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RESEARCH

# VIOLENCE AGAINST WOMEN: CONCEPTIONS OF FAMILY HEALTH STRATEGY PROFESSIONALS ABOUT LISTENING

## *VIOLÊNCIA CONTRA AS MULHERES: CONCEPÇÕES DE PROFISSIONAIS DA ESTRATÉGIA SAÚDE DA FAMÍLIA ACERCA DA ESCUTA*

## *VIOLENCIA CONTRA MUJERES: CONCEPCIONES DE PROFESIONALES DE SALUD DE LA FAMILIA SOBRE LA ESCUCHA*

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## ABSTRACT

The aim of the study was to analyze the conceptions of Family Health professionals about listening to women in situations of violence. This is a qualitative, participant research developed with 38 professionals (nurses, nursing technicians and community health agents). Data were produced in six pedagogical workshops held from November 2015 to January 2016 and were submitted to thematic analysis. Listening was conceived by professionals as a practice that needs to go beyond what the woman reports and requires empathy, sensitivity, serenity and a non-judgmental attitude. It also needs indirect questioning, in a private, confidential and protected environment. The limiting factors indicated by respondents were lack of time, excessive demand on the unit, lack of empathy, unpreparedness on the part of professionals and lack of vigilance of the aggressor. As actions and solutions, the valorization and qualification of listening as a technique and the organization and planning of activities with individual and collective listening were emphasized. We conclude that the Family Health Strategy unit is a service in which listening should be encouraged through the qualification of this practice, aiming at the embracemeng and integral care of women in situations of violence.

**Keywords:** Violence Against Women; Communication; Family Health Strategy.

## RESUMO

*Buscou-se analisar as concepções de profissionais de Estratégia Saúde da Família acerca da escuta às mulheres em situação de violência. Trata-se de pesquisa qualitativa, participante, desenvolvida com 38 profissionais (enfermeiros, técnicos de enfermagem a agentes comunitários de saúde). Os dados foram produzidos em seis oficinas pedagógicas no período de novembro de 2015 a janeiro de 2016. Os dados obtidos foram submetidos à análise temática. A escuta foi concebida pelos profissionais como uma prática que precisa ir além do que a mulher relata, sendo necessárias empatia, sensibilidade, calma e ausência de julgamento. Necessita também de questionamentos indiretos, em ambiente privado, sigiloso e protegido. Os limites indicados foram falta de tempo, demanda excessiva na unidade, ausência de empatia, despreparo do profissional e vigilância do agressor. Como ações e soluções, ressaltam a valorização e qualificação da escuta como técnica e a organização e planejamento de atividades com escuta individual e coletiva. Concluiu-se que a unidade de Estratégia Saúde da Família é um serviço em que a escuta deve ser incentivada a partir da qualificação dessa prática, visando ao acolhimento e integralidade no atendimento às mulheres em situação de violência.*

***Palavras-chave:*** *Violência contra a Mulher; Comunicação; Estratégia Saúde da Família.*

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## RESUMEN

*Se buscó analizar las concepciones de profesionales del programa Estrategia Salud de la Familia acerca de la escucha de las mujeres en situación de violencia. Se trata de una investigación cualitativa, participante, desarrollada con treinta y ocho profesionales (enfermeros, técnicos de enfermería y agentes comunitarios de salud). Los datos fueron producidos en seis talleres pedagógicos entre noviembre de 2015 y enero de 2016. Dichos datos fueron sometidos al análisis temático. La escucha fue concebida por los profesionales como una práctica que debe ir más allá de lo que la mujer relata, debiendo haber también empatía, sensibilidad, calma y ausencia de juicio, así como cuestionamientos indirectos, en ambiente privado, confidencial y protegido. Los límites apuntados fueron falta de tiempo, demanda excesiva en la unidad, ausencia de empatía, falta de preparación del profesional y vigilancia del agresor. Las acciones y soluciones que se realzan son la valorización y calificación de la escucha como técnica y la organización y planificación de actividades con escucha individual y colectiva. Se concluye que la unidad de Estrategia Salud de la Familia es un servicio en que la escucha debe ser incentivada a través de la cualificación de esta práctica, con miras a la acogida y a la integralidad en la atención de las mujeres en situación de violencia.*


***Palabras clave**: Violencia contra las Mujeres; Comunicación; Estrategia Salud de la Familia.*

## INTRODUCTION

Violence against women is a serious problem with global proportions. Its high prevalence was revealed in a study in which Asia presented the highest percentage of this form of violence (37.7%) and the Western Pacific the lowest (24.6%)[1]. Brazil had an index of violence against women of 29.8%.[1]

Violence is present in the social relations between men and women through the social construction of male and female roles. In these relationships, male power is hegemonic, overlapping the female and placing women in a lower position. Differences attributed to the sexes where men are supposedly superior to women generate and perpetuate violence against women.[2]

Although silenced, violence is a concrete and present reality in the lives of women and in the daily routine of health services because these sites assist women who look for care or to mediate the care of their families.[3] When in situation of violence, women are more susceptible to consequences in terms of mental, physical and reproductive health,[1] with possible chronic, vague and repetitive disorders, recurrent urinary infection, pelvic pain, irritable bowel syndrome, depression, anxiety, posttraumatic stress disorder, suicidal ideation and physical injuries that cannot be explained as accidents.[4]

Illnesses resulting from situations of violence lead women to seek health services. The reception with qualified listening is fundamental for the production of care in these situations.[3] Thus, when women express their problems, this needs to be taken into account, as well as the history of violence experienced, so that care can be offered anchored in integrality[5] and in the practice of embracement.[6]

In this context, when health professionals assist women in situations of violence, they should use communication as an instrument of humanization of care.[5] Listening and dialogue with these women permeate caregiving actions of professionals and represent the way through which guidelines on alternatives that can alleviate women's suffering and distress,[7,8] as well as actions to combat violence, are offered.

A study showed that women who were received with due listening started to search less for health services, especially emergency rooms, and use programmed care modalities. In this listening, it is necessary to give credence to the story and stimulate the narrative of women, so that professionals may identify the elements of the history of violence that have the potential of transforming the situation.[5]

In this sense, qualified listening as an embracement strategy to be integrated into clinical and biological care stand out.[7] Listening is necessary to the pursuit of women's empowerment, and not only the relief of pain and treatment of diseases generated as consequences of the violence. To this end, a way of acting with an meaninful interactive dimension is necessary, emphasizing the communication between user/professionals in primary care (PC).[5]

Considering the magnitude of violence against women and listening in the Family Health Strategy (FHS) as a powerful source of production of care, the following guiding question emerged: what are the conceptions of FHS team professionals about listening to women in situations of violence? To answer this question, this study aimed to analyze the conceptions of FHS professionals about listening to women in situations of violence.

## METHOD

This is a qualitative study in which participant research (PR) was adopted as method. PR has the goal of thinking out actions and resolutions for a collective problem. In this type of study, the researcher and the participants find themselves involved with the question, interacting cooperatively in search of solutions. And in this interactive process are articulated research, education and action.[9]

The production of empirical data took place in six pedagogical workshops based on the four phases proposed by Le Boterf[10] for the development of PR. The phases are described below.

### Institutional and methodological assembly of the participatory research

The first phase consisted of two meetings with representatives of the Municipal Health Secretary, the coordination of

the FHS and the Municipal Management Collegiate, to present the study proposal and request a letter of authorization. Subsequently, the project was sent to the Research Ethics Committee and, once approved, a timetable with date, place and time, data production technique and participants of the research were prepared together with the representatives of the Health Department. Thus, six pedagogical workshops were held at the headquarters of the Reference Center for Occupational Health (CEREST) on Fridays in the morning shift.

Nursing professionals (nurses, nursing technicians) and community health agents (CHA) from seven FHS teams were invited to participate in the study. As criteria of inclusion, the following were adopted: being a FHS team professional and being in exercise of their position, as well as working in the unit for more than six months. The exclusion criterion consisted in being absent from work by leave of any nature (pregnancy, sickness, adoption) in the period established for the generation of data. From 65 professionals who worked in the period, 38 accepted to participate in the study, and the number of participants varied in each workshop. It is worth mentioning that the participants were excused from work in order to participate in the workshops.

## Preliminary and provisional study of the area and study population

In the first workshop, an introductory seminar was held with presentation of the research project and delivery of two copies of the Informed Consent Term for each of the participants to sign, one of which remained with them. Subsequently, a sociodemographic questionnaire was distributed to these participants, which was read, completed and returned. Then, a dynamic of presentation was carried out in which the participants formed four groups and they were called "Rose", "100% CHA", "Embracement" and "Facing Violence". Also in this workshop, paper sheets and material were delivered for the preparation of posters based on the inductive questions: "*how do you carry out the listening to women in situations of violence in your daily work?*" and "*At what moment of your daily work do you develop listening?*" The systhesis of the discussion of each group was presented by the rapporteurs of these groups. Twenty-five professionals participated in this workshop.

## Critical analysis of the problems considered to be priorities and which the researchers wanted to study and the objectives of the study

In the second workshop, situations that represent limiting aspects or potentiating aspects of the practice of listening to women in situations of violence were identified and discussed. For this discussion, posters with cutout and collages of magazines were used. The synthesis was presented by the rapporteurs of each group. Thirty-one professionals participated in this workshop.

In the third workshop, the groups discussed the causes, solutions and actions for the limiting factors of the practice of listening to women in situations of violence. The rapporteurs presented the synthesis and the discussions were mediated by the researchers. This workshop was attended by 19 professionals.

In the fourth workshop, the groups met and defined the problem, namely: "*Listening without appreciating the complaint of women in situations of violence*". From this definition, there was the planning of a study workshop on the theme. This workshop was attended by 29 professionals.

## Scheduling and implementing an action plan

In the fifth workshop, the objective was to study and reflect on the practice of listening to women in situations of violence. The groups read articles and discussed case studies guided by the inductive questions: *"How is the situation of violence presented?", "Who should/can question the women about the situation of violence?", "How to make questions to women about violence?", "How can listening be developed and what contents must be approached according to the 'conversation technique'?".* The rapporteurs presented the ideas of each group and these were discussed with the whole large group. This workshop was attended by 29 participants.

In the sixth workshop, a final seminar was held with the purpose of evaluating the knowledge produced in the workshops and the perceived transformations in the practice of listening to women in situations of violence. In order to do so, the following questions were asked: *"What are your reflections about the way of listening to women in situations of violence?", "What are the contributions of the experiences provided by the workshops to the practice of listening?"*. In this workshop participated 37 workers.

The workshops took place from November 2015 to January 2016. The empirical material was submitted to the thematic content analysis technique proposed by Bardin.[11] In this process, the material from the statements of the six workshops and the field diary was recorded, transcribed and printed by the research team, thus composing the *corpus* of analysis.

The team then read the printed transcripts and cut out the expressions that contained the same meaning or sense, separating them into record units. Afterwards, a new reading was made and the record units were classified in meaning units. By means of another rereading, the registration units and meaning units were grouped into three thematic categories: the conceptions of professionals regarding listening to women in situations of vi-

olence, limiting factors in the practice of listening to women in situations of violence, and actions and solutions to face the limiting factors to listening to women in situations of violence. The categories with the record units were discussed in light of the literature found on the theme of the study.

This study complied with the norms of Resolution nº 466 of 2012,[12] which regulates research involving human beings, and the project was approved by the Research Ethics Committee of the Federal University of Santa Maria, under opinion nº 1290,392. To maintain the anonymity of the participants, the participant code P was adopted, followed by a number that indicates the sequence according to the first participation in the pedagogical workshops.

## RESULTS

The group of participants was made up of 38 professionals, of whom 71% were CHAs, 18% were nurses and 11% were nursing technicians. As to the characteristics of the participants, 92% were female, 79% declared to be white skinned, 100% were Brazilian, 60% were Catholic, and with respect to marital status, 74% were married. Regarding schooling, 34% had superior education and 55% had completed high school. With regard to income, 69% received one to two minimum wages. With respect to time of work, 32% had worked for two years and 29% for three years.

### Conceptions of professionals regarding listening to women in situations of violence

For the professionals who participated in this study, listening means hearing to what women say and also observing what is not said, looking for signs of violence at the moment of care. One of the participants also pointed out that it is up to all the professional staff members to perform this role.

> *Listening is hearing* (P1).

> *[...] trying to listen beyond what is happening there, because just when [the woman] puts an end point, it is because something is happening* (P23).

> *We all have to listen. If she was there and looked for your help, you have to hear* (P22).

The practice of listening, according to professionals, should occur without judgment and must be based on secrecy, encouraging the narrative of women in situations of violence. They also stressed the importance of valuing the women's complaints, since the situation of violence can be indicated by a different attitude, not necessarily a verbal account of the situation.

> *[...] while listening, I think we have to be free of prejudice [...] when the woman has this initiative, it takes time for her to confide you this [the situation of violence], that we be able to get rid of prejudice* (P23).

> *[...] we put here to stimulate the narrative and to have secrecy with the woman [...]* (P21).

> *[...] valuing the complaint presented by the woman because, most of the times, they do not arrive at the unit already saying that they suffer violence* (P11).

The professionals believe that the way to stimulate women to report the experience of violence must involve indirect questions, because direct approaches may result in denial of the situation, making it difficult to carry on with the embracement. In this sense, the partipants cited trust and the bond between users and professionals as fundamental elements to make women respond to the questioning.

> *[...] with indirect questions, perhaps addressing other subjects that may induce her to speak there* (P6).

> *[...] when we ask the question directly, sometimes she denies and this denial binds you because if you ask, ""are you suffering violence?"" and she says ""no!", you do not have how to proceed with the care in this sense, you will only work other things [...]* (P11).

> *The trust, the bond created between the actors involved are very strong factors [...] if you do not have it, there will be no opening, no matter how much you ask, she [woman] will not talk* (P1).

As for the environment where the listening takes place, whether in the FHS unit or at home, the professionals mentioned that the environment must guarantee protection, secrecy and security, so that the women speak about the violence experienced.

> *[...] a protected environment for listening both at the outpatient facility and in the home, where she can speak uninterruptedly or make sure other people are not listening [...]* (P11).

> *In a private place, with a guarantee of secrecy, a welcoming atmosphere [...]* (P23).

Professionals also indicated some fundamental characteristics that they need when receiving and listening to women in situations of violence, among them, sensitivity, empathy and serenity.

> *[...] a very strong factor is the sensitivity of the professional [...] to value when it [the situation of violence] is confided ... to have sensitivity and to welcome* (P30).

> *[...] empathy of the person listening [...]* (P13).

> *In listening, you need to be calm, because it is not in the first time you will talk to her [woman] that she will report the problem [...] even if you suspect she suffers violence she will not openly tell you soon; we have to be calm and patient* (P12).

## Limits of the practice of listening to women in situations of violence

According to professionals, one of the limitating factors to listening is the time available to this, once it has to be performed in a time considered short.

> *[...] if listening it ishappens inside the office, we have a few minutes with that woman [...] then we listen, but you there is not enough time for her [woman] to open herself* (P24).

> *[...] more time would be necessary to assist this patient* (P4).

Excessive demand for care in the FHS unit also impairs the practice of listening, especially during the nursing consultation. Thus, nurses recognized that they should dedicate more time to this practice.

> *Another problem is the high demand for care in the units that prevents us from listening [...]a more adequate consultation* (P18).

> *[...] sometimes you are with the woman and you do not have that listening environment [...] the unit is very crowded, people are knocking on the door to ask for other things* (P8).

Lack of empathy on the part of professionals when receiving women in situation of violence was another condition mentioned by the group of professionals as a limiting aspect of listening.

> *Another problem is the professional's lack of empathy towrds the problem of the woman* (P4).

> *Lack of empathy of the professional that is providing assistance [...]* (P14).

Another limitation cited is the lack of preparation of health professionals and the healthcare network for the performance of listening.

> *[...] unpreparedness of professionals, not only health professionals, but the whole network that receives the woman who goes through this kind of situation [violence]* (P25).

> *[...] for listening, the problem is the unpreparedness of the professionals* (P26).

Continuous surveillance of husbands/aggressors both at home and in the consultations in the FHS unit was also emphasized by the professionals of this study as a limiting aspect for the development of listening to women in situations of violence.

> *[...] she is never alone at home, her husband is always close or he is the one who receives the health agent [...] he does not let the woman talk much, is always together in the consultation [...]* (P6).

> *[...] the presence of the aggressor also causes us limitations [...]* (P7).

## Actions and solutions to face the limiting factors to listening to women in situations of violence

With the limitations of listening in mind, the professionals identified actions to overcome them, among which the technical improvement of listening, as well as the promotion of a safe environment for women to expose the violence experienced.

> *[...] valorization and qualification of listening, identification of causes and forms of violence, follow-up and referral* (P15).

> *[...] the actions would be to promote protected environments for women to speak* (P17).

As solutions to the limitations of listening, the organization of the assistance provided by the team of the FHS unit was mentioned, to promote actions that contemplate a collective and individual listening. They also mentioned the importance of bringing to the unit those women with whom they have difficulty developing listening at the home environment. They see the unit as a possible private place to perform a sensitive listening.

*The solution would be a better organization of the services within the team and offer of other activities besides individual consultations and home visits, because they have to go to the outpatient facility every day [...] maybe if there was another activity to which they could be integrated, so that they did not need to use so much these individual consultations* (P11).

*[...] many times, these women who suffer violence do not leave the house, they do not go to the unit, [...] then taking them to the unit to listen to them; this is a solution* (P24).

## DISCUSSION

The professionals of the study have diverse conceptions regarding the listening to women in situation of violence. They said that, in addition to listening to women, what is not verbalized by them should be taken into account. Thus, a qualified listening requires the resort of other senses in order to capture what the subjects want to say and, often, unable to do it.[13]

In this sense, listening transcends hearing the words said by the other; it is necessary to apprehend the meaning that the speaker gives to the narration.[6] It is a difficult action because being and showing availability to the other is fundamental. Still, listening promotes a reflection on the life concepts of the listener, demanding a non-judgmental and prejudiced attitude towards what is said by the user.[14]

The notion that have professionals about listening is close to the conceptual bases of qualified listening presented by the National Humanization Policy of the Unified Health System, and in the embracement as attitude, when they show to believe that all workers should be willing to listen.[6]

Investigating beyond what is said by the women is also a recommendation of the protocol of primary care (PC), considering that few women speak openly about violence. In general, they feel a pain that can not be explained, and in these cases the professionals should suspect the possibility of a situation of violence.[4]

It is important that, when listening is established between professionals and users, this result in a dialogue that investigates acpects beyond physical manifestations. A qualified listening presupposes comprehensive care. In cases of violence against women, listening must be guided by the recognition of women are subjects inserted in a society that has historically determined their subalternity in relation to men and violence as a way to maintain this system.[15]

Professionals mentioned the relevance of developing a non-judgmental and confidential audit. A study corroborates these findings, emphasizing confidentiality, understanding, trust, respect and individual care as necessary elements for qualified listening, aiming at positive results. When listening is made respecting these components, the health needs are verbalized by women and suffering can be alleviated.[16]

Listening is a form of communication. Thus, professionals must not only listen but also interact with users through dialogue.[16] In this perspective, professionals have reported that they should stimulate the narrative of women in situations of violence. For this, it is necessary to ask questions as recommended by the PC[4] protocol, according to which, the professional must use questions to leave the woman at ease to speak, without interruptions and prompt and immediate answers, enabling her to give sense and meaning to the situation she is living. Thus, the guidelines are given so that the woman can strengthen herself as a citizen and may have her desire and decisions respected.[4]

According to the professionals, an important stimulus to the women's narrative about violence is indirect questions. A study reveals that this type of question is used by professionals who respect the expression of what has meaning to the women, because as they feel comfortable and confident, new questions can emerge spontaneously. On the other hand, direct questions are also important, but the best detection strategy is still attentive and interested listening.[5]

Trust and bond between women and professionals are unparalleled factors for women to respond to the questions asked. Study reports that the way professionals should approach the problem depends on the relationship they establishe with the women, in that the more proximity and bond, the greater the possibility of asking direct question. Indirect questions, in turn, are recommended when there is no relationship of bonding and trust, to avoid embarrassement.[5] It is noteworthy that in both direct and indirect questions, health professionals must be calm and ready to listen and deal with the responses given by women without judging them, so as to enable the establishment of a communication channel.

The environment for listening, according to the participants, should guarantee protection and secrecy. Women need and want to talk about violence in places that ensure their safety and privacy, because it is a delicate situation that involvesnot only the wife and children, but also an aggressor, who is usually the husband and/or partner. In the case of the daily routine of services, this environment ahs closed rooms, private meetings, where the woman can not be heard to by other people than the professional who is listening to her.[5] A study shows that in FHS units, the sites considered the more appropriate are the medical, nursing and dentistry offices because they are closed/private.[17]

Among some of the characteristics of the professionals who welcome and listen to women who experience situations of violence are empathy, sensitivity and serenity. In qualified listening, complaints, fears and expectations are heard and the risks and vulnerability of women are identified. Listening is seen

as an encounter in which the act of listening tends to produce a therapeutic effect and knowledge and affections are used to improve the life conditions of the users.[6] In relation to empathy, attention, respect and concern with what the other is, thinks and does is necessary, and to this end, it is necessary to be present in the relationship established through dialogue.[18]

Among the limiting factors to the practice of listening to women who experience situations of violence, the professionals pointed out that the time available for listening is short. A study reveals that it is not possible to determine a pattern; the time necessary for each woman is different and depends on the bond and trust established between the client and the professional that receives them. What can be said is that the time must be more than that usually assigned to nursing appointments and technical procedures.[5]

The high demand for care in the unit, especially for nursing consultations, was another factor mentioned as limiting for the listening to women in situations of violence. Study shows that listening from nurses is compromised by lack of time. In order to carry out an attentive and sensitive listening, besides time, availability of the professional is necessary.[14] Moreover, technical knowledge is needed in the listening. This activity cannot be considered as a simple conversation or just a collection of information about the health needs of the woman and her reality, without considering her protagonist of her life and her suffering.[19]

The nursing consultation is seen as a routine and technical action in the FHS. The limited duration of consultations implies the devaluation of listening. Consultationss are spaces where the demands and problems could be identified, which due to this devaluation, are relegated to the background.[20] Among these problems is violence against women. According to a study, violence is often identified during the nursing consultation.[21]

The lack of empathy on the part of professionals towards the situation of violence experienced by the woman represents another limiting factor for listening. From this point of view, showing empathy means putting oneself in the place of the other. By doing this, the professionals will be able to understand what the woman is feeling/living and they will be able to propose actions that can modify the pain/situation/problem. Empathy produces a sensitive and welcoming care that addresses the needs of those who are cared for more efficiently, since it is based on relational interactions.[18] Qualified listening to women in situations of violence in the FHS when performed with empathy finds resonance in the Policy of Humanization of the SUS.[6]

As for the lack of preparation of professionals for listening to women in situations of violence, a study reveals that professionals are not qualified to act in situations of violence and have little knowledge about the matter, leading to an immobilizing impotence. In general, in these situations the professional ends up developing punctual and medicalizing actions[3] to the detriment of listening and integral care.

In health services, situations in which the professional comes close to unveil the case of violence are frequent, but the lack of ability to address the issue with the woman ends up directing the treatment to a biomedical focus, disregarding the gender-based social problems involved.[6] Empowering professionals to approach women in these situations is closely linked to the qualification of listening, because from it, attitudes of approximation, care and support to deal with violence becomes possible .

The presence of the aggressor as a watcher in the lives of women was considered an obstacle to listening. In this aspect, the social network of women who suffer violence is restricted; their relations are limited to people who do not threaten the power of the aggressor and social isolation of these women predominate. The links, when they exist, are with people who are unable to assist them in their coping with violence.[22]

This attitude of the aggressor makes it difficult to carry out listening both in the individual consultation and in the home visit. Having that said, when the woman is able to access the service, it is important that the professional's listening does not be a merely passive reaction, since part of the users' demands is solved or mitigated when they are understood and respected.[14] Still, listening and dialogue can initiate a project of overcoming traumas based on the empowerment of women.[3] In this sense, efforts are necessary to create conditions to approach the women who suffer violence and to listen to them far from the presence of the aggressor.

Among the actions to overcome the limitations in the development of listening to women in situations of violence identified by professionals, the technical improvement of listening and the provision of a safe environment for the verbal expression of women stood out. Studies reveal that professionals recognize the need for training to deal with the problem more safely and efficiently, and their lack of preparation to receive women in situations of violence is attributed to the lack of approach to the theme in undergraduate and in-service professional qualification.[23-25]

Thus, considering that listening is the basis for embracement, it is recommended that professionals carry out a training that includes the identification of violence, ways in which it is presented, and follow-up of cases in the service network.[5] Moreover, the guarantee of secrecy and privacy is needed[4], and these depend on the environment and the professional's attitude.[17]

Regarding the solutions to the limiting factors, the professionals mentioned the availability of collective and individual listening actions, as well as the possibility of bringing to the FHS unit the women whose cases do not alow the listening at home.

Thus, care management in the attention to violence against women is necessary, for women attend the units with demands that generate the need for a response from the services. Violence

can be identified on an individual basis through listening in nursing, medical and dental consultations.[21] On the other hand, it can be developed in group activities, a tool in which this practice is strongly experienced and promotes autonomy and empowerment of women.[21] Listening to other women who experience violence can awaken the verbalization and the search for help.

Another solution found by the professionals was the active search for women in situations of violence to bring them to the FHS[21] unit and, consequently, develop a quality listening with a view to strengthening these women. When women are in a situation of violence, they report the need to have someone on whom they can trust, who can listen to them and welcome them in health services.[15]

## FINAL CONSIDERATIONS

The conceptions of professionals about listening reveal that this practice must go far beyond what the women report; it is necessary to understand the lines between their speeches, stimulating their narrative. In order that the listening can be considered qualified and sensitive a non-judgmental attitude is needed, as well as safe and confidential environments, through an empathic stance and indirect questions.

Among the limitating factor to the practice of listening, the limited time, high demand in the FHS unit, lack of empathy on the part of professionals, lack of preparation to approach women in situations of violence, and constant vigilance of the aggressor were highlighted.

With this, the need for technically improvement in listening and development in safe environments for the women to expose their situation of violence was verified. The service in the FHS unit must be organized so as to offer actions of individual and collective listening and women whose hearing cannot be done at home must be brought to the unit.

The study presents contributions in the sense that raised evidence of elements to guide a possible training of professionals working in FHS units aiming at the qualification of listening and the guarantee of embracement and integrality in the care of women in situations of violence.

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