Violence against women: visibility of the problem according to the health team*

VIOLÊNCIA CONTRA A MULHER: A VISIBILIDADE DO PROBLEMA PARA UM GRUPO DE PROFISSIONAIS DE SAÚDE*

VIOLENCIA CONTRA LA MUJER: LA VISIBILIDAD DEL PROBLEMA PARA UN GRUPO DE PROFESIONALES DE SALUD

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ABSTRACT

It is extremely important to identify women living in a violent situation. However, the health sector has not always offered a satisfactory response for the issue. We sought to identify how the health professionals of a maternity perceive and act in view of a violent situation. This is a qualitative research, in which the data were collected through semistructured interviews and subject to thematic analysis. The study group consisted of 12 health professionals from a philanthropic maternity hospital located in Ribeirão Preto, Sao Paulo State, Brazil. It was observed that health professionals characterize violence against women as a severe and important problem in society, caused by and leading to gender inequality. However, professional practice tends towards a biologistic and reductionist approach, which fragments women's health care, justified by the lack of professional training, institutional support and a multidisciplinary team.

KEY WORDS

Violence against women.
Women's health.
Health personnel.

RESUMO

A identificação de mulheres em situação de violência é de extrema importância. Entretanto, o setor saúde nem sempre vem oferecendo uma resposta satisfatória para o problema. Buscamos identificar como os profissionais de saúde de uma maternidade percebem e atuam frente situação de violência. Constitui-se uma pesquisa qualitativa, sendo os dados coletados através de entrevistas semi-estruturadas e analisados pela modalidade temática. O grupo de estudo foi composto por 12 profissionais de saúde de uma maternidade filantrópica de Ribeirão Preto. Observou-se que os profissionais de saúde caracterizaram a violência contra a mulher como um problema sério e importante na sociedade, tendo como causa e conseqüência à desigualdade de gênero. No entanto, na prática profissional há uma abordagem reducionista e biologicista com fragmentação da atenção à saúde da mulher, justificado pela falta de formação profissional, suporte institucional e de uma equipe multidisciplinar.

DESCRITORES

Violência contra a mulher.
Saúde da mulher.
Pessoal de saúde.

RESUMEN

La identificación de mujeres en situación de violencia es de extrema importancia. Sin embargo, el sector salud no siempre viene ofreciendo una respuesta satisfactoria para el problema. La finalidad del presente trabajo fue identificar mediante una investigación cualitativa cómo perciben y actúan ante la violencia los profesionales de salud. Los datos fueron recolectados a través de entrevistas semiestructuradas y analizadas por la modalidad temática. El grupo de estudio estuvo compuesto por 12 profesionales de salud de una maternidad filantrópica de Ribeirao Preto – Brasil. Se observó que los profesionales de salud caracterizaron a la violencia contra la mujer como un problema serio e importante de la sociedad, teniendo como causa y consecuencia a la desigualdad de género. Entre tanto, en la práctica profesional existe un abordaje reduccionista y biologicista con fragmentación de la atención a la salud de la mujer, justificado por la falta de formación profesional, soporte institucional y de un equipo multidisciplinario.

DESCRIPTORES

Violencia contra la mujer.
Salud de la mujer.
Personal de salud.

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INTRODUCTION

Violence against women is a complex phenomenon that may be present in all of life moments, in the course of its vital cycle, and it may manifest itself in different forms and countless circumstances[1]. The phenomenon is expressed mainly through sexual, physical and psychological violence. However, it applies not only to the body; it also has repercussions in women's social life[2], as visible marks are not often left.

Among the several situations of violence that women suffer, domestic violence stands out and refers to all forms of violence and dominant behaviors performed in the family core[3]. Investigations performed in healthcare services show annual prevalence of violence against women that is perpetrated by their sexual partners, ranging from 4 to 23%. When violence is considered throughout these women's lives, the rates are 33 to 39%[4].

Regarding this study[5] performed in a primary healthcare unit, in which there was the evaluation of the frequency of cases of violence, its origin, gravity and woman-aggressor relationship, it was found that 44.4% of users reported at least one episode of physical violence during adulthood. In 34.1% of the cases, violence came from partners or relatives. The occurrence of at least one episode of sexual violence was found in adulthood in 11.5% of the women, and in 7.1% of the cases, the offenders were partners or relatives. The author concludes that physical and sexual violence had higher magnitudes in this service. The partners and relatives were the main perpetrators and the cases are mostly severe and repetitive.

...the health sector does not always provide a satisfactory response to the problem, which eventually is diluted in other issues without taking the intentionality of the act that caused the morbidity status into account.

Health services are important to detect such a problem because, in theory, they cover and reach women, being able to identify and treat the cases before critical incidents occur[5]. Hence, identification of women in a situation of violence is extremely important.

However, the health sector does not always provide a satisfactory response to the problem, which eventually is diluted in other issues without taking the intentionality of the act that caused the morbidity status into account. This situation of invisibility is derived from the fact that the services are limited to the symptoms and do not rely on instruments capable of identifying the problem[6]. In these contexts, the studies[7] performed in the health services show that healthcare professionals do not identify women who are violence situation, even when the injuries sustained show evidence of violence.

It should be mentioned that violence against women, especially domestic violence, is still an invisible phenomenon in most societies. It is socially accepted as *normal*, that is, as an expected and customary situation[3]. Therefore, violence in gender relationships is not recognized in the healthcare services or registered in the diagnosis. It is characterized as an extremely difficult issue to be dealt with[8].

Thus, when healthcare professionals fail to identify situations of violence, they contribute to perpetuate the violence cycle, diminishing the efficacy and effectiveness of the healthcare services and consuming financial resources as well[9]. In this perspective, according to the World Health Organization, healthcare professionals have a crucial role in detecting violence. Most of the time, this is the only place women seek in such a situation[10].

In the clinical practice, violence against women tends to be kept invisible. The conduct of the healthcare professionals does not meet women's expectations. The actions are restricted to other consultations, which do not always result in an appropriate answer to the demands.

This study is likely to bring subsidies to the education and training of healthcare professionals so as to promote a better visibility of the problem and allow the implementation of more effective strategies to aid women in situations of violence.

SPECIFIC OBJETIVES

To identify the meanings attributed to violence and to women suffering violence;

To identify the limitations and possibilities in the attitudes of the healthcare professional when it comes to violence against women.

METHOD

This is a qualitative research that dealt with healthcare professionals' perceptions and their professional experiences regarding women in situations of violence.

The healthcare service considered in this investigation is the Aeroporto-Mater Maternity Complex, a philanthropic institution that serves the public healthcare system. It is inserted in the reference system by the Basic Healthcare Network, and it carries out low-risk deliveries in more than 25 cities surrounding Ribeirão Preto, totaling 200 deliveries a month. Mater is related to School of Nursing - Ribeirão Preto and Faculty of Medical Sciences of Ribeirão Preto of the University of São Paulo. It is an undergraduate and graduate, university extension and research teaching ground. The choice of a maternity as the setting for this study is justified by the high number of women. Thus, healthcare professionals are likely to be exposed to women in violence situations.

In this study group, there were 12 healthcare professionals from the institution. The sample size was defined by

data saturation. Only the professionals with higher education degrees were considered (doctors and nurses). Group composition was determined in function of the following criteria: (a) belonging to the maternity staff; (b) direct healthcare involvement with pregnant/puerperal women; (c) experience in assisting women's healthcare for at least one year.

The study was compliant with the norms for research with human beings, established by resolution 196/96 of the National Health Council. Data were collected after approval of the Ethics Committee and the subjects were eligible to participate in the research. After accepting, the subjects were asked to sign the term of consent. With the purpose of guaranteeing the interviewed subjects' anonymity, identification codes were used in the interview fragments.

Data were collected through individual interviews and recorded with the personal testimony technique. The interviews were performed at their workplace, on a day and time previously scheduled by interviewer and subjects, from November 2005 to January 2006.

During data treatment, the interviews with the healthcare professionals were transcribed and then the analysis of the thematic content was performed. It consists of

> discovering the core meanings that compose the communication, whose presence or frequency of appearance may mean something for the analytical objective chosen[11].

The analysis contained the following steps: initial reading, so as to obtain a global understanding of the material; identification of meaningful units that emerged out of the speeches; core discovery, interpretation and core discussions of the meanings found.

RESULTS AND DISCUSSION

The group was composed by 12 professionals, these being five nurses and seven doctors. Overall, eight (67%) participants were females and four (33%) were males. Their ages ranged from 23 to 39 years and the average age was 27 years. Regarding their professional experience, nursing professionals had an average of a year and seven months. The medical professionals presented an average of three years and two months.

Two main thematic categories were apprehended from the speeches: **Understanding violence and women victimization and Attitude and practices of healthcare professionals regarding women in situations of violence.**

Understanding violence and women victimization

The following core meanings were identified in the first main thematic category: a) violence as reality b) violence as cause and consequence of women's social setting c) women's stereotyped view of violence situations.

Regarding the first core meaning, health professionals characterize violence against females as a serious, important problem in society, as evidenced in the speeches:

> [...] it is a serious question and more prevalent than people think (D3);

> [...] it is more serious than it appears (D12).

According to international investigations, violence against females is a much more serious and generalized problem. A study carried out by the World Health Organization in 35 countries found that between 10% and 52% of women had endured physical abuse by their partners in a given moment of their lives. Between 10% and 30% had been victims of sexual violence by their partners[3]. In a comparative study with Brazilian regions, the city of Sao Paulo and the countryside of Pernambuco, using the same questionnaire, applied to 15-49 year-old women, there was a variation in the violence rates found. In the city of Sao Paulo, the rate was 27%, and in the countryside of Pernambuco it corresponded to 34%[12].

The gravity of the phenomenon, as perceived by the professionals surveyed, is recognized in the violence concepts. The scientific literature argues that violence does not have a consensual concept or definition due to its complexity and specificities. Violence is a complex and dynamic biopsychosocial phenomenon, conceived and developed in societal life[13].

In the speech discourses, the reality of violence against women is manifested in different forms:

> Everything that offends other people's integrity(D9);

> [...] violence may be either physical or verbal aggression, and the person is subjugated, humiliated... (D4).

Such views regarding types of violence coincide with the United Nations General Assembly[14], which approved the Declaration for the Elimination of Violence against Women. It was the first international human rights document dealing with harmful behaviors against women. This definition states:

> [...] any gender-based act of violence that results, or is likely to result, in physical injuries, sexual or psychological suffering for women, including the threat to perform such acts, coercion or arbitrary privation of freedom, both in public as in private life[14].

Considering the core meaning: violence as cause and consequence of the woman's social setting, healthcare professionals argue that it is multifactorial. Nevertheless, they essentially perceive violence as both cause and consequence of gender inequalities, as observed in the speech:

> [...] it is a historical, cultural thing [...] submission is the main factor (D1).

Researchers point out gender-related inequalities, as the main explanatory conception of violence endured by

women, based on scientific production investigating the themes of violence and health. The authors refer to publications that focus on violence as a consequence of historical and social conditions in relation to the construction of female-male relationship. It generates several attributes, positions and expectations for people regarding sexuality, insertion in the family core, work and public space, implying specific forms of violence: in the private space, those against women; in the public space, against men[15].

According to the World Health Organization, there is no single factor that explains the reason why some people behave violently in relation to others, or why violence occurs more frequently in some communities than in others. Violence is the result of a complex interaction of individual, social, relationship, cultural and environmental factors[3].

It is impossible to tackle violence against women without associating it with gender inequality. It is not difficult to observe that men and women do not occupy identical positions in society. Female and male social identity is constructed through attributions of distinct roles, which society expects to accomplish in different gender categories[16]. It was made evident in the subjects' speeches in this study.

> [...] there are many men brought up and many women brought up to assume their roles according to gender... men are brought up to be stronger (D7);

> [...] one of the triggering things is machismo (D2).

The last core meaning, a stereotyped view of women in situations of violence, is anchored in the dualist tradition about the social construction of gender identity. Hence, the image of victimized women is associated with the stereotype of submissive and unprotected women. Regarding the offenders, they are seen as powerful and stronger. Violence would be a means of perpetuating this situation of inequality, as identified in the speeches:

> [...] she is a woman without perspectives; they are quiet, shy women (D6);

> They often have a submissive behavior (D11);

> [...] one of the forms to show his power is by beating his wife (D2).

In this gender perspective, men are required to behave masculinely and show aggressiveness, fearlessness and power, whereas women are expected to be soothing, unselfish and obedient. Thus, this unequal hierarchy in the male-female relationships gained ground in the historical male supremacy and domination, making women inferior and subordinate[2].

Attitude and the practice of the healthcare professionals regarding women in situations of violence.

They indicate the following meaningful cores: a) tendency for biological reductionism, fragmented in attention to victimized women; b) professional limitation regarding attention to victimized women.

Considering the first core in this thematic category, the healthcare professionals in this study consider the physical complaints. When they mention healthcare, they tend to be based on the biological processes and after failure, they attempt to use other bases.

> [...] when it comes to gynecological aspects, we deal with some quite chronical complaints (D9);

> [...] there was no medicine that would control her glycemia [...] the cause is emotional and often stems from physical aggression... (D6).

The healthcare professionals' difficulties in coping with these issues are based on the biological educational model, which is fragmented and does not consider biopsychosocial aspects. The healthcare professional creates a fragmentation of the action and the object of work. In this case, the subject reduces the health-disease approach to strictly biomedical knowledge. Therefore, the following speech shows that, after a visible situation of physical violence, healthcare professionals feel the need to take some measures.

> When they come with wounds [...] we have to ask because it is too evident (D3);

A study [17] carried out in 19 healthcare services in the cities of São Paulo, Santo André, Diadema and Mogi das Cruzes had the purpose of identifying the contrast between the prevalence of violence, estimated through interview with users, and violence registered in these women's records. In general, there was a low level of records. According to the authors, such findings may be understood from the studies mentioning that the healthcare professionals have great difficulties in coping with violence in the healthcare services.

A study performed in Ribeirão Preto also corroborates the findings of violence invisibility for the healthcare professionals. When analyzing the prevalence of gender violence among users of two primary healthcare services, there were only 3.8% registries of violence in the records [9].

Regarding undergraduate education, health professionals report that there is little orientation on how to deal with the theme and, when it is introduced, it is usually fragmented. The university syllabi are not ready to deal with this question in a multidisciplinary way.

> Violence, we discuss a little when we talk about alcohol and drug in that mental health course (D1);

> It was discussed by the time we studied female health [...] in ethics-related courses (D10).

It is observed that most health courses do not contemplate continuous education programs in the syllabi and violence-related aspects training. Therefore, healthcare

professionals are not ready to provide attention with effective impact on victims' health[18].

A study[8] performed with doctors working with primary healthcare, in order to investigate their experiences with domestic violence victims and determine the obstacles in identifying and intervening in the cases, found that domestic violence is similar to *opening Pandora's box*. It also includes discomfort, impotence, fear of being offensive, loss of control over the situation and embarrassment. Such condition was present in the subjects' speeches:

> I was kind of afraid of reprisals (D6);

> [...] our impotence is something quite big (D3).

In the practice of the healthcare professionals, attention is focused on specialties, which tends to darken their perception and involvement with violence-related questions, without relation to women's health.

> [...] when we see violence, we do not dig too deep and do not associate one thing with the other (D2).

> When people have recurrent diseases, problems are often caused by weight gain, problems with signs of depression (D6).

This attitude is closely related to conceptions of the private status of violence and it is not appropriate to be explored in the healthcare setting[19]. A study[7] identified that health professionals do not question women when suspecting violence for several reasons, such as lack of time and resources, lack of preparation, fear of causing embarrassment and frustration, because they feel impotent to solve the situation.

Owing to this frailty, professionals tend to behave by institutional protocols, which are exact sequences of actions to be developed, representing a powerful instrument of technical orientation that determines each professional's competence. When they lack these protocols, they feel insecure.

> [...] with a protocol, then, the situation is cool, although it is difficult to deal with a complicated situation (D5).

> [...] a complete gynecological exam is performed to check whether there are injuries, hepatitis B, anti-HIV prophylaxies are performed, and also emergency contraception (D8).

Healthcare professionals show their key role when they pay attention to their technical procedures. When victimized women receive treatment, health professionals assure their medical ideology defining the reality shown, erasing the social, political and cultural roots of the problem[20]. Hence, during intervention with women, there is a predominance of technical-instrumental care relationship.

> [...] we have to check whether there are acute injuries that need to be treated urgently [...]. After that, we try to comfort [...]. We have to know the limits, we cannot cross the line, because we end up getting involved and this is anti-professional (D6).

The healthcare professionals make evident both their limits and action impossibilities in their speeches. Hence, contrary to what is expected of healthcare professionals in a strategic position to detect violence risks, they shy away from interfering.

The last meaningful core, defining professional attitudes when assisting victimized women, includes the difficulties beyond the barrier of professional education, including the lack of institutional support, and also the multidisciplinary team in the staff, leading professionals to restrict their actions, as shown in the speeches:

> [...] it is like that... everyone getting out of it (D5);

> I think we could have a more present social assistance team [...] I think that a psychologist is really useful [...] also, attachments with the patient (D11).

Researchers found in a study[19] with health professionals of Nicaragua's Ministry of Health that the barriers that the healthcare professionals face when it comes to violence, in order of priority, are: little qualification about the theme; lack of privacy during consultations; fear of legal matters; maintenance of safety and absence of places that treat women.

Perceiving violence is a step to improve the efficacy of health actions. Also, it puts into discussion the suffering experienced by women, which exceeds the physical complaints associated with the phenomenon. This reality leads healthcare professionals to recognize that they are in touch with complexity of violence.

They acknowledge that an effective treatment of women in situations of violence requires a multidisciplinary team, which consists of reciprocality, mutuality. It requires a different attitude assumed in face of the problem of knowledge, substituting the fragmented conception for human unity[20].

Through the interviews, there is difficulty in treating women in situations of violence due to the lack of social structures for support and protection. In order to properly respond to the dimensions involved in this problem, the establishment of an intersectorial and coordinated approach is essential, especially with legal and police authorities.

> We try to send them to another sector, but which one? (D1).

> I advised her about the rights she had, the humiliating condition she was in [...]. We advise them to go to a police station, but we cannot do that for them (D9).

With the gender-based violence being considered a public health problem, the WHO begins to recommend training for healthcare professionals. They are supposed to recognize it and discuss it, understanding women's integrity, with human rights. In addition, women should be informed about society resources, such as female-focused police stations and shelters. They should be advised about life-threatening situations so as to preserve their lives. Healthcare pro-

fessionals should work in articulation with other sectors in society[3].

From what is expected from the healthcare professional, as presented by the World Health Organization, the study subjects acknowledged the role of the healthcare professional as being unsatisfactory. They note the essential points to provide better assistance to women in situations of violence.

> [...] first of all, the role of the health care professional is more than simply helping, from the professional standpoint...it is more than simply performing a physical exam and taking a medical conduct (D7);

> [...] our role is very educational (D10).

This perspective drawn here in the sphere of ideas is a step towards understanding violence against women. It recognizes women with their rights, before being regarded as a patient or victim.

CONCLUDING REMARKS

Violence is an instigating theme that has been discussed quite frequently as a health issue, since these services are considered by the World Health Organization as the place where victimized women come because of the outcomes resulting from this practice. The healthcare sector is liable for treating victims, minimizing the trauma and avoiding problems. Thus, the conscious health professionals may begin to act as an important element in the violence cycle process.

In the group studied, health professionals characterize violence against women as a serious problem in society, having gender inequality as cause and consequence. However, the professionals have little knowledge about procedures in these cases. In their professional practice, they tend to have a biological, fragmented reductionism in healthcare attention to women. Such conduct is justified by the lack of professional formation. The academic syllabi rarely contain information about this theme. There is also the lack of institutional support and a multidisciplinary team in the setting.

Therefore, it is necessary to raise the discussion of professional training, making them aware of the violence issues. Approach violence in the services requires background of existing references from the legal system, police, society and psychology. In addition, informal support networks and Non-Governmental Organizatios (NGOs) are important. With them, the professional is able to continue the assistance and look for alternatives to solve the problem.

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