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Violence against women: nurse practice in primary health care

Violência contra as mulheres: atuação da enfermeira na atenção primária à saúde

Violencia contra las mujeres: actuación de la enfermera en la atención primaria de la salud

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Abstract: Objective: to understand nurse practice in primary health care about violence against women. **Method**: qualitative study, descriptive, develop at Family Health Strategy of a city of state of Rio Grande do Sul in 2017. It was used semi-structured interviews and vignette with nurses, data analysis was operative protocol of Minayo. **Results**: the receptiveness, links and the compulsory notification are important points to practice with woman violence situation. The lack of approach about theme in academic formation and profissional and disarticulation of the care network are difficult condicions to care. **Conclusion**: This investigacion show the needs of discussion about the theme in academic and services sceneries and integration and articulation of the care network.
Descriptors: Violence against women; Family health strategy; Nursing

Resumo: Objetivo: conhecer a atuação da enfermeira nas Estratégias Saúde da Família frente à violência contra as mulheres. **Método:** pesquisa qualitativa, descritiva, realizada em Estratégias Saúde da Família de um município do Rio Grande do Sul, em 2017. Realizaram-se entrevistas semiestruturadas e aplicação de vinheta com enfermeiras, e os dados analisados à proposta operativa de Minayo. **Resultados:** o vínculo, o acolhimento e a notificação compulsória constituíram fatores importantes para a atuação junto às mulheres ***em situação*** de violência. A falta de abordagem do tema na formação acadêmica e profissional e a desarticulação da rede de atenção foram identificadas

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como condições que dificultam à atenção. **Conclusão:** essa investigação aponta para a necessidade de discussões da temática nos espaços acadêmicos e nos serviços e a integração e articulação da rede de atenção.
Descritores: Violência contra a mulher; Estratégia saúde da família; Enfermagem

Resumen: **Objetivo:** conocer la actuación de la enfermera[1] en las Estrategias Salud de la Familia ante la violencia contra las mujeres. **Método:** investigación cualitativa, descriptiva, realizada en Estrategias Salud de la Familia de un municipio de Rio Grande do Sul, en 2017. Se realizaron entrevistas semiestructuradas y aplicación de viñetas con enfermeras, y los datos se analizaron por la propuesta operativa de Minayo. **Resultados:** el vínculo, la acogida y la notificación obligatoria constituyeron factores importantes para la actuación junto a las mujeres ***en situación*** de violencia. La falta de enfoque del tema en la formación académica y profesional y la desarticulación de la red de atención fueron identificadas como condiciones que dificultan la atención. **Conclusión:** esta investigación apunta la necesidad de discusiones de la temática en espacios académicos y servicios y la integración y articulación de la red de atención.
Descriptores: Violencia contra la mujer; Estrategia de salud familiar; Enfermería

Introduction

World Health Organization revealed that 30% of women already experienced and/or sexual violence by an intimate partner worldwide in 2019. Beyond that, young women and girls that are part of certain ethnic, transgender and disabled group of people face a higher risk of different forms of violence. Violence against women is a violation of human rights, i tis rooted on gender inequality, it constitutes a public health issue and impediment to social development. [1]

Concerning world data, a systematic review has shown that sexual violence against women is endemic in some areas, such as central and southern sub-Saharan Africa and is less prevalent in southern Asia.[2] In Brazil, 23% of women are subjected to domestic violence, the more recurrent gender violence on the private sphere, being that 70% of these crimes against women occur inside the house and are practiced by her husband or partner.[3]

Gender violence on love relationship reveals the existance of control by the man over the feminine body, sexuality and mind, reiterating the difference that is established between men and women in society, and also the maintenance of power and domination disseminated in the patriarchal order. This power relationship can also be observed in family relationships, reaffirming gender violence.[4]

As a subsidy to combat violence against women, National Policy to Fight Violence against Women was implemented nationwide.[5] This policy is subsidized in structuring axes, which are, prevention, coping and combat, access and care and guarantee of rights and it aims to stabilish concepts, principles, prevention and combat guidelines and actions to violence against women, as well as care and guaranteeing rights to women in situation of violence. National Policy is, also, in consonance with the Law nº 11.340/2006 (Maria da Penha Law).[5]

Damage to women that experience violence are, generally, vast, causing physical and psychological damages and affecting the quality of life. It is important to highlight that psychological violence is rarely noticed by health professionals, because it does not leave physical marks, but it is a factor to sickening. This violence form compromises women's mental halth, as a way to result in disorders on their ability to communicate and of recognizing their resources to fulfill life tasks. Social isolation is one of the main manifestation forms, in which the partner seeks to deviate the woman from her social life, forbidding her to have a relationship with her family members and friends, work or study.[6]

Women's journey on trying to interrupt the circle of violence is ambivalent. It is not only about intitutional issues, but it is also structured on the women's role in society in consensus with their needs and decisions. This way, we recognize that the reasons that make women to delate on their partner, in a relationship permeated by violence, involve fears and concerns with their children and feminicide.[7]

In this regard, a study showed that the primary network of women who report the experience of intimate partner violence, even based on meaningful social relationships, sometimes demonstrated limited support in the situation of violence.[8] Also, poor financial autonomy to manage her life and that of her children can lead a woman to continue in the unwanted relationship with her partner. It also demonstrated that the services that make up the care network for women in situations of violence are not recognized as effective help for their

social and health demands, revealing a fragmented and disjointed network, far from the living reality of women.[8]

Current research has pointed to the need to reinforce the actions that health professionals are already developing in primary health care, such as welcoming and listening.[9] Regarding the reception, it needs to be performed from the moment the woman accesses the health service, until her needs are fully met in this service, or it is sent to another location within the health care network.[9] However, even finding that gender violence is considered as demand by professionals of primary care units, another study states that they do not feel comfortable approaching the issue with their users and, some, never questioned about this issue, remaining the veil.[10]

In this regard, evidence indicates that professionals working in primary care have difficulty addressing the issue of violence against women, feeling unprepared for such an approach.[10-11] This means that the absence of this knowledge makes the care of these women occur in a fragmented way, in which only the clinical issues and not the social demands that pervade violence are valued.

Considering this context, the present study sought to answer the following research question: how are nurse's actions on Family Health Strategy facing violence against women? To answer this question, we aimed to know nurse's actions on Family Health Strategies facing violence against women.

Method

Descriptive study with qualitative approach, developed on a Family Health Strategy (FHS) in an urban area in a city on the border of Rio Grande do Sul/Brazil, in the second semester of 2017. Data collection scenerio is justified because FHS is the entrance and communication door of users with the whole SUS network.

Eleven nurses from FHS participated in the study. For the dimensioning of the number of participants, it was followed that when the sample is ideal, it reflects, in quantity and intensity, the multiple dimensions of a given phenomenon and seeks the quality of actions and interactions throughout the process.[12] The inclusion of participants subscribed the following criteria: being a nurse and being linked to the FHS of the primary care network of the above-mentioned municipality. Professionals who were away on vacation or leave were excluded.

Nurses were personally invited to participate in the study. On this occasion, research aim and methodology were presented while clarifying doubts and a date was scheduled for the interview, according to the nurses' availability.

Data production was developed through semistructured interviews, with a previously defined guideline, followed by a vignette This consisted of a short description of a fictional situation in which respondents were asked to react. Interviews were conducted individually in the spaces of the FHS. All information obtained was recorded on a digital recorder, upon authorization, and fully transcribed.

For data analysis, Minayo's operative proposal was adopted.[13] First level consists on a exploratory phase. Such moment, was marked by the context comprehension of the researched social group, making the characterization of the same with regard to gender, age group, time of professional experience and performance in health facilities and graduate courses. Then we went through the second level, called interpretative. At this stage, the meeting with the participants' statements took place and the aim was to identify in the reports the meaning, the internal logic, the projections and the interpretations about the investigated theme. Still, the interpretative phase was divided into ordering and classification of the data, respectively. The ordering included their transcription and organization into empirical categories. In the classification, an exhaustive reading of the literature was performed to discuss with the findings and the research report was constructed.

Research followed Resolution nº. 466 of 2012 of the National Health Council in the Ministry of Health and it obtained approval by Research Ethics Committee from Federal University of Pampa, CAAE 69364017.7.0000.5323, report nº 2.168.674, on 11/07/2017. To guarantee the participants' anonymity, the nurses were identified by the letter E followed by numbers: E1, E2, E3 (...) E11. Previously voice recording, we requested authorization and signature of the Informed Consent.

Results and Discussion

Mainly female nurses participated in the study, having one man. Participants were on the age range of 23 to 55 years old. Profissional experience was of four and sixteen years. As for work time on health units was of six months to five years. As for Graduate latu sensu studies, they were specializaed on sports medicine (one), health sciences (one), family health (two), public health (three), and mental health (one). In addition, they reported having a master's degree in biochemistry (one) and collective health (one).

From thematic data analysis, two categories emerged, being them: Factors that enable nurses to act in situations of violence against women and Conditions that make it difficult for nurses to act in situations of violence.

Fators that enable nurses to act in situations of violence against women

To care for women in situation of violence involves multidimensional factors, which determine the quality of care. Among factors that enable care to these women on primary care, we identified that it is essencial they bond with the health team for them to prevent and face violence.

> *I believe that one of the positive points is a bond that we have been creating* [...]*they feel very welcomed, they can maintain this bond to reach*

> *and expose a situation, both with nursing and with* [community] *health agents.* (E 1)
> *I have had experienced several situations and that is what I tell you, the importance of bonding and we show her that we are here to help.* (E 4)
> *Ease is the bond that patients have, they trust, so it is easier.* (E 7)

Nurses 'statements show the importance of this correlation, as it favors the users' demand for the health service, being an important connection for them to gain confidence and clarify doubts about their health and expose family problems in the search for understanding, help. and attitude to coping with the problem. Thus, cara practices to such women need to be grounded on listening and co-responsabilizaation, with actions that can contribute to break the violent situation. These actions need to be aligned with these women's demands, that is, for beyond physical issues, it is also needed to direct it to economical, social and emotional attention.[6]

Nurses' speeches indicate that the Bond is important and can be a facilitator to act with the women in situation of violence, however, a study developed with nurses that work on Family Health Strategies in Porto Alegre, Rio Grande do Sul, showed fragility on its construction. In this context, the frequent exchange of professionals in health services weakens the bond, as this is an issue that many women feel ashamed to share with others.[14]

Some participants report that, beyond bond, one of the strategies that contribute to facilitate care is welcoming and medical screening. This can be identified next.

> *You have to establish a trusting relationship by welcoming.* (E 3)
> *We make a more welcoming care, specially, for the fact it is a woman. There is a feeling involved.* (E 4)
> *When we come across these cases, we have to have empathy, put ourselves in her shoes and see how you can help, whether by accompanying, talking, putting what the service has available.* (E 5)

Study about conceptions and actions of health professionals about the care network to women in situation of violence considered that welcoming and listening need to be strenghten.[9] Welcoming should be developed in all moments, since the arrival of this woman in situation of violence, until possible referrals to other places of treatment, on the direction to assist on their needs.[9]

In the face of difficult situations of violence, it is necessary to think of ideas that favor the care of these women, such as talking about their potential not only related to violence.[15] Thus, to reflext about possibilities to the future, of relationship with children and of relationships of friendships and family members, can assist to regain self-esteem.[15] It is up to these women to be empowered with their choices and life stories.

For the nurse, to develop a welcoming care is interesting to look for different faces of violence, this requires professional preparation based on integrated and interdisciplinary discussions.[16] Also, professional qualifications are important on the direction to enable a welcoming and integral care, potentializing constructing bonds.[16]

Primary Care Unit is among services searched by these women to treat accute health and family issues. On these moments in which they seek care, if they feel welcomed or secure, they can reveal situations of violence. However, some times, these women do not reveal these situations, so professionals are aware to identify and develop possible care and referrals that may be needed.[6]

Regarding the welcoming service, justified by being a nurse taking care of another woman, it is considered that this is due to the possibility of approximating some experiences and expectations. This can make women in situations of violence feel comfortable talking about their innermost anxieties and fears with other women. This testimonial reflexts on sorority, that is characterized as a subjective experience among women to seek equal relationships, on

constructing existential alliances and policies with other women and to contribute with social extintion of all forms of oppression.[17]

When a situation of gender violence was detected, the nurses identified the need for compulsory notification, in which violence is registered in the Notification of Disease Information System, as shown below.

> *We have a notification when violence occurs, which has to be filled, too. Violence has to be notified.* (E 3)
> *When they are identified we make a notification that is delivered in epidemiological surveillance, I notify the CREAS [Specialized Reference Center for Social Assistance] and the police [women's police], also.* (E 6)
> *Faço a notificação que vai para vigilância epidemiológica e depois busco sempre uma resposta dos encaminhamentos que foram feitos nos setores.* (E 9)

With regard to legal rights, increasing rates of violence against women have resulted in the creation of specific laws, such as federal law 10.778/2003, which requires compulsory notification of such cases, whether attended at public or private health services.[18] Notification is a link between the health service and the legal space, constituting an integrated action that enables more effective actions. The importance of notification is stated to support the assistance provided and promote the reduction of these situations of violence, as well as to prevent more serious problems to the people who experience it.[19]

Research developed in a northwest city in Rio Grande do Sul reveals that, approximately, 40% of health professionals, that act on primary care, did not know about the practice of this notification, being indicated, on the referred research, did not know about the practice of this notification, being indicated in this research the need for explanations for the development of this practice.[10] Thus, the absence of compulsory notification, points out the importance and the need to qualify this practice, from the knowledge, since, if the professional who does not seek to qualify, waives his professional duties.[20] It is reiterated that compulsory reporting of violence is

conducted in suspected and confirmed cases, but some health professionals feel apprehensive about reporting violence.[9]

Conditions that make it difficult for nurses to act in situations of violence

Treating violence is something complex that needs a qualified approach, however, many times, discussions about the theme are incipient on academic and professional spaces, what can reflect on inadequate practices and fragile prevention strategies. For such, there are factors that make care to women in situation of violence difficult, being professionals unpreparedness one of them.

> *Not qualified for this service, because we did not have a permanent education on the subject.* (E 2)
>
> *I do not feel empowered, because it is a subject that we do not experience every day. I don't feel empowered, because it is a subject that we do not experience every day, in the gym does not have this preparation, is something that has to go looking for over time.* (E 3)
>
> *From the difficulties of care I have the feeling of not being properly trained.* (E 5)
>
> *We never had a training to meet these women, much of the experience, that over time we learn.* (E 6)
>
> *I don't feel prepared, I miss skills because it is a routine situation and we are not prepared to face.* (E 10)

It is observed that the lack of preparation originates in the undergraduate, and violence is a theme little addressed in the context of academic education. This continues afterwards, in professional life, considering that management and management spaces often do not promote discussions and qualification for the development of a qualified approach..

Study developed to identify the relationship between professional training and notification of violence against women showed, on their results, that this theme was not discussed on undergraduate and graduate for a great part of health professional and the other

interviewees, who expressed contact with the theme, reported that it occurred briefly.[21] Research reports the experience of introducing a specific discipline on violence in nursing undergraduate as positive, as it provides broad discussions on the subject, with reflections on the cultural constructions surrounding the theme and the demystification of the subject.[22]

Thus, in order to fully address women in situations of violence, there is a need for continuous qualifications, based on health policies and practices. From this, the nurse with the health team will be able to identify situations of violence beyond the health service.[11] It stands out for the importance of professional qualification in the context of primary health care, because it is evident that the actions developed in this context, about violence, are still fragile and with little resolution.[23]

Among the factors that hinder attention to women in situations of gender violence is the identification of these, because it is necessary to have a sensitive eye to unveil these women in service and qualified to develop the approach and care needed. Some speeches of the interviewees express this difficulty:

> *It's very difficult, the first time, they already say something, we don't identify right away.* (E 3)
>
> *I think it is something that is very much inside the houses, the private space, not even the unit. So it's hard to identify.* (E 6)

Difficulty in identifying cases of violence against women by nurses is often related to situations that are configured as intimate, which are concentrated in their homes. Relationships of these women are restricted, thus protecting themselves from judgments related to their decisions, especially with regard to maintaining contact with the aggressor.[8]

Such women develop isolation, they move away from their friendship and family relationships, which is triggered by feeling sad, ashamed, afraid, without self-esteem and with economic dependence. Due to isolation, they present a reduced number of people that can assist

tem when they need it.[6] Thus, the cycle of violence mantains itself, associated to emotional fragilities, the partner's economical dependence and, at times, to believe that his behavior can be changed.[24]

It is noteworthy that, often, situations of violence in primary care services are not addressed, professionals have limitations to conduct situations that are characterized by the intimate sphere because they believe they can not interfere in these experiences, which causes the invisibility of violence and reflects a weakened professional practice.[23] It is important for professionals to be clear about their role and commitment to women in situations of violence and to their families, demystifying concepts and practices already established in their daily lives, adding scientific knowledge, as well as altruism and sensitivity.

Among difficulties to identify situations of violence on the health service, there are home visits as a tool to be used by health professionals, mainly the community health agent, to identify these situations.[9] Still, home visit allows the formation of a link between professional and user, as a resource that allows the observation of the context and the establishment of a bond, mainly, by the omission of women in talking about what happened.[11]

In addition to the role of the nurse, there is a need for integrated sectors to ensure proper and humanized care for these women. The following statements elucidate the nurses' experience in cases of violence.

> *Some difficulties we have are related to the network not working, this weakens the service.* (E 4)
>
> *We forward and do not have a return, have to go after, do not have a good resolution.* (E 8)
>
> *Routing takes a long time, network joints take a long time.* (E 9)
>
> *I do not have contect with the women's Police station.* (E10)

Through the speeches, it is observed the discontinuity of care and highlights the importance of establishing a care network for women in situations of violence, which needs to

be based on the integration of multiple areas of knowledge and with dialogues in different sectors..[25] It is noteworthy that composing a network is something complex and necessary, because it involves multiple factors, therefore, the feasibility of communication between the spaces that this woman transits is considered, in which professionals need to be committed and articulated to promote the continuity of the work. caution.[25]

Difficulties presented by the participants, such as lack of contact, slowness of referrals and joints, refer to the fragility of care for these women. It is considered essential to seek strategies that ensure adequate care, because women in situations of violence need to be assisted in their vulnerabilities, finding safety, protection and resoluteness in health services for themselves and their families.

Conclusion

Study showed potentialities and weaknesses regarding the nurses' performance, in the primary care setting, among women who experience gender violence. It was found that the bond of users with the health unit and the reception are essential factors for care planning for women who experience this situation. In addition, compulsory notification was identified as a potential agent for the process of coping and preventing violence and articulation between services.

Nurses reported not feeling prepared to attend situations of violence against women, this feeling stems from the lack of approach to this theme in academic education, which is perpetuated in professional life. This may reflect in the identification of these cases and their proper management. Also, the disarticulation of care services was identified as a condition that hinders attention to this population, making it impossible to monitor and resolve the cases of violence identified.

From this study we understand the importance of nursing in its practice to mobilize women for the construction of gender equality and their autonomy, surpassing technicality and

merely protocol orientation. This aim for professional practice is an ethical and political perspective, which presupposes understanding women's health from an emancipatory perspective.

This study had the limitation of presenting only the view of FHS nurses, considering that other professionals are involved in the care of women in situations of violence. Still, the results cannot be generalized, considering the characteristics of the participants and the context of the study, which reveal singularities.

As an intervention proposal, it is suggested that health professionals and managers meet in order to talk about the limits that hinder the assistance to women in situations of violence and the experiences in their care. In addition, it proposes new research with women in situations of violence, seeking to know their perceptions about the role of health professionals in primary care, thus opening new perspectives for the prevention and coping with this form of violence. And in situations of violence, it is necessary to strengthen networking, so that these women feel supported in different multidisciplinary spaces, contemplating their needs and that of their family.

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