

VIOLENCE AGAINST WOMEN: RECEPTION IN THE FAMILY HEALTH STRATEGY

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ABSTRACT

The study aimed to analyze the state of the woman in the Family Health Strategy about situations of violence. Of a qualitative nature, descriptive study was conducted with fifty three professionals from seven health strategies of the family of a municipality in the northwest region of the state of Rio Grande do Sul. The data were produced by the technique of non-participant observation, recorded in a field journal and analyzed by thematic modality of Bardin. The results show that the physical spaces do not provide privacy conditions and access to women in situations of violence. Some of the professionals is concerned to investigate situations of life, but violence is not. One of the units has been identified on a map with women victims of violence and a flow chart to meet the sexual violence. It is concluded that it is necessary to rethink the state of women in situations of violence, propose the inclusion of the issue on the agenda and arrange the services based on policy

Keywords: Violence against Women; Hosting; Family Health Strategy.

INTRODUCTION

Violence against women is a global problem. Globally, one in three women has suffered or will experience violence. Those numbers change according to the countries, social cultures and policies to combat the current violence. In the Americas, the percentage of women who suffer violence is 29.8%, and Brazil is among those countries⁽¹⁾.

That type of violence is a complex and multiple-cause problem, which emerges from the existing inequalities in social relations between men and women, implying the oppression of one gender over another, that is, of the masculine over the feminine. Gender violence, when it occurs in the domestic space, has men as its main aggressor⁽²⁾.

That reality has consequences in women's lives and health. Those who experience violence are twice as likely to have depression and to

drink alcohol; in sexual and reproductive health, they are more likely to give birth to low-weight newborn and to acquire Acquired Immunodeficiency Syndrome (AIDS) and other sexually transmitted diseases. Among women who suffer violence, 42% suffer serious injuries, and, among deaths due to violence, 38% were by their intimate partners⁽¹⁾.

In Brazil, according to data from the System for Information and Notification Offense (SINAN - *Sistema de Informações e Agravos de Notificação*), in 2014, 223,796 victims of some type of violence were attended, and two out of three of those women needed health care, that is, every day, in 2014, 405 women demanded care in some health unit⁽³⁾.

The Family Health Strategy (FHS) is a reorganizing model of Primary Health Care (PHC), considered as the user's entry point into the Unified Health System (SUS – *Sistema Único de Saúde*). In the condition of family-centered attention model, it implies an

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approximation among the multidisciplinary team of professionals and users of an area of comprehensiveness, which enables unveiling problems with multiple determinants and the actions for solutions are intersectoral⁽⁴⁾.

PHC services are places where women seek care, who not always report violence, which is among the demands women bring. The FHS is a privileged *locus* for receiving women in situations of violence, since the link and the approximation among professionals and women can favor obtaining the report of that problem and constructing a shared coping project⁽²⁾.

The National Health Humanization Policy (PHSN – *Política de Humanização da Saúde Nacional*) mentions the host as a conceptual guideline that bases the care on a logic that respects, accepts and legitimizes the user's demand as a health need. The host presupposes a dialogical posture among professionals and users and can provide the formation of the bond from which the production of a care project is feasible⁽⁵⁾.

Sensitive listening, on the other hand, enables users to access technologies that are in accordance with their expressed needs, which should be attended based on priorities defined in vulnerability, severity and risk assessment. The environment is added as a condition that can improve health work and facilitate the meeting between the professional and the user⁽⁵⁾. Therefore, dialogue, listening and bonding are considered potentialities of care^(6,7,8). However, the structure of FH units is not always built to facilitate access. Moreover, there are the sexist and prejudiced positions of some professionals who reinforce the emotional experience of vulnerability of attacked women, keeping them in the cycle of violence⁽⁹⁾.

The host proposal advocated by the public policies within SUS is far from many realities. There is an abyss between what the policy recommends and the practices performed in services, especially when the problem is gender violence⁽⁶⁾.

Based on those considerations, the objective of this study is to analyze the reception of women in the FHS focused on situations of violence.

METHODOLOGY

A descriptive, qualitative study, carried out in a municipality in the northwestern region of the state of Rio Grande do Sul, in seven FH units. In order to analyze the elements that constitute the attention, based on the host reference, the observed items were the physical space, the team, the organization and operation of the service and the service flow.

The technique of data collection was the non-participant observation, modality in which the observer remains in the viewer's function, noting the information. For this, the viewer needs to have prior knowledge of the context, consent of the participants, definition of what will be observed, the scenarios, the people and the behaviors. The information are recorded in field diary⁽¹⁰⁾.

The data were collected from March to July 2015. Before starting the observation, the researcher informed the 53 professionals of the seven teams of the Family Health Strategy, who accepted to participate in the study (nurses, doctors, nursing technicians, dentists, oral health assistants and Community Health Agents - CHA), on the purpose of the research and his presence in those work places: to obtain information about the topic under study, during three days, in the morning and afternoon shifts.

The observed participants were aware of the study's purpose; however, they were not aware of the specific issues that appeared in the observation guide. That aspect, along with the observation time, minimized the possible biases.

In order to record the observations, the researcher used a guide that consisted of: physical structure (reception, nursing consultation, medical consultation and procedures rooms); space for users to identify privacy, comfort and safety; staff, the presence of a link among professionals and users and how they question the biopsychosocial aspects of women's lives and violence; organization and functioning of the FHS teams, working hours, consultation schedules, groups and intensity of demand; service flow - the path traveled by the user within the unit.

The empirical material was read and the units that had the same meaning were highlighted, which were read again and regrouped in the thematic categories: *physical structure, family*

health team and their actions, organization and operation of the service and service flow.

The description was discussed with the Reception referential, since the woman who suffers violence, when accessing the health service, needs to have privacy, sensitive listening and individual and singular care^(8,9). The receptiveness, in a posture condition, guides the actions based on the reception, the listening and the humanized treatment to the users. The receptiveness, as a technique, is present in the procedures and organization of the service to meet the demands; and, as an organization, bases on the existence of an institutional project that directs the work in the health unit^(11,12).

The study was in accordance with the norms of Resolution 466/2012 of the National Health Council (CNS) and approved by the Ethics Committee of the Federal University of Santa Maria, Opinion No. 909978. All professionals who agreed to be observed during their work signed the Consent Informed Form in two ways of equal content.

RESULTS AND DISCUSSION

Physical Structure

The physical structure of the FH units of the study consists of: a reception and waiting room, bathroom for the user, consultation rooms (dental, nursing and medical), procedure rooms, receptiveness and vaccines rooms, pharmacy, kitchen and storage room, bathroom for employees, cleaning service area and deposit of cleaning material, Material Sterilization Central. Among all surveyed FHS teams, only two have a receptiveness room. Masonry walls divide all the rooms, which have windows and entrance doors, with identification plates. Among the seven teams, two work in the same space, and, regarding the physical structure, they both have duplicate offices, except for receptiveness and waiting rooms, pharmacy, vaccine rooms, kitchen, storage room and meeting room.

The physical structure of the units was built in accordance with the recommendations of the Ministry of Health, presenting the mandatory environments for administration rooms, clinical, dental and support services⁽¹³⁾.

There are differences in the environment

between the units, because, in some units, there are large rooms, a bright and airy environment; in others, the rooms are small, poorly lit, ventilated and with infiltrations of water, which may imply discomfort in the execution of the care to users. This reflects the importance of the spatial dimension regarding the receptiveness in health as a requirement to achieve more efficient practices of health production, both for the worker as for the user⁽¹²⁾.

The physical structure where the teams work does not favor the reception of health needs present in the lives of women living in situations of violence, which is a problem, for privacy, comfort and individual security, allied to sensitive listening, are essential for the organization of practices of health production that approach the integrality in the attention and receptiveness as guideline of the humanization⁽¹²⁾. Based on this conception, the physical spaces identified as being of greater privacy and security were the offices (medical, nursing and dental), places where the user and the professional can use to solve needs related to violence.

Resizing the spatial receptiveness through building reforms, with the elaboration of an architectural project shared by users and health professionals, considering privacy and security, could contribute to the access to the FHS and, consequently, to the recognition of that place as an entry point and grievance attention. And, from this, promoting organizational accessibility⁽¹¹⁾.

The adequacy of the physical area and the compatibility between the supply and demand for health actions is an issue that needs analysis when adopting, indeed, the receptiveness as a strategy for care production. It is noteworthy that receptiveness is not limited to a space or place; it also presupposes the professional stance of the team⁽¹³⁾.

Family Health Team and their actions

As for the teams, they all have nurses, doctors, nursing technicians (NT), nursing assistants, and community health agents (CHA). Five have dentists and oral health assistants. Therefore, those units are in line with the recommendation of Ministry of Health, Ordinance 2,027 of 2011(14). According to the

receptiveness proposal, the team consists of different professionals, aiming to broaden the approach of sickness to health demands⁽¹⁵⁾.

Teams, by adopting the receptiveness posture, can perform a sensitive listening that identifies the risks and vulnerabilities of the users in any space of attention and listen to the demands of the subjects related to the psychic and physical sufferings⁽¹³⁾.

It is necessary to move the medical-centered approach towards actions directed to the user/woman, directing the practices of care for the elaboration of individualized therapeutic projects that consider the singularities of the case in detriment to rigid protocols that do not meet the woman's needs⁽⁶⁾.

Health care teams that exercise health care practices approach the concept of receptiveness posture because there is no specific time or professional to do so and should happen at any place and time of service⁽¹³⁾.

The problem of violence against women is complex. Therefore, it demands the intervention of several sectors of society and the health services make up the care network. The FHS is recommended as a place for the care network, for the proximity of the event and the availability of multiprofessional work. The diversity of views on the problem can promote more effective actions^(6,16).

In six FHS teams, CHAs listened to women, had bonds with the users, revealed sensitivity, and investigated beyond what women reported to them. In one of the teams, the hearing made by the CHAs to the users focused on physical signs. The CHA from the seven units did not investigate signs of violence. However, it is important to emphasize that they were not accompanied by the researcher at the home visit, a favorable moment for the identification of violence⁽¹⁷⁾.

The CHA receives, through dialogue, active listening and bonding, the users' psychosocial demands (6,16). They belong to the community, know the local reality, and, often, are the first ones to identify situations at risk of violence or witness such situations. Therefore, they provide information for the team to build a therapeutic project⁽¹⁶⁾.

The NTs check vital signs and weight, record the information in the Outpatient Care Record

(OCR) and refer the patient to the waiting room. The NTs had a bond with the user and asked about symptoms related to gynecological, urinary, digestive and skeletal problems. The woman who lives in a situation of violence, when she looks for the health service, presents biological symptoms and investigating them can lead to the identification of the case⁽¹⁷⁾.

Nurses from five teams investigated the biopsychosocial aspects, and two of those professionals stood out for the sensitive and empathic way they interacted with women. Two other nurses investigated the biological aspects. Clinical conduct, alone, cannot solve the problem of violence against women, it is necessary to use light technologies⁽¹⁷⁾.

None of the nurses questioned women about violence. The reason for not asking may relate to the sense of discomfort when addressing that type of problem - fear of hearing and not knowing how to proceed - as well as prescriptive and medicalizing behaviors⁽¹⁷⁾.

In order to investigate violence, professionals would have to activate personal and technical resources that contemplated intersubjectivity and the interaction between professional/user, which would require a more sensitive look at social issues and the acquisition of more knowledge and skills⁽¹⁷⁾.

The nurse is recognized as a professional of the team that has more management knowledge with cases of violence^(17,18). Most of the time, he/she is the one who attends training and passes the content to the team, in addition to planning and organizing the actions of the units⁽¹⁸⁾.

The physicians of three studied teams investigate biopsychosocial aspects of the users, and those of three other FHS investigate biological signs and symptoms. None of them asked the woman about violence. In one of the teams, there were no medical appointments, because, at the time of data collection, the doctor was on vacation.

Most physicians direct their actions to what is in the biological field, although they act in FH units, a situation similar to another study⁽¹⁷⁾. Medical consultations are recognized as spaces for identifying violence against women, specifically those for prenatal care^(17,18). Nevertheless, in the context of this study, there was a traditional dominant practice with

biological and clinical basis in the service, which limits the field of action, also found in other studies^(17,18).

Listening, risk assessment, vulnerability, guidance, problem solving and care is part of the competence of all professionals, and, if they can work with that notion, there is a possibility of transforming care practices and demedicalizing them⁽¹⁵⁾.

In the receptiveness proposal, teamwork presupposes an unscheduled contact among users and professionals, and everyone should receive and listen, assess biological, epidemiological and psychosocial risks and vulnerabilities; rediscuss and process the problem along with the user and trigger other team members to continue the care⁽¹⁵⁾.

In the teams, the CHAs, the nurses and some physicians, sensitive and empathetic to the problem of the violence, identify the cases and intervene, sometimes listening, sometimes medicating^(16,18,19). The intervention of social worker and psychologist along with the FH teams can help the woman overcome the situation of violence⁽¹⁸⁾.

Functioning and organization of actions

All units are open from Monday to Friday, during business hours. Three of them have intense demand throughout the service period, and, in three others, demand is intense in the early morning and in the afternoon. One unit, when compared to others, has little demand, perhaps due to its recent opening or location, whose population has better socioeconomic and cultural conditions, which may interfere in the non-recognition of the unit as a place to take care of health.

The operating hours of the units do not facilitate the reception of women who suffer severe life-threatening violence, as they more frequently occur during the night and/or at the end of the week, which leads women to access police stations or emergency rooms, services weekend duty⁽¹⁹⁾.

The concentration of users demand at certain time in some units may be an opportunity to think about working with women with individual and collective actions to promote care at lower concentration times, which would leave them less exposed. Group practices are considered

spaces for building links and listening among professionals and users and among users, which enable the empowerment and autonomy of women⁽¹⁷⁾.

The work is organized by scheduling medical and nursing appointments. Nurses follow prenatal care, childcare and gynecology programs on different days of the week. The users leave the scheduled appointments with a return schedule. Establishing actions by scheduling does not exclude the user's search by spontaneous demand⁽²⁰⁾.

The search for the medical consultation is still the focus of the search for care and may relate to the user's conception of health demand in relation to the FHS, contrary to the user-centered acceptance⁽²⁰⁾. The receptiveness proposes working with spontaneous demand, expanding access and being the main gateway to the Unified Health System⁽¹⁵⁾.

As for the health education groups, there were prenatal care groups, which deal with topics related to maternal and fetal health, newborn care, childbirth and puerperium, women's rights at work and breastfeeding, without mentioning violence.

Only one unit, in an intelligent map, identified women in situations of violence, represented by red pins, and had a flow of sexual violence fixed on the mural, which evidences that, in that location, there were women who suffered violence.

Service flow

The user arrives at the unit and goes to the reception, where the demands are received, and in cases of violence, the receptionists (NT and CHA) cannot receive her, so it is recommended to define a space for the listening and care offer to that woman. In a series of services, that space is a reception room⁽²⁰⁾.

Women with non-scheduled demands are sent to the reception room, where risks and vulnerabilities are analyzed, providing care. In that aspect, the flow is in accordance with the guidelines of the receptiveness to the spontaneous demand in Primary Care⁽²⁰⁾.

From the reception room, the user goes to the waiting room, and, there, she waits for the service for 30 - 40 minutes, on average, depending on the type of service.

The nursing consultation where women go to occurs, at all units, in an enclosed room, with a table, chairs, a stretcher and screen. The minimum duration of each consultation is between ten and fifteen minutes, varying according to the type of care. The moment of the nursing consultation is referred as a recognition of violence, especially in prenatal consultation⁽¹⁷⁾.

The medical consultation also occurs in an enclosed room, with a table, chairs, a stretcher and screen. Its duration varies according to the type of service, with an average of 15 minutes. Women leave the office with prescriptions, examination requests for tests and/or are referred to the procedure room. When they receive prescriptions, they go to the pharmacy to get the medicines. When they leave with an examination request, they go to the reception to request authorization.

In the units, there is no specific flow for women and a more reserved place for them to expose their violence problems.

The receptiveness modeling in the units of the FHS teams follows the "Reception by the user's team", in which the CHA and the receptionist perform the first listening, passing, in sequence, for the nursing technician; the nurse and the doctor make the rearguard. The bond and accountability among users and the mentioned population is the greatest benefit observed; however, the scheduled attendance is impaired when there is an excess of spontaneous demand, a situation that is in accordance with the guidelines of the Receptiveness in PC⁽²⁰⁾.

The flowchart, from the receptiveness perspective, should be the starting point of all collective work. It should be organized considering the singularities of the place, with the purpose of facilitating access, listening and attendance to health needs, based on a user-centered health model⁽²⁰⁾.

FINAL CONSIDERATIONS

VIOLÊNCIA CONTRA MULHER: ACOLHIMENTO NA ESTRATÉGIA SAÚDE DA FAMÍLIA

RESUMO

Neste estudo objetivou-se analisar o acolhimento à mulher na Estratégia Saúde da Família em situações de violência. De caráter qualitativo, do tipo descritivo, este estudo foi realizado com 53 profissionais de sete equipes da Estratégia Saúde da Família de um município da região noroeste do estado do Rio Grande do Sul. Os dados foram produzidos pela técnica de observação não participante, registrados em diário de campo e analisados pela modalidade temática de Bardin. Os resultados mostram que os espaços físicos não propiciam condições de

The study shows that the physical structure of the FHS teams consists of obligatory environments and the nursing, medical and dental offices are the only places that provide privacy, confidentiality and security for the attention to women in situations of violence. As for the other spaces, they expose the woman; therefore, considering the possibility of resizing the place would facilitate access and reception.

The health teams are multiprofessional, maintain a link with the users and some members investigate biopsychosocial aspects. The reception, as a posture, is present in the actions; however, there was no investigation on the violence.

The organization of the service of the FHS team takes place through an agenda of programmatic actions directed at women's health and spontaneous demand. One of the units presented a survey of women in situations of violence and a flow chart for the victims of sexual violence. There was no institutional project in the health care of women living in situations of violence.

Including, in the FHS services' agenda, the reception of women in situations of violence, through the elaboration of an institutional project among professionals and academics, through Permanent Education, could contribute to: qualify the professionals in the approach to social issues, such as the investigation of violence; construct a local service, where the woman can access and obtain answers to the needs generated by the aggravation, starting with listening to the problem and continuing with the offer of support of the family health team as one of the points of the closest care network, which can be the articulator of the intersectoral network, necessary to attend that problem. In this way, it would be possible to promote the consolidation of the receptiveness as a Policy in that scenario with attention to the health of women in situations of violence.

privacidade e acesso às mulheres em situação de violência. Parte dos profissionais preocupa-se em investigar situações de vida, mas a violência não. Uma das unidades tem identificado, no mapa inteligente, as mulheres em situação de violência e um fluxograma para atender a violência sexual. Conclui-se que é preciso repensar o acolhimento à mulher em situação de violência, propor a inclusão do problema na agenda e organizar os serviços com base na política.

Palavras-chave: Violência contra Mulher; Acolhimento; Estratégia Saúde da Família.

LA VIOLENCIA CONTRA LA MUJER: RECEPCIÓN EN LA ESTRATEGIA SALUD DE LA FAMILIA

RESUMEN

El estudio tiene como objetivo analizar el estado de la mujer en la Estrategia Salud de la familia acerca de las situaciones de violencia. De carácter cualitativo, se realizó un estudio descriptivo con cincuenta y tres profesionales de siete estrategias de salud de la familia de un municipio de la región noroeste del estado de Rio Grande do Sul. Los datos fueron producidos por la técnica de observación no participante, registrados en un diario de campo y analizadas por modalidad temática de Bardin. Los resultados muestran que los espacios físicos no ofrecen condiciones de confidencialidad y el acceso a las mujeres en situaciones de violencia. Algunos de los profesionales se refiere a investigar las situaciones de la vida, pero la violencia no lo es. Una de las unidades se ha identificado en un mapa con las mujeres víctimas de violencia y un diagrama de flujo para atender la violencia sexual. Se concluye que es necesario repensar el estado de las mujeres en situaciones de violencia, proponer la inclusión de ese tema en el programa y organizar los servicios basados en políticas.

Palabras clave: La Violencia contra la Mujer. Acogimiento. La Estrategia Salud de la Familia.

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