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Women's primary care nursing in situations of gender violence

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Objective. Identify the actions conducted by primary health care nurses for women in situations of domestic violence. **Methodology.** Exploratory-descriptive study with a qualitative approach. Participants were 17 nurses who worked in the Basic Health Unit in a city in the interior of Rio Grande do Sul, Brazil. The data was collected through semi-structured interviews and the information processing was performed using the interview content analysis technique. **Results.** By acting in a context of the violence, the nurses describe some elements and strategies they use that allow recognition and action to combat violence, namely: acceptance and empathy, establishing a bond of trust between the professional and the woman, dialogue, and intent listening. The limitations mentioned by participants were: lack of professional training to address the situation, feeling of unpreparedness, lack of time for the workload, the professional's difficulty in recognizing and dealing with violence given its complexity, low efficiency of the service network, and the sense of professional impotence against the gravity and complexity involved in violence. **Conclusion**. The participants are not adequately prepared to care for women in situations of domestic violence. It is necessary that this issue be addressed in the training of nursing professionals.

Key words: nursing care; primary health care; spouses; violence against women.

Enfermería en la atención primaria de salud y el cuidar de las mujeres en situación de violencia de género

Objetivo. Identificar las acciones tomadas por las enfermeras de atención primaria de salud a las mujeres en situación de violencia de género. **Metodología.** Estudio exploratorio-descriptivo con abordaje cualitativo. Los participantes fueron 17 enfermeros que laboraban en la Unidad Básica de Salud de una ciudad del interior de Río Grande do Sul, Brasil. Los datos se recolectaron mediante entrevistas semi-estructuradas; el procesamiento de la información se realizó con la técnica de análisis de contenido.

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Resultados. Al actuar en el contexto de la violencia de género, el personal de enfermería describe algunos elementos y estrategias que utiliza y que le permite el reconocimiento y la actuación para enfrentarla, estos son: la acogida y la empatía, el establecimiento de un vínculo de confianza entre profesional y la mujer, el diálogo y la escucha con atención. Las limitaciones que mencionaron los participantes fueron, entre otras, la falta de formación profesional para enfrentar la situación, la sensación de falta de preparación, la falta de tiempo por la sobrecarga de trabajo, la dificultad del profesional para reconocer y hacer frente a la situación de violencia de género dada su complejidad, la baja eficiencia de la red de servicios, y el sentido de impotencia profesional contra la gravedad y la complejidad involucrada en este tipo violencia. **Conclusión.** Los participantes no están adecuadamente preparados para el cuidado de la mujer en situación de violencia de género. Es necesario, entonces, que esta temática sea abordada en la formación del profesional de enfermería.

Palabras clave: atención de enfermería; atención primaria de salud; esposos; violencia contra la mujer.

A enfermagem na atenção primária ao cuidar de mulheres em situação de violência de gênero

Objetivo. Identificar as ações realizadas pelo/a enfermeiro/a da atenção primária a saúde para mulheres em situação de violência doméstica. **Metodologia.** Exploratório-descritivo, com abordagem qualitativa. Os participantes foram 17 enfermeiros que trabalhavam em Unidade Básica de Saúde em um município do interior do Rio Grande do Sul, Brasil. Os dados coletados por meio de entrevistas semiestruturadas e processamento de informação foram realizados utilizando a técnica de análise de conteúdo de entrevistas. **Resultados.** Ao agir no contexto da violência o/as enfermeiros/as descrevem alguns elementos e estratégias que eles utilizam e que permitem o reconhecimento e ação para combater a violência, que são: o acolhimento e empatia, estabelecimento de um vínculo de confiança entre profissional e mulheres, diálogo e escuta atentiva. As limitações mencionadas pelos participantes foram: a falta de formação profissional para resolver a situação, o sentimento de falta de preparo, falta de tempo para a carga de trabalho, a dificuldade do profissional em reconhecer e lidar com a violência dado sua complexidade, baixa resolutividade da rede de atendimento, e a sensação de impotência profissional frente à gravidade e complexidade que envolve a violência. **Conclusão.** Os participantes não são adequadamente preparados para cuidar de mulheres em situação de violência doméstica. É necessário que esta questão seja abordada na formação dos profissionais de enfermagem.

Palavras chave: cuidados de enfermagem; atenção primária à saúde; cônjuges; violência contra a mulher.

Introduction

Violence is a major and global issue, with macro-structural roots, representing a historical social problem and presenting a danger to health. It is diluted in society, polymorphous, multifaceted, and has several intertwined manifestations that interact, feed back, and strengthen themselves.[1] Physical and sexual violence against women is a public health problem that affects more than a third of all women in the world, thereby constituting a global health problem of endemic proportions.[2] Gender violence entails each and every action that implies physical, moral, sexual and/or psychological damage that imposes constraints on women, whether in the private or public sphere. This definition is anchored in the analytical concept of gender, designating male and female behavior rooted in socio-cultural elements that individuals have inherited from their forebears.[3] Gender-based violence results in serious consequences for women's physical and mental health. A cross-sectional study carried out in Colombia on 150 women with a history

of violence shows that depressive symptoms and chronic pain were present in 74% and 42% of participants, respectively.[4]

Currently, Brazil counts 4.4 murders per 100 thousand women, a figure that places it in the 7th place of countries for this type of crime. In 2012 in the state of Rio Grande do Sul, 93 women were killed, victims of domestic violence, more than two women dead per week. In the national ranking of female homicides Rio Grande do Sul occupies 18th place, with 226 cases per 100 000 women.[5] The health sector is characterized as a gateway for the care of women in situations of violence.[6] In this context, health professionals play a strategic role in identifying violence, as well as in these women's health care and their referral to specialized services.[7] Primary health care services are key to detecting violence against women because they have wide coverage and close contact with women, and are thus able to recognize and address the case before more serious incidents develop. To this end, the health care system requires prepared and trained professionals to provide a comprehensive and problem-solving assistance to women.[8]

With respect to care for women in situations of gender violence, the nurse must be able to approach these women in an empathic way, seeking to offer humanized care and qualified listening, enabling mutual trust between the professional nurse and the woman, so that the latter can discuss the occurrence of the aggression. From this approach, the nurse, along with the woman and the multidisciplinary team, can prepare a strategic plan to combat, manage, and prevent the recurrence of violence in the woman's life.[9] The importance of nursing actions is thus highlighted within the context of gender violence in primary care. Such reflections oriented the present study, whose guiding question was: What actions does the nurse perform in caring for women in gender violence situations, and what limitations are faced in this context? These reflections also molded the study's objective: To identify the actions conducted by primary health care nurses for women in situations of violence.

When one comes to understand that violence is a serious public health problem, especially in primary care—which requires specialized professionals, mainly nurses within a multidisciplinary team, as well as a network of qualified support—it becomes possible to apply measures to deal with violence. The production of knowledge in Nursing aims to strengthen and clarify concepts, define actions, and devise management strategies relating to the subject of gender violence. Thus it is believed that nurses' performance within this context can contribute to early identification, prevention, quality of care, and the combat of violence against women.

Methodology

This is an exploratory, descriptive study using a qualitative approach, conducted in ten Basic Health Units (BHU) of the primary health care network of a city in the interior of Rio Grande do Sul, Brazil. Study participants were 17 randomly-selected nurses who met the following inclusion criteria: exercise the nursing function and have a minimum experience of three months in primary health care. Exclusion criteria were: being away from work during the data collection period, working temporarily, as a substitute, or not as part of a BHU healthcare team. To determine the number of participants we used sampling saturation, which stops the data collection at the existing number of subjects when new interviews are noted to represent a quantity of repetitions in their content.[10]

Data production occurred from September to October 2012, using the semi-structured interview technique. The interviews were conducted by the lead author of this paper, based on a script prepared by the researchers composed of questions about the work of nurses in the context of gender violence; actions and tools that they use in the treatment of women in situations of violence; knowledge about policies and laws dealing with the subject; and whether nurses felt empowered to perform this function.

Attention was paid to the interview setting, which was a private room in the interviewee's workplace, where there were no interruptions. At that time, the informed consent form was presented and explained to the participants and signed by them. There were no refusals to participate in the survey. This research followed the ethical precepts of Resolution 466 / 2012,[12] with approval from the Ethics Committee of Our Lady of Fatima College (Faculdade Nossa Senhora de Fátima), Rio Grande do Sul (No. 104 425. Approved Ethics Certificate: 04541112.7.0000.5523). To ensure confidentiality we used a code with the letter I (Interviewee) and ordinary numerals in ascending order to identify the participants (I1, I2, ..., I17). The interviews lasted on average thirty minutes, and were audio recorded and later transcribed for content analysis, which consisted of three steps: pre-analysis; exploration of the material; and treatment of results, inference, and interpretation.[11] For the purpose of interpretation, we sought to align the structured interview material with the literature related to the subject matter. In the analysis we highlighted words that formed the core of the meanings, composing two categories: actions taken by nurses in their care of women in situations of gender violence, and limitations to the nurses' performance in the face of gender violence.

Results

The participants in this study were aged between 25 and 57 years, 3 male and 14 female. The professionals 'practice experience ranged from four months to 21 years. It was found that only one did not have a graduation degree (*lato sensu*), while the other were graduates in the areas of Administration of Nursing Services and/or Family Health.

Actions taken by nurses for the care of women in situations of gender violence

With regard to the action of identifying the situation of violence, the nurses mentioned the women's difficulty in verbalizing about violence. Therefore, the duration of the relationship or connection and involvement with the women enables the nurse to approach this experiential context: *We, nurses, sometimes know about the problem because the Community Health Agent sees many things in the home visit and tells us about them, because we perceive in her speech, we see in her expression that there is something more! But she does not verbalize, she does not open herself up, she does not spe*ak (I01); *Sometimes even when doing the screening test for uterine cancer, you know? Sometimes they open a little more, because then you will even see their bodies, you will examine, over time, because it is very difficult for them to come and say spontaneously, 'then I was raped, I suffered abuse, then I suffered violence* [...] *It's hard!* (I02); *A woman in a violent situation, for you to identify requires some talking time, you have to fish for information during the conversation with her because it is not a thing that comes out spontaneously* (I11).

In terms of acting in the context of violence, nurses describe some elements and strategies they use that allow recognition and action in fighting violence, including acceptance and empathy; establishment of a bond and trust between professional and woman; and dialogue and intent listening: *Certainly, the technical side is very important, but if you are not able to connect with her in an empathetic way, the woman will not be open to our care* [...] (I03); *All the people arriving are welcomed and female victims of violence often come due to other complaints, they come to seek a medical consultation or come to talk because she has a gynecological complaint or because it is a problem with the child's school — we have to listen to her, to welcome her!* (I01); *At first it is to welcome and see what needs to be resolved first*! (I17); *While she has no real confidence in the professional she does not open the reality of her life for you* (I11); *When I have a bond with the woman! As I have with most, I visit and talk to them and see what's going on* (I16); *Hearing the woman, listening and not pretending you're listening! Because then you are not qualified* (I03); *The talk is always very open! Many of them talk like*

a confession to us, not as a denouncement (I04); *The service is mainly for guidance. So we listen, provide guidance. We try to listen to what she has and from there I show her what is available for her, what can help her* (I15).

The nurses also reported that referrals to intervention services are an integral part of care for women in situations of violence. The following excerpts show this: *We notified the NAIS [Notification Aggravation Information System], and headed for the female police station. That's how you do it* (I10); *We always attempt to refer them; if it is a physical aggression to the Military Police to make the police report, and if it is sexual violence we have to refer them to the reference hospital for care as needed and according to the type of violence that happened* (I08).

Limitations to nursing action in cases of gender violence

The limitations mentioned by nurses while acting in situations of gender violence include: lack of professional training to address the issue, marked by a feeling of unpreparedness; lack of time due to work overload; the professional's difficulty to recognize and deal with the situation of violence, given its complexity; low efficiency of the health care network services; and the professional's feelings of impotence in the face of the gravity and complexity involved in violence: *No, I do not feel qualified! Because the teaching is very deficient in this matter, even during graduate school. I think I learned only vaguely, without the mention of humanized care. I feel unprepared!* (I03).*In the initial reception I feel capable, but I do not feel very capable in some referrals, because I do not have knowledge of all possible referrals, and how to act in this situation is a very complex problem, involving children, family, justice* (I06); *I do not feel qualified! I think I miss more training on how to approach her. A lot is based on our way of working, but I do not know how to approach, how to best make her bring it up and how to effectively help her* (I12); *We need to be available to listen and sometimes we cannot. Lack of time, right? We are always full of things to do, a lot of work, we end up not giving everything we have to do that service* (I09); *Often the nurse's situation is quiet, often it entails pretending you're not seeing the situation through the trouble. The situation ends up being masked by other situations, but the issue of violence itself ends up being disguised* (I11); *The difficulties are that we do not always see resoluteness in the service* (I14); *I find it difficult to believe they are convinced about the denunciation. Because they already heard reports about other women, or have made them. That they go there and make a document or something that according to which someone has to keep distance is not exactly so in practice* (I05); *It is the impotence of the professionals. You want to act in a faster way, you want to make her denounce and she does not want it. Anyway, this is a difficulty* (I13).

We identified in the nurses' speech that the limitations to the care for women in situations of violence are inscribed in professional issues related to the work process, as well as institutional ones regarding a lack of resoluteness of actions in the health care network and in the women's lives.

Discussion

In the present study, the nurses highlight women's difficulty to verbalize situations of violence experienced in their home. According to scholars, the feelings of guilt and shame, isolation, and especially the stigma appear to be the major obstacles for women to verbalize this situation. A stigmatized experience thus results from the women's shame of being recognized by society as beaten and abused by intimate partners, which would in turn place them in a situation of inferiority and social disadvantage.[13] Brazil's Ministry of Health recognizes the importance of primary health care in the process of identifying women experiencing violence and also advocates that the bond established between people/families/groups and professionals/teams favors the construction of affective relationships and trust between the health user and the health

worker, which facilitates the promotion of health and prevention of grievances.[14]

The professionals in this study mentioned the importance of creating a bond, a relationship permeated by trust, with the women, so they can break the stigma and verbalize about the situation they experience. This finding corroborates a study that names this bond with professionals as a condition for listening and reporting violence.[15] To develop care actions for women in situations of violence, nurses use some enablers such as attentive listening, empathy, and a bond to welcome these women, in addition to the technical-assistance devices in the health service. Welcoming them is understood as an attitude and practice that promotes the building of trust and commitment of the users with the teams and services, aimed at resolving the answers to the problems identified through listening. This assumption is the basis for a more assertive care practice for women in situations of violence.[15]

In the search for a resolution, or even for identifying situations of violence, qualified listening must be used in order to obtain more information on, for instance, the health, housing, and education conditions of the woman and her family group. Based on an open dialogue and trust between professional and user, a bond is formed to enable identification through the woman's speech, thus establishing the gateway for diagnosis and for taking preventive measures together with the woman.[16,17] In the participants' speeches, qualified listening is seen as an important tool for the work of nurses in the context of gender violence. This ability makes it possible to understand the woman beyond the outward signs of injury, since it allows the identification of the psychological scars generated by violence.[18] Moreover, we emphasize that it is through nursing care that qualified listening is applied, this being the main instrument available to perceive the situations in which the women are involved when violence occurs, allowing, through the bond created between the nurse and the woman, the resolution of the problem.[9,19]

According to the results of this study, the nurses recognize the need to empathize with the woman in the diagnosis of violence. Empathy is one of the mechanisms of humanized care and is necessary for the treatment of physical complaints, the construction of a bond, and the provision of effective attention, thereby generating referrals, guidance, and possibly preventing the recurrence of violence. In order to understand the reasons that led the woman to the situation of violence and sometimes remain in it, the professionals' objective must be to understand the experiences and feelings of the health service user.[20] However, attention to women in situations of violence goes beyond humanized care. The nurses in this study reported that women in situations of violence seldom look to a BHU for help in escaping a violent situation. Studies claim that most of the time women go to a BHU for medical appointments, often recurring, with gynecological complaints, headaches, or even to seek help in solving health problems in the family —and from these strategies they end up revealing their problem.[21]

At times, because violence occurs frequently, it goes unnoticed by health professionals, resulting in its continuation and the occurrence of new cases. Therefore, the programs designed to eradicate violence do not succeed due to the under-reporting of cases, the neglect of professionals, their unpreparedness, and even the lack of demand and confidence from health service users in seeking aid, depleting the public coffers as a result of an incorrect application of funds available for violence prevention.[8] In addition to the approach started by humanized care, nurses revealed that their performance in the context of gender violence is through women's referrals to the service network. In their operations, however, these professionals face the challenge of showing the women their rights and the supports available to them to face the situation. In this confrontation, nurses should seek resources together with all qualified professionals from other areas to assist them in the resolution of this situation. The decision-making and resolution of cases of violence require that several sectors be involved, such as health, social welfare, public safety, education, justice, and psychology.[19]

It is noteworthy that the referral to support services occurs according to the women's need

and type of violence affected. It is known that for the operation of a service network skilled teams and well-structured services are necessary to give the necessary assistance for problem resolution, prevention, and social reintegration of women and aggressors. In this sense there are shelters, reference centers, courts of domestic and family violence, women's defenders, centers for rehabilitation and education of the offender, and others. This service network must be coordinated between government, non-government, and community services to avoid women's feeling of insecurity and to provide skilled care aimed at them.[19] Besides guidance toward the service network, some participants also reported using the compulsory *Notification Aggravation Information System* form, which is a document filled out in cases of suspected or confirmed violence. This compulsory notification is mandatory for all medical health professionals - nurses, dentists, veterinarians, biologists, biomedical doctors, pharmacists, and others in the profession, as well as those responsible for public and private organizations and establishments of health and education (Article 7).[22] The important role of health professionals is emphasized, as they are responsible not only for the care of women in situations of violence, but also for the production of useful information to combat this problem.

In order to encourage the adoption of notification services, a decree was made in 2011 defining the notifiable diseases, injuries, and events, including violence against women, which establishes the flow, criteria, and responsibilities of professionals throughout the Brazilian territory.[23] A study conducted in southern Brazil shows some disregard of the surveillance service for the implementation of the notification and its registration in the system, which is not always considered a priority, and an underestimation of the reality of situations of violence.[15] This study found, based on the statements of the respondents, that lack of time for humanized care and the unpreparedness for this type of care are limiting factors to the nurses' performance and contribute to the underreporting of cases of violence. Other studies claim that underreporting is due to unpreparedness of health professionals, lack of time for thorough service, lack of information related to the systematization of care in these cases, among other reasons.[21] In addition, it is known that issues of ethnicity, race, and preconceptions, either by the team or by the woman herself, subordinated to her companion, are factors that directly influence the occurrence of underreporting.[8] Yet another aspect limiting the nursing role in caring for women in situations of violence, which was pointed out by the participants, refers to the extent to which women can expose themselves while searching for aid and accepting nursing work and the support network. This reveals that, in addition to depending on the nurse's differentiated attention, women need a certain awareness of their rights of citizenship. To that end, they need to be presented the ways they have to remedy their situation. It is understood that the best person to present them that would be the nurse, who is included in the area that covers the women's home, through the bond created between the community and the BHU.

The reality observed in this study is that nurses do not feel empowered to care for women in situations of violence. Generally, nurses are the reference professionals of the BHU, who together with the nursing staff maintain close contact with users. From that link, along with preventive measures, the necessary care for each grievance is provided. Based on this premise, it is in the BHUs that policies for preventing, combating, and addressing health problems must start, with nurses as their main articulators.[24]

It is understood that to provide humanized and qualified help it is necessary to provide constant training for all professionals working in the health center, as well as good conditions in the BHU's facilities and sufficient equipment and resources. However, the effectiveness of care is achieved by planning the actions that will be offered to users, as well as adopting joint measures between health professionals and users to reach the objectives of the planning.[6] When it is recognized that violence is a serious public health problem that needs specialized professionals and a support network of qualified individuals, it becomes possible to

apply the coping measures for violence. Thus, it is possible to understand the construction and implementation of strategies already advocated by the policies for fighting and coping with violence through health professionals. To make this possible, however, there should be tools and continuing education that allow the application of these policies.[18] Knowing the limits and potential of the healthcare practice of nurses is an issue that supports the planning of actions to transform and strengthen the weaknesses highlighted above, thereby including the review of the assistential model of care and the guidelines that support the care practices in health and nursing.

It is concluded in this study that there is a need to create spaces for nurses to reflect on their professional practice in caring for women in situations of violence, pointing out potentialities and limits that can be overcome by strengthening the network of care for women, including training and continuing education in the work processes of nurses. The approach to the theme of professional training of nurses, and spaces to qualify them in their services, will allow a better professional preparation for the care of women. The results should be interpreted considering some limitations. The study presents only the nurses' perspectives, which, although showing an important identification within the care process, must be supplemented by those of other health professionals for understanding the care actions for women in primary health care. It is also worth noting that the results are restricted to a single municipality. The development of new studies on this subject is suggested in other scenarios, using other methods. It is hoped that these results contribute to the care practice of nursing, encouraging the improvement of the daily activities they perform in the context of gender violence.

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