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ORIGINAL ARTICLE

The Comprehensiveness and Intersectoral Approach of Primary Health Care in the Network for Addressing Violence Against Women

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Highlights:

1. Fragility of Primary Health Care in the face of the issue.
2. Need for strengthening public policies and the service network.
3. Most professionals are unaware of the services that make up the service network.

ABSTRACT

The objective was to analyze the performance of Primary Health Care in caring for women in situations of domestic and family violence in a municipality in the interior of Northeast Brazil. This is a qualitative exploratory-descriptive research involving seven professionals assigned to Primary Health Care (PHC) and Management. The data collection took place between February and March 2022, through semi-structured interviews and a field diary. The results reveal a weakened, disjointed care network without established flows and protocols, where communication between services is limited to individual referrals. Furthermore, professionals are unfamiliar with the majority of services within this network, hindering the provision of comprehensive, intersectoral, and effective care. However, they identify potential strengths, such as recognizing the strategic and important role of Primary Health Care (APS) as the gateway for women experiencing violence.

Keywords: Violence Against Women; National Health Strategies; Primary Health Care; Intersectoral Collaboration; Health Comprehensiveness.

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INTRODUCTION

Domestic and family violence is a serious public health issue worldwide, constituting one of the main aspects of human rights violation as it affects health, physical integrity, and the right to life¹.

In the USA, despite increased enforcement and penalties, the rate of domestic violence remains high, accounting for approximately 8% of total police calls for service. This number may be even higher, as the police are only notified in about half of non-fatal domestic violence incidents².

Data from the Brazilian Forum on Public Security (2021)³ revealed that in Brazil, between March 2020 (the beginning of the COVID-19 pandemic) and December 2021, there were 2,451 feminicides and 100,398 cases of female rape. Despite these alarming numbers, this study indicates that in 2021, there was a 2.4% reduction in the number of feminicides in the country compared to the previous year, meaning 32 fewer victims of femicide than in 2020 when 1,351 women lost their lives. The study⁹ also indicated that this reduction did not occur in all states of the country, with an increase in feminicides between March 2020 and December 2021 in Tocantins, the Federal District, and Rio Grande do Norte. Data from the latter state, RN, reveals that in 2021 compared to the previous year, there was an increase in the number of feminicides by 53.8%³.

However, a study conducted by the Violence Observatory of the Federal University of Rio Grande do Norte (OBVIO/RN)⁴ shows that in RN, between 2011 and 2020, on average, every three days a woman fell victim to violent death in the state. Throughout these years, 1,050 women had their lives prematurely ended due to entirely preventable causes. In this context, Parelhas, a small-sized municipality located in the interior of RN, stands out. Throughout 2021, this municipality witnessed two notable cases of femicide. In one of these cases, a woman was beaten to death by her partner; in the other, her ex-partner killed her in the presence of her children⁵⁻⁶.

Between the years 2016 and 2020, the municipality recorded a total of 229 cases of violence against women reported to the civil police, in addition to 93 notifications in health services. The discrepancy between police data and health sector data may be associated with the municipality experiencing a two-year period without the functioning of the epidemiological center. This center resumed its activities around mid-2020, resulting in the notification of 24 cases throughout the year 2021. The data presented here were obtained by the researcher directly from the institutions (civil police and municipal health department). The civil police data were extracted from the occurrence logbook, and health data were obtained through the SINAN system.

In an analysis regarding the confrontation of this cruel reality from the perspective of public health, Primary Health Care (PHC) is identified as crucial in this process. PHC, given its characteristics and attributes, plays a decisive role in identifying and supporting women in situations of violence. The professionals in these units serve as a link to the community, creating individual and collective spaces that allow for the recognition of instances of violence and the planning of preventive actions⁷⁻⁸.

In this perspective, PHC should operate based on comprehensive care, providing services for health promotion, prevention, and rehabilitation. This ensures that the population, especially those exposed to situations of violence, has access to quality care across various levels of healthcare⁸.

This is a topic of great relevance, but its multifaceted complexity often leads to neglect. Moreover, few studies address the theme from the perspective of intersectorality and comprehensiveness, justifying the conduct of the present study. Its results are essential in shaping and indicating paths for the improvement of public policies for women in situations of violence, a theme that should be prioritized due to the scale of the problem and its social and, especially, health consequences.

In this regard, recognizing violence as a public health issue and the importance of PHC in caring for women subjected to violence, the following question was outlined: How is PHC acting in the care of women in situations of domestic and family violence?

To answer this question, the study aimed to analyze the performance of Primary Health Care in caring for women in situations of domestic and family violence in a municipality in the interior of Northeast Brazil, which recently witnessed cases of femicide.

METHOD

This is an exploratory and descriptive study with a qualitative approach. The research was conducted in two Basic Health Units (UBS) and the Family Health Support Center (NASF) in the municipality of Parelhas/RN. The population of Parelhas is estimated to be 21,499 inhabitants, according to the Brazilian Institute of Geography and Statistics (IBGE) for the year 2022⁹.

Data collection took place between February and March 2022. The study involved the participation of seven professionals of both genders, including 2 nurses, 1 doctor, 2 community health agents (CHAs), 1 psychologist, and 1 primary care coordinator. To ensure participant anonymity, the job title of each professional was used, followed by an ordinal number in the case of CHAs and nurses. Participant selection was intentional, encompassing professionals directly dealing with the issue. The sample size was determined through saturation of meanings.

Professionals who had been working in their positions for a minimum of 6 months were included in the study. Those excluded from participation were professionals in service as interns, volunteers, or on leave/vacation.

Data was collected through semi-structured interviews, utilizing a digital voice recorder. The interviews were scheduled based on the availability of the participants and conducted in private settings at their workplaces, according to their preference. This approach allowed for complete freedom and privacy during the interviews.

The interview script consisted of guiding questions that allowed understanding the respondents' actions based on their statements. The topics covered included: caring for women in situations of violence within the scope of PHC; how care is provided, procedures, notification, and referrals towards the comprehensiveness of care, as well as knowledge and coordination with the Network for Assistance to Women in Situations of Domestic and Family Violence. Finally, challenges, potentials, and strategies in addressing the issue were explored. Subsequently, the interviews were transcribed verbatim using Microsoft Word.

In addition, a field diary was used, enabling the researcher to record perceptions and insights during the interviews. This supplementary method provides a rich source of context and reflections that may contribute to a deeper understanding of the collected data.

For data analysis, the thematic content analysis technique by Bardin¹⁰ was employed, involving three stages: (1) pre-analysis, which involves analyzing and synthesizing each transcribed interview, compiling and organizing them into a text corpus for analysis and synthesis, with additional floating reading; (2) material exploration, constructing three thematic categories derived from empirical material (1. Care provided by PHC to women in situations of violence, 2. Professionals' knowledge about the assistance network, and 3. Challenges and potentials in the perspective of comprehensive care). These categories were further broken down into subcategories (expressed in the 1st column of tables 1, 2, and 3); and (3) information processing and interpretation, drawing inferences from the understanding and critical examination of participants' statements¹⁰.

This research was approved on February 4, 2022, by the Research Ethics Committee of the Onofre Lopes University Hospital (HUOL), under Approval Number: 5.223.789.

RESULTS

The analysis of the healthcare professionals' statements allowed the extraction of significant information regarding the role of PHC in caring for women in situations of violence in the studied municipality. A synthesis of the most meaningful findings has been organized in tables 1, 2, and 3.

Table 1- Synthesis of Thematic Category 1 and its Subcategories related to Care Provided by PHC to Women in Situations of Domestic Violence in Parelhas/RN, 2022.

| Thematic Category 1 - Care Provided by PHC to Women in Situations of Violence | | |
|---|---|--|
| Subcategory of Analysis | Cores of Meaning | Units of Records |
| 1. Case Identification | Woman's Visit to UBS, Active Search, and Home Visits | The woman can directly seek the unit, or an active search can occur, where a health agent, a family member, or someone informs the institution about the domestic violence. Therefore, we can perform an active search, or the patient can seek the unit herself. (doctor) Cases of violence are identified through the home visits of the community health agent, even when women don't come to the unit to talk to us [...]. (Nurse 1) |
| 2. Care and Approach to Women in Situations of Violence | Valuing Reception with Active Listening | [...] so usually when she (the woman) arrives, we provide a reception, active listening, and we explain to them the procedures that should be carried out. (Nurse 1) |
| 3. Recording and Notification of Cases | Recognize the Importance of Notification | Notification is important because when you report, the information that is presented subjectively becomes objective, turning into real data, and from there, public policies become stronger so that we can take action. (Nurse 1) |
| | Difficulties and Fear of Filling out the Notification Form | I didn't have difficulty filling out the notification. I had difficulty facing the things that came afterward [...] unfortunately, I reported, and we had to take it to the police, and I ended up being more of a witness than the aggressor. (CHW 1) In the medical record (registration). Most of them don't want to be notified. And the truth is, most of these people who come to talk to us about violence, their husbands carry weapons, you know? So, they are afraid, and we... the team itself, working in a vulnerable area because we work on the roads, in rural areas, so we also feel fear... the team itself feels vulnerable in the face of the situation, even though we know, even though we know that it is our obligation to report what is reported. (Nurse 1) |
| 4. Interprofessional Collaboration | Limited Collaboration among Professionals within UBS and NASF | We always work in coordination with each other. If we identify any issues, I bring it to (nurse's name), and we quickly discuss it with the doctor. We try to bring this person to the doctor or the nurse, if possible to the psychologist, to the psychiatrist; we work in this way. [...] (CHW 1) Interprofessional collaboration occurs with the nutrition girls, physiotherapy, the girls from the multiprofessional team who work a lot with integrative and complementary practices. So everyone ends up doing this reception, psychology, physiotherapy, nutrition. (Nurse 1) |

| | | |
|--|---|---|
| 5. Service Flow | Lack of Internal and External Flow between Services in the Network. | No, I don't know of any organized flow that supports this (management). No, I don't recall any specific flow. (doctor) |
| 6. Referral from PHC to Other Services | Limited Referrals | We make referrals to CREAS, to CRAS, depending on the need. (CHW 2) If it's a case that the woman wants us to pursue, I refer to CRAS, I write a report. (Nurse 2) |

Table 2- Synthesis of Thematic Category 2 and its Subcategories related to Professionals' Knowledge of the Assistance Network for Women in Situations of Domestic and Family Violence in Parelhas/RN, 2022.

| Thematic Category 2 - Professionals' Knowledge about the Assistance Network | | |
|---|---|--|
| Subcategory of Analysis | Cores of Meaning | Units of Records |
| 1. Assistance Network | Meaning | It would be a set of facilities that are interconnected in a way, in the sense of providing quality care to these people who are in a vulnerable situation. (Nurse 1) The assistance network is a set of professionals and institutions that will offer the assistance needed for the specific case. (Doctor) |
| 2. Composition of the Assistance Network | Limited Knowledge of Professionals about Services | CREAS, CRAS, I mentioned NASF, but I don't know if NASF still exists (doctor). I think the municipality doesn't have it, if it does, I also don't know (Nurse 2). |
| 3. Organization and Integration of this Network | Fragmentation and Lack of Organization | It is not organized... it weakens when the network itself... we cannot have a flow for this, reference and counter-reference, and weakens because we have nowhere to direct women in situations of violence, in the sense that she does not return home. (Nurse 1) |

Table 3- Synthesis of Thematic Category 3 and its Subcategories related to Challenges and Potentials Identified by Professionals Regarding the Care of Women in Situations of Domestic and Family Violence in Parelhas/RN, 2022.

| Thematic Category 3 - Challenges and Potentials from the Perspective of Comprehensive Care | | |
|--|--|---|
| Subcategory of Analysis | Cores of Meaning | Units of Records |
| 1. Challenges in PHC Regarding Women in Situations of Violence | Insecurity for Professionals and Women | The main issue would be the risk because primary health care is in the locality where the aggression occurred, so this team will get involved in it in a certain way [...]. I see that the team is at great risk because they are in the locality where the aggressor lives, resides, exists, in short... does their atrocities. (management) Here in the municipality, we don't have a shelter for a woman who is a victim of aggression. For example, she depends on the help of family, relatives, friends... if someone agrees to take her and so on, but it's quite complex because there is often a threat with third parties involved in the situation, so it's complicated. (doctor) |
| | Specific Actions and Lack of Training | They (the services) do (actions)... not monthly, they choose those specific months that deal with violence against women and do... CRAS does it, CREAS does it, the public prosecutor's office does it. (CHW 1) Offered by management, we didn't have any (training) (Nurse 1) |
| 2. Improvements for Care | Training of Professionals | I think our municipality lacks... I think training courses; I was thinking these days about a training course to inform these professionals [...]. (Psychologist). |

| | | |
|---------------------|---|--|
| 3. Potential of PHC | Qualified Listening and Home Visits | One of the strong points is home visits, another strong point is the role of reception in primary care, and within reception, we can highlight active listening. It is not only inherent to the nursing professional [...] because everyone is a member of the team as a whole. Of course, each professional has their specificity, but I think the woman who seeks the health center wants to be heard, she wants to share the situation. (Nurse 1) |
| | Family Health Strategy (ESF) as a Gateway for Women in Situations of Violence | The potential lies in proximity, the Family Health Strategy is the gateway and maintenance for these cases and various others, not only domestic violence, but typically the first contact a woman can have is with the Family Health Strategy. The health agent has access, usually has direct access to the home, so it is much easier for the Family Health Strategy to see and contact than other agencies. (Doctor) |

DISCUSSION

The care provided by Primary Health Care to women in situations of violence

Through the professionals' statements, it is possible to perceive the importance given to reception, active search, and home visits in caring for these women. Regarding reception, it should be present in all spaces and stages of the care process, not to be confused with screening, being one of the important factors in facing this issue¹¹.

These professionals play a fundamental role in providing care and support to women in situations of violence, as they can detect cases early on, given that these services are located close to the users in that territory¹¹.

The importance of Community Health Workers (ACS) in the home diagnosis of violence cases is also evident. Although home visits are a characteristic activity for all primary care professionals, ACS stands out as they use home visits as a tool for their work, proving to be crucial in this process.

These visits allow for a closer connection between professionals and the real situation of the community, facilitating the assessment of the health status and living conditions of the population. Additionally, they help build connections with individuals, contributing to the planning of actions and enabling the continuity of care¹².

During the care of women in situations of violence, it is essential to report these cases. In this study, it is evident that professionals recognize the need for notification and understand its importance in the face of such cases.

Notification of cases of violence against women attended in health services, whether public or private, has been mandatory since November 24, 2003, through Law No. 10,778. This law established compulsory notification throughout the national territory and was amended in 2019 by Law 13,931, which stipulates that health professionals must record in the patient's medical record and report to the police within 24 hours if there are signs or confirmation of violence against women¹³.

Notification is a way for public services to bring visibility to cases, identifying and acknowledging that the problem and demand exist. It contributes to the planning of public policies and actions to combat this issue.

However, we perceive that despite its mandatory completion and professionals recognizing the importance of recording and notification, it becomes fragile in the face of emerging difficulties, either due to fear of notification or the responsibilities that the professional assumes when completing it.

The results indicated that the professional's direct contact with the entire family, including the aggressor, and the fear of consequences is a barrier that hinders notification. In other words, despite

advancements, underreporting within health services is noticeable, either due to the professionals' fear of potential retaliation and threats from the perpetrators of violence or the lack of security in their workplace¹⁴.

The coordination among professionals from various services and the service network is of utmost importance to ensure the quality of care. This is because such coordination breaks with the uniprofessional culture and the fragmentation of work. Thus, interprofessional collaboration ensures organization and comprehensiveness in care¹⁵⁻¹⁶.

However, it can be observed that the current interprofessional collaboration is still limited to professionals within the UBS and NASF, without mentioning professionals from other services that also form the service network. These results reinforce similar findings, where primary care services provide fragmented, disjointed care lacking integration with other social facilities¹⁷.

Once the importance of interprofessional collaboration is acknowledged, attention is drawn to the existence of flows within institutions. Some interviewees reported the absence of flows, whether internal or external, in the services. Flows provide support to professionals and help guide continuity between different services or even within the same service. However, it is essential to emphasize that these flows should not be rigid, with a single predefined entry point. They should adapt to the service's reality and be developed by multiple agents, without hierarchical assistance¹⁸.

The absence of a flow directly impacts how professionals make decisions and handle the issue. The lack of organization and flow allows each professional to work in the way they deem correct, potentially causing harm to women's access and care. Therefore, without a suitable tool to guide professionals, referrals are also compromised, as professionals start to make them randomly.

In the professionals' statements, it is noticeable that each one refers women to different places according to what they consider most appropriate. Despite mentioning some services, it is evident that they are not yet prepared to refer these women, as they do not visualize the majority of services that make up the service network. This results in a fragile care that does not guarantee the integrality of the service. Similar findings are reported in other studies¹⁹ regarding the fact that professionals, like the service, are not ready to make the necessary referrals for these women because they do not know the services in their entirety, nor is there dialogue between them.

It is essential that primary health care professionals perceive the services, understand how they operate and articulate, as if there is this lack of knowledge, referrals are limited to one or another institution, constituting an ethical flaw. Therefore, it is crucial that professionals, regardless of their area of expertise, are prepared to identify women in situations of violence and know where to refer them, contributing to their empowerment and, consequently, to the confrontation of violence²⁰.

Knowledge of professionals about the care network

The care network is characterized by the implementation of actions and the integration of services from various sectors such as social assistance, justice, public safety, and health. Its objective is to expand and improve the quality of care, identification, and appropriate referral of women in situations of violence in the country, in addition to ensuring comprehensive and humane care¹.

In this sense, networking emerges as a strategy to confront violence, functioning in a coordinated manner and promoting an intersectoral approach²¹. The network of care for women in situations of violence is divided into non-specialized and specialized services. Non-specialized services serve as the entry point for women into the network, including general hospitals, primary care services, common police stations, CRAS (Social Assistance Reference Centers), CREAS (Specialized Reference Centers for Social Assistance), Public Prosecutor's Office, and public defender's offices. The specialized services consist of those with expertise in addressing violence against women¹.

Analyzing the results, it is possible to perceive that professionals have a good understanding of the meaning of a care network, although they demonstrate fragmented knowledge about it, as pointed out earlier. It is crucial that they have the sensitivity to recognize that the phenomenon of violence goes beyond the health sector, and it is imperative to know the other services and understand how they are composed and organized because without coordination, the network does not exist, fragmenting care. This leads to little or no perspective of intersectoral work, and thus, actions develop with limitations.

This superficial knowledge of the network and the lack of a flowchart result in the isolation of the service, causing the woman to be directed to places that do not meet her real needs²².

The result of this study reveals something very concerning in terms of the quality of the service being offered because the fact is that no service can achieve good results by acting in isolation, as it does not have the capacity to provide a satisfactory response to this complex phenomenon.

Unfortunately, there are still many obstacles and difficulties in addressing the issue of violence against women. The lack of coordination or integration, and even the absence of a support location, causes the network not to function or achieve satisfactory results. As a result, these women end up in the same environment as the aggressor, failing to break the cycle of violence.

Therefore, it is crucial to understand that the mere presence of a set of services in a particular region does not necessarily mean that this network functions adequately, even if they make referrals among themselves. It requires organization and integration in terms of the actions carried out. Additionally, professionals need to provide shared assistance, taking into account each unique situation²³.

Challenges and Potentialities in the Perspective of Comprehensive Care

In addition to the previously discussed issues regarding the fragmentation of knowledge and practices in the context of caring for women in situations of violence, one of the main difficulties in addressing this theme is the fear experienced by professionals. This emotion remains prevalent in services, whether it is related to professionals being afraid of facing retaliation from the perpetrator or fearing to expose the victim without being able to ensure her safety.

These professionals encounter numerous obstacles in their attempt to provide comprehensive care to women in situations of violence. In addition to fear and insecurity, there is a persistent sense of frustration and anguish. Often, they cannot see the expected results because the network is not fully prepared and equipped to resolve all cases²⁴.

The absence of specialized services within the network, such as shelters, specialized police stations, temporary shelters, among others, causes professionals to fear that these women are not fully protected. This situation leaves an impression of incompleteness.

The rundown of these services, the compromise in their structuring and functioning, prevents them from expanding and consolidating, which compromises the assistance and effectiveness of the policy to combat violence against women²⁵.

Another challenge that compromises the effectiveness of this service is the realization of actions in a punctual way and the lack of training focused on the subject for professionals. And this lack of qualification can bring many negative consequences because a professional without the necessary skills and preparation to deal with the subject will not offer assistance focusing on the needs of each woman.

The inclusion of professionals in educational processes, especially regarding the cycle of violence against women, is essential, particularly because it is a complex, sociocultural phenomenon

that involves power relations. Thus, continuous education is a way to strengthen and transform health practices, improving service quality and positively impacting the lives of individuals²⁶⁻²⁷.

Despite many criticisms about training programs, these are planned and scheduled practices aimed at consolidating knowledge and skills, allowing professionals to develop their abilities. This type of continuous qualification is necessary to provide a service that is effective. In this sense, observing the historical trajectory, it is possible to perceive that training is part of permanent health education²⁸.

Therefore, even during training and capacity-building sessions, it is possible to exchange experiences, engage in critical reflections, and have rich discussions. This positively reflects on the work process, allowing for the transformation of the services offered.

Having observed the challenges and opportunities for improvement, let's turn our attention to the strengths of Primary Health Care (APS) regarding this issue.

Once again, home visits take on a prominent role, especially those conducted by health agents, as they often reside in the same area they work, gaining a more in-depth understanding of each family's reality and witnessing or detecting this type of violence²⁹.

It can be observed that the proximity of UBS to the community can be seen in two ways: one as a challenging factor, due to professionals fearing retaliation and being so close to the aggressor, and the other as a potentiality, where closeness to the population and the building of bonds allow for the identification and support of these women more promptly.

Thus, the APS is one of the main entry points for the reception of these women¹⁶, and this proximity of the service to the population can establish security and affection, allowing for advancements, especially regarding the promotion, prevention, and recovery of harm to women in situations of violence²⁵.

The field diary notes aligned with the interview results, where the lack of organization and precarious structures in some institutions was noticeable, not ensuring a proper reception and privacy for these women during the service. Additionally, it became clear through the gestures and posture of the professionals, the fear and apprehension in addressing this issue, especially in services located in more vulnerable areas.

The obtained results can contribute to tackling this serious public health issue, highlighting the need for improvements in the quality and access to services for women of different natures. It also encourages the mobilization of institutional, social, and family means, appropriate referrals to the women's protection network in the researched municipality, as well as fostering the woman's connection with the assistance and rights protection network.

The main limitations of this research are inherent to descriptive qualitative studies, especially the fact that the study was conducted at a local level, in some primary care services in only one municipality, which prevents the generalization of its results to other contexts. However, the main intention at this moment is not to generalize the revealed situation but to provoke reflections, contribute to discussions and practices related to the problem, and stimulate similar studies.

FINAL CONSIDERATIONS

Even in the face of the essential role of Primary Health Care (PHC) in addressing the care of women in situations of domestic and family violence, this research revealed that the performance of PHC appeared weakened, highlighting the need for strengthening public policies and the service network for these women, with a focus on intersectorality and comprehensiveness of care.

In this sense, it is observed that PHC professionals are unaware of the majority of services that make up the service network, or identify them in a fragmented manner without the necessary

dialogue, leaving communication practically limited to individual referrals for each woman, thus compromising the path of these women through various services, preventing the cycle of violence from being broken.

Therefore, among many existing possibilities, it is essential to stimulate continuing education and the construction of spaces that allow health professionals to exchange experiences and opinions, conducting self-assessment and reflecting on individual limits and capabilities.

It is hoped that this research contributes to increasing the visibility of violence against women, especially in the context of Primary Health Care (PHC), as this level of care is located close to the users in that territory and plays a central role in the care of the Unified Health System (SUS).

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