

THE PERSPECTIVE OF PROFESSIONALS IN RELATION TO THE CARE GIVEN TO WOMEN IN SITUATIONS OF SEXUAL VIOLENCE: PERSPECTIVE OF THE UNIVERSAL DECLARATION OF BIOETHICS AND HUMAN RIGHTS

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ABSTRACT

Objective: to analyze the care provided to women in situations of sexual violence, from the perspective of professionals and from the perspective of the Universal Declaration of Bioethics and Human Rights.

Method: a qualitative, exploratory and descriptive study, conducted in a municipality in the north-central region of the state of Rio Grande do Sul, with 30 professionals from the multiprofessional team of intersectoral care services for women in situations of sexual violence. Data collection was conducted through semi-structured interview from January to April 2016. The results were subjected to Thematic Content Analysis.

Results: four thematic categories emerged, entitled: principle of respect for human vulnerability and personal integrity, in which situations of vulnerability surrounding women are found; principle of non-discrimination and non-stigmatization: services with adequate structures, confidentiality of information, acceptance, unprejudiced practices and/or judgments in care; principle of human dignity and human rights, agile actions, prudence, articulation with other services, the role of the state and public policies are mentioned; and principle of autonomy and individual responsibility: in decision making, the importance of emancipation and empowerment.

Conclusion: professionals face the challenge of facing a grievance surrounded by vulnerabilities and sometimes are not supported to meet the complex demands of women in situations of sexual violence. Protective public policies and care-based on user embracement are ways to minimize trauma and can encourage women to access services.

DESCRIPTORS: Violence against women. Sexual violence. Bioethics. Public policy. Patient care team.

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OLHAR DE PROFISSIONAIS NO ATENDIMENTO A MULHERES EM SITUAÇÃO DE VIOLÊNCIA SEXUAL: PERSPECTIVA DA DECLARAÇÃO UNIVERSAL DE BIOÉTICA E DIREITOS HUMANOS

RESUMO

Objetivo: analisar o atendimento a mulheres em situação de violência sexual, na ótica dos profissionais e na perspectiva da Declaração Universal de Bioética e Direitos Humanos.

Método: estudo qualitativo, de abordagem exploratória e descritiva, realizado em um município na região centro-norte do Estado do Rio Grande do Sul, com 30 profissionais da equipe multiprofissional dos serviços intersetoriais de atendimento a mulheres em situação de violência sexual. Coleta de dados realizada por meio da entrevista semiestruturada de janeiro a abril de 2016. Os resultados foram submetidos a Análise de Conteúdo Temática.

Resultados: emergiram quatro categorias temáticas, intituladas: princípio do respeito pela vulnerabilidade humana e integridade pessoal, em que são constatadas situações de vulnerabilidade que cercam a mulher; princípio da não discriminação e não estigmatização: necessários serviços com estruturas adequadas, confidencialidade das informações, acolhida, práticas sem preconceitos e/ou julgamentos no atendimento; princípio da dignidade humana e direitos humanos, para tanto são mencionadas ações ágeis, prudência, articulação com outros serviços, a função do Estado e políticas públicas; e princípio da autonomia e responsabilidade individual: na tomada de decisão, a importância da emancipação e empoderamento.

Conclusão: profissionais enfrentam o desafio de estar diante de um agravo cercado por vulnerabilidades e, por vezes, não estão respaldados para atender as complexas demandas da mulher em situação de violência sexual. Políticas públicas de proteção e o atendimento pautado pela acolhida são formas de minimizar o trauma sofrido e podem encorajar a mulher para acessar os serviços.

DESCRITORES: Violência contra a mulher. Violência sexual. Bioética. Políticas públicas. Equipe de assistência ao paciente.

LA PERSPECTIVA DE PROFESIONALES EN RELACIÓN CON LA ATENCIÓN A LAS MUJERES EN SITUACIONES DE VIOLENCIA SEXUAL: PERSPECTIVA DE LA DECLARACIÓN UNIVERSAL DE BIOÉTICA Y DERECHOS HUMANOS

RESUMEN

Objetivo: analizar la atención brindada a las mujeres en situaciones de violencia sexual, desde la perspectiva de los profesionales y desde la Declaración Universal de Bioética y Derechos Humanos.

Método: estudio cualitativo, exploratorio y descriptivo, realizado en un municipio de la región centro-norte del estado de Rio Grande do Sul, con 30 profesionales del equipo multidisciplinario de servicios de atención intersectorial para mujeres en situaciones de violencia sexual. La recopilación de datos se realizó mediante una entrevista semiestruturada de enero a abril de 2016. Los resultados se sometieron a análisis de contenido temático.

Resultados: surgieron cuatro categorías temáticas, tituladas: principio de respeto a la vulnerabilidad humana e integridad personal, en el que se encuentran situaciones de vulnerabilidad en torno a las mujeres; principio de no discriminación y no estigmatización: servicios necesarios con estructuras adecuadas, confidencialidad de la información, recepción, prácticas sin prejuicios y / o juicios de asistencia; principio de dignidad humana y derechos humanos, se mencionan acciones ágiles, prudencia, articulación con otros servicios, el papel del estado y las políticas públicas; y principio de autonomía y responsabilidad individual: en la toma de decisiones, la importancia de la emancipación y el empoderamiento.

Conclusión: los profesionales enfrentan el desafío de enfrentar una queja rodeada de vulnerabilidades y, a veces, no reciben apoyo para satisfacer las complejas demandas de las mujeres en situaciones de violencia sexual. Las políticas públicas de protección y la atención basada en el huésped son formas de minimizar el trauma y pueden alentar a las mujeres a acceder a los servicios.

DESCRIPTORES: Violencia contra la mujer. Violencia sexual. Bioética. Políticas públicas. Equipo de atención al paciente.

INTRODUCTION

Sexual violence against women expresses the perversity of violence and gender inequality. Treaties and conventions, approved by international rights bodies, state that sexual violence against women is a violation of human rights.¹

Although it is not the most prevalent type of violence against women, sexual violence has a destructive impact.¹ Exposure to violence results in consequences that range from physical injury, risk of unwanted pregnancy and sexually transmitted infections (STIs), problems related to sexual and reproductive health, psychological and emotional distress and, in some cases, may lead to death.¹⁻²

The problems arising from violence also encompass governmental areas such as health, justice, social assistance, human rights, among others, which require integrated policies and actions to address this phenomenon.¹⁻² It is beyond gender inequality, social determinants, the role of the state and the difficulties in implementing public policies which fight against violence.²

Women's movements and other parts of society were instrumental in gaining rights and fostering state actions, and in implementing public policies to combat violence against women. Thus, the legislation and policies related to violence against women that have been developed over the years in

Brazil have the purpose of preventing and confronting violence, health care, protection and guarantee of rights, supported by international norms and rights bodies.¹ The care of women in situations of sexual violence is performed in the care network, which concerns intersectoral actions and services (in particular, social assistance, justice, public safety and health).³

Humanized, qualified and comprehensive assistance is recommended via a multiprofessional, qualified team. In the health area, it is recommended that this team be composed of professionals from nursing, medicine, psychology, and social assistance. However, members may vary depending on the professionals in each health facility. And in addition to health services, there are professionals from sectors such as police stations, the Forensic Institute, the judiciary, social support services, non-governmental organizations. The service occurs according to the needs of each situation.¹

The reality of healthcare practice, in the context of health, as shown by an integrative review on the care of health professionals to women in situations of sexual violence, values care based on the biomedical model, exposes the lack of continuity in intersectoral services and the need to train professionals to care for women in situations of sexual violence.⁴

Other national studies address aspects related to the intersectoral network of services, the use of protocols, and the care provided by professionals in other areas, such as forensic and legal-police⁵⁻⁶ International studies contextualize situations of sexual violence against women in areas of war, the care of health professionals, the health care system and the epidemiology of sexual violence against women.⁷⁻⁸

Despite the existence of studies that portray care to women in situations of sexual violence,⁹⁻¹⁰ there is an integrative review of the recently published literature, which analyzes studies on hospital care to women victims of sexual violence in the Brazilian context from the perspective of bioethics of risk and protection.¹¹ Thus, in view of the gap in field research studies that directly address the care of women in situations of sexual violence, from the perspective of professionals and from the perspective of bioethics, using the Universal Declaration on Bioethics and Human Rights (DUBDH), the purpose of this study is to investigate the approach of DUBDH.

DUBDH was adopted from The United Nations Educational, Scientific and Cultural Organization (UNESCO) as a bioethical reference. DUBDH guides the decisions or practices of public and private individuals, groups, communities, institutions and companies.¹²⁻¹³ It incorporates ethical principles of respect for human dignity and presents a broader bioethics that, in addition to biomedical and biotechnological issues, raises issues related to social, environmental and other inequalities. The DUBDH shows the importance of bioethics as an aid in resolving ethical conflicts that violate human rights.¹⁴

Thus, the study aims to contribute to the production of knowledge and the promotion of reflection on the theme, from a real context where the professional challenges of care for women in situations of sexual violence are processed. Thus, the aim of the study is to analyze the care of women in situations of sexual violence, from the perspective of professionals and DUBDH. The guiding question is highlighted as: how do professionals who integrate health care services, protection and psychosocial support in a city of Rio Grande do Sul perceive the care of women in situations of sexual violence?

METHOD

A qualitative study with an exploratory and descriptive approach performed in a municipality located in the north-central region of the state of Rio Grande do Sul, with professionals from the multidisciplinary team of intersectoral services for women in situations of sexual violence, they included: 2 (two) referral hospitals, Municipal Health Secretariat (SMS) that coordinates the Specialized Care Service (SAE), Primary Health Units (BHUs) and Family Health Strategy (FHS); Secretariat of Citizenship and Social Assistance (SEMCAS) which coordinates the Specialized Reference Center on Social Assistance (CREAS) and Casa Abrigo; the Specialized Police Station for Women Service (DEAM); the Forensic Medical Department (DML); Public ministry; and the extension projects of the local university: Prevention, Intervention and Follow-up Clinic in Violence Situations (CEPAVI), and Legal Service and Multidisciplinary Assistance to Women Victims of Violence and Family (PROJUR/Women).

These locations were selected because they are services that provide care to women in situations of sexual violence. The survey participants were: nurses, psychologists, doctors, lawyers, social workers, and other professionals from other areas. The sample was intentionally composed, totaling 30 professionals. Inclusion criteria were: participants with third level education, who have attended or care for women in situations of sexual violence, regardless of age, gender, working hours and time of work. Professionals who were on vacation or legally absent due to some type of leave were excluded.

The interview was held via telephone at the workplace as to ensure privacy, and scheduled according to the availability of the participant. The order of data collection was flexible and occurred according to the situation of each location and the possibilities presented by the participants.

The study adhered to the guidelines of Resolution N. 466/12 of the National Health Council that deals with the Guidelines and Regulatory Norms for Research involving Human Beings.

The research technique used was semi-structured interview. The interview consists of a field research strategy, using verbal communication and gathering information. The semi-structured interview discusses open and closed questions and follows a script as a qualitative research tool.¹⁵ The questions in this study were open and addressed the organization of care for women in situations of sexual violence, professional practice; difficulties and facilities experienced in care and ethical problems in cases of sexually abused women.

Among the 30 interviews, 23 were given authorization to record, and seven were handwritten, due to participants not authorizing the recording. The average duration of the interview was 20 minutes. The interviews were transcribed in full in a Microsoft Word document by the researcher. Data collection took place from January to April 2016. Participants were identified by the letter P of professional, followed by the initial by area of practice: S = Health (hospital and public health) and PAP = Psychosocial Protection or Support and a number.

Thematic content analysis was used for data analysis.¹⁵ The three steps that make up this technique led to the analysis: first stage (pre-analysis); second stage (material exploration) and third stage (treatment of results obtained and interpretation). The interviews were transcribed and then the content was validated by the participants. The characterization of the participants is also performed.

RESULTS

Among the 30 professionals who participated in the interviews: there were 11 nurses, six psychologists, five physicians, three lawyers and three social workers, and other professions: two participants. In the health area: 12 professionals work in the hospital area and 10 in public health. Eight professionals were interviewed from the protection or psychosocial support area. Length of service ranged from 1 year to 25 years or more, with 28 having third level education and two had technical degrees.

From reading, exploration and analyzing the statements, categories emerged that enabled a productive interface with four of the DUBDH principles. Thus, the thematic categories were given titles with the principles that best added meaning to the statements of the research participants, namely: principle of respect for human vulnerability and personal integrity; principle of non-discrimination and non-stigmatization; principle of human dignity and human rights and principle of autonomy and individual responsibility. These principles were listed because of their concept to support the reflection of situations raised by the participants that emerge in the care of women in situations of sexual violence.

Principle of respect for human vulnerability and personal integrity

This principle addresses the duty to protect vulnerable individuals and groups, as well as respecting personal integrity. Human vulnerability should also be considered when applying and advancing scientific knowledge, medical practice and technology.¹²

The following statements express the concern of the professionals regarding the situations of vulnerability for women in situations of sexual violence; Financial dependence, fear, insecurity and suffering are some of the elements expressed during care and highlight the vulnerability of these women who live and remain in a situation of violence and, at the same time, reveal the possible weaknesses of the care network: *she was afraid that the arrested offender might go out and take revenge for prosecuting him. The person who makes the complaint and then withdraws. These games that can happen from threats is a hypothesis (PS22); they are very afraid and say that they would not like the reported situation to be published. They say: but if I go there and make this complaint, then he will beat me and rape me in the same way (PPAP18); she ends up subjecting herself because if she leaves this relationship, she doesn't know how to do anything, she has no professional preparation and she has to support five children and she will have to stay with that person (PS17).*

In addition to the feelings experienced by women, vulnerability results in silence and invisibility of violence, as well as ignorance of rights and other factors that favor this veiled scenario: *a woman who for about 5 years has been sexually abused by her partner and, if that wasn't enough, he also abused his 8-year-old daughter. The woman was required to have sex with the perpetrator under death threats. She also knew about the abuse with her daughter, but for fear she was silent (PPAP23); The women who come to us, many do not tell us that they suffer violence, because for them the notion of abuse is unknown. Most are raped by their husbands themselves and feel that this is normal, that they have an obligation to fulfill the desire of the husband (PPAP18); when the abuser lives in the same house it gets harder; when it is the husband, because women end up not accusing and that means there is no punishment. They feel love and affection because of being in the relationship for years or the very fear of not being able to be alone. There are several social factors of vulnerability of these women, which sometimes results in them only seeking health care and not going to the police station (PS4).*

Principle of non-discrimination and non-stigmatization

The principle provides that “no individual or group shall under any circumstances be subjected, in violation of human dignity, human rights and fundamental freedoms, to discrimination or stigmatization”.^{12:8}

Stigma and discrimination surround sexual violence against women. Professionals express the “pain” that these women carry: *injured by sexual violence, go through embarrassing situations, through services with inadequate structures for care, causing revictimization of women: the issue of space should be very important, if it is in a little room, no one will come in and disturb; because sometimes care is urgent, sometimes inside a ward and depending on where the person is she will not tell, will not talk, it is very delicate (PS20); At the same time, someone is recording an incident about a stolen car radio, a military police officer recording a bank break-in, and among us, at the other window there is a person saying that she was raped, a victim of rape. It’s just a touch. I think of it as a difficulty (PS19); and for the woman this is already suffering another violence, she leaves the service and then? What she will do? She will be raped again. Because she doesn’t receive the care that she deserves (PS13).*

Information confidentiality is one of the important issues to be observed in order not to favor stigma and discrimination against women: *as for the patient’s medical record, she goes through several people within the unit: reception, nursing, psychologist and doctor. We have a high turnover of third-party employees, so there are often many new employees; and you never know the profile of this professional (PS7); she sought another unit for fear that people working within that basic unit would bring the matter to their neighbors. That was her concern (PS29).*

Another important point to highlight is the feeling that the woman perceives when nobody believes the violence she has suffered: *when she arrived home, she had no family support, because no family member believed she had been abused, even though she was bruised (PS3); first because she is embarrassed to seek care, because she may suffer discrimination and because it is not easy for you to admit that you are a victim of violence [...] she doesn’t talk about it much, it is very great difficult for her and she feels shame for what happened (PS4); A major difficulty is the social prejudice towards the victim of violence. The woman avoids seeking help because she knows she can be discriminated against and probably will be (PPAP28); she took all those days to talk to her husband for fear that he did not believe that she had actually been raped (PS29).*

The stigma surrounding sexual violence, in many situations, focuses on blaming women: *oh, but it’s like that on the streets! The issue of clothing, which sometimes causes the person to cause something to happen, or, ah, went out at night, such a time in the middle of the night (PS4); We already had some patients who had a difficult first consultation. They are always ashamed and/or guilty, although we always explain that they do not have to be ashamed or guilty for what happened (PS17); she may punish herself, not seek help, and blame herself for what happened. Society itself will discriminate. So sometimes, isolation itself is a form of protection, an attempt to preserve herself [...] there is also the difficulty of access, stigma, so these are similar situations at this point, hence why our reception is fundamental for patients to adhere to treatment (PS22).*

Prejudice against women in situations of sexual violence, the judgment and deconstruction of some concepts are elements that also appear and make access and care difficult: *there is still a lot of shame and prejudice to access not only health care , but even to make an Police Report (PS6); as she will say: I was a victim of sexual violence. There is always a pre-judgment! You have nothing to judge, I have to listen to what the patient is telling me and follow the protocol [...] to start tearing down some things that are strongly resisted by peers in dealing with sexual violence (PS24).*

Principle of human dignity and human rights

The principle states that “human dignity, human rights and fundamental freedoms must be fully respected. The interests and welfare of the individual must prevail over the sole interest of science or society”.^{12:6}

Agile actions, prudence, perceiving all dimensions of the person and connections with other services in the municipality refer to respect for human dignity and the rights of the person, specifically women in situations of sexual violence: *the victim of sexual violence is frequently subjected to recapitulating the situation experienced. This causes stress, which impairs care in the investigation, and in some situations, the victim gives up going through with reporting the aggressor (PPAP1); the moment the patient seeks out help, we should act, because if we do not at that moment, she'll give up, because there are so many difficulties and pressure and we have to understand [...] we advise them to make a police report in the Women's Police Station, then we realize the difficulty due to the emotional conditions that this woman has, and we often need to call the service to the unit (PS7); we try not to question too much and move from one team to another; We try our best to make sure that the person does not suffer this embarrassment, because there is already the embarrassment of the situation and the embarrassment of everyone wondering what happened (PS9).*

According to some professionals, the complexity of the situation is a challenge for care. Approaching is difficult and, on the other hand, the woman finds it difficult to report the fact: *she comes with humility and internal suffering. Often they do not want to identify the situation very well; they just talk a little, and then they retract (PS9);* Most of the time, if not all, the victims feel embarrassed to talk about what really happened, because they need to remember the serious situation and how their rights were violated, which aggravates their lives both physically and psychologically (PPAP23).

Another issue is the role of the State in preserving the rights of the person and promoting women's autonomy, as well as the existence of reference places and the constituted care network. However, issues with the continuity of these places are a problem for the professional: what can be done?

There are situations where we just do not know what to do. This direction that we have to have, we don't have yet (PS5); *The government must seek prevention and training for women so that they can get qualifications for some type of job, earn a living, be independent and not depend on the aggressor. Working for women's autonomy [...] I understand that sexual violence against women is a public health problem, so much so that we carry out various activities within our community, within the organs and [...] the State 'violates' us a lot by delaying the consultations, the exams, delaying care to woman, the referrals (PPAP18); The state as a whole today is not prepared for this kind of question. We are unprepared to respond to this issue [...] (PPAP30).*

Principle of Autonomy and Individual Responsibility

This refers to autonomy in decision-making, assuming responsibility and respecting the autonomy of others. In cases of persons unable to exercise their autonomy, special measures should be taken to protect their rights and interests.¹²

In situations of sexual violence against married women, an issue that would enable a person to think for herself and act for herself in decision-making would be emancipation, as well as overcoming social vulnerability as well as other vulnerabilities. Considering respect for decision making and protecting the rights and interests of individuals, the practitioner needs to provide the information, but also needs to understand what is involved in making a decision for women, such as the factors involved in breaking the cycle of violence: *There are also difficulties related to users not knowing their rights. We have to work with various difficulties. Users who do not know about certain rights learn*

about her rights here (PPAP2); At the moment they are approached with the issue of registering the Police Report, seeking to validate their rights, most of them do not seek, they do not want to seek, so they only come for medical care (PS4); so you have to break away from an identity that the woman is a victim of violence and becomes someone who wasn't raped, it's very complicated. It is breaking with a parameter, an identity, and sometimes they run away from treatments because of this [...] that we have no other resources but to guide the patient to reflect and make the report, but it is very complicated, because for some of these women it's bad, but it's the only life they have and for others it means breaking away from a life they've lived their whole lives (PS6).

DISCUSSION

The statements show two specific circumstances of women in situations of sexual violence: the woman who comes from a condition of chronic sexual violence, perpetrated by someone close to her or with an affective bond; and the situation of acute sexual violence, in most cases by strangers. However, both violence points to situations of vulnerability that women experience; as analyzed in the category of respect for human vulnerability and personal integrity.

Regarding vulnerability, the difference between the concepts of vulnerable and vulnerable IS highlighted. Vulnerable is the universal characteristic of any organism, as a weakness and not damage, in which actions of the state of protection are important so that vulnerability, which is an inherent aspect of the human being, does not damage the integrity of the individual. Vulnerable concerns the factual situation of damage and which is important in decision making; and because of the damage, society needs to offer therapeutic and protective services to reduce it. Care should be directed to individuals, families, groups and communities who have become vulnerable by any condition, whether individual, social or environmental. Women are also in the group as vulnerable.¹⁶

In situations of caring for women victims of chronic violence, the professional must realize that there is something beyond the present complaint of the woman. The domestic environment, situations of financial dependence and other factors favor, for example, the social vulnerability of this woman and cause violence to be invisible¹⁷ and silent. Despite being oriented and referred to the responsible agencies to complete the care in the health care network, the health professionals report the situation is often restricted to health care, and that the cycle of violence may possibly continue.

Regarding acute and chronic sexual violence, it can be seen in the statements of professionals that many women fear reporting their aggressor, and an analysis of possible gaps in the intersectoral network can be inferred. A study⁵ carried out in another Brazilian scenario, referring to the intersectoral network of women in situations of violence, describes the fragmentation and discontinuity between the network services, in which its continuity and functioning, as demonstrated by a study on sustainability and continuity of networking, includes active member participation, management investment, meetings, visits, among other strategies.¹⁸

In addition, women express inferiority, insecurity and fear. Sequelae sometimes last forever and trace back to the vulnerable situation of sexual violence against women. Thus, the DUBDH, as a reference for bioethics, contributes guidelines for the construction of public policies aimed at vulnerable groups.¹⁹ DUBDH is a global document that represents an important instrument aimed at supporting the actions of professionals involved in attending this public. For the implementation of practices that welcome women in situations of sexual violence, bioethical elements can become normative because they consider all aspects of vulnerability that involve women, so that protective actions are offered in order to understand and respect the veiled facts of the social context of these women which may influence their decisions. Another situation reported by the participants refers to

situations in which women are raped by their partners, however, they do not recognize as sexual violence because they understand that they are fulfilling their role as partners. This situation is revealed as a common occurrence in services, whereby sometimes the woman does not seek the service due to sexual violence but for other types of violence, such as physical, moral, psychological, or other health situations. For the professional to understand that women believe that it is normal to be in this situation leads to the understanding of a cultural construction and the alienation of rights as a human being of this woman, translating the gender inequality represented by sexual violence.²⁰

The category principle of non-discrimination and non-stigmatization allows us to express the elements involved in sexual violence against women, whether by family members, professionals or society. One factor that contributes to this situation is services that are not suitable to care for women, in relation to the physical structure and professionals who are not qualified to receive sexually abused women.¹¹ Another factor is the care practices that stigmatize and discriminate women in situations of sexual violence, when they are not accepted or treated as the guilty party, judged, among other attitudes, that negatively affect human dignity and human rights, which are fundamental bioethical principles.¹²

The stigma leads to the woman not believing in herself, i.e., she fears not being believed and avoids seeking help. A study²¹, dealing with this theme, analyzes the disbelief or denial experienced by women in relation to reporting rape. In another analytical study concerning the principle of non-discrimination and non-stigmatization, the authors address the importance of understanding the processes of stigma and discrimination production and the implications of these practices on people and society. Therefore, being aware of these processes can prevent such practices from being reproduced in the care of women, since in many situations women are already discriminated against by family and society.

Ensuring the confidentiality of information provided by women in services is a challenge, according to some participants. A study conducted in the health area also highlighted the concern among professionals regarding the confidentiality of user information.²³ These are questions that cause bioethical concern of different professionals beyond the normative questions of the profession and its deontological codes. Confidentiality is an implicated principle in DUBDH,¹² it is one of the foundations of respect for human dignity.

The statements reveal, in some situations, the discomfort and suffering experienced by women seeking care. Regardless of the location of the care network, if there are no professionals prepared to welcome this woman, care and follow-up care are compromised. Therefore, silence and social isolation can be a defense to face the "burden" of stigma and discrimination. Thus, the way in which the professional approaches the women, based on bioethical principles, such as respect, helps the woman to feel truly accepted by the services, different from a service restricted to technical, operational and apathetic aspects. This approach based on empathy is an assumption described in studies that minimizes the pain of women in this situation and encourages them to access the care network and seek their rights.²⁴⁻²⁵

Regarding the category the principle of human dignity and human rights, in the context of care for women in situations of sexual violence, it can be inferred that agility and respect in care are actions used to defend the dignity of women, in addition to other elements already discussed in the previous categories. The professionals, participants of the research, indicate that sometimes women find it difficult to report what happened. Therefore, it is believed that the report may occur to the extent that the care is configured in a differentiated service. Thus, in addition to clinical treatment, it is necessary to provide emotional, psychological and spiritual support, capable of providing effectiveness to relevant conduct and conditions to minimize the trauma suffered.

It is noteworthy that comprehensive care is also recommended in other situations, but in many places women in situations of sexual violence are treated in services that are not exclusive, such as in women's referral centers (public health, police stations, hospitals). Therefore, providing care in general services becomes challenging.

And in addition to professionals, State actions also corroborate the principle of human dignity and human rights. However, there is the perception of participants regarding the weakening of the state, although the right to health is their duty, there are weaknesses in confronting violence against women. This is evidenced by the lack of professionals and the delay in scheduling specialist consultations, also affecting the team that does not have a direction for referrals and thus compromising the protection of women. The role of the State in guaranteeing rights, such as health and social protection, is an element of bioethical discussion. Assuming this criterion to think about conflicts arising from fragile state protection can provide arguments for the production of policies that consider, beyond prevention, the joint responsibility for protection that is both individual and collective.²⁶

In the fourth category, autonomy and individual responsibility, it is understood that women in situations of sexual violence need social and individual support to overcome this reality and break the cycle. Knowledge of their rights, work and study are factors that contribute to the emancipation and empowerment of women. These aspects are pointed out in a research conducted with women in situations of interpersonal violence by their intimate partner, analyzing the factors involved in decision-making in the search for institutional reference support and self-confidence to leave the situation of violence.²⁷

However, study participants express concern that women, in order to get out of violence, need to be helped to break away from an identity which is challenging. Thus, the bond with the professional, in a relationship of trust and support, access and adherence to treatment form a set of elements that within a social context can strengthen her as an emancipated person.²³ A study conducted with women in situations of violence by their intimate partner highlights that the bonds established by the comprehensiveness and effectiveness of care are important for women's autonomy.²⁸

When approaching the concept of autonomy, a reflection study relates it to the freedom of choice based on the information received and options offered. Thus, autonomy is a developed process based on the environment in which the individual lives, such as biological, psychological and sociocultural contributions, which may interfere with the individual's ability to make decisions. Thus, the autonomy of the individual can be increased or reduced by circumstances such as age, psychological state, among other situations.²⁹

The proposed reflection between the daily issues reported by professionals in the care of women in situations of sexual violence and the analysis inferred from the perspective of DUBDH are limited to a specific scenario of care services for this public. Thus, their results cannot be generalized to other realities. Conducting studies in other contexts using DUBDH may broaden the discussion on the subject.

Further studies are recommended in order to develop bioethical aspects involved in care in order to contribute to comprehensive care and confront sexual violence against women.

CONCLUSION

The results emphasize that the issues involved in the care of women in situations of sexual violence identified by professionals refer to elements of bioethics, such as human dignity, autonomy, non-discrimination, non-stigmatization, human rights, state protection and possible weaknesses in the service network, such as discontinuity between services.

It is inferred that professionals face the challenge of facing a problem that affects the health and life of women in all dimensions and sometimes are not supported, either by appropriate structures, network organization or even because they do not feel that they have all the knowledge required to meet the complex demands of women in situations of sexual violence.

The choice of some DUBDH principles, one of the bioethics references, supported the findings of the study, bringing together contextual, technical, operational and subjective questions from a reflection based on bioethical foundations. With this, it changed from a unidirectional compression and unveils a scenario with other possibilities for discussion and construction of new perspectives.

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NOTES

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AUTHOR CONTRIBUTION

Study design: Trentin D.

Data collection: Trentin D.

Analysis and interpretation of the data: Trentin D, Vargas MAO.

Discussion of results: Trentin D, Vargas MAO.

Writing and / or critical review of content: Vargas MAO, Brehmer LCF, Vargas CP, Schneider DG, Leal SMC.

Revision and final approval of the final version: Trentin D, Vargas MAO.

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There is no conflict of interest.

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