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# Violence against women at the Feira De Santana-BA: Networks and joints

Violencia contra mujeres en la Feira De Santana-BA: Redes y juntas

Violência contra a mulher em Feira De Santana-BA: Encaminhamentos e articulação em rede

## ABSTRACT

**Objective:** to describe the perception of the health team regarding the attention to women in situations of violence and the resolution of demands and referrals in the network. **Method:** an exploratory-descriptive study with a qualitative approach with 18 subjects, including health professionals and managers 18 (eighteen) subjects. The collection was carried out through interviews directly in loco with the actors who must manage and execute the preventive actions in Primary Care in the municipality of Feira de Santana-BA. The study respected the ethical precepts of the National Health Council. **Result:** The study revealed that professionals say they do not know how to deal with the situation of violence, do not know the flows for referral and point to the need for greater dissemination of these in order to guarantee women to meet their needs. **Conclusion:** It is of fundamental importance to suggest subjects that include, in their curricula and continuing education programs, the formation and training of aspects related to violence.

**DESCRIPTORS:** Violence; Women; Health Personnel; Family Health Strategy.

## RESUMEN

**Objetivo:** describir la percepción del equipo de salud sobre la atención a las mujeres en situaciones de violencia y la resolución de demandas y derivaciones en la red. **Método:** estudio exploratorio-descriptivo con abordaje cualitativo con 18 sujetos, incluyendo profesionales de la salud y gestores 18 (dieciocho) sujetos. La recolección se realizó a través de entrevistas directamente in loco a los actores que deben gestionar y ejecutar las acciones preventivas en Atención Primaria en el municipio de Feira de Santana-BA. El estudio respetó los preceptos éticos del Consejo Nacional de Salud. **Resultado:** El estudio reveló que los profesionales dicen no saber cómo lidiar con la situación de violencia, desconocen los flujos de derivación y señalan la necesidad de una mayor difusión de estos. para garantizar que las mujeres satisfagan sus necesidades. **Conclusión:** Es de fundamental importancia sugerir materias que incluyan, en sus currículos y programas de educación continua, la formación y capacitación de aspectos relacionados con la violencia.

**DESCRIPTORES:** Violencia; Mujer; Personal de Salud; Estrategia de Salud de La Familia

## RESUMO

**Objetivo:** descrever a percepção da equipe de saúde no que tange à atenção às mulheres em situação de violência a resolutividade das demandas e encaminhamentos em rede. **Método:** estudo de caráter exploratório-descriptivo, de abordagem qualitativa com 18 participantes entre profissionais de saúde e gestores. A coleta foi realizada através de entrevistas diretamente in loco junto aos participantes que devem gerir e executar as ações de prevenção na Atenção Básica do município de Feira de Santana-BA. O estudo respeitou os preceitos éticos do Conselho Nacional de Saúde. **Resultado:** O estudo revelou que os profissionais colocam que não sabem lidar diante da situação de violência, não conhecem os fluxos para encaminhamento e apontam para a necessidade de maior divulgação desses a fim de garantir à mulher o atendimento às suas necessidades. **Conclusão:** É de fundamental importância sugerir disciplinas que contemplem, em seus currículos e programas de educação continuada, a formação e treinamento dos aspectos relacionados com a violência.

**DESCRIPTORES:** Violência; Mulheres; Pessoal de Saúde; Estratégia Saúde da Família.

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**INTRODUCTION**

**V**iolence has a marked presence in the historical construction of humanity in its various moments. It is a complex, multi-causal process, based on the social construction of gender, requiring understanding and knowledge by health professionals for the necessary network referrals.

According to data from the Brazilian Public Security Forum, in the months of March to May 2020 alone, 189 women were murdered in Brazil, which represents an increase, although small, considerable of 2,2% in relation to the previous year.<sup>1</sup> Based on these data from the Mortality Information System (SIM - Sistema de Informação sobre Mortalidade), however, it is not possible to identify which portion corresponds to femicide victims (a gender-based hate crime term, broadly defined as the murder of women, but definitions vary depending on the cultural context), since the database does not provide this information. Although the homicide rate of women increased by 7,5% between 2005 and 2015, when the most recent years are analyzed, there is a gradual improvement, with this indicator

having decreased by 2,8%, between 2010 and 2015, and suffered a drop of 5,3% only in the last year of the series.<sup>2</sup> When analyzing the year 2019 and compared to the year 2018, the cases of femicide had an increase of 7,3%, which represents the death of one every 7 hours.<sup>3</sup>

The data also indicates that, in addition to the mortality rate of black women having increased, the proportion of black women among the total number of women victims of aggression deaths has also increased, from 54,8% in 2005 to 65,3% in 2015. Thus, 65,3% of women murdered in Brazil in the last year were black, in the evidence that the combination of gender inequality and racism is extremely perverse and constitutes a fundamental variable for understanding the lethal violence against women in the country.<sup>2</sup>

According to the World Report of the World Health Organization on Violence, published in 2002, there is a visible human cost and a high cost to the public health network, related to hospitalizations and physical and psychological care; in addition to generating repercussions in the labor market, due to the damage to the victim's professional performance. When treating violence as a health pro-

blem, the sector creates a new internal agenda that is, at the same time, rich, necessary and disturbing, and starts to recognize that this phenomenon is not a disease of the aggressor, nor a disease of the victim, but a serious social problem that causes health problems.<sup>4</sup>

Bandeira and Almeida<sup>5</sup> point to the invisibility of women and violence in the Unified Health System (SUS), a situation that is related to historical and political conditions. In Brazil, the services most sought by women in situations of violence are the police/police station and when they present health demands, they seek emergency care units (UPAS). In this sense, the integration of the network ends up taking place only in these two services, seeking to solve crimes when in the legal/police services and medicalization when in the health unit.<sup>5-6</sup>

The health team's knowledge of violence and network referrals may enable the planning of interventions that are more appropriate to the needs of population groups in situations of greater vulnerability. Therefore, starting from the idea that primary care is the gateway to health services, having units with the potential to welcome, serve and refer women, the

problem of this master's research arises: What is the perception of the health team in what regards the resolution of demands and referrals in the network to care for women in situations of violence?

The general objective of the research was to describe the perception of the health team regarding the attention to women in situations of violence and the resolution of demands and referrals in the network.

This study has relevance of an academic, social and professional nature, as it promotes reflections on public gender policies. A significant aspect is the possibility of contributing to the academic community by promoting discussions about the theme studied, since it presents data from a local case study, reflecting the reality experienced by primary care professionals in the municipality of Feira de Santana-BA, a place that has a network of attention to violence against women. With regard to social relevance, this work may contribute to identify and disseminate which preventive actions are provided to the community that seeks assistance in primary health units and, thus, strengthen the care network.

## METHOD

The study was of an exploratory and descriptive character that allows the researcher to increase his experience around a certain problem, as well as, to seek to base a discussion in the area of public policies, focused on Violence against Women in the prevention actions of the PHC units.<sup>7</sup>

Qualitative methodology was used with semi-structured interviews, which, according to Minayo<sup>8</sup>, it is characterized by answering very particular questions, dealing with a reality that cannot or should not be quantified, working, for example, with the universe of meanings, motives, aspirations, beliefs, values and attitudes.

To achieve the objective of the study, this qualitative research traced a methodological path seeking to combine some pertinent steps and investigative techni-

ques, namely: bibliographic survey, documentary research and semi-structured interviews with 18 (eighteen) participants directly involved with the object in question: 01 (one) doctor, 05 (five) nurses, 03 (three) nursing technicians, 07 (seven) community workers, 02 (two) managers.

The field research was carried out between 9/17/2018 to 10/9/2018, seeking information directly in loco with the participants who must manage and execute preventive actions in Primary Care in the municipality of Feira de Santana-BA. The criterion used to choose the territorial area where the research was carried out was the level of general violence in the municipality, and the levels in its territories, according to data from the Secretary of Public Security.<sup>9</sup> Two Family Health Units (FHU) were selected in more violent neighborhoods and two Basic Health Units (UBS), in neighborhoods with lower levels of violence. In the two most violent neighborhoods (Conceição and Campo Limpo) research was carried out at USF Videiras and USF Campo Limpo IV; and in the two less violent neighborhoods (Serraria Brasil and Jardim Acácia) the UBS Serraria Brasil and Dispensário Santana were used for comparison purposes in primary care units (AB). The choice for two territories with higher and lower levels of violence was made in order to understand that there is differentiation in the types of preventive actions carried out and their possible incidence in terms of effectiveness in reducing violence against women.

Regarding the approach to the interviews, the participants were initially informed about the theme and objective of the research, and those who were willing to participate (a random sample from the multidisciplinary team in the units mentioned above) signed a free and informed consent form, which ensured the confidentiality of the information provided to the participants, which were used exclusively for the purposes of this study, approved by the Research Ethics Committee of the Federal University of Recôncavo da Bahia (No. 3,039,438),

respecting Resolution No. 466/2012 of the National Council of Health - Ministry of Health.

Regarding the data analysis method, the analysis of the narratives collected in the interviews was carried out, being associated with the references of authors discussed in the literature review of this study.

## RESULTS

The statements reveal that, although there are places for referral of women experiencing violence, it is a disjointed network that needs more training, so that everyone can make the referrals in the best way and that in the units of demand open to the lack of bond, hinders the assistance and recognition of the condition. Following is the speech of the professionals who address these referrals:

*There is a network of care for women experiencing violence, however, it is not articulated. This network is made up of health services, legal, police and social assistance sectors, such as the Women's Reference Center, Specialized Police Station for Women, CRAS, CREAS and health services such as polyclinics, UPAS and hospitals. (P1)*

*I try to talk to the woman at the time of the consultation. This moment is fundamental for the reception and referral to the common police station. As a rule, I take care of visible injuries and refer them to complain. I am unaware of the flows for other referrals. (P2)*

*For attending here at UBS, which is spontaneous demand, there is not much bond, the calls are fast. (P3)*

*Here at USF, we include as activities to prevent violence against women: conversation circles, workshops, group dynamics, lectures and home visits. (P4)*

*Units that have a higher incidence of violent cases include conversation circles on the topic. (P5)*

*In meetings aimed at discussing*

*the theme of violence, women express their particular desires, fears and situations. It is enriching, they even suggest themes for the next meetings. (P6)*

*I only take care of the wounds and forward the psychological demands to units with psychologists in the NASF. (P7)*

*I do not know where to refer women who are victims of violence, the municipality does not disclose such flows. (P8)*

*In fact, I attribute the lack of knowledge about the flows to the lack of training and because in college I did not have a discipline that addressed this topic. (P9)*

*I don't understand the referral flows very much, so I pass it on to the colleague to resolve. (P10)*

*There is no feedback when we refer cases to the care network. The counter reference is never filled. We know only of the woman's account. (P11)*

*The care network for women experiencing violence is not articulated. So when I need to make a referral, I call to try to schedule something. (P12)*

*I realize that the consultation the woman is afraid to expose and say that she was raped, especially here in the UBS that has no ties. (P13)*

*Here I get many cases, but I only perceive it as violence when the injury is visible. (P14)*

*The Secretariat should schedule training on referral sites and make the network more articulate. (P15)*

*I never filled out a reference form, because colleagues do not give back with the counter reference, so I do what I can in order to care. (P16)*

*I confess that when I have a case of a woman experiencing violence, I move on to the coordination to resolve it. (P17)*

*We who work in PSF are in a strategic position to resolve family conflicts and learn about cases of violence. (P18)*

## DISCUSSION

### Routing and network articulation

Respondents report that the specialized services that make up the support and care network for victims of violence against women, exist in the municipality as already mentioned. This network is made up of health services, legal, police and social assistance sectors, such as the Women's Reference Center, the Specialized Police Station for Women (DEAM - Delegacia Especializada no Atendimento à Mulher), the Social Assistance Reference Center (CRAS - Centro de Referência da Assistência Social), Specialized Reference Center for Social Assistance (CREAS - Centro de Referência Especializado de Assistência Social) and health services such as polyclinics, UPAS and hospitals. Despite the professionals claiming to know the existence of certain services that assist victims of violence, they reported not knowing the existence of an intersectoral network to care for victims. It is observed that the attitude of professionals to guide the search for services outside the health area occurs informally, out of context and does not constitute an institutional routine based on the articulation of the health sector with other segments.

Knowing the various services that make up the network of care and prevention of violence is an important step for intersectoral articulation. However, it is necessary to modify the professionals' work process, as they have shown difficulties in functioning, thinking and acting in a network. Professional attitudes are still marked by isolated and disjointed work.

When asking the medical professional about his referrals, he placed, quite calmly, that he tries to dialogue with the victim in the consultation when the problem has visibility, or in the cases of those who feel comfortable talking about their fears, before the violence set up, thinking about prevention issues. He points out that, in all cases, even when the patient tries to omit, he is clear in the behavior of the victims, in the way of positioning

himself before the professional. It also adds in the speech that in the AB at the time of the consultation, the function is reception and referral directly to the common police station. When questioning whether he is looking for DEAM, he concludes that he is not, in fact he says that he is so indignant that he directs the patient to look for any police station.

Thus, this professional does not differentiate the ordinary police to a specialized police station, in which treatment will be differentiated, and is unaware of the municipality's coping network. Therefore, it leads to understanding the disarticulation that exists in the network, in view of the inadequate referral that the doctor wishes to give.

Rodríguez-Bolaños, Márquez-Serrano and Kageyama-Escobar 10 highlight other barriers that prevent the identification and referral of cases of violence. For these authors, doctors fear for their personal safety, do not want to be involved in legal issues, do not know places to refer women and do not believe that the health service is an adequate place to treat cases of violence. In addition, professionals tend to suspect that women are really speaking the truth and believe that their attitudes may not contribute to solving the problem. There are also institutional barriers, considering that the institution does not offer support to the service, nor private spaces to carry out the consultation, not to mention the lack of professional training. It is also noteworthy that the established standards of care are not being fully complied with, which include identification, valuing the risk, strengthening, guidance, reference and registration.

In the Unified Health System (SUS), doctor-patient interactions were also shown to be useful for understanding the phenomenon investigated. The perception of doctors about the violence perpetrated by an intimate partner is influenced by the social condition of the woman, who is strongly disqualified. Especially in the UBS in more violent neighborhoods, calls are faster because they are consultations with a specialist.

The interviewed professionals affirm that in the primary health care units they periodically carry out the following activities to prevent violence against women: conversation circles, workshops, group dynamics, lectures, in addition to strengthening the Community Health Agents (CHA) in the actions carried out during home visits.

According to nurses at the USF and UBS with the highest number of cases of violence, fortnightly rounds of conversations take place, group dynamics with support from educational institutions that carry out the practice of the nursing course, a time when information exchange occurs with the aim provoke group reflection and provoke discussions to be aware of the problem and to know how to face it. The situations are different and the prevention and coping measures must be creative and articulate.

Conversation circles enable dialogic encounters, creating possibilities for the production and reframing of meaning - knowledge - about the experiences of the participants. Its choice is based on the horizontalization of power relations. The subjects that compose them are dialectically involved as critical and reflective historical and social actors in the face of reality. Therefore, in the circle, speech is understood as an expression of ways of life. The wheels are more than the physical (circular) disposition of the participants and much more than a cost-benefit ratio for working with groups. They are an ethical-political stance in relation to the production of knowledge and social transformation, taking effect from the negotiations between subjects. The conversation wheel space intends to build new possibilities that open up when thinking, in a continuous movement of perceiving - reflecting - acting - modifying, in which participants can recognize themselves as drivers of their action and their own possibility of "being more".

The CHAs and nurses from the less violent units say that a group of women was formed in the community who discuss various topics, including violence

against women, and hold monthly meetings. During the meetings, women express their particular anxieties, fears and situations. When the meetings are held, the professionals place the theme of violence against women on the coping network and request suggestions for topics for other meetings.

In the Family Health Program (PSF - Programa Saúde da Família), teams are in a strategically favorable position to intervene in family interpersonal relationships. The approach of the family and the strengthening of the bonds between health professionals and the population served are important strategies that can contribute to the prevention, identification and intervention in situations of family violence, allowing to deepen the relationships, making possible the orientation of conflicts for less destructive, healthier ways of coping. In this perspective, family health professionals become actors of the greatest significance for the development of violence prevention actions.

It is important to point out that even from the perspective of the PSF in prevention actions, a logic of symptomatology assistance still prevails, focused on the treatment of physical injuries and the sequelae of violent acts. The existence of structural and cyclical problems in the health sector also ends up affecting the performance of professionals. In this sense, the following stand out: the overload of health professionals; the inadequacy of the units' physical spaces to assist victims; and the isolation of the sector in the face of difficulties in articulating for an intersectoral approach to the problem.<sup>11</sup> Also highlighted are issues related to the fear of reprisals, lack of time and the feeling of powerlessness among professionals who contribute to superficial, fragmented and unresolved action.<sup>12</sup>

Family health professionals have great potential for the detection, approach and qualified follow-up of victims, as they deal daily with situations of domestic and sexual violence and experience in practice the difficulties inherent in the process of assistance and monitoring of cases.<sup>13</sup>

The professionals' ignorance of the existence of care networks for victims of violence was also observed by Moreira and collaborators<sup>14</sup>, which highlight the possibility that disinformation may cause losses in multiprofessional and intersectoral support for victims. This position is corroborated by Santos and Vieira<sup>15</sup>, when they affirm that the lack of knowledge of the existing service networks constitutes a factor of great limitation for the integral approach to health problems.

It was also evident in the professionals' discourse that referrals would be a way to get rid of the problem, as they do not know how to deal with or do not want to get involved in the situation. According to the impression in the Enfa/USF1 speech, she usually directs to cover herself and register in medical records, but she often does not have the case reference, as occurs in the notification forms.

The lack of feedback from the referenced cases does not guarantee a well-defined flow and articulation. Thus, care is fragmented, favoring the cycle of violence. On the part of the entire team with regard to assistance in the units, the visit of the CHA, on the contrary, would represent only a 'transfer' of responsibility to sectors and professionals who would be better prepared for this type of assistance.

Borsoi, Brandão and Cavalcanti<sup>16</sup> note that the identification of a case of domestic violence should only be the beginning of a process that seeks to support victims in overcoming the problem. In this context, they warn that referrals should not be a reference out of service and subsequent loss of control over the consequences of their action, but a strategy designed to involve different segments in the articulation to solve the problem. Given the perspective of comprehensive care, it is essential that referrals are made in an articulated manner with the destination sector and that the user's bond is maintained in both services so that the meeting points are strengthened, and the articulation that must exist on the network.

There is still a knowledge gap in relation to the aggressor's approach and treatment.<sup>17</sup> As highlighted by Lima, Büchele and Clímaco<sup>18</sup>, this issue is not limited to the scarcity of publications, but above all to the diminished presence of services that provide assistance and follow-up to men who commit violence. The aggressor's approach beyond repression and punishment is not a public policy in Brazil and Latin American countries. Thus, the involvement of men in the prevention, care and confrontation of domestic violence remains incipient, which can denote limitations in addressing the problem.

In a perspective of networking, in an interdisciplinary and intersectoral way, broad sectors of society should be involved, such as Rights Councils, Women's Police Station, Non-governmental Organization (NGOs), hospitals, health units, schools, women's centers of reference, women's movements, among others. These resistance movements have the character of denunciation, but also of claim, implying the emergence of new social subjects and political scenarios, characterized by transversality in the struggle for demands for rights.

Thus, it is evident the need for investments in permanent education as a strategy to raise awareness and qualify professionals in the family health strategy to face violence against women. Continuing education, based on reflective practice and the socialization/integration of different types of knowledge, contributes to improving professional performance, developing new skills and building new knowledge. It proposes to train critical-reflective actors who evaluate and modify their practice and are in constant search for new knowledge.<sup>19</sup> However, permanent education only becomes operational when there is an institutional change in the practices of education and professional training.<sup>19</sup> To Santos and Santos<sup>20</sup>, the development of Health Education actions based on liberating pedagogical trends has demonstrated important results for the transformation

of praxis. In this sense, there is a need to overcome the actions of sporadic training, which generate localized changes, individual and temporary, with a natural inability to cause profound changes in the professionals' actions.

**According to this program of women of peace, victims of violence start receiving a grant from the federal government and carry out actions to prevent violence.**

Through the field research and the impressions of the reports of professionals and managers in the confrontation of violence against women and based on the literature, among the challenges exposed is the materialization of the assumptions of networking. Like the horizontality and the confrontation of the existing power relations between different policies and sectors. As possibilities stand out the articulation of professionals from different areas of knowledge, in meeting the complexity of the demands brought by women in situations of violence against women.

It is also worth mentioning here that some programs have been developed within the scope of other sectoral policies in order to prevent violence against women. An example of this is the Women of Peace Program, which benefits women belonging to the kinship and social networks of young people, a territorial focus of the National Public Security with

Citizenship Program (PRONASCI), developed by the Ministry of Justice since 2007. The program marks an unprecedented initiative to tackle crime in the country, articulates security policies with social actions; prioritizes prevention and seeks to reach the causes that lead to violence, without giving up social order and public security strategies.<sup>21</sup>

According to this program of women of peace, victims of violence start receiving a grant from the federal government and carry out actions to prevent violence. The follow-up and monitoring of the program aims to ensure the effectiveness and transparency in the implementation of Women of Peace, ensuring that the benefits are effectively passed on to women.

According to Grossi and collaborators<sup>22</sup>, another PRONASCI initiative was to train women for the labor market and ways of generating income. A group of women formed a cooperative (knitwear) and made uniforms for the school system. Another group started to produce jewelry for sale at fairs in the municipality and there was also training for rural women through agreements with the Technical Assistance and Rural Extension Company (EMATER).

## CONCLUSION

The study revealed that the professionals do not know how to deal with the situation of violence, do not know the flows for referral and point to the need for greater dissemination of these in order to guarantee the woman the attendance to her needs. According to the survey, the lack of training is the reality of health professionals who are not prepared to offer care that has an effective impact on the victims' health. For this, it is necessary to support the various services of attention: legal, police, social, generation and income, housing and health. It is also necessary to undertake studies for the construction of knowledge and practices of interdisciplinary providers, so that they can serve in the different areas of action, filling all the

gaps of victims in the legal, psychological and health spheres.

It is believed that the results of this

study may contribute to a greater visibility of the issues that hinder the process of care for women in situations of domes-

tic violence, offering subsidies to think about actions and strategies for preventing and coping with the phenomenon. ■

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