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RESEARCH

Perfil Sociocultural de mulheres que vivenciaram violência sexual em uma unidade hospitalar de referência

Socio-cultural profile of women who have experienced sexual violence in a hospital unit of reference

Perfil sociocultural de mujeres que vivieron violencia sexual en una unidad hospitalaria de referencia

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ABSTRACT

Objective: Characterizing and analyzing the socio-cultural profile of the women who have experienced sexual violence that were answered in a unit of reference linked to the Municipal Health and Civil Defense of Rio de Janeiro. **Method:** a descriptive, exploratory in the quantitative approach. Data were collected between November 2011 and March 2012 totaling in 157 records. **Results:** most women raped are young, white, unmarried, middle level education and has some form of financial income. Conclusion: the data corroborates the fact that sexual violence focus at all levels of education and in all social classes. Meeting the reality of these women is fundamental to a comprehensive and humanized assistance. The proposed deal must be formulated both from the socio-cultural characteristics of women, as a joint construction between professionals and clients. **Descriptors:** Sexual violence, Women's health, Obstetric nursing.

RESUMO

Objetivos: Caracterizar e analisar o perfil sociocultural das mulheres que vivenciaram violência sexual que foram atendidas numa unidade de referência vinculada à Secretaria Municipal de Saúde e Defesa Civil do Rio de Janeiro. **Método:** descritivo, exploratório na abordagem quantitativa. Os dados foram coletados entre novembro de 2011 a março de 2012, totalizando 157 prontuários. **Resultados:** a maioria das mulheres violentadas é jovem, de cor branca, solteira, escolaridade nível médio e possui alguma forma de renda financeira. **Conclusão:** Os dados corroboram o fato de a violência sexual incidir em todos os níveis de escolaridade e em todas as classes sociais. Conhecer a realidade dessas mulheres é fundamental para uma assistência integral e humanizada. As propostas de cuidar devem ser formuladas tanto a partir das características socioculturais das mulheres, como de uma construção conjunta entre profissionais e clientela. **Descritores:** Violência sexual, Saúde da mulher, Enfermagem obstétrica.

RESUMEN

Objetivo: Caracterizar y analizar el perfil socio-cultural de las mujeres que han sufrido violencia sexual que fueron contestadas en una unidad de referencia vinculada a municipales de salud y Defensa Civil de Río de Janeiro. **Método:** descriptivo, exploratorio en el enfoque cuantitativo. Los datos fueron recogidos entre noviembre de 2011 hasta marzo de 2012, totalizando 157 gráficos. **Resultados:** la mayoría de las mujeres violadas es joven, blanca, soltera, nivel de educación medio y tiene alguna forma de ingresos financieros. **Conclusión:** los datos corrobora el hecho de que el foco de la violencia sexual en todos los niveles de la educación y en todas las clases sociales. Conocer la realidad de estas mujeres es fundamental para una asistencia integral y humanizada. El trato propuesto debe ser formulado tanto de las características socio-culturales de las mujeres, como una construcción conjunta entre profesionales y clientes. **Descriptores:** Violencia sexual, Salud de la mujer, Enfermera obstétrica.

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INTRODUCTION

The violence against women is considered a gender issue, often committed by people of their intimate interaction, usually their own partners.[1] This fact is based on the patriarchal culture that are still ingrained, even where the male biological instinctual impulse is justification for domestic violence to women, making them a natural practice that minimizes man's responsibility for his actions.

Although violence against women is a phenomenon that affects most women in different parts of the world, data and statistics on the extent of the problem is still little explored in the health sector agenda. The difficulty in relating violence to the sociocultural context is still precarious, with a greater need for research to better understand and reflect on the problem and propose solutions.

Violence against women is defined as any act based on gender which causes death or physical harm, sexual or psychological suffering to women, both in public as in private.[1] The main manifestations of violence against women are: physical violence, sexual and psychological / moral / emotional violence, being this last commonly present in all other manifestations.

Sexual violence is not always so visible in stable relationships can be characterized in a variety of situations such as rape, sexual harassment, unwanted fondling, forced sex in marriage, oral penetration, anal or genital or penis with objects forcefully, denial by partner to use a condom or impediment to the use of any contraceptive method.[2] They account for about 33% of all domestic violence in our country.[3]

Being the sexual aggressor, in most cases, acquaintance or neighbor woman, there is a low rate of withdrawal despite high prevalence rates. Sexual violence happens regardless of social, educational and economic status of women. It is estimated that in Brazil, the notifications of cases of sexual violence in police stations accounted for only 10-20% of cases that actually happen. [4-5]

Sexual violence has a major impact on the physical, psychological and social health of the woman. Women who experience various forms of sexual violence become vulnerable, least able to protect themselves, less sure of themselves and their limits, compromising their self-esteem and self-image, leading to isolation, negative feelings such as: anger, guilt, sadness and depression favoring. Besides its psychosocial effects there are also physical effects such as unwanted pregnancy and transmission of sexually transmitted diseases, associated with contraceptive use and adoption of self-care practices.[6]

Against this backdrop of violence will woman have been various government actions to address situations of violence, particularly those perpetrated on women, such as the drafting of legislation as the Maria da Penha Law, National Comprehensive Assistance sexual violence will women's health (own emphasis on assistance to women experiencing domestic violence), the Specialized Police Station Woman among others. Thus, municipalities become

responsible investing in units of reference for health care to woman victim of sexual violence.

Considering government actions aimed at this group of women, we believe it is relevant to analysis of interventionist proposals in violence prevention, knowing the sociocultural characteristics of women who have experienced sexual violence seen at a referral center.

Whereas currently, the health units of the municipality of Rio de Janeiro have been organizing the care for people who experience violence, it becomes important to assess data regarding follow-up of these women who have experienced sexual violence and who are cared for in the public hospitals of reference. Thus, the objective of that study, characterize and analyze the socio-cultural profile of the female population who experienced sexual violence treated at a referral center in the municipality of Rio de Janeiro.

Such data may contribute to the proposition of more qualified, humane interventions that promote prevention and even aid in achieving the resilience of these women, as well as their citizenship.

OBJECTIVE

Characterize and analyze the socio-cultural profile of the female population who experienced sexual violence met in a reference unit in the municipality of Rio de Janeiro.

METHOD

A study of descriptive, exploratory, quantitative approach, having as source the records of women who have experienced sexual violence and were answered in a unit linked references the Municipal Health Secretariat of Rio de Janeiro.

The study was conducted on a municipal Maternity Hospital in Rio de Janeiro, located in the program area 1.0 (covering the districts São Cristóvão, Benfica, Caju, Catumbi, Centro, Cidade Nova, Estácio, Gamboa, Mangueira, Paquetá, Rio Comprido, Santa Teresa, Santo Cristo, Saúde and Vasco da Gama), municipal and state references for the care of women who experience sexual violence. The study was approved by the Ethics and Research of the Municipal Health Secretariat of Rio de Janeiro, protocol number 212/11, respecting ethical principles, according to Resolution 196/96 of the National Health Council.[7] Data collection occurred between the months of November 2011 to March 2012.

The medical records of women enrolled in the period 2008 and 2009, the clinic for Victims of Sexual Violence hospital reference, linked to the Municipal Health and Civil Defense were investigated. We analyzed eighty-two (82) charts in 2008 and seventy-five (75) records in 2009, resulting in a total one hundred and fifty seven (157) records. In order to systematize the survey, a questionnaire containing topics related to the socio-cultural profile of these women was used.

The inclusion criterion was selected only the records of women who have experienced sexual violence with over 18 years of age; this criterion is based not work with children and teenagers, they are not part of the target group of the survey, as well as requiring the issues that are not inherent in the thematic approach of the study.

Finalized data collection and transcription thereof, the quantitative analysis was done in view of the technique of simple descriptive statistics, used as a resource to assess the accuracy of the generalizations of the samples analyzed for the total population of the universe. [8]

RESULTS E DISCUSSION

By investigating the socio-demographic characteristics of women who have experienced sexual violence between the years 2008-2009 and were answered in a municipal unit of reference in the city of Rio de Janeiro (Table 1.), It was found that most women is young, aged between 18-33 years of age, a percentage of 76.83% and 81.33% of all cases of sexual violence treated at the reference in the respective years. Secondly, the age group between 34-45 years of age with the percentage of 14.64% and 9.33% respectively in 2008 and 2009 and over 45 years of age, the percentages ranged from 8.54% in 2008 and 9.33% in 2009.

Table 1: age group of women who have experienced sexual violence met in a hospital unit of reference in the city of Rio de Janeiro - year of 2008 and 2009.

Age / Year	2008		2009	
	f	%	f	%
18 to 21	20	24,39	24	32,00
22 to 25	18	21,95	15	20,00
26 to 29	15	18,29	12	16,00
30 to 33	10	12,20	10	13,33
34 to 37	8	9,76	4	5,33
38 to 41	1	1,22	1	1,33
42 to 45	3	3,66	2	2,67
Over 45	7	8,54	7	9,33
Total	82	100,00	75	100,00

By virtue of Brazilian cultural patterns, women aged between 18-33 years old are more likely to experience sexual violence. There is justification for the aesthetic body itself, where the body during this period is most beautiful in shows and attracts attention, which can lead to insecurity and domineering and violent attitudes in man.[9] The incidence of sexual violence in this age group is four times largest, being a serious problem that occurs mostly in the age group between 15 to 44 years old. [10-11]

As for paid employment or not women who experienced sexual violence in 2008 and 2009 (Table 2). Observe the division of two groups, those with financial income and those without income. Those with income form percentage of 53.66% and 57.33% in 2008 and 2009, are included in this aspect some professions as sellers, teachers, makeup artists, estheticians, among others; those without income form a percentage of 39.2% and 36% in the respective years of 2008 and 2009, are included in this aspect the students, home,

homeless; and without registration (no data records), forming a percentage of 7.32 and 6.67% in 2008 and 2009.

Table 2: economic situation of women who have experienced sexual violence met in a hospital unit of reference in the city of Rio de Janeiro in 2008 and 2009.

Personal Financial Income / Year	**2008**		**2009**	
	f	**%**	**f**	**%**
Without income	32	39,02	27	36,00
With income	44	53,66	43	57,33
Without record	6	7,32	5	6,67
Total	82	100,00	75	100,00

Many women who have experienced sexual violence has some sort of income, which contradicts the main references that relate to the absence of income with the high rate of violence, because women become economically dependent partner, which in most cases is the primary aggressor.[12]

Paid work contributes to reduce the rates of domestic violence, since most women who experience violence is at home. [13] But we must attend to the cases of underreporting of domestic sexual violence, where women do not report for fear and even for being economically dependent on aggressors.

One of the contributing causes for the low frequency of complaints is that most assaults occur in the home environment and are committed by people known with some emotional bond, and these do not always complain or seek care at a health facility, although violence recur for months or years. [14]

Unfortunately, sexual violence is a common practice in the family environment and acquaintances.[11] The same is usually silent, naturalized in marital relationships and causes harm to women's health, especially in relation to the genital-urinary and psychological problems.

The main causes of admission of the female population in 2006 (last available data) are the genital-urinary complications, including sexually transmitted diseases, urinary tract infections, sexual violence, Cervical Cancer and other.[15]

Sexual Violence is the action that forces a person to have sexual, physical or verbal contact, or participate in sexual relations under force, intimidation, coercion, blackmail, bribery, manipulation, threat or any other mechanism to nullify or limit the personal will. Among the types of sexual violence there are: rape, attempted rape, seduction, the indecent assault and lewd act. [15]

Regarding the experience of sexual violence aspect and education levels of women (Table 3), women recorded as illiterate in medical charts in 2008 and 2009 respectively correspond to 1.22% and 0%; Full Elementary School have 9.76% and 10.67%; Incomplete Primary School 15.85% and 10.67%; Complete High School 18.29% and 20%; High School Incomplete 9.76% and 20%; Full Higher Education 13.41% and 5.33%; Incomplete Higher Education 10.98% and 17.33; ignored correspond to 0% 3.66% 17.07% and no records to 16%.

Table 3: Schooling of women who have experienced sexual violence met in a hospital unit of reference in the city of Rio de Janeiro in 2008 and 2009.

Schooling/ Year	2008		2009	
	f	%	f	%
Illiterate	1	1,22	0	0,00
Complete Basic school	8	9,76	8	10,67
Incomplete Basic school	13	15,85	8	10,67
Complete High school	15	18,29	15	20,00
Incomplete High school	8	9,76	15	20,00
Incomplete higher education	9	10,98	13	17,33
Complete higher education	11	13,41	4	5,33
Ignored	3	3,66	0	0,00
Without record	14	17,07	12	16,00
Total	82	100,00	75	100,00

The data show that most women who have experienced sexual violence features corresponding to high school education (complete and incomplete), followed by possessing Higher Education (Complete and Incomplete) and after having elementary school. Therefore it can be said that the occurrence of sexual violence has an impact on all levels of education, not being restricted to populations with low education, and not related only to aspect of poverty and social inequalities as associated issues related to income.

These results have relationships with those found by some authors and differ from others. Some claim that there is a direct relationship between low education and domestic violence; others claim that aggression has occurred with women at all levels of schooling.[16-17]

It is possible to think that the constitution of the population to have greater density of people with less purchasing power and that there is some concern about not exposing themselves in more affluent populations, data from seeking health services could have influenced their results by these socio-cultural aspects, where it is more common to low-income people seeking public health services for care, while the population with higher socioeconomic status tend to private clinics and doctors or family.

Regarding the marital status of women who experienced sexual violence in the years 2008 and 2009 (tab.4), it was observed that single match percentage of 70.73% and 70.67% in 2008 and 2009 respectively; married correspond to the percentage of 19.51% and 14.67% in 2008 and 2009 respectively; widows have no record in 2008 and 2.67% in 2009; separated correspond to the percentage of 3.66% and 2.67% in 2008 and 2009 respectively; ignored, 1.22% in 2008 and without registration (no data records), correspond to the percentage of 4.88% and 9.33% in 2008 and 2009 respectively.

Table 4: marital status of women who have experienced sexual violence met in a hospital unit of reference in the city of Rio de Janeiro in 2008 and 2009.

Marital status / Year	2008		2009	
	f	%	f	%
Single	58	70,73	53	70,67
Married/Stable union	16	19,51	11	14,67
Widow	0	0,00	2	2,67
Separated	3	3,66	2	2,67
Ignored	1	1,22	0	0,00
Without record	4	4,88	7	9,33
Total	82	100,00	75	100,00

70% It appears that of women who experienced sexual

violence in the years 2008 and 2009 are single women. However, the literature indicates that there is no consensus about the marital status of the most prone to experiencing sexual violence, there are those who point to a greater frequency of violence on women in unmarried condition, other condition for married women. [13-14]

It is necessary to consider the fact that many married women experience some form of sexual violence and do not identify as such, for example, non-consensual sexual intercourse during marriage (marital rape), with social support as sex conjugal duty. For longer be part of your daily life becomes somewhat trivialized, as 'naturalized' and therefore do not seek treatment and not perform notification, or even recognize that they are on some form of sexual violence, but for fear of not being understood and not receive support, fear of being blamed for what happened, feeling of protection to children, financial dependence or otherwise not seek care.

With regard to the aspect of ethnicity of women who have experienced sexual violence at the Hospital reference is noticed that the white skin is a percentage of 58.54% and 48%, in 2008 and 2009 respectively; the black skin color percentage with 9.76% and 14.67% in 2008 and 2009; dark brown skin with a percentage of 23.17% and 32% in 2008 and 2009; Indigenous women (yellow) do not have records in both years and there was no record in the chart with percentage of 8.54% and 5.33%, in 2008 and 2009 respectively. Soon this data shows that the majority of women who have experienced sexual violence in the years 2008 and 2009 were white women, followed by brown and black, as can be seen in Table nº5.

Table 5: distribution on the skin color of the women who have experienced sexual violence met in a hospital unit of reference in the city of Rio de Janeiro in 2008 and 2009.

Ethnicity / Year	2008		2009	
	f	%	f	%
White	48	58,54	36	48,00
Black	8	9,76	11	14,67
Dark	19	23,17	24	32,00
Yellow	0	0,00	0	0,00
Without record	7	8,54	4	5,33
Total	82	100,00	75	100,00

Although we have found in records that most women seen in reference hospital and who experienced sexual violence are white women and national surveys often show that violence affects mainly black and brown[(18)], women and, one might think that perhaps Caucasian women are more attend in health services to provide notice and conduct monitoring. Fact possibly linked to the level of education and better social opportunities than brown and black populations. It is worth noting that the ministry / national data represent a diverse reality while at the Rio de Janeiro is a bustling metropolis, dynamic and socially enlightened, because of its tourist, social and economic characteristics and achievements of many women's rights by state action.

It appears that there were no reported cases of sexual violence against indigenous attended this hospital, which is not to say that there were no cases of this form of violence for this population. It is possible to consider the issues related to cultural aspects of the indigenous population associated with the place of his habitation, habits and cultures, their restricted living in their community, in some cases far from urban centers and

consequently, away from contact with the rest of society, factors that could be considered protective.

The data show that there are no reported cases of sexual violence practiced by native who has little contact with the surrounding society or ourselves and others of greater contact time, but living in distant lands from urban centers. Most cases occurred in Mato Grosso do Sul, located on land close to urban centers, where sexual violence happens more frequently.[19]

CONCLUSION

Sexual violence against women is a complex issue and addresses cultural, social, gender issues, as well as physical, emotional and financial aspects. Meet the sociocultural characteristics of women who have experienced sexual violence leads us to think about the various forms of discrimination, oppression and subordination of women and to understand how the characteristics of gender, race / ethnicity, age, occupation, educational level and social class in this context relates of violence which these are embedded.

Observed with regard to the socio-cultural profile, which are young women between 18-33 years old, a period where the body is more attractive, which can generate the same insecurity and domineering attitudes of offenders. Most women had some form of financial income, ie, economically independent (if this aspect include some professions as sellers, teachers, makeup artists, beauticians, etc.) which contradicts the main references that relate to the absence of income with high violence index, since the woman would become economically dependent partner, which most often is the main aggressor.

Regarding educational levels, we found that the occurrence of sexual violence has an impact on all levels of education, not being restricted to populations with low education.

In relation to marital status and race / color was predominantly white and unmarried women, but we must emphasize the fact that many women declare themselves unmarried but live with their partner / partner or has a fixed relationship. Furthermore, we think that perhaps women of white race are the most attend in health services to provide notice and conduct monitoring. Fact possibly linked to the level of education and better social opportunities than brown and black populations.

Most women who have experienced sexual violence were not pregnant. However it is worth noting the full expression in the years 2008 and 2009 of 16.88% of women who experienced sexual violence during pregnancy, especially in the first quarter. These data are quite significant, as well as indicating the occurrence of sexual violence by partners and ex-partners in the household shows that, contrary to what you think, pregnancy is not indicative of protection for the non-occurrence of violence and many often can become a trigger for violence factor.

It is noticed that the data found in the study are fundamental to addressing violence from the actions and joints with various fields such as public safety, welfare, health and education, to ensure support for the raped woman.

However, the records analyzed in the study are permeated with weaknesses in their completion and reports from professionals who often are registered with incomplete information and with low approach to violence presenting difficulty to depict reality, which harms the seizure of data, difficult in some ways a more thorough analysis of the profile of these women.

Despite the issue come conquering space studies and research, there are few health services actually prepared to provide quality care to women who experienced some form of violence.

It is important that situations of violence against women are considered a health problem. It is necessary that health professionals have a more sensitive look at this theme. The dialogical action of care should be based on active, individualized, considering this woman that values the social aspects of gender, human rights, reproductive and sexual rights, public health policies in the area of the woman listens. We understand that the nurse, in particular the midwife has a formation that can greatly contribute to the proposition of actions will take care of this group of women.

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