shown to be necessary for the MH, in partnership with state Health Secretariats and higher education institutions, to develop teaching strategies and methodologies capable of committing and preparing health care professionals in the varying levels of complexity in dealing with sexual violence against women in all regions of the country. Sexual violence against women in Brazil remains a cruel reality that needs to be faced, whether through preventative actions, through care, facing it, placing responsibility on the aggressors and following up both victims and aggressors.

The decade ended with inter-sectoral agreements being constructed, revealing a more mature understanding of the forms of dealing with sexual violence in this country. Efforts were made to imple-

ment international agreements and conventions. The Pnaism went through some difficult stages in search of survival. For the new period, there is a collective expectation to maintain the topic of sexual violence as a priority in order to guarantee continuity and advance the processes in development and to establish tackling violence as a Brazilian State police, without losing any of the hard won advances.

Authors' collaboration

Araújo was responsible for collecting and analyzing the data and writing the article. Deslandes collaborated with analysis and revision of the data and writing the article.

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