Violence against women: The unique health system and medical conduct

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Abstract

Violence against women is any form of discrimination, aggression or coercion, caused by the simple fact that the victim is a woman and causes physical, psychological, sexual, or moral damage, whether in the public or private sphere. It is a manifestation of historically unequal power relations between genders, which were gradually built and which continue today, showing the importance of knowledge of the actions of the Unified Health System (SUS) that coordinate and guide the conduct of health professionals, especially from the doctor. The present study aims to investigate medical conduct in the care of women victims of violence, SUS actions, and programs, specifically carried out at the Santa Casa de Misericórdia do Pará Foundation. This is a quantitative study and the instrument used was a questionnaire, prepared bythe authors. Thirty-three physicians answered the questionnaire, where 97% have already assisted womenin situations of violence, 97% know the protocols for the care of women victims of violence, and 67% judge public health actions to support these victims as ineffective. The data allow us to conclude that SUSactions have the potential to have a direct impact in the context of violence against women, if the necessary support is provided to make complaints, in addition to long-term protection and prevention protocols.

Keywords: Violence Against Women; Unified Health System; Ethics Medical;

1. Introduction

According to the National Council of Justice (CNJ) (Brazil, 2018), violence against women is any conduct (action or omission) of discrimination, aggression, or coercion, caused by the simple fact that thevictim is a woman. It causes damage to physical, psychological, sexual, or moral nature, whether in the public or private sphere. This concept is in line with the definition established by the Inter-American Convention to Prevent, Punish and Eradicate Violence Against Women, adopted by the Organization of American States, known as the Convention of Belém do Pará (Brazil, 1996).

Violence against women is a manifestation of historically unequal power relations between genders, which were gradually built. In this regard, there is a predominance of the patriarchal and misogynistic ideal in institutional macrostructures, which is responsible for marginalizing and embarrassing the victim (Trentin, et al., 2018; Souza & Cintra, 2018).

According to the United Nations, seven out of ten women in the world have been or will be raped at some point in their lives. In Brazil, of the total number of assistance provided by 180 (the Women's Call Center) in the 1st half of 2016, 12.23% (total of 67,962) corresponded to reports of violence. In the State of Pará, more than eight thousand cases of violence against women were registered from January to May 2018, a fact that confirms the seriousness of the matter under analysis (Souza & Cintra, 2018).

In this context, it is worth emphasizing the actions and policies of the Unified Health System (SUS), as well as highlighting the role of the physician as a professional who is part of it with regard to the mishap of the violence under analysis. It is essential to state that the SUS is an equal and universal service structure, which opposes any form of violation of human life and dignity through its principles and guidelines (Villa, et al., 2018). Thus, it is essential to know the existing public health policies that aim to prevent and eradicate aggression against the female gender, in addition to generating social changes (Delziovo, et al., 2018).

Furthermore, the physician is undoubtedly one of the main health professionals, with the duty to notify cases of violence against women and the responsibility to act ethically in the treatment of the victim, in addition to having the acumen to identify cases of aggression to the discussed gender (Moreira, et al., 2018). However, the fragility of uniform knowledge about the procedures to be followed by the medical category in relation to the referral of the victim to health agencies and other institutions is notorious (Delziovo, et al., 2018). Furthermore, there is an urgent need for specific programs to guarantee the protection of women victims of violence and the reversal of the pathological damage generated by them, similar to the actions of the Women's Program: Living Without Violence, of the Ministry of Human Rights (Garbin, Dias, Rovita & Garbin, 2015).

It is clear that even with the implementation of Law No. 10778/2003, which creates mandatory notification of cases of violence against women, and with the existence of Law No. 12845/2013, which provides for the mandatory and comprehensive care of people in situations of sexual violence, there isstill difficulty in the perception of the type of violence suffered by women, whether moral, patrimonial or psychological, by other health professionals. (Garbin, Dias, Rovita & Garbin, 2015)

Therefore, it is essential to highlight violence against women as a social and public phenomenon, built over the years. The maintenance of this cultural type happens, mostly, due to discriminatory and prejudiced ideologies, and it should be suppressed and never accepted because it relativizes the role of women and makes them inferior (Hasse & Vieira, 2014).

The suppression of violence against the female gender faces strong obstacles, especially emotional and financial dependence on the spouse. Thus, many women even denounce their husbands, but they do not manage to separate from them. In addition, there is still the social stigma on the wife who separated, corroborating the aggravation of this situation (Garbin, Dias, Rovita & Garbin, 2015).

The importance of monitoring SUS professionals, especially the physician, is highlighted to help these women overcome the stigma of violence and trauma, in addition to reintegrating them as active citizens in confronting this situation. As this is a study of current relevance, the research is faced with the scarcity of literature based on the correlation of medical practice with the context of violence against women (Moreira, et al., 2018).

The relevance of this study is to elucidate the actions of the SUS (programs, principles, and guidelines)

that coordinate and guide the conduct of health professionals, especially physicians (Moreira, et al., 2018). In addition, it will be analyzed whether there is specific professional training and whether it is carried out comprehensively, not only based on the risk of life but on minimizing the harmful effects caused on women's health by the aggression suffered. Furthermore, the knowledge of how to approach, what to ask, and what to check will be highlighted as to the actual realization of these (Soares & Lopes, 2018).

Therefore, it is known that there is still hegemony of the biomedical model in the formation of knowledge in health. For some authors, without addressing sociocultural themes linked to the phenomenon of violence, such as gender, race, and social class, there is a reinforcement of a limited concept of health andpractices without a transversal approach. As a result, assistance is limited and circumscribed, with no opportunity of articulation with other sectors that could have possible responses to violence (Garbin,Dias, Rovita & Garbin, 2015).

Furthermore, it will be verified that, for the transformation of this reality mentioned above, it is essential that the work process allows physicians to be able to have a dialogical relationship with women, who would change from objects of intervention to subjects of a relationship, whether in actions to promote health, prevent violence or care for the harm caused (Guerrero, 2017). In this context, the objectives of this study are to investigate the medical conduct in the care of women victims of violence, the actions andprograms of the Unified Health System (SUS), specifically carried out at the Santa Casa de Misericórdia Foundation in Pará.

2. Methods

This is a quantitative study, with data collection and without collection of biological material. The research was developed with physicians from the Santa Casa de Misericórdia Hospital of Pará, in the Tocogynecology sector in the Urgency and Obstetric Emergency: Rua Bernal do Couto, 1040 - Umarizal, Belém - PA, 66055-080.

The collection was carried out through the application of a questionnaire (Appendix 1) to the sector's physicians after the professionals involved signed the Free and Informed Consent Form, without exposing their identities. The questionnaire consisted of questions focused on the physician's conduct and the procedures for referring cases of violence against women, in addition to the existing ethical implications and the presence of victim support programs by the SUS, thus making it possible to identify which situations the incident of violence against women occurs more frequently, what is the medical conduct, actions, and programs of the SUS towards this type of violence adopted by physicians at the Santa Casa de Misericórdia do Pará Foundation.

We clarify that to guarantee the validity of the questionnaire, before starting data collection with the research subjects, a pilot group was carried out, with six (06) physicians chosen at random, where the questionnaire was applied. The results were analyzed and were not included in the final calculation of the research.

In all, 33 physicians of both genders from the Santa Casa de Misericórdia hospital of Pará, in the Tocogynecology sector in the Emergency and Obstetric Emergency, who have contact with women victims of violence, were selected. To calculate the sample, the systematic sampling formula described byBarbetta

(1994, p.45) was used.

$$n_0 = \frac{1}{E^2} \qquad n = \frac{n_0 \times N}{n_0 + N} \quad \text{(Equation 1)}$$

Where represents the first approximation of sample size, E represents tolerable sampling error, n represents sample size and N represents population size. Applying the above formula to our work, we have the following values:

$$n_0 = \frac{1}{0{,}05^2} = 100$$
$$n = \frac{100 \, X \, 330}{100 + 330} = 100$$

Physicians who agreed to participate by solving the questionnaire and signing the Free and Informed Consent Form were included in this research, regardless of color, race, creed, length of service and type of work performed and were excluded to physicians who refused to answer the questions in the survey questionnaire or did not sign the consent form.

Data preparation followed a 95% confidence interval (CI) and the Excel 2013 software was used to analyze the information. Fisher's exact tests were performed using the Graph-Pad INSTAT software, with a significance of $p < 0.05$. To assess the variables involving Violence Against Women: The Unified Health System and Medical Conduct, a multiple logistic regression was performed using the Excel 2013 software and STATA 13. The results obtained were shown in tables and graphs so that they were statistically analyzed.

2.1 Ethical Considerations

The precepts of the Declaration of Helsinki and the Nuremberg Code were respected, and the Standards for Research Involving Human Subjects (Rs. CNS 466/12) of the National Health Council, as well as the authorization of the work supervisor.

According to the norms of Resolution 466/12 of the National Health Council, this study was only initiated after submission and approval by the Research Ethics Committee of the Metropolitan University Center of the Amazon (UNIFAMAZ) and by the Foundation's Research Ethics Committee Santa Casa de Misericórdia do Pará (FSCMPA), and was executed after the voluntary signing of the Free and Informed Consent Form - TCLE by the Physicians of the Santa Casa de Misericórdia Hospital of Pará in the sector of Gynecology in Urgency and Emergency Obstetrician interested in being part of the research. Prior to signing, all participants were informed about the nature of the research, the willingness to participate, and the losses and benefits arising from this project.

2.2 Study period

The study began after CEP approval and investigated the medical conduct in the care of women victims of violence, the actions and programs of the Unified Health System (SUS), specifically carried out at the

Santa Casa de Misericórdia Foundation in Pará, in the period from February/2020 to March/2020, due to the Covid-19 pandemic and the lockdown decreed by the state government, the study was suspended and only returned in August 2020, when the Santa Casa de Misericórdia released the entry of researchers to give continue the research. Thus, this period extended from August to October 2020.

3. Results

In all, thirty-three (33) questionnaires were collected, each consisting of three items to identify the participant, ten (10) objective questions and two (2) discursive questions composing the object of study; was applied to physicians of both genders in the Tocogynecology sector in the Urgency and Obstetric Emergency Department of the Santa Casa de Misericórdia Foundation of Pará. After analyzing the questionnaires, the results were divided into two groups, regarding the identification of the participating physician and the object of the search.

The first group is composed of questions focused on the specialty of the participating physician, with 76% of physicians specializing in Gynecology and Obstetrics. As for gender, 85% of respondents are female and with the age of the participant, with a prevalence between 40 and 49 years (37%). These data are shown in Table 1. The second group consists of questions aimed at the object of study, exposed to the following statistical analysis in Table 2, comprising the objective questions, and graphs 1 and 2 thediscursive questions.

Table 1. Profile of physicians interviewed about violence against women in Belém, Pará in 2020.

Profile	**N (%)**
Sex	
Male	5 (15)
Female	28 (85)
Ages	
20-29 years old	7 (21)
30-39 years old	10 (30)
40-49 years old	12 (37)
>50 years old	4 (12)
Medical Specialties	
Gynecologists and Obstetricians	25 (76)
Gynecology and obstetrics residents	4 (12)
Ultrasonographer	1 (3)
Generalist	3 (9)

Source: Research Protocol, 2021.

Table 2. Percentage of responses from physicians interviewed about violence against women in Belém, Pará in 2020

Questions	Yes N (%)	No N (%)
Have you ever attended to women in situations of violence?	32 (97)	1 (3)
Do you believe that women in situations of violence should be treated differently?	31 (94)	2 (6)
Do you judge public health actions to support these victims as effective?	11 (33)	22 (67)
Do you know protocols for the care of womenvictims of violence?	32 (97)	1 (3)
Do you use protocols to care for these victims of violence?	32 (100)	0 (0)
Do you know specific programs to protect womenfrom situations of violence?	24 (73)	9 (27)
Does it refer these patients to SUS programs?	24 (73)	9 (27)
Do you think it is ethical to break medical confidentiality in favor of the patients' physical and mental integrity?	15 (45)	18 (55)
Do you believe it is necessary to offer protection to victims of violence after breaching of confidentiality?	32 (97)	1 (3)
Do you think that the doctor who identifies a case of violence and does not break confidentiality should be warned?	8 (22)	25 (78)

Source: Research Protocol, 2021.

When analyzing question No. 11 (Figure 1), about suggestions for the conduct of the physician and the health system in cases of violence against women, among those surveyed, 09 (nine) refused to answer, which corresponds to 26.5% and 06 (six) indicated that they have no suggestions in addition to those already established, which corresponds to 17.6%. The others presented suggestions such as referring them to specialized services, providing care with a trained multidisciplinary team, offering psychological support, providing humanistic care, and offering assistance for legal measures if it is in the victim's interest.

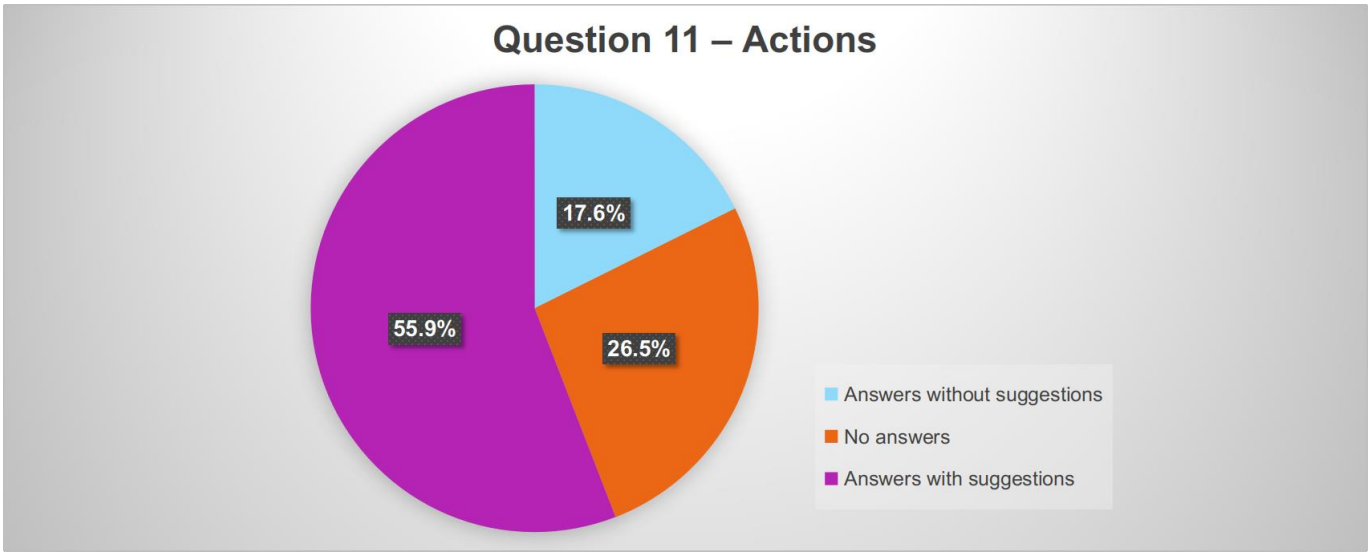

Figure 1. It represents the measures/actions regarding the conduct of the physician and the unified health system in the face of violence against women.

When analyzing question n. 12 (Figure 2), about gaps and difficulties, among the researched subjects, 09 (nine) refused to answer, which corresponds to 27.3%, and 06 (six) indicated that there is no gap and difficulties, corresponding to 18.2%. The other subjects indicated that there is a need for training and qualification of professionals to care for these patients. They indicated that the laws are fragile, that there is a lack of long-term protection, and that it is difficult to file a complaint. Need to have women's police station inside hospitals, which would facilitate complaints. There is a reduced number of reception services and a lack of information, with the need to improve protocols in order to improve prevention.

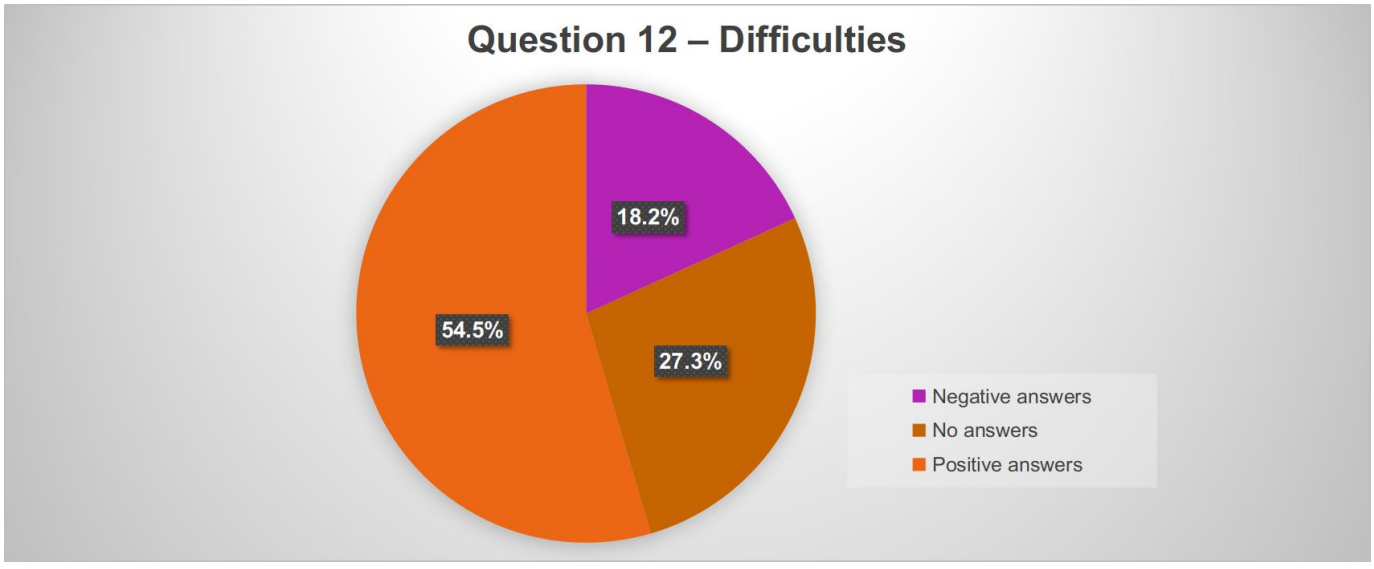

Figure 2. It represents the existence of gaps and difficulties in the actions, programs, and policies of the SUS in combating violence against women.

4. Discussion

From the results obtained, it is possible to identify the profile of research participants, which mostly includes gynecologists and obstetricians (76%), who are the professionals with the greatest experience and contact with cases of violence against women. In addition, other important characteristics of the profile evaluated are the higher prevalence of females (85%), aged between 30 and 49 years (67%) and most have already attended to women in situations of violence (97%), data that are in agreement with the information found by other authors in the national scientific literature (Barbetta, 1995; Hesler, Costa, Resta & Colomé, 2013).

Violence against women (VAW) is characterized as a violation of human rights, sexual discrimination, and a public health issue, according to the United Nations. In this sense, in recent years, there have been significant advances in the discussion and fight against this type of violence, based on the encouragement of debates in society and an increase in the self-perception of the situation of vulnerability of women themselves. The role of the physician in the context of VAW is to act in the identification of cases of violence as well as in the notification and adequate management of situations, a fact that is supported by Law 10.788 and recommended by the Ministry of Health (Serafim, et al., 2016).

The cases of VAW, despite the advances mentioned above, are still prevalent, and in several studies in the national scientific literature, more than 90% of physicians have already provided care to women in this situation, as well as the percentage found in this research, which was of 97%. The high rates of violence against the female figure are associated with a historical and social relationship of subjugation of women in various spheres, and which is currently corroborated by the erroneous self-understanding of thehierarchy between the sexes and the social construction of women as a property of men, in a society still fraught with hidden patriarchal and macho biases (Serafim, et al., 2016; Santos, et al., 2019).

Regarding the care of patients who are victims of violence, the need to identify these situations is highlighted, as well as the proper management and monitoring, especially in the sphere of outpatient care. However, despite acknowledging the need to manage these patients, studies show that health professionals are poorly trained to successfully identify situations of violence, in addition to a lack of preparation for proper referral and punishment of cases. Scientific reports prove that most professionals, especially physicians, do not feel safe and able to carry out the reception and sensitive listening of VAW cases, in order not to account for violence as a diagnosis and health problem, as well as trivialize the real problems of this type of abuse (Serafim, et al., 2016; Vieira, Padoin & Landerdahl, 2009). Although care protocols for people in situations of violence are well publicized by health agencies and theoretically train professionals to support VAW, commitment and safety are factors that are absent in most professionals who provide this care. In the study by Penso et al., (2010), it was identified that the experience of welcoming VAW cases makes knowledge about the management protocols of these patients practical, as well as being drivers of greater capacity for identification, acceptance, and empathy with these cases. In many surveys with physicians, cases of violence against females are underreported, to the detriment of the lack of diagnosis of these situations, so that despite the fact that they report using properly the management protocols for these cases, many are not identified, despite the known high prevalence of this problem (Serafim, et al., 2016; Penso, et al., 2010).

In addition to the proper identification of VAW cases, following the protocols recommended for the care of these patients is an important factor in breaking the cycle of violence and abuse, as an adequate punishment for the aggressors. Thus, notification of epidemiological surveillance, referral to a specialized women's care unit, be it the Specialized Women's Care Unit, Social Assistance Reference Center,Hospital Unit, and others should be carried out. Inserting the patient victim of violence into the integratedand multidisciplinary care network is a holistic patient care strategy, as well as having proved to be a toolthat assures physicians confidence and security in this type of care (Souza & Rezende, 2018; Santos etal., 2019).

Within the protocol for assisting people in situations of violence, one of the problems to be tackled is the perpetuation of the scenario of violence, through due legal procedures and accountability of the aggressor. However, the context that involves the victim and their relationship with their perpetrator can be extremely complex and require a responsible and sensitive assessment by the health professional. Studies show that within the class of health professionals, nurses stand out significantly, as more capable of identifying, evaluating and managing cases of VAW. It is listed that the issue of violence is complex and requires a multifactorial and interdisciplinary analysis, in order to always seek to end the cycle of violence and the non-maleficence of victims (Souza & Cintra, 2018).

The breach of medical confidentiality for notification and communication of VAW cases to police authorities is protected by federal law No. 13.931/2019, which makes cases of domestic and family violence against women mandatory notification, without any claim of confidentiality in these cases. However, there are still questions from the ethical point of view about the breach of confidentiality, through the medical code of ethics treating this breach as prohibited. The greatest concern of health professionals in taking on the commitment to report and notify such cases, however, may be associated with the absence of legal protection and clarity in cases of VAW, in addition to the need to ensure that thisprofessional protects their work activity in safety (Penso, et al., 2010)

Still in this context, the uncertainties about the repercussions of the breach of medical confidentiality, the relationship between the victim and the aggressor, as well as the safety of the health professional itself, do not consolidate the formation of sanctions or warnings to physicians who identify situations of violence they do not break the secrecy. The relationship between the doctor and the community, especially in the context of primary health and outpatient care, is a reciprocal social construction, which when affected by complex situations that are not well evaluated, generate harm for both involved, which can compromise the professional's physical integrity, the quality of service provided to the population and the dialogue between the parties (Penso, et al., 2010; Souza & Rezende, 2018).

5. Conclusion

As can be seen from the data collected, the professionals consulted cooperated with the research by properly answering the questionnaires. It should be reiterated that most participants were female physicians specialized in gynecology and obstetrics, aged between 30 and 49 years.

It appears that the majority of physicians stated that they attend and provide differentiated care to women in situations of violence; it also stated that physicians are aware of the protocols for the care of women

victims of violence and that they use these procedures; however, most health professionals themselves (67%) assume that the support provided by public health actions is insufficient.

However, only 55.9% of the participants made suggestions for the conduct of the physician and the health system in cases of violence against women, while 54.5% explicitly pointed out gaps and difficulties in the care of this type of case.

As the participants themselves highlighted, one of the main limitations to the functioning of the system is the difficulty in filing complaints, as well as the absence of long-term protection. The lack of information was also pointed out, with the need to improve prevention protocols. As a suggestion to improve these limitations, the participants proposed psychological support and humanistic care with a multidisciplinary team, in addition to offering assistance with legal measures.

Therefore, it appears that the transformation of reality goes through a dialogical relationship between health professionals and victims of violence, providing an environment where the victim feels safe, through humanistic care and psychological support, which demands the collaborative work of professionals of different specialties.

It is concluded, therefore, that the actions of the SUS have the potential to directly impact the context of violence against women, if the necessary support is offered to file complaints, in addition to prevention and long-term protection protocols.

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