Sexual violence (encompassing sexual assault [SA], child sexual abuse [CSA], and rape) remains a major public health concern. An estimated 1 in 3 women globally experience physical or sexual intimate partner violence or nonpartner sexual violence during their lifetime. In the US, the Centers for Disease Control and Prevention estimates that 1 in 4 women and 1 in 26 men have experienced a completed or attempted rape in their lifetime. Two articles in JAMA Network Open report on the incidence of CSA and adult SA cases reported to emergency departments (EDs) in Hong Kong and the US, respectively. Wong et al report on incident rates of CSA among youth presenting to EDs in Hong Kong before and during the COVID-19 pandemic. By using medical record data from EDs across Hong Kong, they found that the number of ED visits to report CSA decreased more than 50% during the pandemic. However, the study’s core finding was that the proportion of CSA cases among adolescent girls increased during 2020 to 2021 compared with previous years, using either the overall population or ED visits as the denominator. They also note a significant increase in reporting of CSA and ED visits as schools reopened after approximately 10 months of closure. The authors suggest that the observed increase in CSA cases may be associated with parental economic insecurity, additional stressors related to the pandemic, and shifts in social networks that occurred during the shutdown. The increased incidence rate observed for adolescent girls was not seen among boys. The authors’ analyses accounted for survivors’ sex and did not report on transgender or nonbinary children. As is true for sexual violence prevalence estimates that rely on official reporting, the observed prevalence is likely to be a significant underestimate of actual cases of sexual violence, given the vast number of incidents that are not reported.

Vogt et al studied trends in US ED use after adult SA from 2006 to 2019, before the COVID-19 pandemic, finding a 15-fold increase in ED use during that period. The authors speculated that overall increases in survivor help seeking at EDs may be related to 2 factors: increased recognition and reporting of SA among ED staff and International Classification of Diseases, Tenth Revision coding changes that allow for more specific documentation of SA. They then compared these trends with Federal Bureau of Investigation–reported rapes/SA from 2015 to 2019 and found 7% and 22% increases during that period based on changes in definitions of SA used by law enforcement agencies (LEAs). However, despite an increase in ED use, the authors highlight that even in 2019, far fewer survivors sought ED care compared with those reporting to LEAs. The authors posit that shifts in social norms that occurred after high-profile events, such as the #MeToo movement, and national discourse condemning SA subsequently raised its prominence and encouraged more reporting of exposures to EDs and LEAs about such violence. The growth of the field of forensic nursing has contributed to better documentation, evidence collection, treatment protocols, and connection to support, including survivor service advocates. Thus, EDs have become critically important settings for SA response and tracking trends in SA care seeking. From these ED data, the authors also observed disparities associated with income, race, and hospital admission after an ED visit among SA survivors. For example, Asian or Pacific Islander, Native American, and White patients were more likely to be admitted after presenting with an SA diagnosis. In addition, although fewer individuals were admitted to the hospital over time, older and Medicaid-insured patients were more likely to be admitted, noting contextual factors that contribute to making particular populations vulnerable to more severe forms of violence that require hospital-based care.
Together, these 2 studies underscore several key points. First, sexual violence is prevalent and remains a significant public health concern. Second, support for innovative SA care models, including expansion to outpatient care settings, is urgently needed. Third, pandemic-related stressors are both directly and indirectly associated with increases in the prevalence of sexual violence. Fourth, sexual violence reporting and care seeking are not evenly distributed across populations, and inequities persist. The health consequences of sexual violence are often underrecognized by the health care delivery system among survivors inhabiting multiple marginalized lived experiences at the intersections of sexism, racism, heterosexism, and ableism. Fifth, in addition to strengthening the acute response to sexual assault, greater effort is needed globally to prevent sexual violence.

Although the intervals and focus of these studies differ significantly, both highlight the health care setting as a critical site for connecting survivors to care. Neither of the studies addresses outcomes from ED care, denoting a need for research to assess how prepared health care settings are for addressing the needs of survivors of sexual violence (including children and youth) and quality of care provided. Inequities in post-SA ED care can persist because of clinician bias and mistreatment, particularly among survivors experiencing mental health crises, who are intoxicated, or who identify as Black, Indigenous, or Latinx. However, clinical guidelines and protocols exist for implementing healing-centered approaches to care that support survivor autonomy, increase options for safety, and connect patients to survivor service advocates when desired. In addition to implementing more robust responses to sexual violence in the ED, other health and social service settings should be encouraged to collaborate formally to strengthen the response to sexual violence. For example, as suggested by Vogt et al, trained SA nurse examiners enhance the quality of examinations in ED settings using patient-centered, trauma-informed care models. However, the specialty faces a persistent shortage of professionals, limiting access to quality post-SA care. Current innovations such as the SAFE-T Center use telehealth to address care inequities in rural areas and are gaining traction in legislative as well as clinical settings across the US. Studies about what survivors need and desire in a health care response to sexual violence are needed.

The study from Hong Kong is among several underscoring the extent to which pandemic-related stressors are both directly and indirectly associated with the increased prevalence of sexual violence. These mechanisms include financial instability, social isolation, disruptions to usual sources of support and care, and exposure to exploitation. Survivor service advocates have described creative strategies to deliver care for survivors safely, including assisting with food, housing, and navigating the health care system during a shutdown. What is evident from emerging research on intimate partner and sexual violence during the pandemic is the extent to which this increase could have been anticipated and that future emergency preparedness planning must include attention to prevention of and interventions for violence exposure.

Both studies also highlight that sexual violence is not evenly distributed, drawing attention to sex and age disparities that can be ascribed to social norms, attitudes, and beliefs of society at large as well as existing health vulnerabilities exacerbated in the aftermath of SA. These vulnerabilities should be considered in the context of other marginalization, including sexual and gender identity, ability, and systemic racism. For example, forensic examination techniques and technology bias are potential sources for underrecognized detection and reporting of SA injuries among survivors with dark skin. Stigma and shame associated with sexual violence also contribute to underreporting of SA, especially for boys (as suggested by Wong et al), although reporting trends among adult men may be rising (as documented by Vogt et al). In addition, despite well-documented knowledge that sexual and gender minorities experience some of the highest rates of sexual violence, neither study included analyses of the ED experiences among these populations. Tailored efforts are needed to reach those who may not come to the attention of the health care delivery system or who may be presenting for health consequences of sexual violence that go underrecognized.

In addition to strengthening the acute response to SA, greater effort is needed globally to prevent sexual violence. The increased awareness and reporting of SA noted by Vogt et al is certainly one step in a multilevel response needed for addressing sexual violence. Comprehensive
prevention programs for children and youth that address gender equity, healthy sexuality, and relationship skills need to be combined with larger-scale policy efforts that explicitly address community strengths and resiliency, gender and racial equity, safety, economic justice, and robust support for survivors.

ARTICLE INFORMATION
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REFERENCES