ISSN: 1981-8963 https://doi.org/10.5205/1981-8963-v12i01a230504p265-272-2018

Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

CASE REPORT ARTICLE

WOMEN IN SITUATIONS OF VIOLENCE: (RE) THINKING THE LISTENING, BONDING AND HOME VISITING

MULHERES EM SITUAÇÃO DE VIOLÊNCIA: (RE) PENSANDO A ESCUTA, VÍNCULO E VISITA

MUJERES EN SITUACIÓN DE VIOLENCIA: (RE)PENSANDO LA ESCUCHA, VÍNCULO Y VISITA

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ABSTRACT

Objective*:** to report the experience of educational actions developed in a participant research with Family Health Strategy professionals. ***Method: qualitative, descriptive study, of the experience report type, developed from a participatory research in which eight pedagogical workshops were carried out with health professionals, in order to (re)think the listening, bonding and home visits of women in situations of violence. The problematizing education framework was adopted and applied through the Charles Maguerez arc. ***Results:*** the educational actions allowed the participants to reflect and discuss the practices of listening, bonding and home visits of women in situations of violence, seeking knowledge to qualify them and applying this knowledge in their daily work. ***Conclusion:*** Through a process of action - reflection - action, the professionals were able to improve these practices throughout the accomplishment of the participant research. ***Descriptors*:** Violence Against Women; Women's Health; Problem-Based Learning; Family Health Strategy; Comprehensive Health Care; Nursing.

RESUMO

Objetivo*:** relatar a experiência de ações educativas de uma pesquisa participante com profissionais da Estratégia Saúde da Família. ***Método*:** estudo qualitativo, descritivo, do tipo relato de experiência, desenvolvido a partir de uma pesquisa participante na qual foram realizadas oito oficinas pedagógicas com profissionais de saúde a fim de (re)pensar a escuta, o vínculo e a visita domiciliar às mulheres em situação de violência. Adotou-se o referencial da educação problematizadora, aplicado mediante o arco de Charles Maguerez. ***Resultados*:** as ações educativas possibilitaram aos participantes refletir e discutir sobre as práticas de escuta, vínculo e visita domiciliar às mulheres em situação de violência, como também buscar conhecimento para qualificá-las e aplicá-lo em seu cotidiano de trabalho. ***Conclusão: por meio de um processo de ação - reflexão - ação, os profissionais puderam aprimorar tais práticas ao longo da realização da pesquisa participante. ***Descritores*:** Violência Contra a Mulher; Saúde da Mulher; Aprendizagem Baseada em Problemas; Estratégia Saúde da Família; Assistência Integral à Saúde; Enfermagem.

RESUMEN

Objetivo*:** relatar la experiencia de acciones educativas de una investigación participante con profesionales de la Estrategia Salud de la Familia. ***Método*:** estudio cualitativo, descriptivo, del tipo relato de experiencia, desarrollado a partir de una investigación participante en la cual fueron realizados ocho talleres pedagógicos con profesionales de salud para (re)pensar la escucha, el vínculo y la visita domiciliaria a las mujeres en situación de violencia. Se adoptó el referencial de la educación problematizadora, aplicado mediante el arco de Charles Maguerez. ***Resultados*:** las acciones educativas posibilitaron a los participantes reflexionar y discutir sobre las prácticas de escucha, vínculo y visita domiciliaria a las mujeres en situación de violencia, como también buscar conocimiento para cualificarlas y aplicarlas en su cotidiano de trabajo. ***Conclusión: por medio de un proceso de acción - reflexión - acción, los profesionales pudieron mejorar tales prácticas a lo largo de la realización de la investigación participante. ***Descriptores*:** Violencia contra la Mujer; Salud de la Mujer; Aprendizaje Basado en Problemas; Estrategia de Salud Familiar; Atención Integral de Salud; Enfermería.

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INTRODUCTION

Violence against women is a public health problem and a violation of human rights worldwide.[1,2] It reaches alarming proportions, affecting 35% of women worldwide who experience some type of violence at some point in life.[3]

Physical, mental and reproductive illnesses may occur because of situations of violence against women[1,3] and may lead these women to search for health services.[3] However, when they arrive at these services, they usually present vague complaints and rarely report having experienced a situation of violence.[4]

In this context, the Family Health Strategy (FHS) is the health service that tends to be closer to women in situations of violence. The FHS proposes care actions that allow the identification of social problems, including violence against women, as well as the development of responses to these problems under the perspective of integrality.[5]

FHS teams that deal with violence against women seek to employ care technologies such as listening, bonding and home visiting. However, despite the existence of public policies addressing this problem, in practice, the actions of professionals are constrained by limitations. These limitations relate, among other factors, to the training of professionals which is centered on the biomedical model[5-6] to the detriment of the holistic approach, in addition to the difficulty of intersectoral articulation of services to assist women experiencing violence situations.[7]

Despite these limitations, qualification in service based on problematizing education can provide the reflection of the professionals and search for knowledge, enabling transformations in the previously mentioned care technologies[8]. In this direction, the precepts of critical pedagogy stand out, in which the learner is the protagonist of his learning, becoming co-responsible in this process. The educator, on the other hand, can motivate the interest in the search for knowledge, which is related to the lived reality, as a supporting actor in this experience.[9]

In this perspective, problematizing education aims at developing critical, reflexive and creative thinking, preparing the learner to act autonomously with technical, political and social knowledge.[9] Based on this conceptual basis, problem-based learning is guided by questions about a specific theme, which is elected by groups of learners who observe the reality, and discuss, reflect and propose solutions. In this process they grasp, become aware of their reality and act to transform it. In this way, reality is the point of departure and of arrival.[10]

Considering the above, the relevance of this study comes from the goal to provoke the reflections of professionals about listening, bonding and home visiting in the case of women in situations of violence, disseminating experiences and contributing to the construction of knowledge on this theme in the national and international scenario.

OBJECTIVE

- To report the experience of educational actions of a participant research with Family Health Strategy professionals.

METHOD

A qualitative, descriptive study, of experience report type,[11] as part of a participatory research whose bases are research, education and action that jointly result in changes in the reality.[12]

Educational activities were carried out through eight pedagogical workshops, attended by 38 health professionals from six FHS teams in a municipality in the northwestern region of the state of Rio Grande do Sul, Brazil, in order to (re) think the listening, bonding and home visiting of women in situations of violence. From the total number of participants, 71% were Community Health Agents (CHA), 18% nurses and 11% Nursing Technicians. It should be noted that the number of participants representing each professional category varied in the workshops.

The period of development of the study comprised the months between November 2015 and January 2016. The workshops were held on Fridays at a place provided by the Municipal Health Department of the municipality scenario of the study. The research that originated this experience report was approved by the Research Ethics Committee of the Federal University of Santa Maria under the Opinion number 1,290,392 and Certificate of Presentation for Ethical Appreciation (CPEA) number 49198015.0.0000.5346.

The pedagogical workshops were conducted based on the problematizing and liberating reference of Paulo Freire[9], which proposes to observe reality; identify the available resources; recognize the problems that prevent the use of these resources; look for accessible technologies to use or create new ones, and find means of collective organization to carry out such technologies.

Problematization as a method considers the transformation of an individual and social process and, therefore, must be developed in a group.[13]

The Charles Maguerez Arc was used for the application of the problematizing methodology[10]. This presents five steps; in the first, the participants observed the reality and identified the problems, which corresponded to the first and second workshops. In the second step, the key points were identified, what happened in the third workshop. Theorizing was carried out in the third step, corresponding to the fourth, fifth and sixth workshops. In the fourth step, the chances of a solution were planned, which occurred in the seventh workshop. In the fifth and final step, the application was applied to reality, which occurred in the eighth workshop. Figure 1 illustrates the development of these steps.[14]

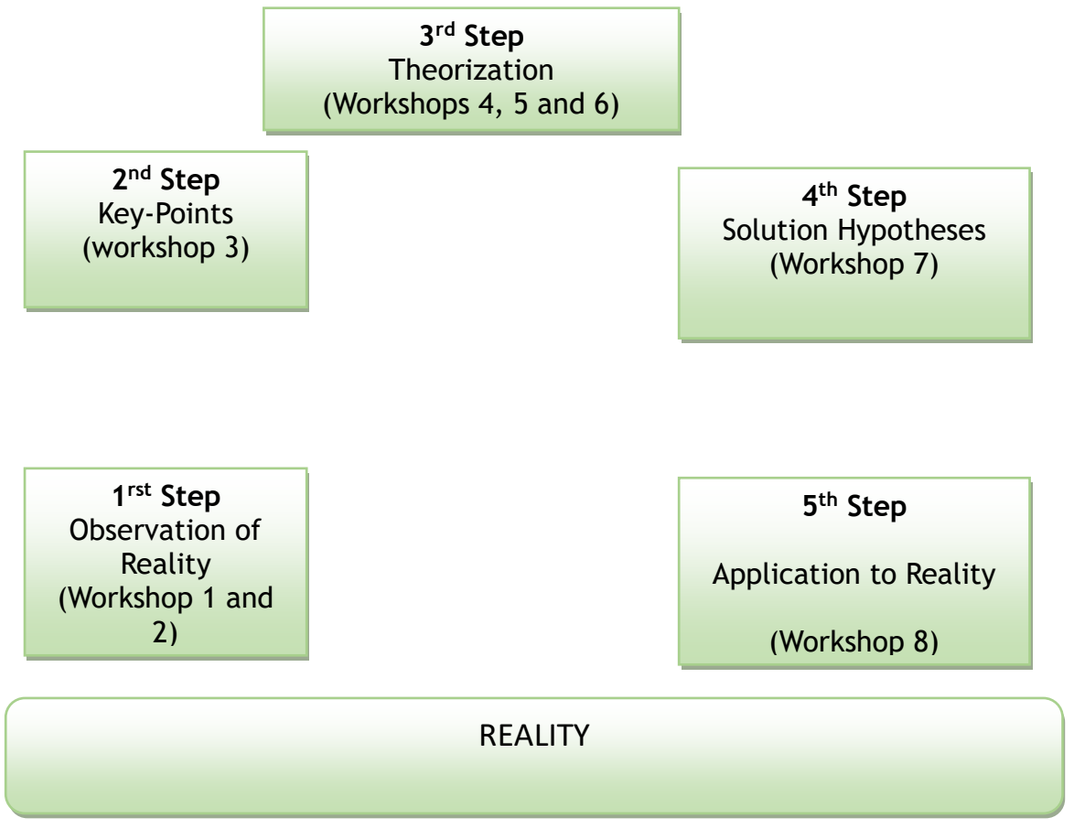

Figure 1. Steps of the development of the Participant Research according to the Charles Maguerez Arc[14]. Santa Maria (RS), Brazil, 2017.

RESULTS AND DISCUSSION

The educational actions developed in the pedagogical workshops of the participant research will be reported below, according to the steps presented in the Charles Maguerez Arc.

First step: Observation of reality.

The educational activities began in the first workshop, in which health professionals first organized themselves into groups. Then, for the application of the Charles Maguerez Arc, there was an observation of the reality that allowed the expression of perceptions and a syncretic reading of the reality experienced by the participants.[10] For this reason the discussion was triggered by the inductive question: How does the practice of listening, bonding with, and visiting women in situations of violence take place?

In this context, the starting point was the reality that health professionals experience when they provide assistance to women in situations of violence. Regarding the practices, they explained that they are carried out in such a way as to provide attention, confidence, secrecy and security, which are essential elements for concrete results in situations of violence against women.

According to the professionals, the listening happens from the spontaneous report of the women, that is, if they do not report the violence, there is no questioning by the professionals. This is due to the fact that they consider violence a sensitive subject to be approached with direct questions, even though they are aware that many of the women they assist are in fact experiencing this problem.

Listening, according to professionals, permeates several spaces of care, such as home visits, nursing consultations and nursing procedures. These spaces are also pointed out by a study as the most referenced for the recognition of violence against women.[5] Qualified listening with the observance of the principles of respect for human dignity, including non-discrimination with direct questioning, is recommended by the Ministry protocol.[15] Listening should take place in a private and safe environment in order to promote dialogue between the professional and the user, as well as the reporting of violence and the confidentiality of care.[15] When held in these spaces, this moment can provide the feeling of relief of the violence experienced.[16]

For professionals, the bond is built with long-term interaction and contact with the women, building a relationship of trust, respect and ethics, without moral judgment. In this way, the bond is based on the continuous assistance and the approximation between the user and the FHS professionals, which makes it possible to know their experiential context[17], the identification of situations of violence[18] and their confrontation.

Regarding the practice of home visits, the professionals reported that they are performed predominantly by CHAs. When these professionals visit the homes and use relational skills, they tend to establish a close relationship with the women. These moments allow them to identify situations of violence even without an open report.[19] The domestic space also provides opportunities for women to discuss their experiences of violence with professionals.[20]

This workshop was attended by 25 professionals.

In the second workshop, the step of observation of reality was continued, through the discussion of the groups on the basis of the question: What are the limiting and potentiating factors in the practice of listening, bonding and home visiting for women in situations of violence?

As for limiting factors of these practices, the participants mentioned: shame, lack of confidence in the professional and vigilance of the aggressor. The factors related to the professionals were the lack of empathy and lack of preparation, excessive demand for care and lack of time. The factors related to the FHS were the lack of support from the intersectoral network, lack of resolution of situations of violence, and lack of privacy in the place.

The presence of family members and especially of the aggressor in the home is considered a factor that inhibits the women from talking about violence. In this sense, a study indicates that in the presence of the aggressor, the user will hardly report the situation of violence to the health professional.[21] Another obstacle to the practice of listening, bonding and home visiting refers to the lack of empathy and time on the part of the professionals. It is necessary to sensitize the professionals in order to perform an assistance that takes into account the subjectivity of the women, offering a space without prejudices, in which the professional places himself in the situation of these women. Specifically regarding the visit, a study corroborates the professionals' report, evidencing that they do not perform the visits due to overload of work.[22]

With regard to the support of the intersectoral network, violence against women is considered a problem whose resolution does not only concern the health sector, but requires the articulation of different sectors to deal with it.[23]

With regard to the factors that enhance the listening, bonding and home visiting practices related to the professionals, trust, confidentiality, empathy, persistence, sensitivity, time and respect were mentioned. The factor related to the FHS was a safe environment to speak about violence. In this sense, a study shows that the physical structure of the FHS, which has nursing, medical and dental offices, enhances the performance of listening with security and secrecy, facilitating the hosting and bonding, as well as the verbalization of violence by women.[24]

This workshop was attended by 31 professionals.

Second step: Key points.

At this step, key points were surveyed, defining what is relevant and essential for the representation of the observed reality and identifying what can contribute to the solution of the problem.[10]

Thus, in the third workshop, the causes and solutions for the factors that limit the practices of listening, bonding and home visiting were discussed. As a solution to the limitations related to the women, the participants suggested persistence in the follow-up of these women, either in the FHS unit or at home, through home visits, in the listening and in the strengthening of the bond as a condition that facilitates the verbalization of situations of violence. For the limitations related to the health professionals,

they suggested a closer relationship with the women and more time available for attending them, which would make it possible to identify signs of violence. For the limitations associated with the FHS, in turn, they suggest the structuring of the intersectoral network for the resolution of situations of violence against women.

At the end of this workshop, the professionals presented a synthesis of the main problems among all the limiting factors, namely: listening is carried out based the report; the bond is fragile due to the lack of involvement from the part of the professional; and the home visit happens under the surveillance of the aggressor.

To help to solve these problems, the following key points to be theorized were listed: conceptual bases and practices of listening, bonding and home visits of women in situations of violence, which in the following workshops were studied and discussed.

Nineteen professionals participated in this workshop.

Third Step: Theorization.

At this step the participants organized themselves to seek information and knowledge about the problem through studies in different sources.[10]

Thus, in the fourth workshop the objective was to discuss and problematize the key point: "Conceptual bases and practices of listening to women in situations of violence". To that end, the professionals arranged themselves into groups and read articles on the subject, besides discussing case studies, based on the questions: What are the purpose and the contributions of listening? What are the obstacles to listening to women in situations of violence? How to develop a qualified listening to these women? Twenty-nine professionals participated in this workshop.

The fifth workshop discussed the key point "Conceptual and practical bases of bonding with women in situations of violence". Thus, the professionals read articles on the topic and discussed case studies, containing the following questions: What is the purpose and contributions of the bond? What are the obstacles to establishing a bond with women in situations of violence? How to establish a proper bond with these women? Thirty-seven professionals participated in this workshop.

The sixth workshop addressed the key point "Conceptual bases and practices of home visits for women in situations of violence". To that end, the groups received articles on the subject and case studies, which were read to the problematization of the questions: What is the purpose and contributions of the home visit? What are the obstacles to carrying out a home visit in the case of women in situations of violence? Which professionals should do the home visit? What elements should be observed at the home? Twenty-nine professionals participated in this workshop.

The theorizing workshops provided professionals with a reflection on the cases of violence against women in their realities, and a (re)consideration about how they could achieve or improve listening, bonding and home visiting practices for these women.

Fourth step: Solution hypotheses.

In this stage, which occurred in the seventh workshop, through their critical-reflexive potential, the participants were mobilized to construct the possible hypotheses for solving the problems as a consequence of the study and the deep understanding they obtained on this matter.[10]

Thus, regarding the problem "listening is happens based on the report", the professionals cited as a hypothetical solution the realization of indirect question, which may stimulate the report of women experiencing situations of violence. Also, through listening it is possible to build a commitment between professionals and users, with a view to creating a project to combat the violence.

For the problem "the bond is fragile due to the lack of involvement from the part of the professional", the professionals listed as a hypothetical solution to carry out the hosting with respect, commitment and empathy, foundations for the formation of the bond with the women in situation of violence, potentiating the women's reports.

Regarding the problem "the home visit happens under the surveillance of the aggressor", the hypothetical solution mentioned by the professionals was the planning of the visit according to the availability of the women, without the presence of the aggressor and/or relatives, what may facilitate the identification of violence and the women's report.

Thirty-one professionals participated in this workshop.

Fifth step: Application to reality.

This step, developed in the eighth workshop, goes beyond the intellectual exercise, since the participants return to their reality, putting into practice the most viable solutions to the problems listed, in order to transform this reality.[10]

Thus, the professionals discussed what they learned and what they applied in their reality. Among the solutions and impacts in practice, they reported that they were able to identify and intervene in some situations of violence against women in their realities, whether through listening, establishing and/or strengthening the bond, or home visiting. This is due to the space of reflection, study and practice provided by pedagogical workshops.

At the end of this workshop, a final evaluation of the educational actions developed in the pedagogical workshops of the participant research was carried out. In this evaluation, the professionals mentioned the sharing of experiences among the professionals of different FHS units that serve women in situations of violence as a facilitating factor. This contributed to the reflection and qualification of their practices regarding listening, bonding and home visiting of these women. As barriers, they mentioned the impossibility of providing continuous care for these women, due to the absence of an intersectoral network.

Thirty-seven professionals participated in this workshop.

As limitations of the present study, we mention the variable number of participants in each workshop, with the consequence of lack of participation of all of them in the five steps of the Charles Maguerez Arc through which the problem-solving methodology was applied. Also, because it was a research developed in a group, it was difficult to guarantee the equal participation of the participants.

Advances in scientific knowledge are related to the use of the problematizing methodology in researches in the Nursing and Health areas. Thus, this report contributed to the dissemination of this fruitful methodology for the scientific research, enabling the improvement of knowledge for its application in future qualitative investigations.

CONCLUSION

The educational actions of the pedagogical workshops developed through the problematizing reference allowed the health professionals go through a process of action - reflection - action, (re) thinking how has been the experience of developing the practices of listening, bonding and home visiting for women in situations of violence in their daily work. They were also able to evaluate the potentiating and limiting factors of these practices and, therefore, to seek alternatives for the improvement of the limiting factors throughout the participant research, with a view to the provision of comprehensive care for women.

Considering that the problem is transversal, we suggest that the study be expanded to include professionals from other sectors, as well as managers, to discuss the care practices directed to women in situations of violence, seeking resolution and coping with this problem from the perspective of intersectoral articulation.

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Submission: 2017/10/22
Accepted: 2017/11/08
Publishing: 2018/01/01

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