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Conditions that interfere in the care of women in situation of conjugal violence

Condições que interferem no cuidado às mulheres em situação de violência conjugal

Condiciones que interfieren en la atención de mujeres en situación de violencia conjugal

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Abstract

Objective: to know the conditions that interfere in the care of women in situation of marital violence. **Methods:** a qualitative study anchored in Grounded Theory. Interviews were conducted, between February and December 2019, with 31 health professionals working in Family Health Units of a municipality in Northeastern Brazil, which integrated one of the two sample groups (professionals of the Family Health Strategy and Family Health Support Center). **Results:** the elements that interfere in the care of women in situations of marital violence were represented in the categories: Understanding the importance of organized professional action; Recognizing the need for professional preparation to deal with marital violence; Realizing the essentiality of the flow of intersectoral care. **Final considerations and impacts for practice:** the study revealed that the care for women in situations of marital violence goes through the professional preparation, the organization of health services and a flow of articulated and intersectoral care. In this sense, it offers subsidies that can guide managers to develop actions to identify and address marital violence against women, based on the co-participation and co-responsibility of the workers of the Family Health Strategy, in order to improve the assistance offered.

Descriptors: Domestic Violence; Intimate Partner Violence; Nursing; Delivery of Health Care; Primary Health Care.

Resumo

Objetivo: conhecer as condições que interferem no cuidado às mulheres em situação de violência conjugal. **Métodos:** estudo qualitativo ancorado na Teoria Fundamentada nos Dados. Foram realizadas entrevistas, entre fevereiro e dezembro de 2019, com 31 profissionais de saúde atuantes em Unidades de Saúde da Família de um município do Nordeste brasileiro, as quais integraram um dos dois grupos amostrais (profissionais da Estratégia de Saúde da Família e Núcleo de Apoio à Saúde da Família). **Resultados:** os elementos que interferem no cuidado à mulher em situação de violência conjugal foram representados nas categorias: Entendendo a importância da atuação profissional organizada; Reconhecendo a necessidade de preparo profissional para enfrentamento da violência conjugal; Percebendo a essencialidade do fluxo de atendimento intersetorial. **Considerações finais e impactos para a prática:** o estudo revelou que o cuidado à mulher em situação de violência conjugal perpassa pelo preparo profissional, pela organização dos serviços de saúde e um fluxo de atendimento articulado e intersetorial. Nesse sentido, oferece subsídios que podem orientar gestores para a elaboração ações de identificação e enfrentamento da violência conjugal contra a mulher, pautadas na coparticipação e corresponsabilização das trabalhadoras da Estratégia de Saúde da Família, com fins em melhorias na assistência ofertada.

Descritores: Violência contra a Mulher; Violência por Parceiro Íntimo; Enfermagem; Assistência à Saúde; Atenção Primária à Saúde.

Resumen

Objetivo: conocer las condiciones que interfieren en el cuidado de las mujeres en situaciones de violencia conyugal. **Métodos:** estudio cualitativo basado en la Teoría Fundamentada en los Datos. Las entrevistas se realizaron entre febrero y diciembre de 2019 con 31 profesionales de la salud que laboran en Unidades de Salud de la Familia en un municipio del noreste de Brasil, quienes formaron parte de uno de los dos grupos de la muestra (profesionales del Centro de Estrategia de Salud de la Familia y Apoyo a la Salud de la Familia). **Resultados:** los elementos que interfieren en el cuidado de la mujer en situación de violencia intrafamiliar fueron representados en las categorías: Comprensión de la importancia de la práctica profesional organizada; Reconociendo la necesidad de preparación profesional para enfrentar la violencia doméstica; Darse cuenta de la esencialidad del flujo de atención intersectorial. **Consideraciones finales e impactos para la práctica:** el estudio reveló que la atención a la mujer en situación de violencia conyugal permea la preparación profesional, la organización de los servicios de salud y un flujo de atención articulado e intersectorial. En este sentido, ofrece subsidios que pueden orientar a los gestores a desarrollar acciones de identificación y enfrentamiento de la violencia conyugal contra las mujeres, basadas en la coparticipación y corresponsabilidad de los trabajadores en la Estrategia de Salud de la Familia, con el objetivo de mejorar la atención brindada.

Descriptores: Violencia contra la Mujer; Violencia de Pareja; Enfermería; Prestación de Atención de Salud; Atención Primaria de Salud.

INTRODUCTION

Intimate partner violence, also known as marital violence, is a global public health problem, given its high incidence in society and its repercussions for women's lives and health[1]. Despite the considerable advances in public policies against this grievance, it is noted that the statistics remain alarming, which signals the fragility of the care offered to women, especially in the Network of Confrontation to Violence Against Women, which includes the Primary Health Care (PHC)[2,3].

Evidencing the broad scope of the problem, data from the United Nations reveals that in 2017, about 17.8% of women worldwide were victims of physical or sexual violence committed by their partners in the past 12 months[1]. In Brazil, a nationwide survey also points to worrying data by elucidating the occurrence of 263,067 cases of domestic violence in 2018 alone[4]. It is observed that the data of this grievance in the country remain alarming, since, only during the first five months of 2021, 25,331 reports of violence by women against their intimate partners or ex-partners were registered through the telephone hotlines *Disque 100* and/or *Ligue 180*, an average of approximately 169 calls per day[5].

This context has made women susceptible to physical and psychological illness, besides causing serious compromises in social interactions. Among the clinical manifestations are abrasions, fractures, burns, vaginal lacerations, sexually transmitted infections (STIs), unwanted pregnancies, and abortion processes, in addition to the psychological damage evidenced, among other forms, by psychosomatic illnesses, depression, and suicidal behavior[6,7]. The whole process may cause women to withdraw from social life, making it difficult to break the cycle of violence[6].

Given the magnitude of this phenomenon, it was realized the need to establish a Network to Confront Violence Against Women[3]. This was established in 2011, through the National Secretariat of Policies for Women, aiming to develop effective strategies for the empowerment of women, ensuring their human rights, holding the perpetrators accountable and promoting qualified assistance to women in situations of violence, fulfilling what is recommended by the National Policy to Confront Violence against Women[8].

The Network for Confronting Violence Against Women includes the Care Network, which is composed of a range of specialized and non-specialized services, including the Family Health Strategy (FHS) and the Family Health Support Center (FHSC)[3]. In this set, the assistance is done through actions such as the identification and adequate forwarding of cases of violence against women, prioritizing the integrality and humanization of the assistance[3,8]. The performance of the professionals in these services, as members of the Network, includes, above all, the early identification of the signs and symptoms of violence, reception, care, notification of cases and referral to other specialized care and social[9].

It is important to emphasize that, despite significant legal advances in addressing cases of violence, the numbers reveal the persistence of female victimization. Data from the 2015 Map of Violence show a 49.2% rate of recurrence of women to health services for injuries resulting from domestic violence, which suggests a low resoluteness of the assistance offered in health services, especially in the PHC, considering the level of care that organizes the care[10,11]. International research also shows that women who have sought emergency services are more likely to experience further abuse in the following months and to need further assistance[12].

In this context, it is essential to know what conditions have interfered with the health care of women in situations of marital violence within the scope of the Family Health Strategy (FHS), since identifying these conditions can guide strategies for preventing injuries resulting from the phenomenon, including feminicide. It is believed that, based on this knowledge, it will be possible to understand the flow used by the professionals of the Network of Care, in the health scenario, as well as their preparation in conducting the cases. Thus, the study aims to know the conditions that interfere in the care of women in situations of marital violence.

METHOD

This is a qualitative research anchored in Grounded Theory (GT). The choice for this method was made because it seeks to understand the ways in which social beings live their experiences from the valorization of subjectivities[13]. The checklist entitled Consolidated Criteria for Reporting Qualitative Research (COREQ) was used to outline the study design and guide the stages of the research, and it was the authors' priority to fully meet the criteria presented therein.

The study is part of a central project funded by the Research for the UHS: Shared Management in Health Program entitled "Confronting marital violence within the Unified Health System: social technology involving women, men and primary care professionals".

For data collection, 22 Family Health Units (FHUs) located in the same health district of a city in the Northeast of Brazil were established as the study setting. At least one representative of each FHU was intentionally invited to compose the theoretical sample of the study. The health professionals working in this setting, who are part of the minimum FHS team (nurses, doctors and dentists) and FHSC team (psychologist and social worker), were contacted by telephone to compose the study through an individual interview. During the call, the theme and objective of the research were shared and a place and time for the interview were scheduled. It is worth mentioning that the study has a partnership with the Municipal Health Secretariat of the State and the coordination of the Women's Health Technical Area, which provided the telephone contacts and previously informed the employees about the project.

The criterion for inclusion in the research was to have been working in the FHS for at least six months, which according to the researchers' understanding is the minimum time necessary for there to be a link with the service users and that these can share their life stories. We excluded those professionals who were away from their jobs due to a medical certificate or did not show up at the time of the interview, for three consecutive times without a

plausible justification, totaling 31 professionals. This number of participants was not previously delimited by the researchers, and priority was given to the verification of the content and consistency of the data until theoretical saturation was verified, marked by the occurrence of repetitions and absence of new data[14].

This collection stage, encompassing two sample groups, occurred between February and December 2019 and was carried out in a private room in the Health Unit where the professionals worked. These interviews were conducted by postgraduates with experience in conducting interviews. The first sample group was formed by 26 members of the minimum teams of the FHU and the second composed of five professionals from the FHSC. To guide these interviews, we used a semi-structured form containing closed questions, with the purpose of drawing a brief profile of the professionals, and open questions allowing them to speak freely about their experiences, guided by the following question: "Tell me about the facilities and obstacles to care for women in a situation of marital violence".

As proposed by GT, the interviews were recorded on a smartphone and then transcribed in full in a Microsoft Word document, being organized and categorized as they were carried out with the participants. It is noteworthy that the transcriptions were carried out by undergraduate students who received previous training and validated by the responsible researchers who were present at the interviews, as well as by the study participants. In order to facilitate the organization and coding of data, in this stage of the study, the NVIVO 10 computer tool was used. In possession of the information from the first sample group, the researchers performed a thorough analysis, from which emerged the hypothesis that directed them to the second sample group, with whom the same question was asked.

For data analysis, the interviews, which lasted an average of 50 minutes, were submitted to the coding and analysis steps provided in the GT, which are open coding, axial coding, and integration. In this last step, analytical categories were formulated from the elements of the paradigmatic model: conditions, actions-interactions, and consequences/results, allowing the unveiling of the phenomenon "Revealing that the care for women to face conjugal violence is linked to actions of identification and intervention of the grievance conditioned by the interest of management at different levels". The validation of this phenomenon was carried out by three researcher(s) with expertise in the method, and also by three interviewees of the study.

In this article, only the component that concerns the conditions of the phenomenon will be presented, found in the narratives of professionals who work in the FHS and make reference to the elements that interfere in the care of women in situations of marital violence. These elements are represented in the categories: Understanding the importance of organized professional action; recognizing the need for professional preparation to deal with marital violence; Realizing the essentiality of the flow of intersectoral care.

Regarding the ethical aspects, it is emphasized that the present study has approval from the Research Ethics Committee (CAAE: 88960217.6.0000.5531/ Opinion Number: 2.639.224/2018). In addition, at the moment preceding the collection, the Free and Informed Consent Term was read individually and the consent of the participants was obtained through the signature of this document. It states the purpose, risks, and benefits of participating in the investigation. In addition, it ensures confidentiality and anonymity to the participants, the latter being related to the replacement of their names by a code that follows the example: "E1, G1", where the numeral that follows the letter "E" refers to the order of the interview and the one added to "G", to the sample group to which the participant belongs.

RESULTS

Thirty-one health professionals who work in the FHU's and FHSC of the FHS participated in the study, being two social workers, three psychologists, four dentists, five physicians and 17 nurses. The age range was between 28 and 65 years, while the time these professionals have worked in the FHS varied between one and 26 years. As for professional training, 25 of them have *lato sensu* post-graduate degrees, with the highest concentration in public health (n = 10) and family health (n = 4).

Based on the narratives of the interviewees, the care for women in situations of marital violence within the FHS is influenced by the interest of management, at local, municipal, state and federal levels, in order to favor or compromise the organization of the work process, the professional preparation and the flow of intersectoral care. These categories are presented below:

Understanding the importance of organized professional performance

Criticizing the logic of productivity, which limits the time allotted for care, the professionals point out the importance of qualified listening and building bonds between professional and user. In this sense, they signal that the organized professional performance will favor the care of women who experience a context of marital violence.

> *Since it is a Family Health Program, I have a link with the woman, I know her story, but the consultation time does not allow for a qualified listening. There is a demand for production and, therefore, situations of violence go unnoticed. This has to change!* (E15, G1)

> *I have a pre-established time to stay with each patient. I can't get to issues as deep as violence in intimate relationships in that time.* (E5, G1)

> *It is from the bond that we are able to establish trust so that the woman can reveal some situations, such as marital violence. We (FHSC) have more time for the service, but it is difficult for the professionals of the unit, with limited time to attend to the users* (E1, G2)

Recognizing the need for professional preparation to deal with marital violence

Professional training was also signaled in the speeches of the participants as a condition that interferes with the care of women who experience marital violence. Faced with the recognition of the difficulty of addressing and dealing with this issue, they believe that professional training is imperative, to be promoted by the management at different levels, which includes the incorporation of the theme in academic training and the promotion of institutional spaces for in-service updates.

> *I felt powerless because she didn't want to report it, she didn't feel ready to leave the relationship and I didn't know what to do to help her. The fragility with the theme of violence comes since graduation because we were not trained to address this issue.* [...] *We needed to receive more training on such a delicate theme* (E20, G1)

> *The management needs to qualify the professionals because many don't even know how to approach the woman if she suffers violence. We have already received several training courses, both from the municipal secretary and the Ministry of Health, but this does not always reach everyone in the unit. I notice that the professionals from the minimum team don't feel able to notify and wait for us, psychologists and social workers.* (E3, G2)

> *Most professionals of the minimum team are not able to investigate situations of marital violence, so they don't address this issue in their routine care of women.* (E4, G2)

Realizing the essentiality of intersectoral care flow

The flow of intersectoral care was another condition, pointed out in the study, as influential in the care or not of women in situations of marital violence. By noticing the fragility of the care network, the professionals point to the relevance of the proper functioning of this flow through the coordination between services, which can be directed by the management in different instances.

> *In the unit where I work there is no referral flow for women in situations of marital violence. If I knew what are the first steps that I should take, I believe that it would help a lot the woman to seek support in the right places.* (E7, G1)

> *We need an organized flow, but the network is fragile and, many times, we depend on the good will of the colleague to refer the woman.* (E4, G2)

> *We bumped into the flow of services for women in situations of violence, which is fragmented. So, she needs to keep going to different places, services such as Emergency Room, Police Station, Prosecutor's Office.* [...] *I don't see any communication between primary care and these services.* (E15, G1)

DISCUSSION

The reports of health professionals show that the organization of the work process within the FHS presents itself as a positive and/or negative influencer in the care of women in situations of marital violence, since it will promote or not the building of bonds between professionals and users. The narratives reveal that the professionals recognize these bonds as an essential condition for the establishment of a relationship of trust that allows the unveiling of the experience of phenomena of difficult verbalization, such as violence in the scenario of conjugality.

However, it is important to emphasize that this bonding process can be made possible at any time of interaction with women, not restricted to formal consultations, such as group activities, home visits, vaccination, dressings, etc. At this juncture, the FHS, which represents a strategy organized through the registration of families by reference team, favors the continuity of care by professionals and thus strengthens the relationship of proximity. Corroborating this, a qualitative study carried out with FHS workers in southeastern Brazil reveals that, based on the establishment of a bond, the identification of cases of violence, as well as the development of the care process can occur in the various socialization spaces of the target community, such as schools, community centers, churches, among others[15].

It is important to mention that marital violence represents a problem that brings together enough elements to make it assume the status of priority in the dynamics of the work of the FHS, given the numerous repercussions for the life and health of women and the imminent risk for feminicide, not justifying, therefore, the limitation of time allocated to this assistance. On the contrary, the listening time of the FHS professional with these women should be the necessary to establish sufficient bonds in order to provide their confidence and thus stimulate the reports of the marital violence experienced. Therefore, this time restriction is pointed out as a limitation for the care of women in different studies[16,17].

To circumvent this difficulty, a multi-method research conducted in a Nepalese community suggests that the teams' work with the community can favor changes in local reality and positively influence individual attitudes and practices around violence against women. For this, the study recommends involving the theme in different scenarios, such as community radio programs, group meetings, street theater, and partnership messages with local leaders, optimizing the time and expanding the reach of the actions of confrontation[18]. Thus, health professionals need to take responsibility for care and, within their possibilities, create strategies to ensure a qualified listening and meet the needs of users, in order to confront the grievance.

Another condition revealed in the speeches as influential in the provision of care, is related to the lack of professional training needed to perform the care to women who experience violence, an element evidenced by the feeling of helplessness for the unresolved cases. Faced with the complexity of the phenomenon of violence, many professionals who are part of the Primary Health Care (PHC) teams feel unprepared to care for women. This difficulty often goes through the limitation during

the approach to the theme, since in the social conception, it is a problem of intimate forum that must be solved in the domestic sphere or in the legal instances. Brazilian studies and another Palestinian study relate the precariousness of the training of health professionals in the field of violence with the need for training that addresses the issue of violence in an articulated manner with the care of the biopsychospiritual health of women who face the phenomenon[19-21].

Even when professionals intervene, advising women to represent the violence at the police station, it is common that they do not accept the referral, often generating in the professional a feeling of helplessness, as reported. Given this scenario, it is necessary that professionals seek alternatives that supplant the referral to the Specialized Police Station (*DEAM*), such as the inclusion of women in educational groups promoted by the FHU, the mapping of a social support network that can be triggered as a partner in this confrontation, which may be formed by family, friends, religious leaders, among other subjects[17]. It is believed that such spaces are essential for the process of empowerment of women and the elaboration of a support and protection network, necessary elements for the confrontation of violence, considering that the report of the abuse can make the victim even weaker and leave her exposed to reprisal by the aggressor[22].

It is also worth highlighting the importance of health professionals knowing the support centers or references for care to women in situations of violence. These spaces, nationally or internationally, are configured as strategic scenarios responsible for promoting psychological, social and legal reception; specialized care by an interdisciplinary team; establishing articulation with other services, governmental and nongovernmental organizations; in addition to contributing to the strengthening of women[23-25].

In the context of the FHS, the multidisciplinary intervention, especially the one linked to the matriciamento, can also be configured as a support for acting against cases of violence. The discussion of cases identified in the community with the FHSC enables the joint work with psychologists, social workers and occupational therapists, focusing on the care of women inserted in the violent context. The exchanges and sharing can occur, for example, during team meetings, and even the cases of violence are a priority among other topics. Cuban and Spanish research highlights the importance of multidisciplinary action in cases of marital violence in the context of PHC. This joint work expands the therapeutic possibilities of physical and mental health care, in addition to favoring the social protection of victims, making them more aware and responsible for making decisions and thus helping them free themselves from abusive conditions[26,27].

Such sharing among professionals may also help to overcome the lack of skills due to deficient education and lack of training, as evidenced in the narratives. This is not an exclusive reality in Brazil, a study conducted with nursing students from the Spanish universities of Barcelona (University of Barcelona and Autonomous University of Barcelona), Tarragona (University Rovira i Virgili) and Girona (University of Girona) shows that, during their training process, these students had little or no contact with the issue of marital violence, pointing to the need for changes in the training curriculum with a view to developing skills and abilities in the management of these cases[28].

However, even though there are gaps in professional training when it comes to addressing this issue, there is an urgent need for these workers to autonomously seek knowledge through documents available for free in digital media. The search for theoretical framework for the construction of their own learning favors the empowerment of health professionals, which encourages them to provide a more qualified care. It is noteworthy that in addition to scientific knowledge, empirical knowledge is mastered by those who work in the FHUs and should be valued, because it is equally significant, since it encompasses the particularities that involve the territorial reality, the experiences of the residents and the perceptions acquired over time of professional performance[29].

It is necessary to emphasize that any damage caused to the users of the health service, in the case of this study, women in situations of marital violence, by health professionals are subject to liability in the civil and criminal spheres. This situation, defined as malpractice, is contemplated in the codes of ethics of different health professions, such as Medicine and Nursing[30,31]. Thus, more than just a motivation, seeking training for action against emerging phenomena of the community assisted, in particular marital violence, is configured as a legal obligation of professional practice.

Although they still have a restricted view on the construction of knowledge, with difficulties to see themselves as agents in the search for knowledge, the interviewees understand the need to be better trained to act on the cases. Besides, the reports also show that the trainings have not been offered in a horizontal way to all professionals, since, unlike what happens to those who work at FHSC, the minimum team of FHU's is not always contemplated with such activities, which can, associated with the specificities of the professions, justify the fact that the narratives point to the referral of women to psychologists and social workers.

Another situation that highlights the FHS is its organization. Although our data reveal an average of nine years working in the FHS, this does not represent a national reality. A study carried out with 811 health professionals linked to FHS teams in a city of Minas Gerais showed that the average time of permanence of the professionals was 20 months, and that more than 48% of the professionals remain for less than 12 months[32].

The high turnover of professionals in the team can be an obstacle to the improvement of the care provided. The entry and exit of professionals necessarily causes the disruption of processes and impairs the quality of care, as pointed out by a Spanish study that reveals that the alternation of professionals affects the cohesion of teams and compromises their ability to engage and establish relationships of trust with colleagues and the community[33]. In light of this reality, management tactics need to be considered by different spheres of government in order to suppress this alternation in jobs. This is because the efforts aimed at preventing and confronting violence against women, a

sensitive issue that needs close relationships to be revealed, suffer particular impact with the high turnover of workers in the FHS.

It is worth noting that the interest of management in training alone does not necessarily guarantee the expected changes, and it is also important that professionals critically reflect on the issue and make commitments regarding their actions against the grievance. In this area, the use of active methodologies that contemplate the cases of the users and the local reality can be configured as a tool, because they make the care plans for women who experience violence more tangible and feasible. The benefits resulting from the expansion of knowledge and acquisition of new knowledge must be collective, and can be enjoyed by the women who receive qualified care, having their demands met; their family, who may indirectly suffer from the aggressions; and the professionals who, in addition to the feeling of well-being, may benefit from the learning in subsequent situations.

The reports expressed the appreciation of the existence of the intersectoral flow of care by professionals, recognizing that its absence negatively impacts the care provided. This reality may be related to the fact of professional unpreparedness, previously pointed out, when the interviewees of this study were unaware of the services and referral routes for women in situations of marital violence. A similar situation was reported in a study conducted in South Africa, in which the interviewed nurses only recognized social assistance as a referral possibility, and even then this referral is forbidden to the medical professional[34]. To overcome the difficulties in handling cases of domestic violence against women, Portugal has, since 2012, a detailed technical tool to guide the identification, monitoring and referral of situations of violence identified in the services[35].

The professionals interviewed in this study verbalized that there is a lack of institutional documents that guide the path to be followed by the user in the network of care. It is worth pointing out that in the absence of these materials, it is necessary that the workers who provide care share with the management the responsibility of promoting the structuring of the care network. To this end, those who work in the FHU, who have knowledge about the specificities of the population they assist, can be a mobilizing agent for contact with other services, which can favor the construction of a network. Ratifying such findings, an international study reveals that the effectiveness of the network of attention to women in situations of violence is related to the organization of established flows, with representation of different institutions such as legal police, social assistance and health, being fundamental that these have autonomy to decide, plan and execute actions for prevention and confrontation of the phenomenon[36].

Even if this network was initially set up informally, through networking among professionals who would seek connections, sharing information, it would later be possible that, with the support of management, they would be organized, structured, and strengthened. Thus, different services can be gradually integrated and, consequently, the flow of assistance to women in situations of violence can be built. International research indicates successful experiences in identifying and acting in cases of marital violence in PHC from an organization based on the articulation with the network of care and social protection, research groups active in prevention and social responsibility with women and spaces for therapeutic support for mental health[26,27].

A facilitating mechanism for communication between the services that make up the network is the referral and counter-referral system. These devices enable the transit of users in the various levels of care; however it is still performed timidly by health professionals. This underutilization of this system can justify the absence of these terms in the participants' discourse, besides which, it can be suggested that the lack of training of these professionals in the theme under study, as seen above, can be one of the causes of the underutilization of the reference and counter-reference system. However, because they support workers and users regarding assistance, they need to have their applicability guaranteed.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

The study shows that the care for women in situations of marital violence may be limited by the logistics of organizing health services, which restricts the time of the consultation, and the professional preparation since graduation to act in these cases. Added to this is the impact of the inexistence or ignorance of a delineated intersectoral flow of care, which can weaken the referral of women victims of violence and compromise their insertion in the Network of Confrontation.

In this context, although limited by not investigating the impacts of these care conditions on the life and health of women with a history of violence, the study advances by offering subsidies that can guide managers in the local, municipal, state, and federal spheres, in order to develop actions to identify and confront the grievance, based on the co-participation and co-responsibility of the Family Health Strategy workers with the purpose of improving the assistance offered to this female public.

Given the reports of professionals that point to a weakness in the process of academic/professional training, the study also points to the importance of colleges of institutions address this content in the curricular components, in order to work the issue of violence in a broad way and better prepare undergraduates for the professional reality. It is also noteworthy the importance of continuing education in health, which enables the updating of professionals and favors their ability to act helping women in the process of confronting violence.

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