REVISTA ONLINE DE PESQUISA

CUIDADO É FUNDAMENTAL

Universidade Federal do Estado do Rio de Janeiro • Escola de Enfermagem Alfredo Pinto

RESEARCH DOI: 10.9789/2175-5361.2018.v10i3.770-777

Domestic Violence Against Women Perpetrated by Intimate Partner: Professionals' Social Representations in Primary Health Care.

Violência Doméstica Contra a Mulher Perpetrada por Parceiro Íntimo: Representações Sociais de Profissionais da Atenção Primária à Saúde

La Violencia Doméstica Contra las Mujeres: Las Representaciones Sociales de los Profesionales de Atención Primaria de Salud

Walquíria Jesusmara dos Santos[1], Patrícia Peres de Oliveira[2], Selma Maira da Fonseca Viegas[3], Thiago Magela Ramos[4], Aryanne Gabrielle Policarpo[5], Edilene Aparecida Araújo da Silveira[6]*

How to quote this article:
Santos WJ, Oliveira PP, Viegas SMF, *et al*. Domestic Violence Against Women Perpetrated by Intimate Partner: Professionals' Social Representations in Primary Health Care. Rev Fund Care Online. 2018 Jul./Sep.; 10(3):770-777. DOI: http://dx.doi.org/10.9789/2175-5361.2018.v10i3.770-777

ABSTRACT

Objective: Our goal herein has been to gain further insights regarding the professionals' social representations in Primary Health Care (PHC) related to violence against women perpetrated by an intimate partner. **Methods:** Qualitative research having focus on Social Representations, which was analyzed by the Structural Analysis of Narrative. The study scenarios were eight PHC units from the municipality of *Minas Gerais,* Brazil. Eight focus groups were carried out, where each group participants number ranged from 8 to 12, comprising a total of 53 professionals. **Results:** Two categories appeared: 1. From popular saying, the domestic violence banalization against women identifying the meaning cores: "do not interfere in a couple fight"; "high incidence of violence legitimized in the social representations". 2. In defense of the intimate partner abuser held the meaning cores: "alcohol and other drugs as violence triggers"; "representations associated to gender perspectives"; "guilt imputation towards the woman". **Conclusions:** This study showed that violence against women is legitimized, accepted and tolerated according to participants' speeches. Moreover, violence against women has been also inferred as something imputed/inherent to women.

Descriptors: Domestic violence, Violence against women, Primary health care.

[1] Master's Degree in Nursing and Ph.D. Nursing student. Assistant Professor at the Universidade Federal de São João del-Rei. Minas Gerais, Brazil. E-mail address: waljsantos@hotmail.com[2] Enfermeira. Doutora em Educação: Currículo e Mestre em Gerontologia. Professora Adjunta da Universidade Federal de São João del-Rei. Minas Gerais, Brasil. E-mail: pperesoliveira@ufsj.edu.br

[2] Nursing Professional. Doctor's Degree in Education: Curriculum and Master's Degree in Gerontology. Adjunct Professor at the Universidade Federal de São João del-Rei. Minas Gerais, Brazil. E-mail address: pperesoliveira@ufsj.edu.br[4] Enfermeiro. Residente em Enfermagem na Atenção Básica/Saúde da Família. Minas Gerais, Brasil. E-mail: thiagomagelaramos@yahoo.com.br.

[3] Nursing Professional. Master's and Doctor's Degrees in Nursing. Adjunct Professor at the Universidade Federal de São João del-Rei. Minas Gerais, Brazil. E-mail address: selmaviegas@ufsj.edu.br /edileneap@ufsj.edu.br

[4] Nursing Professional. Resident student in Nursing in Primary Care/Family Health. Minas Gerais, Brazil. E-mail address: thiagomagelaramos@yahoo.com.br[2] Enfermeira. Doutora em Educação: Currículo e Mestre em Gerontologia. Professora Adjunta da Universidade Federal de São João del-Rei. Minas Gerais, Brasil. E-mail: pperesoliveira@ufsj.edu.br

[5] Nursing Professional. Graduated in Nursing by the Universidade Federal de São João del-Rei. Minas Gerais, Brazil. E-mail address: aryannegpolicarpo@yahoo.com.br

RESUMO

Objetivo: Compreender as representações sociais de profissionais da Atenção Primária à Saúde sobre violência contra a mulher perpetrada por parceiro íntimo. **Método:** Pesquisa qualitativa com o enfoque nas Representações Sociais, analisado pela Análise Estrutural da Narração. Foram realizados oito grupos focais, o número de participantes variou de 8 a 12, totalizando 53 profissionais de oito unidades de Atenção Primária à Saúde de um município de Minas Gerais, Brasil.**Resultados:** Emergiram duas categorias: 1. Do ditado popular à banalização da violência conjugal contra mulheres, identificando-se os núcleos de sentido: "não se interfere em briga de casal"; "naturalização da violência legitimada nas representações sociais. 2. Representações sociais numa perspectiva de gênero, decorrida dos núcleos de sentido: "representações associadas aos papeis de gênero"; "imputação de culpa à mulher". **Conclusão:** O estudo demonstrou que a violência contra as mulheres é legitimada, aceita e tolerada nas falas dos participantes, como algo imputado/inerente à mulher.

Descritores: Violência doméstica, Violência contra a mulher, Atenção Primária à Saúde..

RESUMEN

Objetivo: Conocer las representaciones sociales de los profesionales de Atención Primaria de Salud (APS) sobre la violencia contra la mujer perpetrada por su pareja. **Método:** Investigación cualitativa con enfoque en las Representaciones Sociales. Los escenarios fueron ocho unidades de APS de un municipio del Minas Gerais, Brasil. Se realizaron ocho grupos focales, el número de participantes varió de ocho a 12, por un total de 53 profesionales. **Resultados:** Emergieron dos categorías: 1. Do dicho popular de la representación social de la violencia doméstica contra las mujeres, la identificación de las unidades de significado: no interfiere con la lucha de la familia; alta incidencia de la violencia legitimada en las representaciones sociales. 2. En defensa del agresor de pareja, celebró las unidades de significado: alcohol y otras drogas como causas de la violencia; representaciones asociadas con la perspectiva de género; atribuir la culpa a la víctima.**Conclusión:** Mostró que la violencia contra las mujeres se legitima, aceptado y tolerado en los discursos de los participantes, como algo imputado / inherente a las mujeres.

Descriptores: Violencia doméstica, Violencia contra la Mujer, Atención Primaria de Salud.

INTRODUCTION

Domestic and family violence against women is defined as "any gender-based act or conduct that causes physical, sexual or psychological death, injury or suffering, moral or property damage within the household unit, within the family or in any intimate relationship, in which the aggressor either lives or has lived with the woman, where it is independent of cohabitation".[1]

It is known that this kind of violence can result in physical, mental and emotional health problems in women, as well as entailing high economic costs for a country, either through medical expenses due to the impossibility of productive work or the consequences related to mental health.[2] Violence against women is considered a priority in the human rights area, and it can occur in various forms, such as physical, psychological, moral, property or sexual violence and in 70% of the cases the perpetrator is someone with whom she either maintains or has maintained an affective bond.[1-3]

In Brazil, according to data from the Specialized Attendance Police Stations for Women, about 205,000 women have been reported within a single year.[3] Data from the Notification of Injury Information System showed that 223,796 cases were reported for victims of domestic violence, sexual violence and others violence cases in 2015, where two out of those three cases (147,691 total) were women subjects, and they demanded care in a health unit due to violence. The number of female homicide victims rose from 3,937 in 2005 to 4,762 in 2015, representing a 21% increase in one decade.[4]

Domestic violence against women resembles a sociocultural phenomenon, which is consequence of a society based on power relationships and conflict between genders. The male being and the female being are the fruits of a social construct that values the sexual characteristics. In turn, it has given to the man the physical force and ideologically transfers the power of the biological scope to the social ambit, authorizing its authority over the biologically "fragile" sex, who must surrender herself to the "natural", biological and social order. Such thinking, "strong man and weak woman" has been historically constructed and employed to legitimize the violence perpetrated against women.[2]

Studies indicate that women who have suffered violence are more likely to seek care in health services, even if they do not disclose the situation of violence experienced. The Primary Care Units being are a potential entrance gateway (through reference routes) to specialized services in violence against women (if there is any), or even for other services that the woman demands.[2-5]

In this sense, the Brazilian Health Ministry has been proposing measures to provide effective and comprehensive care to women under violence situations from the Primary Health Care (PHC) services. Public policies advocate that care for women under violence situations should be carried out by intersectoral networks, made up of several services, including the basic health system. They highlight that although violence against women has a substantial impact on their health, it is a problem of social character that besides having resources in the area of health, it also requires several others, such as public safety and social assistance.[6]

The PHC services are essential for preventive action towards domestic violence against women due to reorganization of the care model, through the Family Health Strategy, the possibility of longitudinal care, the established link with users, the capacity for intersectoral action and, primarily, responsibility for health promotion.[7-8]

The PHC professionals are in a privileged position to create a safe and confidential environment that facilitates the violence information dissemination, guarantees

the provision of adequate support and referral to other resources and services.[9]

However, studies performed in the PHC field on the practices of teams in face of situations involving domestic violence pointed out challenges and dilemmas for the construction of integral care. Among the barriers and difficulties in attending to violence situations are the following: the feeling of insecurity by the professionals, absence of training, lack of academic instruction and lack of knowledge about case management, look widening to beyond biological complaints and the non-disclosure of the situation of violence by users, including underreporting of violence against women cases, even though compulsory notification to health professionals or caregivers is required.[8,10]

Another study pointed out that doctors and nurses are the professionals who are least involved in the care of violence against women situations. Conversely, in many cases, these professionals are the ones most sought after by these users, since many families have a fragile bond with the basic health units, where the demand is exclusively for the fulfillment of spontaneous requests.[11]

The health professional must be able to provide assistance that meets the physical, psychological and social people's needs and that are victims of violence. At the same time, they should be able to identify occurrences in the users under care, in order to favor the notification of cases, adequate referral and especially the continuity of health care services for victims. The incipient training for attention to the violence victim, as far the professional education is concerned, constitutes a knowledge gap that makes it difficult to face this issue.[12-13]

The Sistema Único de Saúde (SUS) [Unified Health System] needs to move forward in order to the health care service be able to refer to the premise of protecting the human rights and citizenship of people, who have either suffered or are suffering violence actions.[3] By focusing on complex issues such as domestic violence, there is a need to extend the perception of health professionals towards a paradigm shift, as well as the creation of objective conditions for incorporating this new way of acting, in order to guarantee qualified listening and attention for people under violence situations.[3-5]

Beliefs and representations can determine how the human being stands and responds to situations, and the way that the health professional conceives domestic violence can influence how either he or she will act upon the problem.[7] Thus, knowing the PHC representations and practices performed by the health care professionals in relation to violence is relevant to the proposals construction that might contribute to decreasing their occurrence together with proposing actions, since each social group thinks and experiences violence from its social context.

This study presents a questioning, as follows: what are the social representations of health professionals who work in the context of Primary Health Care on domestic violence against women?

Given the above, the study's objective is to understand the social representations of Primary Health Care professionals about domestic violence against women perpetrated by their intimate partners.

METHODS

The study was conducted as a qualitative research that has as core the theoretical focus of Social Representations.[14] A social representation refers to an organized set of information, beliefs, and attitudes that individuals build regarding an object, a situation or a concept of other persons or groups. It presents itself as a subjective and social form of reality, which contributes to the construction of a reality common to a social group.[14]

The study scenarios were eight PHC units belonging to a regional health priority in health actions from a municipality of *Minas Gerais*, Brazil. Data were collected from November 2013 to June 2014.

In order to know the social representations of health professionals on the theme of violence against women, focus groups were used as a source of evidence, and one focus group was carried out in each PHC unit. The focus groups consist of in depth group interviews, in which people interaction is an integral part of the method and allows their members to explore their standpoints on a particular social phenomenon, constituting a privileged space for reaching group conceptions about a particular fact or event.[15] Aiming to gather as much information as possible, were invited all health professionals linked to each PHC unit belonging to the sanitary region Southeast of the municipality study scenario to participate of the focus groups.

The invitation to the participants was made through either telephone contact or e-mail, divided in two stages. Firstly, the initial contact was made one month before the data collection aiming the following: approaching the possible participants; explaining the study objectives; addressing the disposition of the guest for the date and time foreseen and to clarify doubts; In a second contact, which was made one week before, it was checked whether or not the participants would confirm attending at the date and time scheduled.

Eight focus groups were conducted, one in each PHC unit, with the participation of several professional categories in each group: physicians, nurses, nursing assistants and technicians, psychologists, dental surgeons, oral health aides, community health agents. The number of participants in each group ranged from 8 to 12, the average duration of each focal group was about 60 minutes. The inclusion criteria of the study participants were as follows: being over 18 years old and to be part of the PHC unit teams at the research scenario; having a six months period minimum of performance in the function/position, once it was considered that in this time frame they would be better adapted to work.

There was a formal presentation of the research regarding ethical criteria. The interviewees were informed about the research purpose, the confidentiality and the possibility of interrupting their participation without any loss.

The focus groups were conducted with the help of a moderator and an observer. The moderator was always a nurse, a member of the research group; and the observer, a previously trained nurse or nursing student. The moderator had the objective of maintaining the discussions around the theme, proposing snap questions in order to deepen it and arbitrate to make possible the speech of all participants in the group. The observer had the assignment to record the events of the focus group considering the whole and the important peculiarities, as well as to control the time and monitor the recording equipment, besides assisting the moderator in the management of the discussions.

The debate was proposed from the following central question: "Please, tell me what do you think about domestic violence against women, and also could you share your daily professional practice towards these women?".

The discourse of the participants was recorded in audio and entirety transcribed. Intending the analysis organization, the structural analysis of the narrative described by Demazière and Dubar was used as a strategy, consisting of three stages as follows: vertical, horizontal and transversal readings.16 In the first stage, meaning the vertical reading, we tried to extract the global meaning of each interview, allowing the examination of the existing themes.

In the horizontal reading, the deconstruction of each interview was performed, the whole text being numbered in sequences with the subsequent grouping of the sequences that deal with the same subject, called the interview reconstruction, which allowed explaining the meanings attributed by the subjects interviewed to the cited objects in the narratives. This reconstruction allowed finding, accompanying and reproducing the categorization work that the interviewees themselves performed.

In the third stage, the transversal reading, it was aimed comparing and explaining the meanings that emerged in the focus groups in which they were concordant and discordant. In the end, the study baseline categories (or empirical categories) were obtained, and these were still compared and confronted with the literature results. Participants' anonymity was maintained through the adoption of the letter "I" (meaning interviewee), followed by the research participant sequential number, in addition to the letters "FG" (meaning focus group), which referred to the focal group that the interviewee has participated.

The study was approved by the Research Ethics Committee of the Universidade Federal de São João del-Rei, CAAE nº 20941413.2.0000.5545, according to the Legal Opinion nº 415.203, and obeying the guidelines and norms regulating research involving human beings. The local Municipal Health Secretary was a co-participant institution of this research.

RESULTS AND DISCUSSION

A total of 53 health professionals participated of the study, including 10 nurses, 3 physicians, 12 nursing technicians, 7 nursing assistants, 2 dentists, 5 oral health aides, 1 psychologist and 13 community health agents. Regarding the sex gender, 48 interviewees were women and 5 were men.

The representations are based on the ideas associated with domestic violence against women and the reasons that provoke this type of violence, which emerge from the investigation of two thematic categories: 1. From popular saying, the domestic violence banalization against women; 2. Social representations coming from a gender perspective.

About the first central thematic category, the following meaning cores were identified: "do not interfere in a couple fight" and "naturalization of violence legitimized in social representations";

In relation to the first meaning core, "do not interfere in a couple fight" the popular saying "in a husband and wife fight, no one should come over" emerges, and the interviewees' representations have revolved around the domestic violence issue as a private matter, concerning only the family and the couple:

> *There is that question, nobody interferes, that is a fact. Because, how come can I interfere if no one knows who is right. Also, they are together, "doing great", same thing all the time... it is the old popular saying, "in a husband and wife fight, no one should come over" (I4FG3).*
>
> *I believe that so many people think this way: Why should I intervene? They have been always fighting, and they will keep doing it any way (I5FG5).*

The statements showed that violence against women is legitimized, accepted and tolerated in the participants' speeches, as something imputed/inherent to the woman, and to this crime is given characteristics of natural relationships between male and female living in conflict that should not be interfered. The central representations that support such positions are not related to the biological differences between men and women that determine the use of violence, but with cultural and social constructions imposed on them, reinforced by the patriarchalism that establishes relations of domination and violence between genders.

The results of this study corroborate with studies on the social representations of health professionals about the phenomenon of violence against women.[17-18] The difficulty of health professionals intervening in matters considered delicate issues, make the causes of violence against women to be poorly perceived or undervalued in the health services.[19] Women victims of aggression tend to have low levels of social support due to the common norm of

perceiving domestic violence as a private problem in which people outside the family should not interfere.[20-21]

In addition to cultural and social issues, it is necessary to consider the changes occurred by historical and political interventions during the last three decades in the Brazilian context, which leads to understanding that the occurrence of violence situations within the conjugal relations does not only concern the couple, but the society as a whole.

Regarding the second meaning core entitled "naturalization of violence legitimized in social representations," the interviewees pointed out the existence of an intensification of the violence exposure, leading to a banalization of this phenomenon:

> *In everyday life we realize one's ability to kill the other today. It's scary! It is too much for me! (I4FG7).*
> *I do not know if you think more or less like me, we see so much situation, not only these cases (of violence against women), but so many bad situations, it seems that we are getting like this, kind of... Nowadays, we see violence everywhere, all the time, on television. Over time you start getting kind of immune to this, do not you? (I7FG1).*

Corroborating with this study results, other authors acknowledge the current and naturalized nature of this phenomenon in the present day and daily life of PHC professionals, which makes the intrafamily violence approach in these fields a great challenge.[5,22]

A study carried out having PHC health professionals as subjects, pointed out that family violence is recognized by professionals as a way used by families to resolve conflicts, which demonstrates their naturalization.[22] Therefore, it is necessary to recognize the problem for the action strategies against domestic violence.[22-23]

Social representations, understood as interpretation systems, govern our relationship with the world and one to each other, guiding and organizing conducts as well. The particularity of the study of social representations involves the social belonging of individuals with the affective and normative implications, with the internalizations of experiences, practices, models of conduct and thoughts, socially inculcated or transmitted by the social media that are linked to it.[23]

Among these representations imposed by society and lived culturally, those related to traditional social customs have deprived women from the opportunity to hold their autonomy, freedom, and dignity before the partner aggressor.

On the second central theme category "social representations from a gender perspective" the following meaning cores were identified: "representations associated with gender roles"; and "guilt imputation towards the woman".

The first meaning core, "representations associated with gender social roles," concerns the asymmetric relationships between men and women and how these can influence the continuance of the woman in a violence situation, as explained in the following statements:

> *Sometimes the woman blames herself too much. So sometimes she blames herself. The male society blames the woman for the failure of the marriage. So, sometimes, she already carries this implicit guilt. She carries a guilt that is hers, but she carries a guilt that is also of her husband. So often, she does not divorce because she thinks: "no, I am going to try, because I failed", is that right?! That male culture, all over the woman (I6FG6).*
> *I think it is kind of cultural! Always the woman has to cultivate the home, take care of the children and make things work. The man has to provide, and the woman has to make the family work, the family stay together! I think that responsibility lies deep inside the woman. Oh, I have to make things happen, make my marriage work, my family work and my children do good in life! I think she calls that responsibility towards her (I1FG8).*

As verified in the interviewees' reports, there is still in the social imaginary associations that link the place of women in the relationships of conjugality to the occupation in the domestic space and the exercise of motherhood. As a wife and mother, the woman is seen as the family affective mainstay, which is responsible for the maintenance of the family core, and particularly assumes responsibility for either the success or failure of what can be generated within those relations.[24] There is the existence of an internalized norm that the women's role is to be a good wife and mother.[20]

Thus, in a society that places the burden of family harmony on the woman, she is blamed for the marriage failure, which may be an important factor for her to tolerate situations of violence.[24]

It is understood that the representations fulfill certain functions in the maintenance of the social identity and the socio-cognitive balance connected to them. The representations imposed by the dominant ideology or those that are related to a defined condition within the social structure across individuals. The place, the social position they occupy or the functions they assume determine the representational contents and their organization, through their ideological relationship with the social world.[23]

The woman's view of the housewife, submissive and caretaker of the offspring still exists in the social imaginary. This gender relation places the woman in a position of passivity, then creating a favorable environment for the emergence and maintenance of masculine oppression.[25]

The interviewees' speeches pointed to the social representations associated with gender social roles, where the

mechanisms of inversion stand out, with discourses focused on the image of the woman opposed to the image of the man, with the woman occupying the domestic space focused on the activities family members, bearing responsibility for the maintenance of the home and the family. In other times, the mechanisms of reduction stand out, with discourses related to the search of women for a more egalitarian relationship, especially in the professional environment, a situation that may not be accepted by the dominant category and exacerbate violence.[23]

In relation to the same meaning core above, some interviewees pointed to the devaluation of the feminine before the masculine, and a supposed masculine superiority leading to a power relation of the man to the woman as responsible for the occurrences of violent acts:

> *I think it may also be because many women surpass the men, the man sees this and he does not like it, he does not accept it, he always has to be on the top. Some men do not accept that women earn more than they do, do not accept that the woman has a car, a wallet. So, most of the time they even kill (I3FG4).*
> *The man who beats and uses violence against women has to show that he is "the man", that he must to state himself, that he is greater, that he is the provider. Because, otherwise he would not have the need to beating. Because, in fact, he thinks the woman is more than him. That is my understanding. He wants to state himself (I5FG7).*

Women's rise to the labor market force can lead to women's empowerment and greater participation in decision-making, which may restrain intimate partner violence.[26] On the other hand, these social changes do not always lead to a positive outcome. Some men see women's financial independence as a threat or challenge, so they may be more likely to commit acts of violence in an attempt to have control over their partners, or take it back.[27]

By other way, the idea of male superiority can be reinforced socially when one sees an incentive to the culture of the "dominant male", the type of man who is hostile in dealing with others and who reinforces his manhood by attacking those around him.[24, 27]

In the second meaning core, "guilt imputation towards the woman", the interviewees associate the occurrence of violence with female behaviors, such as submission and acceptance of violence or man provocation, which leads to their liability for the violence suffered:

> It is woman fault, who accepts this situation. So, I think if you accept things, that is it! If you let it happen once and accept, oh, it will happen forever! There is no way for you to change it later (I4FG6).
>
> Why did you hit her? She must have "pissed" him too much, until he got to the point of hitting her. Are you thinking that women are all good persons, just got bit up? When it comes to getting bitten up, it is because the situation is already "ugly." But, there are women who are difficult to deal with (I2FG5)!
> Now, there are women that I am going to tell you, she wants for the man to beating her to sleep well. I have seen many women like that. She goes "attacking" the man, doing wrong thing, implying and jumping over him. And you want the man to "stay" there, just as a saint? No man is going to be just as a saint (I7FG8).

Women's responsibility for suffering violence was also found in other studies with health professionals.[19] Whether presenting as a result of their personal choices,[28] or as justification for inappropriate behavior.[19,29] This type of discourse indicates a social position crystallized in unequal relations between the genders, in which male power is accepted and naturalized by society, and the use of force is justified at the imminence of a rupture of this hierarchical relationship between the sexes to maintain this status quo.[19]

The woman guilt for suffering violence is something common in the gender relations. The predominantly patriarchal culture in which we are still inserted contributes to the definition of roles and functions in the relationship between male-aggressor and female-aggressed. In other words, a woman who suffers violence is often blamed for aggression in the conjugal relations due to affective bonding, financial dependence, having children, etc., or even for being silent in the face of this violence, which reinforces the common imaginary of "whoever remains silent, turns out to agree".[26-27,30]

Corroborating with the findings of this study, the research highlights that the conception about gender and violence of health professionals does not consider, as far as women health care is concerned, the emancipation of women from the oppression of gender, and then converge to a conservative perspective that emphasizes this oppression. This behavior makes it difficult to carry out an intervention transforming the reality of violence experienced by women. It is, therefore, necessary to include a gender perspective in health policies and professional practices.[19]

The conception about gender and its influence on professional practices is a fundamental point to understand visibilities and invisibilities of violence, the actions that have been taken and their senses, as well as the feelings mobilized in the health teams, which strongly influence constructed strategies.[11,31]

Domestic violence against women is a serious public health problem, contributing to the promotion of health problems. It is a complex phenomenon since it involves several factors, such as environmental, social, cultural

and socioeconomic. The invisibility and impunity of most domestic violence cases contribute to its marginalization and the minimum call for help by its victims, contributing to the perpetuation of the cycle because the less it is denounced, the more invisible and unpunished it becomes.

Health professionals should be prepared to receive and perform active listening with violated women, placing them in safe and comfortable situations to report their experiences. In addition to this ability of listening and humanized care, the professional must understand the necessary procedures for the adequate referral of these women, as well as offer continuous assistance and options for the victims.

However, professionals may be unprepared to identify cases of domestic violence and, when identified, they may present difficulties in referring them to other instances. These difficulties might be related to social representations, especially those associated with the violence banalization and those that revolve around domestic violence as a private matter that should not be interfered, even when these struggles affect all the health-disease family dynamics, which evidenced by higher demand for care in PHC units.

Health professionals, especially nursing professionals who deal directly with users, should be trained and empowered regarding the use of active listening, the reception of the woman victimized without judgments and prejudices of the care network connecting the PHC unit with organs that will give rise to potential complaints. A woman who is a victim of domestic violence must feel welcomed and safe to make the complaint, and professionals must offer a welcoming environment, something that is currently considered so far away from the reality experienced in PHC units.

In order to identify cases of violence, it is necessary to mobilize internal resources, such as sensitivity and willingness to listen to others, as well as investment in professional training.[30,32] The nurse is a professional with experience in listening to problems that are not necessarily biomedical, as well as being one of the first professionals to come into contact with women under violence situations, which enables them as an integral part of the health team to share responsibility for identifying cases and guiding the search for solutions in the violence assistance network, which involves other sectors, such as public safety, legal assistance, social assistance, among others.[10]

Presently, in Brazil, there have been intense debates around legislation aimed at confronting violence. The Law nº 11.340/06, known as the Lei Maria da Penha [Mary Penha Act], which came into force in September 2006 in Brazil, establishes that every case of domestic and intrafamily violence is a crime, and it must be legally established through a police investigation and sent to the Public Prosecutor's Office. It encompasses, in addition to physical and sexual violence, psychological violence, patrimonial violence, and bullying.

In addition to legislation, several studies indicate the social support as an important tool to improve the women responsiveness experiencing abuse by their partners.

CONCLUSION

The research participants' reports revealed the meaning cores, which are socially represented by the facts observed throughout life, and also highlighted the high incidence of gender-based violence. Gender relationships and guilt imputation toward women were considered the violence leading causes. In this study, the following were configured innovations that can contribute to enhancing knowledge in this area: the violence banalization and its association with an individual issue, in which is indicated not to interfere.

Nonetheless, those social representations become worrisome when they pervade the professional categories that are supposed to be prepared to take care of these cases in the PHC units.

It was perceived the neediness to offer health professionals the possibility to recognize what is domestic violence against women. In addition to be able to perform its identification, treatment, and referral, also giving the opportunity to solve problems, offering alternatives for improvements and creating an adequate environment. These findings enabled interventions that were carried out in interactive group workshops, and training provided by the researchers to all the health professionals in the research setup.

It is worth noting the study limitations, because despite it encompasses the social representations of health professionals working in PHC on violence against women, case identification and comprehensive care by the professionals were not the study focus. The unpredictability of the violence direction can bring other injunctions and disorders that need to be analyzed in scrutiny and evaluated by health professionals engaged in the daily care of women victims of violence. It is relevant to direct the interventions to be implemented by the health team and other sectors, as well as provide the support to overcoming the situation and the integral attention to the victimized woman, which transcends the professionals' social representations here revealed and discussed.

REFERENCES

1. Brasil. Diário Oficial da União. Lei n. 11.340, de 7 de agosto de 2006. Dispõe sobre a violência doméstica contra a mulher. Brasília(DF); 2006. [cited 2016 Nov 20]. Available from: http://www.planalto.gov.br/ccivil_03/_ato2004-2006/2006/lei/l11340.htm.

2. Almeida LR, Silva ATMC, Machado LS. Jogos para capacitação de profissionais de saúde na atenção à violência de gênero. Rev Brasileira de Educação Médica. 2013; 37(1): 110-19.

3. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde, Departamento de Análise de Situação de Saúde. Viva: instrutivo de notificação de violência doméstica, sexual e outras violências. Brasília (DF): MS; 2011.

4. Waiselfisz JJ. Mapa da Violência 2015: Homicídio de Mulheres no Brasil. 1. ed. Brasília (DF): 2015.

5. Devries KM, Mak JYT, García-Moreno C, Petzold M, Child JC, Falder G et al. The global prevalence of intimate partner violence against women. Science. 2013; 340(6140):1527-8.

6. Osis MJD, Duarte GA, Faúndes A. Violência entre usuárias de unidades de saúde: prevalência, Perspectiva e conduta de gestores e profissionais. Rev. Saúde Pública. 2012; 46(2): 351-8

7. Brum CRS, Lourenço LM, Gebara CFP, Ronzani TM. Violência Doméstica e Crenças: Intervenção com Profissionais da Atenção Primária à saúde. Psicologia em Pesquisa UFJF. 2013; 7(2): 242-250.

8. Porto RTS, Bispo Júnior JP, Lima EC. Violência Doméstica e Sexual no âmbito da Estratégia de Saúde da Família: atuação profissional e barreiras para o enfrentamento. Physis Revista de Saúde Coletiva. 2014; 24(3): 787-807.

9. World Health Organization (WHO). Responding to Intimate Partner Violence and Sexual Violence Against Women. Clinical and Policy Guideline. Geneva (CH): WHO; 2013.

10. Baraldi ACP, Almeida AM, Perdoná GC, Vieira EM. Violência contra a mulher na rede de atenção básica: o que os enfermeiros sabem sobre o problema? Rev. Bras. Saúde Matern. Infant. 2012; 12(3): 307-318.

11. Moreira TNF, Martins CL, Feuerwerker LCM, Schraiber LB. A construção do cuidado: o atendimento às situações de violência doméstica por equipes de Saúde da Família. Saúde Soc. São Paulo. 2014; 23(3): 814-827.

12. Vieira LJES, Ferreira RC, Moreira GAR, Gondim APS, Araujo MAL, Silva RM. Factors associated to the imposition of types of violence against women informed in sentry services. Rev. Latino-Am. Enfermagem. 2013 July-Aug; 21(4):920-7.

13. Roisin J. De la survivance à la vie: essai sur le traumatisme psychique et sa guérison. Paris (FR): PUF; 2010.

14. Moscovici S. Representações sociais: investigações em psicologia social. 6.ed. Petrópolis (RJ): Vozes; 2009.

15. Backes DS, Colomé JS, Erdmann RH, Lunardi VL. Grupo focal como técnica de coleta e análise de dados em pesquisas qualitativas. O Mundo da saúde. 2011; 35(4): 438-42.

16. Demazière D, Dubar C. Analyser les entretiens biographiques: l'exemple de récits d'insertion. Paris: Natahan; 1997.

17. Stöckl H, Devries K, Rotstein A, Abrahams N, Campbell J, Watts C et al. The global prevalence of intimate partner homicide: a systematic review. The Lancet. 2013; 382(9895): 859-65.

18. Fonseca-Machado MO, Alves LC, Freitas PS, Monteiro JCS, Gomes-Sponholz F. Mental health of women who suffer intimate partner violence during pregnancy. Invest Educ Enferm. 2014;32(2): 291-305.

19. Almeida LR, Silva ATMC, Machado LS. O Objetivo, a finalidade e os instrumentos do processo de trabalho em saúde na atenção à violência de gênero em um serviço de atenção básica. Interface Comunic, Saúde, Educ. 2014; 18(48): 47-59.

20. Hayati EN, Eriksson M, Hakimi M, Högberg U, Emmelin M. 'Elastic band strategy': women's lived experiences of coping with domestic violence in rural Indonesia. Global Health Action. 2013; 6:1-12.

21. Kyegombe N, Starmann E, Devries KM, Michau L, Nakuti J, Musuya T et al. 'SASA! is the medicine that treats violence'. Qualitative findings on how a community mobilisation intervention to prevent violence against women created change in Kampala, Uganda. Global Health Action. 2014 [cited 2015 Dec 18] Available from: http://www.globalhealthaction.net/index.php/gha/article/view/25082.

22. Budó MLD, Schimith MD, Silva DC, Silva SO, Almeida PB. Percepções sobre a violência no cenário de uma unidade de Saúde da Família. Cogitare enferm. 2012; 17(1): 21-8.

23. Jodelet D. As representações sociais. Tradução: Lilian Ulup. Rio de Janeiro: UERJ; 2001.

24. Calvo González G, Camacho Bejarano R. La violencia de género: evolución, impacto y claves para su abordaje. Enfermeria Global [Internet] 2014 [acceso 2016 Mar 11]; 16:1-10. Available from: file:///C:/Users/User/Downloads/181941-685661-1-PB.pdf

25. Horn R, Puffer ES, Roesch E, Lehmann H. Women's perceptions of effects of war on intimate partner violence and gender roles in two post-conflict West African Countries: consequences and unexpected opportunities. Conflict and Health. 2014; 8:12.

26. Fonseca DH, Ribeiro CG, Leal NSB. Violência doméstica contra a mulher: realidades e representações sociais. Psicol Soc. 2012; 24(2): 307-14.

27. Santos MA, Vieira EM. Recursos sociais para apoio às mulheres em situação de violência em Ribeirão Preto, SP, na perspectiva de informantes-chave. Interface Comunic, Saúde, Educ. 2011;15(36): 93-108.

28. Santos DF, Castro DS, Lima EFA, Albuquerque Neto L, Moura MAV, Leite FMC. The women's perception on the violence experienced. Rev Fund Care Online. 2017 jan/mar; 9(1):193-99. DOI: http://dx.doi.org/10.9789/2175-5361.2017.v9i1.193-199.

29. Kiss LB, Schraiber LB. Temas medico-sociais e a intervenção em saúde: a violência contra mulheres no discurso dos profissionais. Ciênc Saúde Coletiva. 2011; 16(3): 1943-52.

30. Oliveira PP, Viegas SMF, Santos WJ, Silveira EAA, Elias SC. Women victims of domestic violence: a phenomenological approach. Texto Contexto Enferm. 2015; 24(1): 196-203.

31. Guedes RN, Fonseca RMGS, Egry EY. Limites e possibilidades avaliativas da Estratégia Saúde da Família para a violência de gênero. Rev. Esc. Enferm. USP.2013; 47(2): 304-11.

32. Júnior FJGS, Tolentino ES, Oliveira AKS, Monteiro CFS. Chemical dependency and violence in the female universe: an integrative review. Rev Fund Care Online. 2016 jul/set; 8(3):4681-8. DOI: http://dx.doi.org/10.9789/2175-5361.2016.v8i3.4681-4688

Received on: 01/19/2017
Required Reviews: None
Approved on: 02/07/2017
Published on: 07/05/2018

***Corresponding Author:**
Patrícia Peres de Oliveira
Rua Sebastião Gonçalves Coelho, 400
Chanadour, Minas Gerais/MG, Brazil
Zip Code: 35501-296
E-mail address: pperesoliveira@ufsj.edu.br