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Woman abuse: contributions and shortcomings of the information system

VIOLÊNCIA CONTRA A MULHER: CONTRIBUIÇÕES E LIMITAÇÕES DO SISTEMA DE INFORMAÇÃO

VIOLENCIA CONTRA LA MUJER: CONTRIBUCIONES Y LIMITACIONES DEL SISTEMA DE INFORMACIÓN

Irene Okabe[1], Rosa Maria Godoy Serpa da Fonseca[2]

ABSTRACT

The purpose of this article is to present an overview of the health information system in monitoring woman abuse by analyzing the extent to which each data source may contribute to actual event dimensioning and underlie the decision-making process. Therefore, the text presents advances and contributions of each officially existent database in the health sector, and also its persistent shortcomings due to the scarce sensitivity and specificity of these systems in monitoring woman abuse. The article also discusses the need for further studies in order to deepen the issue, as well as a gender-based information policy for analysis and intervention of the violence determinants against women, considering the significance and seriousness of the issue, not only for women but also for society as a whole.

KEY WORDS

Violence against women.
Information systems.
External causes.
Gender identity.

RESUMO

O artigo tem por objetivo apresentar um breve panorama do sistema de informação em saúde, no monitoramento da violência contra a mulher, analisando em que medida cada fonte de dados pode contribuir para o real dimensionamento do evento e subsidiar o processo de tomada de decisão. Neste sentido, o texto apresenta os avanços e contribuições de cada base de dados oficial existente no setor de saúde, bem como as limitações que ainda persistem pela pouca sensibilidade e especificidade destes sistemas no monitoramento da violência contra a mulher. Discute-se também a necessidade de estudos para o aprofundamento da questão e uma política de informação à luz de gênero para análise e intervenção nos determinantes da violência contra a mulher, dada à magnitude e a gravidade do problema, não só para as mulheres, mas para a sociedade como um todo.

DESCRITORES

Violência contra a mulher.
Sistemas de informação.
Identidade de gênero.
Causas externas.

RESUMEN

El artículo tiene por objetivo presentar un breve panorama del sistema de información en salud en la actividad de monitoreo de la violencia contra la mujer, analizando de que forma cada medida y fuente de datos puede contribuir para el real dimensionamiento del evento y subsidiar el proceso de la toma de decisiones. En ese sentido, el texto presenta los avances y contribuciones de cada base de datos oficiales existentes en el sector de la salud, así como las limitaciones que todavía persisten por la poca sensibilidad y especificidad de estos sistemas en el monitoreo de la violencia contra la mujer. Se discute, también, la necesidad de realizar otros estudios para profundizar la cuestión y la elaboración de una política de información relacionada al género, para análisis e intervención en los determinantes de la violencia contra la mujer, dada la magnitud y la gravedad del problema no solo para las mujeres como para la sociedad como un todo.

DESCRIPTORES

Violencia contra la mujer.
Sistemas de información.
Identidad de género.
Causas externas.

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INTRODUCTION

External causes, including accidents and violence, are a major problem in the healthcare sector, given their magnitude and transcendence. They are currently ranked second on the list of mortality causes in the country, and generate strong impact in population's morbidity[1].

As a cause of death, they are not usually placed on the front line of women's obituaries; however, non-fatal consequences of violence suffered by women are quite problematic because they represent significant costs and a considerable burden to the healthcare sector, and lead to occurrences that result in further traumas and lesions that continue the aggression, adding to the whole health-disease profile.

The magnitude of violence against women in Brazil, also called *gender violence*, can not be measured with precision, since only a handful of grounded research studies of populational basis have been developed in the country; the majority of studies take place in isolation at Healthcare Service Centers and Public Security Departments, which approach the occurrence of events among users of assistance services; this approach does not allow for the generalization of conclusions to the women's population at large.

Gender violence monitoring in our country's healthcare sector currently occurs as a result of existing information systems related to mortality, hospital morbidity or admittance via the Brazilian Public Health System (SUS), and compulsory notification of violence against women, still undergoing the implementation phase in the national territory.

Information on this type of violence is diluted within databases conceived for distinct ends; in other words, mortality has epidemiologic objectives and is grounded in the population, while morbidity is ideally for administrative ends of admittance financial support of a portion of the population assisted by hospitals. These systems show only a partial perspective of the more grievous cases of violence, thus underestimating its true effect, as not all acts of violence cause wounds that require medical attention, and even women who display serious injuries and look for healthcare at private or agreed services are not incorporated into the hospital monitoring system. In spite of the scarcity of more trustworthy information regarding the frequency of violence towards women, these systems still point to – even though partially – the enormity of the and the need for deepening discussions on violence and gender issues.

This article intends to present a brief perspective of the healthcare information system towards monitoring violence against women by means of analyzing the extent each data source can contribute to the real scale of the event and subsidizing decision-making processes.

GENDER VIOLENCE

Violence against women is a type of violence that endures through the history of time and spans throughout all social classes, cultures, and societies. Since the 1950's the problem has been referred to in several different ways, such as *intrafamily violence*, *violence against women*, and *domestic violence*. From the 1990's on, it was also designated as *gender violence*[2].

In order to understand the meaning of gender violence, first of all it is necessary to conceptualize *gender*. The notion of gender was introduced in the 1970's after the creation of the term *gender* – translated into Portuguese as *gênero* – by the Anglo-Saxon feminist studies in order to understand the complex relations established between women and men. The term refers to the social construction of sex and is distinct from the *sex* variable, since this last term corresponds to the biological dimension of the anatomic-physiologic characteristics of human beings recognized as essential and inherent to the determination of differences between men and women[3].

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The discussion of the gender concept, initially connected to sexual roles concerning different social status between sexes, is nowadays used in quite a wider dimension, since it attempts to acknowledge historically built social relations that are established between men and women, women and women, and men and men. This new approach represents a theoretical-conceptual advance, as it breaks up the man-woman duality and attempts to break through compulsory heterosexual bonds[4].

The incorporation of the gender as a category makes way to the understanding of the unrelenting inequalities between men and women. Gender is approached as a constitutive element of social relations and as the basic format of representing power relations, overcoming the perspective that dominant representations are natural and incontestable. Whenever gender is taken as a sociological, and political-cultural construction of *sex*, it is easier to comprehend it in a dimension that integrates the whole cultural and ideological load. In this sense, concrete references are made necessary to the male/female identity, since it is impossible to assimilate the specificity of the female identity without the comprehension of the specificity of the male identity, as well as the common grounds they share as human beings at large[5].

Based on the gender notion, the United Nations General Assembly, in 1993, by means of the Declaration of the Elimination of Violence Against Women, defined violence against women as

> any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion

> or arbitrary deprivation of liberty, whether occurring in public or in private life[6].

From this perspective, violence against women expresses the inequality of power between the sexes, being both recognized as an issue of violation of human rights, as well as a way of discriminating against women[6].

One of the important aspects towards overcoming inequality in gender relations is to shed light on the phenomenon; this can be achieved by means of informing the population, aiming at undermining indifference and complicity that lead to the naturalization and perpetuation of discriminatory social practices. In this sense, it is urgent to broaden knowledge of the phenomenon, with the hope that the recognition of inequality and how it evolves can ground interventions for important changes.

GENDER AND VIOLENCE INFORMATION SYSTEM

The introduction of the issues that surround violence against women to the healthcare agenda took place during the feminist movement in the last decades of the 20th century, seeking to sensitize women and society as a whole toward gender awareness, pushing against the State and demanding actions and interventions for the victims, not only for the treatment of injuries resulting from violence, but also in the recognition of women and their position as citizens and subjects capable of making decisions in their own lives.

As a response, several studies and social policies were developed in order to tackle the problem of violence against women. One of the responses such policies achieved was the International Conference on Population and Development, held in 1994, which recognized violence against women as an obstacle to sexual and reproductive health, as well as all women's rights. In the same year, the Interamerican Convention to Prevent, Punish and Eradicate Violence Against Women took place, representing a massive effort of the international feminist movement to highlight the existing violence against women, and recommending that governments of the Americas adopt measures to prevent, punish, and eradicate this type of violence. The Convention also recommended the investigation and recompilation of statistics and other information on the causes, consequences, and frequency of violence against women, in order to formulate and assess necessary changes[6-7].

In 1995, during the 4th World Conference on Women held in Beijing, female organizations again stood up for the elimination of violence against the female gender and the inequalities between men and women. The conference's agenda included the proposal of incorporating the gender perspective in all public policies, so that both sexes could equally benefit from the positive effects of governmental programs, taking into account that women's issues are global and universal, and that equality is essential for the construction of a more just society[8].

It was necessary to guarantee reliable statistics in order to consolidate the proposal, so that problems and issues concerning women and men could be revealed, among them violence against women. The Beijing 1995 Platform, Article 129, recommends:

> Promote research, collect data and compile statistics, especially concerning domestic violence relating to the prevalence of different forms of violence against women, and encourage research into the causes, nature, seriousness and consequences of violence against women and the effectiveness of measures implemented to prevent and redress violence against women[8].

The recommendation indicates that the reality has to be comprehensively understood so that plans of action to confront the problem are implemented. In Brazil, countless research projects were developed in order to diagnose the status of violence against women; however, in the vast majority of cases, they occur in isolation within victim's assistance services. Hence, it is impossible to broaden results to the whole population, as the sample size is quite limited. In the national scope, there are only two developed studies: the first was performed by the Brazilian Institute of Geography and Statistics (IBGE) in 1998, and the second by the Perseu Abramo Foundation in 2001[1].

As per the insertion of the gender perspective into the public policy agenda, and still under the impact of international movements, Brazilian women created, along with the State, the National Council of Women's Rights, an organization that is judicially connected to the Ministry of Justice and Precinct Houses specializing in assisting victimized women, and the institution of the Women's Healthcare Integral Assistance Program (PAISM)[1].

Accomplishment in the information policy field came by the approval, throughout the national territory, of the compulsory notification of cases of violence against women that are assessed by either public or private healthcare services; this project is still being consolidated all around the country. This system empowers the advance of surveillance of violence against women being currently developed by existing information systems. As a matter of fact, in their conception, these information systems were not developed to respond to gender-related violence issues, thus showing limitations toward an effective action in tackling the problem.

Statistical developments in the gender field are but in their initial phase. From 1970 on, the *sex* category was systematically included into the country's official statistics; this act constituted the first milestone toward the incorporation of a new gender perspective in the information generated by the public sector, and the possibility of codifying and breaking down man-woman events. This was the first step toward an attempt to visualize existing differences and inequalities between men and women; however, besides the categorization action, statistics should point out implications and the impact of the *gender* category in the health-disease process of individuals and social groups[9-10].

The major impass toward the acknowledgement of gender relations, from the public statistics standpoint, is the notion based on gender relative neutrality as the main conception of the system; in other words, the concept is derived from the perspective of the probability theory of the event order assignment, in which the average value of case distribution is featured by an ideal average man depicted in the statistics as a *genderless* individual; in fact, this identity is always portrayed as a *male-based* one[11].

Although there is a general recognition that healthcare is affected by both biological and social determinants, healthcare sectors still approach the gender idea in a secondary manner; the category is rarely mentioned in developed studies, and is often mistakenly applied as a synonym for *sex*. On the other hand, public statistics organizations existing in the country do not allow for the identification of new roles taken by men and women within family boundaries and in social life, both in the qualitative and quantitative aspects.

In the same vein, the database that comprises the Epidemiologic Surveillance System on Violence and Accident, under the coordination of the Ministry of Health, also shows low sensitivity and specificity in monitoring violence against women, as will be presented next.

The death certificate generates the Mortality Information System (SIM); the variable *cause of death* inserted into this instrument reveals, in cases where cause of death is an external one, the circumstances of the accident or violence that produced the fatal injury[12]. From this point on, it is possible to characterize whether or not the event was intentional or non-intentional. In this way, the SIM constitutes a relevant database to monitor external causes of death; in Brazil, it practically represents the only regular data source that makes a population-based analysis possible. SIM data analysis allows for the construction of indicators that will be able to delineate external cause profiles that determine deaths in the country and their impact on the population.

In quantitative terms, the system is presented as a source of reliable information, as it covers 80% of all death processes throughout the nation[1]. In qualitative terms, however, it displays shortcomings regarding socio-demographic data, such as sex, race or color, occupation, and the educational level of victims. A similar situation is observed when the death cause report is filled in, given the lack of competence of the coroner performing the autopsy, as he usually does not provide information on the nature of injury or to the circumstances that originated in the death, thus hampering, in many cases, the characterization of the event as an accident, self-inflicted injury, or act of violence.

Nevertheless, although it represents only fatal cases, the information system in the country is considered to be the major database for the surveillance of external death causes, providing the possibility of comparing regions, and even other countries, by means of the international codification of standardized basic causes of death, and the application of the database to tackle mortality rates as a source of information for the achievement of knowledge on the magnitude and impact of accidents and violence.

Non-fatal cases resulting from external causes are represented by the statistics collected from the victims of violence who require assistance in ambulatory care centers and hospitals, providing an extra database to monitor these problems.

The Admittance Information System (SIH-SUS) has been consolidated as an important database in the construction of assessment indicators and external cause of death trends. The analysis of hospital morbidity takes place from the Hospital Admittance Authorization (AIH) form that is filled in for each and every admittance process covered by SUS. Thus, patients who are admitted into private institutions and those who have healthcare plan agreements are excluded. Even so, the coverage of this system includes approximately 70% of the entire country's reported admittance processes[12].

The major impass toward the acknowledgement of gender relations, from the public statistics standpoint, is the notion based on gender relative neutrality as the main conception of the system

The system's conception is directed towards administrative ends and aimed at hospital requital practices, predominantly valuing information on medical procedures over the cause and diagnosis that motivated the admittance process. This generates an impediment in the correct selection of the major and the second diagnoses due to the low reliability of reported data.

The logic of morbidity diagnosis codification is different from that of mortality's. In admittance processes, the major diagnosis refers to injuries originating from external causes, thus not connecting the circumstances that generated it. In order to improve the information, the Legal Order GM 142 was released on 13 November 1997; it states the compulsoriness of reporting the type of external causes which generated the injuries that triggered the admittance process, such as the secondary diagnosis in the hospital assistance practices related to the injuries, poisoning and other external cause consequences[1,13]. Although this measure represents an advance in the conjoint study of morbidity-mortality for external causes, thus filling the gap between fatal and non-fatal cases, the effective adoption of the Legal Order is not yet configured on the AIH form's filling-in status.

Despite the non-collection of universal data concerning hospital assistance to victims of accidents and violence, and the low quality of information, the system indicates the impact and the cost of external causes for the healthcare sector. In 1996, data from the Admittance Authorization forms presented 679,511 registrations under these causes; this number shows only the hospitals affiliated with SUS.

The relative expenditure for hospital assistance processes in 1997 corresponded to 8% of the total amount of admittances performed for all causes. The hospitalization processes presented an expenditure/day around 60% higher than the other admittance processes[13].

Healthcare network morbidity information is even more precarious and incipient for epidemiologic studies. The Ambulatory Care Center Information System (SIA-SUS) systematizes all data produced by healthcare centers enrolled in the Healthcare Single Service, according to the medical specialty, and does not make possible the analysis of morbidity, since there is no record of the disease or reason that led users to access the service.

The assistance process provided by the emergency unit follows the same logic as the ambulatory care center; therefore, there is no information recorded on the diagnosis and no AIH is filled in because this type of assistance is not deemed as admittance. This fact underestimates the real magnitude of the problem, as many victims are assisted by these services and are treated without the need for being hospitalized.

The notification of violence against women is quite a recent phenomenon in Brazil, established by Law number 10778, from 24 November 2003, which makes law the compulsory notification of cases assisted by public and private healthcare service centers. The implementation of this law allows the Ministry of Health to measure the problem's extent, characterize the circumstances of violence, categorize the victims' and the aggressors' profiles, besides contributing to the production of evidence aimed at the development of public policies and governmental actions. This service is also undergoing implementation[7,13].

The compulsory notification strategy is traditionally employed by public healthcare by means of the epidemiologic surveillance program of transmissible diseases. The operation of the system seeks to streamline and optimize either active or passive actions based on information gathered by the notification. Considering the monitoring of violence against women, the proposal foresees passive surveillance; that is to say, spontaneous notification of services at the moment of the assistance process. This strategy has shown, even with regards to infectious diseases, a low level of sensitivity and representativity due to the subnotification of cases; the active-based notification is mostly recommended for surveillance systems because of the regular existing contact between the information generator source teams and the surveillance teams, thus displaying improved results[12].

Passive surveillance of violence against women can bring about negative experiences similar to what happens to infectious disease control, such as low coverage and low representativity of the event as a result of the subnotification. In the case of gender violence, the possible reason for this status is the fact that it has been just recently recognized as a collective healthcare problem; hence, the phenomenon enjoys poor visibility due to the low level of awareness of the population, and mainly of healthcare professionals, on the consequences of violence for women's health; another alternative is the fact that professionals are not yet prepared to cope with the situation, considering it to be a family-related problem[14], and being thus unable to comprehend the need for properly reporting the notification.

The research concludes, then, that countless factors contribute to the limitation of the comprehensive task of combating violence against women in the country. First, the data sources must be taken care of; they have to comply with international normatization concerning morbidity and mortality codifications. Morbidity refers to injuries treated or investigated at the time of receiving medical assistance as a result of violence or accident, while mortality is related to the circumstance of the event that caused by fatal injury. This distinct logic impairs the conjoint study of morbidity-mortality due to those reasons, even after the compulsoriness of the secondary diagnosis, as data are not always properly completed. In addition, there are other factors, such as the conception of the currently used information system, which was not formatted for this objective, allied with the lack of uniformity in the way data are collected, thus hampering comparative processes among different realities.

Despite several attempts carried out to broaden the understanding of external causes of injury and death, among them violence against women, data are still not optimized in the existing healthcare information systems, each with its specificity and degree of reliability concerning the quality of information. The consolidation of data drawn from different sources constitutes a complex task and is one of the challenges to be overcome. This fact focuses us towards the need to create an information policy in the country that encompasses gender and violence issues in an articulated way, both intra- and intersectorially.

In a nutshell, aiming to minimize deficiencies that negatively impact the current information systems towards monitoring violence against women, we ratify the need of bringing to the forefront the issue by encouraging studies that improve existing statistical knowledge, as well as new research that favors a more trustworthy profile of the situation, in order to trigger decision-making processes and proposals for effective actions to cope with this grave shortcoming.

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