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RESEARCH

Profile of victims of sexual violence receiving care in Campinas

Ana Isabela Morsch Passos[1], *Daniela Angerame Yela Gomes*[2], *Carolina Lourenço Defilippi Gonçalves*[1]

1. Centro Universitário Salesiano de São Paulo (Unisal/Liceu Salesiano), Campinas/SP, Brasil. **2.** Universidade Estadual de Campinas (Unicamp), Faculdade de Ciências Médicas, Hospital de Clínicas, Centro de Atenção Integral à Saúde da Mulher (Caism), Ambulatório de Atendimento Especial do Departamento de Tocoginecologia, Campinas/SP, Brasil.

Abstract

The aim of this study was to characterize the profile of the care offered to female victims of sexual violence with an emphasis on legal aspects. A descriptive and retrospective study of 41 women with an average age of 31 years who had experienced sexual violence within the stipulated period was carried out. The highest frequency of the crimes occurred between 00h00min and 06h00min (n=17). There was a frequency of 56% for the data "police report". The crimes found were rape (n=37) and rape by deception (n=4). A total of 12.20% victims (n=5) completed the proposed treatment. The majority of victims were single, and subjected to rape with violence or serious threat in the "street" location. Although more than half of the sample described completing a police report, the veracity of this information could not be confirmed as the reports were not found in their medical records.

Keywords: Women's health. Sex offenses. Delivery of health care. Ambulatory care.

Resumo

Perfil do atendimento de vítimas de violência sexual em Campinas

O objetivo deste estudo foi caracterizar o perfil do atendimento a mulheres vítimas de violência sexual, com ênfase nos aspectos jurídicos. Foi realizado estudo descritivo e retrospectivo, incluindo 41 mulheres com média etária de 31 anos que sofreram violência sexual no período. A maior frequência dos crimes ocorreu entre meia-noite e seis da manhã (n=17). Para os dados de "boletim de ocorrência" foi encontrada frequência de 56%. Os crimes encontrados na amostra foram de estupro (n=37) e violação sexual mediante fraude (n=4). Do total, 12,20% (n=5) completaram o atendimento proposto. As vítimas eram na maioria solteiras, sujeitas a estupro com violência e grave ameaça no local "rua". Apesar de mais da metade da amostra relatar ter feito registro de boletim de ocorrência, não se pôde confirmar a veracidade dessa informação, pois as cópias dos boletins não foram encontradas nos prontuários médicos correspondentes.

Palavras-chave: Saúde da mulher. Delitos sexuais. Assistência à saúde. Assistência ambulatorial.

Resumen

Perfil de la atención a víctimas de violencia sexual en Campinas

El objetivo de este estudio fue caracterizar el perfil de la atención a mujeres que fueron víctimas de violencia sexual, con énfasis en los aspectos jurídicos. Se realizó un estudio descriptivo y retrospectivo, en el cual se incluyeron 41 mujeres de un promedio de 31 años, quienes fueron violentadas sexualmente en el periodo. La mayor frecuencia de los crímenes ocurrió entre la media noche y las seis de la mañana (n=17). Para los datos del "informe de eventos" se encontró una frecuencia del 56%. Los delitos que se hallaron en la muestra fueron violación (n=37) y violación por medio del engaño (n=4). Del total, el 12,20% (n=5) completó la atención propuesta. La mayoría de las víctimas eran solteras, sometidas a abusos sexuales con violencia y amenaza grave en la calle. A pesar de que más de la mitad de la muestra relató que hizo el registro en el informe de eventos, no se puede comprobar la veracidad de esa información, ya que no se encontraron las copias de los informes en los registros médicos correspondientes.

Palabras clave: Salud de la mujer. Delitos sexuales. Prestación de atención de salud. Atención ambulatoria.

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Declaram não haver conflito de interesse.

From the earliest societies there have been reports of violence, whether interpersonal, work-related, gender-based, social, sexual, racial, physical or psychological. The most common definition is that of the World Health Organization (WHO), which describes violence as *the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation* [1].

Suffering violence can result in serious harm to the individual. It is estimated to be one of the leading global causes of death among people aged 15-44 [2]. When it does not cause death, violence generates pain, mental suffering, psychological distress, bodily injury, affecting global public health [3].

With respect to gender violence, the frequency of physical, mental and sexual abuse of women is high and recurrent [4]. In 1994, the Organization of American States met to discuss violence against women in a conference known as the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women or the Convention of Belém do Pará [5], ratified by Brazil in 1995. Article 1 of the Convention defines violence against women as (...) *any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere* [5].

Brazilian participation in the convention meant committing to institute preventive and punitive measures against gender violence, opening the way for the creation of Law 11.340/2006, known as the "Maria da Penha Law" [6]. Under this law, a person is considered a "woman" regardless of her sexual orientation, in other words the term encompasses lesbian, transvestite, transsexual and transgender individuals [7]. The law has also brought important changes to Penal Code [8], imposing more severe sentences and extinguishing alternative sentences for those who commit crimes of violence against women.

Although international efforts have been made to eradicate all types of violence, the rates remain alarming. One of the most frequent types of violence is sexual violence, described in the Penal Code [8] as a crime against sexual freedom, in the form of rape (article 213), sexual violation by deception (article 215) and sexual harassment (article 216-A). Women are still the main victims of this type of aggression [9], both because of their physical frailty in comparison with the male gender, and because of the historical religious submission related to marriage. In many cases the perpetrators have previously been attacked, and violence generates a cycle in which the family is disrupted and the woman is subjected to the will of the aggressor, fearful of a new wave of violence and sometimes in the name of protecting the children [6].

The Ministry of Health (MS), through the area of Women's Health, has created a booklet with technical guidelines to prevent and treat injuries resulting from sexual violence against women and adolescents [10], which should be followed by the health services, guaranteeing the dignity of women victims of sexual crimes. The booklet contains information on general standards of care, the prevention of infectious diseases, procedures in cases of pregnancy and termination of pregnancy, among others. Care for victims is interdisciplinary [11].

On these issues, the present study sought to obtain concrete data on the care of women victims of sexual aggression, emphasizing the legal aspects of the MS regulatory guidelines for these victims. The overall objective of the study was to characterize the epidemiological profile of the care of these women at the Prof. Dr. José Aristodemo Pinotti Women's Hospital.

Method

A retrospective, descriptive study with a quantitative approach was performed. The sample included all women who sought treatment at the Centro de Atenção Integral à Saúde da Mulher (the Integral Care Center for Women's Health) (Caism) as a result of sexual violence and were treated at the Special Care Outpatient Clinic of the Department of Obstetrics and Gynecology of this center at the State University of Campinas (Unicamp) between May 1 and October 31, 2014.

The study was approved by the Research Ethics Committee of the School of Medical Sciences of Unicamp, following the ethical principles described in the *Declaration of Helsinki* (Seoul, 2008) [12] and Resolution 466/2012 of the National Health Council [13].

Adult female patients receiving care at the Caism Special Care Outpatient Clinic during the stipulated period, with a first recorded complaint of sexual violence, were included. Patients younger than 18 years and those without the necessary data in their medical records to complete the data collection form were excluded from the study. To collect the variables of interest for the research, the medical records of the patients included in the study were used.

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The following data obtained from the medical records of these women were recorded: age; level of schooling level; marital status; profession; location of aggression/violence; previous record of sexual violence; time elapsed (in hours) between sexual violence and medical treatment Caism; whether another health service was sought before Caism; existence or not of police report of occurrence; genre; age of aggressor; existence of a family relationship between the victim and the aggressor; occurrence of penetration (partial or complete introduction of the male genital organ into the vaginal canal) or libidinous act (any act other than penetration capable of producing sexual arousal or pleasure) in sexual violence; existence and severity of personal injuries resulting from sexual violence (this variable follows the definitions of article 129 of the Brazilian Penal Code); occurrence of pregnancy due to sexual violence; infectious diseases caused by sexual violence and whether urgent protective measures were followed; record of psychological or psychiatric disorder resulting from sexual violence; whether the aggressor used violence (physical force) or serious threat (intimidation) to bring about sexual violence; if the perpetrator used deception to reduce or prevent the free expression of will of the victim; if the perpetrator misled the victim by deception, trickery, or any other means of fraud that would reduce or eliminate the victim's ability to respond to or express desire or intentionality with regards to engaging in sexual violence; if the aggressor had a superior hierarchical condition than the victim; whether the offender obtained or attempted to obtain any economic advantage; record of the type of care received in the period (doctor, nursing, psychological, social assistance, legal/judicial counseling or any other).

During the study, the data obtained from the medical records of the patients were kept anonymous. For the security and privacy of the participants, the data were archived in a Microsoft Excel 2010 database to which only the researchers involved had access. The sample was characterized according to the variables in question through values of absolute frequency (n), percentages (%) and descriptive statistics of the continuous variables through mean and standard deviation values.

Results

A total of 72 patients who were victims of sexual violence were selected, with no time limits applied. Of these, 28 were excluded as they were under 18 years of age; one was removed because they had undergone only attempted sexual violence, and two others were eliminated because their medical records were not located, thus preventing data collection. The total number of patients studied was therefore 41 elderly women (n=41). All of the described aggressors were male. Data on the age of the offenders were not found in the medical records in any of the cases. In five cases (n=5, 12%) the participation of more than one aggressor in the criminal act was reported.

Regarding the locations where sexual violence occurred, 40% of the incidents took place on the street while 25% occurred in the home of the victim. Other sites reported were bar, bus stop, nightclub, boyfriend's house, friend's house, scrubland, highway, wasteland and workplace of the victim. The city where most of the crimes occurred was Campinas (n=21). Five of the victims were attacked in a city other than that in which they lived, while for the others the crime occurred in their home city.

The average time between the sexual violence and the seeking of medical care was 3,894.79 ± 14,273.64 minutes, with a minimum of 180 minutes (3 hours) and a maximum of 86,400 minutes (60 days). As for the time of the crime, 42.50% of incidents occurred between 0h and 6h (n=17) and 35% between 18h and 24h (n=14).

The mean age of the participants was 31.46 ± 11.01 years, with a median of 27 years, and a maximum and minimum of 18 and 62 years of age. Data related to the age, schooling and marital status of the victims are described in Table 1.

Table 1. General characteristics of studied population. Data collected between May 1 and October 31, 2014. Caism, Campinas, Brazil

	Frequency (n)	%
Age range (n=41)		
18 to 30 years	22	54
31 to 40 years	9	22
41 to 50 years	7	12
51 to 60 years	2	5
61 to 70 years	1	2
Schooling (n=39)		
Completed elementary	14	36
Completed high school	21	54
Completed higher education	4	10
Marital status (n=40)		
Married	9	22,5
Single	31	77,5

Research

Data relating to the profession of the subjects were considered in 38 cases. The profession that appeared most frequently in medical records was student (13.16%), followed by cleaner (7.9%). Four women said they were unemployed. Other professions described were kitchen helper, retiree, administrative assistant, clerk, assistant clerk, cleaner, production assistant, domestic worker, homeworker, counterwoman, hairdresser, packer, nurse, florist, photographer, monitor at a shelter, judicial assistant, saleswoman and telemarketing operator.

The data obtained found that of the 41 women, 19.50% (n=8) reported having previously suffered sexual violence. Treatment at Caism was sought directly in 73.17% of cases (n=30), while 26.83% (n=11) went to another hospital unit before being treated by the care center. An affective relationship between the aggressor and the victim was confirmed in 24.40% of cases (n=10) and a family relationship in 7.32% of cases (n=3).

No descriptions were found, in the evaluated cases, of a relationship of hierarchical or economic advantage in the crimes committed. There were 9.75% reports that were typical of fraud (n=4) in the records analyzed. Thus, 90.25% of the crimes found in the sample (n=37) were classified according to the Penal Code as rape and 9.75% (n = 4) as rape by deception.

Of the 41 cases, there was sexual penetration in 29 cases, a libidinous act in 25 cases, the use of physical force in 31 cases and severe threat in 15 cases - 46% (n=8) with a firearm and 44% (n=7) with a knife.

Twenty-two (54%) victims suffered personal injury as a result of sexual violence, all of which were classified as minor injuries, based on medical records. The reported bodily injuries were anal laceration, anal edema, anal fissure, bruises, hematomas, scratches, hyperemia and harm to the circulation in the wrists.

Only one victim in the study reported becoming pregnant due to sexual violence, although this individual was undergoing a miscarriage by the time she was admitted to the Caism. Hospital treatment was only sought when the victim was already in this condition, 60 days after the date of the sexual violence, according to information provided by the victim herself. Of the 41 victims, two acquired infectious diseases related to the act of sexual violence. In 10% of cases (n = 4) there were no reports of prophylactic measures for sexually transmitted diseases or emergency contraception taking place. The condition of one of these four cases evolved into an infectious disease. The second case of a victim with an infectious disease received prophylactic measures for sexually transmitted diseases and emergency contraception.

A total of 56% of victims described completing a police report (PR) (n=22); however, the PR was attached to the medical record in only one case, and the remaining 21 only said they had completed a report. A forensic examination was carried out in 10.26% of the victims (n=4), and legal and/or judicial advice was given to 18 of the 41 victims treated at the Caism. Only 12.20% (n=5) of the victims completed the proposed care at the Caism to discharge, while the remaining 36 abandoned treatment before discharge.

All 41 women received medical and nursing care at Caism. A total of 75.61% (n=31) of the victims received social care. Psychiatric care was given to 75.61% of the women (n=31), and psychological treatment was provided to 73.17% of the sample (n=30). Psychological disorders were diagnosed in 90% of the victims (n=37), while psychiatric disorders were identified in 34% (n=14). The frequencies and types of psychological and psychiatric disorders are described in Tables 2 and 3, respectively. There was a high frequency (80%) of rape trauma syndrome.

Table 2. Frequency of psychological disorders (n=40). Caism, Campinas, Brazil

Psychological disorders	Frequência (n)	%
Anguish	2	5
Shame	6	15
Rage	4	10
Fear of disease	5	12,5
Nutritional Imbalance	12	30
Feeling of impotence	23	57,5
Social isolation	22	55
Fear	17	42,5
Anxiety	19	47,5
Nausea	4	10
Rape trauma syndrome	32	80
Humiliation	4	10
Helplessness	3	7,5
Revulsion	5	12,5
Guilt	6	15

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Table 3. Frequency of psychiatric disorders (n=14). Caism, Campinas, Brazil

Psychiatric disorders	Frequency (n)	%
Depression	4	28,57
Suicidal ideation	1	7,14
Emotional lability	1	7,14
Acute stress reaction	3	21,43
Adjustment reaction	2	14,29
Depressive and anxious syndrome	1	7,14
Acute stress disorder after violence	2	14,29

Discussion

When addressing public policies and efforts to implement regulatory guidelines and legislation on violence, Lima and Deslandes [14] considered the evolution of the issue in the 2000s and reported that although the National Policy for the Reduction of Morbidity and Mortality by Accidents and Violence was established in 2002, it did not directly address violence against women. In 2004, the Policy of Integral Care of Women's Health (Paism) was drawn up, which recognized violence against women as a public health problem.

At the same time, the number of police stations specializing in the care of women increased. In 2005, the documents "Emergency Contraception" [15] and the "Technical Guidelines of Humanized Care for Abortion" [16] were released, although some municipal health services did not initially accept the issue of legal abortion. In 2007 the Brazilian government launched the "National Pact for Confronting Violence Against Women" [17], with important changes for state and municipal governments, which treated sexual violence against women in an integrated and multidisciplinary manner.

In addition to Brazil, there are reports of the impact of public and legal policies on violence against women in other countries. The limited influence of these legal measures is notable, as while the perpetrators are registered, the recurrence of crime remains high [18]. Despite the existence of these measures in Brazil, there remains a need for greater social awareness regarding the equal treatment of men and women, to reduce all forms of social violence, to increase the punishment of perpetrators and to ensure adequate training of health workers on the issue throughout the country, and not only in state reference centers [19].

Although cases of violence are more common among women [20], the Federal Constitution of 1988 [21] considers that men and women are equal before the law in rights and duties. The Magna Carta also expresses in article 4, section II, that Brazil is governed by international human rights. The same source establishes the "dignity of the human person" as a fundamental principle of the Federative Republic of Brazil (Article 1, Section III). Violence against women is therefore certainly a violation of human rights, and also an expression of gender inequality [7].

Sexual freedom stands alongside sexual dignity and both encompass the concept of human dignity. One cannot speak of dignity without freedom of choice of sexual partner, sexual activity, sexual orientation and free sexual expression [22]. Since 1993, violence against women has been formally defined as a violation of human rights [6], which therefore includes the violation of sexual freedom through violence. In this context, the Ministry of Health, through the area of Women's Health, has developed a booklet with technical guidelines to prevent and treat injuries resulting from sexual violence against women and adolescents [10], which must be followed by health services to guarantee the dignity of female victims of sexual crimes.

The booklet deals with general standards of care, the prevention of infectious diseases, procedures in cases of pregnancy and the termination of pregnancy, among others. Care for victims is provided by professionals from different areas in an interdisciplinary manner [11]. In many cases, health services are unable to ensure the full adherence to treatment of victims due to feelings of fear, anger, anxiety, and the side effects of antiretroviral agents used in the chemoprophylaxis of the AIDS virus. Often, victims prefer to avoid situations that recall the violence they have suffered, such as gynecological medical consultations or conversations with psychologists. It may be that health professionals are not prepared to deal with such situations, ultimately generating a sense of guilt among women [20,23].

In order to provide legal assistance to health professionals when dealing with victims of sexual assault, the Ministry of Health has a booklet with information on reports of occurrences, humane abortions, medical examinations, and other legal situations [24]. Although the victim is encouraged to register a PR, the decision is at their discretion and there is no obligation to follow this procedure.

Regarding these data, more recent legal provisions have reiterated the guidelines of the Ministry of Health, namely Decree 7.958/2013 [25] and Law 12.845/2013 [26]. These articles demonstrate, respectively, that the victim of sexual violence has a guaranteed right to be informed about the conduct to be performed and on the importance of registering a police report and undergo a forensic examination to identify the offender, although, as informed, these procedures are not mandatory.

In the present study, 56% of the victims (n=22) reported having completed a PR. However, despite requests from the multidisciplinary team, only one PR was attached to a patient's medical record. A previous study in the same hospital unit indicated that the rate of PR completion was similar to that found in this survey, namely 65.2% between 2006 and 2008 and 57.2% between 2009 and 2010. However, the survey does not mention whether the data are derived from patient reports or whether the police reports were attached to medical records [27]. As the completion of a PR by victims can facilitate police investigations and alert public health and safety authorities to offenders, the indices may be considered low [23,27,28].

In the case of adult women who completed a PR, most of the perpetrators were unknown [28]. In the Vargas study [29], 444 police reports related to rape were analyzed from a Women's Police Station in the city of Campinas between 1988 and 1992. The author characterized three types of aggressors: the first, middle-aged, married men who carried out rapes in a family context involving young women; the second, young men known to the victim, capable of committing rape in the victim's house; and the third, young offenders, unknown to the victim, who were rapists of young or adult women outside the home and who threatened the victim with firearms.

Applying the results of the Vargas study [29] to the present work suggests that 68.3% of the aggressors would fit the third type described, although the victims did not report the age of their aggressors. This is because only the minority claimed to know the aggressor, either by affective (10 cases) or familial (3 cases) bonds. As the total sample studied comprised 41 women, these 13 cases represent 31.7% of the total studied.

In addition to the psychological consequences, victims may become pregnant as a result of the act of violence. In this case, their right to an abortion is guaranteed [8,10,24]. Abortion, in the legal sense, means the interruption of pregnancy, which can occur from conception to the beginning of labor [22]. Interrupting a pregnancy is considered a criminal offense under the Penal Code [8], except when pregnancy endangers the mother's health or in cases of sexual violence.

Abortion is regarded as humane when it as a consequence of rape. In this case, there is no unlawfulness in the act and the doctor will not be punished, as long as they fulfill two requirements: the consent of the pregnant woman or her legal representative (in the case of an incompetent minor) is acquired and the pregnancy is actually the result of rape. This type of abortion is provided for in the Penal Code in Article 128 [8].

It is the responsibility of the doctor responsible for the abortion procedure to ensure that the abortion was actually the result of an act of sexual violence, comparing the period of gestation with the date of the sexual violence suffered [30,31]. According to the technical guidelines already described [10,24], legal termination of pregnancy is not recommended after 20 weeks of pregnancy, although the pregnant woman's health conditions should always be considered [31]. If pregnancy is advanced and abortion is contraindicated, the woman can be advised about adoption procedures. In any case, sexual violence continues to result in victims and produce negative consequences.

In the present study, there was only one case of pregnancy due to rape, but the victim was already undergoing a miscarriage upon admission to the hospital, having reported that she had been raped 60 days before on the street by more than one assailant. The victim was a homeless woman and since she did not seek the hospital service until 72 hours after the rape, she did not receive protective measures against the pregnancy. The victim's lack of knowledge of her rights to terminate pregnancy in the event of pregnancy resulting from rape ultimately violates the sexual rights of women, who sometimes only become aware of these rights when seeking the health service as a result of the discovery of pregnancy [20].

The lack of knowledge of doctors about legal abortion procedures and the fear of being deceived by victims when they suspect that the pregnancy is not due to rape, whether for moral or religious reasons or due to a lack of training and information regarding legal procedures provided by their health service, also contributes to the violation of these rights [20,32,33].

A study conducted by Duarte et al [34] found that of 1,493 judges and 2,614 prosecutors questioned in Brazil, 82% were in favor of abortion in cases of rape. The authors also found a tendency among those surveyed to legally expand the circumstances

that allow abortion. It is worth mentioning that 69% of the study participants were male.

A similar research was carried out by Medeiros et al [35], but with undergraduate students in medicine and law from the Universidade Federal do Rio Grande do Norte. The frequency of knowledge of the existence of legal abortion in case of rape among medical students was 100% while among law students it was 87.5%.

In similar studies, most of the perpetrators were also unknown, the victims were single, and the rape occurred at night [27,36]. In a survey conducted in a hospital unit in Sorocaba over two years, with 920 victims of sexual violence, 76% of individuals reported that the perpetrator was known to the victims, with the categories "friend", "stepfather" and "father" being the most frequent [37]. From household interviews with 940 women aged between 15 and 49 years, 28.9% of those who lived in the city of São Paulo and 36.9% of those from the rural region of the state of Pernambuco had experienced at least one incidence of sexual or physical violence carried out by an intimate partner [38].

As in other Brazilian studies, in most of the cases reported in this study the women were young, had little schooling and were single, which leads us to reflect on the reasons that could lead to this phenomenon: younger women with low levels of schooling may not have an established professional status, resulting in possible financial dependence on their partners and, in turn, emotional dependence.

The high frequency of rape cases among women without partners who suffered sexual violence by strangers can be explained by the greater vulnerability of such young women due to their social habits, which explains the high frequency of rapes in the "street" locale in the early hours of the morning [28,29,39,40].

In the present study, 22 (54%) victims suffered personal injury as a result of sexual violence, all of which were classified as mild, based on data obtained from medical records. The classification of the severity of personal injuries was based on article 129 of the Penal Code [8] which defines such lesions as mild, serious or very serious. It should be noted, however, that in addition to the physical violence defined in the code as a bodily injury there are other types of sequelae, mainly of a psychological nature, that have a great impact on the physical and mental health of the victims [41,42].

Fear of suffering a new episode of violence leads women to social isolation, and depressive symptoms can arise that will affect them throughout their lives, depending on the emotional baggage of the victim and the care received [42]. The victim's desire after the rape may be to avoid medical attention, due to the fear and shame of admitting to the incident, besides a whish not to repeat what happened in order to forget and erase the suffering from memory [20].

The psychological situation of the victims was so serious that they described feelings of relief when learning that the perpetrator was arrested or killed. The sensations reported after the rape are of disgust and fear of becoming pregnant, of meeting the perpetrator and of acquiring infectious diseases [43]. In the present study, psychological disorders were diagnosed among 37 (90%) of the victims, while psychiatric disorders were diagnosed in 14 (34%) cases.

Post-traumatic stress disorder (PTSD) was found in 14.29% of the women. In this case, the victim avoids and distances themselves from anything that may bring back memories of the trauma they have suffered and may suffer symptoms such as insomnia, irritability, and muscle tension [44]. The concept of PTSD arose after the Great Wars, especially the Holocaust, based, according to Schestatsky et al., on *how threatening a determined traumatic event was* [45].

This attempt to distance oneself from the traumatic event could explain the high rate of abandoning treatment before discharge, as in the present study only five of the 41 victims completed the proposed six-month treatment plan (12.20%). The resistance of these victims to seeking help or remaining in treatment reveals the extent to which care is neglected in gynecological medical practice [41,42].

In rape trauma syndrome, a frequent condition in the sample, psychological and emotional damage can be long lasting. The duration of such harm may be associated with the initial care the victim receives, and therefore better interaction between the patient and the nursing team is essential to provide some of the self-control that the victim seeks in their emotional rehabilitation. The care provided to women victims of this crime must be broad and multiprofessional, including psychiatric, psychological, medical, nursing, and religious and family support [43,46-48].

Sexual violence brings risks to the physical and mental health of women, leaving scars that sometimes never fade and represent a risk to global public health, which seeks to institute protective and preventive measures against this harm. In Brazil, the

Ministry of Health has created technical guidelines to prevent and treat injuries resulting from sexual violence against women and adolescents. These guidelines are followed and discussed across the country in a multidisciplinary nature. Despite the worldwide fight against violence and specifically in favor of women, there are still high rates of sexual violence, whether due to cultural or legal aspects, the certainty of impunity or the slowness of the judiciary which leads the criminal to believe that "anything goes" and the victim to believe that the crime will never be solved.

The subject encompasses many disciplines and requires greater scientific depth and detailed knowledge of its issues. The understanding of the victim's behavior, from first care to discharge, facilitates the study and understanding of such a significant subject. It is believed that this research contributed scientifically and socially due to its informative content in relation to the theme.

Another important factor that can be improved is the moral view of the general population, who, as they have not been encouraged to change their mentality, tends to believe that rape is "normal" and that "it is the woman's fault", among other misogynistic arguments which are widely divulged on news networks. Miguel[49] criticizes the spreading of such views in humor and advertising vehicles, as, according to the author, they help perpetuate these ideas and legitimize sexual violence against women, leading to it being considered "natural".

Final considerations

Considering the proposed objectives and the results found by this research, it is concluded that the female victims of sexual violence receiving care at the Hospital Prof. Dr. José Aristodemo Pinotti, were mostly young, single adults, subject to rape with violence and serious threat in the location of the "street" in the same city where they lived. The occurrences of sexual violence were more frequent in the early hours of the morning.

The crime of rape was the most frequent. Although more than half of the sample reported completing a police report, the veracity of this information could not be verified as copies of the reports were not found in the corresponding medical records. There was only one case of pregnancy due to sexual violence. As described in the results, in the majority of the cases studied, the care proposed by the technical guidelines for the prevention and treatment of injuries resulting from sexual violence against women and adolescents was not completed, even when patients sought out the medical service for the scheduling of follow-up appointments.

Since this study is limited to a retrospective six-month data collection period, additional studies with a larger sample and a longer data collection period are suggested. Qualitative studies would also be useful to understand the reasons why victims of sexual violence do not complete the care proposed by the Ministry of Health.

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Correspondência
Ana Isabela Morsch Passos – Universidade Estadual de Campinas. Hospital de Clínicas. Rodovia Professor Zeferino Vaz, 970, Cidade Universitária CEP 13083-970. Campinas/SP, Brasil.

Ana Isabela Morsch Passos – Doutoranda – anaisapassos@gmail.com
Daniela Angerame Yela Gomes – Doutora – yela@unicamp.br
Carolina Lourenço Defilippi Gonçalves – Mestre – carolina.defilippi@gmail.com

Participation of the authors
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