

## VIOLENCE AGAINST WOMEN IN THE PERSPECTIVE OF COMMUNITY HEALTH AGENTS

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### ABSTRACT

The current study has the objective of learning and understanding how Community Health Agents conceptualize, develop and perform strategies to counter violence against women attending the Family Health Strategies in a northeastern municipality of Rio Grande do Sul. It is an exploratory research, utilizing a descriptive and qualitative approach, carried out with 35 Community Health Agents. Semi-structured interviews were performed to collect the data, which were analyzed using the thematic model. Conceptions of violence against women are centered around violence as a social construction based on gender inequalities and on violence as having a multifactorial construction. Regarding care practices and interventions to counter violence, the following tools are highlighted: construction of intervention strategies within the staff; forming bonds, listening and dialogue with the women victims of violence; and directing victims to support services. We believe that this study contributes to the visibility of this theme as a need in health care, as well as for the construction of strategies to counter it.

**Descriptors:** Community health workers. Violence against woman. Health services. Gender of health.

### RESUMO

*O presente estudo visou conhecer e compreender a violência contra as mulheres na perspectiva dos Agentes Comunitários de Saúde inseridos nas Estratégias de Saúde da Família de um município da região noroeste do Rio Grande do Sul. Trata-se de uma pesquisa exploratória, descritiva com abordagem qualitativa, realizada com 35 Agentes Comunitários de Saúde. Para a coleta dos dados, utilizou-se entrevista semiestruturada, e os mesmos foram analisados pela modalidade temática. As conceituações da violência contra as mulheres centram-se na violência enquanto construção social e de desigualdades de gênero; e violência enquanto construção multifatorial. Em relação às práticas de cuidado e enfrentamento, observaram-se algumas ferramentas: a construção de estratégias de cuidado junto com a equipe; vínculo, escuta e diálogo com a mulher vítima de violência. Acredita-se que este estudo contribua para dar visibilidade a essa problemática como uma necessidade de saúde e assistência e para a construção de estratégias de enfrentamento.*

**Descritores:** Agentes comunitários de saúde. Violência contra a mulher. Serviços de saúde. Gênero e saúde.

**Título:** Violência contra as mulheres na perspectiva dos agentes comunitários de saúde.

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## RESUMEN

*El presente estudio busca conocer y comprender cómo los Agentes Comunitarios de Salud conceptúan, actúan y elaboran estrategias de enfrentamiento a la violencia contra mujeres en Unidad de Estrategia Salud de la Familia de una municipalidad del noroeste de Rio Grande do Sul. Se realizó un estudio exploratorio, con enfoque cualitativo descriptivo, con 35 Agentes Comunitarios de Salud. Se utilizó la entrevista semiestructurada para la recolección de los datos, analizados por la modalidad temática. Las concepciones de violencia contra mujeres se centran como construcción social y de desigualdades de género y como construcción multifactorial. Sobre las prácticas asistenciales y de enfrentamiento, se observaron algunas herramientas: la construcción de estrategias de intervención con el equipo; vínculo, escucha y diálogo con mujeres víctimas de violencia. Se cree que este estudio contribuyó para la visibilidad de esta temática como una necesidad de salud y asistencia así como de la construcción de estrategias de enfrentamiento.*

**Descriptor:** Agentes comunitarios de salud. Violencia contra la mujer. Servicios de salud. Género y salud.

**Título:** Violencia contra las mujeres en la perspectiva de los agentes comunitarios de salud.

## INTRODUCTION

Since modern times, violence as a societal issue has been addressed in the home, in the public safety and legal environment, and also as the object of social movements. In the health care area, it has become a concern because violence is a threat to the life, working conditions, interpersonal relationships and quality of life of its victims, who are part of the universe of health and public health<sup>(1-2)</sup>.

It is recognized that violence against women is considered a violation of human rights, restricting their condition as autonomous citizens, their freedom to come and go safely, and their right to express and be respected for their physical, mental and social integrity. In light of this, this study bases its analyses on the recognition of this phenomenon as a form of gender inequality, translated into asymmetric power relations. This power may be relational; reality has shown that it hardly benefits women, who are the most frequent targets of violence<sup>(3)</sup>.

In view of this, violence against women has been understood as the result of power struggles between men and women, in which he is the one who determines her role, which makes the inequality between them visible. Thus, we can define it as any act based on gender that results in physical and/or psychological harm or suffering to women that may be employed consciously as a mechanism of subordination in a marital relationship<sup>(4)</sup>.

In the health field, violence becomes a problem when it affects both the individual and collective health, which requires the creation of specific public policies and the organization of services aimed at prevention and treatment<sup>(5)</sup>. It is in this context

that the team work of Family Health is defined as a key element in the identification of violence, in the creation of bonds with the victims of these events and in structuring coping strategies and preventive and promotion actions.

Thus, in the present study it is recognized that the model of care in the Family Health Strategy assumes that the family health unit is the first level of care, which supposes integration into a more complex service network. Furthermore, we seek to truly get to know the families of the territory covered, identifying health problems and existing situations of vulnerability in the community and also developing curative, educational, promotional and cross-sectorial actions with users and the community as a whole. This model has struggled to switch the focus from curative care to interventions centered on the user and the family<sup>(6)</sup>.

Among the Family Health professional teams, the work of the Community Health Agent (CHA) deserves emphasis because he/she performs strategic and complex functions, in addition to being responsible for maintenance of the link between the community and the health staff<sup>(7)</sup>. CHAs have been highlighted in dealing with cases of violence, because during the performance of home visits they are privileged to be present in families and communities, which offers the opportunity to identify cases of violence within the domestic space. The community health workers are not only peace agents, but can also act to prevent violence through their notification and reporting<sup>(8)</sup>.

However, studies have revealed that health services and professionals do not always offer a satisfactory answer to this problem<sup>(9-10)</sup>. This shows that the health sector has not yet incorporated into

its assistance models complex problems originating from daily social life that are atypical, considering the strong biomedical background of medical practice. Thus, the language of symptoms and clinical diagnoses are insufficient in the multifactorial universe of violence, with violence often becoming an invisible hazard in the health scenario.

Thus, the present study aimed to learn and understand violence against women from the perspective of community health agents working in Family Health Strategies (FHS) of a municipality in the northwestern region of Rio Grande do Sul. The intent is to establish a comprehensive and critical reflection regarding the issue, giving visibility to the question and contributing to empirical data to formulate health care practices, as well as local public policies to cope with the issue.

## METHOD

To reach the proposed goal we chose to use exploratory and descriptive research methods with a qualitative approach<sup>(11)</sup>. The study was carried out at the FHS units of a municipality located in the northwestern region of the state of Rio Grande do Sul. The participants were 35 community health agents, whose selection was based on the following inclusion criteria: working in FHS Units for over five years and working during the period of data collection.

To collect the data we opted to utilize semi-structured interviews that, by combining open and closed questions, allow the interviewee to discourse on the issue at hand without being attached to formulated questions<sup>(11)</sup>. A script-guide was structured in two parts: the first part contained sociodemographic data of the CHA; the second part included open-ended questions related to the research problem. The interviews were conducted in an appropriate room at the FHS units and were digitally recorded using an MP3 recorder, in order to fully record the speeches of the subjects, thereby ensuring reliable and rich material for analysis. In order to preserve the identity of the respondents, a number in sequence was assigned for each of the participants when their speeches were transcribed, which was then added to the CHA abbreviation. Data collection occurred from December 2009 to February 2010.

The interview analysis was based on Thematic Content Analysis<sup>(12)</sup>. After the transcription, the interviews were read so that it was possible to be

familiar with the whole, classifying the themes into a similar thematic axis that eventually converged into a common meaning.

To develop the study, the rules of Resolution No. 196 of October 10, 1996 were complied with, which are relative to human research, with the study being approved by the Ethics Committee of the Federal University of Santa Maria (UFSM) case no. 23081.012390/2009-50.

## RESULTS AND DISCUSSION

The discussions arising from the analysis of the speeches of the participants were grouped into two main axes: "Understanding and conceptualizing violence against women" and "Care practices and strategies to combat violence against women."

### Understanding and conceptualizing violence against women

The first thematic axis focused on understanding how the community health agents conceptualize violence against women. In this axis the following meaning units were identified: violence in terms of building social and gender inequalities and violence as the result of multifactorial causes.

In the first meaning axis, violence in terms of social construction and gender inequalities, it was identified that violence from the perspective of health agents consists of the reality and the social context in which women are embedded and the confluence of gender inequalities, being that this type of violence is perpetuated with higher frequency in the domestic scope, and the aggressor, in most cases, is the spouse himself.

The CHAs reveal in their speeches that males dominate over females, public space is directed towards and favors men and men have power and authority as providers and heads of the household; on the other hand, women are expected to be gentle, subordinate and obedient, viewed only as procreators, home makers and house wives, with no right to express their feelings and will. This is evident in the words of the CHAs:

*Violence against women happens in the way that her partner or spouse finds in himself the right to tell the woman to respect him; she has no choice; many women report that violence sometimes occurs when they do not want to have intercourse (CHAs).*

*Discrimination- because it is like this: men can but women cannot. To me violence starts there. Then, other types of aggression follow, verbal, sexual and physical. (CHA10).*

In this sense, it is clear that the social construction of gender is responsible for the naturalization of violence, both by men and by women. In the speeches cited, there is a cultural barrier that is difficult to break because of the ingrained values, resulting in the failure of women to recognize violence for what it is; whether in formal marriages or stable unions, women believe that the behavior of their partners must be accepted, out of respect for the position of power of the man in the relationship.

A study developed in a São Paulo Maternity Hospital tried to identify the meanings ascribed to women victims of violence by health professionals; the results confirm the findings of this study, since maternity professionals recognize gender inequalities as both cause and consequence of violence against women and identify submission as one of the main elements<sup>(10)</sup>.

In the analysis of the CHAs' speeches, the submission of the women was identified as contributing towards the acts of violence of their partners.

*They do not have any freedom, and they are very submissive to their husbands; you know, they get married and they surrender their body, soul and identity [...]. (CHA26).*

*There are very submissive women, you know, who are dependent on the husband; they do not go after what they really want (CHA30).*

These findings show that the attributes and gender roles valorize the man over the woman, authenticating his domination over her inferiority, so that in this condition she is devoid of autonomy and the right to decide, even in regards to her own body<sup>(13)</sup>.

Under this perspective, in the analysis of marital relations, it is clear that the exercise of power occurs unequally between the sexes, with women occupying subordinate positions. This condition of subordination perpetuates violence against women and inhibits the capacity for social and sexual self-determination, making women more vulnerable to the physical and emotional assault of their companions<sup>(9)</sup>.

Given these findings, it is noted that over the centuries, and even today, the idea of women as the weaker, submissive and imperfect sex is entrenched in the social imaginary, which also affects the field of health care, and particularly the care provided to the victims of violence. It appears that, for many CHAs, violence against women is considered "gender destination", which results in naturalization and normalization of these events and therefore prevents actions against them.

In the second meaning unit, the multifactorial construction of violence, other elements reported by the CHA influence violent events, including: alcohol and drug abuse, unemployment and social inequalities.

*The cause of this is the lack of jobs, poor living conditions [...] I think that it impacts the quality of family living more, you know, the most needy, which also brings the abuse of alcohol (CHA11).*

*Look, I think it's more drug use, ok? The drug abuse rate is too high, so much for family planning [...] but alcohol is one of the biggest factors I think, the economic situation also contributes a lot to violence (CHA33).*

Drug use and violence seem to be related, but not in such a simplistic and causal way. Studies show that consumption of alcohol and other drugs are present in social processes in various cultures. The association between chemical substance abuse and violence is cyclical and seems to give a broader meaning to both<sup>(14)</sup>.

Regarding social inequalities and unemployment, two studies confirming this finding are cited: for most professionals working in three health units of Natal (RN), the factors that influence domestic violence are male chauvinism, economic conditions, alcoholism and family history of violence<sup>(15)</sup>. In a study developed with female health workers, the correlation of violence with social inequalities and violence with poverty and unemployment are also mentioned<sup>(16)</sup>.

### **Care practices and strategies to combat violence against women**

In relation to care practices and coping strategies used by community health agents, the following meaning units were identified: construction of care strategies within the team; building bonds and listening and dialogue with female victims of violence.

The first meaning unit refers to the construction of care strategies within the team. The CHAs mentioned that, when identifying or reporting a case of violence, their first action is to report it to the team, in order to discuss the therapeutic and assistive actions to be taken in relation to the case. The speeches below express this.

*I come and I bring the report to the team; as a team we work together [...] I always ask for help because I never know what to do in terms of this particular part (CHA4).*

*We bring our difficulties and problems to our team meeting; we talk here at the station [...] we discuss it together with the team and we try to find some solution for the case [...] (CHA26).*

The speeches reveal the difficulties faced by CHAs in attempting to take action against violent acts perpetrated towards women. As a result, the agents seek to share the difficulties encountered in their daily work with the professional staff of the Family Health Strategy, which are the main actors involved in the process of identification and intervention in cases of violence in Primary Care. However, there is a greater visibility to the role of the FHS workers since, in most cases, women report to them things that they would not say to other professionals, making them responsible for preventing or intervening in these situations, along with the other team members<sup>(9)</sup>.

However, interventions to cope with this issue are still complex and challenging. Obstacles must be continually overcome, and gender violence must be discussed at the meetings and discussions of the health teams, so that they are able to promote health strategies aimed at providing full and comprehensive care to the female victims of this discrimination<sup>(17)</sup>.

Even in this meaning core, it is evident that most of the FHS workers, referring to the need for discussion of cases with the team, reinforce that the nurse is the most responsible and likely professional to develop actions within the community. The speech below illustrates this finding:

*The first thing we do is talk to the nurse [...] Yes, I communicate with the nurse; then, in the team meeting we raise the issue with the others, too (CHA3).*

Thus, the role of the nurse as a professional who prepares and equips community agents to

develop activities to meet the needs of the population is recognized. Nurses perform health education actions in supporting the community to improve their life conditions, in addition to contributing to the identification of incidents of violence against women and formulating care interventions.

The second meaning unit focuses on the formation of a bond and the importance of listening and dialogue with women victims of violence. The interviewees consider the professional bond with the user and the use of qualified listening tools as important in meeting women's needs that often are not brought to the professional as an explicit demand, but are instead uncovered during the dialogue with the user. The following speeches elucidate this fact:

*The first time you care for someone, quite often you hear things and you end up, how shall I say it, helping the person, advising the person regarding her rights, on where she should go, what she can do, how she can proceed [...]. (CHA8).*

*We go there more to listen to what they want to talk about, you know, because you cannot go and simply say, "do it this way and do it that way"; you ask, did you go to the police, did you make a complaint, did you do anything, you know, and they talk (CHA7).*

Thereafter, identifying situations of violence against women becomes possible. From this perspective, it is necessary to work interactively, based on qualified and non-judgmental listening, especially when there is reference to violence in the woman's dialogue with healthcare professionals, taking into account the detection of violence, the security of rights, and the emancipation of women victims of violence<sup>(18)</sup>.

Studies performed with health professionals from a hospital point to the relevance of dialogical relationships between professionals and women victims of violence, in order to establish a connection through sensitive and attentive listening and understand the life history of women, with the goal of identifying violence<sup>(19)</sup>.

Credibility is a predominant factor in the ability to act on behalf of those who suffer this kind of violence. The credibility that the CHAs develop in the course of their work is an essential aspect in assisting victims of violence; without it, there is no trust on the part of the community, and the work

of the agent is impossible. Credibility generates a trusting relationship and bond with users; this results in their opening their homes and discussing their difficulties so that needs may be resolved or addressed, ensuring the continuity of the agent-community relationship<sup>(20)</sup>.

In light of the above, it is considered that the health sector, mainly through the teams of the Family Health Strategy, may intervene in the issue of violence against women through the identification of the problem, the provision of care, qualified listening, providing support to users, and case follow-up, since the health model is based on relational technologies and comprehensive assistance provided to all users. However, it is recognized that the workers cannot solve the problem of violence alone. Instead, it is necessary to structure an intersectoral network that has the objective of guaranteeing women their full rights as citizens.

The importance of interdisciplinary institutional networking is emphasized, resulting in an ongoing process of strategy construction that reduces inequalities and disparities that affect women.

## FINAL CONSIDERATIONS

This study allowed us to know and understand violence against women in the context of CHAs, revealing knowledge of violence as a social construction, related to gender inequalities and with multifactorial causes, in which economic conditions, alcohol and drug abuse are considered influencing factors on the occurrence of this phenomenon. With regard to intervention practices and coping strategies, actions are developed with the help of the entire health team, with the nurse acting as the closest and leading professional. CHAs value the formation of bonds, as well as listening and talking, with women victims of violence.

The study shows the commitment of these health care workers towards women victims of violence; however, their actions have not been translated into effective practices to address this problem. Thus, the actions of CHAs targeted towards women living in situations of violence need to potentiate actions that favor female autonomy, considering the social construction of gender as a determinant of destructive processes in women's lives.

From this perspective, the health care sector has not yet incorporated violence against women

as a challenge that must be conquered; for example, broadening the understanding of gender. We have not yet realized the magnitude of the problem or recognized the victims who suffer; that is, the women who live their private lives in different contexts and with different needs. It is believed that the reconstruction of subjects and scenarios could influence different approaches, and provide new knowledge to guide appropriate interventions supporting comprehensive care for women victims of violence. Moreover, other studies focusing on the concepts and practices of professionals facing the problem of violence are needed in order to contribute to the visibility of this problem, identifying care for victims of violence as a real health care need and providing the means of assistance and the construction of coping strategies.

Finally, it is thought that the training of CHAs should be an important focus, because recognition of violence requires a high degree of suspicion and sensitivity for its detection. Workers must be equipped with knowledge in order to deconstruct situations and encourage and provide subsidies to act. In this context, the role of the nurse is relevant as a co-participant in the process of educating and empowering these health agents, just as it is the responsibility of all health professionals in coping with various forms of violence.

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