



CONCEPTS AND PRACTICES OF HEALTH PROFESSIONALS ON VIOLENCE AGAINST WOMEN

CONCEPÇÕES E PRÁTICAS DE PROFISSIONAIS DE SAÚDE SOBRE A VIOLÊNCIA CONTRA A MULHER

CONCEPTOS Y PRÁCTICAS DE LOS PROFESIONALES DE LA SALUD SOBRE LA VIOLENCIA CONTRA LA MUJER

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ABSTRACT

Objective: analyzing the concepts and practices of professionals of the Family Health team with a focus on violence against women. **Methodology:** analytical- descriptive study with a qualitative approach. Ten interviews were included in the analysis carried out in 2010 guided by a semi-structured script. The data were analyzed according to the technique of content analysis in Theme modality being discussed according to gender studies. The research was approved by the Ethics Committee in Research, protocol 20101509-034. **Results:** knowledge of respondents is incipient; professional dynamic towards violence is restricted to advice and guidance disjointed; health education as a coping strategy does not compose professional interventions. **Conclusion:** it points to the need to introduce the theme of violence in the making of health professionals, investment in graduate and continuing education, as well as an increased effort of local management, in order to stimulate and energize the processes of intersectoral coordination. **Descriptors:** Women's Health; Violence Against Women; The Family Health Program.

RESUMO

Objetivo: analisar concepções e práticas de profissionais da equipe de Saúde da Família com foco na violência contra a mulher. **Metodologia:** estudo analítico-descritivo, com abordagem qualitativa. Compuseram a análise dez entrevistas realizadas em 2010 orientadas por um roteiro semiestruturado. Os dados foram analisados à luz da técnica da Análise de conteúdo na modalidade Temática, sendo discutidos de acordo com os estudos de gênero. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa, protocolo 20101509-034. **Resultados:** o conhecimento dos entrevistados é incipiente; a dinâmica profissional frente à violência é restrita à conselhos e orientações desarticuladas; a educação em saúde como estratégia de enfrentamento não compõe as intervenções profissionais. **Conclusão:** aponta-se a necessidade de inserção da temática da violência no fazer do profissional de saúde, investimento na graduação e educação permanente, assim como maior esforço da gestão local, no sentido de estimular e dinamizar os processos de articulação intersectorial. **Descritores:** Saúde da Mulher; Violência Contra à Mulher; Programa Saúde da Família.

RESUMEN

Objetivo: analizar los conceptos y prácticas de los profesionales del equipo de la Salud de la Familia con un enfoque en la violencia contra las mujeres. **Metodología:** estudio analítico y descriptivo con enfoque cualitativo. Diez entrevistas fueron incluidas en el análisis llevado a cabo en 2010 guiados por un guión semi-estructurado. Los datos fueron analizados según la técnica de análisis de contenido en modalidad temático, siendo discutidos de acuerdo con los estudios de género. La investigación fue aprobada por el Comité de Ética en Investigación, protocolo 20101509-034. **Resultados:** el conocimiento de los encuestados es incipiente; la dinámica profesional hacia la violencia se limita a asesorar y orientar desarticuladamente; educación para la salud como estrategia de afrontamiento no compone intervenciones profesionales. **Conclusión:** se apunta a la necesidad de introducir el tema de la violencia en el hacer de los profesionales de la salud, la inversión en posgrado y educación continua, así como el aumento de los esfuerzos de la gestión local, con el fin de estimular y dinamizar los procesos de coordinación intersectorial. **Descriptor:** Salud de la Mujer; La Violencia contra la Mujer; El Programa de Salud de la Familia.

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INTRODUCTION

Violence against women is a major route of human rights violations, being defined as any action or omission based on gender, which causes suffering, injury or death.¹ Studies show that one in three women has been the victim of violence at some point in life, in 70% of cases, the perpetrator is an intimate partner.² The consequences of this type of aggression are related to physical health (sexually transmitted infections, gynecological disorders and trauma) and mental (post-traumatic stress, depression and sexual dysfunction).³

The issue of violence against women gained greater visibility from the 70s. The search for denaturing abuse, maltreatment and expressions of oppression in the domestic sphere reflected in the creation of coping mechanisms and assistance to women victims of violence in the public sphere. As examples, there are highlighted the creation of the Special Police Assistance of Women in 1985, house-shelters in 2002, the Centers of Reference for Attendance to Women, Defenders of Women's and Accountability and education services of the Offender and of Specialized prosecutors' offices, since 2003.⁴ The multiplicity of agencies and institutions is necessary because the service should consider the multidimensionality and complexity of the phenomenon.

As the health aspect, it underscores the National Policy for Integral Attention to Women's Health, established in 2004, and the first and second Plan of Policies for Women, presented in 2005 and 2008, respectively.⁵⁻⁷ These documents outline the role of health and their agents to deal with violence, involving the promotion of preventive actions, identification, acceptance and reporting of cases of violence, in addition to coordination with other departments participating in the network of care for women in situations of violence. However, the issue of violence is relatively invisibly in health services, which enhances the complexity of the problem, making it an intervention more difficult.⁸

Reducing the issue of violence to its physical manifestations, understood the biomedical perspective, and the resulting inattention to the other existing forms of violence constitute barriers to its confrontation.⁹ So are essential services closer to women, enabling the development actions from the perspective of comprehensive care.

From the viewpoint of completeness, the Family Health Strategy (FHS) is regarded as an important tool in the creation of bonds,

identification and referral of cases, as well as developing strategies to cope with the phenomenon of violence against women, especially when articulated to other network services.¹⁰ Therefore, it is crucial to analyze the work done by the FHS teams related to violence against women in their territory of action.

Given the above the following guiding questions were developed: what forms of protection of women in situations of violence known to the professionals? What are the strategies developed in the workspace geared to women in situations of violence? What strategies need to be developed to deal with violence against women? To answer these questions this study aims to analyze the concepts and practices of health professionals from the Family Health with a focus on violence against women; expected to contribute to the reflection and understanding of the possible barriers to addressing violence against women within the main entrance door to the Health System, ie in primary care.

METHODOLOGY

An article compiled from the research project << Women in Situations of Domestic Violence: beyond the sunset >>, linked to the Labor Education Program for Health, the Ministry of Health, regulated by Act nº 421 of March 3, 2010.

This is an analytical-descriptive study with a qualitative approach, because it applies to the study of relationships, perceptions and views derived from interpretations that individuals make about how they live, feel and think.¹¹

The scenario chosen was a difficult neighborhood in Campina Grande-PB, Brazil, consisting of low-income people living with drug trafficking and street violence. The subjects of the research process were health professionals of both teams FHS. Ten professionals were interviewed, two nurses, two doctors, two techniques in nursing, two community health agents and considering the importance of the reception in the FHS, for being the first contact of the user in the service, it was decided also to interview the two receptionists.

For composition of the corpus analysis technique of semi-structured interview containing questions that corresponded to the objective of the study was used. The application of the interviews took place individually in the corresponding services, using a recorder; there is no limitation of time for responses in order to become faithful transcription of the interviewees' statements.

The subjects were identified by the letter P and the sequence number of the interviews.

The interviews were conducted in October and November 2010, after the consideration and approval of the Research Ethics Committee of the University Hospital Alcides Carneiro, Federal University of Campina Grande, under protocol n. 20101509-034; as called for in Resolution n. 196/96, which deals with research involving human subjects, met up fundamental scientific and ethical requirements, ensured the respect the autonomy of individuals and the confidentiality of collected data.

To develop interpretive analytical process, the material was subjected to the technique of content analysis in the form thematic analysis aimed at discovering what is implied in every manifest content, and verifying hypotheses based on what is written, spoken, figuratively or symbolically drawn explained.¹² From the data analysis the following empirical categories were extracted: knowledge about services that integrate the network of care for women; dynamic professionals towards violence; necessary to deal with violence strategies. The categories were discussed in the light of gender studies and literature relevant to the topic.

RESULTS AND DISCUSSION

Characterization of the participants

Respondents were aged between 28 and 43, of which only one was male. As for education, 05 had completed their secondary education, while others have completed higher education.

There were no significant differences in conceptions and practices related to violence against women among the participating practices. However, community health workers and receptionists reported more experiences with women in situations of violence than Professional Nurses and Physicians, possibly the most closeness and bond established with the community.

• Knowledge about services within the network to assist women victims of violence

For services known to protect women in situations of violence, the professionals mentioned predominantly the women's police station (80%).

Only the women's police station, only; where they can make a complaint, because there is no other service that gives support to them there. (P05)

The Specialized Police for Assistance to Women (DEAM) was one of the first

government strategies designed to address the issue violence against women.¹³ Although this is an important instrument of protection, is insufficient when DEAM disjointed from other services that would promote the establishment a network, because violence is a phenomenon with multiple dimensions, which requires a multitude of services and support institutions who denounces.

The view that the station has the necessary mechanisms to protect victims of violence is a misnomer and is associated with understanding the phenomenon as a problem restricted to a single episode, requiring an immediate response. In this sense, corroborates the belief that violent acts are the result of a sudden moment of uncontrolled and abnormal offender and the victim passivity and inability.¹⁴

Violence against women must be viewed as a social problem and cultural practice, having its origin in unequal gender relations, where the female is assigned the role of submission, while the male is assigned the role of aggression.¹⁵

As for the other protection services, only referral hospital for sexual violence, dial complaint, the woman's house and nongovernmental organizations were reminded by health professionals at a frequency of once for each service. It appears from the testimony that health professionals have incipient knowledge about the services that make up the service network, even when they do not recognize themselves as members of that network.

The poor knowledge about the network of local support is a weakness in the service and demonstrates that the health team is not prepared to receive and forward the users accordingly. This prevents women receive interdisciplinary support that contributes to reflection on their condition, leading them to recognize their rights, and recover their self-esteem, which limits the possibility of breaking the cycle of violence.⁸

• The dynamics of health professionals on violence

The professionals were asked about the actions taken related to violence against women. The professionals said he did not engage in any activity (60%), while others reported some individual guidance when requested by users in situations of violence.

The guidelines relate to the fragmented advice, because violence against women is not included in the activities planned by the staff.

I direct something of the like, to talk, to give a word of comfort, finally, but not more than that. (P-03)

We do not have any groups, nothing. Only if we know of any case, it is sometimes difficult to know, is forward for the industry, but so preventative, preventive type [...] when we do not work do not. (P-04)

Given the complexity of the phenomenon, this kind of attitude is not enough to deal with the problem, because the formulation of practical advice or general formulas is not able to sustain significant transformations.⁸

It is noteworthy that the unqualified guidance can reinforce gender stereotypes that favor the maintenance of the cycle of violence.

We can guide, saying that there is an exit pro problem, but who is defining them. It's the life they want to lead or not. (P-02)

And we know that man is irrational even, it is not rational, women are more rational than men, they are very impulsive, act on time, and man accepts not be affronted by a woman, is culture. Unfortunately it is so and we will not change anything with that beautiful word no, it's their culture. (P-05)

The subjectivity of gender stereotypes has influenced the ways of knowing and facing violence by professionals. Professional practice has shown imbued with prejudices and naturalization of gender inequalities, being guided by the androcentric paradigm that outlines the entire social structure.¹⁵

It is expected that health services and its agents are able to contribute to the deconstruction of gender inequities, interfering with sexist / chauvinistic standards, and promote the empowerment of women to thereby ensure those qualified and humane care in situations of violence.⁴ However, this has not been the practice in the service investigated.

One of the reasons given for the lack of interventions is the difficulty of women in the fire service and denounces the ill-treatment.

Rarely do they actually come to the clinic seeking help because they suffer aggression, precisely because of the shame, is difficult. We know that others here have [women in situations of violence], we listen to other people talking about [...] you seen the tread that wench took yesterday? (P-03)

The perception that violence is a private problem permeates the minds of professionals. However, the team at FHS, from establishing a relationship, should include the issue of violence in professional practices, not only in clinical activities aimed at women who declares himself in situations

of violence, but through educational activities that promote reflection about forms of violence and its implications for the health of women, men and community. The inclusion of the theme of violence at different times of health care contribute to reducing invisibility of the problem by providing subject knowledge and the means to confront the phenomenon.

The fear of retaliation by the offender was one of the reasons given for the lack of intervention. Added to this, the professionals choose not to get involved due to lack of existing mechanisms in services to deal with such a complex phenomenon.⁸

We get very exposed, since you know there is no such safety net effective. (P-10)

It appears that the context of violence in which the health unit is inserted and the lack of more effective local public policies aimed at security and social assistance has a direct negative influence on investment actions that guarantee comprehensive care for women.

Another important issue pointed out by the study is the lack of preparation to deal with the issue, which causes embarrassing situations, and not hold skills to deal with the issue; they feel powerless in the face of the complexity of violence.

I have neither how to do an activity, do not have any specific material to do a particular activity about it. (P-03)

It is noteworthy that the difficulty of professionals to deal with women in situations of violence is a contributing factor to the model of work focused on the disease and incipient discussion on the social determinants of health during training.^{16,17}

When added to this issue, the lack of professional qualification sensitive to the phenomenon of violence and its consequences. The inability to intervene in matters involving violence points to the need to restructure the initial and ongoing training of health professionals.¹⁸⁻²⁰

It is noted that reporting of violence against women by health services, created the Law n° 10.778/2003 and addressed in health pact municipality analyzed since 2008, were not mentioned by the professionals interviewed, nor have they undertaken. We may thus infer that regulatory frameworks are inadequate when unsupervised training of a qualified health and sensitive to the issue of violence.^{21,22}

It appeared that the staff of FHS have not developed strategic actions and ordered intervention on the issue of violence against women. Despite the recognition and identification of the problem by all staff,

reception and qualified hearing, nor the necessary referrals and follow-up of cases are performed are not developed.

While recognizing that addressing violence is not for only the FHS, it is understood that the teams have the prerogative of establishing a bond and a health care model based on relational technologies, and comprehensive care to the individual, which favors the development of actions that allow the insertion of reflection on issues relating to violence, such as gender issues, not only for women who experience violence, but for the collectivity.

• **Strategies needed to deal with violence**

When asked about the strategies should be developed to deal with violence against women professionals showed predominantly educational work.

I think there should be meeting with them, group presentation, disclosure even for them. (P-05)

Health education constitutes one of the main working tools FHS and although permeate the discourse of the professionals interviewed, observed detachment of educational practice and the proposed health promotion, in which the performance of vertical practices on diseases predominate.

It is noticed that the attention tendency to reductionism of the phenomenon and unaccountability of the health service in relation to the problem.

I am health and have no knowledge of what is in our city [...] honestly I'm not. So I think I should know how to work more on this issue, it further to cover other classes, it is not only the health not because sometimes the staff also restricts all just health. (P-06)

Addressing the phenomenon of violence against women compete to different sectors such as public and social security. However, based on the expanded concept of health, health care professionals have an important role.^{10,15} On the other hand, understanding the pros are that the responsibility to develop educational activities that deal with violence should be centralized in other sectors.

I think the service has to be more [...] I wanted to say so [...] approximate more snuggled with them, a must for example be in the city center, they have to go in there, I think that this strategy has to come to them, because they will not look. (P-05)

The distancing of the health professional as to addressing violence against women may be related to restrict on the dynamics of violence and understanding that solving the problem is for the sphere of justice perception.

Even if we form a group, give a lecture [...] I think the women's police station, should be the following, if you called, it was faster for them to come and settle soon, more than [...] spends a lot of time, here comes. (P-09)

The professionals also stated the need for creation of support services to victims.

There should be a place of support, which should welcome these women, like other cities already exist. (P-06)

It reiterates the ignorance by professionals of existing services in the city such as the Service Center Victims of Violence (CEAV), the Center for Reference and Social Assistance (CRAS), the Center for Specialized Reference and Social Assistance (CREAS), the Municipal Social assistance (SEMAS) and specialized services: specialized Police for Assistance to Women (DEAM) and the Women's House.

It is inferred that different strategies need to be designed and developed to effectively deal with violence against women in the investigated context. It is suggested to introduce the theme of violence against women in the healthcare sphere, offering and sale of shares of health education, and the joint effort for the performance of interdisciplinary and intersectoral actions of support services, based on the understanding of violence as a dynamic phenomenon and that manifests itself in different ways, because any strategy that is timely strategy, will surely be able to solve such a complex problem. (E-10)

Attention to women in situations of violence will be efficient if investment in intersectoral work, with clear and effective policies and adequate preparation of health professionals.²³

CONCLUSION

The incipient knowledge of health professionals of the FHS about the services those form the network to assist women victims of violence consists of a gap in health care, which restricts predominantly the women's police station spaces and host intervention. Although being considered a relevant issue, confronting violence against women does not compose effectively the professional interventions.

The disconnection between the demands of users who live in a context of everyday violence, dislocation and reticent professional performance of services within the network are identified as major obstacles to combating violence against women in the scenario investigated.

It is understandable that address the issue of violence must occur in four areas: promoting the creation of more resolute, decentralized and close services to the context in which women are embedded; introduce the theme of violence in the FHS to health care; investment in graduate and continuing education for professionals, especially for those potentially involved with the issue of violence; greater effort of local management, in order to stimulate and energize the processes of intersectoral coordination.

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