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Violence against women: the limits and potentialities of care practice

Violência contra a mulher: limites e potencialidades da prática assistencial

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Violence against women; Family health program; Public health nursing; Primary care nursing; Nursing, practical

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Abstract

Objective: Analyzing the limiting and potentializing situations during the assistance of the Family Health teams to women in situations of violence.

Methods: This is a participatory research carried out with 30 professionals from six Family Health teams. Data production was the result of eight workshop-meetings. The technique of thematic content was used for data analysis.

Results: User embracement is potentialized by qualified hearing and the elaboration of an assistance plan shared with users also respecting their decisions and their family context. It is limited by the understanding that women should report the violence to enable the proposition of an intervention. It is recommended to resume concepts and practices of gender as well as human and social rights to strengthen supportive actions.

Conclusion: Home visits and the bonding between professionals and users are considered potentializers of user embracement and the limitation is the difficulty of obtaining the report of women who suffered violence and engage them in a care project.

Resumo

Objetivo: Analisar as situações limitadoras e potencializadoras da prática assistencial das equipes de Saúde da Família à mulher em situação de violência.

Métodos: Trata-se de uma pesquisa participante com 30 profissionais de seis equipes de saúde da família. A produção dos dados foi resultado de oito reuniões-oficinas. A análise dos dados se deu segundo a técnica de conteúdo temática.

Resultados: O acolhimento mostra-se potencializado com a escuta qualificada e elaboração de plano assistencial compartilhado com a usuária respeitando sua decisão e seu contexto familiar. Está limitado pelo entendimento de que a mulher deve relatar a violência para que seja possível propor uma intervenção. Recomenda-se retomar conceitos e práticas de gênero, direitos humanos e sociais para fortalecer ações acolhedoras.

Conclusão: A visita domiciliar e o vínculo entre os profissionais e a usuária são considerados potencializadores do acolhimento e, como limite, observa-se a dificuldade de obter o relato da mulher que sofreu violência e de comprometê-la em um projeto assistencial.

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Introduction

Violence against women started to be considered a problem of health and public health in 1996, and as a global issue.[1] It is also characterized as gender violence due to the fact that it is linked to stereotypes of unequal behavior of the male and female genders which are socially constructed according to the culture and time.[2]

In Brazil, the problem is treated as a health issue with actions aimed at interdisciplinary assistance to women which occur with numerous challenges. Especially in actions that identify cases in the various types of health services and with the articulation of curative and preventive care practices.[2]

Healthcare practices are aimed at addressing the consequences of violence, especially the physical and psychological harms, reinforcing the idea that these aspects of the problem would be due to the sector. This perspective is based on a model of health strongly rooted in biology, which hinders the development of a social practice that requires knowledge and technological skills that are not domain of all professionals.[3]

Primary Healthcare is one of the health sectors which aims to meet women in situations of violence by recognizing confirmed and suspected cases. These actions included in the Program of Integral Assistance to Women's Health encompass violence along with other demands of women, becoming part of the healthcare practice.[4]

The knowledge of the limits and potentialities of the practice of Family Health Teams is an issue that subsidizes reflections for planning actions that transform and strengthen the visible weaknesses, often including a review of the care model and guidelines that govern the practices.[5]

User embracement as a posture and practice builds a relationship of trust and commitment between users and the health teams and services, aiming at responses to the problems identified through listening. This presupposition is the basis of a more assertive care to women in situations of violence. Given the above, the study aimed to investigate the limiting and potentializing situations during the assistance of the Family Health teams to women in situations of violence.

Methods

The study design is a participatory research, which focuses on the construction and exchange of collective knowledge with the integration of scientific and practical knowledge. The participatory research promotes group analysis of knowledge and how it will be used in reality; critically examines information, establishes causes of the problems, possible solutions, and proposes referrals.

The study was carried out between September and December of 2012 in a municipality located in the northwestern region of the state of Rio Grande do Sul, Brazil.

Among the 67 professionals participating of the Family Health teams, 30 active professionals were included. It is noteworthy that in this type of study the representativeness criterion of the group is given qualitatively due to the social representation that they have for the investigated theme.

Data were collected as follows: 1) organization of an Introductory Seminar with the presentation of the project and application of a questionnaire with sociodemographic questions. The group was divided into five subgroups that discussed the theme of violence against women and care practice in the context of the study; 2) critical analysis of the priority problems with the completion of two meetings: in the first meeting were discussed the limiting and potentializing situations in care practice. In the second one were discussed the problems, causes, solutions and actions to address these problems, and 3) programmation and implementation of an action plan followed by two more meetings, three educational workshops and a Final Seminar. In the meetings were elaborated the problem of practice and the planning of educational workshops. The Final Seminar aimed to evaluate the knowledge and the transformation of the care practice.

Data were recorded, transcribed and analyzed using the method of content analysis of Bardin.

The development of study followed national and international recommendations on ethics in research involving human beings.

Results

User embracement, bond and home visit: potentiality for the practice

Participants offer the unit of the Family Health teams to women suffering violence as a place for assistance and refer them to the nurse and/or staff for treatment.

Professionals, when designing the project to cope with women, respect their decisions and the context in which they live, as the desire of husband's rehabilitation from alcoholism, which is showed in the following speech:

There was a case [...] she thought we'd better hospitalize him, put him in mandatory rehab to treat alcohol and drug addiction than file a report with the Police. I informed quite carefully about the services but ended up agreeing with her, [...] then we chose to treat alcoholism and then, maybe, who knows, if the behavior continued, then yes.

Assessing the risk situation with the woman and proposing security measures and referral to other protected places is another intervention cited:

Assessing the risk situation, [...] actually assessing every risk situation means seeing the case, rethinking together with the abused person, 'cause many times she goes home, doesn't denounce and doesn't come back to us 'cause she dies. So, assessing the risk situation and often social services can't let them come back home. I think it should protect the victim.

In humanized assistance as a care practice, considering the specificities of each case, the protocol must be evaluated and used without rigor, which is confirmed in this speech:

We had four cases there and the actions were different, particular of each situation, of each family and of the possibilities that the family has.

The *bond* with professionals is a prerequisite for the hearing and reporting of violence, as shown in the following speech:

The bond of staff with families, [...], the person trusts more to talk, the direct contact with community agents and families, the commitment of the team with the cases.

The *home visit* is a resource to detect violence against women. During routine work, they can identify the signs of violence and approach the woman, which is confirmed by the speech.

Compulsory notification, service by report and by confession: limitations of the practice

Regarding *compulsory notification*, the group mentions that it is not standardized in all units and not all professionals know how to use it. The Epidemiological Surveillance sector does not record anything in the SINAN - Information System and Notifiable Diseases (Sistema de Informação e Agravos de Notificação) so it is not possible to visualize cases.

The *service by report* in the health unit is a limiting condition for the work of professionals because women do not express the violence they experience, which is confirmed in the speech:

Very hardly a woman will get to the unit telling everybody that her husband hit her. It's even... Often, somebody notices she has a bruise and will ask what happened. Then she'll say she hit somewhere, fell, but the woman will hardly admit she's been hit by her husband [...] Many are ashamed because it's not easy to get to a place in the middle of strange people and talk about their intimacy and say that their husbands beats them, that their husbands assault them.

Professionals perceive the violence report as a *confession* and identify that women do not wish to follow through with a plan to deal with violence, situation expressed in the speeches:

Discussion

The limits of the result of this study relate to the research design that has the collective discourse of participants on the topic of violence against women as empirical material and this may be likely to bias of the subjects.

The results contribute to the reflection of nurses about the care practice of Family Health teams to women in situation of violence from the user embracement perspective, pointing potentialities and limitations that must be overcome.

User embracement is presented in three dimensions: posture, technique and reorientation of services.[6] The notion of humanization in the relations between workers and users integrates with the above mentioned plans. User embracement is part of the organizational accessibility, which in turn must have strategies to facilitate the entry of the user in the Service.[6] It is essential that women realize that the service is interested in their problem and that the staff wishes to help them in coping.[7] This support is given by the nurse, deemed to have a good knowledge of management in confirmed cases of violence against women. The responsibility of the service organization in the unit makes this professional category to commit, transfer knowledge and work in a multidisciplinary team.[8] User embracement as posture, should happen anywhere and at any time in practice.[6] It is necessary to be careful when determining the locations and professionals to support women in the family health unit in order to avoid confusions with screening service.

Supporting women in situations of violence is possible by proposing a plan of action that respects the decision of women themselves.[7] Guidelines such as denouncing the offender, protective measures, for example his removal from home and the support of institutions are the kind of information women need to receive, but the final decision is theirs.[1] The woman can choose to follow the guidance or not. For women, drug addiction and alcohol are seen as triggering of intimate partner violence episodes, and treatment can solve that. This conception makes the option to be the referral of the partner to treatment. Professionals must be prepared to understand the perspective of women and thus include the aggressor in the coping plan, leaving punitive and educational aspects of the legislation for another time of assistance.[9] This mode of intervening shows the ability of professionals to put themselves in the place of others, evidencing the dimension of user embracement as a posture in the relationship of help. The receptivity and solidarity with which employees receive the demands of women facilitate the dialogue.[6] However, it is noteworthy that user embracement cannot be seen as reception and kindness.

When assessing risks, professionals use the instrument of technique and assistance of user embracement, in which they are supposed to consider the user's perceptions about their illness conditions. The assessment of risk situations was mentioned in a study carried out in the southeastern region of Brazil with referral to Social Services.[8] The woman at risk of death may be referred to shelters, and those with ideation or suicide attempts, to specialized services. It is still recommended to check with the woman about forms of protection and her own resources, the family and community that can support her on the verge of severe violence.[1]

As for humanized assistance, the diversity of violence situations shows the need for separate solution plans, considering that a fixed standard protocol would not be recommended.[4] Traditional protocols with technicist guidelines of action prevent the problem from being addressed by qualified hearing. The most appropriate response to the demand would be to establish lightweight technologies in care practice that take into account the inter-relationship and inter-subjectivities with users.[3] The listening and dialogue between professionals and users seeks to identify the demands and alternative solutions that translate into ways of dealing with the situation, which are unique to each condition.[7] The humanized assistance is based on the development of individual therapeutic projects with responsible reference teams, which is recommended by the user embracement as a posture and practice.

In the analysis of the bond, professionals approach users and establish a supportive relationship through empathic listening. The bonding is formed and promotes the reporting of experienced violence. This construction is seen by community health agents.[10] The establishment of the bond and dialogic listening to women in situations of violence is a potential care practice, but there is still much to do to ensure efficient user embracement.[5] Because even with the bond between professionals

and service users and the obvious signs of violence, women rarely assume that the injury was caused by their partner.[8] The bonding must be used to put into practice the project of standing up against violence, as the bond by itself cannot reach a qualitative transformation of women's lives.[5]

The home visit was considered as one of the activities for the recognition of violence. This was referred by the professionals in this study as well as by professionals from another basic health unit.[5] The frequency with which community health workers who visit families under their care and the way they dialogue and participate in the life of these people make them build a relationship committed to a project of life improvement. This close contact of confidence, added to a training focused on actions of health promotion makes them able to detect and support issues such as violence against women.[10] In this respect, the action suggested is to provide information to women about rights and services available in the community and external to it.[10]

Doctors were not listed as members of user embracement because they did not participate of discussions. Some studies bring doctors as professionals who support the team in clinical issues of the situation; eventually one or another doctor, for being more sensitive, can address the grievance with a qualified hearing, but this practice is not considered a routine conduct that should be discussed and improved.[3,11]

Under Brazilian legislation, the Maria da Penha Law contributed to the increase in recognition of violence and, as a consequence, the notification is conduct in health services.[9] To encourage the adoption of notification services, in the year 2011 it was published an ordinance that defines the compulsory notification of diseases, injuries and events throughout the national territory and establishes the flow, criteria and responsibilities of professionals.[11] The neglecting of monitoring services on the implementation of the notification and system registration services can be justified by the views of professionals on the problem, which is not considered a priority, and underestimating the reality of that context. The municipal government does not have an institutional policy committed to combating violence against women, not providing the user embracement dimension as reorganization of the service.[9]

Studies show that women who go to the health units or are visited by professionals from the Family Health teams do not talk about the violence suffered.[3,5,10] One of the possibilities is that women do not report because the attention they receive is almost always about the physical problems, so they do not understand violence as a demand to be met in the unit.[5] Moreover, the lack of privacy in the place of user embracement may also be the reason for women not reporting violence. Violence is discovered unintentionally, often in consultations for evaluation of patients with depression or excessive use of the service.[12]

Notably, there is a difficulty both of women in reporting violence and of professionals in asking and providing user embracement. The silence of women who do not report violence is considered uniquely a problem of the woman, and not responsibility of the professional; investigating suspect cases requires a lot of commitment, which does not fit the conditions of care practice.[3] The silence of women and the absence of an institutional policy are the barriers for support identified by professionals in this and another study.[13]

For women, venting can mean a moment of embracement in which they can talk to someone about what they are experiencing and perhaps lessen anxiety. For some women the simple fact of being in the unit and being heard is the only possibility of coping.[5] This is because their social network is limited to family and friends, who are not always sympathetic to support.[14] There are spontaneous reports of the violence experienced by women, more as an access to a hearing offered by the service than specifically as a health demand. It is necessary to transform the expression of violence in health demand, and unfold it in user embracement.

The prescriptive conduct of some professionals does not build a project of confrontation that takes into account the needs and subjectivities of women.[5] The most subtle signs of gender violence are rarely interpreted as a problem by the

professional. The lack of professional commitment to the problem itself reiterates the idea that women are responsible for the situation so they must solve it by themselves and the solution is outside the basic health unit.[8]

Conclusion

The home visit and the bonding between professionals and users are considered potentializers of user embracement and the limitation is the difficulty of obtaining the report of women who suffered violence and engage them in a care project.

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Collaborations

Silva EB contributed to the project design, carrying out the research and writing of the article. Padoin SMM and Vianna LAC contributed to the project design, carrying out the research, drafting the article and final approval of the version to be published.

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