Revista Brasileira em Promoção da Saúde
e-ISSN:1806-1230
Original Article
DOI: 10.5020/18061230.2019.9271

DOMESTIC VIOLENCE AGAINST WOMEN IN RURAL CONTEXT: RECOGNITION OF CARE STRATEGIES

Violência doméstica contra a mulher em contexto rural: reconhecimento das estratégias de atenção

Violencia doméstica contra la mujer en el contexto rural: reconocimiento de las estrategias de atención

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ABSTRACT

Objective: Describe the role of Family Health Strategy (ESF) professionals in the face of domestic violence against women in a rural context and the limits faced for their development. **Methods:** Qualitative study conducted with twenty ESF health professionals from two municipalities of the state of Rio Grande do Sul, Brazil. Data were collected through structured interviews from January to March 2016. The empirical material was submitted to content analysis, emerging the thematic categories: performance of ESF professionals in attention to women in situations of domestic violence in rural settings; limits faced by ESF professionals to care for women in situations of domestic violence in rural settings. **Results:** The attention developed by the ESF professionals to these women is related to attentive and sensitive listening and teamwork and intersectoral. The limits for the development of the professionals 'performance are the lack of skill, non-participation in groups, denial of the experience of the violence situation and the absence of a protocol to guide the professionals' actions regarding the identification of violence. **Conclusion:** Although the strategies of attention to rural women in situations of domestic violence are based on the assumptions of humanization and health promotion, there are limits to the integral care of these women. It is suggested to create a model that prioritizes the training of professionals to work with women in situations of violence and a protocol to guide the actions in the face of such a situation.

Descriptors: Domestic Violence; Violence Against Women; Family Health Strategy; Health Personnel; Rural Areas; Rural Health.

RESUMO

Objetivo: *Descrever a atuação dos profissionais da Estratégia de Saúde da Família (ESF) diante das situações de violência doméstica contra a mulher em contexto rural e os limites enfrentados para o seu desenvolvimento.* ***Métodos:*** *Estudo qualitativo realizado com vinte profissionais de saúde da ESF de dois municípios do estado do Rio Grande do Sul, Brasil. Os dados foram coletados através de entrevistas estruturadas, no período de janeiro a março de 2016. Submeteu-se o material empírico à análise de conteúdo, emergindo as categorias temáticas: atuação dos profissionais da ESF em atenção à mulher em situação de violência doméstica em cenários rurais; limites enfrentados pelos profissionais da ESF para atenção à mulher em situação*

Received on: *04/07/2019*
Accepted on: *08/08/2019*

de violência doméstica em cenários rurais. ***Resultados:*** *A atenção desenvolvida pelos profissionais da ESF à essas mulheres relacionam-se com a escuta atenta e sensível e trabalho em equipe e intersetorial. Os limites para o desenvolvimento da atuação dos profissionais são a falta de habilidade, a não participação em grupos, negação da vivência da situação de violência e a ausência de um protocolo para nortear as ações dos profissionais diante da identificação da violência.* ***Conclusão:*** *Apesar de as estratégias de atenção às mulheres rurais em situação de violência doméstica pautarem-se nos pressupostos da humanização e promoção da saúde, existem limites para a atenção integral dessas mulheres. Sugere-se a criação de um modelo que priorize a capacitação dos profissionais para atuar com a mulher em situação de violência e um protocolo para nortear as ações diante de tal situação.*

Descritores: *Violência Doméstica; Violência contra a Mulher; Estratégia Saúde da Família; Pessoal de Saúde; Zona Rural; Saúde da População Rural.*

RESUMEN

Objetivo: *Describir la actuación de los profesionales de la Estrategia de Salud de la Familia (ESF) ante situaciones de violencia doméstica contra la mujer en el contexto rural y los límites afrontados para su desarrollo.* ***Métodos:*** *Estudio cualitativo realizado con veinte profesionales sanitarios de la ESF de dos municipios del estado de Rio Grande do Sul, Brasil. Se recogieron los datos a través de entrevistas estructuradas en el período entre enero y marzo de 2016. Se ha realizado un análisis de contenido del material empírico del cual ha emergido las siguientes categorías temáticas: actuación de los profesionales de la ESF para la atención de la mujer en situación de violencia doméstica en escenarios rurales; límites afrontados por los profesionales de la ESF para la atención de la mujer en situación de violencia doméstica en escenarios rurales.* ***Resultados:*** *La atención desarrollada por los profesionales de la ESF a esas mujeres se relacionan con la escucha atenta y sensible y el trabajo en equipo e intersectorial. Los límites para el desarrollo de la actuación de los profesionales son la falta de habilidad, la no participación en grupos, la negación de la vivencia de situación de violencia y la ausencia de un protocolo para orientar las acciones de los profesionales ante la identificación de violencia.* ***Conclusión:*** *Pese a que las estrategias para la atención de las mujeres rurales en situación de violencia doméstica se basan en los presupuestos de la humanización y la promoción de la salud, hay límites para la atención integral de esas mujeres. Sugiérase la creación de un modelo que valore la capacitación de los profesionales para actuar con la mujer en situación de violencia y un protocolo para direccionar las acciones ante tal situación.*

Descriptores: *Violencia Doméstica; Violencia contra la Mujer; Estrategia de Salud Familiar; Personal de Salud; Medio Rural; Salud Rural.*

INTRODUCTION

Violence has become a public health problem, as it affects society in general and has repercussions on the health of those who experience it[1,2]. It should be considered a complex phenomenon, with worldwide proportions, with a tendency of population growth due to its magnitude[3].

According to the World Health Organization (WHO)[2], approximately 30% of women have already suffered some kind of violence from their intimate partner all over the world. In Brazil, 29% of women, throughout their lives, experienced some situations of violence[4].

In the matter of domestic violence, it highlights that it is a phenomenon of multiple determinations, defined as any action or omission perpetrated in the domestic environment by individuals who live in it, with or without parental function, even if eventually[5]. This term denotes violence in its different typologies and can be directed to different populations, such as women, children, and adolescents[6].

When it comes to situations of violence in the rural context, they are enhanced. This is associated with the lives and work of the people living in this context, as well as the fact that this environment is far from the major centers and, consequently, from the social, political, and community resources that could promote greater protection[7-10]. In this scenario, domestic violence is permeated by socio-demographic, economic and cultural conditions, and sustained by the hierarchy of power and domination employed in intra-family, intersexual and intergenerational relations[11,12].

Thus, these aspects should be considered for the successful attention to women living in domestic violence living in rural settings, which is under the principles of health promotion. This, according to WHO, consists of providing the population with the necessary means to qualify their health and exercise control over it, based on programs and policies based on the principles of humanist conception, social participation and equity[13].

In an attempt to overcome the fragmentation of care for women in situations of violence, to be guided by the perspective of comprehensiveness, policies were published to fill the gaps in care for women, such as the National Policy for Integral Attention to Women's Health (*Política Nacional de Atenção Integral à Saúde da Mulher - PNAISM*),

which incorporates gender mainstreaming to achieve health promotion and humanization as guiding principle[14]. In 2006, the National Health Promotion Policy (*Política Nacional de Promoção da Saúde - PNPS*) was published, through which numerous practices were incorporated into all spheres of government and it was understood that, for health promotion, it is essential to intervene in problems such as violence against women because it is aggravating to her health, among others[15].

In this scenario, the Family Health Strategy (*Estratégia de Saúde da Família - ESF*) is the health service that tends to be closer to individuals in situations of violence. The ESF proposes care actions that allow the identification of social problems, including domestic violence, as well as the development of responses to these problems from the perspective of integrality[16]. Besides, it stands out for the possibility of continuity and follow-up of actions initiated after the identification of situations of domestic violence[17].

It highlights the importance of attention strategies aimed at longitudinal and integral care of women who experience situations of domestic violence. However, to ensure qualified care, it is necessary knowledge and preparation of professionals who assist them with effective and resolute actions, especially those working in the ESF[18].

Based on the above, the relevance of this study is to describe the performance of health professionals in situations of domestic violence against women in a rural context and the limits considered by them, to serve as subsidies to other studies. The proposal that converges with the research themes of the National Agenda for Priorities in Health Research (*Agenda Nacional de Prioridades na Pesquisa em Saúde no Brasil - ANPPS*)[19] and the Sustainable Development Agenda, which points out as one of its objectives the significant reduction of all forms of violence everywhere[20].

Thus, the present study has the following guiding question: what is the role of ESF professionals regarding the situations of domestic violence in the rural context and the limits to develop them? To answer it, the objective is to describe the performance of ESF professionals in the face of domestic violence against women in a rural context, and the limits faced for their development.

METHODS

Qualitative approach study, which presents coherence with the object of study, since it is used when approaching the study of history, relationships, representations, beliefs, perceptions, and opinions, which result from the human interpretation of your experiences and feelings[21].

The study had as scenario two municipalities of the Northwest region of the state of Rio Grande do Sul, Brazil. To list these municipalities, we sought a region with a larger rural population than the urban population and Family Health Strategy in rural settings. Thus, four municipalities were listed as invited to participate in the research, obtaining a positive response from two of these municipalities.

The study participants are all professionals (nurses, nursing technicians, community health workers, dental surgeons, and oral health assistants) who worked with the ESF in rural settings. Since these professionals serve women in situations of violence at some point, they could then detail the specifics of the action and the limits in the care of women in situations of domestic violence in rural settings.

Data generation began with the researcher's approach to the study scenario. This strategy allowed us to present the study, negotiate how the interview could be conducted, choose the location and invite professionals to participate in the study. Then, according to the availability of the professionals, the day and time for the interviews were scheduled.

For data collection, we used structured interviews that presuppose previously formulated questions, characterized by being open[21]. The questions were based on the attention of professionals given to women in situations of violence in rural settings, focusing on the performance and the limits of this attention. What is your role in the face of domestic violence against women in your rural workplace? What are the limits found in women's care in situations of domestic violence in their rural workplace?

The interviews took place individually, as previously scheduled, from January 2016 to March 2016, and were held in a room reserved at the service where they worked. To ensure reliability, the interviews were audio-recorded, with the consent of the participants, lasting an average of 30 minutes.

The recruitment of participants ended with the thematic saturation criterion[22], reached in the 20th professional. These professionals include three nurses, three nursing technicians, eleven community health agents, two dental surgeons and one oral health assistant. As inclusion criteria, it was listed: working for at least six months in these services. The exclusion criterion was to be on vacation or leave of any kind during the data collection period. Five professionals from the same municipality chose not to participate.

The interviewees' statements were subjected to content analysis after the transcription. The analysis period was divided into three stages: pre-analysis, material exploration, and treatment of the results obtained and interpretation[21].

As for the pre-analysis, it began with the organization of the material obtained through the interviews for further analysis. Therefore, the transcription of the interview audios in a text editor was firstly transcribed, composing the corpus of the study. Then, the recordings were listened to and the reading fluctuated, which made it possible to generate initial impressions about the material[21]. Afterward, a sequence of exhaustive readings was performed, which allowed highlighting, with different colors, the fragments in which the participants' statements were correlated[21]. The exploration of the material took place by clipping the common information found in the transcribed material. In this sense, the nuclei of meaning were listed, which refer to words, phrases, and expressions that give meaning to the content of the speeches and subsidize the constitution of the categories[21].

The last phase consists of the treatment of the obtained results and interpretation. In this phase, inferences and interpretations were made about the results, always with the return to the objective of the study[21]. Then, they were grouped, allowing the constitution of two thematic categories: performance of ESF professionals in attention to women in situations of domestic violence in rural settings; limits faced by ESF professionals to care for women in situations of domestic violence in rural settings.

This study was conducted to respect the norms of Resolution No. 466/12 of the National Health Council[23], approved and approved by the Research Ethics Committee of the Federal University of Rio Grande do Sul, under Opinion no. 514,865. It is noteworthy that, before the data collection procedure, participants were informed individually through the Informed Consent Form about the research objectives. Because of the participants' anonymity, the professional code P was used, followed by the number representing the sequence of the interview.

RESULTS AND DISCUSSION

Performance of ESF professionals in attention to women in situations of domestic violence in rural settings

The thematic category describes the performance of ESF professionals in the care of women in situations of domestic violence in rural settings, in which professionals mentioned essential elements to understand and give visibility to situations of violence, as well as observing and listening attentively. performed during care and home visits:

> *"[...]our job is more listening." (P1)*
>
> *"[...]my role is to talk." (P4)*
>
> *"[...]In most cases, I try to listen, to observe, to try to understand." (P5)*

By listening carefully and sensitively to women who experience situations of domestic violence in the rural setting, the professionals showed interest in understanding the situations and, thus, the needs of those who experience them. In this sense, it is understood that professionals must always be attentive and available to listen to women in situations of violence, developing nonjudgmental listening[24]. Such conduct will assist in establishing bonds and trust between women and professionals, facilitating the shared construction of coping / overcoming strategies.

Usually, women in situations of domestic violence in the rural scenario report their situation to professionals when they already have a bond and trust in them, as mentioned by the interviewees:

> *"[...] after a while you go home, they can open up first [...] you have to get the trust of the family, then she can put you in trouble." (P1)*
>
> *"Many times, they cry or complain [...] so, talking, over time, they tell what is happening and we also develop empathy [...]" (P15)*
>
> *"[...] on one visit you realize from the observation that they are not well and then on another visit, they tell you 'oh that day I was like this because this and this happened'." (P19)*

It is highlighted by the statements that the bond and trust derive from the way users are treated by professionals. It also has to do with the time spent with the user, because it is not in the first contact with the professional, either in the health unit or at home, that the situation of violence will be reported. Thus, when professionals show empathy, women are more comfortable in reporting situations. The importance of trust and bond between the user and the professional, to break the stigma and enable the report of violence, is also exposed in a study that investigated the actions performed by primary health care nurses for women in situations of domestic violence[25].

Another performance mentioned by the interviewees focused on radio programs and some television programs that spoke about the subject, not trivializing violence. Thus, there was the theme of domestic violence, discussed in radio and television programs to make women understand what is mentioned by respondents:

> *"[...] there are always some programs on radio, on television that explain and guide people, and we also try to guide people to understand and talk about their problem." (P19)*
>
> *"[...] try to approach the subject more, guiding, explaining [...] why I think that sometimes people don't even know that it is not normal suddenly [...] indoors, you live that situation all your life and think that's normal." (P9)*
>
> *"[...] we hardly see, we only imagine that this is violence, [...] it is through the visits that we notice." (P3)*

However, from the lines, it is reflected that poverty is articulated in the construction of violence for this rural population. It is assumed, then, that poor rural women are less likely to exercise citizenship, fight for their rights, for example in the absence or limitation of financial autonomy to support themselves or even to travel the enormous distances between their families homes and state services of care, reception and social control, unusual within the states, being predominantly urban[26].

As for home visits, another form of action is that professionals may observe, perhaps, injuries in these women and the environment of the house, which can report something, as well as obtain information about family relationships in the home environment[27]. This may characterize the experience of some form of domestic violence. In the visits, we highlight the work of the community health agent, whose main task is to carry out this activity. Thus, this professional acts as interlocutor of situations of domestic violence to the health team, due to the proximity to the users, because it acts directly with the families and, therefore, possibly has a more consolidated bond relationship[28].

The results of the research on screen corroborate the study that showed that the ESF team, when suspecting/confirming situations of violence, frequently contacts the CHA due to the knowledge that this professional has about the daily lives of families in their areas of coverage. This professional can warn staff about the risks or failures of any planned action assist in deciding the best approach (consultation or home visit) to access the family, follow up on cases and outcomes of interventions, and gather information from neighbors and family[6].

Professionals reported acting in the collective perspective of teamwork, such as discussion and case planning:

> *"[...] we put this to the group: community health agents, technicians, nurses and doctors and, in joint action, we will try to find a solution." (P1)*
>
> *"[...] When they (community health workers) bring to me the reality of a patient, I ask them how they think we should work. So, I don't plan something on my own; we actually do team planning." (P6)*

The shared performance of the team, through case discussion, for example, is seen as a form of support among professionals in the care of users in situations of domestic violence in the rural context. This form of action, reported in other studies, tends to integrate the points of view of different professionals, at the same time as it encourages co-responsibility among team members so that together they build strategies to confront violence in their working territories[6,29,30]. Therefore, one must consider and respect the competencies of each professional for the success in the integral care of users in these situations.

However, due to the complexity of the problem, the rural ESF is not always able to sufficiently support users in situations of domestic violence, so it is important to support professionals and services from the intersectoral network:

> *"[...] We put this to the large group [...] we have psychologists, we also have support from the social worker Social Assistance Reference Center [Centro de Referência de Assistência Social - CRAS] and Specialized Social Assistance Reference Center [Centro Especializado de Assistência Social - CREAS]." (P1)*
>
> *"[...] depending on the case, we refer them to the psychologist and social worker of Family Health Support Center [Núcleo de Apoio à Saúde da Família - NASF] and Primary Care Support Center [Núcleos de Apoio à Atenção Básica - NAAB]." (P11)*

The professional who makes the first contact with the user, whether at home or in the rural ESF unit, can show which professionals of the team and/or other services can contribute to coping with the situation of violence. Regarding the need to contact professionals from the intersectoral network, participants reported that they trigger the Reference Center and Support Centers. This initiative reiterates that complex problems, such as domestic violence, require the confrontation of different sectors, interdependent with each other.

Specifically, regarding the participation of NASF professionals (psychologists and social workers) in discussing cases of violence, a study showed that this participation implies greater speed and positive responses, both for the possibility of developing core activities such as evaluation. as the dialogue between the various knowledge and practices of professionals involved in coping with situations of violence[6].

Limits faced by ESF professionals to care for women in situations of domestic violence in rural settings

This thematic category describes the limits faced by ESF professionals to care for women in situations of domestic violence in rural settings. One of them refers to the lack of ability of professionals to act in the recognition and coping of these situations:

> *"[...] we could do more as long as we had more knowledge." (P5)*
>
> *"[...] it is difficult to take conduct ... because we don't often know how to act..." (P4)*

In a study conducted with nurses on this theme, the lack of professional training for the recognition and resolution of situations of violence due to the complexity of this problem was mentioned[25]. The unpreparedness of professionals, both during graduation and in services, leads them to develop behaviors far from what is recommended for qualified care in cases of domestic violence[31]. Because of this, continuing education activities with these professionals are urgently needed to raise awareness and enable them to work with users who live in situations of violence, especially in the rural setting, based on geographical distance and in the absence/scarcity of resources (professionals and services) in this scenario.

In addition, the professionals also mentioned as limits the lack of participation of women in situations of violence in the groups to which they are invited. One reason why people do not participate in groups, according to professionals, is the lack of transportation to reach the ESF and / or lack of financial resources to pay for public transport:

> *"There are many programs, but many do not participate [...]" (P3)*
>
> *"We have programs, we have meetings, we have meetings, we don't participate at all." (P6)*
>
> *"Sometimes there is a meeting that they could attend, but as it is far, to come by bus they cannot afford the ticket because [...] that money is needed to buy the food." (P19)*

The fact that users do not participate in the group activities offered by the rural ESF also proved to be a limiting factor for the discussion of this situation, because in these spaces, although not specifically directed to women in situations of violence, one can address the problem of domestic violence as one of the first steps to confront it.

Faced with this limit, the professionals stated that many users are unable to participate in the groups because they are unable to afford public transportation or the lack of transportation or even their means of transportation to travel to the places where the groups occur. That said, professionals should look for ways to geographically approach users. One would be to use the resources available in rural settings as community halls, schools or other rural community spaces. Thus, in view of this difficulty, it is suggested to develop educational activities of the waiting room with women when in the unit awaiting consultations.

Another limit cited by professionals is the denial of situations of violence by those who experience it:

> *"In fact, most of them deny it. We know by his features, by his physique [...] a person who is always downcast. So, we end up diagnosing it, but when we talk about it: 'No! Nothing happens, I am like this, it's my way '[...] There is a lot of denials." (P6)*
>
> *"The difficulty is to make them [people in situations of domestic violence] count, to admit that they suffer [...]." (P14)*

The denial of the experience of domestic violence situations also constitutes a limit for overcoming these situations. Although professionals identify by the physiognomy and expressions of women, when they question them about the experience of violence, they deny and thus limit the possibility of actions to confront this problem. This may be due to the fear of exposing the situation as well as to the naturalization of the problem in rural areas, a scenario in which women historically occupy subordinate positions in the family hierarchy[32].

Sometimes, yes, they are discussed [referring to domestic violence situations], but there is no plan for us to act on. Where I'm going, what I'm going to say:

> *"Sometimes, yes, they are discussed [referring to domestic violence situations], but there is no plan for us to act on. Where I'm going, what I'm going to say" (P5)*

Although participants reported that they sometimes identify situations of violence, they mentioned the lack of a protocol, a limiting situation for the implementation of actions with women in this situation; corroborating another study, in which the fragility of technological resources, in the face of situations of violence, leads professionals to perform their care practices in protocols, which explain the order of actions to be developed[33]. It is believed that the

institutionalization of documents, such as protocols, is important to guide and support assisting people in situations of domestic violence.

The present study allows the visualization of the attention strategies and the limits found, favoring thinking on actions that will strengthen health programs, such as Health Promotion, contributing to the construction of a more humanized care, with a differentiated approach from the traditional view of health biomedical model. From this perspective, the transversality of the National Health Promotion Policy (*Política Nacional de Promoção da Saúde - PNPS*) in the care of women in situations of violence in rural settings includes the theme in networks that provide humanized care practices, promote dialogue and build practices based on the comprehensiveness of the health care[15-34].

As implications for clinical practice, this study provides essential elements to guide the training of professionals, either in undergraduate or in care services for people living in domestic violence in rural areas. The development of interventional studies is recommended to leverage the actions already developed and propose strategies for overcoming the existing limits. New research can be developed to provide subsidies to overcome the limits pointed by professionals during the care of women in situations of domestic violence in rural settings.

This study has limitations inherent to qualitative studies, especially regarding the investigation of municipalities in a single region of the state of Rio Grande do Sul, whose conditions make it difficult to generalize the results.

FINAL CONSIDERATIONS

The investigated professionals develop with rural women in situations of violence attention strategies, such as observation, attentive and sensitive listening, bonding, trust, guidance, home visiting, working with the rural ESF team, and other services available in the intersectoral care network.

Among the limits to develop such strategies, they found the lack of skill, the non-participation of women in the groups, the denial of the experience of violence, and the absence of a protocol to guide the actions of professionals regarding the identification of violence.

It suggests the creation of a model that prioritizes the training of health professionals to work with women in situations of violence and a protocol to guide the actions in the face of such a situation.

CONFLICTS OF INTEREST

The authors declare that there were no conflicts of interest.

CONTRIBUTIONS

Marta Cocco da Costa e **Ethel Bastos da Silva** contributed to the elaboration and design of the study; data acquisition, analysis and interpretation; and the writing and / or revision of the manuscript. **Jaqueline Arboit**, **Fernanda Honnef**, **Karoline Ardenghi Marques**, **Janaína Barbieri** and **Daniela de Mattos da Silva** contributed to the preparation and design of the study and the writing and / or revision of the manuscript.

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How to cite: Costa MC, Silva EB, Arboit J, Honnef F, Marques KA, Barbieri J, et al. Domestic violence against women in rural context: recognition of care strategies. Rev Bras Promoç Saúde. 2019;32:9271.