

Sexual violence against women by intimate partner and gender inequality in the voice of Primary Health Care professionals

Violência sexual contra mulheres por parceiro íntimo e desigualdade de gênero na voz dos profissionais da Atenção Primária à Saúde (resumo: p. 17)

Violencia sexual contra las mujeres por parte de la pareja íntima y desigualdad de género en la voz de los profesionales de la Atención Primaria de Salud (resumen: p. 17)

Líliá Blima Schraiber^(a)

<liliabli@usp.br> 


Janaína Marques de Aguiar^(b)

<jamaragui@alumni.usp.br> 

Cecília Guida Vieira Graglia^(c)

<cecilia.guida@fm.usp.br> 

Stephanie Pereira^(d)

<stephaniepereira@usp.br> 

Nayara Portilho Lima^(e)

<nayaraportilho@usp.br> 

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^(a, b, j) Grupo de Pesquisa e Intervenção em Violência, Gênero e Saúde, Departamento de Medicina Preventiva, Faculdade de Medicina (FM), Universidade de São Paulo (USP). Avenida Dr Arnaldo, 455, Cerqueira César. São Paulo, SP, Brasil. 01246 903.

^(d, e, f, h) Pós-Graduandos do Programa de Saúde Coletiva (Doutorado), Grupo de Pesquisa e Intervenção em Violência, Gênero e Saúde, FM, USP. São Paulo, SP, Brasil.

^(c, g) Grupo de Pesquisa e Intervenção em Violência, Gênero e Saúde, FM, USP. São Paulo, SP, Brasil.

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Studies show how difficult it is to recognize what is experienced in sexual relationships within households. There is an inaccuracy between violence as in the forced sex, and gender inequality as in the acceptance of the marital duty. We aimed to understand what health care providers think about these two experiences, how they interpret women's reports and what they do about it. Interviewed, the professionals say that both forced sex and sex with no explicit consent are violence and so they should be named. By doing so, professionals intend to enlighten their patients about women's rights. However, in everyday life not everyone does and no one recognized or named marital duty as gender inequality. We conclude that if violence is present as an issue, its distinction in relation to gender inequality is still a challenge.

Keywords: Sexual violence. Health. Primary care. Gender inequality. Marital relationship.



Introduction

Intimate partner sexual violence against women (VSPi) is defined as any sexual act, or attempt to obtain a sexual act, using coercion or physical force by her intimate partner. Coercion can cover a whole spectrum of degrees of force: physical force, psychological intimidation, as blackmail or other threats, and lead the woman to be unable to consent, while drunk, drugged, asleep or mentally incapable of understanding the situation. This sexual violence is considered the most extreme situation of the gender violence against women¹⁻³.

IPSV is not a new issue but it is not well studied^{4,5}. Part of the difficulties lies in the fact that the various surveys that address sexual violence against women in the domestic and intimate relationships do not use the same terminology or definitions, creating data inconsistencies. Not always taking into account the same impacts on women's health, the surveys homogenize situations of different severity. This produces difficulties in the estimation of damages, which ends up putting in doubt the adequacy of the instruments used to measure IPSV, which are, in general, the same instruments used in studies of other types of violence against women^{4,5}.

A review on the effects of women's health following IPSV⁵ shows its higher impact on suicides and feminicides, compared to other forms of intimate partner violence (IPV) and even compared to non-exposure to violence. Nevertheless, being part of IPV and co-occurring mostly with physical violence, it is rarely studied in its specificity, remaining an invisible part of the general situation of IPV itself⁴. The same occurs in studies on sexual violence, when IPSV is included in the sexual violence general definition and measured with the same instruments.

Likewise, there are also difficulties among women who have experienced this situation, in recognizing their experience as violence^{4,6-8}. On the other hand health professionals facing violence against women use a variety of terms such as sexual assault, sexual coercion or forced sex⁴, and in general do not use the term rape to name what is experienced by women⁶.

Findings from Brazilian studies also point to the lack of recognition of the forced sexual act that occurs in the domestic sphere and the consequent difficulty of naming it as violence. Many women and men consider sexual coercion within intimate partner relationships as part of the "natural" sexual interaction within relationships, or even a "right" of the man⁹⁻¹¹.

This conception is part of social and gender norms attributing a more passive attitude to women, also in sexual relationship, where acceptance of sexual coercion is the norm. Fear of being abandoned also makes women accept such situation, showing the unequal power between men and women, where women have little power to negotiate when they want to have sexual intercourse.

However, even when women do not define what they experienced with the intimate partner as "violence," further interviews suggest that forced sex with intimate partners often produces feelings of outrage and revulsion similar to those reported by victims of sexual violence committed by non-partners^{10,11}.



Such issues make it more important to have a clear definition of terms considered even more ambiguous than the term violence. We have, as an example, the terms ‘force’ or ‘coercion’, which can mean anything from the use of physical force to emotional or moral constraints, or too much insistence¹². Ambiguity also pervades the term ‘consent’, with the recognized gender distinction as to the meaning of consented or non-consented acts. A Brazilian study¹³ interviewing men and women users of the same basic health unit, not necessarily couples among themselves but belonging to the same users’ territory, and using the same instrument, showed that the perception of violence was low in both genders. However, women reported about six times more episodes of sexual violence they suffered, than men acknowledged as perpetrated by them, and the same did not occurred with physical violence.

Another important imprecision refers to the expression ‘against one’s will’, as when the question is asked (whether the sexual relation occurred against the woman’s will), it is not accompanied by a definition of what this ‘will’ is and not accompanied by the problematization regarding the difficulty of self-recognition and free enunciation of the ‘will’. This last question is of utmost importance because -given the ideological concealment of the will itself, due to the communication blockages caused by the introjection of ideologies- this condition prevents the understanding that a given situation can be argued and socially modified¹⁴⁻¹⁷. In other terms, the recognition and public expression of one’s own will is not always possible, due to the introjection of the values and behaviours of the dominant culture. We will find examples of this order in the historical constructions of traditional gender attributions and identities based on hegemonic masculinity and, in the opposite direction, subordinate femininities^{10,16,18}.

Empirically, these constructions show themselves in mechanisms of trivialization and naturalization of gender violence, and in particular, with regard to IPSV, they show themselves in the forms of bargaining in regards to sexual practices in intimate relationships¹². In this sense, it is interesting to resume the question already formulated in the 1980s: Is it rape when a woman has sex to ‘keep the peace at home?’^{7,8}.

On the one hand, the identification with rape clarifies how oppressive sexual intercourse in these circumstances is for women, but on the other hand, this usage expands and dilutes the meaning of the word ‘rape’⁴. This discussion brings us back to the idea of ‘marital duty’, a situation in which it is believed that a woman’s duty is to have sexual relations whenever her husband so desires, regardless of her own will.

Reviewing the issue of marital rape, Bennice and Resik⁸ examine three dimensions - the legal, the cultural, and the professional - in which sexual abuse becomes socially invalidated as violence, preventing one from seeing this experience as a traumatic situation close to that of rape. From the legal point of view, during the eighteenth-century husbands could not be considered guilty for rape committed against their legally married wives, due to their mutual consent and marriage agreements, which was reinforced by the understanding, expressed in the second half of that century, that husband and wife constituted, from the civil point of view, a single legal person, the woman losing, in her marriage, her individualized civil identity. Rape by strangers, for example, was seen as a crime against the man’s property and not a violation of the woman’s body and integrity. In the Brazilian case, as for this



legal dimension, legislation and legal practice present divergent positions regarding the occurrence of crime in the issues inherent to sexual violence in conjugality. As Santos Junior and Araújo¹⁹ point out, there are different legal understandings, based on heterogeneous currents of thought about the possibility of characterizing the crime of rape in this context, precisely because of the marital debt. After all, this is still a reference, for example, for marriage annulments. In this difficulty of typifying as a crime the behaviors and acts that occur in the family and domestic dynamics, as well as in relation to how effective the criminal approach in the police stations can be facing the will and needs of the woman, it is worth highlighting the study of Debert and Gregory²⁰ in which the authors discuss the judicialization of social relations, given the growing encroachment of law on social life, pointing to the limits of negotiations within the scope of justice to meet the complex relationships in which violence is inscribed.

In the cultural dimension⁸, the historical tradition converted rape by the husband as 'not true rape', characterizing the marital duty of women, which has been greatly reinforced by religious doctrine and practices. Thus, even though this marital duty can be overcome in the letter of the law, morally it can persist as custom in society, maintaining gender inequality. Other religious influence lies in the concept that it is the husband's duty to care for his wife's moral conduct in the protection of the family. Should he interpret his wife's conduct as immoral or suggestively inappropriate, it would be appropriate to use physical or sexual force as a strategy to protect family morals. Furthermore, several studies show that, as the degree of intimacy increases, the less sexual violence is conceived as rape, the more the blame for the situation experienced by the woman increases, and the recognition of damage to health as a consequence of this situation decreases. And the fact that women in these circumstances must characterize themselves as 'victims' of rape or sexual violence in their own domestic environment in order to seek help, means that the search for support to deal with the situation and even for care in health services becomes limited⁸.

Finally, from the professionals' point of view, there are many obstacles to face IPSV. They range from lack of preparation in the training to impediments derived from the organization of services such as productivity goals or lack of permanent education and supervision. The persisting view is that the physical and mental injuries can be treated without inquiring about the experience of violence that generated them^{8,21,22}.

Furthermore, there is the recognition that such difficulties arise from the features of the sexual violence itself. It is a complex object, which demands interdisciplinarity, and sensitiveness, both to scientific studies and clinical practice^{4,23}.

In view of the above, it is expected that health professionals try different strategies, when and if mobilized to identify the situation of IPSV. This study aims to explore strategies adopted by primary health professionals, and their perceptions and social representations²⁴ of IPSV.



Method

The study is part of a multi-country study on violence against women in the context of sexual and reproductive health, conducted by the Global Healthcare Responding to Violence and Abuse (HERA) Research Group^(k). In Brazil, the research aimed to implement and evaluate an intervention with professionals from Primary Health Care services in the municipality of São Paulo, to improve the response of these services to this type of violence^(l)

This research involved 10 Basic Health Units (BHU), belonging to three regions of the municipality of São Paulo. The investigative design was composed of three stages: baseline, intervention and evaluation.

In order to form the baseline, professionals from the UBS were interviewed to talk about the care offered to women in situations of violence, seeking to understand their views on facilitators and obstacles to offering such care.

As part of the intervention, training was given to all professionals involved in offering care to women who experienced violence, members of the Family Health Teams, of the Family Health Support Nucleus (NASF) and/or the Violence Prevention Nuclei (NPV).

The evaluation phase included interviews with health providers which focused on their perceptions about the training and changes (resulting from this intervention) in their practices.

The data presented here refer to the baseline, focusing on intimate partner sexual violence. We conducted interviews with 54 health providers and 8 Unit managers, among them 50 women and 12 men. The 28 interviews conducted in 2019 were face-to-face and, in compliance with Covid-19 pandemic isolation regulations, the interviews in 2020 were conducted by videocall (Google meet platform). No important differences were observed in the interviews derived from the type of access and having similar duration in both modalities, and with an average of 65 minutes per interview. All researchers were trained and supervised throughout the field work, participating in the construction of the interview script, in the semi-structured modality, and participating in carrying out their first analysis, in a supervised manner.

Health professionals ranged from the following categories: nurse, physician, social worker, speech therapist, psychologist, community health agent (CHA), dentist, physical educator, oral health technician, nursing assistant, administrative assistant, nutritionist, environmental promotion agent, and physiotherapist. They were selected by the managers of each BHU, seeking to represent the diversity of professional categories, as well as to include professionals belonging to NASF and NPV.

The research was previously submitted and approved by the Research Ethics Committee of the Faculty of Medicine of the University of São Paulo, (Process n. 3.084.387 and CAAE 03303718.7.0000.0065) and by the Ethics Committee of the Municipal secretary of Health (Process n. 3.097.354 and CAAE 03303718.7.3001.0086), respecting the anonymity of the institutions and interviewees, in both interview modes employed, as guaranteed in the Informed Consent Form.

^(k) Available in:
<https://www.bristol.ac.uk/primaryhealthcare/researchthemes/hera/>

^(l) Available in:
<https://sites.usp.br/generovienciaesaude/>



In accordance with the recording technique²⁵ all interviews were recorded, transcribed and checked for transcription fidelity. All transcripts were subsequently coded using NVivo® version 11.

During content data analysis²⁶ two main categories of analysis emerged, each were further divided into three sub-categories.

The first category presents the professionals' reports on cases that were brought by women and understood by them as IPSV. The second category presents the professionals facing gender inequality in situations brought by women as a marital duty, and shows the complexity of approaching IPSV due to a certain ambiguity of understanding and definition of what women experience, as already discussed.

For both categories the sub-categories are: the perceptions and social representations of the professionals (what they think) on IPSV; what professionals interpreted of what women say; and what they effectively do or do not do about it in their care practices.

Results and discussion

Professionals facing IPSV

What do the professionals think about IPSV

There are professionals who understand that women experience violent relationships that they don't recognize as violence, but as a marital duty, and this idea leads to the invisibility of IPSV both among women and professionals. This also would lead to a lack of care, with professionals feeling powerlessness. Others seem to incorporate a perspective closer to the Sexual and Reproductive Rights of women in their practices, by understanding that it is a right to exercise one's sexuality free from any kind of coercion.

Sometimes [they say]: "Ah, my husband is very aggressive, he has a very strong temper". Sometimes the patient complains a lot like that [...] having a sexual relationship in a certain way forced, because she doesn't feel like it, doesn't want to, but her husband forces her to. [...] So, yes, these things appear frequently. (BHU 2 Physician)

It is a kind of violence, isn't it?, because she is not consenting to something that should be consented to by both parties, right? So, it's a kind of violence. (BHU 1 Physician)



How professionals interpreted women's report about IPSV?

The women's narratives were referred by the professionals when we asked them about reports of IPSV. It is about what they remembered and interpreted what they heard from them. They say that it is important to tell us what they heard, because they understand that the sexual intercourse reported by the woman it is not exactly desired by her, and this is a frequent complaint in the consultations, even if the women themselves do not name it as violence.

Some professionals find that the women they assist have more difficulty in recognising sexual IPSV than other forms of intimate partner violence, such as physical and psychological violence:

For them it is just the physical violence. Even sometimes emotional violence, psychological violence, yes. But sexual violence is not rated for them. So they don't bring it. (BHU 2 Psychologist)

The provider does recognise the co-occurrence of sexual, physical and emotional violence in a relationship, though in their view women seem to label it as violence only when it is physical.

Other studies also point out the correlation between physical, verbal and sexual violence by intimate partners^{10,11}. In this sense, some reports make it clear to the professional that this is a sexual violence, either because it involves physical violence in the act, or because of the way the woman expresses what she feels.

[...] she really suffered an abominable psychological violence, and she really said: 'I'm going to a slaughterhouse, but it's this thing, I have to be a woman, I have to expose myself because, like, he's my husband, I can't upset him. (BHU 3 Nurse)

She said: [...] not even on those days he lets it go unnoticed. [...] he looks for me even on those days and many times I don't want to. I don't want to, and then he gets rough in the situation and then when it's over he apologizes. (BHU 4 CHA)

Sometimes the reports happen outside of the health services and only to the CHA, as she is the professional with whom the woman has more contact and feels closer to. Other times, the reports occurred outside the context of a clinical consultation, as in the case of an administrative assistant attending at the reception of the service.

There was one who said, 'I feel raped every day for a long time, but I can't get away from him, I like him. I know he will change'. These are very strange situations for me [...]. (BHU 5 Aux Adm)

As seen by this report from auxiliary administrative staff, it is important to sensitize the entire work team of the services that exists to deal with or face IPSV cases and not just health care providers. Faced with the violence phenomenon, the health service as a whole must act, reinforcing the specific care scheduled in the protocols for women's care.



Despite the limited space for action and the feeling of powerlessness, most professionals seek to build strategies to break this invisibility.

What professionals do when facing cases of IPSV

In an attempt to break from the invisibility of IPSV, naming the experience as violence seems to be a strategy widely adopted by the psychologists interviewed.

They don't get to characterize this as violence. So, it is up to us to explain to them what the forms of violence are [...]. (BHU 2 Psychologist)

The word violence comes more from my mouth than from theirs. I've heard stories of women saying that they no longer feel any desire to have a relationship with their husband and he forces this relationship. I think that 'force' is a term that comes up a lot. 'He forces me to do things I don't want to...'. And I usually name it for the woman, I usually use the word violence. (BHU 6 Psychologist)

Ensuring a listening space that legitimizes the woman's suffering helps her recognize IPSV but also seems to offer the woman a recognition of her sexual rights, which is fundamental for recognizing women as a social subject, because only then women can refuse to perform sexual acts against their free will¹⁰.

To name what is experienced as violence, seems to be for these professionals a usual behaviour. It is important to remember that regarding the actions to confront violence, as well as regarding the recognition of women's rights and their condition of subjects capable of exercising their subjectivity, it is necessary that, in the care encounter, women are sharing the same values (normative horizon) and the same conception of the situation as a violation of rights. Otherwise, the indications of the professional as to how to deal with the situation, may be refused by the assisted woman.

Other professionals, prefer to avoid the term "violence", due to the fear that this might "scare" the woman, be intimidating, since many of them do not recognize that they suffer from IPV. In this sense, some professionals understand that it is more important to seek to provide the right to non-violence than to convince about naming the situation experienced as such.

And the discussion is: 'why do I need to lie with my husband when he wants and not when we want'? No one understands that a relationship without consent is 'rape'. Even if it is inside your house and by your husband. So, it is difficult sometimes to look at the other person's face and say [...] And I never used this word 'he is assaulting you inside the house, he is 'raping' you. I never used that, even though I was aware of it. We try to use a pretty little word. And then there is that famous 'He cannot'. (BHU 6 CHA)



The possibility of acting as a multidisciplinary team is highly valued by providers as a strategy that may offer greater success. Thus, the professionals recognize that any failure in communication among professionals themselves may mean a lost opportunity in addressing the issue with the woman and offering her help.

We had a case here in our team. She was even sexually exploited by her husband, and here in the unit the necessary care was given to her [...] and nowadays she is no longer from the area. I believe that she managed to get rid of him, because she was about to leave, to leave him, but she was under our care, I think for more than a year. [...] He abused her, he didn't have a schedule, even without wanting to. [...] She only cried, she said that she couldn't stand that situation anymore. That's when the services came, the social worker, psychologist, psychiatrist. But he didn't know that she came to the Unit, that she sought help. Her consultations were all hidden because he didn't allow her to have access to anyone, precisely so that people from outside wouldn't know what was happening. We arranged, whenever she could, that the professional would be at the unit so she could come. (UBS 7 CHA)

The previous case also illustrates that, for professionals, successful cases are always considered those in which the woman is able to break from the perpetrator, either because the aggressor has changed his behaviour, or because the woman separates from her partner, breaking the relationship itself.

How to decide which is the more adequate approach by the professionals is another challenge. Many providers act as judges of the woman's conduct and not as health professionals, concerned with her mental or physical suffering resulting from the situation experienced.

We had a woman who had been raped at night by an intimate partner, so it is that situation that is very 'ah, but she is a girlfriend, raped, it was consensual' and when I saw this situation of 'it was consensual, it was not consensual' I came in and said 'people, you have to make less judgment [...] stick to what the patient said, didn't she say she was raped? [...] think well, if it were you, put yourself in your place, you have your partner and he arrives drunk -which is what happened to this woman- and forces her to have unprotected sex, and she doesn't want to, she does it and the next day she comes back because she wanted to do the tests, well, and then the service thinks that it was the husband then... Then the male nurse said 'you are absolutely right'. (UBS 3 Manager)

Judging women is sometimes more frequent than identifying the suffering and seeking to support women. And in this sense many professionals, especially managers, strive to break with the invisibility of IPSV also among the professionals. As pointed out by other studies, inadequate behaviours and responses of professionals who provide assistance to women who experienced abuse can contribute to silencing the violence experienced, and becoming an important obstacle to both the reporting of the violent crime and the comprehensive care of women¹⁹.



The professionals facing gender inequality

What do the professionals think about marital duty

Is every gender inequality already a form of violence? The answer to this question varies among the professionals. The distinction between gender inequality and violence is another challenge in the face of the blurred boundaries between the two. For many, the absence of explicit consent is understood as violence, there being no implicit consent, as in a marital duty. While others understand that the absence of consent does not necessarily imply a violent act by the partner. However, professionals do not refer to the issue of gender inequality, questioning the situation experienced by women only in terms of whether or not it can be recognized as violence. The issue of inequality does not appear in their reports.

It was not something forced, [according]to what she reported to me, but she had no will and she had relationship with her husband simply to satisfy his will. [...] She said: I am married to him and we have to have relationships, because otherwise he will stop being my husband'. [...] But she didn't understand this as a question of violence, I was not able to bring this concept, bring this context to her. (BHU 4 Physician)

Often the complaints brought by women do not make clear their own perception as to whether or not there has been an IPSV or whether it is part of the marital agreement and there is a prior consent to sexual intercourse whenever desired by the partner.

[...] this thing of having sexual intercourse without wanting to, it is very common to happen. Whether because... to a certain cultural point, of understanding that: "ah, I am married, I have to have sexual intercourse with my husband, because it is my duty as a wife within marriage, regardless of whether I want to or not". (BHU 3 Physician)

it is a very common complaint in gynaecology in these situations, you know? That I don't know if I would frame it in a sexual violence in a way, but... (UBS 2 Physician)

It should be remembered that the acceptance of the marital duty by women, even if no longer supported by a legal norm, is maintained by cultural acceptance, by customs, whether or not rooted in religious practices⁸. In this sense, Zanello²⁷ uses the Foucaultian concept of 'devices' - legal, social, cultural and institutional factors that corroborate towards the maintenance of an inequality of power - to analyse what she calls amorous devices and their role in the subjectivation of women and men. This approach makes it possible to understand that certain situations are experienced as violent by women without, however, involving the direct actions of an aggressor. In this sense some women as some professionals understand any gender inequality in sexual relations as violence.



How professionals interpreted women's report about marital duty

The women's reports speak of a cultural understanding that it would be their obligation to sexually satisfy their husband. Besides, there are also reports from women who explicitly state that this obligation to sexually satisfy the partner is related to the risk or fear of being abandoned or betrayed by their husband. They conform to their role as wife to avoid such risks.

They say: 'Ah but it's difficult, because if he wants to, then I have to'. They understand that it is part of a marriage agreement, so it happens a lot". (BHU 2 Nurse)

There are some that say "ah, you know how it is, if we don't have a relationship, the husband can look for another, so I prefer that too, to avoid confusion at home, I think it's better..." so they bring that. (BHU 8 Physician)

Thus, distinguishing between an act being forced, or being or not against the woman's will is quite difficult for professionals and for the women themselves, which seems to contribute to more variations in the approaches made within the care provided by health services.

What professionals do when facing cases of gender inequality related to sexual acts

Some of those providers interviewed choose to ask if the woman has pleasure in sexual relations, as an indirect way of investigating the marital duty. They understand that this strategy makes the woman more comfortable to talk about the issue. In this sense, the Pap smear consultations are favourable moments for addressing the topic.

but also sexual health - do you have pleasure in the relationship? - that it is not really a disease, but never had pleasure, at last... That it is a form of violence, but sometimes the patient doesn't even see it as violence. (BHU 9 Physician)

Others, when they suspect something, prefer to ask directly if she was forced to have sex or not. Faced with the issue of sex as a marital duty, most of the interviewees seek through dialogue with the woman to deconstruct this conception, seeking to promote the sexual rights of women.

I always ask 'but did he force you' [...] many times they do it just to do it, I can see that [...] I always say 'I think you have to be sincere, you have to show that your body is not just an object to have sex with'. [...] I always talk about foreplay, I always ask 'but do you ever come?', 'does your husband perform oral sex on you', 'do you kiss, caress each other before penetration' and many times they say no, that it's just penetration and nothing else. (BHU 4 Nurse)



Aware of the difficulties of breaking with this culture of “marital duty”, some professionals try approaches that help the couple in the exercise of a more respectful sexuality, either by discussing forms of sexual pleasure, as in the above account of the nurse, or by proposing ways to mediate communication with the partner in this respect as trying to talk directly to the husband about IPSV.

I get a little bit in doubt if this is forced or not. Then I try to say ‘but after it started, was it pleasant for you too? Because sometimes to begin with we are more tired [...] I always say ‘look, nothing forced is good. If you don’t feel like it today, you are tired, then tell your husband ‘love, today we sleep cuddling, tomorrow we’ll date’, it can’t be forced, it has to be good for the couple”, I try to be as discreet as possible. (BHU 8 Nurse)

There are doctors who say - I tried to talk to the husband, but it didn’t work, what can we do? -Can anyone from the unit, from a social worker to a psychologist, help? (UBS 9 Physician)

However, there are also those who prefer not to intervene, in the face of the difficulty of defining whether or not there is IPSV. They assume that if it can not be defined as IPSV, it is outside their scope of action, and then they implied that for the women this is not a big problem.

Sometimes, I will create a problem or I will... in a relationship where this is not a problem for them, suddenly for them it is just that and I think that maybe, the person thinks that I am going to dictate their way of living. I don’t know what answer I would have to give, I keep thinking that the right thing is just to listen and “ah, I got it”, to put it in a way... sometimes what I say is “and for you, how is this? Do you feel bad about this?”, then they say “ah, it is bad, but I got used to it”, but whenever I approach them, it is normal, it is part of life, it is not a big problem. (UBS 8 Physician)

Closing remarks

The way of how health professionals incorporate the perspective of women’s rights in the exercise of their sexuality, with regard to the investigation of IPSV seems to be a recent phenomenon, since studies from the first decade of the 2000s¹⁰ highlight the scarce investigation of this type of violence by health professionals.

Part of this recent development, the testimonies discussed in this study show that in the women’s reports as presented by providers, the perception of sexual relationships against women’s will as a form of violence is, most of the time, a professional’s conception, and not of the woman herself.



The guarantee of a listening space that may legitimize the women's suffering and help them to recognize the IPSV seems to offer women also their recognition as subjects of rights, which is fundamental for the construction of strategies to confront violence. Since sexual objectification serves the purpose of control and submission of women by men, only when women recognize themselves as subjects of rights, it will be possible for them to refuse the sexual act against their free will¹⁰.

Menezes and Gonçalves¹¹ state that there is a paradigmatic change of the understanding regarding sexual crimes as being 'Crimes against customs' in the Criminal Code of 1940, to 'Crimes against sexual freedom' in Law 12.015 of 2009 that amends the Criminal Code, with sexual freedom being the good to be protected. Such change brings the understanding that the woman has the right to guarantee and protect her sexual dignity, her freedom of choice being above the sexual desire of her spouse¹⁹.

However, it is worth remembering that such understanding is relatively recent in the legal sphere, and still insufficient to break culturally with the double invisibility of IPSV, for being a sexual violence and for being in the sphere of private life¹¹.


However, once violence against women is assumed by professionals as an issue connected to health²⁰, there are challenges reported with IPSV that range from the identification of this violence and the rupture of its invisibility, to the safe offer of a more comprehensive assistance that welcomes the demands of women. Although professionals often understand that they have a limited space for action and develop a feeling of impotence in the care they would like to provide to women, most of them seek to build strategies in their daily practice to break with this invisibility.

Finally, it is necessary to consider an important issue raised by the empirical data of this research: the lack of distinction between gender inequality and gender violence. And in this process it can be noticed that violence starts to assume the centrality of the speech, in the narratives of the interviewees. This process deserves to be deepened as a discursive formation of professionals and what it represents in relation to the issue of gender inequality. Based on the empirical data, it is noted that the distinction between violence and inequality is not clear, but it is relevant for a better understanding of how the elaboration woven around violence relates to the hegemonic modern discourse on sexuality. And in this sense, as Foucault treats regarding sexuality²⁸, new regulators may be being activated as a disciplinary look at violence, within the scope of health practices. In addition, the distinction between violence and gender inequality is also relevant in terms of the specific actions that each one requires, as they imply different approaches to care and actions to promote rights, freedom and the end of violence in the exercise of sexuality. We understand that delimiting this conceptual distinction is a cultural challenge of the first order and should be the object of specific future studies.



Authors


Beatriz Diniz Kalichman^(f)

<beatriz.kalichman@fm.usp.br> 

Marina Silva dos Reis^(g)

<marina.silvadosreis@fm.usp.br> 

Yuri Nishijima Azeredo^(h)

<yuri.azeredo@usp.br> 

Manuela Colombini⁽ⁱ⁾

<manuela.colombini@lshtm.ac.uk> 

Ana Flávia Pires Lucas d' Oliveira⁽ⁱ⁾

<afolive@usp.br> 

Affiliation

⁽ⁱ⁾ Grupo de Pesquisa Global Health Care Responding to Violence and Abuse, London School of Hygiene and Tropical Medicine. Londres, Inglaterra.

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Conflict of interest

The authors have no conflict of interest to declare.

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References

1. Cavalcanti LF, organizador. *Violência sexual contra a mulher: abordagens, contextos e desafios*. Rio de Janeiro: Editora UFRJ; 2022.
2. Schraiber LB, D'Oliveira AFPL, França-Junior I. Violência sexual por parceiro íntimo entre homens e mulheres no Brasil urbano, 2005. *Rev Saude Publica*. 2008; 42 Supl 1:127-37.
3. Krug EG, Dahlber LL, Mercy JA, Zwi AB, Lozano R. *WHO report on violence and health*. Geneva: World Health Organization; 2002.
4. Bagwell-Gray ME, Messing JT, Baldwin-White A. Intimate partner sex violence: a review of terms, definitions and prevalence. *Trauma Violence Abuse*. 2015; 16(3):1-20.
5. Barker LC, Stewart DE, Vigod SN. Intimate partner sexual violence: an often overlooked problem. *J Womens Health*. 2018; 28(3):1-11.
6. Jaffe AE, Steel AL, DiLillo D, Messaman-Moore TL, Gratz KL. Characterizing sexual violence in intimate relationships: an examination of blame attributions and rape acknowledgment. *J Interpers Violence*. 2021; 36(1-2):469-90.
7. Bagwell-Gray ME. Women's experiences of sexual violence in intimate relationships: applying a new taxonomy. *J Interpers Violence*. 2019; 36(13-4):1-27.
8. Bennice JA, Resik PA. Marital rape: history, research and practice. *Trauma Violence Abuse*. 2003; 4(3):228-46.
9. Schraiber LB, d'Oliveira AFPL, Hanada H, Figueiredo WF, Couto MT, Kiss L, et al. *Violência vivida: a dor que não tem nome*. Interface (Botucatu). 2003; 7(12):41-54.
10. Dantas-Berger SM, Giffin K. A violência nas relações de conjugalidade: invisibilidade e banalização da violência sexual? *Cad Saude Publica*. 2005; 21(2):417-25.
11. Menezes FM, Gonçalves HS. Estupro nas relações de intimidade: uma violência invisível. *Alternat Psicol*. 2019; 41:33-48.
12. Cordeiro F, Heilborn ML, Cabral CS, Moraes CL. Entre negociação e conflito: gênero e coerção sexual em três capitais brasileiras. *Cienc Saude Colet*. 2009; 14(4):1051-62.
13. Barros CRS, Schraiber LB. Violência por parceiro íntimo no relato de mulheres e de homens usuários de unidades básicas. *Rev Saude Publica*. 2017; 51:7.



14. Habermas J. O conceito de poder de Hannah Arendt. In: Freitag B, Rouanet SP, organizadores. Habermas. São Paulo: Ática; 1980. Cap. 2, p. 100-11.
15. Freitag B, Rouanet SP, organizadores. Habermas. São Paulo: Ática, 1980.
16. Chauí M. Participando do debate sobre mulher e violência. In: Cardoso R, Paoli MC, Chauí M. Perspectivas antropológicas da mulher. Rio de Janeiro: Zahar; 1984. p. 25-62. (Sobre mulher e violência; n. 4).
17. Chauí M. O que é ideologia. São Paulo: Brasiliense; 1982. (Coleção Primeiros Passos n. 13).
18. Couto MT, Schraiber LB. Homens, saúde e violência: novas questões de gênero no campo da saúde coletiva. In: Minayo MCS, Couto MT, organizadores. Críticas e atuantes: ciências sociais e humanas em saúde na América Latina. Rio de Janeiro: Fiocruz; 2005. p. 687-706.
19. Santos JJG Jr, Araújo ANCA. Estupro marital: a violação da dignidade sexual da mulher no casamento. Rev Direito FIBRA Lex. 2019; 4(6):3-14.
20. Debert GG, Gregory MF. Violência e gênero: novas propostas, velhos problemas. Rev Bras Cienc Soc. 2008; 23(66):165-211.
21. D'Oliveira AFPL, Pereira S, Schraiber LB, Gralia CGV, Aguiar JM, Sousa P, et al. Obstáculos e facilitadores para o cuidado de mulheres em situação de violência doméstica na atenção primária à saúde: uma revisão sistemática. Interface (Botucatu). 2020; 24:e190164.
22. Cavalcanti LF, Gomes R, Minayo MCS. Representações sociais de profissionais de saúde sobre a violência sexual contra a mulher: estudo de três maternidades públicas municipais do Rio de Janeiro, Brasil. Cad Saude Publica. 2006; 22(1):31-9.
23. Schraiber LB, D'Oliveira AFLP, Couto MT. Violência e saúde: contribuições teóricas, metodológicas e éticas de estudos da violência contra a mulher. Cad Saude Publica. 2009; 25 Supl 2:S205-16.
24. Moscovici S. Representações sociais: investigações em psicologia social. Rio de Janeiro: Vozes; 2003.
25. Queiroz MIP. Variações sobre a técnica de gravador no registro da informação viva [dissertação]. São Paulo: Faculdade de Filosofia, Letras e Ciências Humanas, Universidade de São Paulo; 1983.
26. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1979.
27. Zanello V. Saúde mental, gênero e dispositivos: cultura e processos de subjetivação. Curitiba: Appris; 2018.
28. Foucault M. História da sexualidade I: a vontade de saber. Rio de Janeiro: Edições Graal; 1984.



É difícil reconhecer o sexo forçado vivido nas relações sexuais no âmbito doméstico como violência. Há também uma imprecisão entre a violência, tal como no sexo forçado, e a desigualdade de gênero, como na aceitação do dever marital. Buscou-se compreender o que profissionais da Atenção Primária pensam sobre essas duas experiências, como interpretam relatos das mulheres e o que fazem sobre isso. Entrevistados, os profissionais dizem que sexo forçado ou sexo sem consentimento explícito são ambos violência, e assim devem ser nomeados. Agindo desse modo, eles pensam esclarecer suas pacientes acerca dos direitos das mulheres. No entanto, no dia a dia, nem todos o fazem e ninguém reconheceu ou nomeou a aceitação do dever marital como desigualdade de gênero. Conclui-se que, se a violência está presente como questão, sua distinção quanto à desigualdade de gênero ainda é um desafio.

Palavras-chave: Violência sexual. Saúde. Atenção primária. Desigualdade de gênero. Relacionamento conjugal.

Es difícil reconocer el sexo forzado vivido en las relaciones sexuales en el ámbito doméstico como violencia. Hay también una imprecisión entre la violencia, tal como en el sexo forzado, y la desigualdad de género, como en la aceptación del deber conyugal. Se buscó entender lo que los profesionales de la atención primaria piensan sobre esas dos experiencias, cómo interpretan los relatos de las mujeres y qué hacen sobre eso. Al ser entrevistados, los profesionales decían que el sexo forzado o el sexo sin consentimiento explícito son violencia y deben ser denominados como tal. Actuando así, ellos piensan aclarar a sus pacientes los derechos de las mujeres. Sin embargo, en el cotidiano no todos lo hacen y ninguno reconoció o nombró la aceptación del deber conyugal como desigualdad de género. Se concluyó que la violencia está presente como cuestión y que su distinción con relación a la igualdad de género todavía es un desafío.

Palabras clave: Violencia sexual. Salud. Atención primaria. Desigualdad de género. Relación conyugal.