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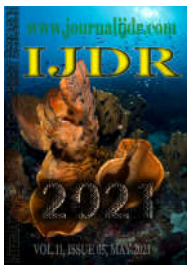

RESEARCH ARTICLE OPEN ACCESS

VIOLENCE AGAINST WOMEN: A PUBLIC HEALTH PROBLEM

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ABSTRACT

Objective: To evaluate the flow of attendance, identify the care provided to victims of violence and if there is the filling compulsory notification form in a hospital in the city of Ponta Grossa, Paraná. **Method:** Qualitative research, where applied to the participants a questionnaire composed of fourteen questions about the theme "violence against women". Twenty-two health professionals who provide care for women victims of violence, with at least one year in the service and who signed the consent form, participated in the study. **Results:** The professionals reported that the flow is unstructured, as for the assistance provided, the care focused on physical and biological complaints only were highlighted and the majority reported compulsory notification of cases. **Conclusion:** The reception was universal, that is, all women who enter the health service are attended. However, there is no established flow in the network for the integrality of the care to the victims.

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INTRODUCTION

The violence against women is considered a historical phenomenon of humanity, however, the term was formally defined in Brazil for the first time in 1994, in the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women, better known as the Belém do Pará Convention, being characterized as "any action or behavior-based in gender, which causes death, damage or physical, sexual or psychological suffering to women"[1]. This is a raising reality with every year in Brazil and all over the world, having no age, education, social class, or ethnicity restrictions. According to the Organization of American States (OAS), violence against women may comprehend diverse situations for instance physical violence, sexual violence, psychological violence, violence by an intimate partner; rape; sexual abuse; sexual harassment in the workplace; torture, women trafficking, forced prostitution, along with others[1], bringing damage toward the victim's health physically, psychically as well as the risk of death. Statistics show that in 2015, Brazil presented a rate of 4,8 homicides of 100,000 women, occupying the 5th position of a country with the largest female murder rate, among the 80 studied countries by a statistics system of the World Health Organization (WHO), only behind of El Salvador, Colombia, Guatemala e Russia[2]. Furthermore, millions of women are non-fatal violence victims daily. By 2017, the Women's Call Center (180) received more than 156 thousand reports, 75,139 of physical violence, 52,195 of psychological violence, and 10,225 of sexual violence[3]. Besides the reported cases, it is estimated that every 2 seconds one woman is a victim of physical or oral violence in Brazil[4]. Ahead of the actual scenery, in the last years had a social mobilization regarding the subject, giving place to discussions and movements concerning the guarantee of women´s rights, ensuring legal frameworks to prevention, intervention, and punishment to the violence cases[5]. As model law nº 11.340/2006, denominated as Maria da Penha Law, creates mechanisms to hinder and to prevent the domestic and familiar abuse against women and establish assistance and protection measures to women in a domestic and familial violence scenario[6]. And law nº 13.104/2015, which determined feminicide as a circumstance of homicide against women for reasons of female sex condition, including the feminicide in the category of heinous crimes[7]. The phenomenon of violence against women is considered by WHO as a public health problem with epidemics proportions[8], although its magnitude is mostly invisible and to decrease this invisibility, the health services have an essential role because it is the victim's first place to choose to seek attendance[9].

In this perspective, nursing, as an integrant part of the health team, has the role of identifying the violence signals, usually subjective and camouflaged[10,11]. The professional needs to welcome, listen, advise, somehow she feels comfortable to share her doubts, fears, and yearnings and pursue alternatives for the problem`s solution, always respecting the woman`s opinion[12]. Another responsibility of the health crew is the compulsory notification, overall the national territory, of a suspect or confirmed cases of violence against women attended in public or private health services[13], boosting the Notifiable Diseases Information System (SINAN). In 2006 was implemented the interpersonal and auto provoked violence notification and in 2011 become compulsory. Since then, the total number of annual notifications has been increasing, exceeding 107,464 notified cases in 2011 to 243,259 in 2016. And the proportion of violence notification is higher with female sex, being 72,3% in 2016[14]. However, even with the occurrences' magnitude, there is sub notification of the cases, attributable to their characteristics[15]. In this manner, professionals who experience this reality need to be properly trained to do the register, which one it is suggested to not happen due to unpreparedness, disqualification, and out of capacity to deal with victims of violence[10,16]. The violence notification is important to support the planning and the execution of integrated and intersectoral public politics, aiming the promotion of articulated actions amongst the locations that attend these women, contributing with reduction of morbimortality due to violence, promoting health, peace, equity, and life quality[17,18]. Thus, this study had for intention evaluate the flow of attendance to women victims of violence, identify the care provided to victims, and if there is an effective filling of the compulsory notification formby health professionals in a hospital of Ponta Grossa, Paraná.

METHODOLOGY

It is qualitative research to assess and describe the attendance flow of women victims of violence in Ponta Grossa, Paraná. After the previous scheduling with the sector responsible to do the research was applied a questionnaire to health professionals of the hospital benchmark of the municipality (Attachment A) by the participant researcher and had a duration of 15 minutes, over January and February of 2019. It was used Theories of the social representation of Serge Moscovici, with a theoretical subsidy of Jodelet and Abric about the concepts and methodological perspective at the construction of social representations of the research´s subjects (Moscovici, 1978; Jodelet, 1986; Abric, 1994). Criteria of inclusion: health professionals who do attendance to women victims of violence, with at least one year at service, and agreed to participate in the research. Criteria of exclusion: professionals that refused to participate in any stage of the research. The research tool involved questions related to the social representation of the subject and objective and discursive questions related to the theme of Violence against women. The data was carefully read and registered by Microsoft Office Word and Microsoft Office Excel programs. The data was submitted to Bardin´s thematical Content Analyses, which is organized in three stages: pre-analyses, material exploration and result treatment, inference, and interpretation 22. To present the social representation of the participants of the research was used the cloud of words tool offered by the free site Wordclouds. The research accomplishment obeyed to precepts of Resolution 466/12 of the Health National Council. Before the interview´s accomplishment was presented, for each of the participants, the goals, methodology, risks, and benefits of the study, as well as the Term of Free and Clarified Consent and requested to sign. Respecting the commitment assumed of keeping the subjects anonymous. The research was approved by the Research Ethics Committee (REC) of the Biological Sciences and Health industry of Ponta Grossa State University (PGSU), REC opinion 3.056.870.

RESULTS AND DISCUSSIONS

Participated in 22 professionals who assisted women victims of violence. Being 5 nurses, 11 nursing technicians, 1 social assistant, and 5 doctors. Of those, 77% (n=17) were female sex and 23% (n=7), male sex. About the schooling, 36% (n=8) were high school graduate, 32% (n=7) bachelor´s degree and 32% (n=7) master´s degree completion. The majority had between 6 and 10 years of service. It was excluded 1 professional to not fit in the criteria. The social representation of "Violence Against Women" to the professionals who do attendance at this benchmarking service involve terms as cowardness, disrespect, machismo, abuse, aggression, among others, according to presented in the "cloud of words", Figure 1.

Figure 1. Definition of violence Against women by health professionals. Source: Drawn up by the authors (2021)

Considering the health professionals provide direct assistance to a large part of women victims of any type of violence, it is ideal that those, know the theme to make the correct identification of signs and symptoms, most of the times masked, support and care supply and correct management of the situation, avoiding bigger embarrassment to the victim. At this perspective, the participants were questioned if during their formation was discussed the theme "Violence Against Women", 68% (n=15) of the professionals confirmed and 32% (n=7) denied. The lack of this initial contact plus the disqualification of professionals relating the theme point inability to interfere in questions about violence[23]. Regarding the compulsory notification form filling, 73% (n=16) of the interviewed answered there is a compulsory notification, 9% (n=2) said that there is no notification filling and 16% (n=4) did not know how to respond. This form must be done at all suspect and confirmed cases of violence against women – physical, sexual, and psychological[13]. The health professionals must notify the cases of violence, looking after the victim´s health and dignity, able to respond by omission in case it is not done. The most referred professionals as the ones who did the notification of violence cases were Nurses (61%), followed by Nursing Technicians (17%), Doctors (17%), and Social Assistants (5%). A similar result can be observed in another study, in which nurses show up as professionals who fill the form with bigger frequency (Sousa, 2015). The notified cases have big matter in front of public health because it is through the notifications the violence receive visibility, getting an epidemiological sizing of grievance, which allows the creation of public politics turned to its prevention, resulting in the decrease of morbimortality due to violence cases[25]. Stem from the content analyses obtained from interviews emerged two categories: 1- Attendance flow to women victims of violence. 2- Approach and care provided by professionals to victims.

Category 1 – Attendance flow to women victims of violence

The establishment of an attendance flow structured in a referred health service to cases of violence is essential to have easy access to open door to victims, in which the attendance be quick, welcoming, at a good environment and be sent to a specific local where gives the necessary support. The professionals reported there is a weakness in this flow, showing it is unstructured.

There is no flow to physical violence, only for sexual violence. There are some gaps because the town does not dispose of a

correct local (permanent) to send the victim […] The flow should be done in partnership with all authorities.
(P1 – Nurse)

No, because it would be structured to have a psychological and physical support team. And speaking of medical center there is no way to accompany.
(P9 – Nursing technician)

The entry of these women into the health service occurs in different ways, willing or not, and being an "open door" public hospital for any and every type of violence, the victim doesn't need a referral to receive attendance. Some of those ways of access were reported by interviewed professionals:

By direct search.
(P1 – Nurse)
Via Emergency Trauma Care Integrated Service (SIATE) and Mobile Emergency Care Service (SAMU).
(P19 – Doctor)
Brang by relatives […]
(P11 – Nursing technician)
Usually comes after needing help. E.g.: Mobile Emergency Care Service(SAMU), neighbors. Never willingly.
(P9 — Nursing technician)

After rendered attendance, the last step of care is the following of the cases at the system, which consists of keeping the flow involving the services of specialized attention for the patient and family monitoring until their recovery[26]. The interviewed referred to some of those services in which the woman can be submitted, but in their speech show there is nothing formally established.

It depends on the patient´s situation, but always at women´s police stations.
(P17 – Social assistant)
Victims of sexual violence, Specialized Attention Service/Counselling and Testing Centers.
(P12 – Nursing technician)
Police and expert medical exam.
(P19 – Doctor)
Depends on the severity.
(P3 – Nurse)

The victims of violence attendance mustn't be limited to just one health service. The interconnections between different services which set the system of women in violent situations attendance are extremally important to establish a submissions flow, promoting, indeed, care to the woman[27]. The attention system to these women need to be formed, dimensioned, and articulated from local reality, starting the attendance at a health institution, but being articulated with other services and institutions (Specialized Police Station for Women, National Council of Women´s Rights, Family Health Support Centers – NASF, Center for Social Assistance Specialized Reference - CREAS, support services, among existent others) with the possibility of attendance 24/7[28].

Category 2 - Approach and care provided by professionals to victims

Concerning approach and care to those women, who, in most cases, fragilized, should be the most welcoming and emphatic possible, focusing not only on physical injuries but on psychological impact to the victim, triggered by this trauma. The interdisciplinary team inclusion in attendance services provides identification of grievances and other health problems, which demand a different attendance through transdisciplinary orientation and intervention[29]. A study described that welcoming brings bonds establishment and people centrality (not at procedures), considering the victims social complexity[30]. The interviews showed there is a welcoming of professionals with the victims at the moment of attendance.

Depends on each situation. But always the best supporting as possible.
(P2 - Nurse)
Talk and listen, a stimulus to pursue legal ways to report.
(P1 – Nurse)
Support and talk about what happened and orientations to necessary questions.
(P17 – Social Assistant)

About the given assistance, were highlighted care of physical-biological reports. Even though mentioned psychological attendance, was referred that the hospital does not have this professional to support the victim.

Clinical and assistance care. At the moment, does not have psychological support.
(P2 – Nurse)
Triage, medication, and further social service evaluation.
(P13– Nursing technician).
Medication, suture, exams, notification.
(P14 – Nursing technician)
In my case, as a surgeon, priority to treat physical injuries. The psychological orientations I leave to the social assistant.
(P19 – Doctor)

Women bring violence marks by physical force, most of the time with bruises and, other times, invisible to the naked eye, going unrecognized by the team[29]. In fact, by leaving marks on the body, physical aggression is more recognized in the field of health, in this context, professionals don't be aware of the different settings that violence can assume, which isn't necessary physically[31]. The welcoming of women victims of violence is different from a traditional triage, it must give a sensitive listening, showing worry and responsibility allowing the creation of bonds, being done by any health service worker, independent of their function[26], taking down the idea only psychologists or social assistants can do this role. In this way, all the care process with women who suffer violence is complex and depends on a prepare and knowledge about the theme. It is therefore up to the professionals and health managers always be reviewing their roles before prevention and treatment of violence cases, aiming assistance improvement and give an integral and with quality attendance to the victims[32].

CONCLUSION

Violence against women pictures the historical genre inequality in this world, the social representation of the theme pictures that it is a social fact, in machismo, cowardness, and disrespect. The health attention system is directly involved with the confrontation of this experience, the presented study pictures the victims' attendance in a referral hospital of the city. The welcoming in this health service showed universality, in other words, all women who use the service are attended. However, the professionals signaling there is no established flow in the system for the integrality of victims´ attendance. The health professionals, even though know the theme, obtained in their graduation, strengthen the focused care idea only in physical reports, setting aside, most of the time, aspects psychosocial of the human being. Highlighting the difficulty in recognizing cases and comprehending the need for compulsory notification of this grievance. In this way, trying to make this moment the less traumatic possible to the victim, it is necessary subsidies to the professionals to provide the best attendance to women victim of violence with the welcoming, attendance, notification, and prevention, through permanent and continuous education and the establishment of a flow of attendance obtained by implementation of an institutional protocol. Enhance the matter of doing more research about the theme, allowing the health professionals a care construction aiming the real necessities of the victim, helping to empower these women confronting violence.

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