Esc Anna Nery (print)2013 Sep-Dec; 17 (4):683 - 689

THE MEANING OF PROFESSIONAL TRAINING FOR THE CARE OF WOMEN VICTIMS OF DOMESTIC VIOLENCE

Significado da capacitação profissional para o cuidado da mulher vítima de violência conjugal

Significado de la formación profesional para el cuidado de la mujer en la violencia conyugal

Nadirlene Pereira Gomes[1], Alacoque Lorenzini Erdmann[2], Luiz Antonio Bettinelli[3], Giovana Dorneles Callegaro Higashi[4], Jordana Brock Carneiro[5], Normélia Maria Freire Diniz[6]

Submitted on 12/15/2012, resubmited on 03/22/2013 and accepted on 06/08/2013

ABSTRACT

This study seeks to understand the meanings attributed, by professionals working in the program Family Health Strategy, to on-the-job training in the health care for women in situations of domestic violence. **Methods:** A qualitative study based on the Grounded Theory. The project was approved by the Research Ethics Committee in 14/05/201. We interviewed 52 professionals working in the program Family Health Strategy (FHS), including technicians, nurses, physicians and unit coordinators, between May and August 2012. The analysis was based in the codifications: open, axial and selective. **Results:** The difficulty in recognizing the injury caused to women and the referrals to the reference and counter-reference systems are the main challenges to confront the problem. The professionals proposed empowerment as a strategy to ensure the health care. **Conclusion:** The study provides insights for managing the women's health care, especially in the context of Primary Health Care.

Keywords: Violence against women; Professional training; Comprehensive health care.

RESUMO

Objetivou-se compreender os significados atribuídos por profissionais que atuam na estratégia de saúde da família sobre a capacitação profissional para o cuidado à mulher em situação de violência conjugal. **Métodos:** Estudo qualitativo baseado na Teoria Fundamentada nos Dados. O projeto foi aprovado pelo Comitê de Ética em Pesquisa em 14/05/201. Foram entrevistados 52 profissionais que atuam na Estratégia Saúde da Família, entre eles, técnicos, enfermeiros, médicos e coordenadores da unidade, no período de maio e agosto de 2012. A análise respaldou-se na codificação aberta, axial e seletiva. **Resultados:** A dificuldade de reconhecer o agravo à mulher e os encaminhamentos ao sistema de referência e contrarreferência constituem os principais desafios para o enfrentamento da problemática. Os profissionais propõem a capacitação enquanto estratégica para garantia do cuidado. **Conclusão:** O estudo oferece subsídios para a gestão do cuidado à mulher, sobretudo no âmbito da Atenção Primária à Saúde.

Palavras-chave: Violência contra a mulher; Capacitação profissional; Assistência integral à saúde.

RESUMEN

Objetivo: Se objetivó comprender los significados atribuidos por los profesionales que actúan en la estrategia de salud de la familia sobre la capacitación profesional para el cuidado de la mujer en situación de violencia conyugal. **Métodos:** Estudio cualitativo basado en la teoría fundamentada. El proyecto fue aprobado por el Comité de Ética en Investigación, en 14/05/2012. Fueron entrevistados 52 profesionales que actúan en la Estrategia Salud de la Familia - técnicos, enfermeros, médicos y coordinadores de la unidad -, en el período de mayo hasta agosto de 2012. El análisis fue por codificación abierta, axial y selectiva. **Resultados:** La dificultad de reconocer el daño a las mujeres y los caminos al sistema de referencia y contra referencia constituyen grandes desafíos para enfrentar el problema. Profesionales proponen la capacitación como estrategia para garantizar la atención. **Conclusión:** El estudio proporciona información para la gestión de la atención de las mujeres, especialmente en el contexto de la Atención Primaria a la Salud.

Palavras-clave: Violencia contra la Mujer; Capacitación Profesional; Atención Integral de Salud.

[1] Universidade Federal da Bahia. Salvador - BA, Brazil.
[2] Universidade Federal de Santa Catarina. Florianópolis - SC. Brazil.
[3] Universidade de Passo Fundo. Passo Fundo-RS, Brazil.
[4] Universidade Federal de Santa Catarina. Florianópolis - SC. Brazil.
[5] Universidade Federal da Bahia. Salvador - BA, Brazil.
[6] Universidade Federal da Bahia. Salvador - BA, Brazil.

Corresponding author: Giovana Dorneles Callegaro Higashi E-mail: gio.enfermagem@gmail.com

DOI: 10.5935/1414-8145.20130012

INTRODUCTION

Domestic violence constitutes a public health problem because of its magnitude and impact on the quality of life and on the economic sector of the country. In Brazil, in the last decade, 43,500 women were murdered, being the passionate crime one of leading causes[1]. This scenario burdens the health care sector which can be perceived by the costs of medical care and the financing of curative treatments and rehabilitation of the victims, which in turn has an impact on the economic productivity, being associated with the absenteeism[2].

The manifestation of diseases in the digestive and circulatory systems, muscular pain and tension, menstrual disorders, posttraumatic stress disorder (PTSD), physical injuries, besides crimes such as murder (victim and/or offender) are some of the repercussions that marital violence can generate[3]. Specifically, in the field of reproductive health, the experience of marital violence is associated with sexually transmitted diseases, miscarriage, unwanted pregnancy, mental health disorders (such as alcohol and drugs) and even suicide attempts[2].

Despite the impact of significant violence on women's health, many professionals fail to recognize this situation associated with the health problems presented. A survey of health professionals reveals that they are not prepared to interact actively and establish a bond with the patient, thus, generally, the symptoms are treated and ignored the person's life history[4]. Reviewing the care provided to women victims of suspected violence, is clear that professional (working in primary health care), have difficulty in assuming an attitude of listening during the care service. If the professional does not consider the experience of women, the relationship becomes fragile; by focusing in caring the professional treats the complaints of symptoms[5]. This undermines an appropriate assistance to women.

A research study shows that professional nursing, due to the proximity with the woman, have the responsibility of sharing the case with the multidisciplinary team, as well as guiding the woman to find solutions in the support network against violence, which covers diverse sectors, such as public safety and social and legal assistance[6]. Hence the importance in encouraging this practice and attempting to create strategies that enable women's empowerment. To help this process, there have been significant changes in Brazilian laws; through them arrived the women's police stations, the shelter homes and the multidisciplinary care centers focusing on care of physical and sexual assaults perpetrated by current or former partners[7].

A study conducted in two hospitals in the city of Sao Paulo showed that professionals consider their training to be inefficient to treat and deal with cases of violence against women; they receive little or no training to break the cycle of violence in which those women are placed, thus, each professional has to develop strategies to deal with the problem[8]. These actions are essential to ensure the completeness of the care.

It is worth mentioning that the Ministry of Health has strategies and policies for the adequate training and qualification of workers to deal with the real needs of health care, as recommended by the National Permanent Education Policy in Health[9]. However, considering the complexity and magnitude of marital violence, we asked ourselves: What are the meanings attributed by professionals, working in the FHS during on-the-job training, to the care for women in situations of marital violence?

The following issue was derived from the question of this study: What are the meanings of actions and interactions, experienced by professionals, of the practices of the nursing care and of the health of women, in situations of marital violence, within the FHS? Thus, the objective was to understand the meanings assigned, by professionals working in the FHS on-the-job training, to the care for women in situations of marital violence.

MATERIALS AND METHODS

The methodological framework of this study was the Grounded Theory, also known as the Theory Based on Data (TBD). This method substantiates concepts based on data, involving a number of participants included in processes of relations and interactions mutually implicated in empirical scenarios. Also, the method allows exploring the diversity, plurality and singularity of human experience, thereby enabling the understanding of the phenomenon experienced[10].

The study was conducted in a municipality in the state of Santa Catarina, in Brazil. The scenario consisted of 16 healthcare teams of five local health units that integrated the health district system. The study location was elected because its heterogeneous socioeconomic contexts, thus, allowing a better understanding of professional practice for the care for women in situations of marital violence.

Data was collected between May and August 2012, using the technique of open interview. The selection of participants was intentional, based on the purpose of the study and had the following inclusion criteria: work in FHS and accept to participate in the study. The theoretical sampling suggested the addition of new participants for the study. The interviews were accepted by the participants after explaining the study purpose, followed by the signing of the Informed Consent. The first group was composed of 17 nursing technicians, 13 nurses and 12 physicians, totaling 42 participants, working in 16 teams within the health district. As recommended by the GT, the collection

and analysis of the interviews occurred concomitantly and were oriented to adjust the instrument of data collection. Once data saturation was achieved (codes and initial categories of analysis) it was defined the hypotheses that guided the second sample group to uncover the meanings assigned, by five healthcare coordinators, to the study's objective. The interviews were conducted in the health units, in a room provided by the coordinator, which ensured the privacy of the informant and the confidentiality of the information given.

The process of data analysis included the following steps: open coding, axial coding, and finally, selective coding, which allowed the reunification and refining of categories and subcategories to define the central phenomenon. With the purpose to collect and arrange systematically the data, during the axial coding step, it was used the organizational scheme called paradigm or paradigmatic model. Thus, the model establishes the interrelationship among the categories and subcategories from the following components: the phenomenon, the context, the causal and intervening conditions, the strategies and the consequences[11]. A substantive theory was named: "Recognizing marital violence as a public health problem and the need of managing the woman health care." The validation of the theoretical model was conducted with health professionals who worked in the units where the interview occurred and with ten researchers with expertise in the Grounded Theory.

The research, linked to the post-doctorate and financed by the FAPESB, was approved by the Ethics in Human Research Committee, under the decision No. 21560/12 adopted on May 14, 2012. Ethical aspects were respected at all stages of the research, as decided by the Resolution 196/96 of the National Health Council. The statements made the participants were identified with the initial capital letter of the professional category, or with the letter C in the case of coordinators, followed by an Arabic numeral. The data were processed with the support of the software NVivo 8.0®.

RESULTS

The categories here presented are related to the professional training, related to the FHS, for the care for women in situations of marital violence. These categories emerged from the relationships and interactions among concepts and went through the paradigmatic model, expressing the components: context (revealing that professionals are not trained to care for women in situations of marital violence), strategies (offering professional training for the care for women in situations of marital violence) and consequences (envisioning the possibility of being able to care for women in situations of marital violence).

Revealing that professionals are not trained to offer a comprehensive care for women in situations of marital violence

The context element is defined as a specific set of facts or circumstances which allows thinking and defining strategies for action/interaction. In this sense, the context within the FHS emerged from the following subcategories:

Recognizing the lack of professional training for the care for women in situations of violence

The research points to the lack of preparation of the professionals, working in the FHS, to identify marital violence as an injury to women's health and to provide care for her, as expressed by the following statements:

> *[...] if I do not investigate a situation of violence, she often will not talk. Also, it is not useful investigating and then do nothing, because of not knowing how to work with such situations. (E-1)*

> *[...] the fear that the professional has is that if he were to investigate, he will have to know how to deal with it. [...] then I will not even ask what happened. (C-4)*

Admitting that the professional was not trained to care for women in situations of violence

The study indicates that the professionals were not trained to deal with the issue of marital violence; they have to learn on-the-job training space, especially when faced with situations of that kind.

> *I had to look for courses, training, seek colleagues who had the experience. Every training I had, I had to find it by myself, because I realized the existence of a demand, I had to attend the demand, because if I didn't do it, I was not even slightly prepared to care. [...] the medical training, at the university, does not prepare for those cases. (M-7)*

> *I do understand the apprehension of them: how to proceed? How to make a referral? Indeed, it is difficult [...] I began to practice - you began to learn after being frightened. (C-4)*

Not receiving professional training, either during the studies or at work, often leads to care in a "personal" way, distancing yourself from a qualified and singular

assistance with regard to specificities and needs of each victim of aggression, as can be perceived in the following statements:

> *I think it's very important to know how to approach the woman - because we do what we think. [...] It becomes very personal. (TE-2)*

> *We, in that moment, just accept the way we imagine to be better. (M-10)*

> *[...]How to protect this woman and give support to her, we do not know. Sometimes, I feel that I am not prepared in that matter. [...] because it becomes a little subjective. (E-1)*

Proposing professional training for the care for women in situations of marital violence

The strategies are understood as interactions or actions taken or to be implemented in order to modify the previously presented context (Charmaz, 2009). This category is illustrated by the following strategies proposed by interviewees:

Pointing out issues to be elaborated

Understanding the need to prepare for the care for women. The respondents mentioned related matters, that could be provided during training or through on-the-job training; these topics could offer greater support and information for the recognition of injuries and treatment of women, as stated in the following declarations:

> *[...] address mainly to domestic violence. Not only against women but also against children [...] it is a very broad and complex matter. (TE-12)*

> *It should have training with a little bit of law and a little bit of practice: how it works, what has to be done, how it should be the approached, the flow. (E-13)*

> *[...] that could explain how it works, in practice, this flow. (M-2)*

Another aspect pointed out by the participants of the study refers to the need of addressing to: How to notify the violence? How is given the support to the family? and How is given the social and psychological support?, as it can be verified in the following statements:

> *[...] that addresses to support of the family, social and psychological. (C-2)*

> *[...] guidance on how it works, how it is made that notification, if our name will appear. To know clearly this computerized system. (M-10)*

> *[...] it could be offered to us cases to discuss and tips on how to deal with situations: physical, psychological, insults. (E-1)*

Promoting training for the multidisciplinary team

Respondents believe that all workers attending in the FHS need to be better prepared to attend women, as illustrated by the statements:

> *I think it is necessary to sensitize all professionals, the basic team with Community Health Agent (CHA) and the Support Center of Family Health (SCFH), training deeper into some of them. (C-3)*

> *Training for everyone. [...] in the morning we attend 10, 20 people. During the admission, the technicians always attend. [...] I would like to learn. Learning never hurts, especially when it's to help others. Many come and tell, but others... we can identify them with experience. (TE-14)*

Defending team meetings as a space for professional training

To the respondents, the training process should preferably occur during team meetings. The following statements show this assertion:

> *The best way that exists today, here in the clinic, is to train by means of spaces that are already offered. [...] here we have team meetings [...] and it is a form of training. (E-5)*

> *Has to be more dynamic and has to be in an appropriated meeting time - there must be a reserve of time for the professional. [...]It became humanly impossible for me; in addition, create another space to do training, lectures and orientation. So, we end up using the planning agenda. So, I think these meetings have to be employed for this. (C5)*

Glimpsing the possibility of being able to care for women in situations of marital violence

This category within the paradigmatic model emerges from the element result, which expresses the outcome or expectations of the strategies of action/interaction already

defined. Within this perspective, the respondents indicated the training strategy as the one that promotes the possibility of identifying and care for women that experienced marital violence, as illustrated by the following statements:

> *As in any subject, if we are prepared, we could probably ask more about it. I might change my view of the patient or the attention, and the approach could be oriented more in that direction. (M-8)*

> *If I'm better prepared, I can direct the situation in a more resolute way. [...] So, we must have a preparation to manage the issue with the women and we must know how to treat it more safely. (E-1)*

DISCUSSION

The study shows that the health professionals working in the FHS feel unprepared to identify women in situations of marital violence and how to attend them. Although these findings reflect the meaning assigned by a group of professionals acting in a specific area, with their peculiarities and specificities, the surveys conducted at the national level showed that not knowing how to recognize health issues and referrals given to women is the main challenge to face the problem.

A study with 51 nurses pointed out that the health professionals have the most trouble investigating and referring cases when there is evidence of violence than when the violence against women is confirmed. These data demonstrate the difficulty that nurses have while working with issues of gender violence and when addressing to them. The study identified also the lack of preparation in the management of cases suspected of violence against women: 82.4% of participants spoke about the importance of using the management protocol (Ministry of Health) in situations of suspected cases of violence against women; however this protocol was intended to care for victims of sexual violence[6].

In another study conducted in the municipality of Minas Gerais, 10 health professionals working at the FHS heard the report of two cases of sexual violence suffered by patients who sought treatment at that unit; when asked about the measures to be taken, one of the interviewees said he often realized that women have something else to say besides the complaint that led them to the FHS; However, he said that having no training for listening, made him becoming indifferent and speechless when a woman verbalized sexual violence[12]. This unpreparedness compromises a comprehensive care of the women's health.

The Ministry of Health, through the Women's Health Program, noticed that the majority of health services do not have professionals trained to prevent, diagnose and properly treat situations of violence against women[13]. The respondents attributed this difficulty to the fact of not being included (or little) the topic of domestic violence in the undergraduate curriculum, which compromises the professional care for women, primarily because it makes difficult the recognition of the injuries, but also because it does not prepare them to deal with that kind of problem.

In a survey conducted, in the municipality of Ribeirao Preto with 12 professionals from different areas of health, the respondents reported that during the training, they got in touch with the theme of violence only when it related to children and adolescents, or when a sexual abuse occurred. They reported not having clarified the transverse issues of violence, including factors such as gender, race and social status. For them, the universities do not include the discussion of political and social violence. The fragile academic education to give support when facing violence against women is reflected in the inability of professionals working in the public health system when dealing with that kind of cases[4].

Due to the lack of training, respondents revealed a health attendance guided in learning during the daily work, often regarded as "personal." In one study conducted in 2007, one of the respondents reported having sought guidance for the management of suspected situations of gender violence with more experienced professionals; also, he reported feeling difficulty in identifying cases of reported violence and not knowing how to approach the alleged victim. The same group recognized that the individual action of professionals, without the proper preparation, is limited because they feel frightened and insecure to intervene in a husband-wife relationship[12].

It has been noticed that many times, the professionals have a tendency to solve the case within an individual perspective, without articulating the case with other support networks. This attitude of health professionals experiencing violence against women can be understood as a conniving attitude; thus allowing the continuity of these violent acts, and compromising the comprehensive health care. The professionals who provide services to women victims of violence need an institutional platform that could enable the offering of a welcoming environment that facilitates the formation of bonds of trust[4]. Considering the above, it is necessary the development of specific policies aimed at orienting practices to be used by the health services.

Considering the marital violence as significant damage to the health of women and acknowledging the difficulty of the team to identify, to approach and to attend the woman, the interviewed pointed out to the need of having a continuing education opportunity on the theme. The need to empower themselves to offer care for women was identified in a study, with professionals, that found a

lack of training to provide care to the victims of violence[13]. The professionals, of this study, often reported suspected situations of violence; however, they prefer to remain silent by not knowing how to give continuity to the care in case of confirmed violence. In this sense, the study pointed out situations where the professional often comes very close to revealing the violence, but the lack of training in approaching the issue makes them to continuing the treatment as a "disease"; thus the social problems are not addressed in the prescribed therapeutics[4]. In a survey conducted in Angola, all interviewees (macro-managers, managers and technicians) working in the healthcare field identified a lack of professional training as the main difficulty to attend victims of violence[14].

As signaled by the respondents, it is necessary to create spaces for discussion on the matter; this measure will facilitate the understanding of the complexity of domestic violence as a whole, thus not being limited to marital violence but addressing also to its many forms of expression. The proposition here presented is to consider: the approach to women and family placed in that context; the conduct of professionals when reporting suspected and confirmed cases; the psychological and social support; and, the legal instruments and flows.

The understanding about the complexity of the violence is essential to the process of caring. A study of women victims of violence showed that most of them do not mention the word violence during their speeches. Thus, when women have complaints against their intimate partners, they utilize words that portray the aggressive character of the relations, referring to their partners as being ignorant individuals who disturbs her daily work. This situation express that women have difficulty talking openly about the violence experienced at home or even not realizing that they are suffering violence. Therefore, the natural way of portraying to have received jostlers, slaps, jolts, even believing being worthy of such "punishment", is based on the feminine vision of subordination and subservience[8,15]. When trying to understand the experience of violence within the family, the health professionals could act more effectively to solve the problem[12].

One obstacle to achieve the training is the release of professionals from de service. A study conducted in 2011, with several health professionals, showed the workers dissatisfaction when confronted with excessive demands on health care[16,17]. However, the respondents point out to the use of meeting spaces as an alternative to proceed with the continuing education, by means of lectures, trainings or discussions. This in turn is configured as the unit management strategy to meet their demands and needs and should include all the professionals of the team. To strengthen and guide these training activities the SCFH supports teams of Family Health and proposes an agenda with varied themes to be addressed during the meetings of health professionals. The proposed themes refer to: reflections on sexuality; knowledge of their own body; vulnerabilities of sexuality (STDs); perspectives that rebuild the sense of accountability on the health of women; new paradigms of man and woman in society; and ways of interacting with women victims of violence[14].

According to the National Policy on Continuing Education in Health, the various actions of professional training - if conducted in coordination with the strategy of institutional change - may represent the continuing education of the health personnel, that is to say a teaching concept in the health sector to create organic links between education and services and strengthen the links between the education and the managerial sector and the institutional development[9].

CONSIDERATIONS

The study points to the little preparation of professionals working in the FHS to deal with the theme of domestic violence; this is evidenced by the difficulty of identifying: the woman who experiences the injury, the proper reception and the subsequent measures to be taken. When care is provided, often occurs in a non-oriented way, which may further compromise the situation faced by the woman.

The professionals requested a continuing education that addresses the approach to women in situations of violence, as well as the domestic violence as a whole; it should consider the theme's complexity, the strategies for identification of injuries and discussions about laws, flows, notifications and articulations with social and psychological services. Thus, the study contributes by providing elements that could guide a proposed to acquire professional qualifications that will sensitize and prepare professionals working in the area of FHS regarding the care for women in situations of marital violence, favoring thus the comprehensive care of health.

The study is limited by the particularities of the respondents and the political context of action in the municipality, pointing out to the need for further studies that address the theme. However, the findings represent useful information for improving the management of care in the Primary Health Attention, especially in the context of local health units. Nursing stands out in this process, since it is present in the minimal team and, in most cases, occupies the positions of coordination of such units.

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