ORIGINAL ARTICLE

https://doi.org/10.1590/1806-9282.20211003

Knowledge of gynecologists in the public health system care of women victims of violence

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SUMMARY

OBJECTIVE: This study aimed to evaluate the knowledge of the obstetricians and gynecologists in the care of women victims of violence in the public health system and the existence of institutional mechanisms to support them.

METHODS: A cross-sectional and observational study was conducted with an electronic questionnaire by physicians who provided care in the obstetrics and gynecology emergency unit of the public health system. This study aimed to identify the care for victims of violence who received the institutional mechanisms of support, the difficulties encountered in determining the appropriate care, and estimates of the prevalence of violence against women.

RESULTS: Notably, 92 physicians responded to the questionnaire. Of these, 85% had already provided care in one or more cases of violence, and 60% believed that <20% of the women received adequate care in these cases, mainly due to the short-time frame of the consultation, lack of team preparation, and lack of institutional resources. A total of 61% of the participants believed that they were not prepared to provide adequate care in those cases.

CONCLUSIONS: Most of the physicians interviewed, although reported to have sufficient knowledge to adequately treat victims of violence, did not provide such care due to lack of institutional support.

KEYWORDS: Gender-based violence. Intimate partner violence. Sex offenses. Domestic violence. Patient-centered care. Obstetrics and gynecology department, hospital.

INTRODUCTION

Sexual, domestic, and intimate partner violence against women is a public concern worldwide, because one in every three women will face violence in their lifetime[1,2]. In 2016, 4,645 Brazilian women lost their lives due to violence of this kind, which has grown by 6.4% in the past 10 years[2,3].

The concept of violence against women may be understood as a relationship characterized by power inequality, which is the end result of a historical process and sociocultural subordination of women to men[4]. Its specific characteristics include male offenders (in 70–90% of cases worldwide), an intimate partner, someone who is trusted, and a family or affectionate relationship linked to the victim and, most of the time, the violence occurs in the domestic environment[2].

Besides being a violation of human rights, violence against women causes immediate and long-term health outcomes, including physical trauma, unwanted pregnancy, miscarriage, gynecological complications, the transmission of infectious diseases and mental disorders[5,6], and high-risk factors for developing a smoking habit or alcohol and drug addiction[7]. Prevention strategies are still scarce and only a few, such as scholastic education, micro-funding programs for women, and reduction of access to alcohol, are efficient but still not widespread[8].

In Brazil, the Maria da Penha Law (Law No. 11.340/2006) was passed in order to treat the phenomenon of domestic violence in an integrated manner[9]. Under this law, social assistance instruments were created to provide victims with lifestyle alternatives, protection, and emergency care[10]. The health system constitutes one of the main gateways of support for these women, because in many cases they seek out these services before calling the police or resorting to special courts for relief[11,12].

Since 2011, declaration No. 104 of the Ministry of Health established the requirement for compulsory notification of any identified or reported case of domestic or sexual violence[9].

Health professionals, however, face a number of difficulties and limitations in the notification of cases, such as how to recognize victims, how to approach and screen

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Conflicts of interest: the authors declare there is no conflicts of interest. Funding: none.
Received on March 03, 2022. Accepted on April 05, 2022.

patients, and even more difficult, how to manage them in the hospital[13,14]. In a study conducted by the Royal College of Physicians and Surgeons of Canada, 94% of gynecologists (GYN) never had a protocol for screening such victims and the same percentage of participants believed that the screening was inadequate[15].

National and international studies in bioethics point out still greater barriers to delivering this physician-centered care, which includes value judgments about victims, lack of training of professionals, and the invisibility of cases in which there was no active questioning[16,17].

The gynecologist is often the first responder providing care for these victims, and the studies conducted so far have shown a lack of knowledge on the part of GYN and obstetricians (OB) regarding the identification of cases and their management[18].

The objective of this study was to evaluate the knowledge level of OB/GYN concerning the provision of care to women victims of violence in the public health system and to ascertain the existence of institutional mechanisms in order to support victims and provide adequate care.

METHODS

Design of the study and study population

A cross-sectional and descriptive study was conducted with an electronic questionnaire (Appendix 1) by obstetrics and gynecology physicians who provided emergency care in the public health system irrespective of the hospital.

Participants were recruited through suitable WhatsApp groups. The transmission list was composed only of OB/GYN who worked in a gynecological emergency room and included 860 professionals from more than nine different hospitals in the state of São Paulo, Brazil.

An electronic invitation was sent to the groups who agreed to participate in the study. At the beginning of the questionnaire, we applied the inclusion criteria and, after data collection, the exclusion criteria for the study.

1) Inclusion criteria: physicians working in the OB/GYN emergency room at any hospital in the public health system, regardless of whether they also delivered care in the private sector, who agreed to and signed the informed consent form.
2) Exclusion criteria: physicians who delivered outpatient care only in a private hospital and did not either agree with the terms of the informed consent or complete the electronic questionnaire.

A self-applied electronic questionnaire required participating physicians to complete all 19 questions about the care of women with complaints or signs of violence (physical, domestic/intimate sexual partners) in the OB/GYN emergency room at public health hospitals.

The authors created questions based on a questionnaire completed by physicians working in prenatal care in the study by Alicia J. Long et al.[15] that was adapted for daily care in the emergency room. The authors included questions on the difficulties encountered by health professionals when providing care to victims of violence, as pointed out in other studies published in the literature[16], and the definition of domestic violence according to the Brazilian law[19].

The questionnaire (Appendix 1) was validated by means of a pilot study, including eight physicians. At the end of the questionnaire, an open field was added to record suggestions and critiques to be used in the development of the final questionnaire.

Ethical aspects

This project was approved by the Ethics Committee for Research Involving Humans, CAAE no. 14503519.7.0000.0071. The informed consent form was made available on the first page of the electronic questionnaire, and the confidentiality of the participants who responded to the questionnaire was strictly observed.

Statistics

No formal calculation of sample size was performed due to the largely descriptive nature of the research. Convenience sampling was used to select the number of participants recruited.

Categorical variables were described by their absolute and relative frequencies and numerical variables, using means and quartiles, in addition to minimum and maximum values[20]. To investigate possible associations between questions and categorical responses, the chi-squared or Fisher´s exact test was used, and the groups of interest were compared via estimates of percentages using the Mann-Whitney non-parametric tests. Analyses were conducted with the aid of the statistics package, SPSS, and the significance level used was 5%[20].

RESULTS

Of the 860 physicians who received an invitation to participate in the research (excluding those who simultaneously participated in more than one group), 104 responded to the questionnaire and 12 met the exclusion criteria. Therefore, the final sample for this study included 92 responses that were analyzed.

The majority of participants were women (83.7%), and 71.7% of the questionnaires were completed by physicians aged up to 30 years. Of these, 69.6% of participants also provided care in the private health sector.

Among the included professionals, 89.1% had already assisted in a case of violence against women, but 30.4% of these physicians reported the absence of any protocol for the care of these victims at their working institution. In addition, concerning programs at the hospital on awareness and/or training of professionals to identify and assist these patients, 44.6% responded that these did not exist, and 37% did not know whether this type of program was present or absent at their institution. Of the 18.5% who responded "yes" to this question, 53% have never participated in such programs.

Concerning their experience with the violence situation, 47 of the 92 professionals had already experienced such a situation in their proximity. More than 90% of the professionals estimated that ≥20% of all adult women had suffered domestic violence at any time in their life.

Signs that drew the professionals' attention to the possibility that a patient was the victim of violence were as follows: symptoms or physical signs of aggression (92.4%), a medical history incompatible with the observed symptoms (88%), reports of having "problems at home or with partners" (82.6%), reports of having already suffered violence in the past (73.9%), patients who introverted, quiet, or distant during the consultation (69.6%), patients who cried (59.8%), and patients who reported an addiction such as drugs, alcohol, or tobacco (41.3%).

In relation to the approach taken to the patient, 80.4% of the professionals reported receiving important help from the multidisciplinary team. Only 59.8% reported that they talked to the patient about the importance of seeking help from family and friends. Only 4 reported not to broach the subject of violence. Of note, 63% of the professionals discussed the subject with the patient, 16% discussed the subject only if the patient reported violence, and 19.5% discussed the subject only to rule out a serious condition.

On case management measures to be taken, more than 80% of the professionals mentioned privacy guarantees and establishment of an environment of care, contraception and disease prevention, referral to a violence service after the initial care, activation of institutional protocol (existing cases), detailed and complete medical record, and care in coordination with the multidisciplinary team.

A total of 94.6% of these professionals believed that less than half of the patients who were victims of violence received adequate care in the OB/GYN emergency unit. The main difficulties mentioned by at least half of them were unprepared multidisciplinary team; short-time frame of visit (more than 70% of them reported a period of 10–15 min); lack of resources; and lack of knowledge of the resources available, what questions to ask, or how to express themselves. A total of 27.2% of the respondents reported feeling uncomfortable while discussing the subject.

Among the general questions about the care delivered, 58.7% believed that they were not providing adequate care to the victims of violence. Among those who believed that the care was adequate, 46.7% pointed to institutional support as the main contributing factor. All professionals responded that they would value the existence of an institutional protocol for violence cases and that they would be likely to follow it.

In a comparative analysis of the questions, we could discern that the existence of institutional protocols led professionals to feel more confident in care delivery. Although there was a tendency to improve the quality of care among health professionals who worked at institutions where there are protocols or who had participated in training and awareness-building activities, no statistically significant association was found.

Half of the professionals, who worked at institutions where there is a protocol, believed that they are providing better care for patients, compared to only 26.5% of the professionals at hospitals where there are no protocols or where there is only a referral protocol, and the difference was statistically significant (p=0.027) (Figure 1).

The percentage of professionals who believed they are providing adequate care to victims of violence was 75.0%; out of those who participated in training/awareness-building activities were promoted by their institution, and this perception was significantly higher than in groups who worked at institutions that lacked such activity or who have never participated in them (38.1%), although there are no statistically significant differences between these factors (p=0.061) (Figure 2).

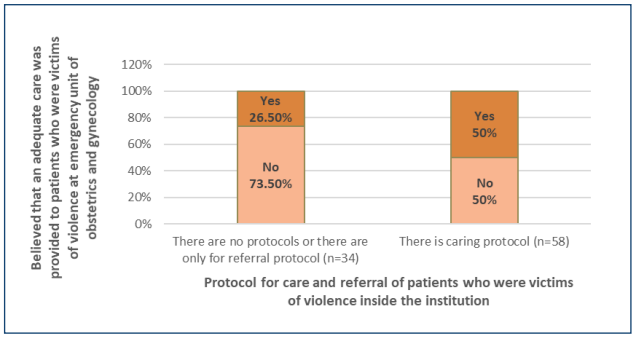

Figure 1. Relationship between institutional protocol and the belief that the care provided by physicians who participated in the study is adequate to patients who were victims of violence.

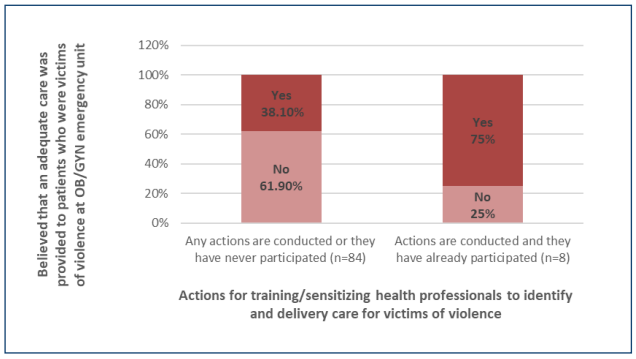

Figure 2. Relationship between institutional activities and adequate care delivery by physicians who participated in the study to patients who were victims of violence.

DISCUSSION

Our main findings in this study were that OB/GYN know how to furnish adequate care to victims of violence; however, we suggest that the main barrier to guarantee such care is a lack of institutional support as well as a standardized care protocol.

Approximately 90% of the respondents had already provided care in a case of violence against women and believed that 20% or more of the women population had already suffered some form of violence. Such a perception agrees with data from the World Health Organization (WHO)[16,17], which confirmed the relevance of cases of domestic violence in our society.

The main signs that drew the attention of the professionals to the possibility that patients were victims of violence are in agreement with those reported in the literature, namely, symptoms or physical manifestations of aggression, a medical history incompatible with the observed symptoms, reports of having "problems at home or with a partner," and reports of previous addictions, and all these situations are compatible with the risk factors identified in the WHO Handbook of Injury and Violence Prevention[7].

However, our sample of physicians apparently showed greater knowledge compared to studies in the literature. The study of Souza, a review of 16 articles on the care of violence victims, showed that 8 of them pointed to the lack of adequate training in medical education as one of the main barriers to adequate care[16]. Lack of knowledge was also described in a Canadian study that evaluated prenatal care physicians[15].

Concerning their approach to the patients, respondents were concerned about seeking help from the multidisciplinary team and about family support, fundamental points proposed in the protocols of the Ministry of Health and Federation of Gynecology in the State of São Paulo[18,21]. Only four physicians reported that they limited themselves to the patient's main complaint and did not investigate the suspected violence, data repeatedly reported in Hasse and Vieira's articles , which showed that 8.2% of the physicians had an inadequate approach[22].

Almost all interviewed professionals (94.6%) believed that less than half of these patients received adequate care in the OB/GYN emergency. An Australian study that addressed violence by an intimate partner in the setting of emergency services also pointed out that these difficulties are associated with the challenge of maintaining a non-judgmental posture and not mixing up care with their own sentiments, particularly among professionals who have experienced violence previously[23].

Of the interviewees, 30.4% responded that the place where they worked lacked any protocol for the care of the victims of violence; however, all professionals would be likely to follow an institutional protocol for care and referral of these patients. The WHO data confirm the importance of existing institutional protocols in facilitating and enabling adequate care of the victims of violence, where the direct approach and referral procedures for the case are identified[7].

It is of fundamental importance that OB/GYN provide an environment that allows the patient to feel comfortable discussing issues of violence while receiving medical care. A Brazilian group studied the consequences of domestic violence on woman's health during climacterium, administering a questionnaire to 124 patients who had suffered some form of violence during their lifetime. Of these, 80.6% did not reach out for medical care after an incident of violence. A total of 75% of the women interviewed indicated that if a medical professional had raised the matter of violence during the consultation, they would have asked for help. The study demonstrates that patients, if given a safe space to discuss issues of violence, would utilize the opportunity. It also highlighted that a majority of women believe professionals should encourage them to be more open about the matter and to proactively report any violence suffered.

It is also important to acknowledge that the violence suffered through life often impacts negatively on the victim's health, both physically and psychologically, lowering their quality of life and contributing to the genesis and/or aggravation of diseases. The same Brazilian study indicates a relation between the kind of aggression endured and the comorbidities in climacterium. The women who suffered physical violence had higher rates of depression and chronic immunological diseases. Those who suffered sexual violence more frequently presented depression and fibromyalgia; in addition, they also had a higher intensity of climacterium symptoms. Notably, 90.3% of the women interviewed had a negative

impact on their quality of life and behavior due to the violence suffered, and only 7.87% of them reported of having a satisfactory sexual life.

Concerning the limitations of the study, due to the descriptive and observational methodology used, we could not infer that the knowledge demonstrated by physicians is really applied in daily practice. Also, due to the type of questionnaire employed, physicians with a stronger interest in the subject matter may have been selected due to sampling bias. Another difficulty encountered was the evaluation of institutional resources, which were only inferred from the physicians' responses to the questions posed.

The main strength is to adopt the weaknesses in the health care of these patients mainly what concerns to lack of institutional support, raising a delicate but extremely important issue like violence against women, to engage health services to act as a source of not only treatment but also care, prevention, and reporting violence.

CONCLUSION

Most of the interviewed physicians recognize the importance and have sufficient knowledge to identify and treat victims of violence. However, the majority of them found it difficult to adequately deal with such cases due to the lack of preparedness of the multidisciplinary team, the restricted time frame of consults, and above all, the lack of institutional support.

As the emergency room is the first care, the professionals must be capable of recognizing the victims of violence and know how to refer them to a multiprofessional network.

AUTHORS' CONTRIBUTIONS

DDAM: Conceptualization, Data curation, Formal Analysis, Formal Analysis, Writing – review & editing. **GGFR:** Formal Analysis, Formal Analysis. **GSG:** Formal Analysis, Formal Analysis. **EJT:** Conceptualization, Formal Analysis, Formal Analysis, Writing – review & editing.

REFERENCES

1. Wood SN, Glass N, Decker MR. An integrative review of safety strategies for women experiencing intimate partner violence in low- and middle-income countries. Trauma Violence Abuse. 2021;22(1):68-82. https://doi.org/10.1177/1524838018823270
2. Nazareth JC, Prates NEVB, Oliveira RA, editors. Bioética e a violência contra a mulher – um debate recorrente entre profissionais da saúde e do direito. São Paulo: Centro de Bioética do Conselho Regional de Medicina do Estado de São Paulo – Cremesp; 2017.
3. Abdul-Ghani R. Polymerase chain reaction in the diagnosis of congenital toxoplasmosis: more than two decades of development and evaluation. Parasitol Res. 2011;108(3):505-12. https://doi.org/10.1007/s00436-010-2245-8
4. Teles MAA, Melo M. O que é Violência contra Mulher. São Paulo: Editora Brasiliense; 2002.
5. Barker LC, Stewart DE, Vigod SN. Intimate Partner Sexual Violence: An Often Overlooked Problem. J Womens Health (Larchmt). 2019;28(3):363-74. https://doi.org/10.1089/jwh.2017.6811
6. Wright EN, Hanlon A, Lozano A, Teitelman AM. The impact of intimate partner violence, depressive symptoms, alcohol dependence, and perceived stress on 30-year cardiovascular disease risk among young adult women: a multiple mediation analysis. Prev Med. 2019;121:47-54. https://doi.org/10.1016/j.ypmed.2019.01.016
7. World Health Organization. Prevenção da violência sexual e da violência pelo parceiro íntimo contra a mulher – Ação e produção de evidência Organização Mundial da Saúde. Geneva: WHO; 2012.
8. Madden K, Bhandari M. Cochrane in CORR (®): screening women for intimate partner violence in healthcare settings (Review). Clin Orthop Relat Res. 2016;474(9):1897-903. https://doi.org/10.1007/s11999-016-4957-2
9. Brasil. Ministério da Saúde. Portaria nº 104, de 25 de janeiro de 2011. Define as terminologias adotadas em legislação nacional, conforme o disposto no Regulamento Sanitário Internacional 2005 (RSI 2005), a relação de doenças, agravos e eventos em saúde pública de notificação compulsória em todo o território nacional e estabelece fluxo, critérios, responsabilidades e atribuições aos profissionais e serviços de saúde. Diário Oficial da União. 2011 Ago 12; Seção 1. Portuguese.
10. Brasil, Observatório da Mulher contra a Violência do Senado. Panorama da violência contra as mulheres no Brasil: indicadores nacionais e estaduais (Observatório da Mulher contra a Violência/Senado Federal, 2016). Brasília: Instituto Patrícia Galvão; 2016.
11. Alvarez C, Fedock G, Grace KT, Campbell J. Provider screening and counseling for intimate partner violence: a systematic review of practices and influencing factors. Trauma Violence Abuse. 2017;18(5):479-95. https://doi.org/10.1177/1524838016637080
12. World Health Organization. Prevenção da violência sexual e da violência pelo parceiro íntimo contra a mulher – Ação e produção de evidência Organização Mundial da Saúde. Geneva: WHO; 2012.
13. Clark CJ, Renner LM, Logeais ME. Intimate Partner Violence Screening and Referral Practices in an Outpatient Care Setting. J Interpers Violence. 2020;35(23-24):5877-88. https://doi.org/10.1177/0886260517724253
14. Todahl J, Walters E. Universal screening for intimate partner violence: a systematic review. J Marital Fam Ther. 2011;37(3):355-69. https://doi.org/10.1111/j.1752-0606.2009.00179.x
15. Long AJ, Golfar A, Olson DM. Screening in the prenatal period for intimate partner violence and history of abuse: a survey of edmonton obstetrician/gynaecologists. J Obstet Gynaecol Can. 2019;41(1):38-45. https://doi.org/10.1016/j.jogc.2018.05.003
16. Souza AAC, Cintra RB. Conflitos éticos e limitações do atendimento médico à mulher vítima de violência de gênero. Rev Bioét. 2018;26(1):77-86. https://doi.org/10.1590/1983-80422018261228
17. Trentin D, Vargas MAO, Pires DEP, Hellmann F, Brehmer L, Cézar LS. Abordagem a mulheres em situação de violência sexual na

perspectiva da bioética. Acta Bioeth. 2018;24(1):117-26. http://doi.org/10.4067/S1726-569X2018000100117

18. Andrade RP, Tizzot EL, Medeiros JM, Barwinski SL. Atenção à vítima de violência sexual. São Paulo: Federação Brasileira das Associações de Ginecologia e Obstetrícia (Febrasgo); 2018.
19. Brasil. Lei nº 11.340, de 7 de agosto de 2006. Cria mecanismos para coibir a violência doméstica e familiar contra a mulher, nos termos do § 8º do art. 226 da Constituição Federal, da Convenção sobre a Eliminação de Todas as Formas de Discriminação contra as Mulheres e da Convenção Interamericana para Prevenir, Punir e Erradicar a Violência contra a Mulher; dispõe sobre a criação dos Juizados de Violência Doméstica e Familiar contra a Mulher; altera o Código de Processo Penal, o Código Penal e a Lei de Execução Penal; e dá outras providências. Diário Oficial da União. 2006 Ago 08; Seção 1. Portuguese.
20. Altman DG. Practical statistics for medical research. London: CRC press; 1991.
21. Secretaria de Estado de Saúde do Distrito Federal. Manual para atendimento às vítimas de violência na rede de saúde pública do DF. Brasília: Secretaria de Estado de Saúde do Distrito Federal; 2009. 24-30 p.
22. Hasse M, Vieira EM. Como os profissionais de saúde atendem mulheres em situação de violência? Uma análise triangulada de dados. Saúde Debate. 2014;38(102):482-93. https://doi.org/10.5935/0103-1104.20140045
23. Dawson AJ, Rossiter C, Doab A, Romero B, Fitzpatrick L, Fry M. The emergency department response to women experiencing intimate partner violence: insights from interviews with clinicians in Australia. Acad Emerg Med. 2019;26(9):1052-62. https://doi.org/10.1111/acem.13721