dx.doi.org/10.5380/ce.v26i0.74083

Cogitare enferm. 2021, v26:e74083

Cogitare Enfermagem

ORIGINAL ARTICLE

CONJUGAL VIOLENCE AND HEALTH CARE PRACTICE THROUGH LEVELS OF HEALTH CARE: NURSES´ SPEECHES

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ABSTRACT

Objective: to describe the nurse's care practice in the face of cases of marital violence in the three levels of health care.
Method: qualitative study conducted with 47 nurses working in a large city in the Northeast of Brazil. The data were collected between September and November 2018, systematized through NVIVO11® software, and analyzed through the Discourse of the Collective Subject.
Results: the research revealed that, in the identification of cases of violence, there is a need to investigate the daily marital life and establish a bond with the user. Regarding referrals, articulation with other professionals is necessary.
Final considerations: the research offers subsidies to guide the care of women in conjugal violence situation in the three levels of attention.

DESCRIPTORS: Domestic Violence; Health Care Levels; Nursing; Public Health; Women's Health.

VIOLENCIA CONYUGAL Y PRÁCTICA ASISTENCIAL POR NIVELES DE ATENCIÓN SANITARIA: DISCURSO DE LAS ENFERMERAS

RESUMEN:

Objetivo: describir la práctica asistencial de la enfermera ante los casos de violencia conyugal en los tres niveles de atención sanitaria. Método: estudio cualitativo realizado con 47 enfermeras que trabajan en una gran ciudad del Nordeste brasileño. Los datos fueron recolectados entre septiembre y noviembre de 2018, sistematizados a través del software NVIVO11®, y analizados a través del Discurso del Sujeto Colectivo. Resultados: la investigación reveló que, en la identificación de los casos de violencia, es necesario investigar la vida conyugal cotidiana y establecer un vínculo con la usuaria. En lo que respecta a los encaminamientos, es necesaria una articulación con otros profesionales. Consideraciones finales: la investigación ofrece subsidios para orientar la atención a las mujeres en situación de violência conyugal en los tres niveles de atención.

DESCRIPTORES: Violencia Doméstica; Niveles de Atención de Salud; Enfermería; Salud Pública; Salud de la Mujer.

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INTRODUCTION

Conjugal violence is a global problem that impacts the lives and health of those involved and thus demands holistic care at all levels of attention. Despite the relevance of the health field work in preventing and facing this phenomenon, it is noticeable the need for more professional preparation to approach cases, from their identification to intervention through intersectoral articulation.

The World Health Organization (WHO) defines three levels of health care, which are differentiated by the degree of complexity. The primary level comprises the basic units responsible, mainly, for disease prevention and health promotion; the secondary level integrates the prompt care units (UPA) and medical specialties with the purpose of stabilizing clinical pictures and attending to organic specificities; and the tertiary level comprises the large hospitals, with the purpose of maintaining life [1]. Understanding the functioning, purpose and insertion of each unit in the attention network can support the work of nursing and contribute to a more effective practice in the face of violence, considering its wide magnitude in the current context.

Revealing the expressiveness of this phenomenon, a study points out that, all over the world, about one in three women has already been raped by their intimate partner[2]. In the Brazilian context, more than 16 million women were victims of violence in 2018 alone[3]. The concept of domestic violence, which includes marital violence, refers to any form of physical, sexual, psychological, moral or patrimonial aggression practiced in a domestic, family environment or anywhere else, if it is based on gender, as defined by Law 11.340/06, known as the Maria da Penha Law [4].

This scenario reverberates in physical and mental illness, with the manifestation of skin lesions, fractures, lacerations, sexually transmitted infections, as well as psychosomatic diseases and self-extermination attempts, leads women to seek health services at all levels of attention [5]. It is estimated that more than 40,000 Brazilian women in conjugal violence situation join the Unified Health Service (SUS), which represents a cost higher than five million in Brazilian Real (BRL) [6]. The repercussions experienced by men and children who, in turn, also demand attention from the health services must also be considered.

In this sense, it is important that health professionals, acting in the most varied levels of complexity, can recognize situations of violence and provide adequate care. However, it is worth mentioning that several studies have pointed out the limitations presented by professionals in their daily work, both in recognition and interventions in face of cases, which may be related to fragility in the approach to the topic during graduation and in spaces of continuous education [7-8].

Considering violence as a complex phenomenon, it is necessary to understand the assistance practice based on integrality, which is a guideline of the SUS, allowing the identification of women in situations of violence as historical, social, and political subjects, considering the society in which they live, their family context, and their particularities [9]. Therefore, the principle of integrality must be used as an analytical axis in health practices oriented to this public at the three levels of attention.

The sharing of experiences and practices carried out by health professionals in face of violence against women can subsidize the reflection on the way care has been provided and even help in the process of professional qualification. This study then aimed at describing the nurse's care practice in face of cases of conjugal violence in the three levels of health care.

METHOD

This is a qualitative study conducted with nurses working in the three levels of health care in a large city in the Northeast of Brazil. To guide this research, the integrality of care paradigm was used, which is based on articulated actions of prevention, promotion and recovery of diseases, considering the singularities of the subjects [9].

The research was conducted in three Primary Health Care units, three UPAs and two hospitals in the network, all belonging to the same territory. The approach to the participants was based on the authorization of the responsible managers and later insertion of the researchers in the referred fields. After that, nurses with at least one year in the service were invited to participate in the research, excluding those who were away. The interviews were carried out individually, in a reserved room, by the principal researcher with the support of three previously trained scientific initiation fellows. It should be emphasized that the interviewees were not on duty, with no change in the work dynamics.

The data collection took place between September and November 2018, through a semi-structured interview guided by a script created by the researchers and adapted based on the census criteria of IBGE [10] (self-declared race/color, age, gender, sexual orientation, marital status, academic background and time in the labor market), besides the guiding question: In your assistance practice, how do you recognize and conduct cases of marital violence? The interviews were recorded and lasted an average of 45 minutes. The sample closing occurred through theoretical saturation, understood as the suspension of new participants when the obtained data present themselves with redundancy or repetition[11].

All the recorded content was transcribed and then submitted to evaluation by the interviewees in order to ensure the representativeness of the statements and later start the analytical process, as recommended by the Consolidated criteria for reporting qualitative research (COREQ).

The collected data was systematized with the help of NVIVO11® software, validated by a researcher with experience in the use of software, and then organized into central ideas and synthesis speeches, through the Discourse of the Collective Subject (DCS). The reliability of the use of this method was guaranteed through the adoption of the stages of speech transcription and analysis of the verbal material, extracting the methodological figures: Central Idea - CI and its Key Expressions - ECH; from the CI and ECH, several synthesis discourses were composed, which were the collective discourses [11].

The data were organized into two analytical categories: "Recognition of cases of marital violence" and "Conduct of cases of marital violence" in the three levels of attention: basic attention, medium complexity and high complexity.

The study was submitted for ethical review and approved under opinion No. 1673856.

RESULTS

Forty-seven nurses participated in the study, 45 (95.7%) female and 2 (4.2%) male. Considering that most of the participants were women, in this study the female form will be used to refer to the set of participants. Regarding the level of health care, 18 (38.3%) participants were from Primary Care, 15 (31.9%) from the UPAS and 14 (29.8) from hospitals. Regarding color, 39 (82.9%) declared themselves white. As far as color is concerned, 39 (82.9%) declared themselves white. The age group varied between 20 and 51 years and the average performance in the labor market was six to 10 years.

The speech of the nurses working in Primary Care revealed that the recognition of cases of violence is through observation by the community health worker, as well as the identification of signs and symptoms during the practice of care, which is favored by the

creation of bonding and qualified listening. From the identification, the nurses perform initial conducts such as medication administration and curatives, besides sharing the case with the teams of the Family Health Support Center (NASF) and, when they are not able to give resolution, they refer to the other levels of attention.

In the secondary attention, the professionals make the identification already in the screening, through the observation and identification of the body marks and behaviors that, according to them, are characteristic of women who have suffered violence. Regarding behaviors, nurses use assistance protocols for the clinical management of cases, besides taking care of physical injuries.

In the hospital context, the recognition of violent situations occurs through the observation of the grievance that led the woman to hospitalization, such as gunshot wounds, blunt force trauma, and severe burns. The behaviors adopted depend on the seriousness of the case, being focused mainly on the resolution of body problems and, when perceived, psychological ones.

The collective discourses will be presented in Chart 1, reflecting the recognition and management of cases of conjugal violence at health care levels.

Chart 1 - Collective discourse of nurses about the knowledge and conduct of cases of violence at attention levels. Salvador, BA, Brazil, 2020 (continues)

Levels of attention	**Recognition of conjugal violence**	**Case Management**
Basic Attention	*Most of the time, it is the Community Health Agents who bring to the team meetings the situations of conjugal violence that occur in the community [...] When these women seek care, I welcome and listen to them. It is at this moment that I perceive the demands not only physical but also psychological [...] Before, the user came to the basic unit with a smile on her face, then we noticed in her countenance a deep sadness. During the nursing consultations, I also notice traces of physical and sexual violence [...] There are signs that are classic, such as bruises, scratches and stains [....] Some of them report absence of libido, however, during the physical examination of the perianal region I notice vaginal and/or anal lacerations.* (DSC, Nurses who worked in Basic Health Care - USF, UBS, CAPS)	*I do not have an action protocol for situations of violence against women. I provide the necessary assistance, such as dressings and medication. Cases of greater complexity we share with NASF and, when we do not have conditions to handle the case, we refer it to other services [...]* (DSC, Nurses who worked in Basic Health Care - USF, UBS, CAPS)
Medium complexity	*During the screening, we already noticed something different [...] Most of the time, the woman who suffers violence presents very characteristic lesions such as bruises on her face, arms and legs [...] Sometimes they arrive accompanied by another woman, being the mother, sister or a friend. In others they are accompanied by a police vehicle [...] this already left us in alert. During the anamnesis, the victims always keep their heads down, cry a lot and cannot give us the information. Usually, I ask the questions to his/her companion, who*	*In situations of physical violence, we restrict ourselves to physical care, such as the administration of medication, evaluation of vital signs and, in the face of a more serious injury, we perform dressings or assist the doctor in suturing [...] In cases of sexual violence, we follow a flow of care. If the act had occurred within 72 hours, we welcomed, performed emergency conception, conducted laboratory tests, HIV and STI prophylaxis and for expert examination. If this*

	reports to me what happened. [...] When it was a situation of sexual violence, she would arrive crying a lot, placing her hand on the genital area. If the person on duty was a male nurse, they did not want to be seen by him. (DSC, nurses who worked in Emergency Units, Outpatient Clinics (Policlinics) and Mobile Emergency Service - SAMU)	*after 72 hours, we welcomed and forwarded it to laboratory tests. In both cases, we made the compulsory notification of the violence and referred to the social assistance and psychologist.* (DSC, nurses who worked in units of Emergency Care, Outpatient Clinics (Policlinics) and Mobile Emergency Care Service - SAMU)
High complexity	*Here at the hospital, we receive extreme situations of physical violence against women, such as gunshot wounds and firearms requiring surgical interventions. [...] When women arrive with signs of burning in certain parts of the body such as the head and limbs, we already understand that it was violence* (DSC, Nurses who worked in the hospital network - Obstetrics, Emergency, Intensive Care, Epidemiological Surveillance, Surgical Center and Hospitalization Units)	*I try to approach with respect, without being invasive and without asking embarrassing questions, seeking to establish a bond with her [...] After that, I give the assistance that I am supposed to give based on what was found during the anamnesis and physical examination [...] Soon, I build the care plan so that this woman can be assisted in the best possible way, not only in the physical field, but also in the psychological field.* (DSC, Nurses who worked in the hospital network - Obstetrics, Emergency, Intensive Care, Epidemiological Surveillance, Surgical Center and Hospitalization Units)

Source: The authors (2020).

DISCUSSION

The collective discourse of nurses working in Primary Care revealed that Community Health Agents (CHAs) play a fundamental role in identifying violence, since they are closer to the territorial context and can perceive cases in the community, which are shared in team meetings. These professionals, in general, reside in the areas where they work and work in monitoring the health situation of the assigned population, which enables the recognition of the grievance [12].

The nurses also revealed that when the women arrive at the family health unit, they are welcomed in order to encourage the sharing of their experiences. For that, it is essential that health professionals have communication skills that are empathetic and sensitive [13-14]. Such elements are indispensable for the formation of the bond, which provides greater openness in the relationship between professionals and users.

Through the bond, it is possible for nurses not only to gather information, but also to recognize changes in women's behavior. From this perspective, studies affirm that women who are in a situation of violence present signs suggestive of the grievance, among them: sadness, apathy, irritability and difficulty in concentration [15-16]. It should be emphasized that the bond is one of the fundamental aspects of integral care, which is reflected in the interest of professionals for their situation, with qualified, confidential and listening without judgement [9].

The narratives also showed that, through physical examination, it is possible to identify the presence of lesions, hematomas and even traces of sexual violence, such as lacerations in the perianal region. The visibility of marital violence is associated, in the

collective imagination, almost exclusively to the presence of marks on the female body, which are considered an expression of the power and domination of the man towards his partner [17].

The recognition of conjugal violence only by physical marks leads nurses to the provision of care exclusively focused on the treatment of injuries, and no holistic care is provided. In addition, the lack of an assistance protocol, added to the lack of knowledge, makes it difficult to direct actions, make decisions and referrals [18].

Faced with difficult management situations, primary care nurses count on the support of the Family Health Support Center (NASF) team, which offers matrix support from the discussion and joint follow-up of cases [19]. This multi-professional action focused on the singularities of each woman is essential for the resolution of care practices [9].

The nurses of secondary care, in turn, revealed that in addition to physical marks, other signs can lead to suspicion of violence, among them body posture and facial expression. The lines showed that the women presented themselves with low head, with expression of crying and difficulty to report the complaint. Corroborating, a Serbian study pointed out that women who sought specialized health services for violent causes presented behavioral symptoms, such as deep sadness, signs of depression and suicidal ideation [15].

In situations of sexual abuse, other behaviors were observed by nurses, such as the positioning of the hand under the genitalia and the refusal of care by male professionals. These attitudes were also evidenced in a Brazilian study, which points out unconscious body manifestations as a defense mechanism [20], and in a study conducted in the United States, which demonstrates the tendency of women victims of sexual abuse to refuse to be assisted by men [21]. It is thus understood that these behavioral signs can serve as an alert for the identification of violence during the attendances.

Another characteristic observed by the nurses was that women usually arrive at the health unit accompanied by another woman or by a police officer. The fact that most victims seek care accompanied by other women demonstrates the relevance of social support for women's encouragement, not only for seeking medical help, but also for requesting legal support [22]. However, it should be emphasized that, while the police presence may represent safety and protection, on the other hand, it may also manifest itself as a form of revictimization of women, since it favors their exposure to other patients [21]. It is also considered the hegemonic masculinity imbricated in the formation of men, which may direct the police conduct in judging the female figure and underestimating the complaints[23].

Still under the perspective of revictimization, it is necessary to reflect on the invisibility of female discourse since the nurses researched reported directing the interpellations to the escorts. A Brazilian study conducted with health professionals reveals the invisibility of women in a situation of violence at the moment of care, due to the "labeling" of some women of several complains and the prejudices originated from the grievance, associated to conceptions of women's guilt for the violence suffered, expressing a sexist perception[24]. It is considered that, even if emotional instability makes the exposure of complaints difficult, it is important that the health professional be able to provide conditions for women to express themselves [25].

Regarding the conducts adopted by professionals in the secondary level of health care, it is observed that they permeated the care with physical injuries, medication administration, performance of laboratory tests, compulsory notification and referrals. It was possible to verify a greater difficulty in putting into practice the principle of integrality of care, considering that the assistance practices were based on the curative model, centered on the logic of rapid care [9].

As for tertiary care, the speeches demonstrated the care of women with more serious physical repercussions as a result of physical violence. Surveys carried out in Brazil show that situations such as burns, fractures, firearm and white-arm injuries are the main implications

that lead to hospitalization and may leave permanent marks in women's life [26].

For the professionals working in the hospital service, the appearance of marks on the head and limbs is a marker that signals that that woman was a victim of marital violence. This is ratified in a Brazilian study when it reveals that the face, head, neck, and lower limbs are the most affected sites in the aggressions perpetrated by men who commit violence [27]. During the occurrence of violence, women are most often assaulted in the upper limbs, for trying, with this part of the body, a self-defense, mainly, of slaps and punches directed to the face. It is worth highlighting that aggression directed to the face is perceived as a social demonstration of male strength and domination in relation to their spouse, considering that this region of the body is considered a privileged body locus of high symbolic value[27].

The speech also revealed the realization of a care plan based on the needs of women in situations of violence. Although there was no recognition of the use of Systematization of Nursing Care, it was pointed out the execution of some stages of the process, for instance the nursing history through anamnesis and physical examination, planning and implementation of the care plan.

It is necessary to articulate the three levels of attention in order to organize assistance practices to women in violent situations, considering historical, political, socioeconomic and individual factors, for the integrality of care [9]. Although the investigation limits itself by not presenting an integrated relationship between the practice of assistance in the three levels of health care for women in a situation of violence, the study advances by disclosing, in a didactic way, how cases of violence are recognized and conducted among professionals. It is urgent that management prioritize care strategies directed to professional training for the care of women who experience conjugal violence, in all levels of care, contemplating their demands and specificities in an integral and humanized way.

CONCLUSION

The study describes the nurse's care practice in cases of conjugal violence in the three levels of health care, which passes through the identification and intervention in the face of the grievance. Despite the identification of the cases, the research revealed the need to investigate the daily conjugal life, establish a bond with the user and the articulation with other professionals, for instance the ACS. The study also highlights the need for qualified listening and articulation between the professionals that make up the minimum team and NASF, considering greater relationship of proximity with women.

The research offers subsidies to guide the care of women in situations of conjugal violence in the three levels of complexity. It is suggested that the strategies evidenced, such as the identification of cases with the creation of links with the users and the articulation with other professionals of the network of attention to women in situations of violence, be integrated to the constructed flows, in order to facilitate the integration between the levels of attention and even to assist in the process of professional training for a holistic and humanized integral care. Considering that nursing is the profession with greater contact and proximity in the care given to these women, it is believed that the use of the strategies pointed out in this study can serve as a guiding axis of an integral, holistic, humanized care and with focus in the prevention of the grievance.

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HOW TO REFERENCE THIS ARTICLE:
Sousa AR de, Estrela FM, Silva AF da, Magalhães JRF, Oliveira MA da S, Loureiro AKN da S, *et al*. Conjugal violence and health care practice through levels of health care: nurses´ speeches. Cogitare enferm. [Internet]. 2021 [accessed "insert day, monh and year"]; 26. Available from: http://dx.doi.org/10.5380/ce.v26i0.74083.

Received: 27/05/2020
Approved: 03/08/2020

Associate editor: Tatiane Herreira Trigueiro

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - ARS, FME, AFS, JRFM, MASO, AKNSL, VRG
Drafting the work or revising it critically for important intellectual content - ARS, FME, AFS, JRFM, MASO, AKNSL, VRG
Final approval of the version to be published - ARS, FME, AFS, JRFM, MASO, AKNSL, VRG