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Violence among female users of healthcare units: prevalence, perspective and conduct of managers and professionals

ABSTRACT

OBJECTIVE: To estimate the prevalence of violence in women who are primary healthcare users and to verify if these situations were detected and how they were tackled by these services' professionals.

METHODS: Descriptive, cross-sectional study carried out with 14 municipal women's health coordinators, 2,379 women who are users of primary healthcare units, 75 managers and 375 professionals, in 15 municipalities of the State of São Paulo (Southeastern Brazil), between August 2008 and May 2009. Data were collected through structured questionnaires and a descriptive analysis was conducted.

RESULTS: A specific protocol for assisting women in situations of violence was mentioned in five municipalities. The majority (83%) of the coordinators reported that situations of violence among female users were detected, although 74% said this was not routinely investigated, which was confirmed by 72.3% of the professionals. Among the women, 76.5% reported having experienced some type of violence throughout their lives, and 56.4% said that an intimate partner was the perpetrator of that violence; almost 30% reported at least one episode in the 12 months prior to the interview; 6.5% reported looking for help at a Primary Healthcare Unit.

CONCLUSIONS: A relevant proportion of users experienced violence in their daily routine, mainly perpetrated by an intimate partner. Most of the women were neither identified nor approached in these services and did not receive help. Although health managers and professionals realized the magnitude of the problem, they did not consider that primary care was prepared to assist these women. The study showed that there is no intersectoral care network to assist women in situation of violence.

DESCRIPTORS: Attitude of Health Personnel. Basic Health Services. Battered Women. Violence Against Women. Epidemiology, Descriptive.

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INTRODUCTION

Violence against women is one of the greatest concerns in the areas of health and human rights. Violence affects women throughout the world and in all the periods of their vital cycle, causing serious damage to their health and psychosocial development.[5,15] Violence against women occurs mainly in the domestic environment, perpetrated by the partner.[2,6,7,15] Violence at home tends to evolve progressively: it begins with psychological/emotional violence, moves to physical violence and culminates in sexual violence.[7]

Violence is harmful to the woman's health and is responsible for many complaints due to which they go to the healthcare services, like gynecological problems in general, sexually transmitted diseases, depression, insomnia, anxiety, sexual dysfunction and eating disorders.[5,7,16] Primary care services deal with these problems on a daily basis and frequently offer inefficient answers to women because they do not approach their origin: violence, which many times is chronically suffered.[16]

The Brazilian Federal Government launched the National Plan of Policies for Women in 2008, aiming to promote coping with all forms of violence against women of all ages and to provide specific and qualified assistance to their health.[a] The Ministry of Health has proposed measures to offer effective and integral assistance to women in situations of violence – assistance that is inserted into an intersectoral network and that starts in primary care, the entrance door to the public health system, including the *unidades básicas de saúde* (UBS – primary care units) and the *Estratégia de Saúde da Família* (ESF – Family Health Strategy).[b,c,d] However, the healthcare services are not the usual places women in situations of violence seek as possible sources of help, in spite of the serious physical and psychological damage they experience.[2]

Many women who consult at UBS and in the emergency sectors of hospitals experience or have experienced situations of violence,[10,17,19] but this is not frequently investigated and the professionals who work there have no knowledge of it. Thus, the opportunity of intervening in these situations and developing preventive actions is lost. Even in developed countries, only a few professionals routinely ask about violence.[4] They allege lack of time; embarrassment to approach the theme with women who do not seem to have problems with violence; fear that they reveal situations with which they would not know how to deal and would not have the resources to; lack of training; lack of support in the healthcare services and in the community to help the women; ignorance of scientifically approved measures to deal with situations of violence.[16] There are controversies about the efficacy of questioning all women about the experience of violence in health assistance.[14]

The present study aimed to estimate the prevalence of violence in female users of UBS/ESF and to investigate whether these situations were detected and how they were treated by the professionals of these healthcare services.

METHODS

Descriptive, cross-sectional study with municipal managers, health professionals and women who are users of UBS in the State of São Paulo, carried out from August 2008 to May 2009. Fifteen out of the 17 municipalities that house *Departamentos Regionais de Saúde* (Regional Health Departments) of the State of São Paulo, of the State Health Secretariat, participated in the study: Great São Paulo, Araçatuba, Araraquara, Baixada Santista, Campinas, Franca, Marília, Piracicaba, Presidente Prudente, Registro, Sertãozinho, São João da Boa Vista, São José do Rio Preto, Sorocaba and Taubaté. It was not possible to collect data in Bauru and Barretos, as we could not identify local coordinators.

The local coordinators received training and qualified interviewers in their localities for data collection.

Structured and pre-tested questionnaires were administered to the municipality and UBS managers. They contained questions about their personal characteristics, insertion in the public health network, and procedures to assist women in situation of violence in the municipality and/or UBS. To the UBS professionals, there were also questions about the suspicion that some woman was experiencing a situation of violence and the adopted conduct, the existence or not of a protocol to investigate the experience of these situations, whether the professional had been trained to this and whether he/she knew about the municipal services network that assists women in these situations.

The questionnaire administered to the women had three sections: sociodemographic characteristics and perspectives concerning gender relations; health characteristics; and experience of situations of violence, based on the Abuse Assessment Screen[15] and on the Conflict Tactics Scales, modified by the Violence Against Women Study (VAW), which was conducted by the World Health Organization in many countries, including Brazil.[16]

The women's health coordinator of each municipality was interviewed, except in one of them, as nobody performed this function nor a similar one. Five UBS were selected in each municipality by simple random sampling. The following professionals were interviewed: 14 municipal women's health coordinators, 75 coordinators/managers of the drawn UBS, and 375 health professionals (doctors, nurses, nursing assistants, receptionists, psychologists, social workers).

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[a] Secretaria Especial de Políticas para as Mulheres. II Plano Nacional de Políticas para as mulheres. Brasília; 2008.
[b] Ministério da Saúde (BR). Guia Prático do Programa da Saúde da Família. Brasília; 2001.
[c] Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Área Técnica de saúde da Mulher. Política Nacional de Atenção Integral à Saúde da Mulher. Brasília; 2004.
[d] Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Atenção integral para mulheres e adolescentes em situação de violência doméstica e sexual. Matriz pedagógica para formação de redes. Brasília; 2006[cited 2012 Jan 30]. (Série B - Textos Básicos de Saúde). Available from: http://dtr2001.saude.gov.br/editora/produtos/livros/pdf/06_0069_M.pdf

It was calculated that the sample of UBS female users should contain 2,386 women for the 17 municipalities, considering the estimated prevalence of 46% of some type of violence in life[19] with acceptable absolute difference of 2% and type I error of 5%. In each one of the 15 municipalities, 159 women were interviewed, as well as 32 in each one of the five UBS of each city, totaling 2,379 women.

The questionnaires were revised and doubly keyboarded by different people to legitimate the process. Procedures for database cleaning and consistence were carried out. Descriptive tables with the variables of interest were elaborated for data analysis.

Participation in the research was voluntary, after the individual signed a consent document. The protocol of the study was approved by the Research Ethics Committee of the School of Medical Sciences of *Universidade Estadual de Campinas* (Process no. 432/2006).

RESULTS

The majority of the women (84.2%) was aged between 18 and 49 years, were married or were in a stable union (66.4%); approximately half (49.6%) had a paid job, a little more than half mentioned eight years of schooling at the most (53.5%), and family income up to R$ 1,000.00 per month (57,6%); 42.4% classified themselves as white. More than three quarters (81%) of the interviewees answered that, if they experienced violence, they would ask for help in a police station; 11.6% in a women's police station, and 6.8% in a healthcare unit. When they were asked why they would not go to a healthcare unit in this situation, 65.5% said they believed that the "units do not provide this kind of assistance", and 18.5% stated they had never heard that "the units could solve these cases" (data not presented on tables).

A little more than three quarters of the women suffered some type of violence in their lives. A slightly lower percentage suffered emotional violence, while 46.8% mentioned physical violence at least once in their lives (Table 1). More than half of the women mentioned violence perpetrated by an intimate partner at least once in their lives, and 32.1% in the 12 months prior to the interview. More than half of the women reported emotional violence at least once in their lives and approximately 30% mentioned at least one episode in the 12 previous months. Almost one third of the women reported physical violence perpetrated by an intimate partner at least once in their lives, and approximately one out of every ten, in the 12 previous months. A total of 12.4% of the women reported at least one episode of sexual violence in their lives, and 4.2% in the 12 previous months (Table 2). Of these women, 6.5% said that they looked for help in a healthcare unit (data not presented on tables).

Ten Women's Health coordinators said that asking questions about experiencing situations of violence was not routine procedure in the UBS of their municipality; such questions were asked if the women spontaneously reported this kind of complaint or if the professionals identified some sign of physical or psychological violence during routine assistance. In five municipalities, the existence of a specific protocol to assist cases of violence against women was mentioned (data not presented on tables).

The majority of the UBS coordinators mentioned that the experience of violence among users was detected in their units; however, 74% said that this was not routinely investigated and 11% reported a specific protocol to conduct this investigation. Of the 62 coordinators who stated that they detected situations of violence, 45% said that the women were referred to reference services and 40%, that they received emergency care at the UBS and were subsequently referred to other services; 31% mentioned that the violence was notified. Of the 65 coordinators who stated that violence was investigated depending on specific situations, 31% mentioned professional training for this investigation, mainly for nurses (17), generalist physicians (11), psychologists and social workers (9 each) (Table 3).

The majority (80.9%) of the UBS professionals said that they detected the experience of violence situations among the women they assisted. Signs of physical injury (88.1%) and emotional/psychological signs (67.9%) were pointed as the main indicators of violence. More than half of the professionals pointed the women's silence as a difficulty in the investigation and detection of these situations; 16% mentioned lack of training/qualification of the professionals themselves to tackle the matter. Those who mentioned that they detect these situations (39.7%) said that the woman was

Table 1. Experience of violence at least once in life by women assisted in primary care units. State of São Paulo, Southeastern Brazil, 2008.

Variable	n	%
Suffered some type of violence		
Yes	1,815	76.5
No	557	23.5
Suffered emotional violence		
Yes	1,716	72.3
No	656	27.7
Suffered physical violence		
Yes	1,110	46.8
No	1,262	53.2
Total[a]	2.372	

[a] There was no information from 7 women

Table 2. Experience of intimate partner violence, at least once in life and in the 12 previous months, by women assisted in primary care units. State of São Paulo, Southeastern Brazil, 2008.

Experienced situations	At least once in life		12 previous months	
	%	n	%	n
Suffered at least one situation of violence[a]	56.4	2,344	32.1	2,195
Emotional violence				
Insulted you, made you feel bad about yourself	46.5	2,343	25.2	2,226
Depreciated or humiliated you in front of other people	31.0	2,342	15.2	2,238
Scared or intimidated you on purpose	28.4	2,342	14.0	2,284
Threatened to hurt you or to hurt someone or something you like	21.3	2,342	9.1	2,297
At least one episode of emotional violence	53.8	2,342	30.6	2,206
Physical violence				
Slapped you or threw something that could hurt you	23.4	2,342	7.9	2,273
Pushed or shook you	24.2	2,342	9.7	2,283
Hurt you with a punch or some object	14.9	2,342	4.9	2,306
Kicked, dragged or hit you	12.1	2,341	3.5	2,285
Threatened or used a firearm, a knife or some other type of weapon	9.6	2,341	2.8	2,317
Strangled or burned you on purpose	3.8	2,340	1.2	2,330
At least one episode of physical violence	32.3	2,341	12.3	2,247
Sexual violence				
You had sexual relations because you feared what your partner could do	8.7	2,341	2.9	2,326
Physically forced you to have sexual relations when you did not want to	8.0	2,340	2.5	2,319
You were forced to maintain a degrading or humiliating sexual practice	5.6	2,340	1.7	2,323
At least one episode of sexual violence	12.4	2,340	4.2	2,314

[a] 27 participants never had a partner/husband and each woman could mention more than one experienced situation.

Table 3. Characteristics of the assistance provided for women who suffer violence, according to information provided by coordinators of primary care units. State of São Paulo, Southeastern Brazil, 2008.

Characteristics	n	%
Detection of violence situations experienced by women		
Yes	62	83
No	13	17
Routine questions about violence		
Yes	19	25
Yes, but only in a specific situation	46	61
No	10	13
Total of coordinators	75	
Attitude in view of the detection of violence[a]		
Referral to a reference service	28	45
Emergency care at the UBS, referral to another service	25	40
Notification to the responsible agency	19	31
Give instructions: denounce; register a report at a police station; go to the Women's Police Station	15	24
Psychological assistance	12	19
Assistance through Social Work	12	19
Complete assistance at the UBS itself	4	6
Other	14	23
Total of coordinators who stated that they detect situations of violence	62	
Protocol to ask questions		
Yes	7	11
No	58	89
Training to ask questions		
Yes	20	31
No	45	69
Total of coordinators who stated that they ask questions about violence	65	
Trained professionals[a]		
Nurses	17	85
Generalist physicians	11	55
Psychologists	9	45
Social workers	9	45
Family Health doctors	6	30
Gynecologists	5	25
Pediatricians	5	25
Other professionals	7	35
Total of coordinators who stated that there was training	20	

UBS: Unidade Básica de Saúde (Primary Care Unit)
[a] The participants could mention more than one alternative concerning which professionals were trained and attitude in view of detection of violence.

directly referred to a reference service; 27% said that emergency care was provided at the unit and the woman was subsequently referred to another service (Table 4).

Almost three quarters of the professionals stated that they do not investigate routinely the experience of violence among users; 42.4% pointed specific situations in which this was performed, among which signs of physical injuries (49.7%) stood out. Among those who reported asking routine questions about violence, 6.2% mentioned a specific protocol and 15% reported some qualification to investigate violence. The majority (61%) of the reported trainings was promoted by the Municipal Health Secretariat; approximately 30% mentioned that participation in training was optional (Table 5).

Table 4. Experience of professionals from Primary Care Units concerning the assistance provided for women in situation of violence. State of São Paulo, Southeastern Brazil, 2008.

Characteristics	n	%
Detection of violence		
Yes	300	80,9
No	71	19,1
Total of professionals[a]	371	
Signs that indicate violence		
Signs of physical injury	327	88,1
Emotional/psychological signs	252	67,9
Fear of questionings/fear to denounce	27	7,3
Others	6	1,6
Total of professionals[b]	371	
Difficulties in the investigation of violence situations		
None	44	11,8
The women do not talk about the matter	195	52,1
Lack of training/qualification of the professionals	60	16,0
Approaching/detecting the problem	38	10,2
Lack of bond between the professional and the women	22	5,9
Professional is scared/afraid of retaliation	22	5,9
Other	46	12,3
Total of professionals[c]	374	
Conduct in view of the detection of violence		
Referral to a reference service	119	39,7
Emergency care at the unit, referral to another service	81	27,0
Assistance provided by the psychologist	51	17,0
Assistance provided by the social worker	42	14,0
Notification to the responsible agency	25	8,3
Complete assistance at the UBS itself	15	5,0
Other	156	52,0
Total of professionals who stated that they detect violence[a]	300	

[a] There was no information from one professional and three did not know what to answer.
[b] There was no information from two professionals and two did not know what to answer.
[c] One professional did not know what to answer.

Table 5. Characteristics of the assistance provided for women in situation of violence in Primary Care Units, according to professionals from these services. State of São Paulo, Southeastern Brazil, 2008

Characteristics	n	%
Routine questions about experiencing violence situations		
Yes	104	27,7
No, only in a specific situation	159	42,4
No	112	29,9
Total of professionals	375	
Specific situations to ask questions		
Signs of physical injury	78	49,7
Suspicion / denunciation	46	29,3
Emotional / psychological signs	40	25,5
Spontaneous complaint	34	21,7
Other	16	10,2
Total of professionals[a]	157	
Protocol to ask questions		
Yes	16	6,2
No	244	93,8
Total of professionals[b]	260	
Training of professionals to ask questions		
Yes	39	14,9
No	223	85,1
Total of professionals[c]	262	
Training promoted by		
Municipal Health Department	22	61
State Health Department	3	8
Ministry of Health	2	6
Other	13	36
Total of professionals[b]	36	
Training		
Obligatory	12	31
Optional	27	69
Total of professionals[c]	39	

[a] There was no information from two professionals.
[b] There was no information from one professional and two did not know what to answer.
[c] There was no information from one professional.

DISCUSSION

A relevant proportion of female users of the primary care network in the State of São Paulo experiences violence on a daily basis. The perpetrators of this violence are mainly intimate partners and/or other relatives. Women tend to silence about experiencing these situations and they rarely make spontaneous complaints during the consultations in the primary care network. Generally speaking, health professionals do not feel qualified to deal with these situations, a scenario that is similar to the one observed in studies carried out in diverse regions of Brazil.[10,17,19] Violence that is daily experienced by women is a challenge to the primary care network.[15]

The predominance of violence against women perpetrated by intimate partners is pointed in studies conducted in Brazil[2,15,18] and in other countries.[6] These studies have also shown that health professionals face difficulties to approach this situation with women who search for assistance in the primary care network due to other complaints and keep quiet about the suffered violence, the origin of this suffering. This silence is related to pain, shame and fear involved in such situations, and leads to gender issues that contribute to the invisibility of violence and of women's cry for help.[18] It also suggests the non-recognition of the healthcare service as a place for looking for and obtaining help.[2]

Although the professionals realized the magnitude of the problem and perceived that they could and should act in primary care to provide adequate assistance for women in situations of violence, they did not seem to have the necessary resources for this, as was reported in other studies.[13,20] There were no specific protocols to deal with this question, as observed among health professionals in the Great São Paulo,[9] who recognized violence against women as a socially important question, but did not identify it as part of their job and/or did not have the necessary resources to intervene in it in healthcare. The absence of specific protocols points to the lack of technical and scientific parameters, essential in the scope of biomedical rationality. This absence may contribute to the fact that these professionals do not feel responsible for assisting these women as part of the exercise of their functions. They understood any action in this sense as a personal initiative. Such perspective is strengthened by their ignorance about the existence of a structured assistance network for women in situation of violence in their municipality.

The absence or lack of knowledge concerning the existence of the assistance network contributes to make the professionals who work in primary care feel limited or incapable of approaching the question in their practice, as observed by Schraiber et al[17] in a primary care unit in the city of São Paulo (Southeastern Brazil), Kronbauer & Meneghel[10] in Porto Alegre (Southern Brazil), Moreira et al[12] in Natal (Northeastern Brazil), Lettiere et al[11] and Vieira et al[20] in Ribeirão Preto (Southeastern Brazil). A similar situation was observed in the United States, in which professionals did not routinely investigate situations of violence among the assisted women because they were not sufficiently trained for that, they had little time for the assistances and considered that effective measures would not be adopted to solve the problem.[1]

Despite the fact that a significant proportion of women uses the public healthcare services of the State of São Paulo and experiences violence, they are neither identified nor approached to receive help. There is a mismatch between the public policies in force[a,b,c,d] and the assistance provided for women. The policies recommend that assistance for women in situation of violence should be provided by intersectoral networks, constituted by diverse services and institutions, including the primary care network. However, primary care is not prepared to deal with these cases. The proposal to constitute care networks is based on the understanding that, although violence against women produces a strong impact on their health, it is a broader problem whose nature is social. Its approach, therefore, requires resources in the area of health and in many others, like, for example, public security and social work. The constitution of care networks aims to enable the articulation of governmental and non-governmental institutions/services that allow to identify, welcome and assist, in an integral form and inserted into an intersectoral network, women who experience situations of violence.[13] In spite of this political emphasis and the intense discussion about the theme among many sectors of society, the concretization of these networks represents a challenge to be overcome,[3,21] which was confirmed in our study.

There are positive examples of construction of intersectoral networks, in operation and in constant improvement, which can be multiplied. In the care model *Conflitos Familiares Difíceis* (Difficult Family Conflicts), there is the articulation between the assistance provided in a healthcare center and a secondary hospital in areas of the city of São Paulo (Southeastern Brazil).[13] Another successful model is *Programa Iluminar Campinas – Cuidando das Vítimas de Violência Sexual* (Program Illuminating Campinas – Providing Care for Victims of Sexual Violence), which was initiated in the city of Campinas (Southeastern Brazil) in 2001, and implemented in other municipalities of the State.[e] Both experiences, however, confirm the difficulties involved in the process of constitution of intersectoral networks, as this implies making distinct

[e] Campinas – Prefeitura Municipal. Iluminar Campinas. Cuidando das Vítimas de Violência Sexual. Disponível em http://2009.campinas.sp.gov.br/saude/ programas/iluminar/iluminar_textobase.htm. Acesso em 28 de Novembro de 2010.

assistance sectors become compatible and articulated. At the same time, it is necessary to convince the professionals to be involved in the assistance without fear and without making judgments, to cultivate the posture of competent and affective listening and, above all, to understand that this kind of violence is a question of health and not only a police matter. On the other hand, it is difficult to convince the services' coordinators to work in network and share positive experiences, learning with the obstacles and searching for help inside the network itself. [13,21]

Among the limitations of the present study, there are the inferences that, in fact, cannot be made based on the results found among the interviewed women. It was a non-probability sample of easy access which, therefore, does not represent the universe of women of the State of São Paulo, not even that of women who use the primary care services. Still, it is possible to say that the results are consistent with what has already been observed in other studies carried out in the same State and in other regions of Brazil. At the same time, the results obtained from the health professionals also confirm the validity of the findings in the sample of women.

So that the primary care services become part of intersectoral networks to assist women who experience violence, it is necessary to be careful not to reduce them to a set of units for screening and/or referring women in situations of violence. Instead, they should act in an integral and integrated way. It is not enough to create a network; it is necessary to constantly evaluate the process and the impact of the actions in order to correct and enhance its development.

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