



OBJN
Online Brazilian Journal of Nursing

ENGLISH

Federal Fluminense University

AURORA DE AFONSO COSTA
NURSING SCHOOL



Original Articles



Perception of health professionals about violence against women: a descriptive study

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ABSTRACT

Aim: to know the perception of health professionals about violence against women. **Method:** a descriptive and qualitative study carried out with members of the Guanambi Family Health Strategy teams in the state of Bahia, Brazil. The researchers collected the data through a semi structured interview, systematized it using content analysis and performed its analysis based on a theoretical reference on the subject. **Results:** the following three categories emerged: Conceptualizing violence against women; (Lack of) knowledge about notification and reporting; (Lack of) knowledge about the law that punishes those who commit violence against women. **Discussion:** the studied professionals present difficulties in understanding concepts, such as reporting and notification, and superficial knowledge about the Maria da Penha Law, which can hinder orientation and referral processes. **Conclusion:** we observed the need for permanent education with an emphasis to the notification, recognition and management of violence cases to improve indicators and empower women to cope with them.

Descriptors: Violence Against Women; Women's Health; Primary Health Care; Nursing.

INTRODUCTION

Violence is the product of a historical construction and is influenced by social, political and cultural issues, which affects all humanity and has negative impacts on public health. Violence against women, in particular, permeates gender relations in different cultures, based on social constructions about feminine and masculine figures. This type of violence has been present in several generations and in patriarchal family models⁽¹⁾.

These models address obligations such as procreation, care for the home, children and husbands to women, as well as establish to men the role of provider and the task of acting in the public sphere⁽²⁾. In this perspective, social norms that polarize and provide arbitrary and unbalanced values for masculine and feminine roles, justify and potentiate the differences between genders in a wrong way.

Violence against women, also known as gender-based violence, is based on a symbolic and cultural view of female inferiority and relegates women to the condition of preferential and chronic victims of physical force or rape⁽²⁾. Any act or omission based on gender that leads to death, physical, sexual or psychological harm or suffering, as well as any situation that violates human rights and violates women's citizenship, constitutes violence against women⁽³⁾.

In recent decades, the number of cases of this type of violence has increased every year, often because of the banal way these crimes are treated⁽¹⁾. In 2013, Brazil presented a rate of 4.8 homicides per 100,000 women, according to data from the World Health Organization (WHO), ranking the country at the unwanted 5th world position in female homicide numbers in a group of 83 Countries with homogeneous WHO-provided data⁽⁴⁾.

Violence against women has negative impact on health field, affects women of different

social classes, backgrounds, ages, regions, civil status, education, races and sexual orientation and is manifested by severe acts directed against women, such as physical and psychological aggression or threats, rape, sexual harassment, assault or libidinous acts.

Feminist movements, especially, which gained greater force in the 1970s, played an important role in articulating and fighting for women's rights against machismo, including against the violence they were suffering⁽⁵⁾ and were essential for a greater visibility of violence against women as a social and public health problem⁽⁶⁾.

With the effective participation of the feminist and other social movements, violence against women reached political spaces that have contributed to more effective discussions about the problem and the recognition of the magnitude of this condition experienced by women, thus promoting a reformulation of policies⁽⁷⁾.

Influenced by the demands of the feminist movement, national government implemented policies and actions to combat violence against women. A notable example is the creation of the Special Police Stations to Assist Women (DEAM) in 1985 - a pioneer initiative which served as reference for other Latin American countries⁽⁵⁾.

Another important step taken towards tackling the problem in Brazil was the approval of the Maria da Penha Act, of August 7th, 2006, which provides for punishment for perpetrators involved in situations of domestic violence, and represents an appeal to assure women the right to their Physical, psychic, sexual and moral integrity^(5,8).

Women under situations of violence attend to health services and often present signs of violence such as physical injuries to the body, nervousness, anxiety, intense sadness and insomnia^(7,9). Violence is also related

to other physical health issues, such as drug and alcohol abuse, gastrointestinal disorders, hypertensive crises, cervical spine discomfort, headache, dizziness, depression and psychic disorders⁽⁹⁾.

In most cases, the signs of violence go unnoticed by health professionals, since some are subjective, masked and hard to identify. Moreover, the non-valorization of this violence as a health problem, associated with the mechanistic nature of biomedical routine activities in the daily work of the multiprofessional team helps to cloak this violence signs, which generates more vulnerabilities to women.

A study carried out with health professionals of the public network of São Paulo reported that, often, the health teams are not able to recognize the violence in their care practice, due to the difficulty of identifying the symptoms or due to the silence of service patients themselves⁽¹⁰⁾. Therefore, it is extremely important to have multiprofessional teams, in which everyone is able to listen carefully and respect the patients' problems, identify signs of violence, notify this to the authorities and provide health care.

Given this, we observed that it is necessary to know the perception of professionals in the family health team in this matter, since they are fundamental agents for coping with violence against women, from the prevention and identification of cases to the proper orientation and management of this problem. In this sense, this research aimed to know the perception of health professionals about violence against women.

METHOD

This is a qualitative research with descriptive and exploratory approach, carried out in three family health units of the municipality of Guanambi, located in the southwest of the state

of Bahia, Brazil. The choice for these units was based on the fact that they constitute a training camp for Nursing undergraduate students and due to the possibility of providing feedback to the teams and community.

Twelve health professionals participated in the study. The following inclusion criteria were used: professionals over 18 years of age, of both genders, who worked for more than six months in the family health units. Those who did not complete the interview were excluded. The delimitation of the number of participants obeyed the criterion of data saturation, defined as the point we observe repetition and redundancy of the data, which justifies suspending the inclusion of new members in the study⁽¹¹⁾.

Data production occurred in February and March 2014 through the semi-structured interview technique. We proceeded with the interviews after verbal and formal approval of the participants regarding the use of the tape recorder, and after reading and signing the Consent Term (TCLE).

To preserve privacy of the participants, we marked the excerpts from the interviews transcribed for exemplification with the letter "E" followed by numbering and professional category.

We performed systematization of the data through the content analysis method, which is the "set of communication analysis techniques that uses systematic procedures and goals to describe the contents of messages"^(12:34). The content of the interviews was transcribed, organized and later discussed in categories based on theoretical reference on the subject.

We respected all ethical precepts in all phases of the research, according to Resolution 466/2012, and study was approved by the Research Ethics Committee of the State University of Bahia under CAAE: 22942113.4.0000.0057 and Opinion no. 478.947.

RESULTS

Sociodemographic data

Twelve professionals participated in the study, as follows: 02 nurses, 02 dentists, 03 nursing technicians and 05 community health agents (ACS). Five claimed to have completed higher education, six had finished high school and one said to have ongoing higher education studies. These professionals claimed to have between 02 and 19 years of experience after graduation - those with technical degree education level had between 03 and 19 years and those with higher education between 02 and 05 years.

There were eleven women and one man. Mean age was 40 years; three were between 50 and 52 years of age, five were between 40 and 46 years of age and four between 25 and 29 years. Regarding ethnicity, seven of the participants described themselves as brown, four as white and one as yellow. As for religion, seven declared to be Catholics, three claimed to be protestants, one a spiritist and one a Jehovah's Witness. Regarding marital status, we registered five as married, six as singles and one as divorced.

Thematic Categories

From the content of the interviews, three categories emerged, as follows: Conceptualizing violence against women; (Lack of) knowledge about notification and reporting; (Lack of) knowledge about the law that punishes those who commit violence against women.

Category 1: Conceptualizing violence against women

Participants reported verbal, physical, moral, sexual, psychological and domestic violence, as well as deprivation of women's rights, disres-

pect, the condition of being considered a fragile sex, and lack of dialogue as conditions/facts linked the concept of violence against women. In addition to physical violence, they mentioned several expressions of violence against women:

Violence against women is not only physical, it is any kind of violence that deprives women of their rights (E3 - COMMUNITY HEALTH AGENT).

Violence is not only physical, but also moral and verbal (E10 - COMMUNITY HEALTH AGENT).

Violence against women is not only hitting, but [...] there is also sexual violence (E12 - NURSING TECHNICIAN).

Many sons treat their mothers roughly, this is also violence (E3 - COMMUNITY HEALTH AGENT).

They also mentioned that violence against women happens at home, caused by partners, husbands, boyfriends and is motivated by alcohol, drug use and excessive jealousy, as evidenced by the following:

Violence against women can be both physical and psychological and is usually caused by partners, husbands, boyfriends, some cases caused by drinking, drug use and excessive jealousy (E11 - DENTIST).

Category 2: (Lack of) knowledge about notification and reporting

Respondents stated that they could distinguish reporting and notification, however, when

they exposed their ideas, they presented lack of knowledge, misunderstandings or superficial knowledge about the terms.

When we arrive and are notified by the local community agent, the ACS does the notification. They bring it to the unit to pick up this notification later and send it to the board, and it is the board that will run it. The reporting is when the council will guide that patient to make the denunciation according to the protocol (E1- NURSE).

We observed, by this speech, that the nurse associates the function of notification to the community agent and the reporting to the "council". The nurse does not know what kind of "council" is this and shows no knowledge about notification and reporting. Only one professional reported that notification is carried out in epidemiological surveillance, as follows:

In relation to the notification, we fill out a form and proceed to the surveillance while for the reporting someone has to go to the police station to register the complaint (E9 - COMMUNITY HEALTH AGENT).

Regarding the reporting, some participants stated that it should be done at the police station, or to the council, or by calling the police (180), as indicated below:

Reporting is when the patients go to the police station and register a formal complaint, in the case, against their companions. Here in Guanambi there is no police station specialized for women, but I know there are some in Salvador. We should have police

stations here to advise women on how to solve these cases. It seems that this is not a priority here. Notification I do not know (E11 - DENTIST).

[...] Reporting is to go to the police station and report what happened (E4- NURSING TECHNICIAN).

Reporting is when you call 180 (E12 - NURSING TECHNICIAN).

The reporting is when the council guides that patient to register the complaint according to the protocol (E1- NURSE).

The reporting is when you look for a responsible agency, you already understand that it happened [...] (E3- COMMUNITY HEALTH AGENT).

Category 3: (Lack of) knowledge about the law that punishes those who commit violence against women

Most of the professionals, when asked if they knew about the existence of any Law that states the punishment for those who commit violence against women, quoted the Maria da Penha Law. However, when asked about the content of this Law, they showed superficial knowledge, as follows:

The Maria da Penha Law, which I really do not know if it is followed to the letter, because we know that the Law in our country is not for everyone [...] I know that there is the Maria da Penha Law, which was originally the case of Mrs. Maria da Penha who suffered

aggression by her husband and became paralyzed. So, what we want is that it is really valid for all, no matter if the victim is rich, poor, white or black (E11- DENTIST).

Among the participants who reported knowledge of the Maria da Penha Law, one who acts as a community agent stated that she had suffered domestic violence committed by her ex-husband and that the Law was not fulfilled correctly:

I know the Maria da Penha Law, now, if it is being fulfilled, like, correctly, I do not know. I myself suffered violence in my marriage, I broke up because of it. He attacked me, he was arrested for six days, then he got loose and left, so the Law was not fulfilled correctly. They ordered him to stay at least 100m away from me at all times, but after I've been separated for six years I have him as a friend, he does not enter my house, but he already comes to my door and takes my boys to spend the weekend with them. The Law is not followed strictly, often the court just orders the convict to pay market baskets to the victim. How many women have been killed [...]? some can be separated for many years and then are found dead. (E10- COMMUNITY HEALTH AGENT).

DISCUSSION

The professionals interviewed acknowledge the different expressions of violence against women, which corroborates with the results of other investigations on the subject, such as

a study carried out with professionals of the family health strategy team of a peripheral district of Campina Grande-PB⁽¹³⁾, and a research with nurses from Basic Health Units of Ribeirão Preto-SP⁽¹⁴⁾.

A study with victims of intrafamily violence in the city of Pelotas-RS⁽¹⁵⁾ and a research with women from a neighborhood of Salvador-Bahia⁽¹⁶⁾ with history of marital violence, showed abuse of alcohol and/or other drugs as a factor which often leads to violence against women. Other factors that increase violence in the perception of professionals are poor access to education and unemployment⁽¹⁰⁾.

However, although the professionals did present knowledge about the definition of the concept of violence, which is essential for the recognition / identification of the problem and coping with this type of violence, they presented difficulties in understanding fundamental concepts such as reporting and notification. This finding indicates the need for critical reflection on health education and performance, which coincides with the non-valorization of violence as a legitimate health problem that requires effective combat. Assistance to women experiencing violence may be undermined, as many participants did not know what to do or where to refer victims.

Specifically, the lack of knowledge among health professionals about notification contributes to the underreporting of violence against women, which is worrying, since health information serves as a basis for formulating public policies to combat violence.

Law No. 10,778 of 2003 establishes as compulsory the notification of cases of violence against women, which is included in the list of diseases and conditions of compulsory notification by Administrative Rule GM/MS No. 104 of January 25th, 2011⁽¹⁷⁾.

Notification of this issue must be made by any health professional or worker, when-

ver they suspect or confirm they are treating one of these cases, in two ways: one copy of the notification form remains in the notifying health unit and the other must be referred to the Epidemiological and Noncommunicable Diseases Surveillance Department of the municipality⁽¹⁷⁾.

Although this notification law exists for more than 10 years, underreporting is still constant. However, instead of blaming the professionals, it is necessary to understand the reality in which they are inserted, to establish strategies to modify such context and to sensitize them to their role as agents of transformation of that process. It is also important to empower women so that they feel capable of reporting the aggressions suffered⁽¹⁸⁾.

In order to achieve this goal, we need to provide spaces for open dialogues with discussions on the theme; to encourage and facilitate the establishment of links and the qualified listening to women; to know the services that comprise the network of attention to women in situations of violence and what referrals should be made; and to establish partnerships with higher education institutions⁽¹⁹⁾.

Regarding the reporting and the Maria da Penha Law, the lack or superficial knowledge directly affects the practice of professionals, who may inappropriately lead the orientation and referral processes, since they do not fully understand the rights of victims of violence.

It should be emphasized that the reporting of violence against women can be done in any common police station, in a DEAM or, even, by a free telephone call, at national level, through the Women's Assistance Center (call 180) that works 24hs, seven days per week⁽¹⁷⁾.

In order to combat and adequately treat violence against women, it is necessary for health professionals to participate in actions of permanent health education, to be sensitive

to this problem and take part on this service, strengthening the relationship with women, bringing them to the spaces of discussion. This will favor joint reflections about violence, to contextualize it and to problematize it in order to generate changes in practices, and better care and coping practices⁽²⁰⁾.

CONCLUSION

This study demonstrated that although the professionals present knowledge about the definition of the concept of violence, which is essential for the recognition/identification and coping with this problem, they present difficulties in understanding fundamental concepts such as reporting and notification, and superficial knowledge about the Maria da Penha Law.

Aiming to contribute to the fight against violence against women, we point out the need for permanent education involving this theme, in order to provide resources so that health professionals can be committed to the recognition and management of cases from an interdisciplinary and intersectorial perspective.

Gender differences, the main motivators of violence against women, are still little discussed in health curricula. The understanding of violence as a problem that generates health needs and demands is fundamental for the adoption of professional conduct in the perspective of its confrontation.

Thus, as a public health problem, violence against women requires effective measures to reduce morbidity and mortality rates. It is basic that the multidisciplinary teams carry out the reporting and the notification of the cases and make the appropriate referrals in the process. In addition, it is essential that the team is sensitive, motivated and engaged with the women's pro-

tection network. A restructuring of the service network is also required so the proposed actions are effectively articulated.

This way, the results of this study provide support to increase the knowledge about the perceptions of health professionals about violence against women and reveal challenges for effective professional action in coping with this problem.

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All authors participated in the phases of this publication in one or more of the following steps, in according to the recommendations of the International Committee of Medical Journal Editors (ICMJE, 2013): (a) substantial involvement in the planning or preparation of the manuscript or in the collection, analysis or interpretation of data; (b) preparation of the manuscript or conducting critical revision of intellectual content; (c) approval of the version submitted of this manuscript. All authors declare for the appropriate purposes that the responsibilities related to all aspects of the manuscript submitted to OBJN are yours. They ensure that issues related to the accuracy or integrity of any part of the article were properly investigated and resolved. Therefore, they exempt the OBJN of any participation whatsoever in any imbroglios concerning the content under consideration. All authors declare that they have no conflict of interest of financial or personal nature concerning this manuscript which may influence the writing and/or interpretation of the findings. This statement has been digitally signed by all authors as recommended by the ICMJE, whose model is available in http://www.objnursing.uff.br/normas/DUDE_eng_13-06-2013.pdf

Received: 07/07/2016
Revised: 05/12/2017
Approved: 06/01/2017