The services for women victims of sexual violence: a qualitatif study

Eleonora Menicucci de Oliveira, Rosana Machin Barbosa, Alexandre Aníbal Valverde M de Moura, Karen von Kossel, Karina Morelli, Luciane Francisca Fernandes Botelho e Maristela Stoianov

Departamento de Medicina Preventiva. Universidade Federal de São Paulo. São Paulo, SP, Brasil

Keywords
Violence. Rape. Sexual harassment. Legal abortion. Women's health services. Battered women.

Abstract

Objective
To assess public services attending female victims of sexual violence in the city of Sao Paulo.
Methods
This is a qualitative study conducted in two public services attending female victims of sexual violence. Interviews with 42 women were conducted, 13 of whom had sought these services for assistance and 29 were professionals working in these services. Evaluation of the services was based on the categories: reception, access, resolvability and sanitary responsibility.
Results
The analysis of the interviews per category has shown that there was reception in both services, problems with respect to access due to the lack of information concerning these services, and quality resolvability with a multi-professional team. As to the sanitary responsibility, it is present in these specialized services but is deficient in the emergency services and basic health care units. Many women are unaware of the rights they are entitled to with respect to specialized services. Frequently their late arrival compromises the efficacy of care. There are deficiencies both in terms of reference and counter reference.
Conclusions
The results ratify the importance of these services and the need for their decentralized expansion. Health courses should introduce the theme of sexual violence at the undergraduate level.

INTRODUCTION

During the past two decades, the issue of violence against women has been recognized by human rights entities as well as international organizations such as WHO (World Health Organization) and PAHO (Pan-American Health Organization) as a public health issue. WHO associates this violence to several physical health disorders, drug and alcohol abuse, gastrointestinal disorders, chronic pelvic inflammations, headaches, asthma, anxiety, depression, psychological disorders, such as suicide attempts, as well as direct physical trauma.[8,10]

Sexual violence reveals the complex context of power which marks social relations between sexes. Sexual violence refers to rape, attempted rape, violent abuse, seduction, obscene acts and harassment, that may occur in conjunction with each other as well as with other types of physical violence (body injury, attempted homicide, abuse and threats).[6]

Violence within gender relations and, specifically, sexual violence may imply in the greater occurrence of several physical, reproductive and mental disorders, and may also result in the more frequent use of health care services by victims.[11] Health services,

Correspondence to:
Eleonora Menicucci de Oliveira
Rua Borges Lagoa, 1341 Vila Clementino
04038-034 São Paulo, SP, Brasil
E-mail: leomenicucci@uol.com.br

Presented at the X Congress on Scientific Initiation - PIBIC/Unifesp, Sao Paulo, 2003.
Financed by the *Fundação de Apoio aos Docentes e Alunos da Unifesp* [Foundation for the Support of Professors and Students of the Federal University of Sao Paulo] (Processo n. 34/2000).
Received on 12/5/2003. Reviewed on 9/9/2004. Approved on 11/9/2004.

above all emergency rooms, are the services most frequently sought by female victims of sexual and domestic violence and have to respond to two dilemmas: on the one hand, perceive/recognize the violence perpetrated against the woman, lending credibility to her complaint and, on the other hand, to break away from the recurrent practice of medicalizing the events observed.

In the majority of cases, female victims of violence present problems that cannot be reduced to the immediate consequences of the violent acts experienced, but rather, present interfaces that depend upon an interdisciplinary approach, such as the scars that are left on the woman's professional, social, emotional, and sexual life. Rape is defined by the Brazilian Penal Code as a crime of action within the private sphere (article 213 Laws 8,069/90; 8,072/90 and 8,930/94) against costumes and not against the person. In other words, it is restricted to the sexual relation between a man and a woman wherein vaginal penetration occurs, against the woman's desire and involving the use of violence. Other incidents of sexual violence different from carnal conjunction are classified as a "violent assault against modesty", as a public action crime (art. 214, art. 263 (8,072/90) and art. 6 (8,930/94). What is considered criminal is the aggression against society perpetrated by means of the female body. It is as if the man (father or spouse) was affronted in his moral integrity by the sexual violence experienced by the woman.[12]

Data concerning sexual violence indicates that there are no distinctions between social classes, social segments or color/ethnic groups. Social treatment of sexual crimes, particularly rape, oscillates between considering them hideous crimes, principally when practiced against children, and banal facts, common occurrences. It may be stated that the perspective upheld with respect to these crimes is still intimately related to the social construction of the victim's image, of her behavior and morality.[6,14]

Considering western society, the issue gains other connotations with the advent of modernity and individualism, gradually being understood as partaking in the sphere of women's citizenship, being, therefore a crime against the person.[12]

In the past few years, care for female victims of sexual violence has come to the attention of several social sectors, particularly, women's organizations and medical associations. Mobilization with respect to the theme resulted in the creation of services that attend female victims of sexual and domestic violence, as well as the creation of legal and juridical instruments that make it possible to attend them more appropriately.

Although, since 1940, the Brazilian Legal Code (articles 127 and 128) obliges health professionals to provide care for the interruption of pregnancies in cases involving rape or risk to the mother's life, only 11 cities, of the more than 6,000 municipalities in Brazil offer services for female victims of rape, putting the Law of "legal abortion" in practice in a total of 24 services.

This number of services is still small, for access to public hospitals that offer this service is still difficult. The fact that information concerning these services is not well disseminated and that sexual violence is still seen as an issue within the sphere of public security or justice may explain the low number of visits to these services, in contrast to the dramatic reality of rapes.

Many women are reluctant to seek assistance or do not go to the services right after violence has been committed because they believe they will have to file a complaint in the police department or submit themselves to a medical examination at the *Instituto Médico Legal* [Legal Medical Institute] (*IML*), responsible for autopsies and other medical investigations. For fear of the constraints associated with these services, they end up not seeking the health service or seeking it out rather late, compromising the prophylactic measures that should be undertaken during the first 72 hours after the event.

Furthermore, there are few academic studies, above all in the field of collective health, that discuss sexual violence from the perspective of gender relations. Among these, Schraiber's[11] study, conducted in Primary Health Units of different municipalities within Sao Paulo State concerning spontaneous demand and screening, is noteworthy.

The objective of the present study is to evaluate the services that attend female victims of sexual violence, from the perspective both of those who utilize these services and the health professionals that provide care.

METHODS

The decision to utilize qualitative methodology was taken particularly due to the fact that the latter emphasizes the research process and not only its results and its products.[3] Interviews with the women who sought the services and with professionals from the teams that provide these services were recorded. All subjects agreed, by means of informed consent, to participate

in this study. Among the criteria for inclusion in this study were: as to the women who sought the service, the fact that they were being attended by the service when they were interviewed; as to the professionals, the fact that they were members of the multi-professional team responsible for providing services to female victims of sexual violence and the need to guarantee the participation of different professional categories in the study. A total of 13 women seeking the service and 29 professionals working in the multi-professional teams were interviewed. The interviews were conducted in the primary health care services with the mean duration of 60 minutes. Women's names were altered in the text so as to conceal their identity.

Analysis of the data from the interviews was undertaken in two phases: the first phase addressed the impact on women's lives of violence suffered in different spheres: sexual, affective professional, psychological and social. Analysis was conducted by means of empirical categories formulated on the basis of the information gathered from their narratives organized in thematic axis.[4] The second phase focused on the evaluation of the implementation of the services by means of the construction of "abstract categories" [15] based on the principles that guide the technical assistance model "*Em Defesa da Vida*" [In defense of life] of the *Laboratório de Planejamento e Administração* [Planning and Administration Laboratory] *(LAPA)* of the University of Sao Paulo at Campinas - Unicamp[13] utilized to evaluate implementation of the services.

The analysis undertaken herein utilized part of this model,[13] employing the categories: reception; resolubility, responsibility in public health, and access to services. The category *collegiate management*, which also comprises part of the model was not included, because the services in question do not contemplate this form of management.

The university service began its activities in 1998 and is constituted by professionals from the fields of nursing, medicine, social assistance, psychology, law and collective health working in an outpatient clinic that has a hospital as a referral center. The woman who arrives at the Emergency Ward during commercial hours is referred immediately to this service.

The municipal service began attending in 1989, and was the first service to perform legal abortions in the city of Sao Paulo. In 1996, when PAS – *Plano de Assistência à Saúde* [Health Care Plan], was implemented by the municipal government, this service was dismantled. In the year 2000, when the *Sistema Único de Saúde (SUS)* [Brazilian Health System] was implemented in the city, the service was reconstructed, including this outpatient program for female victims of sexual violence. It is constituted by a team of professionals from the fields of medicine, nursing, social assistance and psychology.

Both these services follow the medication protocol for emergency contraception and prophylaxis for STDs and AIDS, recommended by the Technical Norm of the Ministry of Health.[5]

The objective of this study was not to undertake a comparative analysis of the services for they had different configurations both in terms of their institutional associations and in terms of the composition of their professional teams. Furthermore, the experiences of both services are very different, thus creating their own demands, herein understood as the service flow and, above all, the duration of the treatment, situations that become evident when considering the narratives of the women attending these services.

This research project was approved by the Research Ethics Committee of the *Universidade Federal de São Paulo* [Federal University of Sao Paulo] (Unifesp).

RESULTS

The results of the analysis of the categories included in this study were:

Reception

This is understood as the respectful, receptive relation established by the service, as a whole and by professionals who manifest solidarity with respect to the different types of people seeking their care.

In both services, the majority of women maintain a relation with members of the team that took care of them even after the treatment is completed, revealing the quality of the reception they received during a difficult moment in their lives.

The narrative of one of the psychologists indicates how she finds it odd that women like the service and manifest the desire to return, although she states that rape victims never like to recollect this situation. Attachment with this service was constructed.

However, it was also verified that, when referring to any other services in which female victims of violence sought help or to which they were indicated, particularly police stations, these were negatively evaluated.

The professionals working in the services included

in this study stated they encountered difficulties in making other professionals (not associated to the service attending sexual violence) sensitive to this issue and responsive in their approach to violence, they also pointed out the need to overcome prejudices so as to accept the discourse of the women attended. This difficulty is related to the social and moral values upheld by the majority of health professionals and which reflects upon their conduct when providing assistance. Furthermore, the theme of sexual violence was only recently incorporated into the undergraduate curriculum of courses in the field of medicine.

"*So any situation may arise and you must be aware of the fact that you have to refer this patient for care and that this is your obligation. If students are aware of this when they leave medical school, tomorrow patients will no longer be attended in the bizarre manner they are now subject to be attended, they won't have the children they don't want to have, or acquire HIV or syphilis due to lack of medical orientation*" (physician).

Resolubility

To place all available technology at the disposal of the patient so as to arrive at a diagnosis and secure adequate treatment in each case, coming to grips with both the individual and collective dimension of health problems.

"*We try to work a lot with the day after pill, which I consider fundamental, because abortions, whatever the situation may be, are complicated. And so the program now offers advances, some possibilities that are much better, like the day after pill and antiretrovirals*" (physician).

In situations where the interruption of pregnancy is indicated, the services' professionals also mention they need to overcome their beliefs in order to exercise their activity as professionals attempting to assist in the best way possible, without being judgmental.

One of the nurses interviewed mentioned that she tries to "forget" her religious orientation so that it won't interfere with the advice she gives to patients.

Women become afraid of staying alone, and, frequently, become incapable of doing daily tasks such as taking a bath, entering an elevator, riding a bus, or remaining unaccompanied in any place. They become continually distrustful of men. When violence occurs near their homes, there is great fear that the aggressor will return and they express the desire to move. Sometimes they don't file a complaint in the police station because they fear the aggressor will return or, when they do so, the fear of vengeance haunts them.

In this sense, care which deals with these different aspects of the situation creates the necessary conditions for this event to be surpassed.

"*Caring for a patient is not caring for a vagina, a breast, a nodule. When the issue at hand is sexual abuse, the patient has no visible marks, in the majority of cases. Corporal injuries are present in only 10% of the cases, while in 90% of them, even when the patient undergoes a gynecological examination, it doesn't usually indicate anything different. The patient is devastated when she comes to seek for help. So then you learn that treating the patient, being a physician, is not simply taking care of physical injuries. Because rape is an injury that attacks the body, the soul, one's character, it attacks everything. So when there's a patient in front of me, I'm not concerned with her physical injury, because in the majority of cases, she doesn't have one. I must be concerned with her as a human being, with her state of mind, with her sexuality, with her job, how she'll treat her son, how she is getting along and if she's getting by or not. Dealing with this problem implies in dealing with a huge difficulty. Treating a clinical disease involves dealing with something you can see, that you describe, that the exam indicates. However, sexual abuse cannot not be seen, it must be treated in the consultation. And this is the great gain for me as a physician*" (female physician).

The need to be granted a leave of absence from work or from school is important so as to insure that the woman may recuperate before resuming her activities. Therefore, clearly the leave of absence due to sexual violence/rape should be included among workers' rights. Many women are subjected to violence on their way to work or on their way home from work, which comprises in a work accident, however these incidents are not characterized in this way, nor do women have access to worker's rights under these circumstances.

"*I don't know how I would manage... go back on the same day without having consulted with a psychologist, I wouldn't be able to handle it, I would have asked to be layed off and gone home*" (Anete).

The professionals interviewed indicated some aspects related to the resolubility of the services that they believed could be improved. These are related to the need for team supervision and the selection of professionals. Focus should be placed on guaranteeing sexual and reproductive rights when sensitizing these professionals.

"*Internally, when hiring professionals there should be a screening process. That is, the hospital's program in relation to sexual violence should be explained to them. If they don't agree with this program, they shouldn't be hired*" (psychologist)

In this sense, some professionals stated that bias existed, to some extent, among their colleagues, due to the fact that they conducted abortions.

"*When abortions were conducted, because there are doctors who uphold their values and these don't change under any circumstances, so some even suffer discrimination as abortionists*" (psychologist).

Sanitary responsibility

To feel responsible for the life and death of the patient, within a given possibility of intervention that is neither bureaucratic nor impersonal.

Sanitary responsibility implies in respect for the women's life history, which is revealed with intense suffering, and their discourse is given credibility. Sanitary responsibility may also be verified in the manner in which women are accompanied, discharges being defined by the team in conjunction with the woman, that is the gate is always kept open in case she wishes to return.

The Technical Norm of the Ministry of Health[5] does not oblige women to pass through a physical examination at the Legal Medical Institute in situations involving sexual violence. However, many police agents, emergency services and primary health care units still consider this procedure obligatory in order to depict the situation as one involving sexual violence.

It may be stated that little is known with respect to the quality of care received by women in different health care units. Furthermore, there is a field of tension with police authorities, who, in most cases, give priority to the *corpus deliciti* exam and to the information they need in order to proceed with the denunciation of the case.

One patient interviewed revealed a story of peregrination through different health care services (emergency wards, primary health care centers) as well as police and judicial services (police stations and forums) in search of assistance, leading to the loss of the legal condition for performing an abortion due to the time limit that had expired.

"*He said it was no longer possible to do anything, that it was no use correcting one mistake with another one, as if he meant to say, since you were raped, it would be mistake to abort, when she got here it was too late, no chance*" (Marta).

Access

Access to services and to benefits is a citizen's right. The former have to organize themselves so as to respond to demands arriving at the service's doors.

In most cases, women's first contact with health services is in the emergency wards of hospitals. From there they are directed towards specialized services.

The university service included in this study is base don a multiprofessional team taht qualifies access both objectively (medical and nursing care – prophylaxis for STDs, hepatitis, HIV and abortion in cases involving pregnancy) and subjectively (psychological assistance, legal and socal assistance).

Despite the fact that the Technical Norm of the Ministry of Health doesn't establish the obligation of proceeding with the *corpus delicti* exam at the IML, this proceedure is still required by the police in order to conduct an inquiry. This situation, which leads the woman to submit herself to another ginecological examination, reinforces the violence she to which she has already been exposed, causing great constraints.

Another aspect that was stressed in the women's discourse was the need to disseminate information on these specialized services.

"*I would like this service to be more d isseminated than it is, people aren't aware of the support that the hospital gives them, I myself had never heard about this service*" (Sandra).

DISCUSSION

Sexual violence entails in a series of effects on women's lives, expressed through a complexity of sentiments, such as emotional trauma, fear, physical sequels, insomnia, the collateral effects of medications, difficulty in resuming sexual activity and work.

The present study reinforces comprehension of sexual violence as a public health issue of great magnitude. It requires an integral and interdisciplinary approach so as to deal with the significant impacts it has on women's lives, including physical, subjective, sexual and affective aspects. This understanding of the issue at hand provokes a rupture with the concept of integral care when the latter is approached with emphasis focused exclusively on the idea of the

standardized protocol.[7] The latter gives little importance to the stories of distress which are brought as the major demand for care, according to some of the accounts of both health professionals and women attended by the services.

According to Camargo Júnior,[1] the concept of integrality understood, "simultaneously as unattainable and indispensable", constitutes a processual approach that is necessary in order to recognize the individual expression of the caretakers and of the subjects that demand care, that seek to put in practice health activities that in fact are resoluble.

This study reveals the difficulties health professionals have in dealing with a theme that confronts them daily with their values and which has repercussions on their involvement and adherence to these services, despite the fact that they are supported by current legislation. This situation was also pointed out in research developed by Right to Choose Catholics.[9]

Another very relevant issue, brought up by professionals, is the lack of orientation during undergraduate studies in the health professions concerning how to deal with it, thereby provoking emblematic situations of anxiety when confronted with the theme of sexual violence. This fact also ends up unleashing pressures against abortion and resistance, among other professionals, with respect to the issue of legal abortion.

The accounts collected during this study indicate deficiencies in relation to referrals due to disinformation concerning the existing specialized health services among the majority of professionals working in the health system. A recurrent complaint refers to the indelicate treatment received by women at the IML and at police stations where they are frequently blamed for the aggression to which they have been subjected.

This study ratifies the importance of these services, in as much as, during the last decade, the number of pregnancies interrupted due to rape has decreased due to the quality of care women are receiving in the services immediately after they were subjected to violence, with the provision of emergency contraception[8] according to data form the *Rede Nacional Feminista de Saúde e Direitos Reprodutivos e Sexuais* [Feminist National Health and reproductive Rights Network].

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