Estrutura representacional de agentes comunitários sobre atenção à saúde da mulher em situação de violência

Representational structure of community agents on health care for women in a situation of violence

Acogida y humanización en una unidad neonatal ante notícias difíciles: fe y religión

RESUMO

Objetivo: analisar a estrutura representacional de agentes comunitários de saúde sobre a atenção à saúde da mulher em situação de violência doméstica. Método: Estudo descritivo, qualitativo, sustentado pela Teoria das Representações Sociais. Os dados foram coletados de maio a agosto de 2019, com 107 agentes comunitários de saúde a partir das evocações livres e analisados através do Software Ensemble de Programmes Permettant l'analyse dês Evocations (EVOC) versão 2005. Resultados: revelaram um núcleo central caracterizado por atitude negativa com a presença do elemento descaso e atitudes positivas com acolhimento, cuidado e psicólogo. Esses elementos são fortalecidos pela zona de contraste apresentando o acompanhamento, Delegacia Especializada de Atendimento à Mulher (DEAM) e escuta. Nas periferias observou-se atitudes práticas e afetivas desses profissionais de saúde. Conclusão: os agentes comunitários de saúde são profissionais essenciais na atenção a mulher em situação de violência doméstica, através da essência multiprofissional e do desenvolvimento das relações intersetoriais.

DESCRITORES: Agentes comunitários de saúde; Atenção à saúde; Violência a contra mulher; Violência doméstica.

ABSTRACT

Objective: to analyze the representational structure of community health agents on the health care of women in situations of domestic violence. Method: Descriptive, qualitative study, supported by the Theory of Social Representations. Data were collected from May to August 2019, with 107 community health workers from free evocations and analyzed using the Software Ensemble de Programmes Permettant l'analyse des Evocations (EVOC) version 2005. Results: revealed a central nucleus characterized by negative attitude with the presence of the element of neglect and positive attitudes with reception, care and psychologist. These elements are strengthened by the contrast zone presenting the follow-up, Specialized Police Station for Assistance to Women (DEAM) and listening. In the peripheries, practical and affective attitudes of these health professionals were observed. Conclusion: community health agents are essential professionals in the care of women in situations of domestic violence, through the multidisciplinary essence and the development of intersectoral relationships.

DESCRIPTORS: Community health workers; Health care; Violence against women; Domestic violence.

RESUMEN

Objetivo: analizar la estructura representacional de los agentes comunitarios de salud sobre la atención a la salud de las mujeres en situación de violencia doméstica. Método: Estudio descriptivo, cualitativo, sustentado en la Teoría de las Representaciones Sociales. Los datos fueron recolectados de mayo a agosto de 2019, con 107 trabajadores de salud comunitarios a partir de evocaciones libres y analizados utilizando el Software Ensemble de Programs Permettant l'analyse des Evocations (EVOC) versión 2005. Resultados: revelaron un núcleo central caracterizado por actitud negativa con la presencia del elemento de abandono y actitudes positivas con acogida, atención y psicóloga. Estos elementos se ven reforzados por la zona de contraste que presenta el seguimiento, la Comisaría Especializada en Atención a la Mujer (DEAM) y la escucha. En las periferias, se observaron actitudes prácticas y afectivas de estos profesionales de la salud. Conclusión: los agentes comunitarios de salud son profesionales esenciales en el cuidado de las mujeres en situación de violencia doméstica, a través de la esencia multiprofesional y el desarrollo de relaciones intersectoriales.

DESCRIPTORES: Agentes comunitarios de salud; Cuidado de la salud; La violencia contra las mujeres; La violencia doméstica.

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INTRODUCTION

Domestic Violence Against Women (DVAW) is defined as any act or omission of gender violence that results in death, injury, physical, sexual and/or psychological suffering, as well as moral or property damage. Currently, forms of domestic and family violence against women are physical, psychological, sexual, patrimonial and/or moral violence. [1] It is noticeable that this phenomenon impacts women all over the world, affecting various aspects of life, including work, social relationships and health, therefore, over time, it has gained notoriety by consolidating itself as a universal problem with impacts in the economic, social and health areas. [2,3]

According to the World Health Organization (WHO) approximately one in three women worldwide has suffered physical and/or sexual violence by a partner or third parties during her lifetime. It is estimated that 37% of women living in the poorest countries have suffered physical and/or sexual violence from their partner. Oceania, South Asia and Sub-Saharan Africa have the highest DVAW rates, ranging from 33% to 51%. [4]

In Brazil, the high rate of violence against women shows the frightening reality to which they are still subjected. Ranking 5th in the world femicide ranking only in 2018, 1,206 women were victims of homicide, of which 88.8% were partners or ex-partners who were the perpetrators of violence. [5] In 2020, around 75,700 complaints related to domestic and family violence against women were recorded in the Federal Government's human rights reporting channels. [6]

Primary Health Care (PHC) is considered the gateway and communication center between services. Considering the complexity of DVAW, the actions of the Family Health Strategy (FHS) team tend to provide greater resolution of cases in a humanized and holistic way through interdisciplinary approaches. In which it constitutes a field for prevention, identification and approach to women in situations of domestic violence. [7]

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In this way, they are fundamental actors in the link process between women and the FHS team in order to make health promotion, prevention and combat possible in the context of DVAW.

It is known that the study of social representation provides a context of analysis and interpretation that allows understanding the relationships between the individual universe and the social conditions in which social actors interact. [8,9]

Therefore, the need to know the social representations of CHAs on the subject is recognized, aiming to highlight its importance in the care work in the health care of women affected by domestic violence. Therefore, this article aims to analyze the representational structure of community health agents on the health care of women in situations of domestic violence.

METHODS

Descriptive study, of a qualitative nature, based on the structural approach of the Social Representations Theory (SRT).

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Based on this approach, social representations have a structure constituted by a set of congemes that are organized, hierarchical, weighted and maintain relationships among themselves that determine the meaning and place they occupy in the representational system. [10]

The study scenario was 18 Family Health Units (FHU) in a municipality in the interior of Bahia and as participants 107 CHAs. The selection of participants was carried out by convenience, the inclusion criterion was the CHA being in functional activity and having worked at the FHU for more than six months, and the exclusion criterion CHA who was on vacation, paid leave or health treatment.

Data collection took place between May and August 2019 individually, in a reserved room at the USF where the ACS is allocated. The 107 research participants responded to an instrument that contained the technique of free evocation of words and later to the sociodemographic questionnaire. The technique seeks to access the organization and internal structure of the representation of the social object, which in this study had as its inducing stimulus "attention to the health of women in situations of domestic violence". Thus, participants were asked to recall five words that immediately came to mind when listening to the stimulus. The evoked words were recorded by the researcher in the data collection instrument.

The data from the evocations of the inducing term were typed into the Microsoft Word software and a lemmatization process was carried out, forming a dictionary of words.

Thus, the corpus was processed in the software Ensemble de Programs Permettant l'analyse des Évocations (EVOC) version 2005, which makes it possible to organize the terms produced according to the hierarchy underlying the frequency and the mean order of evocation (MOE) and favors the construction of the four-box chart. [11]

The four-box table corresponds to four quadrants and organizes the evoked terms as follows: in the upper and left quadrant are located the most significant terms for the subject and, probably, the central nucleus of the representation (higher frequency and lower MOE); the words located in the upper right quadrant (higher frequency and higher MOE) are the elements of the 1st periphery; in the lower left quadrant (lower frequency and higher MOE) are the elements belonging to the contrast zone; the terms located in the lower right quadrant (lower frequency and higher MOE) constitute the most peripheral elements of the representation or 2nd periphery. [11,12]

This study complies with Resolution No. 466/2012 and No. 510/2016 of the National Health Council, which regulates research involving human beings, was submitted and approved by the Research Ethics Committee of the State University of Southwest Bahia under opinion No. 3,233,780 /2019 and CAAE: 07558718.1.0000.0055

RESULTS

The research population consisted of 107 CHA, of which 103 were female, with a predominance of the age group from 36 to 45 years (48), time working as CHA ranged from 10 to 23 years, and the majority had 20 to 23 years of experience (52) and 23 had completed higher education.

From the application of the technique of free evocation of words, 497 words were evoked by the 107 participants, of which 112 were different words. The result of the 4-box chart is shown in Figure 1, considering the minimum frequency [10], the average frequency 22 and the average order of evocations (OME) of the words 2.90. The distribution of terms in the quadrants allowed the analysis of the representation structure, formed by the central core (CC), peripheral elements (1st and 2nd periphery) and contrast zone.

The structural approach evolved from the theoretical point of view and established itself as the Central Nucleus Theory, which emphasizes that social representations are a double system formed by a central nucleus and a peripheral system. The central core is a subset of the representation, formed by elements that define and organize the representation of the social object. [10,11]

In the evocations, in front of the inducing term "attention to the health of women in situations of domestic violence", a distribution of terms between the plans is observed, however, they assume as possible central elements the cognems reception, care, neglect and psychologist who presented a higher frequency and promptly evoked by the participants. These elements of the central core reflect an attitudinal dimension through positive

Figure 1 - Chart of four boxes formed by the evocations of community health agents against the inducing term "attention to the health of women in situations of domestic violence". Bahia, Brazil, 2019. (n=107)

	MOE < 2,90			MOE ≥ 2,90		
Freq. Mean.		Freq.	M.O.E.		Freq.	M.O.E.
≥ 22	Reception	27	1,70	Support	42	3,35
	Care	40	2,47	Orientation	24	3,33
	Neglect	31	2,45	Protection	22	3,09
	Psychologist	35	2,22	Love		
< 22	Follow-up	15	2,40	Rights	11	3,90
	DEAM	13	1,76	Referrals	14	3,28
	Scout	11	2,18	Inefficient	15	3,33
		11	2,45	Ineficiente	12	3,08

Source: Survey data, 2019.

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aspects with reception and care, and negative aspects such as neglect.

In the upper right quadrant, the elements of support, guidance and protection were presented as elements with high frequency, but that did not present evocation readiness, which made them participate in the 1st periphery. These elements reflect on some factors that, for these professionals, women who experience violence need, enable communication and the relationship in which they are established. In the 2nd periphery, the elements with low and high MOE frequency tend to point out the interface of representation with the practices, reality and reactions of these professionals, highlighting the elements love, rights, referrals and inefficient.

In the lower left quadrant are the elements of the monitoring contrast zone, Specialized Police Station for Assistance to Women (DEAM - Delegacia Especializada de Atendimento à Mulher) and listening that can reinforce or complement the elements of the central nucleus and the 1st periphery.

DISCUSSION

As team members, CHAs perform actions that constitute them as a link between the community and PHC services and therefore have the opportunity to be the first health professionals to identify, prevent and monitor diseases. [2]

In view of this, health care for women in situations of violence can be based on the social representation that these professionals have about the social object. From the analysis of this representation, it is possible to understand and intervene in the care and in the elaboration of prevention interventions. [3]

In this way, the possible elements of the central nucleus point out that the CHAs structure and organize their social thinking through the attitudinal dimension, which, for these professionals, reflects a disregard for the health care of women in situations of violence and that they need care focused on welcoming through a multiprofessional perspective.

It is understood that DVAW culminates in major repercussions on psychological health, which also lead to subtle signs of still hidden violent acts, such as anxiety, introspection, fear, sadness and post-traumatic stress disorder. In this field enters the professional performance of the psychologist, forming the category with the greatest support to deal with complaints involving the mental and emotional health of women in situations of domestic violence, who together with other professionals who are part of the team deal with such a situation, making notifications and referring them to other services. [3]

However, the services present a certain degree of fragility regarding the attendance by these multiprofessional demands, recognized by their unpreparedness, insecurity and fear in dealing with and intervening in the face of this issue, favoring the construction of neglect, as well as the existing failure in the interrelationship of coping with situations of domestic violence and the deficit in public policies aimed at the population in question.

In national territory, although the gradual and continuous construction of legal mechanisms for the recognition and combat of DVAW has been envisaged, in the Brazilian reality, domestic violence is still one of the great challenges for the development of public policies, putting into effect the inefficiency of mechanisms and policies in the country. Most municipalities in the national territory still do not have the necessary equipment for care, prevention and punishment in cases of violence against women and, therefore, a large portion of Brazilian women remain unassisted. [13,14]

The conceptions of a good portion of professionals in the health area about the health care network aimed at women in situations of violence, are related to the integration of a wide range of services of an intersectoral and multiprofessional nature aimed at better coping with this complex phenomenon.

Among these services, the Department of Health, Department of Social Assistance, Basic Health Units (UBS), Psychosocial Care Centers (CAPS), DEAM, Specialized Center for Social Assistance (CREAS), Emergency Care and Shelters stand out. [15] These actions are expressed as a form of reception, identified through the existing bonds between users and professionals involved in care. The use of sensitive, qualified and humanized listening is highlighted, which must be present in a marked way.

Based on the elements of support, guidance and protection, the ACSs represent the social object and its relationship between common sense and their technical-professional knowledge. The experiences of these professionals with women in situations of violence suggest that health care should enable the development of identification and intervention strategies with support.

Health care developed with women who experience or have already experienced violence has the support of empowering them, with the purpose of denaturalizing the violent action of their lives. It is also worth mentioning the monitoring and encouragement related to the aggressor's denunciation, in order to demonstrate that they are not helpless both legally and in the community. In this context, when reporting violence, CHAs demonstrate their commitment to facing these situations, reiterating the fact that teamwork is a means to more easily solve cases of violence experienced by women, understanding its relevance to the construction of interventions. [15]

The Maria da Penha law (11,340/2006) introduces innovations for the protection of women and punishment for aggressors by creating mechanisms to curb domestic and family violence and establish assistance measures ensuring them conditions for the effective exercise of the rights to life, security, health, food, education, culture, housing, access to justice, sport, leisure, work, citizenship, freedom, dignity, respect and family and community coexistence. [1]

The representations of the CHAs on the health care of women in situations of

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domestic violence are strongly anchored in practices that strive for well-being, connecting to what is provided for by law to ensure health promotion, prevention and combating violence, signaling the expanded conception of support for women.

CONCLUSION

The study demonstrates that the social representations of CHAs about the health care of women in situations of violence are based on welcoming, qualified listening and comprehensive care, for the occurrence of qualified assistance through the multiprofessional essence and the development of intersectoral relationships.

In the context of PHC, the care provided is still limited, considering the unpreparedness of professionals to face, prevent and combat, associated with fear and the difficulty of resources for the development of such actions, allowing the aggravation of cases, the difficulty in solving them and unfavorable outcomes for them.

So, the immediate need for congruent attitudes to change the current situation is perceptible, which requires more government initiatives that corroborate so that policies are actually efficient, as well as the investment in professional training aiming at the best preparation of the Family Health teams, in order to be able to lead in the fight against violence in the communities.

It should be noted that, although this study was developed in a single municipality, the data obtained corroborate that there is a significant impact on the daily practices of professionals, especially the CHAs, involved in the care network for women in situations of violence about the need to face challenges, so that the interrelationship occurs with the objective of developing actions to resolve cases of violence in the domestic sphere.

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