

Strategies for identification and coping with the violence situation by intimate partners of pregnant women



Estratégias para identificação e enfrentamento de situação de violência por parceiro íntimo em mulheres gestantes

Estrategias para identificar y enfrentar situaciones de violencia de parte de la pareja en mujeres gestantes

Samara Silva Marques^a
Deise Lisboa Riquinho^b
Maxuel Cruz dos Santos^c
Letícia Becker Vieira^b

How to cite this article:

Marques SS, Riquinho DL, Santos MC, Vieira LB. Strategies for identification and coping with the violence situation by intimate partners of pregnant women. Rev Gaúcha Enferm. 2017;38(3):e67593. doi: <http://dx.doi.org/10.1590/1983-1447.2017.03.67593>.

doi: <http://dx.doi.org/10.1590/1983-1447.2017.03.67593>

ABSTRACT

Objective: To know the strategies used by nurses of Units of Family Health Strategies to identify and cope with the violence situation by intimate partners of pregnant women.

Method: Descriptive study with a qualitative approach, in which semi-structured interviews were conducted with 23 primary care nurses from September 2015 to April 2016. Thematic content analysis was used.

Results: The category "It's very complex" has emerged – actions to identify and cope with the violence situation by intimate partners of pregnant women. Physical injuries were the main violence indicative identified at prenatal care. The coping strategies were the referrals to specialized services and joint discussion with healthcare team.

Conclusion: There's a need to organize a nursing protocol that helps in the identification and classification of risk exposure to violence, permanent education of these professionals and strengthening of intersectoral actions.

Keywords: Nursing. Violence against women. Pregnant women. Primary health care.

RESUMO

Objetivo: Conhecer as estratégias utilizadas por enfermeiros de Unidades de Estratégias de Saúde da Família para identificação e enfrentamento de situação de violência por parceiro íntimo em mulheres gestantes.

Método: Estudo descritivo com abordagem qualitativa, com entrevista semiestruturada direcionada a 23 enfermeiros da atenção básica, no período de setembro de 2015 a abril de 2016. Utilizou-se a análise de conteúdo do tipo temática.

Resultados: Emergiu a categoria: "É bem complexo" – ações de identificação e enfrentamento da violência por parceiro íntimo em mulheres gestantes. As lesões físicas foram o principal indicativo de violência identificada na consulta pré-natal. As estratégias de enfrentamento foram os encaminhamentos a serviços especializados e discussão conjunta com a equipe de saúde.

Conclusão: Aponta-se a necessidade de organização de um protocolo de enfermagem que auxilie na identificação e classificação de risco à exposição à violência, educação permanente destes profissionais e fortalecimento das ações intersectoriais.

Palavras-chave: Enfermagem. Violência contra a mulher. Gestantes. Atenção primária à saúde.

RESUMEN

Objetivo: Conocer las estrategias utilizadas por enfermeros de Unidades de Estrategias de Salud de la Familia para identificación y enfrentamiento de situación de violencia por compañero íntimo en mujeres gestantes.

Método: Estudio descriptivo con abordaje cualitativo, con entrevista semiestructurada dirigida a 23 enfermeros de la atención primaria, en el periodo de septiembre de 2015 a abril de 2016. Se utilizó el análisis de contenido del tipo temático.

Resultados: Surgió la categoría: "Es muy complejo" – acciones de identificación y enfrentamiento de la violencia de parte del compañero íntimo en mujeres gestantes. Las lesiones físicas fueron el principal indicativo de violencia identificada en la consulta prenatal. Las estrategias de enfrentamiento fueron los encaminhamientos a servicios especializados y discusión junto al equipo de salud.

Conclusión: Se apunta la necesidad de organización de un protocolo de enfermería que auxilie en la identificación y clasificación de riesgo a la exposición a la violencia, educación permanente de estos profesionales y fortalecimiento de acciones intersectoriales.

Palabras clave: Enfermería. Violencia contra la mujer. Mujeres gestantes. Atención primaria a la salud.

^a Hospital Nossa Senhora das Graças. Canoas, Rio Grande do Sul, Brasil.

^b Universidade Federal do Rio Grande do Sul (UFRGS), Escola de Enfermagem, Departamento de Assistência e Orientação Profissional, Porto Alegre, Rio Grande do Sul, Brasil.

^c Universidade Federal do Rio Grande do Sul (UFRGS), Escola de Enfermagem, Curso de Graduação em Enfermagem, Porto Alegre, Rio Grande do Sul, Brasil.

■ INTRODUCTION

Violence against women is widely recognized as a serious public health problem. For the World Health Organization (WHO), intimate partner violence (IPV) is defined as behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behavior, and this setting applies to both spouses and current or former partners⁽¹⁾.

In all the stages of the growth and development of women, there are reports of violence, however, during pregnancy, the acts of violence may decrease, being a factor of protection; or it may intensify, being a risk factor for the health of the mother-baby binomial⁽²⁾. Regarding the intensification of this act, women with the highest number of pregnancies are even more susceptible to violence. The damages from these attacks can cause various effects on the health and quality of life of the mother-baby binomial, such as: premature labor, bleeding, low birth weight, abortion, premature rupture of membranes, maternal death⁽³⁻⁴⁾.

Such diseases impact on women's physical and mental health and can generate an increased demand for health services. In this sense, the professionals have an important role in receiving and listening to the women, being strategic for the aid in the fight against violence⁽⁴⁻⁵⁾.

In Brazil, in the year of 2007, as a management strategy for guidance and implementation of policies for combating the violence against women, in order to ensure the prevention and combating the violence, providing assistance to guarantee rights to women, the National Pact for Combating Violence against Women was launched. This federal arrangement among the federal government, the government of the states and the Brazilian cities, subsidized the planning of actions to consolidate the National Policy for Combating Violence Against Women, in 2008, through the implementation of integrated public policies⁽⁶⁾.

This political mechanism reaffirms the need for joint action by the various sectors involved, such as health, public security, justice, education, among others; in order to propose actions that deconstruct inequalities and combat gender discrimination and violence against women; as well as interfere in the chauvinist patterns of the Brazilian society and guarantee a qualified and humanized service to those in situation of violence⁽⁶⁾.

The composition of the healthcare services in the network to combat violence against women stands out as the Basic Healthcare (BH) with the potential to become the gateway for women experiencing violent gender relations. The participation of the BH professionals and their insertion

into the community, through the Family Health Strategy (FHS), can favor the early identification of risk factors for violence and the intervention in situations of vulnerability⁽⁷⁾.

Studies indicate the importance of deepening the investigations regarding violence against pregnant women by intimate partners, since there is a scarce literature given the severe repercussions on the life and health of the mother-baby binomial. Regarding the performance of nursing in caring for these women, it is possible to observe a gap in the production of this knowledge⁽⁷⁻⁹⁾.

Since the BH nurse, for being close to the people's lives, develops the listening and the embracement of women in the preconception and parturition period and is attentive to their care needs, the following guiding question was sought: What are the strategies used for the identification and coping with violence by intimate partners of pregnant women attended by nurses who work in FHS?

The objective of the present study was to know the strategies used by nurses of the Family Health Strategies Units to identify and cope with the violence situation by intimate partners of pregnant women.

■ METHOD

It is a descriptive study with a qualitative approach. This approach is based on the perceptions and human interpretations about their experiences and feelings⁽¹⁰⁾. The scenario of the study consists of twenty Family Healthcare Units in the city of Porto Alegre - Rio Grande do Sul, located on territories of greater social vulnerability and violence. The districts where the research occurred are characterized by presenting the highest general coefficient of mortality for the external causes group (accidents and violence) of the city. The participants were 23 nurses. The inclusion criteria were: to be working in this labor activity for more than six months and to carry out programmatic activities aimed at the assistance of women in prenatal care; and as exclusion criteria, to be absent from work by leave of any nature during the period established for data generation.

The semi-structured interview has been used as a data generation technique. It has been held in the service in which the participants worked, in a reserved room, upon prior appointment. Still, they have been performed individually, with an average duration of 30 minutes and recorded in MP3 (audio). For the interview, a script containing questions related to sociodemographic and academic data, and concerning strategies for identifying and coping with the situation of violence by intimate partners of pregnant women has been written.

Data generation occurred in the period from September 2015 to April 2016, and was closed using the data sat-

uration criterion. This is the interruption of the inclusion of new participants when the data, in the researcher's analysis, begin to present a certain repetition, and it is not pertinent to follow up the process of data generation⁽¹⁰⁾.

The data obtained through the interview has been systematized and analyzed through content analysis, in its three phases: pre-analysis, material exploration, and treatment of results obtained and interpretation. Initially, the data from the recordings of the semi-structured interviews have been transcribed verbatim in a text editor program, composing the corpus of the study. In the pre-analysis, the NVivo 10 software has helped in the codification and treatment of the material. Then, from exhaustive readings, the analogous ideas present in the excerpts of the participants have been highlighted.

The exploration phase of the material made it possible to cut common elements of the transcribed statements, constituting categories. For this purpose, the registration units, consisting of words, sentences and expressions that give meaning to the content of the testimonies and support the determination of the categories⁽¹⁰⁾, have been listed. Thus, at this stage, the topics that constituted the registration units have been first sought. After finding these units, the thematic category has been determined. The categorization involves reducing the text to more meaningful words and expressions within the corpus of analysis.

In the last phase, treatment of the obtained data and interpretation, we have tried to propose inferences and interpretations about the results, returning to the objective of the study. Thus, the previous clippings have been analyzed based on the related literature.

It should be noted that, before the beginning of the data generation stage, the participants have been informed about the study objectives and methodological procedures through the Informed Consent Term. Those who agreed to participate have signed this term in two copies, one for each participant and the other for the researcher. In order to guarantee the anonymity of the participants, these have been identified by the letter 'E' referring to the nurse, followed by the ordinal number according to the order of the interviews (eg, E1, E2... E23).

The study has been approved by the Research Ethics Committees of the Universidade Federal do Rio Grande do Sul and the Municipal Health Department of Porto Alegre, CAAE: 38025914.8.30015338/2015.

■ RESULTS AND DISCUSSION

Among the participants of the research, 20 are female and three male; the most frequent marital status was single (17). The age of the participants ranged from 27 to 58

years old, the self-declared race was dark-skinned (1), black (3) and white (19). The training time is between three and 34 years, and the work in BH ranges from six months to 12 years of service. All the interviewees have some type of specialization, being the main ones in the area of the public health, intensive therapy, and urgency and emergency.

The results are presented in the thematic category, constituted from the nurses' statements regarding the strategies used to identify and cope with the violence situation by intimate partners of pregnant women.

"It is very complex": actions of identification and coping with the VIP of pregnant women

The interviewees' testimony shows that the majority of them have already attended women in situation of violence. However, when it comes to pregnant women, few have identified it in the daily routine of their care practices. The identification of situations of violence has been described as a complex phenomenon, since the gestation is a period in which emotions are more exacerbated; and crying and sadness can mask the occurrence of violence. It has been emphasized that, when there is the verbalization or the presence of physical signs, like bruising and lesions, the identification occurs more easily, especially at the moment of the prenatal appointment.

Anything that happens to the woman in this (gestational) period is going to be much bigger than the hormonal issue. Thus, it is difficult to perceive violence in the pregnant woman as against a woman who is not pregnant. (E7)

She had her arm in a plaster cast, so she could not see it, but she did not mention what had happened; it was later, in another appointment, in which she told everything that had happened. (E16)

At the first prenatal appointment, she had marks and bruises on her arm. The woman and her husband are crack and cocaine users, and she would prostitute herself to maintain their addiction, otherwise he would beat her. (E22)

Violence, which is considered a public health problem and a violation of human rights, remains a taboo for women, and often for health care providers as it is an intimate and painful case that must be resolved in the domestic sphere. This attitude indicates that the healthcare services are moving away from the responsibility of facing the problem and pregnant women are even more vulnerable to the fragility shown by these services⁽⁷⁾.

Violence is understood as a complex and multiple phenomenon. It can be understood from social, historical, cultural and subjective factors, but should not be limited to any of them. The discussion about the subject must cover two fundamental aspects: the conceptualizations of violence, which allow the identification of the violent experience and the perspectives of those who are involved in this violent situation, since the way an experience is perceived is related to the way it is felt and identified⁽¹¹⁾. The valuation of the subjective and social dimension in approaching women in VIP by nurses is necessary, since only the objective dimension of care limits their performance in relation to the situation, based only on objective signs and symptoms, with a healing focus and little resolution of the social and health demands of these women.

The prenatal care is an appropriate moment to recognize and identify cases of violence, since it is during this period that visits to the healthcare services are more frequent. However, when there is no evidence of physical bruises resulting from the aggression, there are difficulties for this finding, therefore, greater attention is needed on the part of the healthcare teams, and a close monitoring in each case⁽¹²⁾. A systematic review study indicates that health professionals know the benefits of the prenatal care that covers the VIP, but they are unable to perform these specific appointments routinely, because the partner is present, the time is very variable, or they do not know how to address the issue and how to address the situation⁽¹³⁾. Establishing a relationship of trust and being able to understand what the health user does not verbalize, but expressed in their body and behavior, were the means that the health professionals used to facilitate the identification of the VIP⁽¹³⁾.

The more frequent presence of women in services can generate a greater link with the healthcare team and favor the identification of cases of violence. However, most cases are not registered, constituting the invisibility of the situation. Regarding the nurse's performance in the prenatal care, a study recommends the adoption of an intervention plan with questioning in the team's records, with direct questions to all the users, asking if they face or suffer any type of violence⁽²⁾.

Considering that violence rarely starts during the gestation, since the frequency is a regular and systematic pattern of the relationship of the couple, it is fundamental that the topic is approached from the first appointment in the healthcare services, seeking to identify families that experienced marital conflicts, even before the current gestation⁽¹⁴⁾.

Nurses report the occurrence of manifestations that help in the identification and understanding that violence was repeated in the current gestation, such as: absence in

prenatal appointments due to alternating address, report of living with the partner at one time and with relatives in others, allied to the direct verbalization of the occurrence of violence in the previous gestation.

Her husband used to beat her during the gestation, so she separated from him and came back several times. At a moment she was being taken care of by our unit, and in another she was going to another unit. We found out that sometimes she would go to her husband's house, sometimes to her mother's house, as he would beat and fight with her. (E11)

The pregnant woman was sloppy in her prenatal care, she did not attend the activities (appointment and group), and she lived a little bit in each place [...]. Maybe she did not want this pregnancy from this relationship with her partner, who uses drugs, beats her and their other child, and gets stuck. (E15)

A good quality prenatal care can reduce physical aggression to women during the pregnancy, however, the appointments should cover the health of the pregnant woman in an integral way, including the psycho social aspects, configuring fundamental actions for the development of the care and protection of the pregnant woman⁽¹⁴⁾.

It is observed that women's inadequate or late access to prenatal care may be due to the partner's prohibition for this search or due to the intense psychological stress experienced by the woman during the pregnancy as a result of the abuse. Another aspect to be considered concerns the shame and the fear of being discovered by the health professionals. Thus, she moves away from adequate assistance and becomes more exposed to violence by the aggressor^(4,7).

The findings of this study reveal, in the perspective of the nurse, the removal of the pregnant woman from the prenatal care actions, implying the discontinuity of care and the difficulty of helping her cope with violence.

All guidance was given to this woman, but she changed her health unit and never came back again (E4).

Only after her gestation the patient told me that she suffered aggression during her pregnancy, according to her, only at that time. But she stopped attending the prenatal care, she left the territory of our scope, it was difficult to help her. (E18)

The reception of the pregnant woman and the development of an "interested" listening have been indicated as a powerful tool to identify the violence:

It was during the embracement, after identifying that the patient had a very sad face. During the embracement, the professional has to be open to listen, because, in general, women are ashamed to speak, they feel guilty. (E1)

What should be done is to have a look at this person, to value her as a person, to value her as a woman. So that she will reveal herself in all her facets. If you are too superficial or just look at the body of the pregnant mother, she will probably not feel free to reveal her life if the other person is not showing the slightest interest in hearing. (E8)

The woman must have confidence in you and come to get help, to create a bond with our UBS, to be heard. (E17)

In this sense, the embracement by the healthcare professionals is an opportunity for accountability in listening to women's reports and complaints, allowing the free expression of their concerns and anxieties⁽²⁾. The committed listening from the healthcare professionals is an element that allows the recognition of VIP of pregnant women, so it is necessary that the team is prepared to establish a care relationship that conquers the patient's trust⁽¹⁵⁾.

As a difficulty in the identification of violence, the fragile attachment of the woman to the service and to the professionals has been mentioned, this can be justified by the high turnover of the Primary Healthcare professionals in the local reality of the research, along with the fear of reprisal. Besides the difficulty in revealing the violence situation to the professional by the woman, it was perceived by the shame of herself in exposing the experience of violence, the emotional and financial dependence on the companion. These elements constitute the challenges in facing violence, once the nurses understand that the lack of financial autonomy of the pregnant woman creates difficulties for her to break with the context of the violence, besides weakening them regarding their self-esteem and mental health.

The financial and emotional dependence as motivation/justification of some women to remain in a situation of violence is sustained in issues that constitute gender relations, which bring to the woman the responsibility for the maintenance of the marriage⁽¹⁶⁾; and, in the study, reinforced by the perspective of family constitution through the gestation and raising of the children next to the paternal figure.

Even when they are suffering from violence while pregnant, they take the relationship forward because, in their thinking, if they become pregnant, they have to continue together, keeping the family. (E3)

I perceive the fear, the shame and the guilt felt by the pregnant woman, and the need to stay with this man, for several reasons. (E12)

I made the notification form, I guided her on looking for the Women's Police Station, I sent her to the social service and to the psychologist, I helped her to get "Bolsa Família", but at last she said: "I cannot leave the house now, I cannot do anything, I depend on him, so what am I going to do with this unborn baby? (E15)

When questioned about ways of coping with VIP situations for pregnant women, the nurses interviewed report the referral to a specialized service in the field of the tertiary healthcare. Also highlighted are the referrals to mental health demands. In addition to the discussion of cases, and conduct within the healthcare team.

The first step would be to address the psychological aspects. Then, refer her to the social worker and psychologist. (E9)

I discuss with my healthcare team when I suspect or identify it, and with the community agents who are very familiar with that situation, so we can make joint decisions. (E14)

Refer to a reference hospital. (E21)

Thus, the referral to other services was somewhat recurrent in the speeches, denoting that FHS in cases of VIP has a limitation in assisting and accompanying the pregnant women in situation of violence. When transferring the responsibility of this care to another service/professional, and often not knowing the consequences of this action, it creates a network care with little communication between the points, and sometimes it is not resolute.

The construction of appropriate and sensitive local practices and conduits is done through the referral to specialized services, in a committed way, with effective communication, with a view to optimizing available resources and services, greater agility in referrals and, consequently, more qualified and humanized service to women. It is up to the healthcare professionals the healthcare of the mother-baby binomial, surveillance and monitoring, and prevention and health promotion considering the intersectoral articulation.

The Family Health Support Center (FHSC) has been mentioned by some nurses as a coping strategy in cases of violence, since the proposal of this nucleus to share health practices and knowledge allows broadening the scope of primary care actions to coping with violence, as well as its

resolubility. In addition, for nurses, the support offered by the FHSC regarding the increase of the capacity of analysis and intervention on the problems and social and health needs of these pregnant women would fill gaps in the training/qualification on the theme.

FHSC's help, too, because of the concern for the woman's mental health, and on how to carry out this pregnancy. (E10)

I would like more training and that there were professionals at FHSC so we would be able to discuss the cases. We are very lacking in guidance on the subject. (E5)

Studies point out that the strategies to deal with women in situations of VIP include the creation of linkage and appreciation of women's speech; the institutionalization of spaces for discussions on the issue, the involvement of professionals of the FHSC referral team, and the knowledge about the services that make up the network of attention to women in situation of violence and referrals, as the most important ones⁽¹⁵⁾. These aspects corroborate with the findings of the present study.

The notification of suspected and confirmed cases of violence against pregnant women is understood as a device that allows the visibility of the problem in question. It denotes the State's commitment to the diagnosis of violence against women from the construction of official statistics. The notification must be made in all healthcare services, including the FHS, and, thus, it also becomes a support for the professional, in the sense that they have acted facing such a situation.

The notification, reporting and internal referrals provide protection for the professional as well, since there are other devices involved. So I would send it to the network, even though it does not work as it should, but it is a protection for the professional that it does not just stay inside the unit. (E20)

The first thing to be done is to notify, notify this case for surveillance. And look for all the support, like the FHSC, the psychological, the psychiatric appointment. Try to engage this woman in a whole network of facilitating service so that she can somehow solve it. But the main thing is the notification, and getting her into that psycho social help network. (E23)

The records made by health professionals in BH have been examined in a study, and it demonstrated the occurrence of violence not clearly described in the medical re-

ords, due to lack of data, mostly, they do not contain records of socioeconomic data, nor the user's life history, showing gaps for the understanding of the context in which violence occurs. The actions are focused on the physical or psychological consequences of violence on women's health⁽²⁾.

Although they verbalize in a specific way about the healthcare network, referrals, and notification as possibilities of coping with violence outsource little training focused on the topic and knowledge of the devices to guide their actions.

I would have to have more property to know where to referral. If you direct her to the wrong place, she stays in that go and returns all the time, and it ends up discrediting the situation of the woman. (E2)

The continuity of care for pregnant women (...) runs into the lack of training and in the lack of a network of services with good communication. (E13)

We are not prepared to meet and have a network of services to give us this support (E19).

The professionals are not qualified to deal with this type of situation in the FHS. This is largely due to the absence of the topic in the academic training of nurses and other health professionals. It is notorious that the fear that the professional feels when acting when the topic is violence against women, because they do not perceive themselves as qualified to act in these situations, the attitude taken is often summed up in the removal or denial^(7,17). It is necessary for professionals to move out of from impotence and to become new agents of the social change, being capable of giving direction to women who live in situation of violence⁽¹⁷⁾.

Nurses express concern about acting in a territory where violence and drug dealing are present; and that acting in a purposeful and co-responsible manner in confronting violence against women requires safer and more protective spaces for health professionals themselves.

Many professionals are afraid to make the notification; there is the question of the identification, which we know is not something that needs to be identified. There is also the issue of drug dealing, of violence, with which we know that the professionals are involved with, and that they have to be careful to deal with such situations, be it violence against women, elderly or children. Be it any kind of violence, we would have to have more security as a professional. (E06)

We work in areas of social vulnerability, violence, drug dealing... This exposes our users as well as us. (E08)

Violence at work is present in all sectors; however, it is more frequent in services where there is a predominance of women, such as the health sector and social services. In general, it is more frequent in the healthcare services, because the worker has a very close relation with their object of work that is the health needs of the patient. In this sector, violence is invisible, and any measure adopted for the formation of public policies aimed at workers' health will have repercussions on the quality of care provided to the population⁽¹⁸⁾.

The professionals involved in the care to this clientele perceive the complexity and intensity of the violence experienced, which sometimes mobilize personal issues of each one. There is also the difficulty in establishing strategies to deal with the repercussions of violence on the health and daily life of the professionals, especially given the scarcity and fragility of a support network to deal with these situations⁽¹⁹⁾.

Thus, it is recognized that, in order to identify and cope with intimate partner violence against pregnant women, a support network that goes beyond the basic healthcare services is needed. In order to guarantee humanized and qualified care to those in a situation of violence through the continuous training of public and community agents; through the creation of specialized services and the creation/strengthening of the Healthcare Network for the establishment of a network of partnerships to combat violence against women, in order to guarantee the integrality of care.

It is also reinforced that, for professionals working in the FHS, being a strategic and privileged position for the detection of violence against pregnant women, they should be able to act in this context, by guaranteeing them resources and support⁽²⁰⁾. However, for this to become operational, there is an immediate need of developing professionals' skills and modifying the work processes in order to combat violence⁽⁷⁾.

■ FINAL CONSIDERATIONS

The study showed potentialities and weaknesses in the role of nurses in identifying and coping with IPV. Regarding the identification of strategies, the embracement has been pointed out as a tool to identify the social and/or health needs of pregnant women through attentive and sensitive listening to the suffering caused by violence. On the other hand, in an ambivalent way, the fragile relationship with the service and the professionals, the fear, the shame and the financial and emotional dependence on the aggressor,

appeared as factors that hinder the process of revealing the situation and its consequent identification.

The ways of coping demonstrate the need of nurses to share experiences when receiving women in situations of IPV with the health team, through referrals to specialized services or even through devices such as FHSC. The concern with the referral in a punctual and uncoordinated way with other strategic points of the network indicates an unpreparedness of the professionals in working with such demands. When and how to notify unveil the fears and insecurities of these professionals in BH.

It has been observed that the identification and coping with IPV need specific actions, such as the introduction of a prenatal care protocol that covers the specificity of violence in this vulnerable group, and that they are broad with the nurses and other FHS members, especially regarding the permanent education of the teams, focusing on aspects of the responsibility of each professional and the collective, a space for listening to the insecurities and fears of professionals, as well as intersectoral actions that guarantee compliance with the National Policy for Combating Violence against Women.

Aiming at the organization of nurses' actions in the prenatal care, in the context of coping with violence in BH, there is a strategy to include in the nursing protocol an interview script of the first and/or subsequent appointments, with questions to the pregnant women that would assist the professional in the identification and classification of the risk of exposure to violence.

It is remarkable that this study presented the actions of identification and strategies of the FHS nurses in combating violence, however, there are other actors involved in the healthcare of pregnant women, as other professionals in the health team who should also have their perceptions evaluated in the production of knowledge, opening up, therefore, space for new studies concerning the subject in question. In addition, this is a qualitative research, subject to limitations of this type of study. Although the results do not allow wider generalizations, they are thought to provide an overview of the daily challenges and limitations of the nurses in the context of intimate partner violence.

■ REFERENCES

1. World Health Organization (CH). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013.
2. Oliveira LCQ, Fonseca-Machado MO, Stefanello J, Gomes-Sponholz FA. Intimate partner violence in pregnancy: identification of women victims of their partners. *Rev Gaúcha Enferm.* 2015;36(spe):233-8. doi: <http://dx.doi.org/10.1590/1983-1447.2015.esp.57320>.

3. Jahanfar S, Howard LM, Medley N. Interventions for preventing or reducing domestic violence against pregnant women. *Cochrane Database Syst Rev*. 2014 Nov;12;(11):CD009414. doi: <http://dx.doi.org/10.1002/14651858.CD009414.pub3>.
4. Mauri EM, Nespoli A, Persico G, Zobbi VF. Domestic violence during pregnancy: Midwives' experiences. *Midwifery*. 2015;31(5):498-504. doi: <http://dx.doi.org/10.1016/j.midw.2015.02.002>.
5. Bezerra IMP, Nascimento WL, Machado CA, Machado MFAS. Enfermeiro da Estratégia Saúde da Família frente à violência conjugal: analisando o processo de trabalho em saúde. *Saude Transf Soc*. 2013;3(2):67-74.
6. Presidência da República (BR), Secretaria de Políticas para as Mulheres, Secretaria Nacional de Enfrentamento à Violência contra as Mulheres. Política Nacional de Enfrentamento à Violência contra as Mulheres. Brasília (DF): 2011 [citado 2017 mar 06]. Disponível em: <http://www.spm.gov.br/sobre/publicacoes/publicacoes/2011/politica-nacional>.
7. Salcedo-Barrientos DM, Miura PO, Macedo VD, Egly EY. How do primary health care professionals deal with pregnant women who are victims of domestic violence? *Rev Latino-Am Enfermagem*. 2014 [citado 2015 abr 01];22(3):448-53. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692014000300448.
8. Rodrigues DP, Gomes-Sponholz FA, Stefanelo J, Nakano MAS, Monteiro JCS. Violência do parceiro íntimo contra a gestante: estudo sobre as repercussões nos resultados obstétricos e neonatais. *Rev Esc Enferm USP*. 2014 [citado 2015 abr 01];48(2):206-12. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342014000200206.
9. Fonseca-Machado MO, Alves LC, Freitas PC, Monteiro JCS, Gomes-Sponholz F. Saúde mental da mulher vítima de violência por parceiro íntimo durante a gestação. *Invest Educ Enferm*. 2014 [citado 2015 abr 01];32(2):291-305. Disponível em: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0120-53072014000200012.
10. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14. ed. São Paulo: Hucitec; 2014.
11. Guimarães MC, Pedroza RLS. Violência contra a mulher: problematizando definições teóricas, filosóficas e jurídicas. *Psicol Soc*. 2015;27(2):256-66.
12. Ministério da Saúde (BR). Instituto Sírio-Libanês de Ensino e Pesquisa. Protocolos da Atenção Básica: saúde das mulheres. Brasília (DF): Ministério da Saúde; 2016.
13. Lo Giudice JA. Prenatal screening for intimate partner violence: a qualitative meta-synthesis. *Appl Nurs Res*. 2015 Feb;28(1):2-9.
14. Viellas EF, Gama SG, Carvalho ML, Pinto LW. Factors associated with physical aggression in pregnant women and adverse outcomes for the newborn. *J Pediatr*. 2013;89(1):83-90.
15. Gomes NP, Silveira YM, Diniz NMF, Paixão GPN, Camargo CL, Gomes NR. Identification of violence in the conjugal relationship based on the Family Health Strategy. *Texto Contexto Enferm*. 2013 Sep [cited 2016 Aug 26];22(3):789-96. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072013000300027&lng=en.
16. Porto M, Bucher-Maluschke, JSNF. A permanência de mulheres em situações de violência: considerações de psicólogas. *Psic Teor Pesq*. 2014;30(3):267-76.
17. Leal SMC, Lopes MJM, Gaspar MFM. Representações sociais da violência contra a mulher na perspectiva da enfermagem. *Interface (Botucatu)*. 2011;15(37):409-24.
18. Silva IV, Aquino EML, Pinto ICM. Violência no trabalho em saúde: a experiência de servidores estaduais da saúde no Estado da Bahia, Brasil. *Cad Saúde Pública*. 2014;30(10):2112-22.
19. Porto RTS, Bispo Júnior JP, Lima EC. Violência doméstica e sexual no âmbito da Estratégia de Saúde da Família: atuação profissional e barreiras para o enfrentamento. *Physis*. 2014 [citado 2016 set 24];24(3):787-807. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-73312014000300787&lng=en.
20. Coutinho E, Almeida F, Duarte J, Chaves C, Nelasa P, Amaral O. Factors related to domestic violence in pregnant women. *Procedia Soc Beh Sci*. 2015;171:1280-7.

■ Corresponding author:

Letícia Becker Vieira

E-mail: lebvieira@hotmail.com

Received: 09.29.2016

Approved: 05.08.2017