



EVERYDAY'S VIOLENCE SITUATIONS AGAINST WOMEN WITH HIV/AIDS: IMPLICATIONS FOR CARE

SITUAÇÕES DE VIOLÊNCIA NO COTIDIANO DE MULHERES COM HIV/AIDS: IMPLICAÇÕES PARA O CUIDADO

SITUACIONES DE VIOLENCIA DIARIA CONTRA MUJERES CON VIH/SIDA: IMPLICACIONES PARA LA ATENCIÓN

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ABSTRACT

Objective: to analyze the situations of violence experienced by women with HIV/AIDS. **Method:** a descriptive and exploratory study, with qualitative approach. Participated 12 women diagnosed with HIV/AIDS. The data were produced through semi-structured interviews and analyzed according to the content analysis technique in the Thematic mode. **Results:** women are subjected to various forms of situations of physical, sexual and psychological violence in their own home environment as well as the relationships in society and in daily work what makes them vulnerable mainly in search for monitoring, disease treatment and their participation in community. **Conclusion:** knowing the situations of violence experienced by this group for nursing professional entails recognizing this problem, and propose interdisciplinary and intersectoral care strategies. **Descriptors:** Women's Health; Nursing Care; aids/HIV; Violence.

RESUMO

Objetivo: analisar as situações de violência vividas por mulheres com HIV/AIDS. **Método:** estudo descritivo, exploratório de abordagem qualitativa. Participaram 12 mulheres com diagnóstico de HIV/AIDS. Os dados foram produzidos por meio de entrevista semiestruturada e analisados de acordo com a Técnica de Análise de conteúdo na modalidade Temática. **Resultados:** as mulheres estão submetidas a diversas formas de situações de violência física, sexual e psicológica, no próprio ambiente familiar como também nas relações em sociedade e no cotidiano de trabalho o que as vulnerabiliza principalmente na busca de acompanhamento, tratamento da doença e na sua participação em comunidade. **Conclusão:** conhecer as situações de violência vivenciadas por esse grupo pelo profissional da enfermagem implica em reconhecer essa problemática e propor estratégias de cuidado interdisciplinar e intersectorial. **Descritores:** Saúde da Mulher; Cuidado de Enfermagem; AIDS/HIV; Violência.

RESUMEN

Objetivo: analizar las situaciones de violencia que sufren las mujeres con VIH/SIDA. **Método:** estudio descriptivo, exploratorio de abordaje cualitativo. Participó en 12 mujeres con diagnóstico de VIH/SIDA. Los datos fueron producidos a través de entrevistas semiestructuradas y analizados de acuerdo con la técnica de análisis de contenido en el modo temático. **Resultados:** las mujeres son sometidas a diversas formas de situaciones de violencia física, sexual y psicológica en su propio entorno del hogar, así como las relaciones en la sociedad y en el trabajo diario lo vulnerabiliza principalmente en el monitoreo de búsqueda, tratamiento de la enfermedad y su participación en la comunidad. **Conclusión:** conocer las situaciones de violencia experimentada por este grupo de profesionales de enfermería implican que reconocen este problema y proponer estrategias de atención interdisciplinarios e intersectoriales. **Descriptores:** Salud de la Mujer; Cuidado de Enfermería; SIDA/VIH; Violencia.

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INTRODUCTION

Violence against women is considered a public health problem by the World Health Organization (WHO) regarding the short-term health consequences of woman, represented by injuries and severe trauma, and long-term represented by psychological problems, gynecological, gastrointestinal, chronic pain, etc.¹

The World Health Organization report of 2013 states that violence against women is a global problem and points out that one in three women worldwide suffers physical violence and or sexual by her partner, intimate or non-intimate.²

This grievance is also known as gender violence because it affects a group of women, whose social constructions of femininity are linked to the notion of weakness and inferiority, and masculinity of power and strength, sending the idea of superiority resulting in gender inequality. These unequal notions are present in relationships and end up exposing the woman to various situations of violence.³

The relation between AIDS and violence is intricate and built through web mutual determination revealed by the stories of women who have their lives and their bodies marked by gender violence. Male decision power about the use of protection and sexual desire is naturalized as private behavior, subjecting woman to a subordinate and acceptance condition.^{4,5}

The woman who suffers sexual violence by an intimate partner, for example, is vulnerable to HIV/AIDS by not negotiating power in relation to safe sexual practice with the use of condoms by showing a lack of autonomy in the socio-affective relationship. Suffer psychological, physical and social grievances and, when seeking help in health services, sometimes suffers other violence by professionals as judgment, prejudice, intolerance and social exclusion.⁶ This brings the vulnerability related to the ability that people have to self-determination to seek protection. It is categorized into three areas: individual, social and programmatic.

Individual vulnerability covers biological, emotional, cognitive, behavioral and social relations; social is related to cultural, social and economic issues that influence the chances of getting things and services; programmatic refers to social resources

necessary for the protection of individual risks to the integrity and physical, psychological and social well-being. The vulnerability depends on the articulation of the components of the three domains and how individuals experience these conditions.⁷

By analyzing the vulnerability related to the lives of women with HIV/AIDS, it's shown permeated by various types of violence that interfere with the way they face the challenges posed by infection with HIV/AIDS.⁷

Before the problems described, nursing can produce care to women with HIV/AIDS in addition to the clinical aspects of the disease and recognize the biopsychosocial needs of experienced vulnerabilities and the promotion of actions to strengthen the social and familial network and community assisting the reorganization of life, in a more dignified perspective, less prejudiced and without violence.^{8,9} Moreover, to promote the construction of protection strategies and empowerment of this group, aimed at comprehensive care, promoting autonomy and the reduction of gender inequalities.⁸⁻¹⁰

Thus, this study aims to analyze the situations of violence experienced by women with HIV/AIDS.

METHOD

Descriptive and exploratory study, with a qualitative approach. The qualitative method provides study the phenomena and the facts according to how singularities and subjectivities involving participants and studied contexts occur.¹¹

The study was conducted in a testing and counseling center (CTA in Portuguese) for HIV/AIDS, the municipality of the northwest region of the state of Rio Grande do Sul with 12 women who use the city's CTA. Inclusion criteria were: use public service, with over 18 years of age, living in the county, diagnosed with HIV, being accompanied in the service for at least three months and who agreed to participate. The exclusion criterion was being ill due to HIV and therefore prevented from responding to the interview. The sample was given by theoretical saturation of answers when the speeches presented common and repeating elements can be considered that the sample is saturated.¹²

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The production data took place in July and August 2011 in the morning and afternoon shifts through an interview with open questions on the issue, held in a private room and recorded in MP3 by consent, and transcribed as original speech.

The research was initiated after approval of the research project by the Ethics Committee of UFSM under the case number 23081.007709/2011-40 and CAEE (Certificate presentation to Ethics Assessment): 0118.0.243.000-11. Respected to the norms of Resolution 466/2012 of the National Health Council (NHC) and before starting the interview it was explained about the research objectives and if they feel uncomfortable when asked would be answered in the Specialized Center, located in the same building as the CTA. The following was delivered to and Informed Consent Form (ICF) to sign, and a copy to the woman and the other to the researcher. For the confidentiality of the identity of the participants, were adopted M codes on the woman, followed by the growing numbers regarding the pursuance of interviews.

Data were analyzed according to thematic content analysis proposed by Minayo.⁹ Emerged the following thematic analysis categories: situations of physical, sexual and psychological violence: from the domestic space to the public space.

RESULTS AND DISCUSSION

The theme category *situations of physical, sexual and psychological violence: from the domestic space to the public space* observed that one of the women with HIV/AIDS suffered physical and sexual violence by strangers in public space. In this case, there is no evidence that contracted HIV/AIDS through violence, given that it was not known from previous HIV status to sexual violence. The woman was forced to have sex and kept silent for fear of what people would say about the situation.

It was about five years ago, when I was going to the bus stop, going to service [...] when I passed the college a guy threw himself over me and two others held me and beat me, I did not see the face of any, I just heard what they were saying "if we cannot catch you we'll stick you with infected blood", but I did not understand what it was that infected blood. The three of them abused me I left the place in shock, shaking, trembling, I was all bloody, but still went to stop because I just thought I had to work [...]. I arrived at work and they saw my

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shock and all dirty, asked me what happened and I lied that had fallen on the street. They lent a dress and I took a shower there and worked normally. No, I did not think to report, the police station was very near where I was abused, but did not want people to know. (M: 10).

The proportion of women who experienced sexual violence at least once in life and live with HIV/AIDS is higher than those who do not live with HIV/AIDS, thus, sexual violence makes women more vulnerable to disease.¹³ Suffer repeated and severe violence reveals a greater association with confirmed infection with HIV and violence independent of gravity and repetition is most associated with suspected infection.¹⁴ Sexual violence is a determining factor in the feminization of AIDS.¹⁵

A serious and likely implication in the context of violence and extreme vulnerability is the HIV/AIDS infection. People who have suffered sexual abuse, even if have not acquired the virus, may become more vulnerable to HIV infection because it has less safe sexual practices. In most cases, women do not report the perpetrators, the violence and do not seek assistance.⁷ The tendency of beaten women is to be silent on the subject for fear, retaliation, shame, guilt or humiliation.¹⁶

The woman is still seen as a male object of desire in which men use physical force to get sexual satisfaction without condom use. This is a perverse and cruel form of control of one gender over the other, setting a condition that violates the dignity and human rights.¹⁷

Cases of sexual violence committed against women by strangers are covered by prophylactic treatment in reference services.¹³ However, women need to seek the services and reveal what happened to the professionals, which does not always happen either because access to services is difficult or these are not available, reinforcing the picture of vulnerability experienced by this group of women. The specialized health service is an important source of support to women because they are welcomed, accompanied and guided about the disease, medication, tests and readjustment in their lives, featuring the work in the biological field, however, the woman's biopsychosocial needs are still little explored.¹⁸

There are health services not specialized in HIV/AIDS, where professionals act with

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detachment, in a prescriptive and normative form, strictly following the protocols without taking into account the life history of women and ethical guidelines and confidentiality. Moreover, some professionals have representations of the disease similar to common sense and incorporate in their prejudice and judgment practices making the women are afraid of being identified with a view that people close to them attending the health service.¹⁸

A woman who suffers violence does not seek health services because she is often subjected to other violence.⁷ In this case, she presents individual vulnerability, social and programmatic associated, has no resources to deal with such situations, and cannot access the services that should support and assist her.

Many women suffer sexual violence from childhood, from close or family people, and are afraid to report, remaining in this situation for years as is the case of one of the study participants.

Since childhood I was abused by my grandfather, my uncles, because I'm adopted right, people who adopted me had no guilt were good people, but my mother sent me to go in the grandmother get food and things and the whole time I was there they abused me. I did not know what it was, did not tell anyone, not once you understand what it was they did, I did not tell, because my mother did not deserve to know right. Never used a condom at that time did not exist so I think (M: 10).

The trajectory of these women's lives marked by forms of violence and intervene in situations that different degrees of vulnerability which includes sexual violence must be considered.⁷

Girls sexual abuse in childhood is committed by mothers' fellows who know but hinder and blame the daughter for what happened. The difficulty in identifying cases of sexual violence is the shame felt by the victim, which helps the child to be abused for prolonged periods and present psychological and physical health problems.¹⁹ There are cases that the girls reported the abuse to family and parents who adopt protection measures, notifying cases and the aggressors are kept away from family. However, the social and emotional support network faces challenges to ensure appropriate protection for children's health and wellness.²⁰ The family is no longer a

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place of full protection and guarantee of survival and rights, on the contrary, it becomes space of violence and helplessness.⁷

Sexual violence by strangers and family follows the lives of some women and this makes them more submissive in their relations to the point of not being able to negotiate condom use in search of safer sex practices in their affective relationships with their partners.⁷

The vulnerability is based on the articulation of emotional, cognitive, behavioral and social factors revealed the difficulty of transforming knowledge about HIV/AIDS in protective and preventive measures as the case of condom use in relationships. The influence of the role of male and female socially constructed, negotiating condom use suggested by the woman puts into question the power of man in a socio-affective relation, going against what is set up as a social norm.²¹

Psychological violence is represented by attitudes such as prejudice, humiliation, discrimination and isolation and, in this study, women suffered abuse from their family and friends what did pass battered physical violence practitioner.

My mother had enough prejudice, was the one that had prejudice. My mother did not sit where I sit, do not sit on the toilet, not looking at me. Bah, it was very difficult! [...] For her thought took even talk to me. For me it was there that the worst [...] Oh, because of the prejudice of the people do not want more live with agent are ashamed, friendships depart. I'm more at home, my home was always full of visitors, now do not get visits (M: 2).

My neighbor's wife my kid, she walked spreading to everyone that I was HIV positive and that my grandchildren were also, I was mad and I (hit) it. Then she sued me, there was the now sixth forum there until the judge wanted to humiliate me, but I told her: do you not know what she said to me, she called me eidetic my granddaughters also had, I step to have my granddaughters but I'm sure has already took. Now you will be talking about (M: 2).

Psychological violence represented by humiliations cause damage to self-esteem and identity of the woman, disqualifying her.¹⁷ This condition is exacerbated by the disintegration of family and community ties resulting from domestic violence and helplessness.⁷ Neglect, loneliness and hopelessness are conditions experienced by

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women and are marked by the violence of discrimination suffered by HIV.⁴

The stigma of the disease in society is to be a grievance that has no cure is contagious. The diagnosis of seropositivity derails life and relationships with friends and family and often the woman feels abandoned, isolated, scared and rejected socially.⁹

The family and social support is, for women, a help in the monitoring and treatment of disease and acceptance of HIV status for people who have affection. The family when complicit in the confidentiality of woman's HIV status, keep in secret unacceptable and socially disapproved behaviors, and it gives support to face what is to come.²² On the other hand, the family can also move away and be hostile as friends and acquaintances resulting in losses in the social network. Therefore, the woman feels obliged to build a new restricted social network, composed of health workers and close relatives who accept the new condition without judging.²¹ Hide the diagnosis is an alternative that preserves the identity of the woman and maintaining family and social relations, as the stigma and violence are compounded when you have to confirm the diagnosis.²²

In the context of marital relationships violence against women is committed by partners, in this case the woman is the victim and the man is the aggressor.²³ Family relations and friends aggression can occur among females, motivated by the conflict showing that women also have aggressive behavior and that this is not a male prerogative.²⁴

Violence at work is also a condition experienced by women in the study. This situation is aggravated when the diagnosis is made without consent and with a positive result for HIV/AIDS occurs due to the transfer at work and resignation. The relation with the work becomes weakened and leaves women without living conditions and thus without the possibility of obtaining basic features of housing, food, clothing, transportation and demand for assistance. The stigma of the disease removes the woman from the labor camp, as well as prevents the reintegration into new locations.

And oh did a battery of tests of employees, without my consent, and then this was taking, it was taking the result of my own,

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so I thought: Bah I's with a hepatitis, a bad thing, never thought about HIV and then came the diagnosis of HIV. [...] then, right, gave the news and you have told me will have to take the coat and go looking for another job or not work anymore, because no one will give you the job knowing that you are carrying will not want more. So it was a very, very difficult. They even wanted to relocate me, I put in the books and such, but then I coerced not to accept, because even so if I there had people would not want me would meet because it was a thing that looked like a tuberculosis, a contagious thing, contagious in the extreme. In my service they raped me the right to exercise my profession, and had no problem I continue, I considered a more horrendous attitude of the world which I will remember forever (M: 9)

I stopped making programs, I had to come back here [city] again, to take care of my mother and to take care of me too. What bothers me is that I cannot work, even if I ask job nobody gives, knowing that I have HIV and was a prostitute, who will give me tells me (M: 11)?

As for work, study reveals that among women with HIV/AIDS is out of the labor market and access to social security⁸, situation that converges with the results of this study. Women with HIV/AIDS who work are allocated in precarious and services that do not require qualification which is consonant with low schooling them.⁷

Social prejudice and discrimination in society inculcated reinforce the isolation and remoteness of women the world of work, a situation that worsens when this is provider of the family. The distance from work may be related to non-exposure HIV status of the woman or the health to produce.⁹

The meaning of work for women with HIV/AIDS goes beyond the notion of subsistence, is also seen as a possibility to maintain independence and autonomy, occupies a central position in their lives providing opportunities for the discovery and development of skills, and make no think all the time in his health.²⁴

Discriminatory and hostile behavior by colleagues to women with HIV/AIDS causes the resignation is the only alternative for them. However, in some cases there has been effort and understanding from colleagues and supervisors to maintain the confidentiality and follow-up treatment resulting in the adaptation of the work

routine which shows a welcome and solidarity conception.²⁴

Work is essential to face the women seropositive status, having a job and keeping it is critical to the quality of life, however, on the verge of illness and treatment there is a job loss threat and even the reintegration market work.²⁴

As the diagnosis form, few women seek diagnostic once they understand they are not at risk.⁸ The diagnosis is usually made from the companion illness and or own so belatedly gives.²² Get the diagnosis without being prepared can cause fear and insecurity about the support being received by family, friends, work colleagues and professionals of health services. Affective and social bonds are re-established after receiving the diagnosis, some other break solidify. The social network of a person can serve as support for therapeutic actions, but when it is limited or nonexistent, there may be loss of health status.²¹

Getting the diagnosis of seropositivity is a source of suffering for the woman to be discriminated decreases the chances of having a normal life with family, coworkers, friends, and sometimes with the professionals of health services themselves.²²

CONCLUSION

Women with HIV/AIDS in this study were vulnerable to sexual violence from childhood to adulthood, a condition that certainly contributes to the contamination. It appears that violence situations in their lives show how much they are unable to protect themselves in different stages of life. As child, they need protection and security of those who abuse them and, as adults, public security and judicial and police efficiency failures allow them to be abused by strangers on public places.

The consequences of violence and the spread of HIV/AIDS among women undergo psychological violence, humiliation, prejudice of family, friends and neighbors handicapping their emotional and social ties what, mainly in the pursuit of monitoring and treatment of disease.

By knowing the situations of violence women with HIV/AIDS, nursing can act beyond the biological dimension and, in shared way with women, their social network and support services, build a reorganization project of life in view of the

social demands the disease requires. Include in care production qualified listening and empowering women in order to pursue their social, educational, labor and economic in an attempt to reduce the factors that make them vulnerable in individual, social and programmatic aspects.

Health education activities, such as campaigns, group activities, talking groups can be structured with women in all stages of life, in order to promote more protective, preventive and greater female empowerment postures.

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