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Abusive alcohol consumption by rural women: Primary Health Care

Consumo abusivo de álcool por mulheres rurais: o atendimento na Atenção Primária à Saúde

Consumo abusivo de alcohol por mujeres rurales: La atención en Atención Primaria de Salud

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ABSTRACT

Objective: to analyze care provided, in a Primary Health Care service, to rural women who use alcohol, as perceived by the women. **Methods:** in this exploratory, qualitative, descriptive study, data were obtained between March and August 2018, through interviews of 23 adult women who made abusive use of alcohol and lived in rural areas of a municipality in the Centre-West of Rio Grande do Sul. The data were subjected to Thematic Analysis, guided by the Bioecological Theory of Human Development. **Results:** health approaches focused mostly on medicalization and clinical gynecology, and not to recognize alcohol abuse as a problem that also affects women. **Conclusion:** it is necessary to reorient the health care model for the context of alcohol consumption among rural women, by restructuring health approaches that prioritize the expanded clinic.
Descriptors: Rural Population; Women's health; Alcohol Drinking; Primary Health Care.

RESUMO

Objetivo: analisar o atendimento a usuárias de álcool, em um serviço de Atenção Primária à Saúde, na percepção das mulheres rurais. **Método:** estudo qualitativo, descritivo, exploratório, cujos dados foram obtidos mediante entrevistas realizadas entre março e agosto de 2018, com 23 mulheres adultas em uso abusivo de álcool, moradoras em áreas rurais de um município da região Centro Ocidental do Rio Grande do Sul. Os dados foram submetidos à Análise Temática, balizada pela teoria Bioecológica de Desenvolvimento Humano. **Resultados:** as abordagens em saúde estão majoritariamente centradas na medicalização e na clínica ginecológica, sem reconhecer o consumo abusivo de álcool como um problema que também acometem as mulheres. **Conclusão:** se faz necessário a reorientação do modelo de atenção à saúde no contexto do consumo de álcool entre mulheres rurais, por meio da restruturação de abordagens à saúde que priorizam a clínica ampliada.
Descritores: População Rural; Saúde da Mulher; Consumo de Bebidas Alcoólicas; Atenção Primária à saúde.

RESUMEN

Objetivo: analizar la atención brindada a usuarias de alcohol, en un servicio de Atención Primaria de Salud, en la percepción de las mujeres rurales. **Métodos:** estudio cualitativo, descriptivo, exploratorio, cuyos datos se obtuvieron a través de entrevistas realizadas entre marzo y agosto de 2018, junto a 23 mujeres adultas que hacían un uso abusivo de alcohol, que viven en áreas rurales de un municipio en la región centro occidental de Rio Grande do Sul. Se sometieron los datos a Análisis Temático, fundamentado sobre la Teoría Bioecológica del Desarrollo Humano. **Resultados:** los enfoques de salud se centran, principalmente, en la medicalización y la clínica ginecológica, sin reconocer el consumo abusivo del alcohol como un problema que también afecta a las mujeres. **Conclusión:** es necesario reorientar el modelo de atención de salud en el contexto del consumo de alcohol entre las mujeres rurales, a través de la reestructuración de los enfoques de salud que prioricen la clínica ampliada.
Descriptores: Población Rural; Salud de la Mujer; Consumo de Bebidas Alcohólicas; Atención Primária de Salud.

INTRODUCTION

Primary Health Care (PHC) is based on a set of individual and collective health practices. In Brazil, during the implementation of the Unified Health System (SUS), PHC began to be called Basic Health Care. Currently, PHC is internationally regarded as the basis for a new model centered on the user/citizen. It should become the gateway to an open and problem-solving healthcare system that can ensure access to all health actions[1].

However, a system that is centered on individuals is not enough to guarantee the resolution of problems and comprehensiveness of care. The care offered must also consider the social, environmental, and cultural context of the individual[2]. Specifically, in relation to alcoholism among women who live in rural settings, it is important to develop new strategies to care for these women, so that their individuality and specific needs can be addressed, contributing to the treatment process.

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A study carried out in the state of Paraná analyzed the perception of rural women about the care received in a health service and found that the actions prioritized the spontaneous demand in the Family Health Strategy (ESF), with no actions directed to the scheduled demand, such as therapeutic projects, community actions and health education[3]. This situation shows the different forms of women's health care in society, as these women face double social exclusion and prejudice, both for being women and for being alcoholic.

These data show that, even in health services, professionals find it difficult to provide care for patients with problematic alcohol use. The results of a study show that the actions taken by the professionals are like the care provided for acute alcohol intoxication. Most of the times, their actions are based on a quick assistance, with medication and diagnostic procedures such as blood pressure measurement, blood glucose levels, among others4. Probably due to their values and beliefs, they believe that alcoholic women behave inappropriately, increasing the social stigma and suffering of these people.

Particularly in the rural context, cultural norms do not tolerate alcohol consumption among women, making it difficult for them to seek help due to fear or shame and thus leading to complications. Alcohol abuse has several physical consequences for women, including cardiomyopathy, myopathy, and brain damage. Alcoholic hepatitis almost always progresses to cirrhosis. On the physiological side, women experience more clinical consequences from alcohol use than men, even with a shorter time of use. This is because a woman's body contains less water and more fatty tissue than a man's[4]. Female alcoholism involves a set of meanings and factors related to the female condition, the social space and the situation of being an alcoholic woman. Among these situations, some cultural aspects can be pointed out, such as the lower use of alcohol among women when compared to men, and the exclusion that they experience in the family, in society, and in health services[5].

A search in the national and international literature in January and February 2019 showed that studies focus primarily on the physical complications associated with alcohol use. In this sense, we identify the need for a careful look at the context in which women live, which can affect their use of alcohol. Within the scope of nursing in Rural Primary Care, it is important to identify early signs of alcohol abuse among rural women and to develop educational actions with them and their families.

Even the most recent National Policy for the Comprehensive Health of the Population of the Countryside and Forest, of 2013, does not mention a treatment proposal for alcoholism among women or among rural women, considering the specificities of the rural context. Moreover, the gaps identified in the literature and in the health services justify the need for further study on the health care of these women. Health services are institutions designed to promote health, protect the patient from diseases and illnesses, prevent and limit damages and rehabilitate patients when their physical, psychological, or social capacity is affected, as in the case of alcoholic women.

This study aims to analyze the care provided to users of alcohol in a Primary Health Care center according to the perception of rural women.

THEORETICAL FRAMEWORK

Research guided by the conceptions of the Ecological Systems Theory of Human Development, which allows the analysis of the phenomenon according to four interconnected domains: process-person-context-time. According to the theory, the development process involves the fusion and the dynamic relationship between the individual and the context; the person, as their own individual repertoire of biological, cognitive, emotional, and behavioral characteristics; the context of human development, defined as intertwined levels or systems of ecology (microsystem, mesosystem, exosystem, and macrosystem); and time, involving the multiple dimensions of temporality (ontogenetic time, family time, and historical time)[6].

This theory was chosen due to the need to know the reality of rural women with alcohol abuse issues in its singularity. This context involves their condition of being women who use alcohol and live in a rural setting, and the difficulties inherent to this context, especially in relation to access and bonding in public health services.

METHOD

This is a qualitative, descriptive, exploratory study, developed with 23 adult women who live in the rural area of a city in the central western region of the state of Rio Grande do Sul. This city was chosen because it has large extensions

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of rural areas and is strongly based on family farming. The city has one Health Center (HC) and one Family Health Strategy (ESF) team.

After obtaining institutional approval, the nurse manager of the city's Primary Health Care was contacted to present the research project and explain the objectives. After that, a meeting with the Community Health Workers (CHWs) was scheduled, with the objective of reaching the rural women with alcohol abuse.

The sample was selected by convenience. The participants were indicated by the CHWs and none refused to participate. Data was collected between March and August 2018, at a place and time determined by the participants, who were selected based on the inclusion criteria: being a woman, being over 18 years old, residing in rural areas of the selected city for at least one year, and being or having been a user of alcohol. The exclusion criterion was not living in the area covered by the ESF.

After reading it, the participants signed two copies of the informed consent form, one of which they kept to themselves and the other they gave the interviewer. At the time of the face to face interview the CHW did not participate. The conversation was only between one of the researchers and the participants and it lasted an average of 50 minutes. The material was duly recorded and transcribed.

Semi-structured interviews were carried out with the 23 selected women, using a script with four stages: (1) Characterization of the participants; (2) Women's interaction with alcohol; (3) Women's interaction with family and (4) Women's interaction with health services. In this article, we will address the answers related to the questions of the fourth stage.

After the transcription by the researcher, the data were submitted to thematic analysis[7]. The categorization was based on elements of the Ecological Systems Theory of Human Development[6].

This study was approved by the Research Ethics Committee of the institution.

RESULTS

Characterization of the participants

Among the 23 women interviewed, 11 lived in rural areas, which are spaces where people work with agriculture, livestock or extractivism, and 12 lived in rural settlements, which can be defined as new agricultural production centers, created through government policies, with the objective of reorganizing land use or searching for new social patterns in the organization of the agricultural production process, i.e., they are areas where peasants and rural workers reside.

The women came from different regions of the state of Rio Grande do Sul and were residing in rural areas of the City of Capão do Cipó - RS. Table 1 shows the profile of the study participants.

Variables	N	Variables	N
Age group		**Religion**	
21 to 30	10	Catholic	18
31 to 40	6	Other religions	5
41 to 56	5		
57 or more	2		
Number of children		**Income**	
One child	8	One minimum wage	7
Two children	3	Two minimum wages	1
Three children	7	Three to five minimum wages	2
Four children	3	One minimum wage + Family Grant	10
Eight children	1	Two minimum wages + Family Grant	3
No children	1		
Level of education		**Occupation**	
Incomplete elementary education	17	Work in farming	16
Complete secondary education	3	Work at home	3
Incomplete secondary education	3	Work in dairy	4

TABLE 1: Profile of the study participants. Rio Grande do Sul, RS, Brazil, 2018.

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Invisibility of alcohol dependence among rural women

Four participants (M2, M3, M10 and M9) reported several reasons that led them to seek health services but at no time were they questioned by the professionals on alcohol use, with the exception of one ACS who explained the risks of alcohol use during home visit. On the other hand, the issue of smoking is mentioned.

> *I went to seek health care when I started having high blood pressure and more recently because I had to have a bladder surgery. When I went for the tests, the doctor only asked if I smoked, so I told him I smoked and drank. I told him, I smoke around three packs a day (laughs). But it is true, why would I lie? And drinking, I always drink, every day, I wake up and I drink my beer. (M2)*
>
> *I talked to them [health professionals], but only about the stomach problem, because I was vomiting too much, I would drink one can of beer and feel bad, and I was shaking and had spots on my body. I wanted to do an endoscopy, but I went there for this stomach problem. They didn't suspect that I drank, but the [CHW] knew. He told me to stop drinking, but I didn't listen, because I didn't want to stop drinking. Then they treated me for my stomach. (M3)*
>
> *The professionals ask about cigarettes, yes, but not about drinking. (M10)*
>
> *(...) only once the doctor told me to stop smoking. He didn't talk about drinking. I (laughs) never talked about it. I am ashamed. (M9)*

On the other hand, M4 and M11 report that they sought health services and felt welcomed. These participants recognized the attention received and pointed out the bond developed with the health team.

> *I always go to the health center, but for other things. The team is very good, they always see me, I'm very grateful to them. I tell the agent I want to make an appointment and he always helps, schedules and brings information. But going to the health center for a consultation because of drinking, no! I was ashamed. (M4)*
>
> *I go [to the health center] for the gynecologist. We don't talk about the use of alcohol, but we talk about smoking. They have these signs with information about smoking. They [professionals] talk a lot, whoever wants to try to quit smoking has to come here to the health center, there is a lot of information about this. I really like the service of all of them, I get along well with all of them [professionals], they are very attentive, but they have never talked to me about drinking, this would be good. (M11)*
>
> *When I had a problem in my right breast, both the doctor and the nurse were very attentive, they asked for a mammography and exams, but we did not talk about that other problem of mine [alcohol use]. (M5)*

The health care was described was welcoming, but the speeches reveal that rural women seek PHC almost exclusively for gynecological appointments or prenatal care. On these occasions, in general, they omit their addiction to alcohol. And, at the same time, they are not questioned by the professionals, which leads to the invisibility of alcoholism among rural women.

> *They have never asked me about alcohol, but they ask about the pap smear, if it is up to date, and about the children's vaccines. (M14)*
>
> *The doctor and the nurse don't ask about drinking. They ask other important things about the pap smear and smoking. (M18)*
>
> *They don't ask about drinking, only about smoking. And since I went there a lot because of my pregnancy, the questions were more about prenatal care. They never asked me about drinking, maybe because I was pregnant. (M19)*
>
> *The doctors only ask if the blood pressure is high and if we had the pap smear, just those women's things. Maybe they think that women don't drink (laughs). But the Health Agent asked me once. She is smart. Hey, don't you think you are drinking too much? (laughs). (M23)*
>
> *I always go to the health center for other problems, but I never talked about my beer (laughs), and they also don't ask. (M1)*

Shame and fear as limitations

Participants M4, M3, M9 and M6 mentioned feelings of shame in front of health professionals. This feeling seems to be related to the values that prevail in society and the conflicting fact that they are women, as alcohol use is usually considered a masculine behavior.

> *I didn't seek the health service and it was a mistake. I should have looked for their help. Well, I made a mistake, because I was ashamed to go and talk about drinking and tell them I needed help. It's hard for people to admit that they drink, and for women it's worse than for men. (M4)*
>
> *I didn't go to the Health Center, because here everybody knows everybody, so I was afraid of being judged. For fear I preferred not to go. (M3)*

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> *They never talked about it! I also don't like to talk about it [drinking], but I am very well treated by the nurses, we talk about everything, about women's health, day to day problems. But about my drinking problem, it is better to keep quiet, I am ashamed. (M9)*
>
> *This drinking problem I believe that it is not bothering me, this is a small town, everyone knows each other, I don't talk about it. (M6)*

Some interviewees (M15 and M9) reported feeling ashamed of themselves regarding the use of alcohol due to the embarrassing situations that drinking causes. M22 and M7 reported that they prefer to drink at home, for fear of judgment from family, neighbors and health professionals.

> *I think it is ugly, I think about myself, sometimes when we are at a gathering [party], where there are many friends, we get careless and drink a few too many beers, then I get home and think, oh my God, why did I drink beer like that, what a shame. (M15)*
>
> *I feel shame! Shame, why do we think like that, it is ugly, we should think better, because sometimes we make a fool out of ourselves. (M9)*
>
> *I only drink at home, because if women drink outside they hear a lot from others, so here at home I drink my beer at ease, no one says anything, not my family, not the neighbors, and not the health staff. I am ashamed of myself (silence). (M22)*
>
> *I don't go around drinking, I drink my beers quietly at home so that I don't embarrass myself. (M7)*

In this situation, the woman has the opportunity to hide her alcohol addiction.

DISCUSSION

The results show that the health care provided to rural women is focused on medicalization and gynecological care and does not recognize alcohol abuse as a threat to women's health. It is, therefore, an approach that focuses on complaints or symptoms associated with "socially acceptable" disorders, leaving stigmatized disorders in the background.

In their encounters with health professionals, these women often hide their alcohol dependence and the professional also does not ask about it. A possible explanation is related to the biomedical model of health care, with emphasis on medicalization, meaning that at the time of the consultation alcoholism is not detected as the cause of the disorder [8].

The literature shows different health approaches in PHC as examples that require innovations in work processes, such as welcoming, listening, bonding, and responsibility in the perspective of expanded clinical practice, as well as multiprofessional, interdisciplinary and intersectoral interventions on the social determinants of health[9]. A broader view of alcohol abuse as an issue that is also a social problem and a closer relationship with users can expand the possibilities of intervention with these women, going beyond the prescription of medication [10].

Interpersonal structures are also important[5]. A reciprocal interpersonal relationship is the basic and most important premise for a mutual relationship. Welcoming women with this type of suffering is essential to minimize the consequences of alcoholism[11].

Among the reasons for omitting alcohol consumption, women mentioned feelings of guilt, which result in the use of alcohol only at their homes. Thus, it is possible to infer that the invisibility of alcohol consumption among rural women occurs because in our society, regardless of being male or female, the alcoholic person is seen as weak, irresponsible and incompetent. Probably due to these values, women who abuse alcohol are seen as immoral and their behavior is considered inappropriate, increasing the social stigma and their suffering. However, women experience feelings such as shame, fear and low esteem more easily than men and, therefore, alcoholism among women is a phenomenon that is veiled and little talked about[12].

It is not uncommon for rural women in this study to seek health services with different complaints but hide the problem that really affects them. They tend to seek PHC for the gynecological clinic, prenatal care, or even for pain symptoms, keeping the alcohol problem hidden. This fact confirms the taboos in relation to women and the use of alcohol, both in society in general and, often, also in health services. As exposed by rural women in this study, the issue of alcohol is not addressed by health professionals.

Corroborating the results of other studies, the interventions for problems related to alcohol show that the most frequent approach is through the association with comorbidities or consequences of alcoholism[13]. On the other hand, the literature emphasizes that the majority of PHC users who use alcohol at risk levels do not necessarily have a poor general physical condition[12,13]. In this context, health services, especially the PHC, must be prepared to identify people

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who abuse alcohol so they can prevent social and health consequences in the populations[13]. Therefore, it is important to carry out screenings to identify patterns of alcohol consumption among populations and to develop preventive and harm reduction strategies in relation to drinking[14]. Many of the rural women in this study who consumed alcohol at risk levels were not necessarily addicted or had a poor physical condition (extreme thinness, weakness or others).

This result indicates that the beginning of the alcohol addiction process is not being identified and consequently, not being prevented. This study corroborates the literature that highlights that alcoholism is a process that can take years, marked by a long interface between normal drinking and dependence[15]. Hence the importance of having intervention strategies for individuals with problematic alcohol use in health services, especially in PHC, which is the main gateway for the health system[13].

Socially, female alcoholism is stigmatized. Women are considered immoral and inappropriate, suffer from stigma and seek treatment less often than men, which leads to worse consequences during alcohol use[10]. Therefore, the context has a fundamental role, as it is in it that interactions take place[6].

There are many barriers for rural women with alcohol problems to seek help, starting with the location and the treatment offered. In addition, there are no specialized services for alcoholic women. Furthermore, guilt and taboos are some of the factors that make it difficult to seek treatment[11].

The literature confirms that these labels cause more harm for women, especially when labeling comes from people in their affective relationships. Momentarily, alcoholism seems to be individual; however, at the same time it affects women, it also affects their social and family relationships. Thus, it is clear that women face obstacles within a culture of invisibility[11-14], associated with social and cultural constructions.

Limitations of the study

A limitation of the study was that the research was carried out in one rural region. It can be expanded to other rural areas and different regions to obtain more diversified information, aiming to find more comprehensive health approaches for women with alcohol abuse in the rural environment.

CONCLUSION

The health care provided for rural women with alcohol abuse in the researched context showed the acceptance of professionals. However, there are still approaches that focus on the disease and do not consider the context in which these women are inserted.

Transforming disease-centered approaches into approaches that prioritize an expanded clinical care is a challenge from the perspective of the SUS, since a PHC based on medicalization is still very present in health services. Therefore, it is necessary to reorient the PHC model in the context of alcohol abuse among rural women, restructuring and strengthening services that allow close contact with the population.

The study showed that women seek health services for different needs, such as gynecological complaints, pain, prenatal care, among other reasons, but they hardly ever address the issue of alcohol use, nor are they asked about it. This is because the use of alcohol carries strong social stigma, which becomes an aggravating factor, especially for women.

Thus, it is necessary to have health approaches that include care and tretment actions, as stigma can directly or indirectly influence the results and quality of the care provided and the type of approach chosen by the professional can reinforce the stigma attached to rural women who experience this problem.

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