

2.4 HEALTH POLICIES AND VIOLENCE AGAINST WOMEN IN BRAZIL: NORMATIVE FRAMEWORK FOR PREVENTION AND CHALLENGES

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In 1983, the theme of violence against women was included in the Integrated Women's Health Assistance Program (PAISM), incorporating sexual and reproductive rights of women in its actions, following the global trend in the feminist movement (MINAYO, SOUZA, SILVA and ASSIS, 2018). In 2004, PAISM was transformed into the National Policy for Integrated Women's Health Assistance (BRAZIL, 2004), giving priority to women and adolescents in contexts of violence (MINAYO et al., 2018).

Over the past eighteen years, Brazil promoted a series of advances in its legal framework, assuming in the aftermath of international legislations, the necessity to focus attention of public health system on gender violence, as a serious social problem and severe violation of Human Rights (SCHRAIBER, 2001; BRAZIL, 2019). The national framework is distributed among laws and technical regulations for primary, secondary, and tertiary prevention. This article briefly explores some of the main Brazilian norms pertaining to the prevention of violence against women.

In the field of primary prevention, attention to epidemiological ends may be observed when, in 2003, notification of cases of violence against women became mandatory with an aim to share information within the sanitary system as established by Law n. 10778/2003 (BRAZIL, 2003).

From the enactment of Law n. 10778/2003 up to 2018, a total of 1,282,045 cases of violence against women, children, elderly, indigenous populations and LGBTI (BRAZIL, 2019) had been reported. It is important to realise that even though the law came into force in 2003, the Vigilance System of Interpersonal and Self-Provoked Violence (VIVA/SINAN)²⁶ only

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26 This system is part of the national health monitoring and has as its scope "knowing the magnitude and gravity of violence by means of producing and disseminating epidemiological information and defining public policy to combat such violence such as strategies and interventions in prevention, assistance, and protection of people in violent situations", according to information extracted from the official Health Ministry website: <<http://www.saude.gov.br/vigilancia-em-saude/vigilancia-de-violencias-e-acidentes-viva/vigilancia-de-violencias/viva-sinan>>. Retrieved: August 26, 2020.

began to register cases in 2009. It was only in 2011, with the publication of Norm MS/GM n. 104, of January 25, 2011, that notification became effectively compulsory throughout the national territory (BRAZIL, 2019).

Along with an increase in the number of notifications in that period, a growing number of municipalities reported at least one case of violence against women during the year (BRAZIL, 2019). In 2011, 38% of the country's municipalities had notified cases in the system, while in 2018 this percentage reached 79% (BRAZIL, 2019).

Between 2011 and 2018, more than half of notifications (53.4%) corresponded to young women between 15 and 39 years old. Among children (0 to 9 years old), an elevated proportion of neglect/abandonment can be observed (34.5%), followed by sexual violence (29.8%). For the group of adolescents between 10 and 14 years old, sexual violence was the most common type of notification (42.3%). Within the ages of 15 to 29 and 30 to 59, physical violence stood out with proportions of 60.3% and 62.3%, respectively. For the population of 60 years old or more, physical violence also prevailed (43.4%), with a significant proportion in cases of neglect/abandonment (25.0%) (BRAZIL, 2019).

In terms of secondary prevention, the Decree n. 7958, from March 13, 2013 (BRAZIL, 2013), provided guidelines for professionals at the Unified Health System (SUS)²⁷ on how to treat victims of sexual violence following directives for humanised assistance and qualified listening²⁸. Another significant step taken by the health system in combating sexual violence was the enactment of Law n. 12845/2013, making the integrated treatment of people in situation of sexual violence mandatory within SUS (BRAZIL, 2013a).

After the referred legislation came into force, the Ministry of Health included, in the National Registration of Health Establishments (CNES), a specialised service for the support of people in situation of violence (Code 165) that enabled the provision of the following services directed towards gender violence: *i*) integral attention to people in situation of sexual violence (Code 286); *ii*) ambulatorial attention to people in situation of sexual violence (Code 425); *iii*) termination of pregnancy allowed by law (cases of rape and fetal anencephaly, in a total of 101 health units). The possibility of registering the service by speciality was a significant advance for policies to prevent sexual violence, since only those under CNES may receive public funding to deliver such services²⁹.

The referred services registered a tendency of increase between 2014 and 2018, except for ambulatorial attention, that has been falling since 2017 (BRAZIL, 2018). The registered

27 SUS is the Brazilian universal public health system, that offers since primary attention to hospital care. It focuses on "health with quality of life, aiming at the prevention and the promotion of health", according to information extracted from the following website: <<https://www.saude.gov.br/sistema-unico-de-saude>> Retrieved: March, 2020.

28 Before enacted the referred decree, guidelines for humanised and not re-victimising treatment was already available on the part of health professionals, by means of *Norma Técnica de Prevenção e Tratamento dos Agravos Resultantes da Violência Sexual contra Mulheres e Adolescentes* (2012), with its first edition published in 1999.

29 Information extracted from the following website: <<http://cnes.datasus.gov.br/>>. Retrieved: March, 2020.

growth shows many regional disparities, however, especially in the Brazil's Northeast Region, where some capitals did not have any service registered to receive victims of sexual violence (BRAZIL, 2018).

Beyond the creation of service, it is necessary to look to its quality, following criteria such as good governance, calling for openness, integrity, and accountability on the part of public management (CADBURY, 1992). As affirmed by Tejasdas (2012), the mere normative provision for social protection (rights guarantee) is not enough, making it imperative that this protection be effectively materialised. One such example of a lack of correspondence between rights provided and those effectively delivered is the research started in 2018 (ongoing) by the Psychosocial Sector upon demand from the Unit to Combat Violence and Sexual Exploitation against Children and Adolescents (NEVESCA) of the Public Prosecution Office of the Federal District (MPDFT)³⁰. Preliminary results point that the level of services of integral attention to people in situation of sexual, family or domestic violence in the region, in spite of an expansion in terms of its unit numbers, do not correspond to the proportion needed to account for the growth of notifications in the local registration system (SINAN) in the Federal District, presenting also deficiencies in terms of human resources available.

Furthermore, the referred research verified a slow pace of institutionalisation of services to attend victims of sexual, familiar, and domestic violence, that up to 2019 existed only as a mere program provision. Edit n. 942, of November 18, 2019 (FEDERAL DISTRICT, 2019), finally qualified the existence of such services. Follow-up on the actual institutionalisation of such services is pivotal to guaranteeing its continuity.

In terms of the actual response to the practice of violence (tertiary prevention), between 2013 and 2019, there were new important normative advances in the health field, such as: i) Law n. 13239, of December 30, 2015, that brought about the offer and actual delivery within SUS of reparatory plastic surgery for lesions and sequels resulting from violent acts practiced against women (BRAZIL, 2015b), regulated by the inter-ministerial Edit n. 331, of March 8, 2016 (BRAZIL, 2016); ii) the Decree n. 7958/2013, establishing guidelines for health professionals on how to treat victims of sexual violence in the network of services connected to SUS (BRAZIL, 2013); iii) the inter-ministerial Edit SPM/MJ/MS n. 288/2015, that brought orientation for organising and integrating the treatment of victims of sexual violence by public security agents and the SUS professionals, focusing on the humanisation of treatment and registration of information, as well as the collection of vestiges of sexual violence (BRAZIL, 2015); iv) the Edit n. 1662/2015, that defined the eligibility criteria for services to collect vestiges of sexual violence within SUS (BRAZIL, 2015a).

30 The study in comment was solicited in the sphere of the administrative process number n. 08190.168529/17-81, ongoing at NEVESCA/MPDFT, established to follow up on the Research Program on Assistance and Vigilance of Violence – PAVs, currently transformed into the Specialised Centres of Attention to People in Situation of Sexual, Family or Domestic Violence – CEPAV.

Finally, and still in the field of tertiary prevention, it is important to remember the recent sanction of Law n. 13931/2019 (BRAZIL, 2019), that obligates health professionals to make an external communication to the police authority, in all cases of suspicion or confirmation of violence against women. The legislation came into force in March 10, 2020, and still lacks the publication by the Ministry of Health concerning the orientation for health professionals on cases of external communications about situations of violence against women that should be reported. According to the law, all the following types of violence are object of compulsory notification: *i*) suspected or confirmed case of domestic/intra family, sexual, self-provoked, human trafficking, slave labour, child labour, legal intervention and homophobic violence against women and men of all ages; *ii*) cases of violence outside family/ communitarian, in these cases only those violence committed against children, adolescents, women, elderly, disabled people, indigenous and LGBT* population shall be notified.

Regardless of the advances on the part of the Brazilian State such as the mentioned regulations for the integral treatment of women in situation of violence by the Health System, some challenges still lay ahead: *i*) integrate the health network into the other networks acting on combating violence against women (social assistance, public security and justice); *ii*) spread within the health system attention to women in situations of violence (including effective primary attention in health and the network of psychosocial and mental health); *iii*) establish guidelines for risk management of health units, with an aim to prevent femicide (in special, the intimate type); *iv*) prepare mental health professionals to assist cases of sexual violence (especially those working in the psychosocial attention network); *v*) guarantee treatment for the indirect victims of femicide in the Health System; *vi*) guarantee treatment for the many types of violence against women in the specialised services of attention to sexual violence registered in CNES; *vii*) implement Law n. 13931/2019 on the external communication of the Health System to the police authority in cases of violence against women, as well as defining the scope of such communication; *viii*) oversee structure (human and material resources) to services of integral attention to people in situation of domestic, sexual and family violence; *ix*) foster the institutionalisation of specialised services of attention to people in situations of violence to guarantee the sustainability of public policy of violence prevention.

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