

Care for women victims of violence: empowering nurses in the pursuit of gender equity



Cuidar mulheres em situação de violência: empoderamento da enfermagem em busca de equidade de gênero

Cuidar de las mujeres en situación de violencia: fortalecimiento de la enfermería en la búsqueda de la equidad de género

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DOI: <http://dx.doi.org/10.1590/1983-1447.2015.esp.57162>

ABSTRACT

Objectives: To study the care of women victims of violence provided by nurses in emergency services and to analyse the practices that target the empowerment of women and gender equity.

Methods: A qualitative, descriptive study conducted by means of interviews with 10 nurses of an emergency and obstetrics unit of a university hospital and local emergency service of a city in southern Brazil from January to April 2013. We used thematic content analysis and defined gender as the analytical category.

Results: Clinical elements refer to nursing procedures and techniques. Non-clinical elements refer to conversation, listening and orientation to the women and their families.

Conclusion: Revealing these actions is important to qualify nursing care in relation to the other health professionals and care services for women victims of violence.

Keywords: Violence against women. Gender and health. Gender identity. Delivery of healthcare. Nursing. Millennium Development Goals.

RESUMO

Objetivos: Conhecer as ações de cuidar de mulheres em situação de violência por enfermeiras em serviços de urgência e emergência e analisar as ações que busquem o empoderamento de mulheres para a equidade de gênero.

Métodos: Estudo qualitativo, descritivo, realizado mediante entrevistas com 10 enfermeiras trabalhadoras do Centro Obstétrico e Pronto Socorro de um Hospital Universitário do Sul do Brasil e Pronto Atendimento Municipal, de janeiro a abril de 2013. Realizou-se Análise de Conteúdo Temática, adotando-se gênero como categoria analítica.

Resultados: Elementos do cuidado clínico: remetem-se aos procedimentos e técnicas de enfermagem. Elementos de cuidado não clínico: remetem-se a conversa, escuta e orientação às mulheres e familiares.

Conclusões: Desvelar tais ações torna-se relevante a fim de qualificar a assistência de enfermagem junto aos demais profissionais de saúde e os serviços de atenção às mulheres em situação de violência.

Palavras-chave: Violência contra a mulher. Gênero e saúde. Identidade de gênero. Assistência à saúde. Enfermagem. Objetivos de Desenvolvimento do Milênio.

RESUMEN

Objetivos: conocer las acciones de cuidado de las enfermeras en servicios de urgencia y emergencias y analizar las acciones que buscan el empoderamiento de las mujeres para la equidad de género.

Métodos: estudio cualitativo, descriptivo, realizado a través de entrevistas con 10 trabajadores del centro obstétrico y sala de urgencias de un Hospital Universitario en el sur de Brasil y Servicio de Urgencia, de enero a abril de 2013. Se utilizó la técnica de análisis de contenido temático, adoptando la categoría analítica de género.

Resultados: Elementos clínicos: relacionados con procedimientos y técnicas de enfermería. Elementos que no son clínicos: la conversación, escucha y orientación a las mujeres y familias.

Conclusión: Revelar tales acciones es relevante para calificar la atención de enfermería con otros profesionales de la salud y atención servicios a mujeres en situación de violencia.

Palabras clave: Violencia contra la mujer. Gênero y salud. Identidad de género. Prestación de Atención de salud. Enfermería. Objetivos de Desarrollo del Milenio.

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■ INTRODUCTION

Violence against women (VAW) is treated by the World Health Organization and the United Nations as one of the greatest public health problems and one of the most systematically practiced violations of human rights in the world. It has several repercussions on the health and quality of life of women and their families, among which we can cite morbidity and potential losses on a personal, social, emotional and economic level⁽¹⁾. In addition to the evident economic and social costs of this problem in the lives of women, it has a high cost for the development of nations.

The problem is rooted in the naturalization of disparities between the sexes, based on hierarchical categories built throughout history, while one of the ideological mechanisms that legitimize the status quo, including the social classifications, is the classification based on differences between the sexes. Women are consequently forced into a position of subalternity in their gender relations and disqualified as inferior due to biological differences⁽²⁾. In this sense, one of the many achievements for women in Brazil and around the world was the inclusion of the gender perspective as an important determinant of women's health.

Gender is defined as social relations between women and men of a historical and cultural nature that establish the models of men and women and delimit their bodies and field of action⁽³⁾. With regard to the extreme manifestation of inequalities between men and women, this type of violence is now included as an important social determinant of the health and life of women, and demands government investments and extended debate among multiple social sectors.

The phenomenon became an indispensable item in the agenda of gender issues. The United Nations (UN) brought together representatives and heads of state and government of 191 countries to the Millennium Summit and defined eight Millennium Development Goals (MDGs). As a reflection of the growing concerns about the sustainability of the planet and the serious problems affecting humanity, the international community established objectives that target priority areas to improve the conditions of health and education, and eliminate extreme poverty and inequalities in the nations⁽⁴⁾. Among these objectives, the third MDG aims to promote gender equality and the empowerment of women.

The goal proposed by the summit for the third MDG establishes the equal access of men and women at all levels of education until 2015. However, the major obstacles to

the promotion of gender equality and women's autonomy are not found in access to education, but in other aspects such as the inclusion of women in the labour market and in politics and, above all, the vulnerability and exposure of women to domestic and sexual violence⁽⁵⁾.

In the last three decades, Brazil has seen a significant increase of services for women victims of violence, permeated by the intense activity of women's human rights movements, scientific literature about the subject, the creation of women's councils, coordinating bodies and police stations, and specific services and laws. Brazil has also adhered to commitments established at various international conferences in the struggle against women's violence, including the achievement of the MDGs. Despite the progress made by these initiatives, there are many difficulties with regard to the quality of care and the articulation of the specific services⁽⁶⁾.

In the field of health, whilst progress has been made by considering VAW as being a problem that demands intervention due to its many physical and psychological consequences, the difficulties are related mainly to the fact that professional practices focus on the signs and symptoms of physical illness.

In different services, health centres or emergency units, many situations that are not always characterized as ailments, although they may be potential health hazards, are not clearly communicated since they are expressed as a series of complaints or pain that is inaccurate or lacks a known pathological correspondence. Consequently, the demands presented by women victims of violence are often considered care situations that are destined for failure. These situations evidently require some reflection on the realignment of management and professional practice⁽⁶⁾.

With regard to nursing care, nurses are also considered key elements for the achievement of the MDGs since they are trained to understand the complex nature of the concept of health and wellness, as well as the impact of psychosocial and socioeconomic factors such as poverty, ethnicity and gender⁽⁴⁾. Thus, women's empowerment and human rights are part of the commitment of these professionals, who, during their daily routines at the health services and social spaces, fight to reduce the inequalities that hinder access to quality health services and care.

Based on these reflections, the guiding question of this study was: What are the care actions professional nurses perform when providing care for women victims of violence? The objectives were to study the care of women victims of violence provided by nurses in emergency services and to analyse the practices that target the empowerment of women and gender equity.

■ METHOD

This is an exploratory-descriptive qualitative study from a dissertation⁽⁷⁾, presented to the Programa de Pós-graduação em Enfermagem (PPGEenf) of the Universidade Federal de Santa Maria (UFSM), in 2014. This study was conducted with 10 nurses of an emergency and obstetrics unit of a university hospital and local emergency service of a city in southern Brazil. These professionals were chosen because the services at which they work are a benchmark in tertiary and secondary care, respectively, for cases of women suffering from violence in the region and the municipality of this study. The criterion for inclusion was nurses working at these locations and who had attended cases of women victims of violence at least once. The criterion for exclusion was to be on vacation or away from work during the period of data production. The number of participants was not pre-established since the number of interviews was determined by theoretical saturation⁽⁸⁾, or from the convergence of findings to the objective proposed in the study.

Data were collected by means of semi-structured interviews once the participants were notified of all the ethical aspects of research and they signed the informed consent statement. This statement was presented in two copies, one of which was given to the researcher and the other to the interviewee. The questions addressed actions taken by the nurses in their daily routines with women victims of violence. The interviews were previously scheduled and carried out in rooms provided at the services to guarantee the privacy of the participants who agreed to participate voluntarily. The data production period was from January to April 2013.

The produced information was submitted to thematic content analysis that consisted of the stages: pre-analysis, material exploration and treatment of the obtained results⁽⁹⁾. In the pre-analysis stage, the transcripts of the interviews were skimmed. The material exploration stage consisted of identifying the core meaning of the actions performed by the professionals. The common ideas were grouped and the answers to the central question were outlined, followed by chromatic encoding of the findings in order to categorise them. For final analysis, the material was structured around specialised literature in order to answer the research questions based on the objective.

Gender was adopted as a category of analysis since this topic has been the basis of studies on violence against women. It is also the result of a debate anchored by the feminist movement⁽¹⁰⁾ that understands the iniquities generated by hegemonic patterns between men and women as a substrate of violent relationships.

Ethical aspects involving research with human beings were respected throughout the research process, in compliance with Resolution No. 466/2012 of the national health council. The study was approved by the Comitê de Ética em Pesquisa of the Universidade Federal de Santa Maria with protocol CAAE: 12224212.2.0000.5346. The anonymity of the participants was guaranteed by using the letter "E", the nurse's initial and a number.

■ RESULTS AND DISCUSSION

The nurses described their experiments and experiences in relation to providing care to women victims of violence during their daily routines. The results demonstrate that the actions are based on clinical and non-clinical elements. The clinical elements refer to nursing procedures and techniques, while the non-clinical elements include dialogue, listening and guidance, referrals, or lack of referrals, and team articulations.

Clinical elements of care

We pretty much just do what is prescribed. If there is a wound, we dress it, x-ray, ultrasound, we run the tests[...] STD, AIDS and hepatitis control [...] and if she is stable, she is released. (E1)

The therapeutic part, [...] in relation to medication. (E3)

What she's feeling at the moment, her clinical issues, or pain, or open wounds that have to be dressed, nursing care. (E8)

It's a more mechanical work, taking care of her body, her health, with the health status, help her recover from the trauma she suffered. (E9)

When the nurses provide care for women victims of violence, they tend to the initial wounds and the trauma that are the consequences of violence. The care provided is technical, often registered, or a care that the participants consider "normal" and restricted to biological issues. The participants mentioned procedures such as administering medication according to the violence suffered and the established protocol, in cases of violence, or with a medical prescription, checking the vital signs, examining any wounds resulting from violence, referring them to clinical tests, talking about symptoms, and dressing the wounds. Secondly, they mention non-clinical care elements, such as talking, listening and providing guidance to the women and their families.

In general, individuals seek health services due to the physical injuries resulting from violence⁽¹¹⁾. Clinical care is a means that enables the identification and recognition of violence. Although this should not be the only purpose of this care, it is an important point of contact with the woman and allows their access into the service network. The clinical and non-clinical elements of care complement one another and are important and necessary for health professionals to provide care for these women.

However, when the participants described the context of care, they referred to a location where the demand for nurses is high and there is little time for dialogue, which shows that the care provided is punctual and focuses on the technical procedures. The participants referred to this technical care as “mechanical” and mainly consisting of service protocols and doing what is prescribed. The care provided to women victims of violence is often permeated by the appreciation of technical knowledge. This finding converges with other studies related to healthcare, in which the health professionals limit their care to treating physical injuries⁽¹¹⁾.

Thus, the difficulties found at the health services are caused by reducing the problem to the physical manifestations perceived from the biomedical perspective. This process of medicalization limits the pathological and social problems of care⁽¹²⁻¹³⁾. This can be attributed to healthcare education and its incapacity to fully train health professionals to deal with the social problems since this would counteract the rationality of diagnoses and treatments⁽¹³⁻¹⁴⁾.

The need for professionals to act beyond the biological aspects of care becomes evident when the women themselves request that the nurses show interest in aspects other than their bodies, and claim to need information on the available services and support resources⁽¹⁵⁾. Therefore, professionals should not merely act as interventionists in physical issues, but also as promoters of women’s health and constituents of a network of services that deal with the sequela and dissemination of a culture of violence⁽¹⁶⁾.

The context of the violence experienced by the women is barely addressed, unless they mention the situation of violence. This reveals that violence at the health services is invisible, that is, if the women do not mention the violence they have suffered, the nurses rarely raise the question. In other studies^(12, 14, 17), violence is also presented as a veiled situation.

It is critical to unveil violence within the health services in order to understand its clinical and social dimensions and create the appropriate social assistance and intersectoral practices to ensure comprehensive care. This process would narrow the gap between health and human rights

and the empowerment of women, and retrieve those rights by restoring ethics in interpersonal relationships and addressing recurrent health issues in an integrated manner. An identification strategy is to approach the topic of violence with the users, which requires proper registration, teamwork, confidentiality and privacy, and use of the existing intersectoral network to guarantee non-judgement and respect for the women’s decisions^(12, 18).

It is also important to consider that the basis of violence is unequal gender relations. This requires the cross-sectional inclusion of the topic of VAW and gender inequalities in vocational training.

Non-clinical elements of care

Provide the necessary guidelines. Show her what she has to do. And even what could happen if she doesn't want to have the test, you have to explain the risk she faces. (E1)

I ask her if she will file a complaint [...] if she says she will, we tell her to go to the police station and register a complaint. (E2)

I try to show them they don't need to go through that [...] That she can and has alternatives, other things she can do with her life, she can go look for a job, a judge, she can get rid of that partner, if she's not happy in that situation, she can get a job [...] I try to show her that she is a person, that she has a right to be happy. (E3)

I prefer to listen than to talk [...] one listens to be able to help her, in the sense of figuring out what is best for her at that moment. (E4)

I try to talk to them so that they wake up, that they are not required to go through this [abuse from a partner], to get help... there is help, there is a women's police station, there are other support services [...] so they can see they have rights. I try to talk to her [...] and with her family [...]. (E7)

Listening and talking to the women permeates the care and advice nurses provide on the importance of registering complaints. Moreover, they hope that listening and providing guidance can help ease and reassure the woman. The nurses expressed their concerns in relation to reducing the possible consequences and preventing the harm that results from violence, such as unwanted pregnancy and sexually transmitted diseases, so that women who suffer sexual violence can feel more secure. Listening is revealed as a moment in which the women vent their problems and ease their suffering.

By identifying the cases of violence women suffer at the hands of their partners, many professionals talk, listen and guide women to increase their awareness and help them identify their relationships as violent and unnatural. In this way, the professionals hope the women will turn their backs on the violence. Many times, the women do not report the situation and the actions of the health professionals are restricted to their personal availability, structural and organisational issues and traditional conceptions of gender that can lead to the scapegoating of women who have suffered violence.

This result revealed that healthcare services must recognise violence as a health and social demand of women. In order to acknowledge and meet the needs of women victims of violence, health practices must denaturalise gender inequality and promote women's empowerment. The women claim that they need to be heard and supported by the health workers⁽¹³⁾ and that they value the consultations when this bond is established with the team. Follow-up and family support are also considered important by these women⁽¹⁵⁾.

When the professional-user relationship is based on elements that transcend the strictly clinical approach, the professionals can provide care according to more subjective dimensions. When they listen, talk and guide the users, they share a common space in which they can understand the lives of these women and perceive them as human beings with rights, especially the right to live without violence. They base their actions on the understanding that the women must be aware of the problem in order to separate themselves from the situation.

The care they provide can transcend the physical well-being of these women and approach their empowerment and autonomy to make decision about their lives and obtain a more individualised assistance. A study points out that autonomy relates to women as the subject of their decisions, health practices and strengthening, and the pressing need to horizontally include the perspective of gender in health policies and daily practices⁽²⁾.

Support is a possibility that demands accessibility, privacy and the empathy of health professionals. Care cannot be restricted to routines and procedures, and must guarantee that the women are not judged for their decisions. Listening must produce a narrative that helps identify the elements that can transform the situation of violence. Women change the way they use health services after consultations that include listening techniques, which reduces the demands of emergency rooms and allows a more programmed care modality⁽¹²⁾.

Qualified listening is a care strategy that can create a bond between clinical and biological care that is important

for women who need extended care. Nurses who use clinical and non-clinical elements enforce or seem to enforce the empowerment of these women, which converges with policy guidelines. When a women who suffers violence seeks help, the investments must reach beyond the specific need (physical lesion) and provide room for women to talk about their experiences and receive guidelines on other services and their right to a violence-free life, so they can denaturalise the situations they are experiencing.

Healthcare professionals must act with interest and provide the required support, without judging or victimising these women. Although qualified listening is very important, it is not enough. Health workers must understand the demands and offer care alternatives to the women and their families (support groups, appropriate contraception, psychotherapy, support for substance abuse). Additional support (women's police station and public defender, social, labour and housing services) require the recognition of the services network⁽⁶⁾.

Sometimes, the health workers also talked to the women about their rights as women, the possibility of being free of their abusive partners and of getting a job. Their hope is to strengthen the women so they do not continue in the situation of violence. They stress the possibility of seeking help with the support services, such as the special women's police station and halfway house. The participants acknowledged that the families need to help the women and talk to them so they can also get help from their families or someone in their social network. However, these moments of non-clinical care are not always present in professional practices. Some commented that the emergency service is too busy for assistance that is anything other than punctual.

The emergency room does not have that system of chatting, there is always something to do, we do what is prescribed, quickly. (E1)

Our contact is minimal, sometimes, we don't even know there is a case of violence because the emergency unit is always very busy, you are involved, we get involved with the back beds, with the emergency rooms and procedures. There is no time for chatting or listening. (E5)

The statements reveal that the context of violence is complex, especially due to the financial and emotional dependence of these women on their companions, which can result in the submission of women. The nurses recognised that the situation can only be overcome if the families provide support and the women pursue finan-

cial independence. They talked about work, seeking legal and public safety services, family support and the right to non-violence in order to strengthen the women, prevent more violence and help the women leave the violent environment. Emotional support, information on the available legal resources, confidentiality and encouraging the autonomy of women are fundamental elements in healthcare⁽¹⁸⁾.

The nurses stressed the need to refer the women to other professionals such as psychologists and social workers, and mentioned approaches adopted by the family health service with community health agents. They also mentioned services such as the specialised social welfare reference centre (CREAS), the halfway house and the obstetrics centre, for cases of sexual violence. Some claimed they preferred not to get involved with the situation since they considered it the work of a specialist, psychiatrist, psychologist or social worker.

Refer to a psychologist. (E1)

She is referred to psychological support and then she continues with the outpatient unit for contagious diseases, if needed, if she wants to go to the forensic medicine department. There's also the halfway house. I'm not too involved with that [...]. I wish that [...] that I could have a network that sheltered these women [...] I don't know how that network works [...]. It would be ideal to have something to say like: now you leave, you go to this place where people will be waiting for you and will provide the support you need to do something with your life from now on. (E3)

The statements reveal the need for professionals to refer "to other" professionals or services that assist women victims of violence. With these referrals, they hope to obtain the support and continuity of care the women require to build a perspective of life without violence. Studies show that the continuity of care is an important factor for the development of assistance for these women^(12, 18).

In some cases, partnerships were instituted in the outpatient service of infectious and contagious diseases at the hospital. Situations experienced in the community included the articulated help of physician, community health officer, social worker, nursing technician, psychologists and other services like halfway houses. At the obstetrics centre, the nurses had the support of psychology professionals and social workers and relied on the referrals made by these professionals. In the emergency room, in the absence of these professionals, they recognised their lack of training to refer patients to other services and delegated the task to psychologists, social workers and doctors.

Others reported difficulties in referring patients, in articulating the follow-up of these women with other services and complained of the lack of articulated services in the health system. Their statements reveal their need of instrumentation to cope with cases of violence against women.

Referring is not a problem, the problem is where and who will receive the women. We send them away, we don't refer them anywhere. (E2)

A referral to the specialised reference centre of social welfare, but I can't say if they go there, don't know if they go because there is no counter referral system. (E4)

I think that an emergency room, we should have training, or a more specialised service. There is no psychologist to help us here, or even to refer the patients correctly afterwards. Some stay here in the emergency room and they are discharged right here, they go home. (E7)

The psychological part, I didn't really get involved. I mean, I don't think that treatment is part of my work. Like, what happened, tell them about making a complaint [...] I leave that to the people who have to do that part of the work, social workers or psychologists, experts in that field, a doctor. (E9)

In the nursing consultation, we managed to diagnose, but not me alone, sometimes she goes to the doctor and the doctor transfers the situation to me, and we transferred to the health worker to observe the situation better [...] and tried to steer her toward special women's groups [...] to the social worker, to the halfway house, we referred them [...]. We discussed it as a team. This situation, both at the hospital and the health unit, has to have multidisciplinary participation [...]. (E10).

These results converge toward two perspectives. They reveal that the professionals understand the complexity of violence and its impact on the lives and health of women, and that violence is a social issue and not merely a health issue, which also shows their limitations in relation to solving the problem. Thus, they chose to only do what was within their reach in the emergency setting and, by referring the patient to another professional, they create the false idea of problem resolution, which reduces their responsibility concerning a complex issue that transcends the health service. This finding converges with a study that showed that the existence of a visible mark of violence prioritizes care and suggests a specificity. In the case of hospital services, this

specificity is to tend to serious injuries. Their understanding of the process of referring patients to specific locations is based on the idea that violence against women is something that should be kept at a distance and is the sole responsibility of the professionals who have chosen to deal with these problems⁽¹⁹⁾.

In the present study, the professionals recognised the necessity of multidisciplinary care that is articulated with other services. However, they also expect the existence of a network, a specialised service, that receives women who suffer from violence. In spite of these expectations, they do little to create this system or ensure the continuity of care. This lack of mobilisation reveals the limited interaction and insertion of the health services in the women's support networks. In terms of the existing services, they mentioned difficulties in monitoring and communicating with these services.

This result converges with a study on the critical itineraries of women in the pursuit of care, where the network is seen as fragmented and far from the reality of these women. The limiting factors mentioned by the women are difficulty in understanding the guidelines and processes, fragmentation and the absence of a centre that provides comprehensive care. However, some professionals stated they were willing to change the methods of intervention and create mechanisms to approach the actors and organise the work flow⁽¹⁰⁾.

In order to integrate care and structure a network, it is important to understand that the determinants of the occurrence and permanence of women in violent relationships are part of a complex social dynamic that requires the interaction of services. The appreciation of women's relationships and their social networks is also considered a challenge. Therefore, it is important to incorporate new ways of forming the women's support network that will enable a flow between the services, institutions and significant actors in the lives of these women⁽²⁰⁾. Violence against women, in addition to the law enforcement and health issues, demands the guaranteed access of women to primary care services and multidisciplinary teams. In order to ensure that the provided services can receive women victims of violence and guarantee the continuity of care, the health professionals must engage with these women and their families.

■ FINAL CONSIDERATIONS

A better understanding of the actions of health workers, permeated by clinical and non-clinical elements, proved useful since nurses provide care with goals and intentions

that need to be unveiled in order to qualify nursing care in relation to other health professionals and care services for women victims of violence.

Clinical care actions, such as reception and qualified listening, are a valid possibility for women when they access the service. However, the continuity of these actions requires the expansion of the scope of care in relation to the needs of these women, that is, beyond the physical issues they present. It is also necessary to reinforce the inclusion of health determinants that permeate the lives of these women, such as their relationships with their companions, children, family members and neighbours, and when these relationships present a certain fragility. These issues are permeated by traditional gender roles related to income and housing, and target the articulation with other services in an attempt to minimize the damages of violence these women experience or to help them end the situation.

The nurses demonstrated the extent to which the work process in an emergency sector focuses on the manifestations of disease, to the detriment of the women as subjects. These challenges must be overcome at the level of service organisation in order to eliminate the fragmentation of care and the weak or non-existent articulation with other services of the network. Due to the typical characteristics of the study sites, the need to implement a reception that is based on risk classification and the assessment of the degree of physical vulnerability and distress of the women and their families also emerged. The nurses and other professionals can control this technology and (re)organize women's access to emergency services.

This development requires nurses to approach the women, seek to understand their care needs, and commit to them. Consequently, they must take control of this care, share the responsibilities with the women, their families and other professionals and reflect on the possibility of confronting violence and gender inequality. The continuity of care is still a challenge since care is permeated by the social and cultural heritage of the biomedical model. However, the reasons that led the nurses to act are configured as possibilities to re-invent everyday care and to share the responsibility through the horizontalisation of care and coordination with other services. Nurses must recognize their subjectivity and their empowerment as women to ensure that the relationship they establish with the users is based on dialogue and a permanent construction. They must also use communication and their social role in the health team.

Finally, we highlight the contribution of the study for the development of nursing care, women's empowerment and the fulfilment of the third MDG. The study

demonstrates that we must constantly develop competencies in the clinical practice through care protocols and the dissemination of evidence that contributes to the advancement of women's rights and autonomy, and competencies based on education, society and gender to implement policies for the comprehensiveness of care.

This study presents some limitations that are characteristic of qualitative research, such as the delimitation of the study in a hospital and emergency setting. However, its contribution is to extend the studied subject, which explains the importance of the adopted approach.

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Received: 18.07.2015

Approved: 03.12.2015