

The evaluative limits and possibilities in the Family Health Strategy for gender-based violence

LIMITES E POSSIBILIDADES AVALIATIVAS DA ESTRATÉGIA SAÚDE DA FAMÍLIA PARA A VIOLÊNCIA DE GÊNERO

LÍMITES Y POSIBILIDADES DE EVALUACIÓN DE LA ESTRATEGIA SALUD DE LA FAMILIA PARA LA VIOLENCIA DE GÉNERO

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ABSTRACT

The study aimed to understand the evaluative limits and possibilities of the Family Health Strategy (FHS) in acknowledging and confronting the health needs of women experiencing gender-based violence. This was a case study with a qualitative approach, conducted in a Basic Health Unit that operated under the FHS in São Paulo (SP). Data were collected through interviews with health professionals of the multidisciplinary teams, and women users of the service who experienced gender-based violence. The results were analyzed according to the analytical categories: gender, gender-based violence and health needs. Medicalization was seen as the most significant limitation of professional practice. Moreover, there were opportunities related to the bond afforded by the logic of attention brought by the FHS. Such possibilities, however, were still curtailed by the limitations of the biomedical model and the absence of specific technologies to deal with violence.

DESCRIPTORS

Violence against women
Family Health Program
Health services needs and demand
Public health nursing

RESUMO

O estudo objetiva compreender os limites e as possibilidades avaliativas da Estratégia Saúde da Família (ESF) no que tange ao reconhecimento e enfrentamento de necessidades em saúde de mulheres que vivenciam violência de gênero. Trata-se de um estudo de caso, de abordagem qualitativa, realizado em uma Unidade Básica de Saúde que opera sob a ESF em São Paulo (SP). Os dados foram coletados por meio de entrevistas com profissionais de saúde e com mulheres usuárias do serviço que vivenciaram situações de violência de gênero. Os resultados foram analisados segundo as categorias analíticas gênero, violência de gênero e necessidades em saúde. A medicalização foi constatada como a limitação mais significativa das práticas profissionais. Entretanto, foram constatadas possibilidades relacionadas ao vínculo propiciado pela lógica de atenção instaurada com a ESF, ainda que cercadas pelas limitações do modelo biomédico e a ausência de tecnologias específicas para lidar com a violência.

DESCRIPTORIOS

Violência contra a mulher
Programa Saúde da Família
Necessidades e demandas de serviços de saúde
Enfermagem em saúde pública

RESUMEN

Se objetiva comprender límites y posibilidades de evaluación de la Estrategia Salud de la Familia (ESF) respecto de detección y enfrentamiento de necesidades de salud de mujeres víctimas de violencia de género. Estudio de caso, de abordaje cualitativo, realizado en una Unidad Básica de Salud operando bajo la ESF en São Paulo-SP. Datos recolectados mediante entrevistas con profesionales de salud y con mujeres pacientes del servicio que experimentan situaciones de violencia de género. Los resultados fueron analizados según las categorías analíticas: género, violencia de género y necesidades en salud. Se constató que la medicalización fue la limitación más significativa de las prácticas profesionales. Sin embargo, se establecieron posibilidades relacionadas al vínculo facilitado por la lógica de atención instaurada con la ESF, aunque cercenadas por las limitaciones del modelo biomédico y la ausencia de tecnologías específicas para hacer frente a la violencia.

DESCRIPTORIOS

Violencia contra la mujer
Programa de Salud Familiar
Necesidades y demandas de servicios de salud
Enfermería en salud pública

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INTRODUCTION

Violence itself is permeated throughout society, and is not specific to the health field. It affects those involved not only by causing death, injuries and traumas, but also by its impact on life conditions and health of individuals and collectives. This requires the creation of specific policies and the organization of practices and particular services. In today's reality, violence configures, along with chronic degenerative diseases, a new epidemiological profile within the health panorama in Brazil. The phenomenon demands an approach with which the health system is not historically used to coping, since it requires an emphasis on social determinants and on production and reproduction of the ways of living and getting sick⁽¹⁻²⁾.

The high prevalence of gender-based violence against women using basic health services has been identified by national and international studies^(3-5,6-8). Researchers on the theme have shown that women who reported seeking assistance in health services were not routinely attended by professionals sensitive to the approach to domestic and sexual violence⁽⁹⁻¹⁰⁾. A population-based study performed in several countries highlighted that around 35% of the complaints which drove women to search for a health service were related to some kind of violence⁽¹¹⁾.

A study performed in the city of São Paulo in 19 Basic Health Unites (BHU)⁽⁶⁾, in which 3193 women were interviewed, showed that 45.3% of them had experienced physical or sexual violence by an intimate partner in their lifetime. The violence rate perpetrated by others than the partner was 25.7%.

However, violence still consists in a phenomenon unviable as a demand for services. A study that investigated professional practices of the FHS for women experiencing violence showed that professionals recognized the importance of embracing women with such demand, but they felt powerless and fearful of dealing with those situations⁽¹¹⁾. Powerlessness is reiterated in several other studies with similar methods when it came to professional attitudes and practices related to gender-based violence^(2,10-12). Misinformation and lack of specific professional capacity were also evidenced as elements that feed the invisibility of violence throughout the services⁽¹¹⁾.

The FHS has been the cornerstone for making the Brazilian Health System (Sistema Único de Saúde - SUS) viable, by facilitating the approach among health professionals and clients within the defined area covered, thus revealing problems that previously remained unknown within the services⁽¹²⁾. Collectively, this strategy has been the most productive mark of implementation in public health practices in Brazil, configuring the privileged locus for the recognition of health needs, while also constituting

spaces that articulate to further instances of the health care network, seeking to meet those needs⁽¹³⁾.

Gender-based violence, as well as the needs determined by it, is socially produced and directly related to the historical and economic process of society and state creation, as well as with the health-disease process. Understanding the work as praxis, a moment of theory and practice synthesis, allows the argument that gender is a sociological category capable of encompassing the analysis of research between what is announced at the political level and what takes place in the plane of practices of health professionals, in order to meet the health needs of women in violent situations in public health services, especially in the FHS.

From the perspective of a gender-guided practice of women's health care, there are several possibilities of investigation which the universe of changes in the health field and the gender perspective support. In this study, changes that are occurring within professional practices in the context of the health care needs of women in the FHS in São Paulo are highlighted. Thereby, this study aimed to understand the assessment limits and possibilities in recognizing and confronting gender-based violence within the space of implementation of the FHS.

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METHOD

This was a case study with a qualitative approach, performed in a BHU that operated under the FHS in São Paulo (SP). Data were collected through in-depth interviews with 22 health professionals of the multiprofessional teams, and with 13 women users of the service who experienced gender-based violence. Interviews were recorded, transcribed and submitted to discourse analysis⁽¹⁴⁾ according to the analytical categories of *gender*, *gender-based violence* and *health needs*. The results were analyzed with the perspective of discourse analysis⁽¹⁴⁾ and according to the analytical categories of gender, gender violence and health needs.

The voluntary nature of participation and anonymity of the subjects were guaranteed, complying with the ethical requirements for research with human beings. The study was approved by the Committee on Ethics in Research of the *Escola de Enfermagem da Universidade de São Paulo* (protocol number 822/2009/CEP/EEUSP).

RESULTS

In this study, medical and nursing consultations were the areas in which violence recognition was most frequently reported, with pre-natal consultation standing out. Home visits were also frequently reported. Areas

not specifically focused on women's health were cited, such as child treatment, dressing rooms, vaccine rooms and screening as the loci of recognition of gender-based violence. There was no report of the use of specific instruments for recognition of violence or women's needs. The issue was identified through signals, verbalization by the woman herself, or by a close person.

When I was about to measure fundal height, I noticed that her navel was darkish, as if it had been burned (N3).

She comes to the unit, looks for me straight away and tells me. Sometimes, she comes with a lowered eye, with a swollen mouth (N10).

In the following testimonials, women tell their experiences seeking support in services which deal with violence attention.

There are four police reports, but they have never done anything about it. I left home one day with my five children, because he had kicked me out. I went to the women's police station and the police chief said 'Well, mom, you go home and if he does not let you in, you call a police officer to bust the door down and go in (W1).

The recognition of violence as a problem whose confrontation is not the responsibility of the health sector also translates into the scope of practices, and also in referrals to professionals who are mental health specialists. The understanding of needs under the biopsychic or biosocial dichotomy is reaffirmed when translated into practices. Considering that the way in which a problem is defined as an object of work is essential for intervention, practices identified under the dichotomized view biologically identified eventually result in a disclaimer of services with problems whose complexity escapes the hegemonic logic.

We are having support from a psychologist to work on this emotional side of this patient. Now, on the part of medicine, I believe that I will not get help in order to know the diagnosis, if she is mentally dependent or not (E 8).

Understanding the services needed for specific mental health attention was significantly mentioned by professionals. Considering that health services also establish needs, such understanding is recognized in the women's speeches when they refer to their search for attention and expectations for the health services to face the problem.

Today, when I came to have the Pap test done, I was even going to check if there was a psychologist or a social worker. If there was not, I was even going to pay for a consultation to see what I had to do. I wanted a specialized person who could help me by orientating me, if I must take some medicine, or act in a certain way, a psychologist really (W7).

In the professionals' testimonials, practices reveal the biomedical attention towards responding to needs of assistance to physical aggravations recognized by the services. That was cited as a specific attribution of the health

services, reinforcing the dichotomized vision between the biological and the social and the understanding that only the former is the work object of the health services.

The doctor examined her, requested exams for her. An ultrasound to check if it had affected the baby (N2).

The team has only been responding to her needs thinking that she is a psychiatric patient and constantly overreacts. They have not been trying to investigate what leads her to always being here (N12).

The traditional practice dominant in the health services limits the field of action of professional practice. This is recognized in the statement that follows, in which the professional affirms that in cases involving violence, he utilizes insignificant doses of medication as a tool available for intervention, recognizing that it would be a simulation that aims to make the user believe it is being effective to confront a disease process that, in fact, it is not.

Sixty percent of the time I get to see an improvement with insignificant doses of medication. At that moment, the medication does not have the effect to which the patient would respond if she was in fact ill. And patients do get better, because they feel a bit calmer, or because they feel embraced and end up creating a certain bond (N20).

The testimonials also reveal the powerlessness felt by the professionals when approaching problems such as gender-based violence.

Several times during a consultation I cannot notice results or responses to my own treatment. It is a sensation of 'oops!', there would have to be other measures in order to have a result, or in order to get that person to have a life a little more worthy, with other factors, education... Anyway, it is not an issue that we can technically treat with medication or therapy (N20).

The reports of women who use the service also reproduced the non-recognition of violence as a competence of the health services. This reproduction finally results in the invisibility of violence and lack of verbalization by the women, who reiterate the attention they receive and understands that only the physical problems are a field of action within health services.

I come here to be taken care of, Pap test, pre-natal, treat my epilepsy. I have never talked about that. Not even to the psychologist I went to (W10).

The following testimonial highlights the psychosocial dichotomy clearly illustrated in the speech of a health professional who recognizes violence, but limits his actions to problems which fit into interventions relevant to the structure.

At that moment, pregnant, she needed psychological support, and that is what I tried to provide; I talked to her for about 40 minutes. She was also a bit nauseous and then we gave her some medication and talked for a long time. So I think that was her need, there was a physiological one and a psychological one (N13).

Interventions for families also show up in the results as strong marks of gender construction by orientating professional actions and speeches, like the following examples, in which female frailty and pregnancy are highlighted as central issues of the professional actions in order to promote non-violence.

I told him that the pregnant woman needed much care, affection (...) explained all of that to him to see if at least on this pregnancy he gave her a break. I told him to be a good father, be affectionate, kiss her belly. And he said that he would be very careful (N13).

We found that the instrumental knowledge mobilized in daily work in the FHS are strong aggregate marks of androcentric hegemonic logic, reiterating female submission and resulting from the construction of the gender identity of men and women health professionals. These aspects can be illustrated by the following statements, one from a professional and the other from a user.

It was great that I talked to both; we cannot incriminate only the man, she is also blamed, because which man wants to get home and see his wife drunk on the bed? (...) I told her that a man does not go beating a woman for no reason (N13).

The only thing the doctor said was that, that I should have patience and that I cannot face him because it would be worse for me, because of my baby, that is all (W11).

The following testimonial reveals the health unit as one of the few areas recognized as a possibility of detachment from the everyday suffering lived at home.

This unit helps me because I have already laughed my socks off. Because from the time I leave home I am so happy! And I leave the house only to come to the unit get milk for my child (W5).

Prescriptive measures permeating the professional-user relations at the consultation were also observed as a limitation that permeates health attention.

I advised her a lot. Only through legal complaint can she create a barrier for him not to beat her anymore (n12).

Users and professionals point to responses related to more qualitative transformations when they refer to group practice. Although listening during individual consultations has been seen as a possibility of the service, group treatment was disclosed as a space that, besides establishing a bond and listening, gives more autonomy to women.

People have been satisfied (...) because we talk, share experiences, and through their speech, I have noticed that they have been able to solve things out of there (E21).

The responses to the needs recognized by the women using the service were also disclosed as a possibility of group practice. Listening and relationships established with the professionals and with other users in the group are a possibility of strengthening.

Something that I have kept inside me and then tell people relieves me. The group has talked to me, oriented me. I am recovering the will to live (W2).

DISCUSSION

Women and violence: the visible and the invisible in the daily health work

According to the World Health Organization (WHO), women can experience violence for several years without seeking help. However, that leads to several problems, which end up putting those women in contact with health services⁽⁴⁾.

In this study, the results show the diversity of areas where violence is recognized, so it can be stated that, in health services, the areas of violence recognition are spaces attended by women seeking responses to their health needs, translated into a care demand, either for themselves, or for their children or their relatives.

Women use health services more frequently, mainly those aimed at prevention and health promotion, either due to their cultural placement as caregivers, or due to their responsibility for taking care of other people. That function is strictly related to the higher frequency with which women seek health services, when compared to men, whose masculinity profile contradicts involvement with care. In this study, the spaces of care sought also constituted spaces of recognition of violence that becomes implicit among the demands they bring, since care and gender-based violence are constructs historically carried out and lived much more frequently by women.

Although it is known that notification of violence is mandatory⁽¹⁵⁾, the service neither notifies nor registers it, thereby revealing a strong determinant of invisibility of violence as a health problem in the scenario. According to some testimonials, the possibility of violence recognition, embracing and responding by the health services requires specific approach, either through strengthening of communication channels which potentiate the emergency of the issue or through creation and use of instruments that enable qualification of listening and translation of the demands to obtain services.

It was verified that violence constitutes a problem, which rarely shows up as an immediate demand to the service. It is expressive as an implicit demand. Nevertheless, FHS appears in this study as a fertile ground to enable the widening of the scope of their work in order to recognize violence as a problem whose prevention and confrontation are inherent to the sector, one that is a reality in the life of the users, and which is intrinsically related to its health-disease-focus process of every health action.

Gender-based violence and FHS practices: identifying limits, glimpsing possibilities

When reporting violent situations against women whom they attended, the professionals talked about prac-

tices operationalized to respond to recognized needs, revealing limits and possibilities of coping. Once the professionals recognize violence as a psychological or social problem, their practices end up being a referral to other services of these sectors, which would supposedly be responsible for the issue. Articulation with other services occurs through punctual and personal initiatives, and there is not an established articulate reference network for these cases. Disarticulation among services is also a gap to be overcome, so that the existence of a group of isolated services, and not a network, is more likely.

Integral attention to women is not restricted to health services, which demands the effective use of a wide cross-sector network⁽¹⁶⁾. The simple knowledge of the coping resources available is able to transform the vision that women have about violence, taking them out of isolation and demonstrating how collective the problem is. That translates into power to overcome the understanding that takes violence as a private and stigmatizing phenomenon, locating it within the political and social scenario of human rights⁽²⁾.

Considering the circularity between established work process and health needs, the work processes established at the FHS have recognized needs such as necessities for health services⁽¹⁷⁻¹⁸⁾, with a meaning that comprehends the needs of attention as the isolated physical, social and psychological aspects.

It was verified that incorporation of violence to the health field does not happen without gaps. As judicial language and language of other sectors dealing with the issue do not express the whole complexity of gender-based violence, such is also true within the biomedical perspective. The testimonials point out that violence recognition as a health problem ends up translating into interventions related to physical alterations, so that violence itself is disqualified as a problem when not subject to classification into the menu of needs offered by the services operating under the biomedical reasoning, in which the disease constitutes the object of actions.

The institutional culture of the traditional and still hegemonic model is centered into the complainant conduct model and is characterized by a work process based on linear and mechanistic reasoning, exclusively falling back on the biological knowledge and on technical interventions and medications. The treatment is the result of a historical process whose roots are in the group of dichotomies that goes through the organization of the health services and which has been sustained by the market logic, leaving health needs in a secondary plane. These statements of the author do not refer to denying the importance of technical and biomedical knowledge, but highlight the need of not taking this approach as the only one, and of seeking a way to initiate actions able to satisfy the users' needs in their singularity when facing a problem, establishing relations with the emotional, cultural and social aspects and channeling into a collective perspective⁽¹⁹⁾.

It is important to consider that violence is a situation that extrapolates a lot of the health sector sphere. It is a life situation, with all of the complexity that this implies. However, the logic that permeates health practices is historically guided by short-term results, standardized interventions, which can be extremely contradictory, with the potential to be translated into another kind of violence, since it can disrespect the trajectory of the woman and end up frustrating the professionals, who feel impotent with little capacity for resolution⁽²⁰⁾.

A resolute action should not be ignored, a clinical approach, but the possibility should also be raised of using all soft and soft-hard technology available to face or prevent the determinants of the problems, also seeking measures that promote health. Thus, clinic-based actions by themselves are not enough to enable the responses needed for several dimensions of the problem and for the health needs of women. The strengthening of cross-sector and collective actions, as well as the focus under the gender perspective for the recognition of needs that women have are fundamental to overcoming the importance of dealing with violent situations reported by the professionals.

In terms of the FHS scope, on one hand, women do not talk about, and on the other hand, professionals do not ask about violence. Medication logic limits the development of tools that potentiate the recognition of violence and needs, which leads women to ignore health services as a possibility for support.

Moreover, gender determination is a social attribute that covers the biological one within its historically built meanings. From that process, derive many wasting and strengthening processes different for men and women, different needs, like diverse recognitions of their health needs by the services. Within the process of need medicalization, that determination as well as the inequalities deriving from it, are absent dimensions in the health services and in the demands valued by the users.

The testimonials show that practices translate into the predominance of the biomedical knowledge, under the perspective of the multifactor approach to health, as a work instrument used to recognize responses to the health needs of women experiencing violence. Besides that, practices are also centered into the singular dimension, not trespassing the individual barriers. Some testimonials point out to a widening of this profile for the family, still within the singular dimension, because there is no reference to relations with the social insertion or with social structure.

The focus dislocated from the individual to the family constitutes in a significant finding so much for the recognition of needs as for the practices. That aspect points out to convergences with the Health Ministry speech which fundamentals and defines the FHS purpose having as a focus the family, valuing the bond with its central point and also showing up, in this study, as a possibility.

Nevertheless, this focus, here, reveals itself as limited to the family nucleus, in its singular dimension, not considering what the FHS purpose presupposes about the widening of actions and criteria to achieve higher social meaning.

Subalternity and victimization of women users might have been potentialized by the gender identification of the professional women. Studies point out that health professionals bring into the practice field strong marks of gender identity construction⁽¹⁰⁻¹²⁾. These marks, when constructed under an androcentric referential, reiterate and make oppression natural, thus being counterproductive to the work as a social emancipation tool of women.

Thus, services frequently reproduce violence, either because they see it as natural, or because they victimize women who seek their care. When women are not crystalized into the victim's position, frail and inferior, they are understood as violence provokers for not obeying socially imposed behaviors, like loyalty, passivity and submission.

The results about professional practices also reveal potentialities. FHS enables the creation of bonds between health teams and the community. In this study, that translates into the establishment of bonds of relationships and trust between professionals and users, enabling the access to the health service. The practices to respond to that bond-related need and listening revealed by professionals were developed in the individual treatment, through dialogue between health professional and users, and in the group treatment, which also enables sharing experiences and dialogue among users themselves.

A study about psychotherapeutic group practices for women experiencing violence has shown that, especially at the FHS, those spaces have been a possibility to offer treatment to more users, besides promoting sharing of practices, anguish and problems experienced by the individuals, contributing for violence experiences to have meanings and signification in people's lives, providing possible changes, coping and qualitative transformations⁽²¹⁾.

Studies within the collective health field⁽¹⁹⁻²²⁾ important considerations have arisen about the theme of communication and listening of users and health professionals. In this study, those themes are related to health needs that converge to the understanding of professionals and users interviewed. The testimonials refer to responses related to practices that involve listening, in which trust relation and professional-user bond are potentialized. It is necessary, although, to highlight the potential to intervene in violence coping and in the needs that it produces. The bond, by itself, produces momentary responses and not a qualitative transformation of women's lives.

It is understood that professionals reveal the potential of listening and bonding with women users in health work. However, there is a big gap between potentials revealed and effective acting to embrace and face the problem with effective responses to their needs.

For some women, the simple possibility of attending the service is associated with happiness, and they recognize this aspect as a contribution of the service for coping with the problem. It is evident here the importance that health services represent for many women who experience violence, the only channel of communication in their reality, being, for her, the only possibility of coping. How can one not expect something out of this service?

It is necessary to be careful so that listening does not translate into guardianship and blaming of the individuals, avoiding grounding the listening process on a competent speech, bearer of a supposed technical and neutral knowledge, which carries the truth about individuals and their needs. Understanding that it is the professional's responsibility to make users aware or sensitive of their own lives has occurred under a vertical logic, in which one talks about the individual, when one is supposed to talk to the individual, through sensitive and problematizing listening about their needs and life projects⁽²²⁾.

Despite the potentialities revealed, the biological and clinical limitations are realities that stand out within the findings of this study. The users interviewed point out to recognized limitations in their testimonials. Taking into account that violence, like health, is a pluridimensional social issue⁽¹⁾, complex problems demand multifaceted solutions. It is about facing the challenge of inserting gender-based violence into the marks of a conceptual and technological interdisciplinarity, taking as reference health integrality in order to start work processes which constitute in an action compromised with human and women's rights and with gender equity⁽²⁰⁾.

CONCLUSION

From the analysis presented here, medicalization is understood as the most significant limitation identified in professional practices for women experiencing violence. On the other hand, bond-related possibilities facilitated by the logic of attention brought by FHS were also evidenced, but still curtailed by the limitations of the biomedical model, by the absence of mechanisms for recognition and coping, as well as by the gaps related to cross-sector attention.

In order to contribute to the rethinking of the way of caring for women, it is important that professionals produce new categories and appropriate themselves of the ones existing within the several knowledge areas, especially within the social sciences, so that the principle of integrality of health assistance at SUS can be a product to be reached also by women experiencing violence. That means thinking of health care not only as an application of an instrumental or specialized technical knowledge about the hegemonic instrumental technological reasoning, which does not allow understanding the phenomenon, but also a limited explanation of the process of living, getting ill and dying.

The work that qualifies health attention to women experiencing violent situations must overcome the biomedical model of attention, limited to the process of biological reproduction, which still characterizes most work processes of women health practices, keeping itself loyal to the positivist conception of science. Overcoming this model implies on reviewing the professional practice, once, from the perspective of the emancipation of women oppression, critical knowledge about health needs, as a consequence of the oppressive situation that the gender-based approach contains, constitutes in one of its elements, one of the instruments that must orientate all the work of professional practices in that field.

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