THE ASSISTANCE REALITY OFFERED TO WOMEN IN A SITUATION OF DOMESTIC VIOLENCE

A REALIDADE ASSISTENCIAL OFERECIDA À MULHER EM SITUAÇÃO DE VIOLÊNCIA DOMÉSTICA

LA REALIDAD DE LA ASISTENCIA OFERECIDA A LA MUJER EN SITUACIÓN DE VIOLENCIA DOMÉSTICA

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ABSTRACT
Objective: understanding the reality care offered to women in situations of violence. Method: a qualitative, exploratory study. We used a semistructured interview script with 12 health professionals from the Family Health Strategy of João Pessoa-Paraiba, in September 2012. Data were analyzed by the Technique of Discourse Analysis that supported the construction of sub-categories / themes. The research project was approved by the Research Ethics Committee, CAAE n° 0005.0.126.000-11. Results: domestic violence is invisible in everyday services; it is constantly associated with socioeconomic factors by professionals. Conclusion: the knowledge of professionals about the unequal relations between men and women is configured as a key instrument to act on a comprehensive health, contributing to a powerful process of working encouraging the emancipation of gender oppression. Descriptors: Gender; Domestic Violence; Work Process.

RESUMO

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Objetivo: comprender la realidad de la atención ofrecida a las mujeres en situaciones de violencia. Método: un estudio cualitativo, exploratorio. Se utilizó un guión de entrevista semiestructurado con 12 profesionales de la salud de la Estrategia de Salud de la Familia de João Pessoa-Paraiba, en septiembre de 2012. Los datos fueron analizados por la Técnica de Análisis del Discurso que se apoyó la construcción de sub-categorías / temas. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación, CAAE nº 0005.0.126.000-11. Resultados: la violencia doméstica es invisible en el cotidiano de los servicios, que está en constante asociación con los factores socioeconómicos de los profesionales. Conclusión: el conocimiento de los profesionales acerca de las relaciones desiguales entre hombres y mujeres se configura como un instrumento clave para actuar en una salud integral, aportando un poderoso proceso de trabajo para fomentar la emancipación de la opresión de género. Descritores: Gênero; Violencia en el Hogar; Proceso de Trabajo.
INTRODUCTION

The World Health Organization/WHO defines violence as the use of physical force or power, in which has been committed aggression, or as a form of threat against another person, against a group or community, or even against himself, culminating in injury, death, psychological harm, developmental disability or deprivation.¹

The expression of violence in its most extreme form translated into numbers represents a rate of homicidal violence of 26.2 per 100 thousand inhabitants in Brazil, referring to the year 2010. In an analysis by gender, the rate of homicidal violence, for the data for the same year is 4.4 per 100 000 women inhabitants, according to the Map of Violence 2012, published by the Institute Sangari.²

Violence against women is not a recent phenomenon, represents a form of violence that persists in time, in all social classes and in many cultures.³ This kind of violence is often materialized in private domain, and the home than in other situations would be the reference of refuge and protection in these cases appears as a privileged site for practice and blind violence. The risk of a woman suffering some type of aggression inside the house by his companion is almost nine times higher than the risk of being attacked in the street.⁴

Violence against women is defined by the United Nations/ONU⁵ as any act of gender-based violence, which may culminate in injury or physical, sexual or psychological harm. The breadth and complexity of these cases of violence resulted in many terms to their name may be mentioned: gender violence, domestic violence and family violence that despite the specificities found in each of them, both are based on inequalities of power relations.

The violence is presented as a way of legitimizing power of men over women is called gender violence, this can be interpreted as an educational and punitive.⁶ The understanding of gender violence depends on the understanding of the concept of gender, which corresponds to the social construction of exercised by women and men based on differences between the sexes, manifested by gender identities corresponding to the female and male roles. Clarifying the category of gender leads to understanding of the inequalities between men and women over the years. The low summarizes the definition of gender as follows:

[...]

The genus is discussed as a constitutive element of social relationships, which integrates a cultural and ideological baggage, manifesting as a basic form of representation of power relations, overcoming the view that the dominant representations are natural and unquestionable.³

The analysis of relationships between men and women reveals excessively unequal conditions for the exercise of power, where women are occupying subordinate positions to men in relationships. Thus, one can understand the phenomenon of gender violence, based on these power relations.⁷

Family Violence falls on family members, and is not restricted to the physical territory of a household, domestic violence victims fit non-kin or relatives, such as maids, or others who live partially or entirely at home in which the aggressor is the father.⁵

The violence experienced in the domestic sphere just beating the walls of private and reaching the public space, including health services, due to the implications of violence in the health-disease process of victimized women.

The need for protection and reassurance in a prime location can generate social domination strategies such as violence, which accentuates inequalities, and have placed over the years, the woman in an underprivileged position as the biological condition for the exercise of power, where women inhabitat, according to the Map of Violence 2012, published by the Institute Sangari. The understanding of gender violence, in its origin, is a socio-historical phenomenon and follows the whole experience of humanity. Is transformed as a public health issue for the individual and collective impact that prints on the health of individuals, so now requires formulation of
The assistance reality offered to women...

units scenarios of the study. 22 professionals were interviewed, two medical, two dentists, two auxiliary oral health, two techniques in Nursing, and two nurses, eight community health agents, a matrix supporter, two markers of exams, and one administrative assistant.

The first stage of the research was the selection and reading of the documents that inform policy attention to women's health, to identify the themes that make up the categories that guide the organization of services and professional practice. Subsequently gave the application of research instruments: semi-structured interview scripts. The interviews were scheduled in advance with professional services and occurred individually observing the privacy of all respondents.

The empirical material was analyzed by the technique proposed by Discourse Analysis Fiorin for whom discourse analysis must be employed by researchers in any area of performance as a tool to understand texts or produce them to meet and objects of specific studies. 14

The speech is a social position and that is what should be analyzed:

The discourse analysis will, as the study of discursive elements, mounting by inference the worldview of the subjects enrolled in speech. Then shows what determined that vision on it revealed [...] While the speech is the materialization of ideological formations, being so determined by them, the text is solely the place of conscious manipulation, in which man organizes, in the best possible way, the elements of expression that are at your disposal to serve his speech. The text is therefore individually, while the speech is social. 15-16

At first the analysis of the study was transcribing the interviews, printing and reading of texts. In the second stage, the themes and figures were identified in the reports on the various questions put to respondents. Then the texts were decomposed and organized into blocks of meaning by coincidence / divergence of the theme. Throughout the process of analysis and discussion the empirical material was related to the relevant literature to anchor the social positions revealed in the themes identified which allowed the identification and construction of categories that explain the phenomenon investigated.

All recommendations of resolution that comes to research with human subjects were observed. The institutions involved were consulted and their commitments formally requested and met. The subjects involved
were also treated this way. The project was explained in detail the services team in a scheduled for this purpose with professionals who were part of the sample, at which time they signed the Consent day. All subjects were informed of the possibility of its withdrawal at any time he wished. The research project was approved by the Research Ethics Committee of HULW/ CCS/UFPB under Protocol No. 028/11 and CAAE No. 0005.0.126.000-11.

**RESULTS**

The statements provided enabled the elaboration of the following subcategories: The invisibility of domestic violence in the work process in the Family Health Strategy and socioeconomic issues and gender violence.

♦ The invisibility of domestic violence in the work process in the family health strategy

The non-recognition of violence as something pertaining to the field of health is one of the major challenges for comprehensive women's health care. Violence is almost always taken as relative to the fields of public safety and the judiciary. The following statements depict that professionals understand violence as something inherent to the process of social assistance:

*Look, for me, never gets anyone complaining. But, appearing, I send them to the Social worker.* (E6)

*We, the same team, didn't get it done, you know! Will only go forward through the supporter or Social worker.* (E16)

Another important aspect highlighted in the testimony of E6, is that professionals do not understand the investigation of cases accordingly as their assignment, and elect the silence of women as a significant difficulty in their work process.

In this sense, it is evident that another problem is the difficulty of the approach to women victims of violence. Professionals end up being omitted when there is no exposure of the problem by the victimized woman when need to adopt a posture can minimize barriers and thus approach the issue. The following testimonials bring silence as a difficulty for assistance to women victims of violence:

*The first is his own wife that she doesn't want to identify [...]. I think the first problem is she. Is the woman.* (E4)

*Now the difficulty sometimes is it come to us, her look for the health service, and put yourself right? Because either way she's exposing yourself.* (E5)

In their statements, some experts say have knowledge about domestic violence, but it is possible to identify not consider these cases as a matter that is the subject of their interventions. In this sense, the proposed deliberate entirety by the laws is not the same view on practice. In care reality, the practice of completeness does not match the idealized by the policies of care for women, with a gap between what is proposed and what actually is in the services offered.

* [...] we know everybody, we know of several cases, several things, but some things you can't do anything.* (E10)

*A lot of stuff that happens in the area we have to view and keep quiet.* (E8)

You can also identify that the professionals did not deny the existence of violence suffered by users but do not develop coping mechanisms of the problem, or even fail to understand how their work can contribute.

*But we don't have how to act, how to [...] intervene. The health agent has no way of [...] interfere in this situation. Even what I know, to my knowledge, I don't know how to forward, what to say, where to send, how to advise [...] I do not know.* (E8)

* [...] should have lecture to assist, and we also know, be aware of how and where power forward. Because we don't know.* (E3)

The cases of violence, even when present in health services are not seen by professionals as related to their work process, having a negative impact on the tour, and hindering the possible consequences for the construction of strategies to deal with domestic violence.

♦ Socioeconomic issues and gender violence

Regarding gender violence, social issues have also been targeted. Some professionals when asked about their conceptions of such violence, its occurrence associated with a disadvantaged socioeconomic classification, according to the statements below:

*Financial factor. We work in poor communities, we see what is [...] What is the weight of the financial situation in the communities.* (E9)

*It's more the social condition, their socioeconomic that interferes.* (E4)

The use of drugs and alcohol by the offender was also remembered by professionals as a contributing factor, or even as a cause for resuscitation episodes of violence in the domestic sphere, as the testimonials:

*But so, in my perception, [...] occurs the weekend often is very related to drugs, whether alcohol, is another kind of drug.* (E11)
The violence, she often gives by jealousy over the top, isn't it? [...] also by the use of drugs, alcohol and drugs, because in our community there are a lot of these two factors. (E19)

So, this violence is doing with respect to the drug [...] cases that we see has to do with alcohol or drugs, you know? Itself, because these three cases there, all three are junkies. And we unfortunately have a very large amount of drugs in our area. (E21)

Another noteworthy finding is that professional, yet when asked about his views on gender violence, attributed to education and social indicators related to the existence of violence in the social context in which violence victims users are located.

Now, is the kind of thing we have to understand that culture is not? Lack culture, lack courage. And another thing, it's just that it's the 'illiteracy' of the people. (E7)

I think one of the main factors, may be not, but illiteracy influences too. Lack of knowledge, [...] Not knowing the right and duty of the other. (E9)

An overly worrying factor is that some professionals become skittish to act in an area characterized by a high rate of violence and drugs.

I don't feel that way [...] Safe to take a stance, to interfere [...] Because we work in a violent community, isn't it? [...] And actually on my referral, I even like that, or cite something because suddenly the wingman that my referral. (E11)

I feel, I feel sometimes difficulty in approaching this woman. Because, as we live in an area considered at risk, isn't it? Themselves, they have a certain fear of denouncing, talking about what's going on with her husband's account, and everyone gets a little afraid to enter in this case too, scared of threats, so the difficulty I think bigger is just that. (E19)

In this sense the victimized woman ends up suffering a new aggravation, since in addition to suffer violence, the professionals still have fear in taking care of the woman so directed by fear of the attackers.

**DISCUSSION**

For a long time the health care service provided to women, restricted to the reproductive health. With the creation of the Program for Integral Attention to Women's Health (PAISM), in 1983, there was a deepening of the approach of the concept of completeness which was a breakthrough for the discussion and development of policies for the perspective of the gender approach.

The framework of PAISM broke with the mother-child paradigm, where the woman was seen by the health system as a producer and reproducer of the labor force that is, in its condition of mother, nurturer and caretaker of the offspring, opposing the formulators policies hitherto focused primarily to ensure the well-being of infants and children.  

This policy emphasized the comprehensive health care at all stages of women's lives, including actions concerning the assistance to women victims of violence, an issue that was not previously brought to the scene of the discussion which was very much to the invisibility of the phenomenon.

Seize this opportunity to advance in the daily routine of health services incorporating the issue of violence has shown modest and hesitant and commitment that was made by political authorities have not directly reached the work of concrete agents health practice is not easy to recognize.  

violence as a question relating to this field and the historical precedence of his approach by the humanities and social sciences reinforce this view.  

[...] the silence is seen as a problem only for women and not referred to the responsibility of the trader. In their reports, the attempt to get a kind of 'confession would be so cumbersome that would become a big problem, or would be, infeasible in context of work. Moreover, domestic and private nature of violence against women contributes to decline it targeted assistance  

"Like all professional workers can only recognize and accept an assignment to the intervention that visualizes beforehand as the object of their technical competence".  

Unrecognized issues focused on the everyday activities of the health care professional, also will not be targets of an effective outreach response.

The desire to understand such a complex problem as the violence has resulted in three main streams that seek the explanation of the phenomenon. There are authors who attribute the violence to human nature itself, as biological result. Other authors, in turn, believe that violence is the sum of individual behaviors as part of the will of the individual. And there are also those who elect the social sphere as the dominant environment in the production of violence.  

With regard to gender violence, social issues have also been the subject of attention of researchers. In a desenvolvido9 study, 80% of women whose partners used drugs were victims of some type of violence. And although studies conducted by WHO are not conclusive in the association of socioeconomic status with violence, the authors found associations between some forms of violence.
against women and lower socioeconomic status, lower education, and drug use by their partners, as well as a history of violence in the family.

For the Ministry of Health “social, economic and cultural differences are revealed in the process of falling ill and dying populations and every particular person, in a different way.” 20 However, although some practitioners have reported a close intertwining between the occurrence of this type of violence based on gender inequalities in socioeconomic indicators related to poverty does not mean to say that women belong to a privileged social class are exempt from this type of violence.

With regard to the use of drugs and alcohol, theme constantly reminded the statements analyzed; these factors are not consolidated as the main triggering factor of the cycle of violence. The above factors as well as economic problems are not the cause of violence, although leverage violent situations.21

Low educational factor associated to domestic violence is also featured in other studies22, wherein when considering the association between physical violence and factors related to women, the risk of perpetration of violence was significantly higher for lower levels of education, being almost 10 times higher for 0-3 years studied, compared to 11 or more years. However, this variable related to education should not be analyzed without considering who is also associated with disadvantaged socioeconomic conditions, especially through its influence on low-skilled culminating with a considerable level of unemployment or modest salaries.

The health service is one of the most sought after by women who have experienced violence. Thus, they do not always find a termination action, or even care quality when contemplated under the sphere of completeness.23,24

The professionals in the health field in any of the levels of assistance cannot sneak the duty to assist women in all cycles of life, safeguarding the specificities of different ages and different population groups such as black women, Indians living in urban and rural areas, living in hard to reach places, at risk, prisoners, homosexual orientation, disabled, among others, as recommended by the National Policy on Health Care for Women.20

The fact that violence occur or not in a medium with a lower socioeconomic status, the presence of drugs and too violent does not relieve the responsibility of the professional to intervene and use his technical and scientific knowledge in order to result in attitudes that encourage gender emancipation, and may thus contribute to solving the conflicts experienced by the user victim of violence.

CONCLUSION

The analysis of the collected testimonies concluded that the suffering that goes beyond the dimensions of the disease ends up being away from the focus, not part of the scope of health interventions. Although public health policies point to the issue of domestic violence as a target for intervention of the field, the incorporation of resolving actions, or that contribute to minimizing the problem still presents one more possibility than a reality in the context of the practices of professionals. You can identify that even that most respondents have alleged the existence of this type of violence in their area of work, the assistance given to cases boils down to biologist mode. Professionals to understand the harm caused by violence as the scope of their assistance, however, the phenomenon of violence in itself, is not considered a problem in the health field, setting this way, the invisibility of violence in the service.

Binding of socioeconomic profile with domestic violence, through notes made by professionals, referred to a speech that women inserted in a social context characterized by poverty, low levels of education and use of drugs and alcohol, would almost certain to suffer with the problem of violence by exempting health care professionals from the responsibility to act in such cases. Violence against women is based on power relations, historically constructed, which by its social character, not biological, is subject to change.

The reception capacity of the woman by the professional who does not recognize violence as a matter inherent in their work process is limited and belief that domestic violence is a problem restricted to the private sphere and that concerns only those directly involved reiterates the shortcomings such assistance and the complexity of the phenomenon. The knowledge of professionals about the unequal relations between men and women is configured as a key instrument to act on a comprehensive health, contributing a powerful process of working to encourage the emancipation of gender oppression.

REFERENCES