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Perceptions of professionals in an intersectorial network about the assistance of women in situation of violence

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The study aimed to know how the professionals working with the assistance of women in violent situation in an intersectorial network perceive the assistance. Thirty interviews were carried out with professionals of the health sector, social work, public security and legal system located in a mid-sized city of Sao Paulo State, Brazil. Using thematic analysis the results were classified in five categories: How women who suffer violence are perceived? Prejudices of the professionals. How the professionals perceive the assistance they provide? Emotions and feelings of the professional during the assistance. Barriers and progress related to the assistance. There are fragmented and stereotyped perceptions and the need to improve the existing structures, to prepare and to care of the professionals in order to humanize the assistance. To create special services and to invest in prevention is fundamental since there is a huge distance between the public policy proposals and the reality.

Keywords: Violence against women. Policies for tackling violence. Work process. Humanization of assistance.

Introduction

Although gender violence is an ancient phenomenon, it has only recently started to be tackled through appropriate conceptualization and methodology and through development of specific public policies. At the end of the 1990s, the World Health Organization (WHO) accepted in several documents that violence against women is a serious public health problem because of its high prevalence and damaging consequences for health. Since then, a variety of studies have been developed in Brazil and elsewhere, and a significant increase in knowledge on this topic has been generated. Among these studies, there have been investigations on the prevalence of the phenomenon of violence against women in different countries and in different regions of Brazil; the consequences of this violence and the factors associated with its occurrence; and the provision of care for women in situations of violence, which is the topic that the present study addresses.

The understanding that this phenomenon is not natural and not a private matter requires effort from public policy formulators to prepare services for dealing with violence as harm of social nature that produces a variety of consequences. With the aim of combating it, several measures have been taken over recent years[1,2].
In 1995, Brazil ratified the Convention of Belém, which recognizes and gives visibility to the rights of girls and women to live without violence.

The convention defines violence against women as "[...] any gender-based action or conduct that causes death, harm or physical, sexual or psychological distress to women, either in the public or in the private sphere", and establishes that all women have the right to live free from violence[3] (p.2).

To comply with this convention, law no. 11.340 (the "Maria da Penha" law) was enacted in 2006. This typifies domestic violence as a form of violation of human rights, sets forth penalties of greater severity for aggressors and provides greater judicial and police protection for women who are victims of violence[4].

Although this law was only enacted in 2006, other measures had been taken earlier on. In 2003, the Ministry of Health in partnership with various sectors of society

drew up the national policy for comprehensive women's healthcare (PNAISM), which was published in 2004. Among its priorities, one of its objectives was to incorporate promotion of care for women in situations of violence through organizing integrated protection networks, establishing harm prevention actions and promoting female empowerment[5].

In the same year (2003), the Department of Women's Policies (SPM) was created with the task of promoting equality between men and women by combating all forms of prejudice and discrimination. Tackling violence against women is one of the three lines of action of the SPM. Since its creation, it has issued a variety of publications that discuss, seek agreement and provide guidance on this topic, always from the perspective of gender inequalities and the assurance of comprehensive humanized care for women in situations of violence[6].

One of the SPM's publications, the National Pact for Tackling Violence against Women, links services together in intersectoral networks as a priority strategy for dealing with the problem of violence[7]. This proposal has been shown to be both relevant and challenging.

Thus, there are many treatises and documents outlining measures for combating violence against women in this country. Putting them into effect depends on work undertaken by various players within the spheres of government and society, and on incorporation of specific knowledge and new technologies both within healthcare and in other governmental and non-governmental sectors. Nonetheless, despite these advances and efforts, the care provided for women in situations of violence is still reported to be precarious and unsatisfactory[8,9].

A large proportion of the studies on intersectoral networks and violence against women have sought to ascertain what practices have been developed by these services and understand how they interlink. They have focused on the quality of the assistance, the capacity of these services to respond to women's demands and the possibilities for linkage that exist. Studies have evaluated whether the professionals involved might be lacking in preparation for working both within the theme of violence and from an intersectoral perspective. Such unpreparedness would lead to persistence of the

history of prejudicial and discriminatory practices, particularly in the judicial and public security sectors, which reinforce traditional gender stereotypes and make it difficult to provide effective care[10,11]. Meneghel et al.[12] stated that since most services do not work within a gender-based perspective, they end up reiterating non-emancipatory, prescriptive and standardized practices that reinforce maintenance of abusive relationships. In many services, the only focus is on listening to the complaint, thus generating so-called invisibility of violence. This inhibits both full reception and effective and responsible referral, which shows that there is a mismatch between women's demands and the care provision available[10-16]. The fragmentation of effort and unpreparedness of those involved in production of care is emphasized by discontinuities within public policies, according Schraiber et al.[9]. Many referrals within sectors and to specialized services take place, and these represent flight from general services' obligation to become prepared to attend to situations of violence. This is reinforced by uncommunicative managerial practices that do not encourage autonomy among the organization's professionals[9].

We developed this study with the objective of ascertaining the perceptions among professionals in a municipal intersectoral network who are involved in assisting women in situations of violence, regarding the assistance that they provide. We believe that the information analyzed here may contribute towards improving the assistance for women in situations of violence.

This article presents the responses of professionals within the healthcare, social work, judicial and public security sectors to the following questions: *How are women who suffer violence perceived?* and *How do the professionals perceive the assistance that they provide?* The analysis includes data on these professionals' prejudices, emotions and feelings and on the barriers and progress relating to this assistance.

Method

This study was developed in a medium-sized city in the state of São Paulo and in order to conduct it, all the services in different sectors that provide assistance to women in situations of violence, along with their professionals, were mapped out. For

each sector, professionals were selected according to their different functions, with the aim of achieving greater diversity. The saturation criterion was used to determine the end of data-gathering. Thirty interviews were conducted with professionals and service managers: eight interviews in healthcare sectors; eight within social work; ten within the judicial sector; and four within public security. The interviews with healthcare professionals included doctors, mental health service psychologists and social workers at district primary healthcare units. Psychologists and social workers at a specialist service for attending to situations of violence were also interviewed. The interviews with professionals in the social work sector were with lawyers, social workers and psychologists at a specialist service dealing with violation of rights and a service for interlinking public policies and providing assistance for women. The interviews in the judicial sector were with judges, defense lawyers, public prosecutors and psychologists, and those in the public security sector were with police chiefs, records officers, police investigators and military police officers. The interviews were conducted at the participants' workplaces between July 2013 and July 2014. The interviewees had previously given their agreement to participate through signing a free and informed consent statement, in accordance with Resolution 466 of the National Health Council[17]. There were no refusals to participate over the course of this study.

The data were fully transcribed and the thematic analysis was conducted using the following categories: 1) 'How are women who suffer violence perceived?'; 2) 'Prejudice among professionals'; 3) 'How do professionals perceive the assistance that they provide?'; 4) 'Professionals' emotions and feelings while providing assistance'; and 5) 'Barriers and progress relating to assistance'. Categories 1 and 3 were used as classifications in the four sectors studied, while the other three categories provided discussion of perceptions in a more general manner. Categories 3 and 5 were defined a priori, while the others were categories that emerged.

Results and discussion

How are women who suffer violence perceived?

Healthcare

The perceptions among the professionals in the healthcare sector regarding women who suffer violence included the following descriptions: they are people who have become weakened and impaired; they live at the mercy of their companion; they have a neurotic personality and depression; they have a high level of vulnerability and risk; they suffer from anguish and distress; and they cry a lot and are unstable. Studies have shown that violence affects the health and wellbeing of those involved. This leads women in situations of violence to be frequent users of healthcare services[2].

Social work

The professionals in the social work sector described women in situations of violence as people who arrive at the services in a state of great vulnerability and emotional fragility, with much fear and difficulty in establishing connections and relationships of trust. The interviewees believed that this fear was consequent to the impunity of the perpetrators of the violence, which would lead to a feeling of unprotectedness among the women. They stated that these women's vulnerability was also economic and that many of these women perpetrate violence against their own children.

Judicial sector

There were different perceptions regarding the women who seek assistance from the judicial sector, among the professionals of this sector. According to some of them, there are women who experience chronic situations of violence and only seriously seek help from the judicial sector when their children are threatened. On the other hand, some of the professionals stated that there are women who only want a divorce and do not sue their companion for violence, because they believe that this action could harm their children.

Public security

According to the public security professionals, most of the women who seek assistance from the services are married, have children, depend financially on their companion and belong to classes C, D or E. These perceptions correspond to the findings from a survey on factors associated with violence that was conducted among women living in the same municipality as in the present study, who were users of the public healthcare system (SUS). The study found that there was greater prevalence of violence among women who were married or in stable partnerships (66.5%), with companions who were the head of the family (58.2%) and who were in classes C, D or E (69.1%)[18].

Furthermore, they stated that many women were poorly informed about how police stations work and what the function of an Incident Report is. In a study conducted in another municipality, the professionals also agreed that women did not know about the services provided by the public security sector, especially those provided by Women's Protection Police Stations, along with the procedures for formalizing complaints[19].

Prejudice among professionals

Some of the professionals correlated violence and poverty, and this perception had previously been encountered in a similar study[19]. However, according to other studies, whereas gender-based violence in undeveloped countries is associated with poverty, women in emerging countries who ascend socially and economically are more exposed to violence because they have violated gender norms. Thus, women with greater social and economic autonomy are more exposed to violence in some countries and in some regions of Brazil[8,18,20].

The interviewees also reported that there was a relationship between violence and use of alcohol and other drugs. This association has been discussed in several studies and these have affirmed that violence may be associated with alcohol and drug use by one or both partners, and not just by the man[8,18,20]. In the case of women, substance use may often be the consequence of violence and not its cause[18]. However, unlike men, whose aggressive behavior is explained by their substance use, women

who use alcohol and other drugs are held responsible for the violence that they experience.

The discourse of some professionals within the judicial sector contains generalization of cases such as those in which women are the perpetrators of violence against men, although these situations are in reality exceptional. According to the Map of Violence[21], 43.1% of the aggressors in situations of violence against women are the male partners or former partners. On the other hand, in situations of violence against men, female partners are the perpetrators in only 15% of the cases, and friends and colleagues are prominent as the source of conflicts (27.1%). There are also other ideas, such as the perception that the judicial sector is used for their own benefit, through lies, motivated by vengeance. According to the interviewees, this was a matter of concern for them because such actions have extremely serious consequences, both for the people who face the accusations and for the women themselves, who may face legal action for making false accusations.

In the public security sector, some of the professionals held these women responsible for poor functioning of the service. They stated that since many women who seek the service do not really know whether they will take legal action against the aggressor, they end up overloaded because they are unable to take care of the cases that require effective assistance. There seemed to be something strange in their attitude, i.e. a lack of recognition that the women who seek the service are the ones for whom the service should be providing assistance. This discourse promotes laying the blame on the woman, and this was also found in another study that affirmed that unsatisfactory assistance at women's police stations and institutional violence are not the reality only of third-world countries[22]. According to Hague et al.[23], there are reports of insufficient listening, disbelief and poor protection even in services in countries such as the United Kingdom. Nonetheless, the police are still one of the resources most used by women who seek help[23].

How do professionals perceive the assistance that they provide?

Healthcare

In services that specialize in dealing with situations of violence, most of the assistance provided is for children and adolescents, with priority given to cases of greater vulnerability and impairment. Because of the severity of some situations, it is sometimes necessary to provide shelter for the victims or make a social placement in order to move the victims away from the perpetrators of the violence.

In relation to the visibility of such cases, the professionals who work in non-specialized services report that there are few complaints: patients do not speak clearly about the problems and there is difficulty in revealing them. They state that situations of violence are subtle and that only the cases of greater severity appear, and mainly when there are body injuries.

Surveys conducted among female users of healthcare services have shown that the prevalence of occurrences of physical violence once during their lifetime is 34.5 to 40.3%[18,24]. These numbers are larger than those found in a study on the general population in São Paulo, which showed that the prevalence of occurrences of physical violence once during the respondents' lifetime was 27.2%[20], which confirms why these women are present at healthcare services. Consequently, studies in Brazil and elsewhere on public policies for tackling violence have affirmed that recognizing it is a prerequisite for providing adequate care. Therefore, care professionals need to be prepared to ask about violence when they identify physical and emotional symptoms that might be associated with it[2,25-27]. However, it was stated in these studies that women speak about this topic more readily than professionals ask about it, which means that many cases are discovered by chance, during assessments on depressive conditions and situations of repeated use of services[26].

Among professionals working in specialized services, different reasons for this invisibility are put forward. According to some of them, it results from the professionals' lack of preparedness, in that because they do not know what to do with the cases, they do not investigate them. According to others, the cause is insensitivity and low commitment among them, such that they end up "pretending that they do not see the violence". According to some authors, biomedical reasoning, which continues

to dominate within healthcare practices and work, has been shown to be an obstacle to addressing social issues like violence[8,27].

Some interviewees state that some professionals may also be in denial regarding violence if they themselves have suffered or are suffering violence within their personal lives, which makes it difficult for them to care for other people. A study on the prevalence of violence among nurses found higher rates than in the general population[28].

Social work

Because professionals working in specialized services tackling violation of rights deal with many situations of violence against children and adolescents, they affirm that in these cases there is also a high chance that there will also be violence against their mother.

There are also women who come to these services with complaints and demands other than those relating to violence, such as requests for passes and basic grocery packages.

On the other hand, exceptionally, active searches for women in situations of violence are conducted by some specific services for women. For these to be developed, partnerships with the public security sector have been formed. Contact information for women who the police have assisted is passed across to the social services every month. These women are then contacted and informed by telephone about the existence of social services and how they function, and are given guidance regarding their rights. The situations that are given priority attention are those of intimate partner violence: many of these women need to request protective measures or shelter for their own safety.

The interviewees in this sector had a particular view of violence in which it was taken to be a single concept without any differences in its nature or determinants. This led them to have similar perceptions of violence affecting children, women and elderly people and even in relation to urban violence.

The professionals interviewed took the view that their main aim in interventions was the family, which is a perception coherent with the nature of social work. For this reason, in cases of violence against women, the concept of domestic and within-family violence is used, in which it is not possible to define who is the victim and who is the perpetrator of the violence[29].

Nonetheless, the professionals within this sector had a broad view of women's need for comprehensive assistance from difference services and sectors, and of the importance of intersectoral action and linkage into networks. Thus, they made responsible referrals and seek to monitor these women's course in seeking care.

In relation to the attendance provided by other sectors, there was praise and criticism. Within healthcare, the specialized service for tackiling violence is a reference point recognized within the sector, through the humanized and comprehensive care that it provides for the cases that it receives. However, there was much criticism for mental health services because of the difficulty in accessing vacant spaces and because very few preventive actions are available through general services. In relation to the public security and judicial sectors, despite recognition of the efforts that have been made towards improvement of services, there was criticism of the low effectiveness of the protection measures provided for women.

Judicial sector

The interviewees said that they assisted women in different situations of violence, but took the view that the cases that reached the judiciary were generally severe. They believed that because of misinformation regarding the role of the judiciary, there were women who went to their services seeking other solutions for their marital and affective problems.

To improve and assistance provided, they saw a need to create specialized courts for dealing with domestic and family-based violence against women, which is a measure that was recommended through law no. 11.340/2006[4]. In their view, in addition to speeding up the progress of cases, these institutions would give rise to

greater uniformity in caring for cases, since these would have specific specialized teams for dealing with the civil and criminal issues resulting from violence.

According to Pasinato[30], interlinking the three axes of action of the "Maria da Penha" law, i.e. criminal, protective and preventive/educational measures, depends to some extent on creation of courts, which need to be organized in order to be made effective. However, this author stated that this was not just a structural problem, given that the courts would only become important if they had professionals who were committed to the law and were available for networked dialogue[30].

The interviewees also believed that it would be important to create reeducation services for the perpetrators of violence. This is also foreseen through the "Maria da Penha" law, which is a fundamental tool for cessation of violence. There are authors who affirm that reeducation of men who perpetrate violence and construction of new forms of masculinity from gender concepts and a responsible approach are fundamental for avoiding recurrence[31].

There is concern among the professionals in this sector regarding humanization of assistance within their own sector and efforts are being made towards disseminating information on the "Maria da Penha" law and other rights for women, among professionals within other fields.

In relation to assistance provided by other sectors, the interviewees made reference to the public security and social work services, i.e. the ones with which they had more contact. They gave positive assessments to the actions of both of these sectors. They only noted that many occurrences were registered but few representations of cases by the women themselves, which generated some difficulties that were shared with the public security sector. They stated that these registrations ended up resulting in shelved cases or in cases that were dismissed through insufficient proof.

Public security

Most of the cases attended by public security professionals comprise violence against women, although there are some cases of violence against children, which

cause major mobilization of the service. Reports from the Institute of Forensic Medicine affirm that only 10% of the cases are severe and that the majority are cases of mild aggression, threats and injuries. Only one of the interviewees disagreed, stating that “among women, nothing is mild”, and that the mismatch between what comes to the service and the reports that are issued comes from the delay in attendance at the Institute of Forensic Medicine, such that when the injuries are examined, the individual is already recovering.

The interviewees stated that many women seek the service without knowing what it provides, thus resulting in unfulfilled expectations and frustration, both among the professionals and among the women: the professionals because they work on inquiries that will not result in legal proceedings and the women because they see themselves involved in legal proceedings that they did not agree with and which often expose them to more violence at home and to institutional violence.

Furthermore, some of the interviewees reported that there are some women who do not want to open legal proceedings against their husband but, rather, just want to frighten him with an Incident Report, so that he will stop being violent. These data are in line with findings from other studies that have stated that opening legal proceedings against the husband seems to be the last resource available for these women. They seem to be unaware that registering an occurrence of body injury will generate an automatic representation[19,22].

In accordance with the “Maria da Penha” law, cases that involve body injuries give rise to an unconditional public penal action, i.e. they do not depend on representation[4]. This is because the Supreme Court takes the view that women who suffer physical violence and go to a police station to make a complaint about the aggressor are already manifesting a desire that he should be punished. For this reason, there would be no need for formal representation to open legal proceedings based on the “Maria da Penha” law[31].

The interviewees regarded the assistance for women provided by their own sector and by the judicial sector as effective protective measures, but recognized that there is a need to improve the care provided. To do so, increasing the human

resources available would be fundamental. According to a document on standardization of specialized police stations for providing assistance to women, a municipality of the size of the one studied here should have four times as many services as currently exist, and should have six times as many professionals in order to attend to the existing population adequately[32].

Professionals' emotions and feelings while providing assistance

Assistance provided for cases of violence was seen as exhausting work that brings in many doubts and feelings of impotence, sadness and anxiety. Other emotions such as mistrust, frustration and dismay were also cited, as well as stress and fear. In evaluating the work of other sectors, feelings such as intolerance and neglect were cited by these professionals when they perceived that another professional did not know how to deal with such cases. Such situations have also been mentioned in other studies. These studies reiterate that no positive feelings are associated with working to deal with violence. This topic has taken on a marginal position as an intervention objective and it always ends up being sent out to different fields, in a game of passing the buck between services and sectors[8,19]. However, another study conducted among healthcare professionals also found positive feelings, such as indignation and empathy towards cases that were attended. This indicates that the possibility of providing adequate care and pro-active action would exist if the professionals were better capacitated and supported by an effective intersectoral network[33].

Barriers and progress relating to assistance

Regarding barriers that hinder assistance, lack of infrastructure and particularly of human resources was one of the problems most commonly cited by the professionals. Such references were also found in a study that affirmed that improvement of attendance for situations of violence comes through improvement of working conditions, such as larger numbers of employees and adequate structure[19].

The difficulty with infrastructure in relation to specialized police stations for defending and assisting women is a reality throughout Brazil, according to Osis et al.[25]. These authors stated that only 2.9% of these police stations in Brazil had rooms for examinations, while 17.7% had specific waiting rooms for perpetrators of violence and only 12.9% functioned 24 hours a day.

According to the professionals, presence of a single location where all the services could be provided would avoid situations in which women enter a so-called critical route. Absence of such a location was also regarded as a barrier, and this perception was also found in another similar study[12]. However, a study[34] developed in a service that provided multiple forms of assistance in a single location showed that simply sharing a space is not enough for ensuring comprehensive attendance, given that this does not have the capacity to eliminate all the situations and the reasons that hinder women's attainment of a life without violence.

The difficulty in establishing attendance flows between services in different sectors was identified in this study as a barrier. According to some documents and studies, creation of these flows is fundamental for networking. However, in addition to the absence of defined routines, they affirm that there is lack of knowledge about the topic and lack of availability of professionals involved in intersectoral networks for these flows to be constructed[22,25,35,36].

Another issue that was identified as a barrier according to some interviewees was a lack of preparedness for dealing with the topic of violence. This creates difficulty both in identifying cases and in dealing with the situations. Thus, good attendance still depends on the goodwill of professionals who have not had access to appropriate training either during their academic training or at the service where they work[25,27,32,37]. However, according to Garcia-Moreno et al.[2], isolated instances of training and dissemination of information are ineffective for promoting real changes to the capacity for assistance.

Thus, in some services, the interviewees recognized that supervision of mental health professionals would be necessary, in order to have better attendance of cases. Some studies[37,38] have indicated that although assistance for cases of violence is not

an activity exclusively performed by mental health professionals, they could contribute towards conducting such activities since they have training and resources for dealing with emotional distress and effects implicated in care relationships. This supervision should lead to discussion of the dynamics of family/marital violence, and to reflection and awareness about gender concepts and values.

The model for attending to violence, which was predominantly paternalistic, with victimization of women, was also regarded as a problem. According to the professionals, this occurred because it was poorly emancipative and did not promote reflection and possibilities for women's choice and independence. This perception has been corroborated by another study[19].

Lastly, there is the issue that few studies on preventive action have been developed. The professionals believed that if so many cases were arriving at specialized services, it was because prevention was ineffective. Moreover, if no preventive action were to be undertaken, there will never be sufficient services. Thus, the role of prevention, especially the actions developed within the education, healthcare and social work sectors, which provide basic services and are in contact with the community, is fundamental and should be prioritized[19,39].

In relation to points of progress, the professionals identified some actions that have occurred over recent years. They stated that today there is more visibility and sensitivity, along with greater humanization in the attendance provided by the services available. The perception that healthcare and public security professionals are willing to provide positive responses for situations of violence has been reinforced through several studies[25,33,39]. The "Maria da Penha" law was generally regarded by the interviewees as representing major progress for women's rights, and this perception has also been echoed in other studies[40].

Final remarks

There are similarities of perceptions regarding these women among healthcare and social work professionals, who see them as victims of violence (state of

victimization), while the professionals within the judicial and public security sectors tend to perceive them based on other stereotypes of women in society.

These stereotyped views are probably much more related to the characteristics of the demands that are made on these services and to the vocation for assistance that these services present, than to the real women who are assisted. It can be considered that there is some fragmentation of these perceptions, such that only the demand is discerned. These perceptions may be related to alienation generated by the work, which does not allow each case to be viewed individually, with reflection on these women's real needs. The issue of humanization reappears here, with the need for recognition of the other person as a subject with rights. These perceptions also become clearer when the prejudice in relation to violence and the strangeness of attitudes produced at the places where assistance is provided. According to Gomes et al.[41], these issues are related to dehumanization that is produced through alienation in the work process.

The invisibility of violence is still a challenge for professionals within non-specialized social work and healthcare services, which do not differentiate between the social determinants of different types of violence. This differentiation is fundamental for comprehending violence against women as a phenomenon relating to gender issues, and it may make it possible for prejudices not to be reproduced within the assistance provided.

It has been recognized that there is a need to humanize the assistance provided and improve the infrastructure, as well as to create some specialized services, especially those that have been envisaged through laws (specialized law court, referral centers and reeducation services for perpetrators of violence). Moreover, violence prevention programs, which are also foreseen through the "Maria da Penha" law, are urgently needed in order to be able to work on the causes of violence and not just on its consequences.

It has been perceived that professionals' knowledge about services other than their own is partial and that no flow diagram has been established and no coordinated networking exists[22,25,34]. This lack of knowledge may generate isolation and facilitate a

"critical route". In other words, women may be referred to places where they will not find answers for their demands. Integration through intersectoral work firstly requires an initial dialogue between the services so that communication can begin.

The importance of and need for preparation to deal with this topic and with the correlated unpreparedness (in both information and emotional terms) has been recognized. Nonetheless, many sectors have not adopted the practice of updating knowledge on this topic or supervision for discussion of cases.

Kiss et al.[35] noted that within healthcare, there is still a large gap between policy intentions and professional action. This affirmation can be extended to other sectors, in which we also found practices that prioritized technical-scientific rationality, with difficulty in integrating gender-based perspectives and promotion of rights in planning and implementing care logic.

Collaborators

Elisabeth Meloni Vieira conceptualized the article and analyzed and discussed the results. Mariana Hasse discussed the results and analyzed the data. Both authors participated in the final review on the article.

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