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HEALTH CARE PERCEPTIONS IN THE MARITAL VIOLENCE CONTEXT

PERCEPÇÕES DO ATENDIMENTO EM SAÚDE NO CONTEXTO DE VIOLÊNCIA CONJUGAL

PERCEPCIONES DE LA ATENCIÓN SANITARIA EN EL CONTEXTO DE LA VIOLENCIA CONYUGAL

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Objective: to know women's perceptions of health care in the marital violence context. Method: qualitative, descriptive study, developed with eight women in marital violence assisted in a Family Health Unit. Data collected in interview and data analysis based on thematic content analysis proposed by Bardin. Results: there was an experience of asymmetries in relation to the perceptions attributed to the care received in health services, ranging from the perception of good care, permeated by attention, respect and quality in communication, to the experience of inadequate care, thus perceived as a result of non-investigation and non-approach of violence by health professionals. Conclusion: women in situations of marital violence revealed that, in view of the physical and mental illness resulting from the experience of marital violence, they sought the support of the health care network.

Descriptors: Gender-Based Violence. Intimate Partner Violence. Women. Health Services. Women's Health. Comprehensive Health Care.

Objetivo: conhecer as percepções de mulheres sobre o atendimento em saúde no contexto de violência conjugal. Método: estudo qualitativo, descritivo, desenvolvido com oito mulheres em situação de violência conjugal assistidas em uma Unidade de Saúde da Família. Dados coletados em entrevista e análise dos dados fundamentada na Análise de Conteúdo Temática proposta por Bardin. Resultados: evidenciou-se vivência de assimetrias em relação às percepções atribuídas à assistência recebida nos serviços de saúde, indo desde a percepção de um bom atendimento, permeado pela atenção, respeito e qualidade na comunicação, até a vivência de atendimento inadequado, assim percebido em decorrência da não investigação e não abordagem da violência por parte dos profissionais de saúde. Conclusão: as mulheres em situação de violência conjugal revelaram que, frente ao adoecimento físico e mental oriundo da vivência de violência conjugal, procuravam o suporte da rede de atenção à saúde.

Descritores: Violência de Gênero. Violência por Parceiro Íntimo. Mulheres. Serviços de Saúde. Saúde da Mulher. Assistência Integral à Saúde.

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Objetivo: conocer las percepciones de las mujeres sobre la atención sanitaria en el contexto de la violencia conyugal. Método: estudio cualitativo y descriptivo, desarrollado con ocho mujeres en violencia conyugal asistidas en una Unidad de Salud Familiar. Datos recogidos en entrevistas y análisis de datos basado en análisis temático de contenido propuesto por Bardin. Resultados: bubo una experiencia de asimetrías en relación con las percepciones atribuidas a la atención recibida en los servicios de salud, que van desde la percepción de una buena atención, impregnada de atención, respeto y calidad en la comunicación, basta la experiencia de una atención inadecuada, percibida así como resultado de la no investigación y la no abordaje a la violencia por parte de los profesionales de la salud. Conclusión: las mujeres en situaciones de violencia conyugal revelaron que, en vista de las enfermedades físicas y mentales resultantes de la experiencia de violencia conyugal, buscaban el apoyo de la red de atención médica.

Descriptores: Violencia de Género. Violencia de Pareja Íntima. Mujeres. Servicios de Salud. Salud de la Mujer. Atención Integral de Salud.

Introduction

Marital violence is a worldwide public health problem that demands strategies articulated in order to prevent and face the issue. The role of professionals working in health services is considered the adequate management of health repercussions on women and family members.

By revealing that 33% of women experience marital violence at some stage of their lives, the United Nations (UN) recognizes it as a "global pandemic"[1]. This proportion may be higher, depending on the country and the group studied. A study conducted in Western Ethiopia identified a prevalence of 44.5% of marital violence during pregnancy[2]. Moreover, given the difficulty that permeates the identification of the problem, these rates might be even higher.

Marital violence has a negative impact on women's biopsychosocial integrity. National and international studies reveal that this violence marks the appearance of significant consequences in physical, sexual and psychological health, which are presented through low esteem, isolation, fear, anxiety, suicidal thinking and behavior, depression, posttraumatic stress disorder, sexually transmitted infections, gastrointestinal disorders, diabetes, hypertension, asthma and injuries, such as hematomas and fractures[3-5,7].

Consequently, the demand for care in health services emerges from illness[6]. Studies conducted in Brazil and Sweden recognize that, for being closer to women in situations of marital violence, professionals working in Primary Health Care (PHC) should be prepared to embrace and direct women who experience violence perpetrated by their intimate partner to restore health and break abusive relationships[8-9].

Given the wide repercussions on health resulting from marital violence and the need for health care as an intensifier of female empowerment, especially in the PHC scope, the care provided needs to offer embracement, respect, safety and satisfaction of women's individual needs[10]. The question is: How does health care occur in the Family Health Unit in the context of marital violence?

The aim of this study is to know women's perceptions of health care in the context of marital violence.

Method

This is a descriptive research with a qualitative approach, approved by the Human Research Ethics Committee at the University of the State of Bahia, according to the Certificate of Presentation for Ethical Appreciation (CAAE) n. 55253116.5.0000.0057 and Opinion n. 1.731.629.

The research was carried out in the area covered by a Family Health Unit (FHU) in a municipality in inland Bahia, Brazil. The approach with the community occurred through the insertion of the researchers in the health care team, with the systematic development of health education activities in the service. There was need to develop educational activities to build a bond between researchers

and interviewees, aiming to allow reliability to the latter to share their experiences.

Thus, the possible collaborators were identified and approached through extensionist educational actions in the FHU on the themes: gender, marital violence, women's health, mental health and use/abuse of alcohol and other drugs. During the extension activities, many, despite referring to contexts concerning physical, psychological, moral, patrimonial and sexual expressions in the marital relationship, did not recognize the problem or denied it by fear or shame of socializing information considered intimate. It is noteworthy that the fear of sharing the experience was present even before the researchers' care to become familiar, in a welcoming way, with the environment, a timely strategy for bonding with potential collaborators.

Inclusion criteria were women who lived in the area covered by the FHU, aged 18 years or more and with a history of marital violence. Those with signs of emotional instability, manifested through states of anguish, suffering, depression, agony, nostalgia, cardiac changes and distress, were excluded. The investigation of these signs was carried out by three nursing graduate students, under a professor's supervision, who made up the research-executing team. After evaluating the research criteria, two women were excluded because they presented signs of emotional instability. All the invited guests agreed to participate in the research and signed the Informed Consent Form. Finally, eight women met the inclusion and exclusion criteria and participated in the study. This number of collaborators occurred through data saturation.

Data collection, performed by the executing team, occurred from December 2018 to February 2019, in a single and individual moment, in a closed room of the FHU. It was preceded by four months of thematic and methodological training with the executing team. Data collection occurred through semi-structured interviews, a technique that allows the interviewee to contribute to the investigation process with freedom and spontaneity, without losing objectivity. Furthermore, it also admits the exploration of social themes with wealth of information and detailing of perceptions and experiences, an essential context for developing the study. The rescue of women's memory about health care in the context of marital violence occurred with the support of a form that investigated sociodemographic information and health care. For the latter, the following guiding question was used: How was the care provided to you in the health unit, in the context of marital violence?

The individual interviews, with an average duration of 25 minutes, were recorded and later fully transcribed in the Microsoft Office Word 2016 software. In order to ensure the privacy of the collaborators, they were identified by name of flowers (Orchid, Sunflower, Hydrangea...).

The empirical material, previously fully transcribed, was analyzed from the perspective of content analysis proposed by Bardin. The three phases were sequentially fulfilled: pre-analysis, which refers to the stage of approaching the material, through floating reading and subsequent organization; exploration of the material, which concerns the period of codification and categorization; and treatment of the results, when there is the synthesis of the selected results aiming to build the scientific knowledge about the object studied[11]. The results were analyzed in the light of marital violence and health care.

Results

The eight collaborators of the research were between 34 and 81 years old. Most were brown, Catholic, with incomplete primary education, housewives, income of up to half minimum wage, unmarried, with one to three children and with occasional or suggestive abusive consumption of marijuana, hypnotics/sedatives and alcoholic beverages. Regarding marital violence, three women revealed the associated experience of all forms of expression in the last three months, including: physical, sexual, psychological, moral and patrimonial. For the same period, the other collaborators (five) informed the associated experience of physical, psychological and sexual violence.

The women's report allowed knowing women's perceptions of health care in the context of marital violence, which were organized into two scientific categories: Recognizing an adequate service and Identifying an inadequate service. It is clear that some elements guiding the first category also permeate the second, such as the experience of marital violence as a driver of the search for health care.

Recognizing an adequate service

Women, upon unveiling good care in health services, reported the experience of a communicative, respectful, attentive and patient care, defined as welcoming and driving the sharing of the experience of marital violence with the health team. These aspects can be evidenced in the following statements:

> *I got sick because of the violence perpetrated by my husband, so I sought the health service. There, the doctor met me so well, prescribed sleeping pills, but explained that pills would not solve my marital problems, and that I would need follow-up. In the psychologist, I also feel good, I talk and with her help I am having the strength to support life with my husband.* (Orchid, 34 years old).

> *I always seek help at the health center because of my violent husband. There the receptionist always treats me well and I also have nothing to say about the nurses' call. The doctor also treats me very well and, when I asked, she explained my husband that diabetes and menopause affected the liquid that lubricates the vagina and that, therefore, he had to be careful in sexual intercourse, because he ended up hurting me.* (Hydrangea, 40 years old).

> *I got sad and with a low self-esteem, because my husband does not respect me and I ended up seeking a psychologist. It is amazing how much I liked his service and felt it because, for the first time, I was able to talk about living with my husband.* (Rose, 81 years old).

Identifying an inadequate service

The set of statements of the study participants also showed that women in situations of marital violence experienced non-investigation and non-approach of violence by health professionals, and these experiences are attributed to a disqualified care.

> *Always suffering from forced sexual intercourse, attempt to strangle, makes me sick and seek care. The worst part is, I still suffer a lot. Even to be met at the service is almost impossible. Even the health worker, who was supposed to visit us, is not that good, because he hardly visits me.* (Lily, 35 years old).

> *The professionals at the post are aware of my husband's ignorance, that he is violent, and that my blood pressure keeps rising, making me taking injections. Even so, they never asked about my* [marital] *relationship or the reason my pressure is always high.* (Sunflower, 43 years old).

Discussion

The study reveals that the violence experience in marital relationship, as lived by the study collaborators, leads to illness, which impels the search for care at health services. Concerning the perceptions of the health care in context of marital violence, the reports alert to the experience of asymmetries.

The perceptions attributed to inadequate care were experienced before episodes of non-investigation and/or non-approach of gender violence by health professionals, behavior conducive to non-identification of subtle and/or evident signs of violence and its repercussions. The act of not detailing women's marital context is also a shared reality in other care areas, especially in the health, public security and social assistance sectors[12].

It is important to mention the structural aspects of the services that are among the reasons that hinder health professionals to investigate and/or address marital violence. The physical space of the network facilities often does not allow a welcoming environment, which inhibits the sharing of intimate issues between the client and the professional. Added to this fact is the limitation in the number of professionals, a reality that affects the unavailability of care with women or work overload for the worker, as pointed out by studies developed in Brazil, Sweden and Saudi Arabia[8,13-14].

In addition to the structural factors that drive the non-investigation of violence, there are also individual aspects intrinsic to professionals, such as: fear of being confronted by the perpetrator of violence; naturalization of the relationship of superiority established by men over women, especially in the context of conjugality; or, also, not seeing marital violence as an object to be identified and handled in health services[12,15-17].

In view of these aspects, and based on the experience of the collaborators of this study,

it is notorious the fragility of the care provided by some health professionals to women in situations of marital violence. By not looking at the context in which women are inserted and by disregarding the experience of marital violence as one of the social determinants of health, professionals who work in the health sphere contribute to the solidification of a fragile and ineffective network. Moreover, by denying the right to a welcoming, qualified and problem-solving care, the care network favors the permanence of women in the marital relationship with violent interactions[(18)].

The non-investigation and non-approach by health professionals also resonate in the underreporting of cases of marital violence, which provides for the minimization of indicators and, consequently, of investments. Regarding the notification, a study conducted in Rio Grande do Sul, Brazil, with 53 health professionals, found that slightly less than half of the professionals understand the importance of the action[(10)], a fact that contributes to the non-valuation of records. National and international researches recognize that this action is essential to cope with violence against women, since it provides subsidies for directing comprehensive care to needs and the development of health policies[(8-10,19)].

In opposition to the urgency of qualified and problem-solving care, the fragility of the care received by the collaborators made them think that professionals are disqualified to assist the demands arising from marital violence. Given the perception of an inefficient network regarding the impact of gender violence, it is appropriate that women no longer seek care in health services to assist demands arising from relationships with violent interactions. This understanding is revealed in a study conducted in Porto Alegre, Rio Grande do Sul, Brazil, with 21 women in situations of marital violence and 25 operators in the areas of health, legal, social action, police and non-governmental organizations, addressing the path taken by women upon deciding to seek help[(20)]. Thus, the rupture of one of the support bonds they need to cope with marital violence stands out, that is, the support network between women and the health service, which expands the vulnerabilities experienced and hinders the disruption of the cycle of violence[(21)].

This context highlights the need for qualified, evidence-based care, including trust and the search for resolution of the original problem. Therefore, the presence of subsidies to assist women in situations of marital violence with quality in the network is essential. These findings are corroborated in researches developed in Brazil and Spain, which add the need for professionals to build a relationship of trust with clients and, through qualified support, adequately manage the problems arising from marital violence inherent to their field of activity[(10,22)].

In this study, the women pointed out as characteristics related to good care: the one that provided listening, drug therapy and the recommendation to break the marital relationship with violent interactions. Therefore, women in situations of marital violence legitimized a reduced view of the concept of the problem-solving capacity of care.

The shared understanding in the discourse of the collaborators about good care is limited to a biomedical model centered on two strategies, namely: management of health complaints, through drug therapy; and agreement about the isolated responsibility of women for leaving marital violence. The latter occurs through professional judgment, which, before the risk of feminicide, guides the immediate break-up of the marital relationship by the woman and her departure from the residence as a survival strategy.

This vertical imposition demonstrates the distancing of the ideal of embracement, imaginary necessary to the humanizing model, which guides being constructed collectively with a view to strengthening relationships of trust, bond and commitment between users and professionals of the health sectors. These aspects are fundamental for the formation and performance of an expanded clinic in order to address the complexity of the health-disease process in view of the uniqueness of the patient/client in the context of violence[(10,23)].

In this sense, the consolidation of health services as healthy spaces is crucial for fostering qualified dialogue, in order to ensure timely access and effectiveness of health practices. Thus, the Unified Health System (UHS) is encouraged to be more agile and problem-solving in the care of women in situations of marital violence. The need for attention towards the phenomenon in its entirety and globality is also tied to the female non-understanding of the relationship between marital violence and illness, an awakening that, in these cases, must occur through professional intervention.

There is need to highlight the need for permanent education on the National Policy to Fight Violence against Women, to make workers more sensitive to relate health demands to marital violence. Nevertheless, national and international studies reveal that this ideal is distant, in addition to the existence of professionals' difficulties to suspect and/or identify the psychological and physical repercussions of marital violence, fragility present since training. What also stands out is the unawareness or fear of making referrals to the support network[16,24].

Some studies already point to possible educational interventions with health professionals. As an example, an action carried out in Rio Grande do Sul, Brazil, with 38 primary health care professionals, showed that the development of pedagogical workshops allows reflecting on listening practices and bonds with women in situations of violence. This conjuncture allows qualifying and applying knowledge in daily work[25]. In addition to the specific intervention, the preparation of the professional to support the demands arising from marital violence must also begin in the training, with a continuous characteristic, whether in technical and university courses, in the preparation for public service exams and even in the continuous training of health service professionals[14].

Although the continuing education of health professionals is currently a cornerstone for the care of women in marital relationships with interactions of violence, this reality is still embryonic worldwide, as recognized by the UN[1]. This statement corroborates studies conducted in Brazil, Chile, Saudi Arabia and Spain, upon identifying that most health professionals recognize that they had not received training related to marital violence during graduation and/or professional action, in addition to the interface with unpreparedness in acting in this context[3,13,22-23].

It is important to highlight the active role of women in this process. There is need to reconstruct the ideal of embracement, so that it does not accept or understand as sufficient a simple palliative listening followed by an inefficient intervention. Nonetheless, it is necessary to understand that, due to the fragility of the physical and psychological health status and the emotional conflicts usually surrounding women in a situation of marital violence, they will hardly be able to rationally judge the attention received. This fact makes them value even the innocuous care provided by some professionals.

The study limitations were the local peculiarities and the number of collaborators; however, despite this, the research contributed to elucidate the health care received by women in situations of marital violence. By allowing the discovery of this knowledge gap, it warns to the need to qualify assistance in the care network, especially concerning the non-investigation of the problem and the non-access to the service.

Conclusion

Women in situations of marital violence revealed that, in view of the physical and mental illness resulting from the experience of marital violence, they sought the support of the health care network. In the services that make up this network, they experienced asymmetries regarding the service received. This, for some, is driven by communicative, attentive, respectful and patient attention. Concerning inadequate care, there was the non-investigation of marital violence by health professionals.

Since it represents a potential space for health care, the devices composing the care network must be equipped to embrace this

demand and professionals must be prepared to investigate, recognize and work the problem, its repercussions and the needs presented by women. It is noteworthy that this aptitude should be constructed from professional training, a process that should be continued in the services, aiming to sensitize and prepare these professionals for the proper management of the phenomenon.

Finally, but equally important, it should be reiterated that health services cannot fully encompass all the demands arising from women in situations of marital violence and that efforts are necessary for municipalities to organize networks that integrate the various devices in the areas of education, social assistance, health, public security and justice.

Collaborations:

1 – conception, design, analysis and interpretation of data: Rafaela Guimarães Freitas, Larissa Nascimento de Souza, Everton da Silva Santos and Milca Ramaiane da Silva Carvalho;

2 – writing of the article and relevant critical review of the intellectual content: Rafaela Guimarães Freitas, Larissa Nascimento de Souza, Everton da Silva Santos, Eliene Almeida Santos and Milca Ramaiane da Silva Carvalho;

3 – final approval of the version to be published: Eliene Almeida Santos and Milca Ramaiane da Silva Carvalho.

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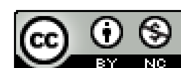

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