Attitudes and opinions of professionals involved in the care to women in violence situation in 10 Brazilian cities

Atitudes e opiniões de profissionais envolvidos na atenção à mulher em situação de violência em 10 municípios brasileiros

Elizangela Gonçalves de Souza[1], Ricardo Tavares[2], Julia Guimarães Lopes[3], Márcia Andréa Nogueira Magalhães[4], Elza Machado de Melo[5]

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[1] Universidade Federal de Minas Gerais (UFMG), Núcleo de Promoção de Saúde e Paz – Belo Horizonte (MG), Brasil. Orcid: https://orcid.org/0000-0001-8374-8927
elizsouzacb@gmail.com

[2] Universidade Federal de Ouro Preto (Ufop), Departamento de Estatística (DEEST) – Ouro Preto (MG), Brasil. Orcid: https://orcid.org/0000-0002-9060-0477
tavares@ufop.edu.br

[3] Universidade Federal de Minas Gerais (UFMG), Núcleo de Promoção de Saúde e Paz – Belo Horizonte (MG), Brasil. Orcid: https://orcid.org/0000-0002-4473
juliaglopes@hotmail.com

[4] Universidade Federal de Minas Gerais (UFMG), Núcleo de Promoção de Saúde e Paz – Belo Horizonte (MG), Brasil. Orcid: https://orcid.org/0000-0002-2447-912X
marcia.andrea@pbh.gov.br

[5] Universidade Federal de Minas Gerais (UFMG), Programa de Mestrado Profissional em Promoção de Saúde e Prevenção da Violência – Belo Horizonte (MG), Brasil. Orcid: https://orcid.org/0000-0002-3577-0721
elzammelo@hotmail.com

ABSTRACT This research aimed to analyze opinions and attitudes of professionals of the network of care to women in violence situation in 10 Brazilian cities. It is a quantitative cross-sectional study, carried out through semi-structured interviews with the participants of the workshops in these cities, totaling 438 individuals. A descriptive analysis was performed with frequency distributions, bivariate analysis and correspondence analysis. The number of professionals working on the suspected cases is higher than the number of those working on the confirmed cases of violence against women. Less than half of the professionals who attended the suspected cases has taken action on the matter of the fact. The adoption of some attitudes by the professionals was more common – even also being less than half of the majority of actions – in the face of the confirmed cases. Underreporting occurs in suspected cases and confirmed cases. Most of the interviewed people consider to be responsibility of the public health sector to develop preventing actions toward violence against women, with a high rate of unanswered cases. It is concluded that there is a long way for care to women in violence situation to be properly offered; professionals routinely refer more than address the cases, they poorly report them, they do not feel qualified, and sometimes do not even see themselves as the responsible for this care.

KEYWORDS Violence against women. Health personal. Health personal attitude. Intersectoral action.

RESUMO *Esta pesquisa objetivou analisar opiniões e atitudes de profissionais da rede de atenção às mulheres em situação de violência em 10 municípios brasileiros. Estudo transversal quantitativo, realizado mediante entrevistas semiestruturadas com os participantes de oficinas realizadas nos municípios em estudo, totalizando 438 sujeitos. Realizou-se análise descritiva com distribuição de frequências, análise bivariada e análise de correspondência. O número de profissionais que atenderam casos suspeitos é maior do que o número dos que atenderam casos confirmados de violência contra a mulher. Menos da metade dos profissionais que atenderam casos suspeitos adotou alguma atitude frente a eles. A adoção de alguma atitude pelos profissionais foi mais comum – embora também abaixo da metade para a maioria das ações – diante dos casos confirmados. Subnotificação ocorre nos casos suspeitos e nos casos confirmados. A maioria dos entrevistados considera ser papel do setor saúde desenvolver ações de prevenção da violência contra a mulher, com elevada proporção*

de respostas deixadas em branco. Conclui-se que falta muito para que a atenção à mulher em situação de violência seja devidamente ofertada; os profissionais rotineiramente encaminham mais do que abordam os casos, notificam pouco, não se sentem capacitados e, às vezes, sequer se veem como responsáveis por essa atenção.

PALAVRAS-CHAVE *Violência contra a mulher. Pessoal de saúde. Atitude do pessoal de saúde. Ação intersetorial.*

Introduction

Violence is a problem that has always been present in the history of humankind, and is sustained by a social structure marked by inequalities and injustices, which are expressed in domestic relations, gender, class and within institutions[1].

With regard to violence against women, this is a global public health problem, which requires intersectoral articulations in the effort both to prevent the occurrence and to provide adequate services to the victims. The health sector has an important role to play in this scenario[2].

Because it is a historical, social and health phenomenon, of great magnitude, this appeal requires interventions directed at the equity of rights, protection and security of women who experience situations of violence. Therefore, the recommendations of the World Health Organization (WHO) are that the provision of health care occurs in several places/points of the care network and that professionals are prepared to respond with intersectoral responses[2,3].

In the health field, care practices are limited to dealing with the consequences of violence, especially physical and psychological damages, intensifying, thus, the idea that this would be the problem that should be dealt with by the sector. This perspective reinforces the biomedical tradition of recovery and prevention practices that constitute the traditional basis of professional activity in the sector, which hinders the development of social practice, which requires knowledge and technological skills that are not the domain of all professionals[4,5]. Added to this is the fact that violence against women is poorly identified in the health services, since many professionals do not associate it with the health problems presented by women[6,7]. In this regard, WHO emphasizes the urgent need to integrate issues related to violence into clinical training, pointing to the need for all health care providers to understand the relationship between exposure to violence and health problems of women, so that they are able to respond appropriately to the demands brought by this public[2]. The present study sought to analyze the opinions and attitudes of professionals involved in the care of women in situations of violence in 10 Brazilian municipalities.

Methods

A cross-sectional study, of a quantitative nature, carried out within the Project for Women – For Her, For Him, For Us, to approach women in situation of violence at the national level, carried out by the Health and Peace Promotion Center of the Department of Preventive and Social Medicine of the Faculty of Medicine/Federal University of Minas Gerais (UFMG), through the Postgraduate Program and Professional Master's Degree in Health Promotion and Violence Prevention, in partnership with the

Ministry of Health (MH). The project has as one of its goals the organization of networks of services and teams of care to women in situations of violence in 10 Brazilian municipalities, headquarters of Citizenship Territories, elected by the Permanent National Forum to Combat Violence against Women of the Field and Forest and the Secretariat for Policies for Women (SPM), in 2011, as priorities for the implementation of related public policies. They are: Igarapé-Miri (Pará); Cruzeiro do Sul (Acre); Algustinópolis (Tocantins); Irecê (Bahia); Quixadá (Ceará); Santana do Matos (Rio Grande do Norte); Posse (Goiás); Saint Matthew (Holy Spirit); Record (São Paulo); and São Lourenço do Sul (Rio Grande do Sul).

The universe of study was composed of professionals invited to participate in the Workshops promoted, in each municipality, by the Municipal Health Secretariats, the Ministry of Health and the 'For Women' project team, with which semi-structured interviews were conducted. It was attended by professionals from different sectors and levels of attention involved in the care of women in situations of violence in the 10 municipalities studied. Blank questionnaires or with a response rate of less than 70%, students not linked to the women's care network in situations of violence, questionnaires without identification and/or without an Informed Consent Form (ICF) and duplicate questionnaire were excluded from the research.

The data were collected during the workshops held in the 10 municipalities under study, using a semi-structured and self-administered questionnaire, containing demographic data (age; sex; city; marital status; color/race; level of education; academic background), occupational (institution; current function; time in function; weekly hours that work in the function; work link; additional links) and on the performance of professionals (attitudes towards suspected and/or confirmed cases of violence against women: approach, notification, discussion with the team, return; follow-up of the woman; follow-up of the family; referrals, others; opinion on the role of the health sector in the prevention of violence against women). All were used in the analysis performed.

The questionnaire was developed by the 'For Women' project team and evaluated by specialists (teachers of the professional master's degree) and professionals of the network of attention to women in situations of violence. A pilot study was conducted with masters of other research groups of the professional master's degree, which led to adjustments of the questionnaire. The data collection period was extended from 2013 to 2015.

The informations were stored in a database, using the Statistical Package for Social Sciences – SPSS software, version 17.0. The following were performed: a) descriptive analysis with frequency distribution; b) bivariate analysis; and c) multivariate analysis, specifically, the correspondence analysis.

The present study obeyed all the provisions contained in Resolution nº 196/96 of the National Health Council, on guidelines and norms of research involving human beings. The research was approved by the Research Ethics Committee of the Federal University of Minas Gerais, on June 5 of 2013, with the issuance of the opinion nº 14187513.0.0000.5149. Participants were informed about the objectives of the research, about the right to confidentiality and the voluntary nature of participation, and the ICF was signed.

Results

The demographic profile of the research participants can be observed in *table 1*, which shows, as well, the opinion of professionals on the role of the health sector in the prevention of violence against women. The study population consisted of 438 subjects. There was a majority of females (82.4%), with discrete predominance of married couples (54.1%). The most frequent age group (60.5%) was people between 20 and 40 years old, with a

greater participation of the race/brownish color (44.1%).

Information on work *(table 2)* shows that the majority of participants had some function related to higher level care (39%), had been in the job for more than 3 years (36.8%), worked from 31 to 40 hours per week (83.8%), belonged to the municipal sphere (84.2%), was tenured (42%), had no other work link (70.8%) and belonged to Primary Health Care (PHC) (35.6%) and to management (31.7%).

With respect to educational training, the vast majority (79.6%) have higher education and are mainly represented by Nurses (37.2%), followed by Social workers (9.4%), Psychologists and Doctors, who presented the same percentage of representation (3.9%), and graduates (3.7%).

The proportion of answers related to the opinions of the participants about the role of the health sector in the development of actions to prevent violence against women was 83.5%, where 332 (75.8%) answered 'yes', 4 (0.9%) answered 'no', 72 professionals (16.4%) left blank and 30 (6.8%) reported not having formed opinion, as observed in *tables 1* and *2*. In this sense, most interviewees responded positively, with small differences for the variables gender, marital status and hours worked per week, however, there were larger differences for the variables age, color/race, current function, time in function, work shift, administrative sphere, work link, having more than one link, level of education, academic background and level of attention.

Some of the aspects deserve to be highlighted: the high percentage of answers left blank or of those who said they did not have an opinion, a fact that gains importance when there are participants who work in management and technical reference, social workers and mid-level professionals, among them, the Community Health Workers (CHW), presenting this type of response. There was a decline in positive responses as a result of increasing age, given that, among participants over 61 years, only 62.5% answered 'yes'.

Table 1. Opinions of professionals on the role of the health sector in the prevention of violence against women, according to sociodemographic variables, in 10 Brazilian municipalities, 2016

Variables studied	Is it one of the health functions to develop actions to prevent violence against women?								Total	
	Yes		No		No opinion		Blank			
	N	%	N	%	N	%	N	%	N	%
Gender										
Male	52	73.2	1	1.4	7	9.9	11	15.5	71	16.2
Female	278	77.0	3	0.8	21	5.8	59	16.3	361	82.4
Blank	2	33.3	0	0.0	2	33.3	2	33.3	6	1.4
Marital status										
Married/stable union	181	76.4	2	0.8	17	7.2	37	15.6	237	54.1
Single, divorced/separated, widow	151	75.5	1	0.5	13	6.5	35	17.5	200	45.7
Did not inform	0	0.0	1	100.0	0	0.0	0	0.0	1	0.2
Age group										
Up to 20 years	1	33.3	0	0.0	0	0.0	2	66.7	3	0.7
21 to 30 years	110	82.7	0	0.0	6	4.5	17	12.8	133	30.4
31 to 40 years	103	78.0	4	3.0	10	7.6	15	11.4	132	30.1
41 to 50 years	49	70.0	0	0.0	7	10.0	14	20.0	70	16.0

Table 1. (cont.)

51 to 60 years	27	69.2	0	0.0	4	10.3	8	20.5	39	8.9
Above 61 years	5	62.5	0	0.0	1	12.5	2	25.0	8	1.8
Blank	37	69.8	0	0.0	2	3.8	14	26.4	53	12.1
Color/Race [IBGE]										
Black	21	72.4	1	3.4	2	6.9	5	17.2	29	6.6
White	132	81.5	0	0.0	7	4.3	23	14.2	162	37.0
Yellow	5	83.3	0	0.0	0	0.0	1	16.7	6	1.4
Brownish	135	69.9	3	1.6	18	9.3	37	19.2	193	44.1
Indigenous	1	100.0	0	0.0	0	0.0	0	0.0	1	0.2
Blank	38	80.9	0	0.0	3	6.4	6	12.8	47	10.7
Level of education										
Primary School	1	50.0	0	0.0	1	50.0	0	0.0	2	0.5
Secondary School	45	54.2	2	2.4	11	13.3	25	30.1	83	18.9
Undergraduate degree	125	76.2	0	0.0	13	7.9	26	15.9	164	37.4
Postgraduate degree	159	85.9	1	0.5	5	2.7	20	10.8	185	42.2
Did not inform	2	50.0	1	25.0	0	0.0	1	25.0	4	0.9
Academic Background										
Nurses	135	82.8	1	0.6	6	3.7	21	12.9	163	37.2
Social workers	32	78.0	0	0.0	2	4.9	7	17.1	41	9.4
Psychologists	16	94.1	0	0.0	0	0.0	1	5.9	17	3.9
Doctors	17	100.0	0	0.0	0	0.0	0	0.0	17	3.9
Graduate students	13	81.3	0	0.0	1	6.3	2	12.5	16	3.7
Other	72	75.0	0	0.0	8	8.3	16	16.7	96	21.9
Blank	47	55.3	3	3.5	12	14.1	23	27.1	85	19.4
NSA	0	0.0	0	0.0	1	33.3	2	66.7	3	0.7
Total	**332**	**75.8**	**4**	**0.9**	**30**	**6.8**	**72**	**16.4**	**438**	**100.0**

Table 2. Opinions of professionals on the role of the health sector in the prevention of violence against women, according to work characteristics in the health sector, in 10 Brazilian municipalities, 2016

Variables studied	**Is one of the functions of health the prevention of violence against women?**								**Total**	
	Yes		**No**		**No opinion**		**Blank**			
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Current position										
Middle level Assistance	59	59.0	3	3.0	17	17.0	21	21.0	100	22.8
Higher level Assistance	149	87.1	0	0.0	5	2.9	17	9.9	171	39.0
Technical reference/Coordination	71	76.3	0	0.0	4	4.3	18	19.4	93	21.2
Management/Administration/Direction	34	79.1	1	2.3	2	4.7	6	14.0	43	9.8
Administrative support	10	62.5	0	0.0	2	12.5	4	25.0	16	3.7
Not informed	9	60.0	0	0.0	0	0.0	6	40.0	15	3.4

Table 2. (cont.)

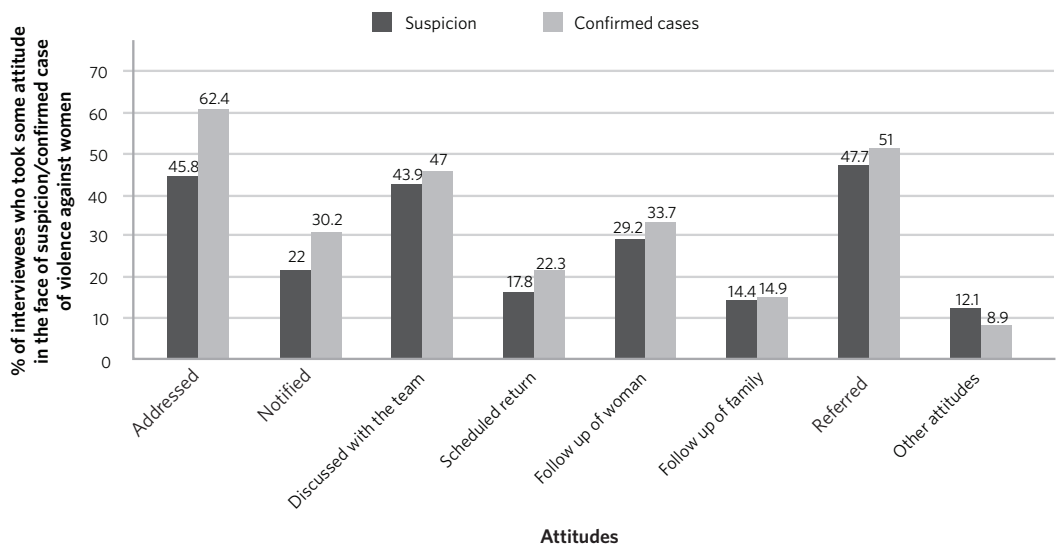
Time in the current position										
< one year	85	76.6	1	0.9	3	2.7	22	19.8	111	25.3
1 to 3 years	100	85.5	0	0.0	3	2.6	14	12.0	117	26.7
> 3 years	116	72.0	2	1.2	18	11.2	25	15.5	161	36.8
Blank	30	62.5	1	2.1	6	12.5	11	22.9	48	11.0
How many hours/week work in that position										
Up to 20 hours	15	71.4	0	0.0	0	0.0	6	28.6	21	4.8
From 21 to 30 hours	39	75.0	0	0.0	4	7.7	9	17.3	52	11.9
From 31 to 40 hours	232	79.2	3	1.0	19	6.5	39	13.3	293	66.9
> 40 hours	13	76.5	0	0.0	2	11.8	2	11.8	17	3.9
Blank	33	60.0	1	1.8	5	9.1	16	29.1	55	12.6
Work shift										
Morning	22	73.3	0	0.0	2	6.7	6	20.0	30	6.8
Afternoon	5	83.3	0	0.0	1	16.7	0	0.0	6	1.4
Night	2	40.0	0	0.0	1	20.0	2	40.0	5	1.1
Two shifts	242	75.9	4	1.3	24	7.5	49	15.4	319	72.8
Three shifts	32	88.9	0	0.0	1	2.8	3	8.3	36	8.2
Blank	29	69.0	0	0.0	1	2.4	12	28.6	42	9.6
Administrative sphere										
Federal	7	87.5	0	0.0	0	0.0	1	12.5	8	1.8
Estate	31	93.9	0	0.0	1	3.0	1	3.0	33	7.5
Municipal	272	73.7	4	1.1	28	7.6	65	17.6	369	84.2
Philanthropic	3	60.0	0	0.0	1	20.0	1	20.0	5	1.1
Private	3	100.0	0	0.0	0	0.0	0	0.0	3	0.7
Other	4	66.7	0	0.0	0	0.0	2	33.3	6	1.4
More than one sphere	7	100.0	0	0.0	0	0.0	0	0.0	7	1.6
Blank	5	71.4	0	0.0	0	0.0	2	28.6	7	1.6
Work link										
Tenured	137	74.5	3	1.6	13	7.1	31	16.8	184	42.0
Freelancer (RPA)	5	100.0	0	0.0	0	0.0	0	0.0	5	1.1
Outsourced	6	85.7	0	0.0	0	0.0	1	14.3	7	1.6
CLT employee	24	72.7	0	0.0	1	3.0	8	24.2	33	7.5
Temporary Contract	93	83.8	0	0.0	5	4.5	13	11.7	111	25.3
Other	31	72.1	1	2.3	3	7.0	8	18.6	43	9.8
Not informed	36	65.5	0	0.0	8	14.5	11	20.0	55	12.6
Have another work link										
Yes	97	88.2	1	0.9	2	1.8	10	9.1	110	25.1
No	223	71.9	3	1.0	27	8.7	57	18.4	310	70.8
Not informed	12	66.7	0	0.0	1	5.6	5	27.8	18	4.1

Table 2. (cont.)

Level of Attention										
Primary Care – PHC	116	74.4	3	1.9	15	9.6	22	14.1	156	35.6
Secondary Care	31	75.6	0	0.0	4	9.8	6	14.6	41	9.4
Tertiary Care	15	83.3	0	0.0	0	0.0	3	16.7	18	4.1
Management	109	78.4	1	0.7	5	3.6	24	17.3	139	31.7
Other	14	63.6	0	0.0	3	13.6	5	22.7	22	5.0
Not informed	47	75.8	0	0.0	3	4.8	12	19.4	62	14.2
Total	**332**	**75.8**	**4**	**0.9**	**30**	**6.8**	**72**	**16.4**	**438**	**100.0**

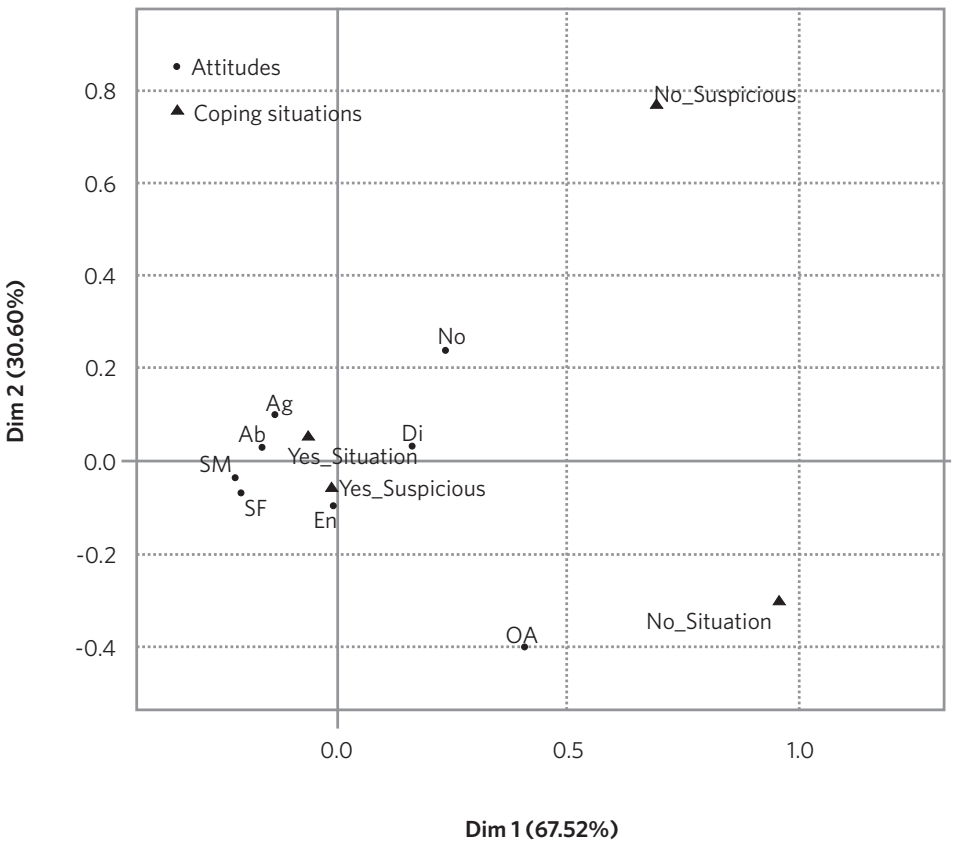
The number of interviewees who suspected violence against women in some care was 264 (60.2%). The number of professionals who reported having attended a woman in situations of violence was lower: 202 (46.1%). Although the largest proportion of professionals report having taken care of suspected cases, less than half of them have adopted some attitude towards these cases, both for the actions as a whole and for each one in particular. The adoption of some attitude on the part of the professionals was more common – although also below the half for the majority of the actions – in the face of the confirmed cases, in all categories analyzed, except for the category 'other attitudes', that appears discreetly higher in the suspected cases. Emphasis was placed on 'addressed' and 'notified' attitudes, which showed greater differences between the two types of suspected and confirmed cases *(figure 1)*.

Figure 1. Attitudes of professionals to suspected and confirmed cases of violence against women in 10 Brazilian municipalities



The map of correspondence between attitudes and confrontation situations *(figure 2)* shows the association between the attitudes of the professionals according to the cases, whether suspect or confirmed. For the interpretation of the association between the levels of the line profiles (attitudes) and the column profiles (confrontation), *table 3* should be analyzed. With regard to attitudes, a better representation of all levels in dimension 1 is shown. bold), except for 'referred', which must be interpreted in dimension 2 (in bold). With respect to confrontation situations, it is shown a better representation of the levels 'Yes_Suspect' and 'No_Suspect' the dimension 2 (in bold), while all other levels give a greater contribution if interpreted in dimension 1 (in bold).

Figure 2. Map of the correspondence between the attitudes adopted by professionals and the situations of coping with violence against women in 10 Brazilian municipalities, 2016



Source: Own elaboration.

Ab – Addressed; No - Notified; Di – Discussed the case with the team; Ag – Scheduled return; SM – Follow up of the woman; SF – Follow up of the family; OA – other attitudes; En – Referred.

Table 3. Relative contributions of dimensions 1 and 2 on line profiles (attitudes) and column profiles (coping).

Relative contributions of dimensions 1 and 2 on line profiles (Attitudes).		
Attitudes	**Dim1**	**Dim2**
Ab	0.896	0.021
No	0.502	0.498
Di	0.979	0.012
Ag	0.617	0.350
SM	0.952	0.041
SF	0.821	0.092
En	0.005	0.993
OA	0.504	0.493

Relative contributions of dimensions 1 and 2 on column profiles (Coping).		
Coping situations	**Dim1**	**Dim2**
Yes_Suspicious	0.016	0.806
No_Suspicious	0.445	0.550
Yes_Situation	0.615	0.295
No_Situation	0.901	0.095

Ab – Addressed; No - Notified; Di – Discussed the case with the team; Ag – Scheduled return; SM – Follow up of the woman; SF – Follow up of the family; OA – other attitudes; En – Referred.

Based on *figure 2* and taking into account the weight of the contributions of the two dimensions, as shown in *table 3*, it is verified a very strong association between interviewees who reported having attended a woman suspected of violence and those who said they had taken the attitude to refer, as well as those who discussed the case with the team. It was also observed a strong association between those interviewed who reported having attended cases of violence against women and those who followed the woman and family, as well as those who approached and those who scheduled return. A weak association was observed among respondents who attended cases of violence against women and those who reported.

Discussion

The existence of a greater number of professionals who dealt with suspect cases than the number of those who attended confirmed cases could be associated with the fact that professionals, routinely, adopt a posture of not seeking the identification of suspected cases, thus, leaving, the cases of violence installed in the invisibility, a fact corroborated in a study carried out with professionals of the Family Health Strategy in Santa Catarina/Brazil, where the participants have reported many times suspecting situations of violence, preferring, however, to keep quiet because they did not know how to follow up to care in case of confirmed violence[7]. On the other hand, the difficulty of detecting cases of violence is revealed by the low percentage of professionals who reported having attended to women in this situation – less than half for confirmed cases and, in a slightly higher proportion, but still insufficient, for suspected cases –, a fact corroborated by the literature, for example, in a study with professionals of a hospital in Barcelona/Spain. This report occurred with less than half of the interviewees[8]. Another study with health professionals in Murcia/Spain, revealed that only a quarter of the respondents reported having attended cases of violence against women in their professional practice[9]. The low case detection is also reported in a study with primary care professionals, in Madrid[10], and also by health professionals in Angola[11]. Ramsay et al.[12], when studying a cohort of doctors and nurses in the cities of London and Bristol/England, found that

more than half of the professionals did not ask women about abuse in their work routine, given that 40% of professionals never admitted – or only rarely – interrogate the woman about experiencing situations of violence, even in the presence of physical injuries. D'Oliveira et al.[13], in turn, affirm the importance of these findings, since they may imply, both for women and for professionals, the banalization of the occurrence, its disfigurement and its perception as a problem not inherent to the health sector.

The omission of professionals against violence is further enhanced by the high proportion of professionals who have not adopted any attitude towards the conduct of the cases, whether suspicious or confirmed (although a little lower for the latter). It is known that the search for the health service is often due to the physical injuries resulting from the violence, however, the attendance to these cases should not be restricted to the treatment of such injuries.

Although the percentage of professionals who deal with violence is far below what is desired, it is necessary to recognize that there is a better performance when it comes to a confirmed case, at least in quantitative terms, as shown by the association between confirmed cases and follow-up attitudes and scheduling of return of the woman, family follow-up and approach of the cases, in the analysis of correspondence. The explanation for such a finding would be the fact that in the clear evidence of an established violence, whether by the presence of injuries or by the own report of the woman, the professional feels obliged to adopt some attitude towards these cases, even if they are punctual attitudes, a situation that was explained by one of the participants of a survey conducted by Kind et al.[14]. If this is a positive finding, the situation, as a whole, is complex and worrying, for all that has been said before and also for the fact to be added, now, that one of the most frequently adopted attitudes is exactly the referral. As the problem is complex, it demands the involvement of several sectors and professionals, with a view to guaranteeing integral attention to these women. However, referral without a system of reference and counter-referral and without knowledge of well-defined flows and articulations does not guarantee continuity of care[11], instead, it would represent only a 'transfer' of responsibility to sectors and professionals that would be better prepared for this kind of assistance[15-17].

Another crucial problem concerns notifications. The results showed that the professionals report more confirmed cases than the suspects, and, still, the correspondence analysis showed a weak association between confirmed cases and an attitude of reporting, thus, revealing, underreporting in both suspect and confirmed cases of violence against women. This reality is identified, also, by other researchers[5,14,15,18].

It is known that the notification is an important device for the generation of epidemiological data that allow to reveal the magnitude of the violence against the woman and to subsidize the elaboration of public policies of confrontation with the problem. In Brazil, since 2003 the suspicion or confirmation of cases of violence against women is configured as an appeal of compulsory notification by public or private health services[19]. However, compulsoriness alone does not guarantee increased notifications[14], a fact that can be corroborated in the present study and by other authors who mention the precariousness of performing this act in their studies[5,20]. In a research carried out with health professionals in the city of Belo Horizonte, Minas Gerais/Brazil, Kind et al.[14] sought to identify the difficulties faced with reporting violence, and found that these professionals experienced many dilemmas and crossings in the face of violence against women. Fear of retaliation, difficulty or embarrassment to fill out the Form, overload in the daily life of the service and difficulty in dealing with the cases were justifications presented for not performing the notification. There were, also, aspects observed by the researchers that, according to them, make it difficult to

advance the discussions and actions related to the problem, such as the conception of notification and denunciation as synonyms.

Despite the insufficient performance of professionals, the predominance among them is the recognition of violence against women as an inherent problem in the health sector, which is also found in other studies on this subject[10-12,20,21]. The fact that this is a greater recognition among younger professionals is corroborated by Machado et al.[22], when studying the beliefs and attitudes of health professionals, security agents and teachers, in the face of conjugal violence. The authors analyze this finding as a result of the fact that younger professionals have grown up in a social context where there is an increasing awareness of human rights, the importance of equality in intimate relationships and the deleterious effects of violence on women's lives, in psychological, social and health aspects.

In spite of this knowledge, there are studies that reveal, as happened with a significant number of participants in our research, that many professionals do not recognize violence against women as an object of health work[4,8,15,16,23,24]. Thus, although our results are positive in identifying relatively low levels of non-recognition of the relationship inherent to violence and the health of women and, therefore of their confrontation by the health sector, the presence of negative or omission responses cannot be minimized when they involve a number of professionals who hold positions in management, technical reference/coordination of care for women in situations of violence and direct role in care, such as social workers and mid-level professionals, among them the CHW, because, acting in the network of attention to women in situations of violence in several sectors, these professionals are responsible for coping with the problem and for promoting comprehensive care for women experiencing such situations.

Managers play a key role in planning and implementing public policies and actions, as well as participating in the allocation of resources to instrumentalize the services and professionals that deal with the problem of violence against women in their daily work. The responsible for the health of women, as coordinators or of technical references, work in the training and capacity building of caregivers and also serve as articulators of the care network in order to provide an intersectoral response to the problem of violence against women. However, there seems to subsist a reluctance or hesitation on the part of these professionals responsible for women's health to intervene, and this position may be due to the lack of knowledge and recognition of violence as a problem to be faced by the health sector, according to a study that analyzed local public health agendas, aimed at coping with violence against rural women, from the perspective of the municipal managers of the Southern Half of Rio Grande do Sul[25]. The authors identified a trend of 'transfer of responsibility' from the health sector to the security sector, which, in their opinion, results in the exclusion of violence in health priorities, understanding that violence is the responsibility of another sphere.

It is not, however, only among managers and responsible for women's health care that this conception has been identified, although, as has already been said, violence against women is a complex problem that produces women's demands that go beyond the power of resolutivity of a single sector[15,26]. Social workers also showed a lack of recognition of the role of the health sector in addressing this problem, a fact which reveals the need to seek among these professionals a better understanding of the different dimensions of the existence of the suffering of women in situations of violence, among them, damages to health.

Reaffirming such need, Gomes et al.[27] report that the social worker has been gaining space in the health scenario, through the recognition of the potential this professional has to identify and intervene in social problems that interfere in the process of illness of women in situation of violence.

The need to increase the recognition of violence against women as an object of action in the health sector also extends to the portion of mid-level professionals, among them, the CHW, since such professionals, as some studies point out[28-30], are strategical actors in the care for women in situations of violence. A study that sought to understand the overview of the CHW on violence against women showed that the positions and conceptions of these professionals were mostly based on common sense and based on the ideology of male dominance in relation to gender violence[29], which emphasizes the lack of preparation of these professionals before violence against women. In this sense, the training of the CHW can be an important focus, since the recognition of these diseases requires a high degree of suspicion and sensitivity for its adequate detection, capable of denaturalizing situations, stimulating and providing subsidies to act[31]. Still in the same sense, Silva et al.[32] point out that the reflection and discussion of care practice, from a gender perspective, can subsidize professionals in the construction of behaviors and make them think of mechanisms that overcome the conjugal difficulties of women and men who live in situations of violence, generated by gender inequalities.

Regarding the reasons for the lack of recognition identified among the professionals participating in the research, of violence against women as a problem to be faced by the health sector, the current literature on the subject points to several factors that appear as explanatory hypotheses for this finding, all indicative of deficiencies in the process of training professionals to deal with complex issues such as violence against women[15,25,33,34].

In our view, the success in recognizing and coping with violence against women by professionals who attend them, whether in health services or in other points of the care network, focuses on how professionals approach this issue with the women assisted by them, in contradiction to the acknowledged difficulty of professionals, especially health professionals, in the conduct of this process, as shown by numerous studies on the subject[4,15,23,25,35,36].

An important aspect related to the recognition of this appeal by professionals dealing with women in situations of violence is related to the social construction of gender[21]. Many studies have revealed that professionals, especially health professionals, bring to the field of professional practice strong traces of the construction of gender identity[4,29,33,34,37], which reproduce the naturalization of female oppression in the context of health care[16], a fact that hinders the exercise of professional practice as an instrument for the social emancipation of women[29,33]. Thus, interventions aimed at women in situations of violence are guided by the understanding that professionals have on the phenomenon and the needs presented by the people who experience it, requiring, thus, that these professionals have awareness and clarity of their own beliefs and conceptions, so that moral judgments do not interfere negatively in their actions[35].

One of the difficulties of the inclusion of violence in health agendas is associated with the 'invisibility' of the phenomenon by the managers and responsible for women's health in the municipalities studied, since, if the problem 'does not exist', it does not arise as a generating problem of health practices[25].

For many reasons, women who seek care in the health services present difficulties in reporting to the professionals the experience of violence, establishing, then, a kind of tacit agreement where 'women do not tell and professionals do not ask'[6]. This phenomenon, named as the 'invisibility' of violence in the health field[23,38,39], has been attributed by many authors, to a great extent, by health care practices reduced to biologicism and fragmented, hegemonic practices in health professions[4,24,34]. By reducing the problem to the biological scope, there is an appreciation of the physical complaint and the signal to recognize the pathology, to treat and care[32], a fact that leads the professionals to direct their eyes to the individualized body and separated

from their psychic existence, the specificities of their social insertion and the cultural meanings attributed to the experience of the individual in the world, as was well placed by Kiss and Schraiber[4].

Coupled with the factors already described above, the lack of professional training to deal with the issue has been widely disseminated in the current literature as a factor that makes it difficult to care for women in situations of violence, especially to the recognition of the appeal by professionals[2,3,15,18,25,26,40].

A study carried out in Rio Grande do Sul/Brazil, with the objective of analyzing the limitations of the care practice of professionals of family health teams to women in situations of violence, showed that the lack of preparation of professionals to deal with violence was pointed by them as one of the restrictive conditions to an efficient practice[3].

Also in the same sense, in a research with health macro-managers, nurses, doctors, psychologists and nursing technicians, in three national hospitals in Luanda/Angola, the view that the lack of professional qualification represents the greatest difficulty of acting in situations of violence was unanimous among the interviewees[11]. A reality that was presented, also, in another study carried out in London and Bristol/England, with doctors and nurses, which found that these professionals were not prepared to meet the needs of women in situations of violence[12].

This deficiency negatively affects, of course, the process of recognizing and approaching violence against women by caregivers and would speak in favor of the need for professional qualification identified, which, in this study, elucidates the low performance of professionals to deal with suspect cases and violence against women, as well as for actions aimed at this public in the routine of services. This finding also highlights the need to integrate issues related to violence against women in the undergraduate curricula of all care providers to women in situations of violence, as well as in-service training, as has been, also, pointed out by many studies[2,12,18,20,34].

Notwithstanding the demand for professional training and the reaffirmation, in the Brazilian literature, of the training of professionals as an effective strategy, it is intriguing to repair, as revealed in a systematic review that evaluated the effectiveness of interventions for the prevention of violence against women and girls, that the training of security and police personnel and the training of health professionals, in isolation, do not constitute an adequate path for investment of resources, since there is insufficient scientific evidence to recommend them. In contrast, the evidence indicates that multicomponent actions may be more effective than isolated action[41]. Corroborating this formulation, a study carried out in Germany on the experience of implementing a pilot project to improve the approach of doctors to women in situations of violence showed that the combination of the personal approach (sensitization) of these professionals, specific training and networking, produced improvements in addressing this problem[42].

Another important randomized controlled study, conducted in London and Bristol/England, which evaluated the training effectiveness associated with implementing a computerized program to support referrals done, with well-defined flows and combined with support for the professional and the women referred by them, has concluded by strong evidence that such intervention improves the response of clinicians to women experiencing domestic violence, as well as allowing access to defense, which, in this case, has the potential to reduce revictimization and improve quality of life and health results of these women[43].

Final considerations

Unveiling violence against women is a challenge that needs to be taken as a commitment by professionals working in the care network to women. Despite its high magnitude and

repercussions on women's lives, violence is a problem that remains hidden and sometimes ignored by professionals. The low performance in dealing with cases of violence against women, whether suspected or confirmed, identified in this study, invites us to reflect on the care that has been provided to women in situations of violence. The promotion of comprehensive attention to this public requires the recognition of the problem in all its complexity, calling upon professionals that attend it sensitivity to accept violence as a demand of women, as well as reorientation of professional practices in order to break with the traditional hegemonic model, fragmented and exclusively biological.

Although the notification of cases of violence is mandatory throughout the national territory, the predominance of underreporting points to the need to sensitize professionals about the importance of this action to raise awareness of the problem of violence and to subsidize policies to address it.

The study points, also, to the need to raise the recognition of violence against women as an inherent problem, not only, but also, to the health sector, and the lack of indicative recognition of deficiencies in the training of professionals to deal with complex issues such as the violence. Professional attitudes based on personal values and beliefs, fragmented care practices with a biological approach and the lack of professional qualification emerge as factors that make it difficult for professionals to recognize this grievance and constitute a great obstacle to an efficient action in the face of cases of violence against women.

The challenges are enourmous and, as a complex problem, they require, as well, complex solutions. The inclusion of issues related to violence against women in the undergraduate curricula of professionals and the professional training to attend cases are configured as very important strategies, however, they will only be effectively efficient if integrated with other components, such as, for example, the awareness of professionals to work with this problem and the capacity for networking and in an interdisciplinary way.

Collaborators

Melo EM contributed to the planning and design of the project; analysis; writing of part of the text, critical review and final approval of the article. Magalhães MAN contributed to the design, execution of the research and revision of the text. Tavares R contributed to the statistical analysis and revision of the manuscript. Lopes JG contributed to the field execution, data processing and writing of part of the text. Souza EG contributed to the conception and planning, analysis and interpretation of the data, elaboration of the draft and critical revision of the content. ■

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