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Violence against women: perception and professional approach in primary health care during the Covid-19 pandemic*

Violência doméstica à mulher: percepção e abordagem profissional na atenção básica na pandemia de Covid-19

Violencia intrafamiliar contra la mujer: percepción y enfoque profesional en atención primaria en la pandemia Covid-19

Bruna Odorcik[I], Brígida da Penha Ferraz[II], Karina Castilhos Bastos[III], Maíra Rossetto[IV]

Abstract: Objective: To analyze the approach of health professionals in the identification of violence against women and their perception of the cases during the Covid-19 pandemic in Family Health Centers. **Method**: Qualitative study carried out in two health units, through semi-structured interviews with 23 health professionals. Data were collected between November 2019 and February 2021, and organized with the use of content analysis**. Results**: the categories created showed that health professionals know how to identify the types of domestic violence, but need greater awareness to support, identify and report the cases. According to the perception of the health professionals during the pandemic, there was an increase in violence attributed to social distancing. Conclusion: it is necessary to improve networking, provide better training to health professionals, offering support and active listening skills to women who face situations of domestic violence.

Descriptors: Violence Against Women; Primary Health Care; Health Professionals; Covid-19; Mandatory reporting

Resumo: Objetivo: analisar a abordagem de profissionais de saúde na identificação da violência doméstica às mulheres e a sua percepção sobre os casos durante a pandemia da Covid-19 em Centros de Saúde da Família. **Método:** pesquisa qualitativa realizada em duas unidades de saúde, mediante entrevistas semiestruturadas, com 23 profissionais de saúde. A coleta de dados ocorreu entre novembro de 2019 e fevereiro de 2021, e os dados foram organizados por meio da análise de conteúdo. **Resultados:** as categorias mostraram que os profissionais sabem identificar os tipos de violência doméstica, mas que necessitam de maior sensibilização para acolher, identificar e notificar casos. Na percepção dos profissionais

I Psychologist, Specialist in Collective Health. Universidade do Oeste de Santa Catarina. Chapecó, Santa Catarina, Brazil. Email: bruna.odocik@hotmail.com, Orcid: https://orcid.org/0000-0002-0876-0843

II Medical Student at Universidade Federal da Fronteira Sul. Chapecó, Santa Catarina, Brazil. E-mail: brigidaferraz00@gmail.com, Orcid: https://orcid.org/0000-0003-0288-8763

III Medical Student at Universidade Federal da Fronteira Sul. Chapecó, Santa Catarina, Brazil. E-mail: karinacastilhosbastos@gmail.com, Orcid: https://orcid.org/0000-0002-8439-7230.

IV Nurse. Professor of Public Health in the Medicine course at Universidade Federal da Fronteira Sul. Campus Chapecó. Chapecó, Santa Catarina, Brazil. E-mail: maira.rossetto@uffs.edu.br, Orcid: https://orcid.org/0000-0002-5683-4835

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durante a pandemia, ocorreu um aumento da violência atribuído ao isolamento social. **Conclusão:** necessita-se melhorar o trabalho em rede, aumentar as qualificações dos profissionais, oferecendo técnicas de acolhimento e escuta qualificada às mulheres que passam por situações de violência doméstica.
Descritores: Violência Contra a Mulher; Atenção Primária à Saúde; Profissionais da Saúde; Covid-19; Notificação de Abuso

Resumen: **Objetivo:** analizar el abordaje de los profesionales de la salud en la identificación de la violencia intrafamiliar contra la mujer y su percepción de los casos durante la pandemia Covid-19 en los Centros de Salud de la Familia. **Método:** investigación cualitativa realizada en dos unidades de salud, mediante entrevistas semiestructuradas con 23 profesionales de la salud. La recolección de datos se llevó a cabo entre noviembre de 2019 y febrero de 2021, y los datos se organizaron mediante análisis de contenido. **Resultados:** las categorías mostraron que los profesionales saben identificar los tipos de violencia intrafamiliar, pero necesitan una mayor conciencia para recibir, identificar y notificar los casos. En la percepción de los profesionales durante la pandemia, hubo un aumento de la violencia atribuida al aislamiento social. **Conclusión:** existe la necesidad de mejorar el networking, incrementar la calificación de los profesionales, ofreciendo técnicas de recepción y escucha calificada a las mujeres que viven situaciones de violencia intrafamiliar.
Descriptores: Violencia Contra la Mujer; Atención Primaria de Salud; Personal de Salud; Covid-19; Notificación Obligatoria

Introduction

Primary care is defined as the entry point to health care services by the National Policy on Primary Care (Pnab) and can play a significant role in supporting women victims of domestic violence.[1-2] This offense can be defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether in public or in private life.[3]

In Brazil, the enforcement of the Maria da Penha Law (Law 11.340 of August 2006) involves strategies to prevent, punish and mitigate the different types of violence against women.[4] However, despite this law, the levels of this type of violence have increased in recent years. This is corroborated by data from the National Council of Justice, which estimated the occurrence of about 1 million cases related to domestic violence against women in Brazil.[5] In the State of Santa Catarina, this increase can be demonstrated by data from the Integrated Public Security System, which reveal an 83% increase in feminicides between January and March 2019, compared to the same period of the previous year.[6]

Also, with the onset of the coronavirus disease pandemic (Covid-19), rates of gender-based violence gained national prominence, due to the worsening of this scenario of violence. This fact was demonstrated by data published by the Brazilian Yearbook of Public Security. In a comparison of the years 2019 and 2020 by the referred publication, it was found that 1,350 feminicides occurred in 2020, an increase of 0.7% compared to the previous year; 694,131 phone calls were made to 190 (toll-free number for emergencies) related to domestic violence, an increase of 16.3%, and 294,440 emergency protective measures were granted by the court of justice, corresponding to 3.6%[7]. In this regard, ONU Mulheres Brasil – A United Nations organization dedicated to gender equality stresses that the pandemic has worsened living and working conditions and aggravated cases of sexual and gender violence against women and girls.[8]

The resurgence of cases of domestic violence during the pandemic has been attributed to social distancing and assessed through an intersection analysis between the categories *of racial, gender and social class inequalities*, arising from the oppressive relations of the patriarchal system.[9] However, the situations described are not new, and what happens is the exacerbation of problems, reinforced by retrograde and misogynistic models about what it means to be a woman in the Brazilian society.[10]

The above data shows that this offense is a public health problem and, thus, health professionals can play a key role in promoting and implementing practices that allow identifying and fighting domestic violence. Therefore, knowledge of the approach of primary care health professionals in the identification of cases of domestic violence against women is necessary, particularly in the pandemic period.

The positive attitudes of health professionals in this regard have shown that women tend to appreciate active listening, non-blaming and the offer of possibilities of assistance in the health service network.[2,11] The professionals who support these women must be aware of their unique needs, offering services from the intersector network and mental health care. [12] Another important

aspect related to the actions of health professionals' concerns the possible underreporting of cases of domestic violence during the pandemic, as women were isolated and had more difficulty in accessing health services.[9]

Therefore, this study aims to analyze the approach of health professionals in identifying domestic violence against women and their perception of cases during the Covid-19 pandemic in Family Health Centers (CSF).

Method

This is a qualitative and exploratory study carried out in two Family Health Centers in the city of Chapecó, Santa Catarina, Brazil. These CSFs were chosen because they have different conditions: one is located in an area of greater social vulnerability and the other in an area with higher-income residents. The two neighborhoods were indicated by the municipal health department as scenarios for data collection, as they both have high rates of domestic violence.

The inclusion criteria for the study participants were as follows: health professional available to schedule an interview during the data collection period (not on vacation or leave). The exclusion criterion was health professional not directly involved in assistance to CSF users. The researchers were not familiar with the health units or with the professionals linked to the services, and contacts were made through the Municipal Health Department.

Data collection was performed in two stages. At first, in November 2019, data was collected by the researcher through in-person interviews. There was prior contact with the coordination of each health unit and potential study participants were identified. Also, a list with the names of health professionals working in the CSF was made. Then, the dates and times were selected for the interviews that were conducted in a room available at the health unit and at the most convenient time for the professional. None of the professionals who were contacted in person refused to participate in the study. After their acceptance to participate in the study, the participants signed

the Informed Consent Form (FICF). The interviews were carried out by the same researcher, who had previous experiences in such interviews. The participants answered the questions posed by the researcher in interviews lasting approximately 40 minutes. These were recorded and stored in a portable voice recorder, and later transcribed in full by the researcher who replaced the names of the respondents with codes. A psychologist who performed her duties in a private service and had no connections with the participants collected the data used in this study.

The second stage of data collection was online, with participants completing a questionnaire, as, due to the onset of the Covid-19 pandemic, face-to-face collection was not possible. To ensure the continuity of the research, an amendment was submitted to the research ethics committee requesting the following changes to the research: method of data collection, questions related to risks, benefits, application of the informed consent form and the instrument, and the addition of a question related to the pandemic (answered by 15 individuals). After approval by the committee, online data collection was carried out from December 2020 to February 2021. The instrument and the TCLE were sent by electronic link by the municipal health department to the CSF coordinators, who in turn sent this data back to the health professionals, through a cell phone application.

The data collection instrument addressed issues related to personal and professional identification; understanding of domestic violence; professional experience regarding suspicion, identification and conduct; knowledge about the care network for victims of domestic violence in the municipality; understanding of the support to be offered to victims, and of the identification of the need for training for professionals, as well as perception of an increase in the cases of domestic violence in the pandemic scenario (this question was inserted only in the online instrument after the onset of the pandemic). The interviews recorded in the first stage of data collection were transcribed and the completed instruments were not returned to the participants.

The required sample size was not determined *a priori.* All professionals from the two health units were invited to participate in the study, and of the 34 participants, 23 completed the data

collection instrument. Some health professionals did not complete the data collection instrument sent online, and it is not possible to measure the reasons for such refusal to participate in the study. A total of 23 professionals participated in the survey, eight in the face-to-face stage and 15 in the online stage.

Content analysis was performed.[13] In the pre-analysis stage, after all the interviews transcribed in full (first stage of collection) and the answers obtained by electronic questionnaires (second stage of collection) were inserted in a single document, free-floating reading of the material was conducted. Furthermore, the organization of the collected data was also carried out, with the selection of what was relevant, in order to allow the identification of the ideas to be analyzed in the following stages. It should be stressed that in data selection, completeness, homogeneity and relevance were observed.[13]

In the exploration of the material, proper completion of the actions of the previous phase was verified prior to the beginning of the codification and analysis of the collected constructions. For coding, the record units were established by theme, and the statements related to each theme were identified and grouped. Categories that transform raw data into organized data were created, providing a simplified representation.[13] In each category, the related recording units were gathered and the categories were named, with a comprehensive title, for example: *Professional perception*: identification of domestic violence and how it manifests itself; *Need for external guidance*: possibility of a project to guide the team; *Professional's opinion on the relevance of the theme*: does the discussion make sense in the CSF of Chapecó?; *Increase in cases of domestic violence*: Covid-19 context; Was there an increase in such cases due to social distancing? In the exploration stage, the recording units were also listed by counting the frequency with which these units appeared in the statements in each category, and the importance of each recording unit is directly proportional to the number of appearances. The recording units were also listed by direction, with "knows/does not know/knows little" directions in one given category.

Finally, in the stage of treatment, inferences and interpretations of the results, efforts were made so that the results obtained were significant and valid. At this stage, "Tables of results, diagrams, figures and models are established, which condense and highlight the information provided by the analysis".[13:127] For this purpose, tables that facilitated the visualization of information and helped in the interpretation of the results were created.

The research project was submitted to the Ethics and Research Committee of Universidade Federal da Fronteira Sul and was approved under Protocol No. 3,687,958, on November 6, 2019. The study was conducted in accordance with ethical standards (Resolutions 466/2012- 510/2016 - 580/2018, of the Ministry of Health).

Results

A total of 23 professionals participated in the survey, eight in the face-to-face stage and 15 in the online stage. Some characteristics of the participants, such as profession, age, year of graduation, previous professional experience and area of expertise in the CSF/length of time of working in the area are shown in Table 1.

Table 1 – Characteristics of the participants of the study

Name	Profession	Age	Year of graduation	Previous professional experience	Area of expertise / Length of time working in the referred area
P1	Nurse	45	1997	Professor	Coordinator 23 years
P2	Nurse	37	2006	Only academic	13 years
P3	Nurse	30	2010	Hospital	09 months
P4	Nurse	33	2009	None	10 years
P5	Nurse	27	2015	Hospital, Emergency Care Unit (UPA)	Coordinator 04 years

P6	Nurse	44	2007	UPA	06 years
P7	Physician	34	2014	Preceptorship	5 years
P8	Physician	33	2015	UPA, Emergency Service, Samu	01 year
P9	Dentist	37	2004	Dentist in private practice	14 years
P10	Dentist	41	2002	None	17 years
P11	Social worker	35	2010	Community health agent (ACS)	06 years
P12	Psychologist	54	2003	Psychologist	11 years
P13	Pharmacist	39	2006	Hospital, private pharmacies	09 years
P14	Oral Health Assistant (OHA)	42	Does not remember	Pharmacy attendant, receptionist, telephone operator	14 years
P15	Nursing assistant	35	2008	None	10 years
P16	Nursing assistant	45	2012	None	10 years
P17	Administrative assistant	38	2011	Unimed, Sadia, Unochapecó	20 days
P18	ACS	53	Does not remember	Saleswoman, seamstress	14 years
P 19	ACS	30	Does not remember	Saleswoman, endemic disease control agent	03 years
P20	ACS	27	2018	Commerce	02 years
P21	ACS	38	2011	None	10 years
P22	ACS	40	2009	Meat packing industry	02 years and 06 months
P23	ACS	35	2000	None	01 year

As for the profile, most participants were female professionals, mostly nurses or ACS, aged 30-39 year who graduated between 2000 and 2010, had other jobs before working in the health area and who had been performing their current professional activities for over 10 years.

Four categories emerged from data analysis: Identification of domestic violence: [...] *there are several forms of violence, not only physica*l [...]; Need for guidance for the team: [...] *training to get to know the service network* [...], [...] identify suspicious cases and direct assistance [...]; *Discussing violence is important:* [...] [violence] *increased because of the stressful situation experienced and the fact that people spent more time in close contact at home.*

Regarding the identification of domestic violence against women, these professionals know what domestic violence is. Deprivation of property, moral and sexual aggression were also mentioned, but less frequently. The testimonies revealed how the participants identify domestic violence in their daily work routine.

> So, there are several forms of violence, it's not just physical [...] many women are psychologically and financially violated, often by bullying [...] And maybe they don't realize they are being verbally abused [...]. (P1)
>
> *Both verbally and physically, women come and tell what happens to them at home, sometimes they are humiliated simply because they are women, or they are physically assaulted.* (P7)
>
> Al*l kinds of violence - psychological, verbal, physical violence* [...] *one person threatening someone else* [...]*and also disturbing someone, by calling attention to their physical disability, to embarrass them in some wa*y [...]. (P2)
>
> [...] *all kinds of violence, - physical or verbal - that occur at home, in the family environment, not only against relatives with blood ties, but also people with whom one lives* [...]*children, men or women* [...]. (P3)
>
> *Any act that violates the physical or psychological integrity of a person, within the home or by family members/partners.* (P9)
>
> *Any violation, oppression, threat, physical and verbal violence against women in their family environment in a relationship that involves affection.* (P11)

It can be seen in the statements that the participants know the concept of domestic violence, as they identify violence and its different forms of manifestations in users assisted by them in primary care. Health professionals can perceive the different manifestations of physical, verbal, psychological, moral and financial violence in the women they care for.

The team needs guidance: [...] *training to get to know the service network* [...], [...] *identify suspicious cases and refer patients for proper care* [...]

The professionals recognize the importance of moments of guidance to the team in the assistance to women in situations of violence. Regarding the need to implement training programs for the health team on the identification and approach of women victims of domestic violence, the participants perceived the need for guidance to properly carry out the identification, care and referral of the victims. Training processes are also necessary, especially to help health professionals develop the confidence to offer assertive guidance, when required, according to the testimonies of the participants.

> *Training to get to know the service network, identify suspicious cases and refer patients for proper assistance.* (P13)
> *I think that health professionals need training on this subject. I don't feel comfortable guiding, referring or even suggesting actions for patients who are victims or suspected victims of violence, due to lack of knowledge or fear of "invading" the patient's privacy. (P9)*
> *Some professionals need training to understand that women return to their partners who assaulted them for several emotional reasons and not because they want to get beaten.* (P12)

Proper training could also dismiss the judgments of some professionals, preparing them for care.

> *First of all, health professionals need training. This would help them cease to make judgments, eliminate what is hidden behind many behaviors. Improve assistance and train everyone to support the women and identify possible situations of violence, train professionals on the support network and the care protocol for victims of sexual violence, approaching compulsory notification again. Develop strategies with the community so that people also report situations of violence in their next-door neighbors' homes. Discuss epidemiological data to reflect about educational actions in the territory.* (P11).
> *This should be addressed in the training, as these events will become increasingly common in health services.* (P13)

The health professionals also revealed the need to improve the reporting the records of violence in order to produce more reliable data on this issue.

> *We know that this happens very often, and that even statistical data is underreported, but we don't know the reality [...] it is an important issue that should be debated, as it happens all the time.* (P10)
> *These were often women's reports of violence committed by their partners a few hours ago, and we had to notify the event and fill out paperwork.* (P17)

The professionals reported that the health team needs guidance to feel more comfortable

when referring women to the care network. Ongoing training is mentioned as a way to improve knowledge and the ability to report and generate data on this offense.

Discussing violence is important: *[...] it is also necessary to raise the professionals' awareness on this issue even more*

When asked about assistance to these women, the participants exposed the importance of discussing the topic, as they believe it is necessary to raise health professionals' awareness of the care to women victims of violence.

> [...] it could be another service that provides a house or shelter for women; there are several services that can be the entry point; they are also part of the women's health care network. (P1)
> [...] *I think there should be a network that worked in collaboration with the police station and the women victims of violence, a service that provided not only psychological care, but also medical care. (P3)*
> *I think we are not prepared for these services, and contacts with other sectors are insufficient and usually take time. Refusals for assistance from other sectors are troubling for us professionals.* (P4)
> *We have a lot to discuss collectively and improve the dialogue between the service network.* (P11)
> [...] *Get to know the service network, identify suspicious cases and refer the patients to assistance.* (P13)

Nursing professionals are often considered by the team as responsible for supporting the women and notifying cases of violence.

> *It is necessary to further raise the awareness of all health professionals about this situation, not only nursing, but also physicians, in short* [...] *all occupations in the health area, health agents, who go to people's homes, who can sometimes witness some situations of violence* [...]. (P1)
> [...] *I think that the nursing staff offers guidance to other professionals, reporting that something is happening* (P14) [...]

The professionals mentioned the need to sensitize health workers from the entire multidisciplinary team about the other points of the care network, with devices that contribute to an adequate support to these women. Nursing is perceived as one of the professions responsible for support in situations of domestic violence.

Context of the Covid-19 pandemic: [...] [violence] *increased because of the stressful situation experienced and the fact that people spent more time in close contact at home.*

In the second stage of the study, when asked about the changes in the scenario of domestic violence in the context of the Covid-19 pandemic, the participants reported that they perceived an increase in the number of cases. Among those who answered affirmatively and justified their opinions, there was a consensus that such increase in the number of cases of violence was due to the longer time spent by these women with their partners (aggressors), as a result of the social distancing measure adopted by the population to contain the pandemic, according to the statements.

> [*Cases of domestic violence against women have increased] [...] due to their full-time coexistence with their partners and the pressure that we have all faced due to the fear of a disease for which there is no specific treatment and all its consequences.* (P15)
> *Violence rates increased because of the stressful situation experienced and the fact that people spent more time in close contact at home.* (P12)
> *Increase in the number of cases of Covid-19 shown in the news, in view of the social distancing and the resulting economic and emotional consequences.* (P13)
> *Users find it more difficult to access the services, economic and life routine changes can have an impact on this situation.* (P17)

According to the participants, the various stressful situations triggered during the pandemic can contribute to the increase in domestic violence rates. In addition, social distancing measures and changes in the routine and income of families can lead to intra-family conflicts.

Discussion

Primary care can be the entry point for first contact, longitudinal and comprehensive care to people and assist in the identification, in its coverage area, of women victims of domestic violence.[2] Therefore, health care units must be ready to offer the necessary support to the victims, so that they can be able to make their decisions about how to handle these situations.[14] In the pandemic context, the mapping of situations of violence in the living territory is essential for the prevention of cases, support to the victims and referrals through the service network.[15]

The respondents can identify domestic violence. They understand that, in addition to the physical and mental aspects of violence, there is also verbal and economic violence. However, although they often recognize violence, participants feel insecure and need to develop interpersonal skills to address the issue of domestic violence with the women.[16] It is important to recognize domestic violence, but in primary care it is essential to know how the health care team will assist women victims of domestic violence and the resources necessary for the delivery of proper care to these women.[2]

Complex situations may occur in health units, and patients may need to be referred to other sectors. Domestic violence requires more than the ordinary actions developed by health organizations. Health professionals must access services that provide comprehensive care and that are interconnected, avoiding critical routes.[17] Thus, the entire team involved in care needs to carefully reflect about the necessary steps from notification to patient referral.

In addition to complex referrals, there is a need for constant identification of the care network, which may undergo frequent changes. This requires that all professionals define and build this care path, as it is urgent to identify the protection network against violence to face the problem.[18] Often, women who decide to break up with their aggressors need different care services, ranging from legal and social care to physical and mental health care.[19] Thus, intersector work and communication between health services is necessary.[17]

This coordination imposes on health professionals involved in assistance the responsibility of identifying housing options (in support homes), protective measures, socioeconomic assistance and support for school-age children, among others, and referring the victims to these services. Such referral carried out by the care network, which is sometimes necessary in a situation of violence, is not considered by professionals as a duty of the health care area. Hence, it is often neglected, and the women themselves have to seek their own care.[19]

As for the profile of primary care professionals, other factors that can interfere with their

performance include inadequate training to the occurrence of moral and ethical conflicts that culminate in blaming and accountability of the victims for the situation of violence faced.[20] Therefore, lack of training of health professionals and non-identification of situations of violence lead to the invisibility of these situations, which are not reported in the health surveillance system.[21] These problems are aggravated by the lack of regulations on technical procedures for notification and by the absence of legal protection mechanisms for health professionals in charge of the notification of these cases.[22-23]

Some professionals are not familiar with this topic, as in some statements the view that nursing is responsible for the support to women in the health unit was prevalent. Centrality of care is perhaps more attributed to nursing due to its role of listening and screening in many health units.[19] However, when the training of professionals for the Unified Health System (SUS) is discussed, the role of each professional of the family health team and of primary care may lead to some stress. The knowledge of health professionals about services not performed by them cannot be partial, and there must be an established flowchart and coordinated work in the network.[17]

In this regard, several publications address the importance of including discussions that address gender and support in undergraduate curricula.[16-17,19] Proper assistance cannot depend on the good will of professionals, who often do not have access to adequate training, either during their academic or in-service training.[17]

To help change this scenario, and in view of the great demand for these services, Continuing Education in Health can be a tool to update, qualify and assist in the in-service training of professionals, in view of the dynamism of legal, social and health actions and services that must be simultaneously activated on the network to ensure proper assistance to women victims of violence.[24] Continuing education can encourage trained workers to be knowledge multipliers, in order to contribute to reducing the number of cases of violence against women.[25]

Participants also reported their perception that cases of violence during the Covid-19

pandemic had increased. In the current scenario of social distancing, women are more often watched and prevented from talking to family and friends, which facilitates their abuse.[26] The control of domestic finances can also cause trouble due to men's loss of financial control, the economic consequences of the pandemic scenario, and because men spend more time in an environment that is more commonly dominated by women. The prospect of losing male power directly hurts their image, serving as a trigger for violent behavior. Aspects related to stress, fears and consequent marital differences implicit in the context of instability also contribute to this situation.[10,27]

The drop in visits to health services can also contribute to the occurrence of situations of violence.[22] Due to the need to stay at home because of the pandemic and with lower access to health facilities, there was underreporting of cases of domestic violence against women, and the victims had fewer opportunities to talk about the violence suffered with health professionals.[27]

The pandemic reconfigured the functioning of many services, not only in the health sector, but also in other areas, such as police stations, social work agencies, support houses, schools and churches. With the pandemic, all these services/institutions that were usually easily accessible, were available only at certain times or even temporarily closed, as they could not be made accessible online.[22] Therefore, the proper training of health professionals and permanent in-service education actions can have positive impacts and produce qualified care, because even during the pandemic, the reconfigurations of the intersector network could be mastered and health professionals would be able to refer patients to proper care.[15]

Finally, it should be noted that the onset of the pandemic was a limitation of our study, causing delay and the need to reorient data collection. According to the researchers, after the pandemic, some professionals were reassigned to other services, became ill with Covid-19 or were overloaded in their work functions, and this may have influenced their participation in the study. Moreover, the online instrument limited interaction with the researchers and some participants may have found it difficult to use it, as not everyone accesses and answers a digital instrument easily.

In the care area, it is worth mentioning the contributions to the expansion of training spaces for professionals to work in the intersector network, even during the pandemic. Regarding teaching, the importance of sensitizing and raising health professionals awareness about the need to gain knowledge on this topic as early as during their graduation studies is highlighted. The search for techniques of support and listening used in psychology aimed at guiding nursing professionals is also suggested, because they must be prepared to listen and promote health care whenever necessary. It is important to develop studies that can contribute to the identification of the intersector network, pointing out the necessary devices for the delivery of adequate assistance to women who suffer violence. The professionals must also be familiar with research practices that can detect changes in the care process, as well as during the pandemic, as there were changes in various care services targeted to women victims of violence.

Final considerations

Health professionals can identify domestic violence and its different manifestations. However, many are unaware of the care network and support services. This lack of knowledge leads to underreporting of cases and the invisibility of violence. Training and the implementation of permanent health education actions can contribute to the permanent qualification of the health team to work in primary care.

During the pandemic period, health professionals detected an increase in the number of cases of domestic violence associated to social distancing and many stressful situations. The participants explained that health professionals must be familiar with the service network and with the reconfiguration of intersector actions, due to the dynamic character of assistance to women who face domestic violence.

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Corresponding author

Maíra Rossetto
E-mail: maira.rossetto@uffs.edu.br
Address: Travessa Tijucas 109e, apt 802, bairro Presidente Médice, Chapecó, SC. CEP: 89801307

Authors' contributions

1 – Bruna Odorcik
Conception or design of the study/research, analysis and/or interpretation of data, final review with critical and intellectual participation in the manuscript.

2 – Brígida da Penha Ferraz
Analysis and/or interpretation of data, final review with critical and intellectual participation in the manuscript

3 – Karina Castilhos Bastos
Analysis and/or interpretation of data, final review with critical and intellectual participation in the manuscript

4 – Maíra Rossetto
Conception or design of the study/research, analysis and/or interpretation of data, final review with critical and intellectual participation in the manuscript.

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