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## The response to gender violence among Brazilian health care professionals

Respostas à violência de gênero entre profissionais de saúde

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**Abstract** *The scope of this paper is to identify the experience, attitudes and impressions of health care professionals (HCPs) in addressing the needs of women patients suffering from intimate partner violence (IPV). In-depth interviews were conducted with 14 doctors and 11 nurses in Ribeirão Preto. Results show that there is an 'apparent invisibility' of IPV, the convenience of a tacit compact of silence about such violence on the part of women and HCPs. We studied the reasons given by HCPs for failing to deal with IPV. We also addressed the health service facility context, and the diversity of the professionals' responses to violence, with indications of the emergence of a more proactive and positive stance. Qualitative data analysis highlights previous survey findings. A positive response from HCPs shows that there is perhaps some change from a narrow, medically-focused model of health care, to a more broadly defined social model.*

**Key words** *Violence against women, Domestic abuse, Health care professionals*

**Resumo** *Objetivos: Identificar a experiência, as atitudes e os sentimentos dos profissionais de saúde (PS) quando abordam as necessidades de mulheres que sofrem violência do parceiro íntimo (VPI). Método: Foram realizadas entrevistas em profundidade com 14 médicos e 11 enfermeiras em Ribeirão Preto. Resultados: Há uma aparente invisibilidade e a conveniência de um acordo tácito de silêncio por parte da mulher e do PS; exploramos as razões dadas por eles para esta inabilidade em atender VPI. Também abordamos o contexto dos serviços de saúde, a diversidade de respostas dos profissionais e a emergência uma postura mais proativa e positiva. Discussão: A análise qualitativa realça os resultados de um inquérito prévio. Uma resposta positiva mostra que talvez haja algumas mudanças de perspectiva de um modelo medicalizado de cuidado à saúde para um modelo mais abrangente ou integral que define saúde como social.*

**Palavras-chave** *Violência contra a mulher, Abuso doméstico, Profissional de saúde*

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## Introduction

According to WHO violence against women also known as gender-based violence is widely recognized as human rights abuse and a public health matter<sup>1</sup>. Intimate partner violence (IPV) has been one of the major forms of gender violence all over the world being responsible for about 80% of gender violence.

The WHO Multi-country study on women's health and domestic violence against women<sup>2</sup> found high prevalence of psychological, physical or sexual violence. In Brazil the prevalence of physical and/or sexual violence ranged from 29% in an urban setting to 37% in a rural context<sup>3</sup>.

IPV became a legal issue and an object of justice in parallel with its emergence of the recognized problem within healthcare, as one of the targets of the public health area and of medical and sanitation practices<sup>1,4-6</sup>.

Although informally recognized for many years, efforts to combat violence against women were strengthened when it was placed explicitly in the international agenda after 1979 when the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was held. CEDAW in turn was given greater significance when it was adopted by the General Assembly of United Nations<sup>1</sup>.

Several studies highlighted women's health problems as consequence of this type of violence<sup>7,8</sup>. There is a consensus that the health sector cannot be the only one responsible by the fight against violence. However its institutional involvement is expected in order to establish connections in a social and institutional network to address the problem<sup>6</sup>.

Women who suffer IPV are often frequent users of health services being this a phenomenon observed internationally and in Brazil. Therefore, women's visit to the health care service is an especially important nexus where such problems can be identified and practical steps taken to try to assist them.

In Brazil the recording of any case of suspected or confirmed domestic violence has been compulsory in the health service since 2003, although it has not always been carried out. A new paradigm was introduced to the scene in the legal area with the creation of the federal act titled Maria da Penha in 2006, because it has extended the protection of women who suffer IPV. In addition, in the last decades there have been an increasing number of organizations which assist women

who face violent situations. Society and public power show concern with this problem and the network of services are being expanded. All over the country Special Police Stations for women have been created, as well as shelters and Special Victims Services in order to assist women who suffer from domestic and sexual violence. A great number of governmental and non-governmental organizations were created including those which could assist men and aggressors.

The assistance of Health Care Professionals (HCPs) to women suffering IPV and their perceptions have been subject of investigation in several studies<sup>9-16</sup>. However, only few studies<sup>16</sup> approach the emotional concerns of HCP's regarding this situation. HCP's attitudes are founded in values and affective dimensions which need to be understood since they influence the perceptions the professionals have about this phenomenon.

Primary health care has strategic importance in the detection and referral of IPV cases because among the frequent users of health care are women who does not search for other IPV-related social support. Therefore health professional's knowledge and perceptions of violence against women are crucial for this detection.

In this paper we report on qualitative findings from a study of doctors' and nurses' perceptions of gender violence perpetrated by women's intimate partners, and the problems faced by them in dealing with such type of violence. These professionals involvement is crucial since they are probably the first or the only professional to establish contact with the woman.

We seek to explore some of the complexities of the encounter between HCP and women in identifying and addressing signs of violence. Initially we discuss a traditional 'apparent invisibility' of IPV, the convenience of the a tacit compact of silence about such violence parting terms of both, the reasons given by HCP's for a past inability to address IPV, HCP's awareness of, and more acutely, feelings about, the problems of addressing IPV. We also include a discussion about the health service facility context and the diversity of HCP's practical responses to gender violence with some more encouraging indications of the emergence of a more proactive and positive stance.

This knowledge can be a key element in the capacity building of health professionals taking into account that developing sensitivity and sense of responsibility to IPV is crucial in the changing of attitudes.

## Method

In Ribeirão Preto, a city placed in the Brazilian Southeast region, there is a network of services to assist women suffering of IPV and they act to protect health and rights of women. This network includes the public local health system, social institutions and NGOs. The health services comprise 30 primary care clinics, five district clinics, 12 units of family health and 11 services of social and psychological support such as CAPS (the Center for Psychological Support), seven CRAS (Referral Center for Social Support), 35 community centers and two public services, one for the protection of women suffering IPV and another specialized in sexual abuse of children and adolescents. There is a Specialized Police Station for Women and the legal system offers free legal services. There are also several councils such Women's Rights and the Children's Council that also act in terms of designing local public policy. Finally there are 25 NGOs which assist the victims of violence.

Despite all these resources the articulation in the network is still at an incipient stage, since there is not much communication and cooperation between the services, and so the care is fragmented. In addition there are no shelters for the victims.

We conducted the study within five government District Health Clinics in Ribeirão Preto, Brazil. We pilot tested the interview guideline with five doctors, which included 21 questions concerning gender attitudes, perceptions of domestic violence, and their management of IPV. The pilot testing showed that the questions "worked" effectively, but it was decided to change their order. The pilot testing was particularly useful in providing guidance upon the optimal times of the day to contact the doctors and conduct the interviews.

The semi-structured interviews were undertaken with 14 doctors, nine of which were gynaecologists and five general physicians, comprised of eight men and six women, with a varied range of work experience from one to 25 years. We also interviewed 10 nurses and all of them but one were female and had between one and 22 years of work experience. The interviews took between thirty and fifty five minutes to complete with the average time taken being forty minutes. They were undertaken within the health centers from June to August 2007.

Although a small minority of the doctors did find the subject difficult to discuss, it turned out to be a subject about whom they had very strong feelings and quite definite perspectives, although

as discussed below there was a widespread sense of the complicated nature of addressing patients suffering from IPV. Field notes were taken immediately after the interview to record non-verbal response to questions and other relevant observations noticed by the interviewer.

The interviews were tape-recorded and transcribed verbatim 100%. These were no objections to the tape recording. Data analysis involved the customary combination of deep immersion in the data set, along with the more systematic and structuring process of content analysis<sup>17</sup>. While both the objectives and interview questions were guided by a literature review of studies of IPV and health service settings, every effort was made throughout the analysis to approach the data with open minds and to avoid interpretation based on any prior notions<sup>18</sup>. The more systematic element of the analysis followed the steps of reduction, display (mostly using listing tables but also as the study progressed some working diagrammatic schemas), and prior to the final stage of interpretation<sup>17</sup>. A range of codes were first identified which were thereafter condensed as appropriate to enable the structuring of the data set by themes in the process of content analysis.

## Some Key Quantitative Findings

We wish to stress from the outset here that given that the focus of this paper is upon the qualitative findings, we make only the briefest reference to the study's quantitative component and some of its key findings. The quantitative findings derive from a questionnaire survey of 221 HCP's (doctors and nurses), undertaken in 2007 in all five District Health Clinics in Ribeirão Preto, Brazil. The survey findings indicated that few HCP's were aware of the high prevalence of IPV in Brazil. For instance in our survey<sup>16</sup> whilst 18% of women attending these clinics reported having suffered physical IPV within the last year, some 82% of the doctors year estimated that the figure would be 10%. Two fifths of doctors admitted that if the woman did not admit to suffering from IPV, even if they believed it was occurring they would not directly raise the subject, and three fifths (incorrectly) believed that the prescription of tranquillizers could be appropriate for such patients. More positively they had a good awareness of IPV case management, were highly sympathetic towards female victims of IPV and the vast majority agreed that it was part of their role as HCP's to address IPV when indicated by their patients.

## Results

We present the qualitative findings with reference to identifying signs of IPV, the problems of, and reasons for, women's not admitting such causes of bruising and so on, HCP's' traditional reticence to probe for IPV, and reasons for avoiding such probing, HCP's' feelings about the encountering of IPV in the health clinic setting, and finally indications of a more proactive stance.

### Identifying Signs of Gender Violence

Of the three basic forms of gender violence it is physical (rather than sexual or psychological) violence that is most likely to be noticed or suspected by the HCP. They highlighted two basic types of evidence of violence, firstly, among women attending for emergency treatment, where the indications were obvious and the woman would occasionally be accompanied by a police officer (and the doctors do not feel the need to further investigate the source of the injuries), and secondly, in other more common and routine consultations where the more subtle signs are rarely immediately recognized as being caused by violence. For instance, alluding to the difficulty of identifying IPV

*In fact the woman does not come here directly for that (IPV), but for the consultation and she talks a lot about vague complaints, seemingly psycho-somatic, pain, several symptoms that don't seem to match, and you start searching but you don't find anything, and then in a second visit the woman speaks out [admitting the source is partner violence] (Male, general practitioner, 47 years old).*

The above case indicates the way a rapport needs to develop between the doctor and patient, which can take a number of visits, before the woman may admit that she is suffering from IPV.

Even when they suspect signs of domestic violence, for instance when the woman presents diffuse complaints and signs of having suffered aggression, doctors generally have not traditionally raised the matter with the patient. Furthermore it is rare for a woman to freely admit that the source of her injuries is her sexual partner. For instance, talking about patients affected by IPV:

*We see the signs of the violence in her lesions, but women say 'I fell, I slipped, I banged my eyes' (Male, gynaecologist, 52 years old).*

### Barriers to Raising IPV in the Consultation

Even in the rare event of being questioned by the HCP about possible IPV, women will omit reference to domestic violence or often deny it if pressed more explicitly. Thus there has been an "apparent invisibility" of gender violence in the Health Clinics consultations in Ribeirão Preto, Brazil. We understand that this invisibility is only apparent because in fact health professionals do detect cases of violence. The results show that doctors and nurses are aware of the problem.

The first set of reasons for this "apparent invisibility" are emotional in that the women feel shame for their situation and fear social stigmatization, and losing their family, as in

*There are women who are beaten through their whole life but they never complain. They don't want to complain, they are afraid of the husband, they are afraid of losing their children, they are afraid of losing the house (Male, general practitioner, 52 years old).*

*Many times they hide their condition, many women do not tell the reason they have problems and we end up getting suspicious of violence... we perceived that the story does not make sense people perceive you are lying (Female, nurse, 54 years old).*

*Sometime somebody has to warn us about the violent situation otherwise we do not identify it... (Female, nurse, 30 years old).*

The traumatic emotions involved inhibit both the HCP and patient from discussing violence. Such emotions threaten to damage the desired customary convivial tranquillity and detached piece of mind of the HCP-patient encounter. By not probing for or seriously seeking to explore the domestic source of the injuries the HCP is seeking to avoid embarrassment upon the part of both themselves and the woman.

Furthermore such doctors do not recognize benefits in making an effort to address the problem of gender violence. Based upon an outmoded notion of health care many have traditionally felt it is outside of their medical remit, as a social, rather than health, problem. For instance,

*If she [the patient] wants to solve the problem [of IPV] she should look to the police... [...] ...not come to the health centre... because this does not solve the problem but creates more problems. Such assistance is available from the Women's police station... this is not a health problem, it is a psycho-*

*social-family problem, we are not prepared to assist them* (Male, general practitioner, 57 years old).

In relation to this is the common belief that intimate partner violence is a matter that is 'private' to the couple and not the direct business of the health service. This private aspect is highlighted in that sometimes the immediate cause of the IPV relates to the wife not wanting sexual intercourse and thinking that the doctor can provide some kind of official justification, as in

*Just last week a woman who was due to have a caesarean section the next day called my colleague, screaming and desperate because her husband tried to choke her. When she arrived the next day for her operation she was covered in bruises, it had happened because she did not want to have sexual intercourse* (Female, gynaecologist, 29 years old).

*A woman came to me for a consultation asking for a letter that would say she couldn't have sexual intercourse for one month. I found that strange and said 'This has no medical or legal value, why do you want this letter?' She replied 'This is to show my husband, to prevent him having sex with me as we go through this separation' She told me that on Thursday, on Monday I heard her husband had killed her. So it's complicated to interfere* (Female, gynaecologist, 37 years old).

### Concerns with Referral

In the instance that the woman raises the subject of domestic violence many doctors have felt uncertain about how to take the matter further within the health service. Some doctors have a sense that if the violence is reported there are inadequate services to protect the woman who will then face even greater violence from their abusive partner. For instance:

*One patient told me "I have been beaten by my husband, I went to the police and presented my case, but he keeps hitting me and nobody does anything". How am I going to help her? I give advice. It's terrible, it's complicated* (Male, gynaecologist, 52 years old).

*Another doctor noted that when they suggest victims of IPV go to the police, many times the women have replied I know this, I've already looked for justice, but so what?* (Female, gynaecologist, 37 years old).

These concerns and uncertainties about precisely what procedure needs to be followed in the case of a female patient who is suffering from domestic violence may well be related to doctors' customary practical orientation to what we may call effective action. They are trained in specific

medical protocols of testing, diagnosis, prognosis and treatment. The contrasting 'messiness' of social problems such as domestic violence may thus be counter to, and uncomfortable for, a traditionally, medically-trained mindset. Doctors express this as a frustration asking that if they report the violence: who is going to take care of this woman? Who is going to follow-up with the more wide-ranging care needed in dealing with the problem of the violence? Will the doctor in turn be threatened with violence by the perpetrator? For instance,

*Sometimes women [sufferers of IPV] come here in secret from their husband, because they know he will hit her even more if he knows she's coming here for help* (Female, general practitioner, 36 years old).

*[...] know a colleague, who the husband came here looking to shoot, because he'd told the woman to separate from the husband who kept hitting her so badly. We can't say things like that, we need to refer the case to people who know how to handle this kind of problem* (Male, general practitioner, 55 years old).

Thus traditionally in Brazil, due to a complex interplay of emotional and service-related reasons, there has been a tacit compact of silence between doctor and patient, which has served to keep gender violence, although common, invisible within the health care setting.

A contrast between medical doctors and nurses discourses was observed regarding the referrals and how to manage the cases of violence. Nurses assume they have to provide orientation, referrals and notification of the cases while medical doctors do not. In addition, nurses emphasized that the cases should be assisted by a multi professional team.

*[...] recently we have to report the cases and refer the cases. We ask the woman to seek the police station and to register the complaint against the partner. If the violence is more serious we refer to the hospital if it is lighter we refer to a social work for orientation* (Female, nurse, 30 years old).

*Normally we assess the risk and refer to the social worker to make an investigation but I think that as a nurse besides doing the notification I have to provide orientation* (Female, nurse, 33 years old).

Probably the different discourses between doctors and nurses are related to the fact that nurses are obliged to participate of training for the implementation of the notification but the doctors are not. Nurse scope of work includes organization and paper work. Besides they know



well the protocol of assistance to sexual violence which is the only one with a specific protocol.

*We work together with the social worker. We call her and follow that protocol, so the patient is referred to the hospital and this has to be quick especially in cases of sexual violence because they have to start the medication to avoid HIV, unintended pregnancy* (Female, nurse, 32 years old).

### Feelings about IPV

In understanding the emotional dimension to this situation it is important to stress that doctors and nurses are only too well aware of the problem, and it is something that very definitely troubles them. Their feelings have obviously come through in some of the prior quotes, but are more directly expressed here,

*It makes me feel very bad, I don't know how to explain my feelings, I feel great discomfort, sometimes I feel revolted, its something that shocks me* (Male doctor, general practitioner, 47 years old).

Also as shown in some of the prior quotes, IPV cases are something that they discuss with colleagues. Many of our interviewees, and especially those with greater years of experience vividly recounted cases of patients who had suffered terribly at the hands of violent intimate partners. Many of these cases were clearly deeply embedded in their memories from years past. Whilst they may be uncertain of the precise scale of domestic violence suffered by their patients, it is still something that many strongly feel needs to be addressed.

In relation to both this sense of revulsion and the difficulty of helping patients suffering IPV the doctors interviewed frequently expressed a sense of impotence, as it has been reported by other authors<sup>19</sup>.

*I just don't accept violence against women, I think it's an abomination. I feel impotent against it* (Male, general practitioner, 52 years old).

*I feel completely impotent, because this is a problem so complex* (Female, gynaecologist, 30 years old).

*[...] we can do nothing because there is not a psychological care that could refer to follow these women to help them to change their situation, so there is not much we can do* (Female, nurse, 30 years old).

It was this indignation along with the combined advocacies and lobbying of both the feminist movement and HCP's that has in fact led to the establishment of a whole tranche of measures to address gender violence within health care settings in Brazil. Many of the foregoing quotations

show that HCP are clearly moving beyond the traditional compact of silence about IPV in consultations. Although they are acutely conscious of the complexity of the domestic dimension of dealing with IPV cases they are openly raising their concerns when it's suspected.

Others HCP's show their fear of intimidation and revenge from the aggressor what could have a paralyzing effect over them.

*We saw cases in which the aggressor comes here to intimidate us. They come to know if we had reported the case to the police, they do not want us to take any measures, so, we are exposed to the risk of violence as well* (Female, nurse, 30 years old).

*[...] most women fear the aggressor come here for revenge and he will make her situation worse. We have to explain that she has the right of protection, but they are afraid and do not denounce the violence because of the fear* (Female, nurse, 57 years old).

### Indications of a More Proactive Stance

Based upon the sympathy and indignation many HCP's feel for and about IPV, and with the recent facilitating legal and procedural developments, there were many indications of doctors taking a more proactive stance to the problem when identified in their clinics, for instance:

*As a doctor, I think I am the one who should give orientation...I should warn the person about the risk she has...and which actions she should take...It must be appropriate.... the decision is hers ...but I think we play the role of detectors and counselors but the real action is up to her* (Female, gynaecologist, 48 years old).

Reflecting the emphasis noted above concerning the need to develop a rapport, another doctor commented:

*You have to give moral support. Try to be like a friend to this person, try to listen to what she has to say...Try to calm her down, to say that everything will be OK, otherwise she does not feel supported. If she does not feel she is with friends she does not open up [about the IPV]* (Male, gynaecologist, 55 years old).

Furthermore even despite the possible threat to themselves from the violent partners, some doctors still assert the need to give robust advice:

*I had case like this...I had a patient that I saw in the emergency room and she had been violently beaten ...she had bruises all over her neck and I told her to go to the police, to make a complaint. Then she came back with the husband and the husband came to confront me because I had asked her*

*to make a complaint. It is a complicated situation, but we have to give orientation always...it is our duty to do so* (Female, gynaecologist, 29 years old).

Contrasting these more proactive and positive comments with some of the more almost fatalistic and negative quotations noted above, we could tentatively assert that we are in a phase of transition in Brazil in providing more effective support for women sufferers of IPV attending health services.

Besides, we identified in the nurses discourse ideas of how should a health clinic properly manage the cases of women in the situation of violence.

*We should have a multiprofessional team to assist women in violent situation. We should have a gynecologist, a nurse and a social worker in this team. We also should have a better communication with the police. This should be better because sometimes women go to the Health Clinic and she has to go after to the Police Station. She can give in the way. The ideal it would be to have the referral center of violence with all resources in one building* (Female, nurse, 33 years old).

*First of all we need privacy, respect to see the person as I am talking to you now, door closed, not to be judgmental and try to help* (Female, nurse, 29 years old).

*I think that we should have a multi-professional team working together, comprising a psychologist, a social worker, a nurse and a medical doctor. We could have a link with the Youth Council, so we could do a better job if we all work together* (Female nurse, 57 years old).

## Discussion

We found a broad congruence between the qualitative and quantitative findings in this study, in that both present a picture of HCP's who are highly sympathetic to patients suffering from IPV, with the vast majority of whom wishing to help such women in these situations, albeit primarily through appropriate referral. Thus in terms of customary triangulation, the convergence of the two sets of findings provides some confidence in the overall validity of the study. The broad congruence also provides support for some confidence that the small sample of qualitative interviewees were not atypical of the larger population of doctors in Ribeirão Preto, Brazil. However the qualitative findings present a much stronger sense of the obstacles to, and complications in, assisting such patients through the health care

setting, and a much richer evocation of HCP's feelings.

We are clearly in a stage of transition with respect to the addressing of intimate partner violence within health care settings in Brazil. A potentially effective policy is in place, yet even if (as the survey findings suggested) there is an underestimation of the scale of IPV in Brazil, the comments so many HCP's made in the qualitative interviews clearly indicate that such perspectives on prevalence in no way diminish the real feelings of indignation and outrage at the violent domestic situations of some of their patients. We assert that such feelings, which are usually lost in quantitative statistical analyses of survey data, are in themselves important. The clinical setting is obviously one in which HCP's have to find means of managing emotion in relation to almost daily encounters with tragedy. Yet it was the way (as indicated in both the words used and detail gleaned from the field notes that accompanied the interviews) the doctors repeatedly responded to these questions of handling IPV, with sadness, often a sense of impotence and perhaps above all, outrage, that testifies to the importance of finding ways of making the case management strategies, as yet primarily articulated in legislation, work.

Maybe the positive and sympathetic response shows that many HCP's in Brazil have moved on from a narrowly, medically-focused model of health care, to at least a willingness to be part of the more broadly defined social model of health care<sup>1</sup>. These qualitative findings showed a variety of stances towards seeking to assist women who provide indications of IPV. Many doctors are aware of the fairly recent improvements in the legal support available to such women and are clearly prepared to take a proactive stance to try to guide them towards appropriate assistance including the mandatory record of violence<sup>20</sup>. Support to carry this forward is clearly already there on the part of many HCP's in Ribeirão Preto, Brazil.

Some of the interviewees are not so much ignoring the potentially protective legislations but they are not aware of the existence of a network of services and the mechanisms of referral and referral procedures. Indeed, the implementation of integral care in the public health system is a challenge even considering that integrality in health is one of the principles that the Unified Health System is based on.

Furthermore there is need to problematize the context of violent relationships, taking into account the woman and her partner<sup>21</sup>. One subject that emerged strongly in the narratives was



how difficult it is for HCP to talk about any private subject. We need to consider why those subjects are felt to be debilitatingly embarrassing?

The discussion about the construction of private life in Brazil<sup>22</sup> can certainly contribute to the debate. Social life is divided between the public and private space. Historically the domestic universe is identified with the construction of intimacy in order to preserve the bourgeois individuality. For this reason, not only health care professionals find difficult to talk about private matters.

In this study it is clear that doctors also suffer when coping with the manifestation of IPV in their patients. This findings is consistent with the results of other studies which showed that managing cases of violence prorate negative feelings such as impotence, frustration, revolt, indignation, fear, angst, sadness distress and loneliness<sup>10,15</sup>. For this reason training is a key answer to the transformation of this scenario contributing to fostering pro-active health professionals. During medical school, students are conflicted by a “cold and impersonal” knowledge of the biomedical model and their personal empathy with human suffering. When they became doctors they have to integrate their personal experience with the contradictory legacy of the medical practice, which is at the same time romantic and rationalist<sup>23</sup>. So, when it was mentioned by doctors that they feel afraid or threatened when facing IPV cases, this can be seen as arising out of the dilemmas and contradictions inherent to this aspect of the medical profession. Therefore training can facilitate a more proactive response to this form of violence instead of silence.

By the way, one study pointed out that 23 a 32% of HCPs have never inquired about IPV<sup>9</sup>. This shows that part of health professional it is unnecessary to investigate IPV. Major barriers alleged are: fear of offending the patient, lack of time and training. Moreover there is the fact that being raised in the same cultural tradition of the patients make them to accept the attitudes which supports violence against women<sup>10,11</sup>. Health care professional are not prepared in dealing with women seeking health service due to ignorance about how to proceed against these cases<sup>12</sup>. So, there is a perverse combination of low interest with ignorance causing the problem to be neglected. Women often do not report violence because they are not questioned<sup>13</sup>. In addition to the lack of training and information about their responsibilities, the reduced time for consultations and the lack of privacy in health service also hinder the involvement with the issue IPV<sup>14</sup>.

Unknowing the real dimension of IPV is consistent with lack of interest and undervalue of the subject in the health area<sup>13,16</sup>. Many HCP end up keeping a certain distance to avoid frustrations facing a problem for which they do not feel prepared to deal<sup>10</sup>. Some cases are recognized as violence, but not as a subject of intervention in health<sup>15</sup>.

How does this compact of silence between doctors and patients operate? What maintain this apparent invisibility of IPV within health care settings?

Perhaps the answer can be found in how medicine sees gender issues considering that gender differences are the main explanation for the phenomenon of IPV. Although gender bias has been detected in various areas of clinical and academic medicine, resistance and difficulties has also been found<sup>24</sup>. The WHO's definition of health is that it is a biological, psychosocial and social phenomenon, but traditionally medicine as area of knowledge and field of research does not deal with such a broad concept of health but rather with a narrower focus upon disease. It is also a hierarchical discipline in which “true medicine”, as clinical and basic sciences, is defined by the biomedicine model. Because disease explanations are predominantly limited to the biological body, the concept of gender is marginalized. In addition, there are social and cultural contexts in which violence against women is considered natural and accepted and women feel powerless and thus unable to reveal the violence, in turn collaborating to the phenomenon's apparent invisibility<sup>25</sup>.

Although it was not our focus in this paper we should note that the quantitative findings were more useful in, not only showing the prevalence of patterns of knowledge and attitudes to IPV, but more specifically in pin-pointing the level of particular misunderstandings and lack of knowledge (for instance of specific referral procedures) that can be directly addressed in health service training and education<sup>13</sup>. However in policy terms the ways in which the qualitative findings highlight the complexities of addressing IPV through the health care setting, are probably more useful than survey findings in contributing to the refinement of the existing (and admittedly recently formulated) case management strategies including training. Therefore these findings provide more accurate and specific guideline for designing trainings and capacity building of health professionals on violence against women. This must be an important step to be taken even knowing beforehand that only training will be not sufficient to improve the management of cases of vi-

olence. Studies<sup>4,15,16,26</sup> have shown that identifying and overcoming barriers of health system is crucial to improve care for violence victims.

## Collaborations

EM Vieira, NJ Ford, FG De Ferrante, AM Almeida, D Daltoso and MA Santos participated equally in all stages of preparation of the article.

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