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Weaknesses in the work process in Health Care for Women in situations of sexual violence

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Abstract *This paper aimed to identify in the discourses of managers and workers assisting women in situations of sexual violence the conditions that compromise the care to these women, and the structuring of the network. This is a qualitative study conducted with 19 professionals of these services through semi-structured interviews. The method of discourse analysis underpinned the analytical process, evidencing two discursive formations: weaknesses that affect the work process, and limitations imposed by professional practice. The results indicate that the daily routine of these services is permeated by the lower number and turnover of professionals, poor working conditions, inadequate physical structure for the development of care, as well as gaps in training and awareness. Workers and managers must be urgently assigned to the care teams to reduce turnover, and the implementation of qualified care by these workers, effective incorporation into the service network, ensuring interdisciplinarity, intersectoriality, and comprehensive care, to ensure and respect the sexual and reproductive rights of these women.*

Key words *Sex Offenses, Work, Health Staff*

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Introduction

Sexual violence against women is a severe violation of human rights[1] related to gender issues[2]. Its extent requires effective coping actions[3], which include the organization of a care network that articulates different actors and devices in the areas of health, public safety, promoting actions for prevention, and coping in an intra and intersectorally[4].

In the health sector, actions must follow the logic of comprehensive care, paying attention to social, economic, environmental, and emotional vulnerabilities[5], as well as recognizing individual needs[6]. To this end, health professionals are required to be creative in the forms of care, investment, and desire to care for users in psychological distress[7].

However, these professionals are exposed to a work process with vertical, hierarchical, and fragmented models[8,9]. At the same time, they must follow management rules that call them to submit to uncertain working conditions[7]. Despite efforts to modify the care models, comprehensive care is compromised by fragmented healthcare systems[8] in the provision of care based on biomedical standards coupled with substandard health work[7].

Given the evidence of fragility in the actions of care to women in situations of sexual violence and the need to restructure health services[10], the demand for the assessment of the work processes involved emerges. The knowledge produced by this analysis may foster strategic actions for the improvement and qualification of care, even avoiding re-victimization of women seeking services.

In this context, the following question emerged: what are the main weaknesses that interfere in the work process to provide women in situations of sexual violence with comprehensive care? To understand this phenomenon, we aimed to identify in the statements of managers and workers who assist women in situations of sexual violence the conditions that compromise care to these people and the structuring of the network.

Methodology

The municipality in which the research institutions are located is in northeastern Brazil, and ranks fifth in the country in population size, with 53.19% of females[11], and 504 cases of rape recorded in 2017, which corresponds to a rate of 19.2/100,000 inhabitants[12].

Nineteen workers participated in the research: four from the reference center for women, and 15 health professionals, among whom, seven also served as managers working to assist women in situations of sexual violence from eight different institutions, namely, two reference centers, and six hospitals, meeting the inclusion criteria: working in the care of women in situations of sexual violence, availability to participate in the research, signing the Informed Consent Form (ICF) and with at least six months seniority in the service. Workers removed from work activities due to vacation or sick leave were excluded. Participating workers were selected with the snowball technique[13], through the key informant in the area of women's health, who provided the contact of a manager/worker who triggered the initial interview. With this access, the participant was asked to indicate another worker assisting women in situations of sexual violence, and so forth. The saturation of this stage occurred when they indicated a person who had already been interviewed.

Semi-structured interviews were conducted, guided by open-ended questions, allowing participants to discuss the protocol and care flow freely, referrals made, activities performed in the service, and the service's strengths and weaknesses. Interviews were previously scheduled, held in a separate place chosen by each participant, with a mean duration of 15 minutes. Audios were recorded and transcribed in full. A protocol consisting of a notepad to record daily observations, reflections, and concerns arising from observation[14] was adopted.

After transcription, the analysis was based on the principles of Discourse Analysis (DA)[15]. The material was read exhaustively and in-depth in search of the discourse marks that would allow situating its materiality in a discursive and, therefore, ideological affiliation[16]. Based on these marks, the texts were segmented, and the semantic groups were organized, and convergent segments were gathered. The discursive formations were then contextualized and associated with the current social discourses, in order to bring out the underpinning Ideological Background. Ideological background is understood as "a complex set of attitudes and representations that are 'neither individual', 'nor universal', but are more or less directly related to class positions in conflict with each other"[17], to reach discursive processes. The discursive formations were related to the ideological background and semantic phenomena in the light of the socio-historical context,

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giving rise to the discursive memories that guide the limits of interdiscourse, as well as what is the unspoken[16]. In this process, two discursive formations emerged: (i) Strengths and Weaknesses that affect the work process; and, (ii) Limitations imposed by professional practice.

The ethical principles contained in Resolution No. 466/12 of the National Health Council[18] were respected. Managers used the letters T or G, respectively, followed by the number (1, ..., 19), as follows T1, T2, G1, G2, and the like, to safeguard workers' identities. Next to the identification, the first reference of each participant contains professional training and gender.

Results

Characterization of participants

Nineteen workers participated in this research (seven also held management positions), from eight different services that assist women in situations of sexual violence, two of which are reference centers, and six are hospitals (Table 1).

Table 1. Distribution of participants according to gender, age group, marital status, professional training, training time, seniority in the service and sexual violence courses.

Profile	Number
Participants	19 workers (seven are also managers)
Gender	
Women	18
Man	01
Age group	
Up to 40 years	10
41-50 years	03
50 years and over	06
Professional training	
Medicine	06
Nursing	05
Social Service	05
Psychology	03
Training time	
Up to 05 years	06
6-10 years	02
11-20 years	06
20 years and over	05
Seniority in the service	
Up to 05 years	11
06-10 years	01
11-20 years	07
Sexual violence courses	
With	10
Without	09

Strengths and weaknesses identified that affect the work process

Strengths and weaknesses affecting the work process emerge among the points raised by participants. Concerning strengths, the service provided by the professionals stands out:

I think the professionals try to provide care in the best way they can, you know, providing a humanized reception, giving all the care they need at that moment. (T6, nursing, female).

Among the weaknesses, worth highlighting is a lower number of workers as a factor that compromises comprehensive care with scheduled follow-up, not allowing systematization of care based on the user's needs:

So I can't do something systematic; every 15 days calling women to come in, within the working hours today. I can't have an appointment schedule as if it were a clinical follow-up that we manage better. (T2, psychology, female).

Besides not allowing the planning of actions, the shortage of workers reverberates in care. If the professional is in the service, the service is streamlined, as illustrated by T1:

If we identify that she is very affected, very fragile emotionally, and if the psychologist is in the service, we try to make the psychologist see her right away. (T1, social service, female).

However, the lack of a professional in the service will result in a delay in specific care, breaking the care chain. In this context, the organization of the professionals' shifts is an intervening factor for the failure to achieve comprehensive care. T1 reinforces the challenge of this offer, to the extent that it interconnects the low number of professionals and their mismatches with the service users, justifying that:

As we are only three professionals, then she will not be there in many moments, and the user will not necessarily attend the period she is in. So the social worker or lawyer ends up attending. (T1, social service, female).

Associated with the lower availability of human resources is the loss of supplies required for the service; for example, the loss of the car used to carry out the home visit that:

We performed (...) *to see these women, but from the dismantling that has been occurring in recent years with public policies* (...)*, we no longer have a car to make these visits. This is also due to the 50% staff decrease.* (G1, social service, female).

It is noteworthy that the municipality in question experiences the disruption of the psychosocial care network, exposing these women to pronounced suffering and narrowing the possibilities of being received in the recovery and maintenance of their mental health, because:

(...) *apart from the referral for psychological and psychotherapeutic follow-up, which we, unfortunately, do not have in the municipal network, what we have are the CAPS that are working in deplorable conditions, and attend to medium and severe disorders, but are a service that is not prepared to address traumas, for example.* (G1, social service, female).

A good part of the participants signaled the disarticulation of the mental health care network and fragmentation in the search for comprehensiveness:

We get in touch (CAPS)*, but there is no vacancy. So they stay on the waiting list.* (T12, social service, female).

Even with the mentioned difficulties, the referral is made to the network, but workers recognize the weaknesses in this action, the state's mental health flow is disorganized and destroyed. That is a fact. (G5, medicine, female).

In order to fill this gap, workers use the psychology offices of the universities so that users can access the psychosocial service, recognizing the incipience in the implementation, implantation, and monitoring of public policies:

It is not easy, because what happens has not been established as a public policy for psychotherapeutic care. We call in the colleges, the clinical schools. (G1, social service, female).

Besides weaknesses are the scarce professional training actions to address sexual violence, which was identified by one of the participants as a vital point of the services:

Unfortunately, we are not prepared for this. We do not have a course. We do not have an extension that prepares reception nurses for this here in this unit. (T4, nursing, female).

The gaps in the academic training of workers, which should be filled by training and in-service training, are learned in daily practice through the services provided, which cover inadequate and non-resolving flows. These workers would only need to know the existence of the flows, but they admit that:

(...) *we still have many flaws. Most professionals, including obstetricians and nurses, right at the beginning, they do not know how to do it. What I can say is that it's the protocol of this patient's progress, sometimes.* (T6, nursing, female).

We have a staff turnover that ends up interfering in the awareness and involvement with the theme in question due to the workforce's labor recruitment modalities, which overly weakens the work process' longitudinality, as explained in this statement:

(...) *we have new professionals every day. So the most significant weakness is internal communication and team awareness, which we have not yet managed to achieve. It's a long way to go before we do.* (G4, medicine, female).

Workers are also concerned about the lack of intersectoral articulation and announce that the Care Network is far from establishing itself, as:

(...) *the support network outside the hospital is a weakness, I believe. Interdisciplinarity, the support network, the lack of flow, the lack of preparation of professionals, the lack of... I think it is the preparation itself* (...). (T4, nursing, female).

The inappropriate environment is also cited as a complicating factor in the work process. Inadequate physical structures hinder humanized practices that consider and respect the antagonistic moments to which these women are exposed. The outburst of T7 outlines how far the services are from implementing the guidelines and strategies to provide ethical and legal assistance:

Thus, they are separate rooms, but all within a single scenario. (...) *So, this abortion induction happens, and on the side, we have a patient in labor,* (...) *I think it's even inhumane,* (...) *living in a birth environment,* (...) *So I think there had to be a place for curettage, for the care of women in situations of abortion* (...) *and we don't have that now.* (T7, medicine, female).

Another point highlighted for interfering adversely in the work practice is related to the loss of financial resources. This question ends up anchoring all the points mentioned above, because, as a reference to verbalization:

we depend on municipal funds. If the municipality is bankrupt, or if the municipality is complicated concerning onlendings, it directly affects the service (...) *since building renovation and maintenance, computer equipment provision and maintenance, furniture, we don't have access to that. What we have today in the service since its implementation in 2006* (...). *For example, there were no reforms after 2012* (...). *The environment is welcoming because of professionals who make it*

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so, not because of the physical structure. (G1, social service, female).

Limitations imposed by the practice of professionals and managers

Besides issues identified as weaknesses are those that emerge from silencing actions. For example, although pointing to the lack of network articulation, T4 is silent about protocols and flows agreed as guiding axes for comprehensive care. When questioned directly about the flows, the informant exposes the lack of training offered by the service, as well as exempts herself from a commitment signed with the service for which she was assigned:

Not that it was passed on to me. (T4, nursing, female).

Some statements are thus filled with silence and contradictions. T10's statement verbalizes that there is no protocol, although she recognizes that it is described in the booklet. She justifies this lack because a service has not been created. Soon afterward, she states that professionals had been trained for the service. Then, T10 confirms the existence of the protocol, but justifies the non-use for personal reasons of some professionals, silencing the existing and recommended strategies to alleviate this issue:

We had to follow what is in the booklet. Since we don't do it, we don't have any. It's like I already told you, we can't, we don't follow a protocol, because the service was not created. The service was trained, but there was no continuity. The protocol for the service exists, what we have to do, but not all doctors want to attend. There is no follow-up. So it's no use. (T10, nursing, female).

In this context, the recurring discourse that instructive and legal devices are restricted to roles, and the inertia of texts comes to the fore. This understanding can be detected in the statement that borders on common sense, by venting that:

It exists on paper. In practice, I don't know how to do it (...). (T10, nursing, female).

It is worth mentioning that the unit where T10 operates, in the initial project, there was a space for the care of women in situations of sexual violence, keeping confidentiality, and reception. That space was equipped with a place geared to interrupt rape-related pregnancies. The building was delivered with these reserved spaces, but institutional decisions shifted the use of this area to other purposes. While the lack of flows and protocols is pointed out as fragility, its existence is ignored by some professionals, as illustrated by G5's statement below:

This is how the flow was thought of. Which was to attend, do the pre-attendance and refer: we had a big banner, but it was torn, and nobody did another one. We had this in place. (G5, medicine, female).

Silencing the reason why the banner with the care flow was not redone reveals the lack of interest in favoring the effective functioning of the network, a recurring weakness in the participants' statements. The statements also expose a verticalized care model organized in a production line rationale, in which some professionals are limited to technical aspects, neglecting the recommended comprehensive care:

My role is only the medical part. When she comes to me, she has already been to the psychology service and the social worker. Everything is all right. So I am in charge of the medical part of administering the medication. (T8, medicine, male).

It is identified that the distancing of many prevents recognizing care to women in situations of sexual violence as inherent to their work so that there is not only ignorance about the theme, but a clear lack of interest in the issue. In this context, G2 states:

The main weaknesses, I believe, are the knowledge of professionals in general, because we inform, and people act as if they don't know. This has been in place for 2-3 years, and there is still a doctor who says he didn't know, although we disclosed it at the time through WhatsApp, directly showing it to the professional, and then people say they didn't know. So, I think that this is the greatest weakness, perhaps the interest of professionals in participating in this service, in providing the patient with a service that rightfully theirs. (G2, medicine, female).

The manager's recognition that the alleged ignorance is actually a reflection of disinterest did not, however, motivate sensitizing actions. Although silent about the need for awareness, G2 emphasized the existence of documentary aspects:

(...) *I made a summary of the handout that we received that was huge, so I made a summary so that the person does not waste a lot of time reading. So it's all there, I really think that the professionals lack a little interest in taking notice.* (G2, medicine, female).

It is evident that even in institutions with protocol documents and flows, these are not accessed by workers, seeking other ways to encourage reading and familiarizing with the theme:

We've already said this a lot; magazines have their flow. Now, it's like I told you, people don't take

it very seriously. I won't tell you that this is something that is very ingrained, because it's not. (G8, social worker, female).

Discussion

The results found in this research reveal that the lapses in the work processes can forcefully interfere in the care to women in situations of sexual violence. The statements verbalize complaints about the lack of an effective network, which has progressively deteriorated in recent years. The dismantling of women's health care, especially with regard to sexual and reproductive rights[19], traverses the institutional route[20] and low investments in this area[19]. These care lapses are not exclusive to women's health care. The lower number of professionals, high turnover and lack of training are events associated with factors such as the fragile employment relationships and the growing outsourcing of health services, compromising the health of workers[21] and the quality of care[22]. This reality, however, is associated with the dismantling of public health policies, and is present in other spheres[23,24].

Another emerging weakness in the statements that is not exclusive to care to women in situations of sexual violence is the fragmented, verticalized care. Although efforts are being made towards horizontal and integrated practice, changes in this health care model are modest[25], since the biomedical paradigm predominates in traditional urgent and emergency services, which "continue to operate traditionally, complaint-conduct-based, resulting in a reductionist and ineffective clinic [...]"[5]. Thus, when it comes to sexual violence, service follows this same logic, based on evident signs and symptoms focused on medicalization and with little attention to psychosocial aspects[26]. Thus, care is directed to the chief complaint, which ends up succumbing to comprehensive care[8]. Despite the evidence that associates sexual violence with the development of mental disorders[27], lapses and barriers of access that culminate in lack of care are recursive[8,28]. It is important to note that these services have a history of insecurity, deepening and reflecting notable setbacks in mental health policies[29].

However, the weaknesses of care to women in situations of sexual violence have singularities, insofar as the ideological context reinforces them. The contingent silence of the unequivocal[15] marked the absence more than evidence of the main lapses recorded in the work processes in question.

Regarding the environment, its adequacy is one of the strategies planned to ensure the privacy of these women seeking care[30]. It is undisputed that the legal interruption of shared pregnancy in areas destined for deliveries and births compromises humanization and contributes to women revictimization, which is partly associated with the decision to incorporate health care services for women in situations of sexual violence into public maternity hospitals, where inadequate physical structure predominates[31]. On recognizing the seriousness of these non-conformities, there is no coherent explanation for the use of planned spaces, built and delivered for the specific purpose of assisting women in situations of sexual violence, and reallocated for other purposes.

The results reinforce the need for continued training of workers for the consolidation of public policies[32], since the non-use of care protocols and flows limits the assistance provided[22]. Failure to follow protocols and flows also reflects lapses of management, which does not incorporate sexual violence as a demand inherent in the service, culminating in hostilities without accountability and mistaken referrals[25]. However, the statements show that the lack of training is coupled with the lack of interest of managers and workers.

It is essential to point out that "comprehensiveness is a central element for the consolidation of a health model that incorporates more effectively universality and equity in the care of people to achieve resolutive actions in health" [33]. Based on the ethical dimension of care, Franco and Merhy[34,35] argue that the ability to accommodate the needs of others cannot be "learned" by any specific knowledge, and is linked to relational and intersubjective processes. In this case, it is necessary to contextualize these statements in order to bring out the ideological formations that guide this lack of interest – and, in some cases, obstruction – on the part of workers in structuring services or following care flows.

Besides the standardization disciplines originating from biopower[36] are sex-political devices that place "sex" (genital anatomy, sexual practices, socio-cultural codes of masculinity and femininity, and identities) in the calculation of power, making an agent of life control[37] of these discourses. In this context, one cannot ignore that the subjectivity of many of these professionals was built amid these discursive processes[38] and sexopolitics[37] guided by the control of women's bodies and sexuality[36,39]. Advances in arguments marked by political conservatism and religious

fundamentalism, such as those that have gained strength in Brazil in recent years[19], do not appear so vehemently without the guidance of socially standardized statements[15,38]. These statements are legitimized by social organizations and were previously standardized socially and culturally supported by diverse gender processes, discourses, and technologies[38,39]. It is not a coincidence that the obstruction to sexual and reproductive rights has been exposed and questioned in several countries[40,41], as it is not justified in the context of Public Health. On the contrary, it results in increased female mortality[42], reinforces a social structure that subordinates the social role of women to their reproductive capacity[43], and predisposes them to psychic illness[44].

It should be noted that the lack of identification with the demands of women in situations of sexual violence was not linear among professionals. The respondents' statements stemmed from different ideological backgrounds, which recognized the health needs of the women they assisted and sought to provide comprehensive care to[45]. Noteworthy is that the ideological differences concerning the care and reception of users are unrelated to the professional category, with higher affinity in the statements, depending on the care scenario instead of the profession itself. These professionals effectively participate in this care and see their work process obstructed on countless fronts[46,47], because besides stigmatization[46], obstacles at work already cause suffering. Clot[48] affirms that "(...) professional effectiveness is a source of health at work when performance is not reduced to the abstraction of numbers".

Thus, the perception of workers in doing a job well done is a health operator, and the inexistence of this experience could be seen as a source of frustration and loss of sense of work for those who feel sensitized to the importance of this issue. The low number of sensitized professionals leads to work overload, which added to the intense pressure and the lack of breaks, rest, and recovery times can affect the mental health of workers, which is inseparable from health as a whole[49].

Final considerations

The study advances in the discussion of the theme of care to women in situations of sexual violence, insofar as it analyzes the work processes involved, starting from Discourse Analysis, which unveils what is not said, but is there and more naturalized in daily practices.

Fragmented care, service underfunding, inadequate physical structures, gaps in training, the low number of professionals and their high turnover in services act in line with ideological beliefs based on the control of sexuality and female bodies, building an intricate system of weaknesses, which impairs the work processes of assisting women in situations of sexual violence. These obstructions compromise the performance of sensitized professionals and managers, limiting the effectiveness of specific public policies.

These findings lead to an urgent need for structuring the network to implement and ensure the position of workers and managers involved in the care teams, so as to enable their continued qualification and promote awareness actions for others. The inclusion of continuing education aimed at addressing sexual violence in the workload of workers can be a tool for professional participation and continuous qualification, as well as the effective incorporation of care for women in situations of sexual violence in the service network by managers to ensure interdisciplinarity, intersectoriality, comprehensive care, and respect for the sexual and reproductive health of these women.

The effectiveness of these measures requires the recognition of the ideological background that hinders them. It is worth highlighting the Brazilian macro-political context that, despite the secularity of the Brazilian State, issues such as the guarantee of women's sexual and reproductive rights, and interference in emergency contraception, are discussed based on religious dogmas and moralist attitudes of representatives of the legislative power, whose decisions are retroactive in the achievement of public policies for women. Thus, services must be organized to provide protection and care to women in situations of sexual violence, placing themselves in the countercurrent of loss of rights.

Collaborations

JGO Branco, AVM Brilhante, and LJES Vieira participated in the conception, planning, analysis, interpretation, and drafting of the work. MH Batista participated in the critical review of the content. All authors approved the final version.

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