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NURSES' BEHAVIOR IN CASES OF DOMESTIC VIOLENCE AGAINST WOMEN

CONDUTA DE ENFERMEIRAS DIANTE DE CASOS DE VIOLÊNCIA DOMÉSTICA CONTRA A MULHER

CONDUCTA DE LAS ENFERMERAS EN CASOS DE VIOLENCIA DOMÉSTICA CONTRA LA MUJER

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Objective: to identify the behavior of nurses inserted in the Family Health Strategy in confirmed or suspected cases of domestic violence against women. Method: study of a qualitative nature, carried out in 2012 and 2013, at units of the Family Health Strategy, in the city of Maceió, Alagoas, Brazil, guided by semi-directed interview with 11 nurses, using content analysis. Results: nurses approach the domestic violence against women in different ways, either through discussion of the case with the other team members, either sending women to other services and professionals. Most nurses feel insecure to meet women victims of violence. Conclusion: there is a heterogeneity in the behavior of nurses inserted in the Family Health Strategy in confirmed or suspected cases of domestic violence against women, showing that women's healthcare network, in this situation, needs to be strengthened.

Descriptors: Nursing. Violence against Women. Family Health Strategy.

Objetivo: identificar a conduta de enfermeiras inseridas na Estratégia Saúde da Família diante de casos confirmados ou suspeitos de violência doméstica contra a mulher. Método: estudo de natureza qualitativa, realizado em 2012 e 2013, em unidades da Estratégia Saúde da Família, na cidade de Maceió, Alagoas, Brasil, guiado por entrevista semidirigida com 11 enfermeiras, utilizando a análise de conteúdo. Resultados: a violência doméstica contra a mulher é conduzida pelas enfermeiras de diferentes formas, seja por meio de discussão do caso com os demais integrantes da equipe, seja pelo encaminhamento da mulher para outros serviços e profissionais. A maioria das enfermeiras sente-se insegura de prestar assistência às mulheres que sofreram violência. Conclusão: existe uma heterogeneidade na conduta de enfermeiras inseridas na Estratégia Saúde da Família diante de casos confirmados ou suspeitos de violência doméstica contra a mulher, evidenciando que a rede de assistência à saúde da mulher, nesta situação, necessita ser fortalecida.

Descritores: Enfermagem. Violência contra a Mulher. Estratégia Saúde da Família.

Objetivo: identificar la conducta de las enfermeras insertadas en la Estrategia de Salud Familiar en casos confirmados o sospechosos de violencia doméstica contra la mujer. Método: estudio de naturaleza cualitativa, llevado a cabo en

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2012 y 2013, en las unidades de la Estrategia de Salud Familiar, en la ciudad de Maceió, Alagoas, Brasil, guiado por entrevista semi-dirigida con 11 enfermeras, utilizando análisis de contenido. Resultados: la violencia doméstica contra la mujer es llevada a cabo por enfermeras de diferentes maneras, sea a través de la discusión del caso con los otros miembros del equipo, bien como el encaminamiento de mujeres para otros servicios y profesionales. La mayoría de las enfermeras se sienten inseguras para proporcionar asistencia a las mujeres que han sufrido violencia. Conclusión: existe una heterogeneidad en la conducta de las enfermeras insertada en la Estrategia de Salud Familiar en casos confirmados o sospechosos de la violencia doméstica contra las mujeres, mostrando que la red de atención de la salud de la mujer, en esta situación, necesita ser fortalecida.

Descriptores: Enfermería. Violencia Contra la Mujer. Estrategia de Salud Familiar.

Introduction

The object of study explored in this research was the behavior of nurses inserted in the Family Health Strategy in cases of domestic violence against women. This type of violence affects all social classes, ethnicities, religions and cultures, occurring in populations of different levels of economic and social development. The Convention of Belém do Pará/Organization of the United Nations (UN) conceives this phenomenon as any act based on gender, which causes death, physical, sexual or psychological harm or suffering to women, in both the public as private sphere[1]. Gender is a concept whose origin lies in the Social Sciences, appearing as a theoretical framework for analysis and understanding of the inequality between the attributions of women and men. The use of the term as an analytical category was proposed in the 1970's by historians as Joan Scott, linked to the feminist movement[1].

In Brazil, in recent years, there have been discussion on the aspects related to domestic violence and gender differences, with the National Policy to Fight Violence Against Women as one of the exponents to reduce gender inequalities. This policy aims to establish the concepts, principles, guidelines and actions for preventing and fighting violence against women, as well as for assistance and guarantee of rights for women in violence situations, according to international human rights norms and instruments and national legislation. Furthermore, it is structured base on the National Plan of Policies for Women (PNPM), drawn up based on the I National Conference of Policies for Women, held in 2004 by the Department of Policies for Women (SPM) and by the National Council of Women's Rights (CNDM)[2].

The creation of the National Policy to Fight Violence Against Women by the SPM aims to clarify the conceptual and political foundations of coping with the issue, which have guided the formulation and implementation of public policies for preventing, fighting and coping with violence against women, as well as assistance to women in violence situation[2].

Concerning the scale of the problem, and in response to the recommendations to the Brazilian State of the Committee on Elimination of All Forms of Discrimination Against Women (CEDAW/UN) and the Inter-American Convention to Prevent, Punish and Eradicate Violence against Women, in 2006, Brazil began to rely on the Law n. 11.340[3], called the Maria da Penha Law, specific to suppress the domestic and family violence against women. After this law, the crimes began to be tried in the Specialized Courts of Domestic and Family Violence against Women or, while inexistent, in the Criminal Courts. The Maria da Penha Law, considered an important step forward in fighting the problem, represents a significant step toward ensuring women their physical, psychological, sexual and moral integrity[2-3].

In accordance with Article 7 of the Law Maria da Penha, family violence is the one that happens within the family, i.e., in the relations between the family community members, formed by natural (father, mother, daughter, etc.) or civil (husband, mother, stepfather or

other) ties of kinship, by affinity (a husband's cousin or uncle) or affection (friend living in same household). The domestic violence, according to this same law, occurs at home, in a domestic environment or in a relationship of familiarity, affection or cohabitation[3].

Considering that the violence significantly affects the health-disease process of women, the health sector can be regarded as a privileged locus to identify, assist and direct victimized women. Throughout their lives, women who experience violence have more health problems, generate more health care costs and seek, with more frequency, hospital and urgency services than other people not suffering ill-treatment do[4]. In this direction, the Primary Health Care, represented by the Family Health Strategy (FHS), is recognized as a space to receive women in situations of violence, since this model of attention has the bond as the basis of the professional/user relationship and works with adscription of the population in the territory, favoring an assistance not focused on the treatment of possible physical injuries and their consequences, but on their primary prevention[5].

Therefore, violence against women has been a topic discussed worldwide, with a growing increase of published scientific papers in recent decades. This fact demonstrates that this is an issue to be explored, being increasingly frequent in the routine of health services, since the health professionals can detect early and intervene, avoiding the deterioration of the process and its consequences for women's health[6-7].

Thus, taking into account that, in the FHS, the nurses act directly on prevention, health promotion and recovery and that violence against women has been responsible for the illness not only of the female population, but also of the whole family, this article aims to identify the behavior of nurses inserted in the Family Health Strategy in confirmed or suspected cases of domestic violence against women.

Method

Descriptive research of a qualitative nature, carried out in FHS Units, in the city of Maceió, capital of the state of Alagoas, Brazil, whose protocol was approved by the Human Research Ethics Committee of the Federal University of Alagoas (CEP/UFAL) under n. 010304/2009-72.

At the time of this study, the FHS in Maceió was composed of 80 family health teams distributed in 39 Family Health Units (FHU) installed in seven district regions of the capital. These FHU allocated the FHS teams, composed of physicians, nurses, nursing assistants and community health agents. The study sample was composed of voluntary participants, nurses inserted in the FHS teams. The inclusion criteria for choosing the teams regarded the characteristics of the aforementioned regions. One of these characteristics relates to the fact that some districts have units with different or equal number of teams. In this way, there units with one, two or even three teams. Based on this distribution, there was selection of two teams by district aiming to encompass the several existing realities in the city.

To this end, the teams were selected taking into account two aspects: the first is related to the number of teams by unit, having in view that a BHU with more teams represents the greatest demand from women users; the second aspect comprised the existence of more than one BHU with the same number of teams. Thus, with the identification of the BHU that would be included in the study, they were randomly chosen through a draw, which resulted in the selection of 14 teams. As each team has a nurse, the established number of participants of this professional category was 14. Nevertheless, 11 interviews were carried out, bearing in mind that, in the process of collection and analysis of information, no new element was being added, in the nurses' speeches, on the researched object, with no need to proceed. The exclusion criteria adopted were professionals on vacation or medical leave, being replaced by others from the same unit.

The choice of the technique of semi-directed interview provided to study participants precious moments in order to build a collaboration to give direction to the research, representing a gain to gather the data according to the proposed goals. For this purpose, the triggering questions

were created to allow interviewees to answer freely. In this way, all efforts were leveraged to better build the moments of study and guide the interviews, in an empathetic and gradual process of conversation between researcher and interviewees, using the following questions triggers: During your service, have you already suspected or detected a case of domestic violence against women? If so, what behavior would you adopt in a suspected or confirmed case of this type of violence?

The concept chosen for this research in relation to the term behavior, within the framework of existing understandings in the health area, was the one present on the Virtual Health Library (VHL), in its descriptor entitled "behavior" descriptor, which claims to be the observable response of a person in the face of any situation. Considering a more comprehensive concept, the dictionary defines this expression as the "way in which someone acts, behave; procedure"[8:204]. Although both definitions cover the sense this research tried to adopt, the meaning extracted from the dictionary approaches the one of the term in this study. Thus, behavior, in this study, is the way nurses act and/or approach suspected or confirmed cases of domestic violence against women.

The information was collected through recorded interviews, during the second half of 2013. The nurses who participated in the study were previously contacted, some by phone, others during the visit to the unit, when there occurred the invitation to participate in the study and scheduled the time and location of the interview. On the days of the interviews, the researcher walked up to the participants in their own ward where they worked. In order to maintain secrecy about the identity of the nurses, the units were not identified and all interviewees were identified by the expression "Nurse" followed by a numeral that identified the order of the interview. The professionals were informed and clarified about the ethical aspects of the NHC Resolution n. 466 of 2012, listed in the Informed Consent Form (ICF), and signed it in two copies: one was delivered to them, and the other remained with the researcher.

After the interviews, there were the listening and careful transcription, organized, seeking to find meaning cores, which, being approached, originated the respective categories and subcategories. The listening, transcription and reading of the interviews allowed for an approximation and convergence of the interviewees' statements. The data were subjected to analysis of categorical content[9].

The theoretical-methodological framework that subsidized the analysis of selected themes and the respective categories was the content analysis technique, specifically the Thematic Analysis, which can be translated into a technique that seeks, in verbal or textual expressions, the recurring and/or relevant general topics, after thorough readings of the records of interviews and observation[9]. Thus, after the readings of assimilation, using criteria of relevance and repetition, according to the theoretical-methodological framework of this research, two categories emerged, which will be presented in the results.

Results

The participants were only female professionals who worked in the FHS teams, since there was no males in the contacted services. Regarding the characterization of the study participants, the mean age is 41 years old, the majority has over 15 years of training and 11 years of professional experience in the FHS. Importantly, all interviewees have attended some course of Specialization in the area of public health, collective health or family health. Two nurses reported having seen the theme on violence against women at graduation.

The results showed that domestic violence against women, such as the one perpetrated by an intimate partner, lies in the daily work of nurses in their various forms of manifestation. However, the institution does not prepare them to act in a purposeful manner along with the women victims, noting that this can lead them to adopt different behaviors in suspected or even confirmed cases, as evidenced in this study. In this way, the reports of the interviewed nurses

revealed two categories of analysis that revealed the types of behaviors adopted in the care with women in situations of violence: the first refers to the nurses' behavior in suspected or confirmed cases of violence against women; the second refers to the limitations and inadequacies of instrumental knowledge and services.

Nurses' behaviors in suspected or confirmed cases of violence against women

The analysis of the responses from the interviews showed that the behaviors adopted by FHS nurses in the care with women in situations of domestic violence were diverse. This heterogeneity in the behavior in situations of violence, in most studied services, may be related to the absence of a protocol directing the actions of these professionals in the care with women in situations of violence, that is, that guides the behavior to be adopted.

The analysis of the reports revealed that some nurses, when detecting a situation of violence suffered by women, adopt the behavior of sharing the case, so that the unit team becomes aware:

> [...] *she* [the victim] *called me to talk at the hillside area and introduced herself, told me about the case. Then we ask for the social worker's help.* (Nurse 6).

Other statements revealed that nurses send the case to the so-called bodies responsible for assisting women in situations of violence, that is, the nurse transfers the responsibility to other services:

> *There is the Women's Police Department, in the city center, and I don't even know if it's still there* [...] *I think it's indeed police department, a police case.* (Nurse 5).

> *I guided on what she should do: seek the Women's Police Department to report the partner.* (Nurse 8).

In addition to citing the Women's Police Department as reference service to follow up the cases of domestic violence against women, other interviewees cited another type of service to which they sent them:

> *This is the one* [Sheltering Home Dr. Terezinha Ramires] *I remember well, because it's the place of choice* [during the lecture she attended from the Health Municipal Department of Maceió] [...], *but I know, because we didn't have a qualification, but a lecture* [...] (Nurse 6).

> *I guided her to seek the Pam Salgadinho.* (Nurse 1).

Concerning the behavior they would adopt in a suspected case of violence, considering the woman had already experienced this situation, Nurse 7 showed concern with these cases, when affirming she would give her best to seek support, but, at the same time, showed unawareness of how she should lead the case, being a FHS nurse:

> *In case there appears a problem situation* [some case of domestic violence against women] *I would do my best; seek a colleague. If I didn't succeed, I would seek another* [colleague]. *The same when there emerges something we aren't used to dealing with.*

The units that had a social worker, all professionals reported that, in case they identified, during the appointment, something suggestive of a woman who was in a situation of violence, they would send the case to that professional. Thus, once again, it shows that the nurse's behavior in relation to women in situations of violence was related to transferring the jurisdiction:

> *We have a social worker, so that any problem* [...] *we don't feel capable to solve. We tell her and she seeks the service.* (Nurse 2).

> [...] *we seek the social work from the post. I really know she has already guided us, but we know no other ways.* (Nurse 3).

The passage above makes it clear that the nurse would not develop a direct care behavior with a possible victim, since she did not considered herself prepared to act in the context of violence in which the woman was inserted. In this way, the nurse resorted to another professional, a social worker, to follow up the case. At these units with a social worker, the nurses mentioned being unaware of other means but to bring the case for that professional. One aspect that stands out in the speech above is a generalization, when using the term "we" instead of "I".

A good part of family health teams rely on only with the categories that comprise the basic team: physician, nurse, nursing assistant/ technician and the community health agent. In teams that did not count on the presence of the social worker, the professionals reported they would approach the victim in order to provide emotional support and send the case to the bodies responsible for this topic.

> [...] *in an emergency situation* [of domestic violence against women] *I would call the Women's Health* [Municipal Department]. *I remember we used to send those cases to Santa Mônica. They even guided us* [during the qualification on violence against women around three years before], *in these cases* [of violence], *no to do anything, just guide the woman to seek the service* [Santa Mônica] *where they would do everything: the guidance procedure, diagnosis, acquisition too, STD prevention, everything. I even wrote down the number. I think I should have it in my agenda.* (Nurse 7).

The nurses kept adopting the behavior of sending the woman to another professional to deal with the situation, even if placing themselves as mediators. Therefore, the psychologist was mentioned as the professional capable of giving support to women.

> [...] *I would try to make her tell if there was something happening, would send her to a psychologist from the unit itself, but I believe I would say: psychologist first, so that she receives the best guidelines as possible, to adopt the most plausible behaviors to try to leave that environment. I would go to the psychologist at first, to try to get things from her.* (Nurse 8).

Limitations and inadequacies of instrumental knowledge and services

Despite all the efforts in an attempt to adopt a favorable behavior in the care with women, all nurses in this study reported difficulties to deal with the situation. Some problems reported in this study were: lack of equipment and services, lack of personnel and concentration of services in the capital. Although there is a State Department for Women, Citizenship and Human Rights in the municipality, specific structures to deal with the matter are almost non-existent, and when there is one, they are often attached to some Coordination.

Several reasons were cited not to properly maintain the care with women in situations of violence. Among these, the main ones are the fear of exposing themselves, non-consent to intervene, insecurity and unpreparedness in the behavior.

> *Honestly, I don't know. I know I should do something – which would be to report –, but, honestly, I don't know why. I live here* [she mentions the place, near the Unit where she works], *I would fear for me later. I don't know the* [aggressor's nature]. *What if I report him and end up getting in trouble, see?* (Nurse 5).

> *And what am I supposed to do? I'm too afraid! I'm going to say something and her husband gets to know about me, that I'm talking* [encouraging to report] *with his wife?* (Nurse 8).

In the face of the subjectivities and weaknesses with respect to the theme here explored, all interviewees concluded their participation recording they felt the overwhelming need to be trained to deal with the issues of violence against women, despite the fear registered by some, since they did not feel prepared or lacked support from bodies to which were directly linked.

> *We told them we needed support... Ahh!... I called... It kept ringing, ringing, but nobody answered the phone* [...] *I kept trying other extensions of the Department, but didn't succeed.* (Nurse 1).

> *We have women's health that relates more to prenatal care, cytology, those things. I don't know if they* [of the Health Municipal Department] *have it in women's health, where I should seek this information* [about violence] *got it?* (Nurse 2).

> *But I think we need support, I wouldn't be safe. I would call the management, the social worker, if the woman allowed me to. But we are still afraid... The thing is still too loose, we have nothing attached.* (Nurse 3).

Discussion

Meeting women who suffer violence is to ensure human rights and appreciate, in the health space, where the FHS is, their accomplishment. The defense of these rights permeates the commitment of nurses, who, in the routine of health services and social spaces, strive to promote the reduction of inequalities that hinder access to services and quality health care[5,10].

These professionals working in FHS teams, due to the wide coverage and bond they establish with the families, are believed to be powerful allies. This is because they act both in the FHU and at home and, in this contact, they know the intimacy of homes, which facilitates the recognition and action in cases of domestic violence against women[11].

A study, whose objective was to understand the strategies used by nurses from FHS Units to identify and cope with a situation of violence by an intimate partner in pregnant women, revealed that violence against women was characterized as a serious and important problem in society, whose cause and consequence was gender inequality. In this way, in professional practice, there is need to organize a nursing protocol to

assist in the identification and classification of risk exposure to violence, permanent education of these professionals and strengthening of intersectoral actions[12].

Among all FHS units included in this study, only one of them had a poster with the protocol for approaching women victims of violence, displayed in an informative mural for users. This situation suggests the need for disseminating information, such as posters with protocols to approach cases of violence, to help professionals and women in situations of violence who need information on the mechanisms and existing procedures. No report revealed the protocol for notification of violence as a behavior to be carried out by nurses, when identifying the experience of a situation of violence.

The protocol found in the aforementioned unit cites one of the locations to where women victims of violence must be sent. It is the Care and Reference Center for Women Victims of Domestic Violence Dr. Terezinha Ramires, inaugurated on 8 March 2002, installed in a Medical Care Post (PAM) linked to the Health Department of Maceió, which provided the technical team for the institution, and has four three psychologists, three social workers and three administrative assistants. This Center, implemented by Law n. 4,446, of September 1995, arose from the struggle of the feminist and women's movement from Alagoas, whose author was the then city councilor Terezinha Ramires. This law provides for the creation of a Reference Center and a Sheltering House to meet women victims of violence, which represent a major step forward, not only in the city of Maceió, as throughout the state of Alagoas, in coping with the gender violence[13].

On the other hand, nurses in this study reported that, when faced with the delay in problem solving, even when adopting the behavior of sending the cases of violence to the available services, they identified the fragility of the network of services in the health and legal sectors. Although the law provides for the creation of local support to women victims of violence, these were overcrowded, which contributed to the increase and the invisibility of cases. This ended up placing women in a position of vulnerability in gender relations[14-15].

In addition to the delay in the feedback from cases sent by nurses, women in situations of violence also realized the lack of adequacy in the care received in the services to which they were sent, a fact mentioned by nurses in this study. Therefore, there are difficulties of professional qualification as a motivating factor. The lack of training or qualification in service reflects directly on the actions of care with women with this problem, influencing the non-recognition of the violence that affects many of those who seek the service[5,16].

Another study, whose objective was to analyze the structure and content of social representations of nurses about domestic violence against women, shows that, rooted in the collective memory, physical aggression carries meanings for the professional practice, since it is the most common form of recognition of nurses of a woman in this situation. In this context, the assistance can prioritize the treatment of injuries, without contemplating the subjectivity of women, which can be a barrier to the practice in the care with women in situation of risk[11,17].

The nurse, or any other professional category, has their way of understanding the violence and assisting the attacked woman based on her conception. In relation to this, the unpreparedness, associated with the weight to deal with stories of violence, generates dilemmas and contradictions, limiting, in this context, the care actions. Therefore, the approach of this phenomenon is permeated by beliefs, judgments and stereotypes among health professionals, inhibiting an effective and humanized care with victimized women[18].

With respect to the inhibition in the service, most participants of this study adopted as a behavior to send the situations of violence against women to other professionals, such as the social worker and the psychologist. They believed that such professionals, mainly the psychologists, had greater affinity with the theme and, for this reason, would assist the woman in her emotions and weaknesses concerning the experienced situation.

In this context, however, the professionals from the nursing area are those who often perform the first care with women in situations of violence at various levels of the healthcare network. Thus, they need to be qualified in relation to receiving multidimensional needs and intersectoral demands from these women. This requires that nurses be able to recognize the dimensions of relational and social level, also seeking to consider the issues of gender, race/ethnicity and generation[19-20].

Health professionals are of great value in the identification of individuals and population groups at risk for violence and the implementation of initiatives that promote prevention and the most appropriate interventions. This is important because, every day, there is an increased need for care with women in situations of violence that reach health services[21].

In this study, the reports corroborate the mentioned researches, because the nurses realized the increasing number of women who seek the services where they work, including a history of violence by an intimate partner. They also highlight, for example, the passage of women by reception centers for women victims of violence, from the nurse's behavior to send them to these locations and even try to lead the case through the notification of the suffered violence, despite not knowing them.

A survey conducted with 35 health professionals, including nurses, in 20 FHU in Salvador, Bahia, Brazil, aimed to identify the relationship between training and notification of violence against women in the FHS. The results showed that the theme violence against women was not addressed in the graduation and/or post-graduation of most professionals; for the others, the approach occurred superficially and punctually. Regarding education in the service, the study revealed that the theme is not a focus of discussions in trainings or meetings. The relationship between the approach of the theme of violence against women in educational spaces, as well as in services, and the notification of the issue is narrow[22-23].

The nurses in this study also resented the lack of training and support. Despite the severe impact of violence on the physical and mental health of women, there is still resistance and need for further preparation of nurses included to address situations of domestic violence within the health system.

When qualified on the theme, its dimensions, its concepts, its magnitude and the easiest way to identify and learn to take care of women who experience violence, nurses may assist in minimizing possible injuries to the health condition of women[18-19]. In the case of nursing (field of knowledge), in relation to women who experience violence, there is need to create conditions that may constitute and articulate their internal world with the external demand, repairing the experience of pain, so that the woman may, from this experience, develop new ways of being and acting in the world, in order to give her the opportunity for "a new beginning", that is, a reconnection with pleasure, love and life.

Conclusion

In this study, the results showed that domestic violence against women is present in the daily work of nurses, who identified it in their various forms of manifestation. However, despite this reality, the approaches adopted were distinct. In this context, domestic violence against women must be seen as a public health issue that requires supported interventions, i.e., specific public policies. The FHS, the research site, for example, should be envisioned as a healthcare model with great potential to fight this problem.

The results of this research are expected to allow for discussions, contributing to the prevention of violence against women, the expansion of political strategies and extensive nationwide campaigns for prevention and control geared to the theme, among others.

The results of this research may contribute to reflecting on the work process of nurses in relation to the theme of this study. In this context, the incorporation of the theme in the syllabus, at health units, with multidisciplinary discussions focused on analysis and monitoring of met cases, the continuous encouragement to researches

and consequent production on the subject, as well as the interdisciplinary work with the professionals involved with the theme, lead to increasing awareness and attention to the issue of domestic violence against women.

Collaborations:

1 – conception, design, analysis and interpretation of data: Patrícia de Paula Alves Costa da Silva and Ruth França Cizino da Trindad;

2 – writing of the article and relevant critical review of the intellectual content: Patrícia de Paula Alves Costa da Silva, Ruth França Cizino da Trindade and Walter Matias Lima;

3 – final approval of the version to be published: Patrícia de Paula Alves Costa da Silva.

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