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Care Provided to Women Victims of Intimate Partner Violence From the Perspective of Health Professionals

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Abstract

Intimate Partner Violence (IPV) is a recurring phenomenon in society and can have important repercussions for the lives and health of women worldwide. Even in this alarming global scenario, many health workers still have difficulties approaching IPV with women and providing care for the victims of this type of violence. Given this context, this qualitative study aims at understanding how primary health care professionals provide care for women victims of violence by intimate partners. In view of the methodology design proposed in the Grounded Theory, data collection took place through theoretical sampling. Data collection was carried out in 22 institutions offering primary health care, with 31 female workers from different professional categories being interviewed individually and in depth, including physicians, nurses, dentists, psychologists, and social workers. The results show that, in order to overcome the difficulties encountered in caring for victims of IPV, primary health care workers have been developing strategies for the care of these women. These strategies include identification of such cases through questions about the woman's intimate relationship, by establishing a bond with the victim so that she feels welcomed, and through articulation with other team professionals to propose expanded health care. The interventions carried out by these professionals include meeting the demands of women in the health institution where they work, referral to other services in the network, if necessary, and notification of IPV cases to epidemiological surveillance. Based on this understanding of the care offered by the professionals to women who are victims of IPV in primary health care, the research aims at contributing to the sensitization of professionals working in health institutions regarding the identification of signs that raise suspicion of IPV, as well as at addressing such cases in a way to fully meet these women's needs.

Keywords

intimate partner violence, care, health professionals, primary health care, women's health

Highlights

1. Intimate Partner Violence (IPV) is a recurring phenomenon in women's daily lives, with important repercussions for their lives and health worldwide. Despite the legislation in force in several countries guiding the health professionals' performance to care for victims of this type of violence, there is a need for specific guidelines regarding the actions of these workers in relation to preventing and coping with IPV in primary health care.
2. Understanding that the difficulties that permeate the care offered to IPV victims in primary health care, especially

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with regard to objective guidelines on how to approach the issue with women and to provide care for this type of violence, can interfere with the outcomes of the cases, dissemination of strategies that can favor the care offered to these women is considered relevant. Consequently, the objective of this study was to understand how primary health care professionals provide care to women who are victims of intimate partner violence.

3. Based on this understanding of the care offered by the professionals to women who are victims of IPV in primary health care, the research aims at contributing to the sensitization of professionals working in health institutions regarding the identification of signs that raise suspicion of IPV, as well as in addressing such cases in a way to fully meet these women's needs.

What do we already know about this topic?

Intimate Partner Violence (IPV) is a recurring phenomenon in women's daily lives, with important repercussions for their lives and health worldwide. Despite the legislation in force in several countries guiding the health professionals' performance to care for victims of this type of violence, there is a need for specific guidelines regarding the actions of these workers in relation to preventing and coping with IPV in primary health care.

How does your research contribute to the field?

Understanding that the difficulties that permeate the care provided to IPV victims in primary health care, especially with regard to objective guidelines on how to approach the issue with women and to provide care for this type of violence, can interfere with the outcomes of the cases, dissemination of strategies that can favor the care offered to these women is considered relevant. Consequently, the objective of this study was to understand how primary health care professionals provide care to women who are victims of intimate partner violence.

Which are the implications of your research towards theory, practice, or policy?

Based on this understanding of the care offered by the professionals to women who are victims of IPV in primary health care, the research aims at contributing to the sensitization of professionals working in health institutions regarding the identification of signs that raise suspicion of IPV, as well as at addressing such cases in a way to fully meet these women's needs.

Introduction

Intimate Partner Violence (IPV) is a recurring phenomenon in women's daily lives, with important repercussions for their lives and health worldwide. Despite the legislation in force in several countries guiding the health professionals' performance to care for victims of this type of violence, there is a need for specific guidelines regarding the actions of these workers in relation to preventing and coping with IPV in primary health care, mainly because of the difficulty identifying the problem due to lack of professionals duly trained in relation to the theme and to the difficulties in the articulation between the services that comprise the reference care network for women in IPV situations. There is an urgent need for the care strategies targeted at women in the PHC space to be rethought.

Regarding the alarming prevalence of this problem, an international study points out that more than one third of the women have already been subjected to violence in the context of intimate relationships.[1] In Brazil, the reality is also worrying, as revealed by the Institute for Applied Economic Research (*Instituto de Pesquisa Econômica Aplicada*, IPEA), evidencing that, every year, nearly 1.3 million Brazilian women are assaulted, with partners or ex-partners being the main perpetrators.[2] Regarding typification of the problem, a study evidenced that the most recurrent IPV expressions are the following: psychological (90.09%), physical (76.64%), moral (69.34%), patrimonial (24.06%) and sexual (19.34%).[3] It is emphasized that the groups of women with greatest vulnerability to suffering IPV are as follows: age between 25 and 49 years old, black-skinned, single, mothers, low schooling, low income, in use/abuse of alcohol and other drugs, and with a weak support network.[4,5]

In addition to being potential fatal victims of violence, women who experience abusive relationships are also vulnerable to illness. Regarding the above, it is to be noted that these women who are IPV victims are susceptible to physical harms resulting from the aggressions, such as hematomas, scratches and fractures. They are also exposed to contracting Sexually Transmitted Infections (STIs) and present psychosomatic symptoms, such as headache, epigastric pain, nausea, dizziness, and inappetence.[6,7] Mental impairment is expressed through feelings of fear, disgust, deep sorrow, low self-esteem, and other depressive symptoms.[8]

In the social context, oppression, on the other hand, can make women find difficulties in creating affective bonds, or even feel forced to distancing from work, friends and even family members.[6,9,10] These situations make it difficult to end the relationship. Added to this are the implications to the lives of the children who, inserted in a violent family context, can, in addition to becoming ill, reproduce violence in adult life.[11] Considering that IPV is strongly influenced by gender asymmetries, this study will use the concept of social vulnerability, which is related to individual behavior with the

characteristics of social space, such as: life cycle, social identity, social and institutional norms, and gender relations, among others aspects.[12] (Ayres et al, 2006).

All these repercussions point to the urgency of care strategies aimed at women who suffer IPV, addressing their needs in an integral manner, as proposed, for example, by the National Policy for the Comprehensive Care of Women's Health (*Política Nacional de Atenção Integral à Saúde da Mulher*, PNAISM), instituted in Brazil in 2004. In addition to the PNAISM, other legal instruments created in the country have shown the political interest in confronting IPV, such as Law No 11,340 (2006), which, in its eighth article, recommends integration of the legal sector actions with the health and social assistance fields, a course of action also adopted in Portugal, since Order No. 6,378/2013 (2013).[13,14]

In the Brazilian health scenario, the Ministry of Health published a Primary Care Booklet (2001), which is a document with guidelines for the professional practice in health services related to cases of intra-family violence, including violence against women.[15] This document acknowledges that the professionals who work in the context of primary health care are in a privileged position to prevent and cope with IPV since, in general, primary health care centers are easily accessed by the population and meet their various needs, such as routine appointments, reproductive planning, vaccination, and healing procedures, among others. This reality enables early identification of harms, for which intervention actions must be designed.

Although there are governmental documents to target health care to women in IPV situations, these are not widespread for the health professionals working in primary health care, who, in general, receive general guidelines, without deepening the approach to specific issues, such as care for women who are victims of IPV.[16] Corroborating this statement, diverse international scientific evidence have pointed out that these professionals do not feel sufficiently prepared to intervene in the face of the situations of violence they deal with in their daily work.[17,18]

This weakness to act in IPV situations can be related to different factors associated with working in primary health care services, such as additional job responsibilities, lack of adjoining/responsive referral networks, non-familiarity with safety planning, time constraints on the PHC worker, and productivity demands.[19,20] Added to this, this unpreparedness can be related to the sensitivity of the topic that is considered a social taboo, limiting the approach of this theme in the appointments with women in the different health care services, which is added to the absence of this content during the professional training process and to the nonexistence of training actions aimed at health care workers.[21-23] This context favors that violence remains restricted to the victims' family nucleus, with referrals that allow breaking with the violent relationship not being made, thus impacting on the women's permanence in these relationships for many years.

Understanding that the difficulties that permeate the care provided to IPV victims in primary health care, especially with regard to objective guidelines on how to approach the issue with women and to provide care for this type of violence, can interfere with the outcomes of the cases, dissemination of strategies that can favor the care offered to these women is considered relevant. Consequently, the objective of this study was to understand how primary health care professionals provide care to women who are victims of intimate partner violence.

Method

This is a study with a qualitative approach, whose methodological contribution was adopted from the Grounded Theory (GT). The GT was chosen because it values the subjectivities, seeking to understand the ways in which social beings live their experiences in a given social context and groups of subjects, extracting from them the meanings of what and how they feel and the way they think. The assumptions of this method guide the researchers about the importance of investigating the meanings of the relationships, interactions, behaviors, and emotions in the social, cultural, or organizational contexts for each individual in order to know the reality in which they are inserted, providing deepening of the phenomenon under study.[24]

The research was conducted in 22 institutions offering primary health care, located on the periphery of a capital city in the Brazilian Northeast region, marked by disorderly urban growth, linked to low socioeconomic conditions, which, added to other social markers, contribute to the increase in crime, which makes the region socially vulnerable.

The GT instructs that data collection should take place by means of sample groups, which shall be constituted throughout the research process, enabling identification and development of concepts for data collection, coding and analysis.[24] Considering that the first step to obtain the theoretical sampling is data collection with people considered pertinent to answer the research question and objectives, it is up to the researcher to define the participants of the first sample group, in order to conduct the theoretical model that is being constructed.[24,25] In the case of this research, aiming to attain the study object, care provided to women in IPV situations in the primary health care setting, the researcher defined those professionals working in services at this health care level as the first sample group, them being nurses, physicians, and dentists.

New participants can be included during the collection phases and even in data analysis, with the possibility of interruption and/reassessment of the pre-established inclusion criteria and, if necessary, formulation of hypotheses that favor new directions to the study.[24] In this sense, the following research hypothesis emerged from the analysis of the data obtained from the first sample group: "The professionals working in the primary health care reference team share the understanding that psychologists and social workers are better prepared to provide care to women in situations of

violence by intimate partners." This hypothesis pointed to the need to interview a new sample group, in the case of this study, comprised by psychosocial care professionals, them being psychologists and social workers. Theoretical data saturation was achieved after collection of the second sample group, with no need to search for new information to achieve the objective proposed in the study.

Thus, professionals from different categories were reached. For selection of the study participants, the inclusion criterion established was working in the primary health care institution for at least 6 months; and the professionals excluded were those who did not attend the scheduled interview 3 consecutive times. All the professionals, intentionally selected for working in one of the institutions where the research was conducted and for meeting the inclusion criterion, were invited to participate in the individual interview through a phone call made by the lead researcher. Only one professional refused to participate.

The in-depth interviews took place between February and December 2019, in the face-to-face modality and a single time with each participant, in a reserved place at the health institution, and lasted a mean of 50 minutes. In view of the list of recommendations in the Consolidated Criteria for Reporting Qualitative Research (COREQ), data collection was conducted by MS and PhD students with experience in qualitative research and in the theme of violence, using a semi-structured questionnaire. This form, prepared, tested, and validated by the researchers, contains objective questions related to the study participants' sociodemographic characterization, as well as open-ended questions based on the study guiding question: "Tell me how you promote the care provided to women in situations of marital violence." This question, the first to be asked during data collection, aims at stimulating the participants to speak freely about their experiences in the care of women in IPV situations in primary health care, which is the analysis object of this research.

The interviews were recorded in the researcher's own digital recorder and were subsequently transcribed in full, organized, and categorized as they were conducted with the participants, in accordance with what is proposed by the GT. It should be noted that the transcriptions were performed by undergraduate students who received prior training and validated by the researchers responsible for data collection. In order to facilitate data organization and coding, in this stage of the work the NVIVO 10 tool was used, which facilitates organization and grouping of the ideas presented by the participants.

Given the assumptions of the GT, proposed by Corbin & Strauss (2015), the data analysis process took place in 3 interdependent stages: Open Coding, Axial Coding, and Integration. In the Open Coding stage, the first of this analytical process, the researcher separated, examined, compared, and conceptualized the data obtained.[26] A sentence that was transformed into a preliminary code was attributed to each fragment of the interview. These codes were grouped by similarities and constituted subcategories, named according to the theme they deal with.[25,26] Subsequently, the substantive codes were identified, as well as their properties and dimensions.

The second stage was Axial Coding. During this stage, a preliminary code becomes a conceptual code migrating to subcategories or categories.[26,27] Once the coding, conceptualization and categorization stages were completed, an analytical tool called paradigmatic model was used, which allows for the creation of a theoretical framework to explain a social phenomenon and is supported by 3 components: Conditions, which refers to the reasons given by the participant(s) for the occurrence of certain fact, as well as explanations about the reasons why they respond to an action in a certain way; Actions-interactions, understood as the responses given by the participant(s) to problematic events or situations; and Consequences/Results, which refer to the expected or actual results of the actions and interactions.[24]

Consequently, using the paradigmatic model allowed constructing an explanatory theoretical matrix of the phenomenon under study, namely: "Enabling the empowerment of women in situations of violence by intimate partners." This phenomenon was presented to researchers with experience in the GT and also to a group of research participants, who validated it, confirming the reliability of the data presented in this research. In this article, it was decided to present the component referring to the actions-interactions related to the phenomenon described and that make a reference to the elements present in the experiences regarding the care provided to women in IPV situations, narrated by the professionals, even if they are not necessarily performed systematically and/or by all the primary health care professionals. These elements are represented in the central themes, namely: "Working to identify marital violence" and "Intervening in the cases of marital violence."

Participation in the research occurred after signing the Free and Informed Consent Forms (FICF), where signature of this document represented confirmation of voluntary adherence to the study and without any financial reward. These signed documents will be stored in virtual files for a period of 5 years after collection. In addition to that, privacy and confidentiality of the participants' identity was ensured, since their names were replaced by the letter "E" for "interviewee" ("*entrevistada*" in Portuguese), followed by an Arabic number according to the order of the interviews, plus G1 or G2, depending on the sample group. Example: (E1 G1...E15 G1) and (E1 G2… E4 G2).

Results

The study participants were 31 health care professionals from different categories, specifically: 17 nurses, 5 physicians, and 4 dentists, who comprised the first sample group; and 3 psychologists and 2 social workers, members of the NASF, who made up the second sample group. In the professional aspect, most of them (87%) had graduate studies and have

worked in primary health care for a mean of 9 years. Regarding the sociodemographic aspects, the mean age of the professionals was 38 years old, most of them were married or lived in a stable union (48%) and stated professing the Catholic religion (45%).

The professionals participating in the study reported only the care provided to cisgender women involved in intimate heterosexual relationships with cisgender men who perpetrated violence. Most of the professionals declared themselves to be female; thus, this study allows for the interpretation of the study object from a gender perspective; therefore, it is care provided by women (health workers) to other women (IPV victims).

Thus, through the interviewees' testimonies, it was possible to know how care is provided to women who are victims of IPV in the context of primary health care, which permeates the professionals' actions and interactions in order to identify the problem and intervene. The interviewees' speeches were organized into 6 categories linked to one of the following 2 themes: Theme 1: Working to identify IPV, which adds 3 categories; and Theme 2: Intervening in the IPV cases, which also consists of 3 categories.

Working to Identify Intimate Partner Violence

The study shows that, in order to provide care to women in situations of IPV, it is necessary to identify the problem. This category can be illustrated based on the following subcategories:

Investigating the Woman's Intimate Relationship with the Perpetrator of the Violent Act(s)

When interacting with the victims, the health professionals are concerned with the subtle investigation of the everyday life of their intimate relationships. Due to the lack of an institutional document for IPV screening, this investigation is carried out through informal questions, seeking, above all, to learn about the partner's behavior. In general, suspicion is raised by observing hints, such as physical marks and signs of psychosomatic illness like arterial hypertension.

> Through the appointments we manage to identify violence, even more psychological issues. When I suspect, I ask how marriage is going, if the husband drinks, if he uses other drugs. Many of them also come with marks, so I directly ask her what that purple bruise in her arm is, what can be making her blood pressure go up, if it is salt in the food or the partner's anger" **(E21 G1).**

> *In the home visit, I noticed marks over the body and asked her if she was in any intimate relationship* ***(E1 G2).***

Establishing a Bond with the Victim

The testimonies reveal that it is essential to establish a bond with the woman in a situation of IPV to investigate the condition, so that she feels safe talking with the professional and exposing details of her intimate relationship. According to the interviewees, this bond is established intentionally, even in informal conversations during vaccination and healing moments.

> *The woman comes to the appointment full of fears and concerns, but gradually opens up from the moment I welcome her. Once you win her trust, you can get her to speak* ***(E17 G1).***

> *I need to bond with the woman so that she feels safe in telling what is happening in the intimate relationship! During the appointment, as professionals, we bond with the community. […] sometimes, in informal conversations, during vaccination or healing moments, the women reveal the situation of violence they are going through* ***(E5 G2).***

Articulation with Other Professionals

Another means used by the professionals to recognize the cases of violence suffered by the women living in this context refers to the articulation with other professionals. Thus, when they suspect IPV, they report to their peers, especially those in charge of the follow-up and/or who have a closer relationship with the women, in search for information or for them to investigate the situation.

> *When I suspect that it can be violence, I ask another professional from the unit, a nurse or a doctor, and they generally know the life story of these women. The community agent also provided us with a lot of information; they know if the husband is a dealer, if he beats her or locks her at home* ***(E3 G1).***

> *All the professionals are guided as to how to speak to the women in these situations and refer them to us. […] sometimes, the nursing technicians, who are in the healing room, point to me about suspected cases of violence* ***(E4 G2).***

Intervening in the Cases of Intimate Partner Violence

In addition to the interaction process with women to identify IPV, the professionals also intervene in the cases identified. The care strategies within the scope of primary health care are presented from the following subcategories:

Assisting the Woman in Primary Health Care. In the care process provided to women inserted in an IPV context, primary health care professionals offer assistance that encompasses welcoming through qualified listening, assistance to clinical demands, whether physical or psychological, and also outline a multidisciplinary care plan in partnership with the psychosocial care network professionals. In addition to that, they point to the importance of recording the story told by the woman in the medical chart.

> *I record in the chart the whole testimony of the woman. Depending on the lesion, we perform the care here and I always ask*

her to come back in fifteen days. I also involve the whole team to take care of her. We even have the support of a center that helps us with a psychologist and social service ***(E16 G1).***

We have a welcome consultation, listen to the story, make the necessary referrals and book a return visit. Multidisciplinary care is important, because that way we can think together on how to help her. If today she doesn't want to report or leave him, we need to link her with the service in another way, through health education groups. At the meetings, we pass on the information to the reference team ***(E1 G2)***

Referring the Woman to Other Services. In order to meet the women's demands, which transcend what is possible to be solved within the scope of primary health care, the health professionals refer them to other spaces, such as those that address legal-police issues and also others that provide more complex health care. In view of the need for referrals, the professionals warn about the importance of monitoring from counter-referral.

I make referrals according to each woman's demands, but we never have feedback from the service she was referred to. I'm not sure that she will *arrive at the referral site and will be welcomed and cared for* ***(E6 G1).***

We refer women to services specialized in assisting victims of violence, which seek to solve issues related to the criminal process and to continuity of health care. I call the institution to where I'm going to refer the woman beforehand and I make a prior contact, schedule and pass on all the important information to continue the care ***(E3 G2).***

Notifying the Problem. In the field of the interventions related to IPV situations, the study also points to the notification of cases within the scope of the health system, which is not a legal report, since it is a record for the purpose of epidemiological analyses that does not generate any criminal investigation. However, for some professionals this practice is still permeated by the belief that only confirmed cases can be recorded and/or that can result in retaliation, even though anonymity is preserved and mandatory for all the health professionals.

I only notify cases reported by the women. I don't notify in front of her: I collect the necessary data and notify later ***(E24 G1).***

When the professional that referred to me doesn't notify, I do. I do it because it's part of my job, but I know that, even though it's confidential, the aggressor may find out and confront me ***(E2 G2).***

Discussion

The study shows that care for women in IPV situations in the primary health care setting is based on the action-interaction between the professionals and the victims of violence for the purpose of identifying the problem and intervening in the cases.

Perceiving implicit IPV signs was only possible from an attentive look by the professionals when assisting the victim, since this interest makes them seek elements indicative of the IPV problem. This interested and detailed care presented in the results indicate that investigation of the problem must not be restricted to the visually identifiable aspects, such as physical lesions, with the need for an attentive look at the mental health changes and somatization signs of the problem, such as increase in blood pressure. In this sense, as revealed by Brazilian and German studies conducted with women, it is indispensable to examine the psychological changes or clinical symptoms resulting from the somatization of the IPV experience, such as: headache, high blood pressure, anxiety, and low self-esteem.[6,28]

Regardless of the IPV signs, the study reveals that investigation of the problem can occur in any and all spaces of interaction with the women: during individual appointments, procedures, home visits, group activities, etc. Thus, there are many opportunities for the professionals to be able to talk about violence and search for clues that allow them to start a delicate conversation.[7,17] Thus, any welcoming environment that allows sharing information becomes essential for the phenomenon to be addressed and identified, especially considering the constant female presence in daily care in the context of primary health care institutions. In the meantime, it is up to the health professionals to be prepared to create a favorable method to achieve the attributions inherent to primary health care within the scope of IPV through a relationship of proximity and trust in the professional/victim relationship.[29,30]

In order to establish effective communication that favors establishing a trusting relationship, it is important that the professionals show themselves available to attentively and empathetically listen to the victim's report, value the stories shared, communicate using accessible language and exhibit commitment to devise coping strategies together with these women.[31] Another point to be considered by the managers of the services is avoiding turnover of the professionals in the primary health care services, since that alternative can favor interruption of the victim's bond with the health service and compromise care continuity, which vulnerabilizes her to stay in the violence cycle.[32]

However, despite the narratives about the importance of IPV research, the discomfort that permeates the approach to the topic by health professionals and the women's difficulty in verbalizing intimate experiences must be considered. Regarding this, a research study carried out in Uganda reveals that the improvement in the handling of cases is related to the training process of these professionals, which should contemplate this topic from the demonstration of national and international assistance protocols that assist the professional praxis with respect to screening and

monitoring, notification and legal consequences for the perpetrators.[33]

In addition to the professional's difficulty in approaching the topic, women are afraid of verbalizing their daily life, a reality that is related to the fears, myths, and taboos that permeate the experience of abuse. Considering that the phenomenon studied involves the diversity of aspects of women's lives, associated with socioeconomic issues, race, ethnicity, language, nationality, gender, gender identity, sexual orientation, religion, geography, ability, and age, the importance of professional training to investigate such aspects must be considered, in order to offer individualized care that meets the specific demands of each case. Thus, it is necessary to establish a trusting relationship between professional and woman since, as noted in the narratives, a close relationship permeated by welcoming and trust, understood as a bond, is the foundation for investigating phenomena that are difficult to verbalize and allows the professionals to empower the IPV victims and offer them support.[34]

The narratives reveal that articulation between professionals is also a strategy used to identify IPV cases. Thus, the study points to the importance of raising awareness in these professionals so that they are engaged and understand the value of shared care among members of the health team as a strategy for identifying cases, regardless of the scope of action within the unit.[35] In this sense, the professionals responsible for planning should consider ways of ensuring, in favorable circumstances, the sharing of information in team meetings without, however, exposing the women's experiences to other people. In view of this scenario, there is an urgent need for the development of educational actions by those who work in administering and organizing the health services, in order to contribute to the visualization of this multidisciplinary dialog as a strategy to promote changes in the care of IPV.

It is clear that, given the understanding of the complexity of IPV and of women's needs, there is a need to mobilize several spheres to ensure more comprehensive care, where the support of the multidisciplinary team is inserted through the Family Health Support Center (*Núcleo de Apoio a Saúde da Família*, NASF). This center was created in Brazil in 2008 to expand the offer of assistance services as well as to improve the resoluteness of primary health care; it is composed of a multidisciplinary team, which includes, for example, a psychologist, a social worker, and an occupational therapist. The professionals offer specialized clinical support for primary health care units, favoring the management of difficult-to-solve situations, such as IPV cases. A Brazilian study shows that, in the face of IPV situations, the team that works in primary health care can activate the Family Health Support Center (NASF) team in order to organize care, as follows: by discussing the cases and by the concern to follow-up the victims and to monitor the results of the care actions proposed.[36]

In the health professionals' testimonies, concern regarding referral of women to specialized services is also observed, considering their needs, whether they are focused on health, legal-police, social, or educational issues. This is related to the absence of a defined flow for dealing with IPV cases, as is the case in several countries, such as Brazil, Spain, and Norway.[37,38] In view of this difficulty, the health teams use direct communication, often through telephone contact, with other professionals who work in other services in an attempt to ensure care continuity. However, referrals cannot be the professionals' responsibility and should assume an organizational character, with professionalism in the care provided and attribution of competences and responsibilities.

It is noteworthy that the narratives reveal the importance of counter-referral for the care provided to be carried out in a continuous and integral manner, with a focus on solving the problem. With the organization of the Health Care Networks, the referral and counter-referral system across the different technological levels is an important communication channel that brings together the points of attention in search of decisive and comprehensive provision of care.[22] However, due to cultural issues and lack of knowledge about the flows, few professionals fill out the counter-referral form.[39] This situation suggests the need for training promoted by the institutions, in order to sensitize the professionals about the importance of filling not only the referral, but the counter-referral for continuity of the care provided.

Another strategy unveiled by the health professionals in the care of women when intervening in cases of IPV concerns notification of the cases. In this regard, Law No. 10,778 (2003), valid in Brazil, determines that suspected or confirmed IPV cases identified by the professionals must be notified to the government.[40] The professionals are afraid to fill-in this document for fear of reprisals from the spouse, especially in health services located in areas with high urban violence indices, which points to these professionals' lack of knowledge about the secrecy nature of notifying the problem. The purpose of the notification is to generate epidemiological data that allow evidencing the magnitude of the problem, devise public policies targeted at prevention and coping with the problem and assess the effectiveness of the local planning actions performed to such end.[11,18,41]

The theoretical implication from the findings of the action-interaction theoretical component, focus of this study, alludes to a preliminary social and conceptual process focused on improving the way in which PHC serves women who are victims of IPV, aiming at sensitizing the PHC professionals regarding these issues and at promoting comprehensive and effective care. Despite the non-institutional character of the actions, as there is no uniformity in their implementation, they are essential to the process of preventing and facing the problem, being in line with the recommendations of the National Policy for the Comprehensive Care of Women's Health in Brazil.

In this sense, by unveiling guidelines for the in-service practice in the face of IPV cases in primary health care, the study praises, in this setting, the adoption of actions aimed at the social determinants, among them coping with IPV situations from identification and intervention in the problem. Studies carried out on different continents (Asia, Europe, and South America) show successful experiences in the identification and handling of IPV cases in primary health care, such as extended hours of the units with multidisciplinary activities, expanding the therapeutic possibilities of physical and mental health care and creation of groups with topics focused on harmonious marital relations, in addition to activities outside the unit, such as street theaters and partnerships with local leaders.[42-44] In view of the above, it is urgent that the organizations prioritize and guide, based on these care strategies, professional training for the provision of care to the women experiencing IPV, contemplating their needs and specificities in an integral and humanized manner.

Therefore, although this study is limited for not guiding the care strategies related to each of the expressions of IPV, the research contributes to care organization within the scope of primary health care for women who experience this problem. It is also hoped that this study may raise awareness among health professionals so that they are attentive to the identification of indicative signs of IPV. This sensitive look at the theme must go beyond the physical space of the office and include other spaces, such as the woman's home and co-living spaces in the health services. In this context, it is also pointed out that the professionals who work in management organizing and coordinating the health services must promote training opportunities to better prepare the health care team to intervene in the IPV cases, identifying them, empowering the victims and offering them all the necessary support.

Conclusion

The data indicate that the professionals working in primary health care have been using strategies aimed at providing care to women in IPV situations. These strategies go through identification of the situation of violence, which includes investigation of IPV, creation of bonds with the user, and articulation with other professionals of the team; as well as through intervention in cases of violence, which includes meeting the women's needs in the unit, referral to other services in the network and notification of cases.

With regard to the interventions carried out with the purpose of helping women exit the context of violence experienced in the intimate environment, it is important to understand that reporting the situation of violence to the police station is not always a possibility for this population, since the woman may not be prepared, organized and empowered to end the relationship. Thus, in order to avoid a feeling of impotence due to denial of referral to this police service, it is fundamental that the health professionals know other alternatives that assist in coping with violence, such as the Reference Center for Assistance to Women Victims of Violence and support groups for women who experience the problem, which are offered by legal-police and/or social institutions.

The feasibility of the group activities in health units can also be an important strategy to prevent and cope with violence. These spaces are favorable to approach violence in a didactic way with women, who sometimes do not perceive themselves in this situation, and also to educate men about the construction of masculinities and their relationship with gender violence. In addition, these interaction spaces can contribute to the establishment of a trusting relationship with the professional and with other women, so that they feel safe to share personal experiences, which can facilitate identification of cases, design of strategies, and creation of a support network that contributes to empowerment.

Declaration of Conflicting Interests

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Ethical Approval

This study has been approved by the Research Ethics Committee of the Nursing School at the Federal University of Bahia, under opinion No. 2,639,224/2018.

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References

1. Nation Unies. *International Day for the Elimination of Violence to the Law of Women*. New York, NY: United Nations; 2015. Retrieved from https://www.un.org/fr/events/endviolenceday/index.shtml.
2. Cerqueira D, Moura R, Pasinat W. *Participation in the Labor Market and Domestic Violence against Women in Brazil*. Brasília, Brazil: Institute of Applied Economic Research; 2019. Retrieved from http://www.ipea.gov.br/portal/images/stories/PDFs/TDs/td_2501.pdf.
3. Estrela FM, Gomes NP, Lírio JGdS, et al. Expressões e repercussões da violência conjugal: processos de mulheres numa vara judicial. *Revista de Enfermagem UFPE On Line*.

2018;12(9):2418-2427. DOI: 10.5205/1981-8963-v12i9a231013p2418-2427-2018.

4. Estrela FM, Gomes NP, Gusmão MEN, Lirio JGdS, Couto TM, Cerqueira TP. Aspectos demográficos e sociodemográficos de mulheres em situação de violência conjugal: estudo descritivo. *Online Braz J Nurs*. 2016;15(3):423-443. DOI: 10.17665/1676-4285.20165380.
5. Silva AFd, Estrela FM, Soares CFSe, et al. Elementos precipitadores/intensificadores da violência conjugal em tempo da Covid-19. *Cien Saude Colet*. 2020;25(9):3475-3480. DOI: 10.1590/1413-81232020259.16132020.
6. Carneiro JB, Gomes NP, Estrela FM, Santana JDde, Mota RS, Erdmann AL. Domestic violence: repercussions for women and children. *Esc Anna Nery Rev de Enferm*. 2017;21(4). DOI: 10.1590/2177-9465-ean-2016-0346.
7. Leonardsson M, San Sebastian M. Prevalence and predictors of help-seeking for women exposed to spousal violence in India - a cross-sectional study. *BMC Women Health*. 2017;17(1):99. DOI: 10.1186/s12905-017-0453-4.
8. Guimarães RCS, Soares MCdS, Santosdos RC, Moura JP, Freire TVV, Dias MD. Impact on the self-esteem of women in situations of domestic violence treated in Campina Grande, Brazil. *Rev Cuid*. 2018;9(1):1988. DOI: 10.15649/cuidarte.v9i1.438.
9. Albuquerque Netto Ld, Moura MAV, Fernandes e Silva G, Penna LHG, Pereira ALdF. Mulheres em situação de violência pelo parceiro íntimo: tomada de decisão por apoio institucional especializado. *Rev Gaucha Enferm*. 2015;36(spe):135-142. DOI: 10.1590/1983-1447.2015.esp.54361.
10. Burnette CE, Cannon C. "It will always continue unless we can change something": consequences of intimate partner violence for indigenous women, children, and families. *Eur J Psychotraumatol*. 2014;5(1):24585. DOI: 10.3402/ejpt.v5.24585.
11. Sant'Anna TC, Penso MA. The generational transmission of violence in the marital relationship. *Psicol Teor Pesqui*. 2018;33:e33427. DOI: 10.1590/0102.3772e33427.
12. Ayres JRCM, Calazans GJ, Saletti Filho HC, et al. Risk, vulnerability and prevention and health promotion practices. In: Campos GWS, Minayo MCS, eds. *Collective Health Treaty*. São Paulo, Brazil: Hucitec; 2006:375-417.
13. Presidency of the Republic. Deputy director for legal affairs. *Law No. 11,340*. 2006. Brazil.
14. OASSMH. Office of the assistant secretary of state to the minister of health. *Order No. 6378/2013*. 2013. Portugal.
15. Ministry of Health. *Primary Care Notebooks, No. 8*. Brazil: Intra-family violence Guidelines for in-service practice; 2001. Retrieved from https://bvsms.saude.gov.br/bvs/publicacoes/violencia_intrafamiliar_cab8.pdf.
16. Martins LCA, Silva EBD, Dilélio AS, Costa MCD, Colomédos ICDSS, Arboit J. Gender violence: knowledge and professional conduct of the family health strategy. *Rev Gaucha Enferm*. 2018;39:e20170030. DOI: 10.1590/1983-1447.2018.2017-0030.
17. Lawrenz P, Macedo DM, Hohendorff JV, Freitas CPPde, Foschiera LN, Habigzang LF. Violence against women: notifications of health professionals in Rio Grande do Sul. *Psicol Teor Pesqui*. 2018;34:e34428. DOI: 10.1590/0102.3772e34428.
18. Sehnem GD, Lopes EB, Tier CG, Ribeiro AC, Maciel VDQS, Castilhos L. Violência contra as mulheres: atuação da enfermeira na atenção primária à saúde. *Rev Enfer UFSM*. 2019;9:e62. DOI: 10.5902/2179769235.
19. Elliott L, Nerney M, Jones T, Friedmann PD. Barriers to screening for domestic violence. *J Gen Intern Med*. 2002;17(2):112-116. DOI: 10.1046/j.1525-1497.2002.10233.x.
20. Knezevic S, Gajovic I, Marinkovic A. Barriers to health care professionals in detecting more domestic violence. *Opšta Med*. 2017;23(3–4):67-77. DOI: 10.5937/opmed1703067K.
21. Arboit J, Padoin SMdM, Vieira LB. Violence against women in primary health care: potentialities and limitations to identification. *Aten Primaria*. 2020;52(1):14-21. DOI: 10.1016/j.aprim.2018.09.008.
22. Pereira JdS, Machado WCA. Referência e contrarreferência entre os serviços de reabilitação física da pessoa com deficiência: a (des)articulação na microrregião Centro-Sul Fluminense, Rio de Janeiro, Brasil. *Physis Rev Saúde Colet*. 2016;26(3):1033-1051. DOI: 10.1590/s0103-73312016000300016.
23. Simsek HG, Ardahan M. The level of recognition of the symptoms of violence against women by senior year nursing and midwifery students. *Contemp Nurse*. 2020;56(1):23-33. DOI: 10.1080/10376178.2020.1737554.
24. Strauss A, Corbin J. *Qualitative Research: Techniques and Procedures for the Development of Grounded Theory*. Porto Alegre, Brazil: Artmed; 2008.
25. Santos JLGD, Cunha KS, Adamy EK, Backes MTS, Leite JL, Sousa FGM. Data analysis: comparison between the different methodological perspectives of the Grounded theory. *Rev Esc Enferm USP*. 2018;52:e03303. DOI: 10.1590/S1980-220X2017021803303.
26. Corbin J, Strauss A. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks, CA: SAGE; 2015.
27. Dantas CdC, Leite JL, Lima SBSd, Stipp MAC. Grounded theory - conceptual and operational aspects: a method possible to be applied in nursing research. *Rev Latino-Am Enferm*. 2009;17(4):573-579. DOI: 10.1590/S0104-11692009000400021.
28. Stöckl H, Penhale B. Intimate partner violence and its association with physical and mental health symptoms among older women in Germany. *J Interpers Viol*. 2015;30(17):3089-3111. DOI: 10.1177/0886260514554427.
29. Machado MEDS, Rodrigues LSdA, Boa Sorte ET, Da Silva JM, Silva DDO, De Oliveira JF. Percepção de profissionais de saúde sobre violência contra a mulher: estudo descritivo. *Online Braz J Nurs*. 2017;16(2):209. DOI: 10.17665/1676-4285.20175596.
30. Madu JC. Domestic violence legislation for development, peace and security in Nigeria. *Afr Secur Rev*. 2015;24(3):279-290. DOI: 10.1080/10246029.2015.1070274.
31. Greene J, Ramos C. A mixed methods examination of health care provider behaviors that build patients' trust. *Patient Educ Counsel*. 2021;104(5):1222-1228. DOI: 10.1016/j.pec.2020.09.003.

32. Miranda D, Lima RCGS. Confiança: valor-fonte da experiência de usuários com o programa mais médicos em um município catarinense. *Interface Comun Saude Educ*. 2020;24:e190434. [online] DOI: 10.1590/Interface.190434.
33. Tsai AC, Kakuhikire B, Perkins JM, et al. Measuring personal beliefs and perceived norms about intimate partner violence: population-based survey experiment in rural Uganda. *PLoS Med*. 2017;14(5):e1002303. DOI: 10.1371/journal.pmed.1002303.
34. Visentin F, Becker Vieira L, Trevisan I, Lorenzini E, Franco da Silva E. Women's primary care nursing in situations of gender violence. *Invest Educ Enfermería*. 2015;33(3):556-564. DOI: 10.17533/udea.iee.v33n3a20.
35. Borth LC, Costa MCD, Silva EBD, Fontana DGR, Arboit J. Network to combat violence against rural women: articulation and communication of services. *Rev Bras Enferm*. 2018;71(suppl 3):1212-1219. DOI: 10.1590/0034-7167-2017-0044.
36. Santosdos RABdGd, Uchôa-Figueiredo LdR, Lima LC. Apoio matricial e ações na atenção primária: experiência de profissionais de ESF e Nasf. *Saúde Debate*. 2017;41(114):694-706. DOI: 10.1590/0103-1104201711402.
37. Almeida PFd, Gérvas J, Freire J-M, Giovanella L. Estratégias de integração entre atenção primária à saúde e atenção especializada: paralelos entre Brasil e Espanha. *Saúde Debate*. 2013;37(98):400-415. DOI: 10.1590/S0103-11042013000300004.
38. Hetlevik Ø, Hustoft M, Uijen A, Aßmus J, Gjesdal S. Patient perspectives on continuity of care: adaption and preliminary psychometric assessment of a Norwegian version of the Nijmegen Continuity Questionnaire (NCQ-N). *BMC Health Serv Res*. 2017;17(1):760. DOI: 10.1186/s12913-017-2706-1.
39. Cunha KSd, Higashi GDC, Higashi GDC, et al. Myocardial revascularization: factors intervening in the reference and counter-reference in primary health care. *Rev Esc Enferm USP*. 2016;50(6):965-972. DOI: 10.1590/s0080-623420160000700013.
40. Presidency of the Republic. Deputy director for legal affairs. *Law No. 10,778*. 2003. Brazil.
41. Shamu S, Gevers A, Mahlangu BP, Jama Shai PN, Chirwa ED, Jewkes RK. Prevalence and risk factors for intimate partner violence among grade 8 learners in urban South Africa: baseline analysis from the Skhokho supporting success cluster randomised controlled trial. *Int Health*. 2015;8(1):18-26. DOI: 10.1093/inthealth/ihv068.
42. Clark CJ, Shrestha B, Ferguson G, et al. Impact of the change starts at home trial on women's experience of intimate partner violence in Nepal. *SSM Popul Health*. 2020;10:100530. DOI: 10.1016/j.ssmph.2019.100530.
43. Vives-Cases C, Goicolea I, Hernández A, Sanz-Barbero B, Davó-Blanes M, La Parra-Casado D. Priorities and strategies for improving Roma women's access to primary health care services in cases on intimate partner violence: a concept mapping study. *Int J Equity Health*. 2017;16(1):96. DOI: 10.1186/s12939-017-0594-y.
44. Zorzella VL, Celmer EG. Gender reflection groups with men accused of domestic violence: perceiving vulnerabilities and rethinking polarizations. *Gender Law*. 2016;5(1):25. http://periodicos.ufpb.br/ojs2/index.php/ged/index.