REVISTA DA ESCOLA DE ENFERMAGEM DA USP
JOURNAL OF SCHOOL OF NURSING · UNIVERSITY OF SÃO PAULO

ORIGINAL ARTICLE

DOI: http://dx.doi.org/10.1590/S1980-220X2016013603207

# Health care for women in situations of violence: discoordination of network professionals*

## Atenção à saúde de mulheres em situação de violência: desarticulação dos profissionais em rede

## Atención a la salud de mujeres en situación de violencia: desarticulación de los profesionales en red

**Jaqueline Arboit[1], Stela Maris de Mello Padoin[1], Letícia Becker Vieira[2], Cristiane Cardoso de Paula[1], Marta Cocco da Costa[3], Laura Ferreira Cortes[1]**

**How to cite this article:**
Arboit J, Padoin SMM, Vieira LB, Paula CC, Costa MC, Cortes LF. Health care for women in situations of violence: discoordination of network professionals. Rev Esc Enferm USP. 2017;51:e03207. DOI: http://dx.doi.org/10.1590/S1980-220X2016013603207

## ABSTRACT

**Objective:** To learn the conceptions and actions of health professionals on the care network for women in situations of violence. **Method:** A qualitative, descriptive, exploratory study was conducted between April and July 2015 with the participation of 21 health professionals from four primary health care teams in a city of the central region of the state of Rio Grande do Sul. Data were collected by means of individual semi-structured interviews. Content analysis was used for data systematization. **Results:** Health professionals recognized the importance of the health care network for coping with the problem of violence against women. However, their conceptions and actions were limited by the discoordination or absence of integration among professionals and services of the care network. **Conclusion:** The conceptions and actions of health professionals contribute to the discoordination among the services. It is necessary to reflect on the daily practices of care for women in situations of violence.

## DESCRIPTORS

Violence against Women; Health Personnel; Women's Health; Health Care.

* Extracted from the dissertation "Concepções e ações de profissionais da saúde para atenção em rede às mulheres em situação de violência", Programa de Pós-Graduação em Enfermagem, Universidade Federal de Santa Maria, 2016.

[1] Universidade Federal de Santa Maria, Programa de Pós-Graduação em Enfermagem, Santa Maria, RS, Brazil.

[2] Universidade Federal do Rio Grande do Sul, Escola de Enfermagem, Porto Alegre, RS, Brazil.

[3] Universidade Federal de Santa Maria, Departamento de Ciências da Saúde, Campus Palmeira das Missões, Palmeira das Missões, RS, Brazil.

**Corresponding author:**
Jaqueline Arboit
Av. Roraima, s/n, prédio 26, sala 1336,
Cidade Universitária, Bairro Camobi
CEP 97105-900 - Santa Maria, RS, Brazil
jaqueline.arboit@hotmail.com

Received: 19/04/2016
Approved: 13/12/2016

## INTRODUCTION

Violence against women is globally recognized as a form of violation of human rights, impacting on the rights to life, health, and physical and mental integrity[1]. According to the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women – Convention of Belém do Pará, this problem is related to any act or conduct based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere[2].

As a globally prevalent health problem, coping and prevention of violence against women requires dialogue among various sectors of society. Thus, it is necessary to invest in political, social, and economic actions promoted by government, institutions that provide care for these women, and society as a whole[1]. In this perspective, the health sector has to be part of the multisectoral response[1,3], as alone it cannot meet the needs of women in situations of violence given the complexity of this problem.

Therefore, it is essential that health care for these women takes place within the scope of the Health Care Network. It is defined as "a network of organizations that provide or make arrangements to offer equitable and comprehensive health services to a defined population"[4].

In the health sector, particularly in the scope of Primary Health Care (PHC), professionals are in a strategic position to provide care for women in situations of violence[3,5], showing the importance of supporting, listening, and providing follow-up[6].

Therefore, when PHC is inserted in the health care networks it reorients the system rather than being just a level of it[7]. Its role in this network includes constituting the center of communication, ordering, and reorganizing flows and counterflows of users, products, and information throughout all of its points in order to promote qualified, comprehensive care that meets the needs of users[4], particularly those for women in situations of violence.

Considering the importance of further research on this theme, the object of the present study consists in the conceptions and actions of PHC professionals of the network care for women in situations of violence. The research was guided by the presupposition that the work of PHC professionals represents a key element in the detection of situations of violence, promotion of health and well-being of women, and prevention of problems resulting from the experienced violence and potential future occurrences[5-6,8].

In light of the above, the objective of this study was to learn the conceptions and actions of health professionals on the care network for women in situations of violence.

## METHOD

A qualitative, descriptive, exploratory study was developed between April and July 2015 with four teams, being a traditional health team, called Basic Health Unit (BHU), and three teams from the Family Health Strategy (FHS) in a city of the central region of the state of Rio Grande do Sul. In the context of this study, there is no structured health network to provide care for women in situations of violence. There are reference services to provide care for women in situations of sexual violence, emergency units for life-threatening situations, and social work reference centers, but they develop their services without any communication with each other.

The participants of this study consisted of 21 health professionals from the BHU and FHS teams. The inclusion criterion was being a health professional working in these places. Those who were absent from work by virtue of any type of leave (pregnancy, disease, adoption) within the study period were excluded.

Considering that the participants consisted predominantly of women and that violence against women is a problem anchored in the unequal construction of gender identity, the researchers chose to refer to participants as women.

Access to the participants occurred by contacting the coordinator of each unit included in the study, through which a list of the professionals that could participate was built. Semi-structured interviews were individually conducted at previously scheduled times according to the availability of each participant. The interviews were conducted at the service in which they worked, in a space that ensured privacy. The average length of the interviews was 35 minutes; they were recorded in MP3 format with the consent of the participants to allow the full record of the speeches and ensure an authentic material for analysis. The recordings were subsequently transcribed in full with the use of the Microsoft Word software.

A script divided into two parts was designed for the interview. The first part relates to sociodemographic and training data of the health professionals, containing closed-ended questions; the second part consists of open-ended questions related to the network conceptions and actions developed by these professionals for women in situations of violence. The empirical focus was delimited by data saturation, used to establish or close the final number of participants in the study, ceasing the inclusion of new participants when the obtained data started to present, in the evaluation of the researcher, a certain level of recurrence, making it irrelevant to continue the data collection process[9].

This study was evaluated and approved by the Human Research Ethics Committee of the Universidade Federal de Santa Maria (UFSM) under CAEE protocol no. 39432114.1.0000.5346 and opinion no. 928.490. It complied with Resolution 466/2012, respecting all ethical principles of autonomy, beneficence, nonmaleficence, and justice.

Prior to the data collection procedure, the participants received explanations on the research and signed two copies of a free and informed consent form; a copy for the participant and another for the researcher. The participants were identified with the letter E followed by an ordinal number (for example E1, E2...E21) in order to ensure their anonymity.

Content analysis enabled the identification of two empirical categories through three stages: pre-analysis, exploration of the material, and treatment and interpretation of the obtained results[9]. The obtained data were firstly transcribed in full from the recorded semi-structured interviews in a text

editor, making up the research corpus. The transcriptions were then printed to make it easier to handle.

Pre-analysis corresponded to the organization of the material for future analysis based on the study objective. This stage was performed by listening the recordings and skimming the text, consisting in the first contact with the material obtained from the interviews, and which resulted in the initial impressions. Then, through a sequence of thorough readings, excerpts from the speeches of the participants were marked with multi-colored highlighters according to the similarity of ideas. The implementation of the chromatic technique enabled the elaboration of the material that was submitted to in-depth analysis.

In the material exploration stage, common information found in the content of the transcribed speeches was collected, supporting the constitution of categories. The researchers then listed the units of registration related to words, phrases, and expressions that give meaning to the content of the speeches and support the definition of the categories.

In this stage, the first step included the search for the themes that made up the units of registration. After finding these units, it was possible to define the two thematic categories. Categorization consists in a process of reducing the text to more meaningful words and expressions within the *corpus* of analysis.

The last stage consists in the treatment of the obtained data and interpretation. In this stage the researcher seeks to propose inferences and interpretations on the results with a focus on the objectives of the study. Therefore, the previously taken excerpts were analyzed according to the theoretical foundations.

## RESULTS

The interviewed health professionals consisted of seven community health agents, six nursing technicians, five nurses, and three physicians. They were characterized by being aged between 26 and 66 years old with a predominance of female professionals (71.4%). Their educational level ranged from complete secondary education (33.3%) to complete graduate education (29.0%). Time of profession ranged from less than one year (19.05%) to more than 30 years (4.8%).

Data analysis generated two empirical categories: conceptions on the health care network and actions developed in Primary Health Care.

### Conceptions of the professionals on the Health Care Network

The study shows several conceptions of health professionals on the health care network: conception of network limited to the health sector; understanding that the network is a municipal responsibility; network resulting from the integration of services of various areas; and network limitations.

The **conception of network is limited to the health sector** when the participant points out that the care for women in situations of violence shall occur within the scope of health.

*Places that offer services for these women: basic health unit, emergency services, health surveillance* (E4).

Other participants reveal a conception that the network is a responsibility of the municipal government through the services offered by its departments.

*The health care network would be the Health Department, Social Work* (E1).

*It is a support set that the city offers to these cases (violence against women)* (E8).

Some participants show a **conception of the network as resulting from the integration of services of several areas**, consisting in an expanded conception of what the care network for women in situations of violence would be, including other institutions in addition to the health sector.

*Care network includes several bodies* (...) *women's police stations, social work reference centers, intermediate care facilities* (E15).

*Women's police station, health units, care facilities* (E13).

*Working with that concept of expanded network: police stations, schools, psychosocial care centers* (...) *seeking to build the support network according to the profile of the woman* (E16).

Through previous experiences the professionals revealed **the conceptions of the network limitations**, in which some care services for these women are not integrated, therefore they are not able to meet the demands of women in a resolutive way.

*Everybody talks about the network, but the network has several gaps* (...) *our work is supposed to be in a network, but it still does not work as a network* (...) *not all services work. Our service here may work, but when it reaches the other side it does not work* (E17).

*In practice, it does not work as in the theory* (E14).

### Actions developed in primary health care

In the actions pointed out by the health professionals, care for women in situations of violence may be developed in primary health care services, such as actions for initial embracement; guidance and referrals; and notification.

In relation to the work of the professionals, **initial embracement** regards the act of listening since the moment the woman is admitted into the service. They were also available when they were seeking to understand the context of the situation of violence and the feelings experienced by the women.

*Receiving this woman, listening to her* (...) (E4).

*First of all, I welcome her, I talk to her* (E5).

*Talking to her* (...) *if she came to us, she wants help* (E14).

*The first thing I ask the woman: how did she feel* (...) *what does she want (to do)* (...) (E15).

**Guidance and referrals** represent another form of work revealed. The testimonies demonstrate that the participants of the study mention some guidance and clarifications, reinforcing the idea that violence should not be

seen as something trivial and that it is necessary to report any occurrences. With the team, they sought a resolution of situations of violence against women in their territory of operation. In general, they started with the referral of the situation to the coordinating nurse of the FHS or BHU to determine which actions would be adopted. They also revealed that they referred cases to professionals of other health care services.

*We advise them to file it (police report)* (...) *We monitor, we talk to the Community Health Agent, we check if the woman carried out the procedures* (...) *if that partner will remain or not in the house* (E1).

*We explain their rights, we talk about the Maria da Penha Law* (E3).

*Take them to a doctor, request the referral to a psychologist or psychiatrist* (...) *it's about working together* (E4).

*Referral to the Institute of Legal Medicine for Corpus Delicti evidence examination* (E7).

*I always call the nurse and decide with her.* (...) *better solutions arise when we work together* (E20).

The health professionals mentioned in their actions that **compulsory notification** of violence was performed in both confirmed and suspected cases. However, some health professionals were afraid to report cases.

*Notify the case, because even in suspected cases they should be notified* (E8).

*I advise the woman on the importance of notifying; I calm her down, explaining that it is not an accusation* (E16).

*I advise, but I do not notify because this involves the police* (E7).

## DISCUSSION

For these professionals, the conception of a network restricted to the health sector goes beyond the existence of services operating in an individualized way with no dialogue with each other; it prevents professionals from identifying the services they may refer to develop the care for women in situations of violence.

In this sense, the health sector needs to know the responsibilities of the professionals and services that may be part of the health care network in order to establish communication with the social equipment beyond its area of coverage, reaching other resources of the community[10-11].

According to testimonies of the health professionals, the limitations of the network in the studied scenario are related to the services that operate in an uncoordinated way. These data are consistent with those of a study conducted with women in situations of violence in Germany, which evidenced that half of the women had experienced isolation between the services of the health care system, consisting in their first formal support with the other available sectors, such as criminal justice, which does not characterize networking[12].

Despite the several advances occurred in Brazil in relation to legislation, public policies, and the constitution of services of specific care for women in situations of violence (such as women's police stations, facilities, shelters, public defenders for women), there are still a series of obstacles to be overcome. These are related to the quality of the care offered by these services to women who experienced violence and particularly to the difficulty of intersectoral coordination[11].

The conceptions of most health professionals on the health care network for these women are related to the integration of a wide range of intersectoral services. These services include health departments, social work departments, BHUs, psychosocial care centers, women's police stations, CREAS (Social Work Specialized Reference Centers – *Centro Especializado de Assistência Social*, as per its acronym in Portuguese), emergency services, and intermediate care facilities.

These conceptions are in line with the ministerial and political guidance, which states that health care should be provided in an intersectoral and multidisciplinary way through collective efforts of the services in favor of a common objective[13], regarding the care for women in situations of violence.

The results revealed the need to reinforce the actions currently developed by PHC professionals, like embracement and listening. Embracement refers to a continuous process permeated by qualified listening that enables an understanding on the context of the situation; it should be performed from the moment when the woman accesses the health service up to when her needs are fully met, or until the woman is referred to another service within the health care network.

Studies point out that it is important for health professionals to remain available for the demands of women in situations of violence, listening to them with empathy, and offering them a safe space where confidentiality of the reported information on the experienced violence is guaranteed[3]. Moreover, considering that manifestations of violence are explicit and nonexplicit, the attitude of listening becomes critical, as demonstrated by a study conducted with PHC professionals of Catalonia and Costa Rica[8].

Therefore, embracement includes the protection and care offered by professionals to women in situations of violence[14]. It sets the relational dimension of the work in health[15] and may overcome the professional relationship of health *versus* women, characterized in some studies as fragile[16].

The guidelines are related to denouncing the aggressor and the legislation that protects women in such situations, such as Law 11.340/2006 – Maria da Penha Law[17]. In addition, they aim at empowering these women so they may denaturalize the violence present in their lives. Recognizing that violence is not something banal and that reporting it is necessary represent essential actions for coping with this problem.

Specifically in relation to the Maria da Penha Law, created to restrain domestic and family violence against women[17], the DataSenado research revealed that this law is known by 100% of the Brazilian women[18]. The legislation was appropriated by the population, understood as a right of women and a legal instrument to be evoked by them for coping with situations of violence[19].

By notifying the cases of violence the professionals demonstrate commitment with the process of coping with

these situations, understanding their relevance for the construction of the epidemiological framework of the region in which the BHU and the FHS are inserted. The analysis of this framework will enable managers to rethink the public policies and programs related to violence against women in order to qualify them to offer better health care for this population. This procedure is in line with the regulations of the Ministry of Health in an ordinance that defines the compulsory notification of diseases, health problems, and other events throughout the national territory[20-22].

In this study, the health professionals followed up women through data collection from the Community Health Agents (CHA) as these professionals are closer to women in situations of violence and their families. These data corroborate a study that aimed at understanding violence against women in the perspective of CHA, revealing that these professionals are among the main agents involved in the identification and coping with situations of violence against women[6].

Among other aspects, this is due to the frequency in which CHA visit the families of the women within the territory of the FHS as well as the dialogue established with them, which enables the construction of a relationship based on trust. Regarding the relevance of home visits, a study evidenced the effectiveness of this activity in the short-term to reduce violence by intimate partners and in the follow-up of women who experienced it[23].

Therefore, the role of the CHA is critical in the creation of strategies aimed at changing the situations of violence experienced by women in their areas of activity. However, to make this possible, these professionals need support from other members of the team, such as nurses, to qualify them to identify and refer users experiencing violence[24].

Teamwork was pointed out by health professionals as a means to solve the situations of violence experienced by women in an easier way. In this sense, this study points out the need to overcome the fragmentation of the work process and strengthen relationships among the different professionals aiming at achieving common goals considering the interdependence among the members[25].

The referrals aim at the qualification of the care initially provided at the care service for women in situations of violence. The health professionals of the present investigation referred the women to other professionals within the care network, such as social workers, general practitioners, gynecologists, and psychologists. The services of the Teaching Hospital, Emergency Unit, and Basic Health Units varied according to the type of violence. Following these findings, a study pointed out that besides the identification of the violence experienced by the women, the actions of the health professionals should include the initial support to them with subsequent referral to other services[3].

However, the act of referring women to other services may be a way for health professionals to get rid of the problem[10], leading to revictimization. This revictimization occurs because women in situations of violence need to report again their experience to each service or professional. It is a difficult experience that represents a personal barrier in the search for health care[12].

Professionals may make use of some strategies to avoid revictimization of women, such as knowing the services to which they will refer the women for social support[26] and recognizing the singularity of each woman and their context of life, dialoguing and conceiving new perspectives for the care by means of joint discussions to value the woman as an individual in their own history[27].

According to the Map of Violence, of 2014, young and adult women in situations of violence were referred in 46.2% and 46.1% of the cases, respectively, after seeking the Brazilian Unified Health System. Most referrals were made to general police stations, women's police stations, Public Prosecutor's Offices, and CREAS[10,21].

In the present study, the professionals reported that the referrals were made to professionals and services beyond the health sector, such as psychologists, public security agents, and social workers. However, the actions are not coordinated among the services, evidencing the absence of a structured care network for women in the city of this study.

## CONCLUSION

The conceptions of health professionals on the care network go beyond a vision limited to the health sector and the responsibility of the city government. In a positive way, they conceive the network as a result of the integration of services and areas, but the discoordination or absence of integration prevents the network from working properly. In relation to the actions developed in the PHC services, initial embracement, guidance, referrals, and notifications were emphasized.

The conceptions reported in this study are related to the actions of the participants, implying uncoordinated actions between professionals and services. In this perspective, this study recommends that health professionals be prepared to offer women resolutive care based on embracement and qualified listening, focused on the comprehensiveness of health actions.

Although the study is limited because it was developed in only some PHC services, of a single municipality, the results contribute for health professionals to reflect on their daily practices in relation to care for women in situations of violence in the perspective of networking, pointing out challenges that need to be overcome, such as the need to create strategies aimed at the integration among services.


## RESUMO

**Objetivo:** Conhecer as concepções e ações de profissionais de saúde sobre a rede de atenção às mulheres em situação de violência. **Método:** Estudo qualitativo, descritivo e exploratório, realizado no período de abril a julho de 2015. Participaram 21 profissionais de saúde de quatro equipes da Atenção Primária à Saúde em um município da região central do estado do Rio Grande do Sul. A coleta de dados ocorreu mediante entrevistas semiestruturadas e individuais. Para sistematização dos dados, empregou-se a análise de conteúdo.

**Resultados:** Os profissionais de saúde reconheciam a importância da rede de atenção à saúde no enfrentamento da problemática da violência contra as mulheres. Contudo, suas concepções e ações eram limitadas pela desarticulação ou ausência de integração entre os profissionais e serviços da rede de atenção. **Conclusão:** As concepções e ações dos profissionais de saúde contribuem para a desarticulação entre os serviços. Faz-se necessário refletir acerca das práticas cotidianas de cuidados direcionados às mulheres em situação de violência.

**DESCRITORES**

Violência contra a Mulher; Pessoal de Saúde; Saúde da Mulher; Assistência à Saúde.

**RESUMEN**

**Objetivo:** Conocer las concepciones y acciones de profesionales sanitarios acerca de la red de atención a las mujeres en situación de violencia. **Método:** Estudio cualitativo, descriptivo y exploratorio, llevado a cabo en el período de abril a julio de 2015. Participaron 21 profesionales sanitarios de cuatro equipos de la Atención Primaria de Salud en un municipio de la región central del Estado de Río Grande do Sul. La recolección de datos ocurrió mediante entrevistas semiestructuradas e individuales. Para sistematización de los datos, se empleó el análisis de contenido. **Resultados:** Los profesionales sanitarios reconocían la importancia de la red de atención sanitaria en el enfrentamiento de la problemática de la violencia contra las mujeres. Sin embargo, sus concepciones y acciones estaban limitadas por la desarticulación o ausencia de integración entre los profesionales y servicios de la red de atención. **Conclusión:** Las concepciones y acciones de los profesionales sanitarios contribuyen a la desarticulación entre los servicios. Es necesario reflejar acerca de las prácticas cotidianas de cuidados dirigidos a las mujeres en situación de violencia.

**DESCRIPTORES**

Violencia contra la Mujer; Personal de Salud; Salud de la Mujer; Atención de Salud.

## REFERÊNCIAS

1. García-Moreno C, Zimmerman C, Morris-Gehring A, Heise L, Amin A, Abrahams N, et al. Addressing violence against women: a call to action. Lancet. 2015;385(9978):1685-95.
2. Brasil. Presidência da República. Secretaria Nacional de Enfrentamento à Violência contra as Mulheres; Secretaria de Políticas para as Mulheres. Política Nacional de Enfrentamento à Violência Contra as Mulheres [Internet]. Brasília; 2011 [citado 2015 dez. 10]. Disponível em: http://www.spm.gov.br/sobre/publicacoes/publicacoes/2011/politica-nacional
3. García-Moreno C, Hegarty K, d'Oliveira AFL, Koziol-McLain J, Colombini M, Feder G. The health-systems response to violence against women. Lancet. 2015;385(9977):1567-79.
4. Organización Panamericana de Salud. Redes Integradas de Servicios de Salud. Conceptos, opciones de política y hoja de ruta para su implementación en las Américas [Internet]. Washington: OPAS; 2010 [citado 2016 Jan. 15]. Disponible en: http://www.paho.org/uru/index.php?option=com_docman&task=doc_view&gid=145&Itemid=250
5. Bair-Merritt MH, Lewis-O'Connor A, Goel S, Amato P, Ismailji T, Jelley M, et al. Primary care-based interventions for intimate partner violence: a systematic review. Am J Prev Med. 2014;46(2):188-94.
6. Hesler LZ, Costa MC, Resta DG, Colomé ICS. Violence against women in the perspective of community health agents. Rev Gaúcha Enferm [Internet]. 2013 [cited 2016 Jan 29];34(1):180-6. Available from: http://www.scielo.br/pdf/rgenf/v34n1/en_23.pdf
7. Organização Pan-Americana da Saúde. A atenção à saúde coordenada pela APS: construindo as Redes de Atenção no SUS: contribuições para o debate [Internet]. Brasília: OPAS; 2011 [citado 2016 jan. 17]. Disponível em: http://apsredes.org/site2012/wp-content/uploads/2012/03/aps_verde_new.pdf
8. Loría KR, Rosado TG, Alvarado R, Sánchez AF. Actitud hacia la violencia de género de los profesionales de Atención Primaria: estudio comparativo entre Cataluna˜ y Costa Rica. Aten Prim. 2015;47(8):490-7.
9. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14ª ed. São Paulo: Hucitec; 2014.
10. Rodrigues VP, Machado JC, Simões AV, Pires VMMM, Paiva MS, Diniz NMF. The practice of family health strategy workers when caring for women in gender violence situations. Texto Contexto Enferm [Internet]. 2014 [cited 2016 Oct 14];23(3):735-43. Available from: http://www.scielo.br/pdf/tce/v23n3/0104-0707-tce-23-03-00735.pdf
11. Menezes PRM, Lima IS, Correia CM, Santos SS, Erdmann AL, Gomes NP. Process of dealing with violence against women: intersectoral coordination and full attention. Saúde Soc [Internet]. 2014 [cited 2016 Oct 12];23(3):778-86. Available from: http://www.scielo.br/pdf/sausoc/v23n3/en_0104-1290-sausoc-23-3-0778.pdf
12. Larsen MM, Krohn J, Püschel K, Seifert D. Experiences of health and health care among women exposed to intimate partner violence: qualitative findings from Germany. Health Care Women Int. 2014;35(4):359-79.
13. Brasil. Presidência da República. Secretaria Nacional de Enfrentamento à Violência contra as Mulheres; Secretaria de Políticas para as Mulheres. Pacto Nacional pelo Enfrentamento à Violência contra as Mulheres [Internet]. Brasília; 2011 [citado 2015 dez. 12]. Disponível em: http://www.spm.gov.br/sobre/publicacoes/publicacoes/2011/pacto-nacional
14. Barros LA, Albuquerque MCS, Gomes NP, Riscado JLS, Araújo BRO, Magalhães JRF. The (un)receptive experiences of female rape victims who seek healthcare services. Rev Esc Enferm USP [Internet]. 2015 [cited 2016 Jan 05];49(2):193-200. Available from: http://www.scielo.br/pdf/reeusp/v49n2/0080-6234-reeusp-49-02-0193.pdf
15. Oliveira RNG de, Fonseca RMGS. Health needs: the interface between the discourse of health professionals and victimized women. Rev Latino Am Enfermagem [Internet]. 2015 [cited 2016 June 13];23(2):299-306. Available from: http://www.scielo.br/pdf/rlae/v23n2/0104-1169-rlae-3455-2555.pdf

16. Vieira LB, Souza IE de O, Tocantins FR, Pina-Roche F. Support to women who denounce experiences of violence based on her social network. Rev Latino Am Enfermagem [Internet]. 2015 [cited 2016 June 13];23(5):865-73. Available from: http://www.scielo.br/pdf/rlae/v23n5/0104-1169-rlae-23-05-00865.pdf

17. Debert GG, Gregori MF. Conceptualising violence and gender in the Brazilian context: new issues and old dilemmas. Feminist Theory. 2016;17(2):175-90.

18. Brasil. Senado Federal. Secretaria de Transparência. Violência doméstica e familiar contra a mulher [Internet]. Brasília; 2015 [citado 2016 fev. 08]. Disponível em: http://www.senado.gov.br/senado/datasenado/pdf/datasenado/DataSenado-Pesquisa-Violencia_Domestica_contra_a_Mulher_2013.pdf

19. Meneghel SN, Mueller B, Collaziol ME, Quadros MM. Repercussões da Lei Maria da Penha no enfrentamento da violência de gênero. Ciênc Saúde Coletiva [Internet]. 2013 [citado 2016 jan. 09];18(3):691-700. Disponível em: http://www.scielo.br/pdf/csc/v18n3/15.pdf

20. Brasil. Ministério da Saúde. Portaria n. 104, de 25 de janeiro de 2011. Define as terminologias adotadas em legislação nacional, conforme o Regulamento Sanitário Internacional de 2005 (RSI 2005), a relação de doenças, agravos e eventos em saúde pública de notificação compulsória em todo nacional e estabelece fluxo, critérios e responsabilidades e atribuições aos profissionais e serviços de saúde [Internet]. Brasília; 2011 [citado 2015 dez. 03]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt0104_25_01_2011

21. Waiselfisz JJ. Mapa da Violência 2015. Atualização: homicídios de mulheres no Brasil [Internet]. Rio de Janeiro: Centro de Estudos Latino-Americanos – Cebela; 2015 [citado 2015 dez. 05]. Disponível em: http://www.mapadaviolencia.org.br/pdf2015/MapaViolencia_2015_mulheres.pdf

22. Silva LEL, Oliveira MLC. Violence against women: systematic review of the Brazilian scientific literature within the period from 2009 to 2013. Ciênc Saúde Coletiva [Internet]. 2015 [cited 2016 Oct 15];20(11):3523-32. Available from: http://www.scielo.br/pdf/csc/v20n11/en_1413-8123-csc-20-11-3523.pdf

23. Prosmana GJ, Lo Fo Wong SH, van der Woudenb JC, Lagro-Janssen AL. Effectiveness of home visiting in reducing partner violence for families experiencing abuse: a systematic review. Fam Pract. 2015;32(3):247-56.

24. Arboit J, Costa MCC, Hirt MC, Padoin SMM, Colomé ICS, Soares JFS. Violência doméstica contra mulheres rurais: interfaces de gênero na concepção de agentes comunitários de saúde. Ciênc Cuid Saúde [Internet]. 2015 [citado 2016 jan. 15];14(2):1067-74. Disponível em: http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/23650

25. Galavote HS, Zandonade E, Garcia ACP, Freitas PSS, Seidl H, Contarato P. The nurse's work in primary health care. Esc Anna Nery Rev Enferm [Internet]. 2016 [cited 2016 Oct 15];20(1):90-8. Available from: http://www.scielo.br/pdf/ean/v20n1/en_1414-8145-ean-20-01-0090.pdf

26. Gomes NP, Erdmann AL, Rebouças-Gomes N, Silva-Monteiro D, Santos RM, Menezes-Couto T. Apoio social à mulher em situação de violência conjugal. Rev Saúde Pública [Internet]. 2016 [citado 2016 out. 14];17(6):823-35. Disponível em: http://www.scielo.org.co/pdf/rsap/v17n6/v17n6a01.pdf

27. Vieira LB, Padoin SMM, Souza IEO, Paula CC. Perspectivas para o cuidado de enfermagem às mulheres que denunciam a violência vivida. Esc Anna Nery Rev Enferm [Internet]. 2011 [citado 2016 jul. 27];15(4):678-85. Disponível em: http://www.scielo.br/pdf/ean/v15n4/a04v15n4.pdf