REME • Rev Min Enferm. 2021;25:e-1390
DOI: 10.5935/1415.2762.20210038

RESEARCH

VIOLENCE AGAINST WOMEN: PERCEPTIONS OF MATERNITY HEALTH PROFESSIONALS

VIOLÊNCIA CONTRA A MULHER: PERCEPÇÕES DE PROFISSIONAIS DA SAÚDE DE UMA MATERNIDADE

VIOLENCIA CONTRA LAS MUJERES: PERCEPCIONES DE LOS PROFESIONALES DE LA SALUD DE UNA MATERNIDAD

Ana Paula Chaves de Miranda[1]
Ana Maria dos Santos Rodrigues de González[1]
Everliny Fraga[1]
Erika da Silva Dittz[1]

[1]Hospital Sofia Feldman - HSF. Belo Horizonte, MG - Brazil.

Corresponding Author: Erika da Silva Dittz
E-mail: erikadittz@gmail.com

Authors' Contribuitions:
Data Collection: Ana P. C. Miranda, Ana M. S. R. Gonzáles, Everliny Fraga, Erika S. Dittz; ***Investigation:*** Ana P. C. Miranda; ***Methodology:*** Ana P. C. Miranda, Everliny Fraga, Erika S. Dittz; ***Supervision:*** Erika S. Dittz; ***Validation:*** Ana P. C. Miranda, Ana M. S. R. Gonzáles, Everliny Fraga, Erika S. Dittz; ***Writing - Original Draft Preparation:*** Ana P. C. Miranda, Ana M. S. R. Gonzáles, Everliny Fraga, Erika S. Dittz.

Funding: No funding.

Submitted on: 2020/09/22
Approved on: 2021/06/17

Editores Responsáveis:
Mariana Santos Felisbino-Mendes
Luciana Regina Ferreira da Mata

ABSTRACT

Objective: to know the perception of health professionals about the care of women in situations of violence who are assisted at *Hospital Sofia Feldman in Belo Horizonte, Minas Gerais*. **Methods:** this is a descriptive study with a qualitative approach carried out from May to June 2018. Twenty-one professionals who work in direct assistance to women in the maternity and emergency care services or who establish contact with women in situations of violence during follow-up at the institution were included in the study. Data were obtained through the focus group technique, performing a total of four focus groups, with an average duration of 50 minutes, and submitted to content analysis in the thematic modality. **Results:** in the data analysis, the following categories were identified - ways of manifestation of violence against women; how women express that they are in a situation of violence; what health professionals do with women in situations of violence; support network for women in situations of violence. The different forms of violence represent a challenge for health professionals, who feel unprepared to deal with the care needs of women living in situations of violence. **Conclusion:** there is a clear need for training, qualification, creation of protocols, and the promotion of multidisciplinary work for comprehensive health care for women in situations of violence.

Keywords: Violence Against Women; Intimate Partner Violence; Women´s Health; Comprehensive Health Care.

RESUMO

Objetivo: *conhecer a percepção dos profissionais de saúde acerca do atendimento às mulheres em situação de violência que são atendidas no Hospital Sofia Feldman em Belo Horizonte, Minas Gerais.* ***Métodos:*** *estudo descritivo de abordagem qualitativa realizado de maio a junho de 2018. Foram incluídos no estudo 21 profissionais que atuam na assistência direta à mulher na maternidade e no pronto-atendimento ou que estabelecem contato com mulheres em situação de violência durante o acompanhamento na instituição. Os dados foram obtidos por meio da técnica de grupo focal, realizando o total de quatro grupos focais, com duração média de 50 minutos e submetidos à análise de conteúdo na modalidade temática.* ***Resultados:*** *na análise dos dados foram identificadas as seguintes categorias -formas de manifestação da violência contra a mulher; como a mulher expressa que se encontra em situação de violência; o que fazem os profissionais de saúde frente à mulher em situação de violência; rede de apoio à mulher em situação de violência. As distintas formas de violência configuram um desafio para os profissionais de saúde, que se sentem despreparados para lidar com as necessidades de cuidado das mulheres que vivem em situação de violência.* ***Conclusão:*** *percebe-se a necessidade de treinamentos, capacitações, criações de protocolos e a promoção de um trabalho multiprofissional para um atendimento integral à saúde de mulheres em situação de violência.*

Palavras-chave: *Violência contra a Mulher; Violência por Parceiro Íntimo; Saúde da Mulher; Assistência Integral à Saúde.*

RESUMEN

Objetivo: *conocer la percepción de los profesionales de la salud sobre la atención a las mujeres en situación de violencia que son atendidas en el Hospital Sofia Feldman en Belo Horizonte, Minas Gerais.* ***Métodos:*** *estudio descriptivo con abordaje cualitativo realizado de mayo a junio de 2018. Fueron incluidos 21 profesionales que laboran en la atención directa a la mujer en los servicios de maternidad y atención de emergencia o que establecen contacto con mujeres en situación de violencia durante el seguimiento en la institución. Los datos se obtuvieron mediante la técnica de grupos focales, realizando un total de cuatro grupos focales, con una duración promedio de 50 minutos y sometidos a análisis de contenido en la modalidad temática.* ***Resultados:*** *en el análisis de los datos se identificaron las siguientes categorías - formas de manifestación de la violencia contra la mujer; cómo las mujeres expresan que están en situación de violencia; qué hacen los profesionales de la salud con las mujeres en situación de violencia; Red de apoyo a mujeres en situación de violencia. Las diferentes formas de violencia representan un desafío para los profesionales de la salud, quienes se sienten poco preparados para atender las necesidades de atención de las mujeres en situación de violencia.* ***Conclusión:*** *existe la necesidad de formación, capacitación, elaboración de protocolos y promoción del trabajo multidisciplinario para la atención integral de la salud de la mujer en situación de violencia*

Palabras clave: *Violencia contra la Mujer; Violencia de Pareja; Salud de la Mujer; Atención Integral de Salud.*

How to cite this article:
Miranda APC, Gonzáles AMSR, Fraga E, Dittz ES. Violence against women: perceptions of health professionals in a maternity hospital. REME - Rev Min Enferm. 2021[cited _____ ___ __];25:e-1390. Available from: _____ DOI: 10.5935/1415.2762.20210038

INTRODUCTION

Violence has deep social roots, with important economic and social repercussions. At the 49th World Health Assembly/World Health Organization (WHO), violence was declared a public health problem through a decision published in the World Report on Health and Violence.[1]

Violence is defined as the intentional use of physical force or power, real or in threat, against oneself, against another person, or against a group or community, which results or is likely to result in injury, death, psychological harm, developmental disability, or deprivation.[1]

Among the different forms of violence, there is any action or behavior based on gender and that causes death, physical, sexual or psychological harm or suffering to women, in the public or private sphere.[2]

Despite being difficult to investigate by health professionals, violence against women is mostly practiced in the domestic environment. According to the WHO, it represents an important public health problem, considering that 35% of women around the world are subject to physical and/or sexual violence by an intimate partner or sexual violence by a person without an emotional bond.[3]

In domestic violence against pregnant women, the prevalence varies between 1.2 and 66%. This large variation is due to differences in studies and cultural aspects that make it difficult to compare the results.[4]

To ensure better systematic and official statistics that present the real situation of violence against women in Brazil, the federal government created two systems to guarantee the records of these notifications: the compulsory notification system of cases of violence against women and the National System of Public Security and Criminal Justice Statistics (*Sistema Nacional de Estatísticas de Segurança Pública e Justiça Criminal* - SINESPJC), under the responsibility of the Ministries of Health and Justice.[5]

In 2006, the National Policy to Combat Violence against Women was created. This policy is in line with Law 11,340/2006 (Law Maria da Penha), international conventions and treaties ratified by Brazil, which aim to prevent and combat violence against women and to guarantee assistance and rights.[5] Actions aimed at combating violence against women require an articulation involving sectors such as health, education, social assistance, public security, culture, and justice, among others, to address the problem, and ensuring comprehensive care to those who experience such a situation.[5]

We should highlight the importance of the health team in the process of identifying women in situations of violence to favor the construction of closer bonds between the patient and the professional and possible interventions.[6] Therefore, the team needs preparation and safety to recognize the violence and to welcome the woman, through sensitive listening, identifying and understanding the complexity of the situation for her, as well as her anxieties and weaknesses.[6]

Violence against women can occur at any time in life, including during pregnancy, and can lead to maternal illness and compromise the baby's health.[7] Also, there are repercussions on health and quality of life such as unwanted pregnancy, abortion, low birth weight of the newborn, prematurity, depression, and post-traumatic stress syndrome.[8]

Pregnancy can lead women to attend the health service more frequently, favoring the identification of cases of violence by the health team[9] and requiring the qualification of the multidisciplinary team to ensure the comprehensive care of the woman, as well as of her possible injuries resulting from violence.[10] Despite the importance of health professionals in identifying and monitoring situations of violence, we observe their lack of knowledge about this situation and its different forms of manifestation, compromising the assistance to women in situations of violence.[11]

Given this circumstance, the question is: are health professionals prepared to work with women in situations of violence and their respective problems? How do professionals identify and address the situation of violence? Such questioning led to this study, to know the perception of health professionals about violence against women who attended a maternity hospital.

METHOD

This is a descriptive study with a qualitative approach, carried out in a philanthropic hospital in Belo Horizonte, Minas Gerais. The institution is specialized in maternal and child care and assists exclusively patients of the Unified Health System (*Sistema Único de Saúde* - SUS). In 2019, it attended an average of 900 births per month and has been a reference in care from the city and the interior of the state.

We included in the study the professionals who work in direct assistance to women in maternity and emergency care or who establish contact with women in situations of violence during follow-up at the institution.

We identified the participants, using a list with the names of the professionals working in the service and the work schedule. One of the researchers individually approached them and invited them to participate in the study. The service coordinators were informed about the study, with no impediment. We identified 31 professionals who met the inclusion criteria but 10 did not participate due to the following reasons: the difficulty of leaving the shift due to the number of consultations on the day of the focus group (6); difficulties with coverage of the scale (3); difficulties in releasing coordinators (1).

We used the focus group technique to obtain data, which is considered appropriate when seeking to acquire or complement knowledge about a particular theme characteristic of a group.[12]

Data collection was carried out from May to June 2018. On May 4th, 2018, a pilot focus group was carried out to verify the adequacy of the group's planning and guiding questions to the research objectives. Five professionals participated, with no need for changes to be identified. Thus, the data collected at that time were considered for this study. In addition to the pilot focus group, we held three more focus groups (on 15 and 30 May, and 7 June 2018).

The focus groups had an average of five people and in their composition sought to ensure the diversity of professional categories that work in assistance to women in situations of violence. The first focus group included 1 psychologist, 1 occupational therapist, 1 social worker, and 2 obstetric nurses. The composition of the second group was 1 psychologist, 1 social worker, 2 obstetric nurses, and 1 gynecologist and obstetrician. The third focus group included 1 psychologist, 1 social worker, and 3 obstetric nurses. The fourth focus group included 5 obstetric nurses, 1 resident of Medicine in Gynecology and Obstetrics.

The groups were carried out during the working hours of the participants, three in the daytime, at 2 pm, and one in the evening, at 8 pm. The participation of professionals was organized in such a way as not to compromise care activities. The groups were conducted by researchers with experience in this data collection technique and who were included in the study setting. However, in the planning and carrying out of data collection, we sought to ensure that the group coordinator did not integrate the duty of the participating professional to avoid interfering with the data. The average duration of the groups was 50 minutes and they were recorded on a digital voice recorder and later transcribed in full by the researchers.

The groups started with the presentation of the coordinator and rapporteur of the group and the participants. Two guiding questions were presented for the discussion: a) for you, what is violence against women? b) what is your perception, in daily care, of women living in situations of violence? Then, the video "Violence against women: what do health professionals have to do with it?" was presented.[13] Then, a question to conclude the discussion was made. The rapporteur presented a summary of the discussions so that the participants could add and validate the information exposed by the group. In all groups, participants validated the information without the need to change the content presented.

The closure of the collection took place through the saturation criterion, verifying the repetition of themes in the focus groups.[12]

The data were transcribed in full and submitted to content analysis in the thematic modality,[12] occurring in three stages: pre-analysis, material exploration, and treatment of the obtained results added to the interpretation. Initially, three independent researchers read the material to identify the thematic nuclei present in the participants' reports. Thus, the themes that were related to the object of study were grouped by similarity, giving rise to four empirical categories. Then, a fourth researcher verified the pertinence of grouping into categories to guarantee the reliability criterion, and in this process, there was a consensus of researchers regarding the groupings carried out. For the interpretation of the results, we used the empirical material together with the theoretical reference produced on the topic, to respond to the objective of the study.

The research was submitted and approved by the Hospital Sofia Feldman Ethics Committee, Opinion number 2,549,693, and met the determinations of Resolution 466/2012 of the National Health Council. All study participants signed the Informed Consent Form (ICF). To ensure confidentiality and integrity, the names of the participants were replaced by the letter "P" followed by the numerical code referring to the order of participation in the focus groups and the letters "FG" to indicate the focus group (FG1, FG2, FG3, and FG4).

RESULTS

A total of 21 workers participated in the study, 1 resident of Medicine in Gynecology and Obstetrics, 1 obstetrician, 11 obstetric nurses, 3 social workers, 3 psychologists, and 2 occupational therapists. Among the 21 participants, only two were male. The age of the participants ranged from 25 to 50 years old and the average length of experience at the institution was 8.7 years. Other data referring to the characterization of the sample will not be presented since their combination allows the identification of the participant, such as the length of experience in the institution, age, and profession.

The set of speeches by the participating professionals gave rise to the following categories: ways of manifestation of violence against women; how women express that they are in a situation of violence; what health professionals do with women in situations of violence; support network for women in situations of violence.

Ways of manifestation of violence against women

Violence against women is perceived as an act performed by people close to her, belonging to the same family nucleus, and even by other women:

> *We also see ignorance from woman to woman. A woman in everyday life expresses that she is a victim of violence in the service, we see a lot. And sometimes we don't see it as the same violence when it's with the husband mistreating his wife. But many times, we see a lot of mothers mistreating women with words...* (P1 - FG1).

> [...] *physical violence by the family, mother-in-law, mother* (P17 - FG4).

Also, there is the perception of professionals that some women are unable to recognize that they are in a situation of violence:

> *How will her life be without that person there? Sometimes he is the livelihood of the house, for example. Sometimes it depends on him financially* (P5 - FG1).

> *And there are those women who bring reports without knowing they are victims of violence. With the naturalness of violence, but that is her context and she does not perceive it as violence, but we here know that this woman is a victim of violence, whether psychological or physical. And then, it's so natural for her, a routine so present that she doesn't even notice, and then it's a little different from those who suffer and know that they are violated and are more cornered* (P9 - FG2).

Violence against women is expressed in different ways, including verbal, moral, physical, sexual, patrimonial, psychological, and social violence, in addition to obstetric, traffic, media violence, and others:

> *In a way, it is physical, moral, verbal violence and, as she said, obstetric violence that sometimes we see even being in a reference institution* (P5 - FG1).

> *Physical, psychological; when I talk about morals, I'm thinking about those that go against what that person puts himself in society. So, it affects that person, like slander, defamation, which for me is a type of violence. The patrimonial I had already heard* (P7 - GF2).

> [...] *so, maybe from the media, I don't know if there is this way of violence, but media that build the woman's model, which she is a sexual object* (P12 - FG4).

> *"Violence in traffic"* (P17 - GF4).

According to study participants, violence against women is closely linked to the power relationship. This situation of submission can generate feelings of fear and impotence in women when exposed to violence:

> *Violence against women in the process of the history of power relationships, in gender issues, how throughout history, within the power relationship, of gender between men and women, how this is something that generates violence, as if, within this logic, women were subordinate* (P3 - FG1).

> [...] *I speak of humiliation, demotion. I see this very strong in violence against women* (P4- FG1).

> *We identify signs that the woman is submissive, that she is cornered* (P17 - FG4).

Sexual violence is a way of violence against women identified by health professionals and may have repercussions during pregnancy. Professionals in their daily

lives realize that some women find it difficult to verbally express the violence that they were exposed to and even understand what happened. Considering that the woman's experience is due to a non-consensual act and, as a consequence, an unplanned pregnancy, it can generate a process of insecurity and distrust in the relationship with the other. Participants believe that sexual violence can sometimes be accompanied by other ways of violence.

> *Here we have a lot of access to sexual violence because the product of sexual violence arrives here for us with the pregnancy since this woman is going to have the baby here. But what about the other types of violence that this woman suffers? Sexual violence is not pure violence, it is not just violence. So, what are we going to do with it? This reflects on the woman as a whole* (P9 - FG2).

> *We also notice some violence that we imagine it to be. Many women who come to have babies here, especially children, 12 and 13-year-old girls,* [...] *we realize that they don't say anything, but you can see that there is something violent behind it. They do let give you space to express something* (P1 - FG1).

How women express that they are in a situation of violence

Professionals report and identify in the behavior of some women signs that may indicate that she is in a situation of violence, such as the fact that they remain withdrawn, with their heads down, without making eye contact, making it difficult for the health professional to approach.

> *It seems like anyone who has that little bit of authority, they have an attitude of fear. They withdraw, they don't communicate and they have that posture of not looking in the eyes, of always lowering their heads.* [...] *it even seems that they are afraid to say: I'm in pain, these things like that* (P3 - FG1).

> *Yeah, sometimes I realize she doesn't want to talk, you know? She gets more reclusive. According to the way she responds too. There are times when we, as professionals, need to realize that, even in a more aggressive response, what is behind that aggressive response. And it's not even because she's trying to be aggressive with you. These are signs that we are getting in assistance and that leads us to believe that it could be violence* (P2 - FG1).

The reports also show that the aggressors can also adopt behaviors suggestive of a violent relationship against the woman, such as maintaining an attitude of surveillance, making it difficult to approach the professionals who are assisting the woman.

> *He* [Partner] *was glued to her all the time and had this difficulty in reaching out and approaching her and being able to ask. My shift ended and I don't know what happened to this story, but there was that, he* [Partner] *didn't leave. So, there was no way to have this approach, not at least while I was on duty* (P5 - FG1).

Violence can manifest through the illness process experienced by women, through subjective and clinical signs that are evidenced in health care.

> *At the time of pregnancy, it is time that we can understand why this woman has so many urinary infections. Why does this woman have so many symptoms that are not typical of pregnancy?* (P17 - GF4).

> *In my sector, when we go to "take" a patient more* [...] *for example, with hyperemesis gravidarum, the patient was really bad, she had to pass the probe, with medication, so she got anorexia, only losing weight, she was malnourished, and then with the help of the whole team, we knew that there was something that was not within the normal range* (P16 - FG4).

What health professionals do with women in situations of violence

The research participants described the role of health professionals with women in situations of violence as a care practice that should involve a multidisciplinary team, to strengthen women, respecting their limits and their decisions. Also, the importance of involving the equipment of the social assistance care network is highlighted and the need to notify cases. Participants highlight what health professionals should do in a situation of violence against women:

> *I think you have to notify, welcome, and support the follow-up. Isn´t it? Follow up; if she was a victim of physical violence, especially if she was a victim of sexual violence, there is a whole medication protocol, in addition to all the psychological factors* (P11 - FG4).

The data show some behaviors adopted by professionals in assisting women in situations of violence and what they believe should be done in such situations. For the professionals, it is not always possible to intervene, but when they suspect that the woman is in a situation of violence, they make available the Psychology and Social Service sectors of the institution, as a way to support the woman at that time.

> *Sometimes you are very inhibited from saying something, then you usually offer to the woman if she wants some psychological help. We inform that there is the Psychology service, there is the social service, that she is not helpless and it has been very valid.* (P1 - GF1).

One of the participants expresses that he did what he thought was right at that time, trying to follow the flow adopted for these situations. However, he felt fearful about the consequences of the case by the partner of the woman in a situation of violence. In this report, the professional's desire to help is evident, but the lack of knowledge about how to do it was a barrier:

> *First, I tried the information of which ideal flow, but I couldn't because of the time, I did what I thought was correct, then I kept thinking and this man later with me, that I'm working at the same time every day, 7:00 hours in the morning alone* (P12 - GF4).

Respondents stated that welcoming is a strategy that facilitates the approximation between the professional and the woman in situations of violence, being the opportunity to establish a trusting relationship with the woman, facilitating the identification and understanding of their needs:

> *And we must have a reception so that she can be calm, have the confidence to talk, to be able to at least help or advise what she can do. When we talk about this practice, what we perceive is in this embracement. The welcoming* (P2 - GF1).

> *First, I think it's welcoming this woman, so she can feel safe, confident for her to expose herself, the first situation, another thing I think is to approach this issue more with the professionals* (P12 - FG4).

In addition to welcoming, the need to offer support to the woman was mentioned to strengthen her to face the situation of violence, considering that it is a process that comprises several steps making a break with the situation of violence.

> *Helping to strengthen so that she [the woman] can go through the entire process, of denunciation, of reinforcing this denunciation, of representing this denunciation at the police station. So, it is not simply welcoming that moment. It is to be able to accompany or encourage this woman so that she can do it. We have to be careful to observe how far she can continue with this process* (P6 - FG1).

Support network for women in situations of violence

We found that some participants were unaware of the flow of care for women in situations of violence and identified the need to publicize these care flows and institutional protocols.

> *I think it's cool for us to know this flow* (P15 - FG1).

> *Depending on the situation the woman arrives in, we have to have a priority. So, I think a protocol helps us more to follow this flow* (P6 - GF2).

> *And I'm quite anxious about it so that we can implement the entire protocol for the care of victims of violence against women in the hospital. You have to train everyone. You have to train from the person at the reception to the doctor, nurse, social worker. Everyone has this protocol that is already well developed* (P11 - GF3).

> *I don't know what to do in these cases* (P9 - GF2).

On the other hand, some participants were aware of a set of behaviors to be adopted in the care of women in situations of violence but depended on the woman's choice to face the situation.

> [...] *I think it is necessary to strengthen the internal network of a multidisciplinary team. And I also agree with what was said suddenly, for me it will only work when the woman decides, makes a decision, puts a limit on it* (P4 - FG1).

Regarding the care for women in situations of violence, they showed the need for professional training, the importance of health education as a strategy for the acquisition of technical knowledge, and the review of personal values that can interfere in the care practices of the health professionals.

> [...] *it was clear here that everyone wants to be trained to do their best, but to think not only about the issue of training in the theoretical sense but also to try to assess within us some prejudices, some values that sometimes prevent us from seeing what is violence and what is not* (P6 - FG2).

> *I think we needed to include this in the plan and train all employees who assist these people* (P11 - FG3).

Professionals highlight the importance of the support network for women in situations of violence so that they have a place to seek help and assistance. Basic Health Units (*Unidades Básicas de Saúde* - UBS) are identified as support and welcoming strategies for these women and as the gateway to the health network.

> *We need to have the support network of the health system so that this woman is welcomed and guided and it would be very important to bring these discussions to the health units* (P17 - FG4).

> [...] *which network, where it is and hours of operation, because often you call and say: it's only tomorrow or only Monday* (P8 - FG3).

DISCUSSION

Domestic violence against women can be practiced by family members, relatives, and people around who live in the same household. Intimate partner violence is understood as any way of threat or use of violence, whether physical, sexual, psychological, or emotional. It also considers the forms of control, domination, intimidation, and humiliation used by the current or previous partner, in marriage, in common-law marriages, or dating.[14]

Studies show that this type of violence against women has always existed, being associated with several factors, including gender issues. Other implications are related to the fact that many of the women remain in abusive relationships due to financial and emotional dependence, leading to periodic events of domestic violence.[15]

The relationship between men and women is marked by the historical heritage of submission that configured an image of inequality, fragility, and inferiority towards women. The factors that drive violent relationships are rooted in a historical context based on the valorization of the male figure, attributing to the woman the housework and little voice in society. Violence can be linked to concepts related to the distinction between power and coercion, conscious will and impulse, determinism and freedom, and women in situations of violence express feelings of sadness, fear, shame, guilt, concern, and impotence in the reality experienced.[15]

It is important to emphasize that violence against women is, above all, a violation of human rights and, therefore, a public health problem. We need to invest in practices that enable us to break with cultural standards and norms that contribute to naturalize and perpetuate male domination over women.[16]

Violence against women impacts various aspects of women's lives, whether in social and work relationships and/or physical and mental health. Violence by intimate partners or by people close to the woman, people she trusts, can lead to emotional damage, impaired educational and economic performance, the adoption of unsafe sexual practices, reduced parental bonding skills, and increased risky behaviors.[17] Similarly, sexual violence can have devastating results in a woman's life, in the short or long term.

Other illness processes identified by health teams resulting from situations of violence experienced and that need attention are unplanned and repeated pregnancy, reproductive tract infections, sexually transmitted diseases (STD), gynecological, urinary, and sexual disorders, hemorrhages, and chronic gastrointestinal disorders. Women in situations of violence can also develop psychiatric symptoms such as depression, panic, somatization, suicide attempt, abuse, and dependence on psychoactive substances.[18]

Such behaviors adopted by women in situations of violence demonstrate different ways of being in the individual and collective space. This is because, given the possibility of confrontation, she is faced with the repercussions that situations of imposition, intimidation, and humiliation reverberate in her feelings in a derogatory way in her values and devaluation in her human condition of submission.

Women who suffer violence are the ones who most seek care in the health service, even if they do not report the situation out of shame or fear.[19] Thus, health teams need to be aware of the signs and symptoms of violence, from the perspective of an efficient approach that reduces the sequelae and trauma for the woman.

In this sense, the health professional need to have a sensitive look at the patients and users of the service, providing and ensuring humanized and quality care for all.

Clinical care can be a strategy for identifying and recognizing the signs of violence. We should not consider it as the main objective of care but as an important strategy for interaction with the woman, enabling her to be welcomed and included in the health care network.[20]

The National Humanization Policy (*Política Nacional de Humanização* - PNH) recommend a humanized reception. Reception according to the PNH[21] Booklet is to welcome, listen, serve, receive, that is, humanized welcoming is an attitude of inclusion, it is an act or effect of welcoming the patients within their specificities. Health services and other equipment are responsible for welcoming, listening, supporting, and offering a positive response, capable of minimizing most of the population's health problems.[18] Adequate and qualified care is an indispensable tool in welcoming, protecting, and, mainly in the encouragement and empowerment of women.[22]

Carrying out care practices and behaviors through the identification and referral of women to specialized services enables them to qualify and humanize the care offered to this group. The health professionals who assist the mother-infant binomial is important, investing in surveillance, monitoring, prevention, and health promotion actions, considering the intersectoral articulation.[23]

Mandatory interpersonal and self-provoked notification performed by the health team that provided care to women in situations of violence is an important strategy to give visibility to cases. The Ministry of Health (2018) emphasizes that it should not be understood as a denunciation, but as a guarantee of the right, and that the notification form works as an instrument to trigger the line of care for people in situations of violence.

The feeling of insecurity by the professionals, the lack of training, the gaps in academic education, the lack of management and knowledge of cases, and broadening of the view towards the biological complaints, are Among the various barriers faced for the care of women in situations of violence from the perspective of comprehensive care, considering veiled violence.[19]

Given the complexity of the problem, researchers say it is important for professionals who work with women in situations of violence to appropriate new knowledge, as well as interdisciplinary and intersectoral discussions, to support and improve their practice. The movement to seek and identify the network makes the woman have the possibility to take care of her health in an integral way, to face and strengthen herself in this experience.[24]

Considering that living in a situation of violence significantly impacts the health/disease process, we should discuss the processes of continuing health education for the qualification of health care, preparing professionals to address violence against women, recognizing it as a multifactorial phenomenon that demands an articulation of the health care network.

One of the limitations of the study is the disparity between the gender of participating professionals, predominantly female. Also, the study was carried out in a specific set of services to this audience, and research in other areas can broaden the discussion on the topic.

FINAL CONSIDERATIONS

This study was dedicated to the practice of professionals in a maternity hospital facing women in situations of violence. Professionals have different feelings and perceptions about the women assisted and about the issue of violence against women. The different ways of manifestation of violence are a challenge for professionals from non-specialized health services. This knowledge is essential to understand the phenomenon of violence against women and offer assistance that meets their needs and rights. The humanization of care with listening and welcoming practices is seen as a way to care for women in situations of violence.

The professionals recognized the need to qualify to deal with situations of violence against women, and this lack of preparation is related both to the knowledge of protocols and flows and to emotional aspects. The creation of protocols and multi-professional and network work is an alternative to meet women's needs and put into practice what is provided for in legislation and health policies.

The challenge is to deepen studies on the perceptions of professionals who assist women in situations of violence, implementing training processes, and positively impacting the practice of these professionals.

REFERENCES

1. World Health Organization. World report on violence and health: summary. Prefácio de Nelson Mandela. Geneva: WHO; 2002[cited 2020 Sept 19]. Available from: http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf

2. Comissão Interamericana de Direitos Humanos. Convenção interamericana para prevenir, punir e erradicar a violência contra a mulher: convenção de Belém do Pará; 1994[cited 2018 Feb 13]. Available from: http://www.cidh.org/basicos/portugues/m.belem.do.para.htm

3. Organização Pan-Americana da Saúde. Organização Mundial da Saúde. Folha informativa - violência contra as mulheres. Brasília: OPAS; 2017[cited 2020 Aug 5]. Available from: https://www.paho.org/bra/index.php?option=com_content&view=article&id=5669:folha-informativa-violencia-contra-as-mulheres&Itemid=820

4. Ramalho NMG, Ferreira JDL, Lima CLJ, Ferreira TMC, Souto SLU, Maciel GMC. Violência doméstica contra mulher gestante. Rev Enferm UFPE Online. 2017[cited 2020 Oct 5];11(12):4999-5008. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/download/22279/25328

5. Presidência da República (BR). Secretaria Nacional de Enfrentamento à Violência contra as Mulheres. Secretaria de Políticas para as Mulheres. Política nacional de enfrentamento à violência contra as mulheres. Brasília: Secretaria de Políticas para as Mulheres; 2011[cited 2020 Oct 5]. Available from: https://www12.senado.leg.br/institucional/omv/entenda-a-violencia/pdfs/politica-nacional-de-enfrentamento-a-violencia-contra-as-mulheres

6. Gomes NP, Erdmann AL. Violência conjugal na perspectiva de profissionais da "Estratégia Saúde da Família": problema de saúde pública e a necessidade do cuidado à mulher. Rev Latino- Am Enferm. 2014[cited 2020 Oct 5];22(1):1-9. Available from: https://www.scielo.br/pdf/rlae/v22n1/pt_0104-1169-rlae-22-01-00076.pdf

7. Campos LM, Gomes NP, Santana JD, Cruz MA, Gomes NP, Pedreira LC. A violência conjugal expressa durante a gestação e puerpério: o discurso de mulheres. REME - Rev Min Enferm. 2019[cited 2021 Apr 19];23:e-1230 Available from: https://cdn.publisher.gn1.link/reme.org.br/pdf/e1230.pdf

8. Islam MJ, Mazerolle P, Broidy L, Baird K. Exploring the Prevalence and Correlates Associated With Intimate Partner Violence During Pregnancy in Bangladesh. J Interpers Violence. 2017[cited 2021 Apr 19];088626051773002. Available from: http://journals.sagepub.com/ doi/10.1177/0886260517730029

9. Rodrigues DP, Gomes-Sponholz FA, Stefanelo J, Nakano AMS, Monteiro JCS. Violência do parceiro íntimo contra a gestante: estudo sobre as repercussões nos resultados obstétricos e neonatais. Rev Esc Enferm USP. 2014[cited 2020 Oct 5];48(2):206-13. Available from: https://www.scielo.br/pdf/reeusp/v48n2/pt_0080-6234-reeusp-48-02-206.pdf

10. Vieria LJES, Silva ACF, Moreira GAR, Cavalcanti LF, Silva RM. Protocolos na atenção à saúde de mulheres em situação de violência sexual sob a ótica de profissionais de saúde. Ciênc Saúde Colet. 2016[cited 2021 May 28];21(12):57-3965. Available from: https://www.scielo.br/j/csc/a/sJtr5C56L4nftLLNCHnymmx/?format=html

11. Souza EG, Tavares R, Lopes JG, Magalhães MAN, Melo EM. Atitudes e opiniões de profissionais envolvidos na atenção à mulher em situação de violência em 10 municípios brasileiros. Saúde Debate. 2018[cited 2020 Oct 5];42(4):13-29. Available from: https://www.scielo.br/pdf/sdeb/v42nspe4/0103-1104-sdeb-42-spe04-0013.pdf

12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 13ª ed. São Paulo: Hucitec; 2013.

13. Conselho Federal de Psicologia. Violência contra as mulheres: o que os profissionais de saúde têm a ver com isso? [vídeo]. Brasília: Canal do Conselho Federal de Psicologia; 2016[cited 2020 Oct 5]. Available from: https://www.youtube.com/watch?v=084Z58rI8rE

14. Melo EM, Celani MFS, Dias NCA, Silveira AM, Claret TAM, Santos EAR, *et al*. Rede de atenção e ambulatório Para Elas: práticas de promoção de saúde da mulher em situação de violência. In: Melo EM, Melo VH. Para elas: por elas, por eles, por nós. Belo Horizonte: Folium; 2016. p.285-96.

15. Gomes IR, Fernandes, SCS. A permanência de mulheres em relacionamentos abusivos à luz da teoria da ação planejada. Bol Acad Paul Psicol. 2018[cited 2021 Apr 19];38(94):55-66. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1415-711X2018000100006&lng=pt&nrm=iso

16. Alencar GSP, Locatelli L, Aquino MGCGS. Mulheres e direitos humanos: uma perspectiva normativa acerca do enfrentamento da violência de gênero. Rev Polít Públicas. 2020[cited 2021 Apr 20]. Available from: http://www.periodicoseletronicos.ufma.br

17. Garcia LP, Silva GDM. Violência por parceiro íntimo: perfil dos atendimentos em serviços de urgência e emergência nas capitais dos estados brasileiros 2014. Cad Saúde Pública. 2018[cited 2020 Oct 5];34(4):e00062317. Available from: https://www.scielo.br/pdf/csp/v34n4/1678-4464-csp-34-04-e00062317.pdf

18. Lourenço LM, Costa DP. Violência entre Parceiros Íntimos e as Implicações para a Saúde da Mulher. Rev Interinst Psicol. 2020[cited 2021 Apr 19];13(1):1-18. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1983-82202020000100010&lng=pt. http://dx.doi.org/10.36298/gerais2020130109

19. Santos WJ, Oliveira PP, Viegas SMF, Ramos TM, Policarpo AG, Silveira EAA. Violência Doméstica Contra a Mulher Perpetrada por Parceiro Íntimo: representações sociais de profissionais da atenção primária à saúde. Rev Pesq Cuid Fundam online. 2018[cited 2020 Oct 5];10(3):770-7. Available from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/viewFile/6197/pdf_1

20. Costa DON, Lima ER, Tenório MCA, Silver TFC. A mulher vítima de violência doméstica no Brasil: acolhimento e assistência da Enfermagem. Cad Grad Ciênc Biol Saúde Unit. 2019[cited 2021 Apr 20];5(2):227-38. Available from: periodicos.set.edu.br

21. Ministério da Saúde (BR). HumanizaSUS: caderno de textos: cartilhas da Política Nacional de Humanização. Brasília: Ministério da Saúde; 2010.

22. Tavares GP, Rodrigues MB, Barroso MF, Vieira NMS, Sousa VR. Atendimento humanizado às mulheres em situação de violência: a percepção das mulheres atendidas na DEAM/Parintins, Amazonas. Gênero na Amazônia. 2017[cited 2020 Oct 5];7-12:141-5. Available from: http://www.generonaamazonia.com/edicoes/edicao-7/12-atendimento-humanizado-as-mulheres-em-situacao-de-violencia.pdf

23. Marques SS, Riquinho DL, Santos MC, Vieira LB. Estratégias para identificação e enfrentamento de situação de violência por parceiro íntimo em mulheres gestantes. Rev Gaúch Enferm. 2017[cited 2020 Oct 5];38(3):e67593. Available from: https://www.scielo.br/pdf/rgenf/v38n3/0102-6933-rgenf-38-3-e67593.pdf

24. Xavier AAP, Silva EG. Assistência de Enfermagem no atendimento de mulheres em situação de violência na atenção básica. RECIEN Rev Inic Cient Ext. 2019[cited 2021 Apr 20];2(Esp.2):293-300. Available from: https://revistasfacesa.senaaires.com.br/index.php/iniciacao-cientifica/article/ view/279