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RESEARCH

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THE PERCEPTION OF SEXUAL VIOLENCE'S VICTIMS ABOUT THE EMBRACEMENT IN A REFERENCE HOSPITAL IN PARANÁ

A percepção da vítima de violência sexual quanto ao acolhimento em um hospital de referência no Paraná

La percepción de la víctima de la violencia sexual a respecto de la acogida en un hospital de referencia en Paraná

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ABSTRACT

Objective: to identify the perception of victims of sexual violence about the embracement given by the Nursing team in an emergency unit of a reference hospital in Curitiba, Paraná. **Method:** qualitative-approach, descriptive research with women victims of sexual violence who received care at the gynecological infectious unit in july and august 2017. The data gathering occurred by semi-structured interviews and analyzed through content analysis. **Results:** it highlighted the care provided as technical procedures, and also the individual care to the patient's needs and the constant presence of the professional during said care, even if some patients were unaware of this professional category. The perception of the interviewees regarding the service was based in the posture of the professionals, creating positive feelings, like security and calm. **Conclusion:** nursing lacks social recognition; however, its care was perceived as positive and as the source of feelings of protection and acceptance by women.

Descriptors: Nursing; User embracement; Violence against women, Sex offenses.

RESUMO

Objetivo: identificar a percepção das vítimas de violência sexual em relação ao acolhimento prestado pela equipe de enfermagem no pronto atendimento de hospital referenciado em Curitiba, Paraná. **Método:** pesquisa descritiva de abordagem qualitativa com mulheres vítimas de violência sexual atendidas em ambulatório nos meses de julho e agosto de 2017. A coleta dos dados foi por meio de entrevista semiestruturada e analisados por meio de análise de conteúdo. **Resultados:** evidenciou-se como o cuidado prestado não somente procedimentos técnicos, mas também o cuidado individualizado às necessidades e a presença constante do profissional durante o atendimento, embora algumas entrevistadas desconhecessem a categoria profissional deste. A percepção

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quanto ao atendimento centrou-se na postura dos profissionais, gerando sentimentos positivos como segurança e tranquilidade. **Conclusão:** a enfermagem carece de reconhecimento social, porém seu atendimento foi reconhecido como positivo pelas mulheres e gerador de sentimentos de proteção e acolhimento.

Descritores: Enfermagem; Acolhimento; Violência contra a mulher; Delitos sexuais.

RESUMÉN

Objetivo: identificar la percepción desde las víctimas de violencia sexual de la acogida de los equipos de enfermería en la unidad de emergencia de un hospital de referencia en Curitiba, Paraná. **Método:** investigación descriptiva de enfoque cualitativo con mujeres víctimas de violencia sexual atendidas en ambulatorios en los meses de julio y agosto de 2017. La colecta de datos se dio mediante entrevistas semiestructuradas analizadas por análisis de contenido. **Resultados:** se evidenció la manera como los cuidados, no solamente procedimientos técnicos, pero también cuidados individualizados y la constante presencia del profesional durante el atendimiento, mismo que algunas entrevistadas no supieran la categoría de dicho profesional. La percepción acerca del atendimiento se concentró en la postura de los profesionales, generando sentimientos positivos como seguridad y tranquilidad. **Conclusión:** la enfermería carece de reconocimiento social, pero su atendimiento fue reconocido como positivo por las mujeres y generador de sentimientos de protección y acogida.

Descriptores: Enfermería; Acogimiento; Violencia contra la mujer; Delitos sexuales.

INTRODUCTION

Sexual violence against women has big repercussions on physical and emotional health, on the productive and social lives of victims. Faced with these consequences, it is considered a global public health problem and violation of human rights by the World Health Organization (WHO), which estimates that approximately 35% of women worldwide have suffered sexual violence.[1]

In Brazil, in 2011, it is estimated that more than 13 thousand women assisted by the *Sistema Único de Saúde (SUS)* [Unified Health System] were victims of sexual violence. In *Paraná* State, from 2008 to 2011, 10,515 cases of violence were reported, with 21.87% referring to sexual violence (2,300). In *Curitiba* city, during the period from 2003 to 2006, 2,687 cases of violence were reported by the health services, of which 1,872 were sexual violence against women.[2,3]

When it comes to health care, the Technical Standard - Humanized Care for Victims of Sexual Violence with Information Recording and Trace Collection underscores the importance of receiving care for quality of care, as a "set of measures, posture and attitudes of professionals of health that guarantee credibility and consideration to the situation of violence" and this has been pointed out as a form of care centered on the subjective and particular issues of the individual that surpasses the biomedical view, and also an important decisive factor in the continuity of the proposed treatment.[4,5]

Thus, it must occur in all places and moments, by all the professionals of the team, extrapolating the reception carried out in the triage, understanding that this initial welcome only makes sense if seen as the beginning of a process and not only an isolated step.[6]

Understanding that nursing professionals are the first with which women in situations of violence have contact when seeking a health service, these professionals become a reference and responsible for the first approach and the beginning of the reception process to assist these women in the recovery of their self-esteem, mental health and their quality of life.[7,8]

Nevertheless, the precariousness of relationships and working conditions can end up harming intersubjective relationships, generating a process of lack of empathy and the production of indifference towards the other. Added to this scenario are the prejudice and the individual moral burden of the caring subject that can interfere with the care quality.[6,9]

Not only by providing care permeated by their own ethical and moral beliefs and values, but by providing it focused only on protocol and technical procedures, it may end up producing a negative result, such as a woman's revictimization and non-adherence to treatments.[9]

Despite understanding that this first professional contact of the nursing team with women victims of violence is a great contribution to adherence to treatment and effective self-care afterwards, the lack of studies was perceived in a survey carried out in 2011, which found only one study as a result of the cross-referencing of the "rape" and "user embracement" descriptors in the *BIREME* database [Latin-American Center for Health Sciences Information], indicating that the scientific community lacks studies on this topic, making this study relevant.[10]

Given this context, this research meant to identify the sexual violence victims' perception regarding the user embracement given by the nursing team in an emergency unit of a referral hospital in *Curitiba* city, *Paraná* State.

METHODS

It is a descriptive research with a qualitative approach. This study has proposed to analyze the meanings attributed to the experiences and how they were understood within the natural context of the participants[11] - in this case, nursing care provided to women victims of sexual violence. The study was carried out in a large public hospital that is a reference for the care of women victims of violence in the capital of the *Paraná* State.

The study participants were 11 women assisted at the ambulatory specialized in gynecological care of sexual violence victims. As criteria for inclusion, it was necessary to be a woman, to have been a victim of sexual violence, to be 18 years old or more, to understand and speak the Portuguese language and to attend at least one consultation in the

specialized outpatient clinic. Considering the 40 patients scheduled during the collection period, 14 met the criteria for participating in the study.

Data collection was carried out in the period from July 18th, 2017, to August 31st, 2017, through a semi-structured interview, guided by a previously elaborated instrument with three questions related to emergency care provided to women by the professionals, and how the women felt about them.

The interviews took place individually in the office of the gynecological-infectiology ambulatory, prior to the consultation with the gynecologist and according to the arrival of the patients. The interviews were conducted after an explanation of the research, by signing the Informed Consent Form (ICF) and digitally recorded with the consent of the interviewee.

Considering the data analysis, the content analysis was used according to Bardin, which consists of categorizing the central elements of the participant's perception and reflecting not only on the meaning of the discourse itself, but also on the construction of the meaning of this discourse for the participant, identifying and exploring the subjective sense attributed to the report.[12] This was followed by the pre-analysis phase, where the interviews were transcribed and organized in the Word program, along with the characterization of the participants, to make a superficial reading of this material aiming at the approximation and recognition of the ideas brought. In the material exploration phase, the significant excerpts from the speeches were highlighted with the help of the "text highlighting" in different colors, and those with similar ideas were highlighted with the same color. The selections marked with equal colors were regrouped in another table with the aid of the Excel program and constituted a category. The phase of treatment of results, inference and interpretation consisted of re-reading the organized and regrouped excerpts, interpretation of the context of the explicit message and identification of the central idea of each category.

In order to ensure the anonymity of the participating women, they were identified by the letter "W" followed by a numeral that corresponds to the order in which the interviews took place. Therefore, the first woman interviewed was given the name "W1" and so on.

This research was performed according to the ethical aspects addressed by the Resolution No. 466/12. The study's purpose was explained to the participants, and also its voluntary nature, so the non-participation would not bring any burden to the participant or her assistance in the institution. It was clarified the maintenance of anonymity throughout the process and the possibility of withdrawing participation at any time in the research. The study was submitted and approved by the Research Ethics Committee of the institution where the research was carried out, under the Legal Opinion No. 2.131.679 and the *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Assessment] No. 68725717.7.0000.0096. The data collection was only carried out after approval of the committee.

RESULTS AND DISCUSSION

Initially, a sample characterization was carried out (**Table 1**) and then, after comprehensive reading of the interview reports, the three categories found were listed.

Table 1 - Characterization of the research participants. *Curitiba* city, *Paraná* State, 2017.

	Age	Marital Status	Religion
W1	38 years old	Single	No religion
W2	24 years old	Single	Catholic
W3	19 years old	Single	No religion
W4	24 years old	Single	No religion
W5	29 years old	Single	No religion
W6	23 years old	Single	No religion
W7	20 years old	Single	Catholic
W8	32 years old	Married	Evangelical
W9	58 years old	Divorced	Evangelical
W10	35 years old	Single	Catholic
W11	31 years old	Single	No religion

The categories are as follows: the care provided by the nursing team; the woman's perception concerning the care service received; the feelings experienced by women as a care service outcome.

In the category "the care provided by the nursing team" it was possible to distinguish two units of context. The first one is formed by the report of seven participants and concerns the recognition of the professional who answered them in the ready obstetric and gynecological care.

Considering the seven participants, two were not able to affirm with conviction the recognition of the professional category to which the employee belonged, three had the knowledge of the professional category, a report that the professional identified only by name and one did not know any of the information; as the following statements illustrate:

> *I believe the girls who were at the counter at the time were from the nursing team. Within the emergency care, in the office at the time when it was necessary to examine and when it was necessary to take the medications.* (W11)

> *The first person who answered me I think it was (from the nursing team), then came the head nurse.* (W2)

> *I arrived, explained what happened to me, and I was assisted in the first room. She said her name.* (W6)

> *I do not know; I just know it was a woman.* (W3)

The second unit of context was formed by eight reports and refers to what the interviewees identified as care provided by the team, where the notes made do not only refer to the technical assistance performed, but also to the presence of the professional during the service, making the woman did not feel alone, the explanations that were provided throughout the care process and the individualized care provided at that time:

She explained that it would take long, because she was getting too many pregnant women in labor (...). They put me inside the room, explained that I needed to dress with the hospital apron. They also explained the time I needed to do the urine test, they told me I was going to have to collect more blood. (W11)

The moment I stayed there alone she gave a lot of assistance, gave me the injections, the medications, she was talking to me (...). the blood was collected, medication was given, I was waiting for the doctor to come to the exams (...). Every time someone was talking to me, afterwards, I was kept under observation, every time someone was looking at me, taking care of me. (W10)

As soon as I got here, they already showed up and came with me into the room (...). I spent all day without eating, they arrived, they brought me snack so I could take medicine, however, I cannot swallow pills, they cut me off... We talked, I even got to say it all. (W7)

In the category "the woman's perception concerning the care service received", ten of the participants perceived the assistance provided and evaluated it in a positive way, mentioning the attitude of the professionals and the attention given by the team to them, as follows:

They were very caring, appreciative, very calm, they asked me the questions in a nice sequence that I felt comfortable answering, they were super professionals for me (...). They convey that 'it's not just because I'm here working, I'm a woman too', I think they put themselves a little in our shoes. (W1)

They wanted not to ask so much, they were worried if I was hungry, if I was cold (...). They encouraged me to keep going. (W5)

There was another person that talked to me, went to the seat where I was sitting, said that I should be calm and any doubt that I had I could go there and ask her (...). They were very helpful; they were very discreet. (W11)

Three women, however, brought negative aspects perceived during the nursing care regarding the non-recognition of the offered service and the lack of explanations about the care to be performed:

At first, they were a little lost because I came with the forensic medical institute file, the girl did not know what kind of service it was, then she called the head nurse who was there and she said 'no, this one is right here', because I was kind of lost where it was. (W2)

The first contact was bad because she could not explain what I was supposed to do, she just said I had to wait, she took my documents, she said I had to wait. She was not solicitous (...). I was worried about the delay, not because I wanted to be taken care of first, it was just because I had another problem in my home. (W11)

In the category of "the feelings experienced by women as a care service outcome", eight participants reported that despite the traumatic situation they were experiencing, they felt calmer, secure and welcomed by the nursing team when receiving the care of these professionals based on the care provided and in the individualized care:

I felt welcomed! I felt safer because I sought the care was not the same day, it was later because I did not want to come and even regretted not coming because I imagined something else. We think millions of things when this happens, nonetheless, I felt super good, I thought I should have come sooner. (W1)

I was afraid about the medicines to take and everything, but the lady who answered me was very calm, explained everything right, comforted me, then I felt welcomed. (W4)

I did not have much pressure on me, I was calm, I just have to say thanks. (W7)

Only one of the participants brought a speech with negative aspects vis-à-vis the feeling experienced during the care service, as follows:

The treatment is indifferent. By any means I felt like I was being judged, but the treatment of this person I quoted I think there was a bit of indifference towards me. Because when you arrive you do not even know where you want to go or what happened to you. You are still in that denial process of what happened to you (...). By the time you arrive at the service, it is in fact the moment that you are most fragile. (W11)

The women victims of sexual violence in this study have a similar age group as that found in other studies, mainly from 18 to 35 years old, as it resulted in the study of 1,272 tokens of violence reported in a university hospital in *Curitiba* city between 2009 and 2013, study with 687 records of women assisted by sexual aggression in a hospital in *Campinas* city between 2006 and 2010. The predominant marital status also coincides with these studies, pointing out the greater number of single women.[13,14]

Considering the religious belief, the present study shows that most of the interviewees (54.5%) do not have a religion, diverging from a survey conducted in the year 2013, which indicates that 84.9% reported having religion, being 52.6% Catholic, and an interview conducted in the emergency room of the university hospital in *Londrina* city, from 2003 to 2004, where 62.7% of the 83 women interviewed were also Catholic.[14,15]

In the category "the care provided by the nursing team", it was possible to find statements regarding the recognition of the professional category that assisted these women in early care. The speeches brought by some interviewees demonstrate doubts and even lack of knowledge about the caregiver's profession in emergency care to the situation of violence, pointing out that Nursing lacks social recognition.[16]

Two of the justifications for this lack of recognition would be the historical construction of Nursing, which began with a character of charity and passivity that still has traces in the current professional practice; and the lack of knowledge on the part of the population as well as other professionals in the health area with regards to the performance of the nursing professional and their competencies. Both justifications make it difficult to promote this category.[16]

Still concerning the care provided by the nursing team, it was also possible to perceive that in addition to the technical procedures to which they were submitted, women also identified subjective aspects such as the attention given by the team professional to provide explanations and to individualize the technical care for the needs of the patient.

This result differs from that pointed out in an integrative review with publications between 2003 and 2013 on health care for women victims of sexual violence, where the persistence of assistance focused on the biomedical model with the medicalization of physical injuries and the concern with the technical make are considered predominant.[8,17]

The grievances resulting from sexual violence are manifested both in the physical, psychological and emotional aspects of the victims. These can have repercussions throughout life and reflect on the behavior of women in relation to their daily life and their relationship with the world, so it is necessary that the first assistance provided after the aggression is directed to the reception and beginning of the reestablishment of their health.[18]

The differentiated look of the woman in situations of violence is fundamental for the construction of empathy and the bond between user and professional. Once this link between the two parties is established, then the professionals manage to ensure that their care services are received with confidence and credibility, as well as reflected in their personal marketing.[17,19,20]

Hence, there is a need for health institutions to have teams trained to meet the demand for sexual violence "from the user embracement, qualified listening, ensuring a harmonious environment so that the woman establishes trust with these professionals".[17]

Observing this framework, the Ministry of Health has focused on strategies for improving care guided by the concept of humanization, becoming policy in 2003 with *HumanizaSUS* [National Humanization Policy], which has as one of its guidelines the acceptance, defined as "recognizing what the other brings as a legitimate and singular need of health", being "built collectively, based on the analysis of work processes and aims to build relationships of trust, commitment, and bond between the teams/services, employee/teams and users with their social network".[21]

"The woman's perception concerning the care service received", which is the second category identified in the present study, demonstrates that the professional position described by the interviewees is similar to that recommended by the Ministry of Health and other studies, as well as what is established in the Law Decree No. 7.958 in 2013 on care for victims of sexual violence, which should be based on "principles of respect and dignity, non-discrimination, secrecy and privacy", and all information on procedures to be performed should be as well as the importance of their realization, and the victim's decision whether or not to carry out any procedure must be respected.[22]

The category "the feelings experienced by women as a care service outcome" indicates that this way of performing care generated in the participants a positive perception of care and resulted in positive feelings with the assistance experience.

In agreement with these findings, a study carried out with 11 rape victims who were assisted at the referral maternity hospital in *Alagoas* State also points out that the participants emphasized the attention received and the feelings resulting from the assistance in a positive way, reporting that they felt welcomed, protected and careful about receiving explanations about medications and the availability of professionals to support them.[10]

Although most of the interviews present a positive outlook for the nursing staff, the notes about the non-recognition of the service offered and the lack of explanations about the attendance to be performed, generating a negative feeling in the participant in relation to the attendance, reinforce the standing of Bedone and Faúndes (2007, page 468):

> *All professionals [...] must be motivated and feel themselves to be important parts within the team.*

They must be aware that all care services can be compromised if they do not properly do their part.[23]

It is then up to the hospital management staff to provide constant training and permanent education of its health teams in order to guide the practice and referral flows, both internal and external to the institution, in cases of care for women in situations of sexual violence.[24]

In addition to training, it is pointed out the possibility of selecting professionals with a specific profile to work in sectors that support women in situations of violence, in order to guarantee the reproductive and sexual rights of these victims and to promote adherence to ambulatory treatment through good technical assistance and a humanized welcoming.[8,15]

CONCLUSIONS

The research shows that the emergency care service provided by the referral hospital in *Curitiba* city, *Paraná* State, is close to the humanized care proposed by the Ministry of Health.[4]

It was noted by the participants' statements that there is certain invisibility concerning the recognition of the nursing professional, but even so, the care provided by the team was recognized for seeking to provide protection and protection through listening and individualized care allied to procedures for disease prevention and health promotion.

The failure reported by the participant in relation to the professional's lack of knowledge regarding the assistance provided to the victims of sexual violence points to the need for training and permanent education of the institution's employees in regards to the type of service offered and the internal and external flows to the hospital.

The precariousness of working conditions should also be considered when thinking about the lack of knowledge of the routine of the service. The high turnover of professionals in the sector and the incomplete work scales with the need of employees assigned from other units make difficult the routine homogeneity and knowledge about the service.

Understanding that good technique and a humanized welcoming increase the rate of adherence to ambulatory treatment, one of the limitations that the present research has is to have identified only the perception of women who, until the moment of data collection, have been following the treatment. Therefore, it is believed that there may be some difference in the reality of the panorama vis-à-vis the quality of the service provided in relation to the shown here.

Another limitation was the time available for data collection. Since this occurred in only two months, it cannot be ruled out that the results presented here refer to a specific period of the institution and may not reflect the quality of the assistance offered as a whole.

Hence, it is recommended that research be carried out with a longer time for data collection and also with women in situations of violence that did not continue the outpatient follow-up, in order to obtain the cause of non-adherence and, consequently, to verify if it is related to the user embracement given by the healthcare team from the emergency service in cases of sexual violence.

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