Original Article

Care network for women in situation of violence: the challenges of care transversality*

Rede de atenção à mulher em situação de violência: os desafios da transversalidade do cuidado

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* Article extracted from the Doctoral thesis "The care network for women in situation of violence under the perspective of complex thinking", presented to the Nursing School of Riberão Preto at Universidade de São Paulo.

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ABSTRACT

A qualitative study aimed to understand how is configured the care for women in situation of violence, under the sight of professionals. Data was collected by interviews with seven key-informants, and it was analyzed by the method of interpretation of meanings. In the central theme category: auto eco-organizer system of institutions, two meaning nucleus were identified: Care axis and Institution Functionality. In the first, the care axis was classified as psychosocial care, health care and police care. At the institution functionality, attention to women was found while obtaining demands and referrals through triage. From the professional's perspective, although advances were obtained on the past years, the "mismatch" still persists in the care network for women in situation of violence, which does not contemplates what is conceived by attention transversality. The study pointed aids to strengthen the network, aiming to guarantee women's rights.

Descriptors: Violence Against Women; Women's Health; Social Networking; Nursing Care.

RESUMO

Pesquisa qualitativa, cujo objetivo foi compreender, sob a ótica dos profissionais, como se configura a atenção à mulher em situação de violência. Os dados foram coletados por meio de entrevistas com sete informantes-chave e analisados pelo método de interpretação dos sentidos. Na categoria temática central: Sistema autoeco-organizador das instituições identificou-se dois núcleos de sentido: Eixo da atenção e Funcionalidade da instituição. No primeiro, o eixo de atenção foi classificado em assistência psicossocial, assistência à saúde e assistência policial. Na funcionalidade da instituição, evidenciou-se atendimento às mulheres na captação das demandas e encaminhamentos por meio da triagem. Na perspectiva dos profissionais, apesar dos avanços obtidos nos últimos anos, ainda persiste o "desencontro" da rede na atenção às mulheres em situação de violência, o que não contempla o que se concebe por transversalidade da atenção. O estudo apontou subsídios para fortalecimento da rede, a fim de garantir os direitos da mulher.

Descritores: Violência Contra a Mulher; Saúde da Mulher; Rede Social; Cuidados de Enfermagem.

INTRODUCTION

The care network for violence is constituted of the articulation within governmental institutions, non-governmental and community, and aims to broaden and improve the assistance quality, adequate referral, and development of effective strategies for prevention. Thus, the network is occupied by the violence complexity and the multi-dimensional character of the problem, surpassing health, public safety, social and legal assistance, within other fields[1]. The network care model allows integral and inter-sectorial care and it is recommended by national and international studies[1-3].

However, the scientific production dedicated to analysis of service network is still scarce, in contrast with the enlargement of care network. A study[4] identified that the international production is recent and one of the major care problems is the lack of support networks, showing the need to discuss the question of violence against women in everyday services, to define priorities as professional training and, to establish partnerships with other services[4]. In this direction, the difference between work proposals and finalities in institutions represent a barrier for the inter-sectorial and multi-professional attention[5]. In practice, institutions try to adequate interventions in their practice for violence cases, without an integral and transversal attention, compromising the quality of care.

In this sense, there is a need of investigations focusing in specific aspects, as equipment availability, organization knowledge, functionality of institutions and available services that can favor the assessment and monitoring of public policies and allow its improvement[6]. Thus, it is fundamental to recognize how structures and social systems evolve and interact to constitute social fields, and then, to use network models as instruments to transform reality[7].

The theoretical option adopted in the present study to comprehend this phenomenon was the complex thinking paradigm[8], aiming to sensitize professionals to weaknesses in the positivist and fragmented model. The theory is based in three principles: the dialogue that allows contextualizing the object, promoting articulations, without eliminating differences. The organizational recursion understands that in the process, products and effects are at the same time, the cause, and the producers of what is produced in a self-constitutive cycle, self-organized and self-producer. The last principle – holographic, defines the part being in a whole, as well as the whole is in a part[8]. Such ideas contribute to comprehend the notion of knowledge integrality and the concept of trans-disciplinary[7].

The interface between the theory of complex thinking and the violence against women allows working the theme in the research field as well as in the intervention one, under an integral perspective, as an issue demanding trans-disciplinary and inter-sectorial actions. It involves diverse knowledge and practices, affecting the subjectivity of women and operators acting on their coping, being one of the challenges for institutions and professionals[9-10].

Facing this context, the present study aimed to comprehend, under the sight of professionals acting in services that compose the network, how is configured the care for women in situation of violence.

METHODS

This was a descriptive and exploratory study with qualitative approach. The field of investigation was a city in the Southeast region of Brazil, and three governmental institutions composing the Network of Care for Women in situation of violence, denominated Institution 01, Institution 02 and Institution 03. The choice for these institutions is justified for being services attending women in situation of violence.

Seven professionals considered key-informants[11] participated in the study, recognized by being references and responsible for hosting and guiding women, as well as by articulating with services of the care network for necessary referrals to their demands. The empirical cut of

the study was by data saturation, that is, when there is information re-incidence[12].

To develop the investigation, the recommendations of Brazilian norms for research with human beings were considered, and the data collection was initiated after approval of the Ethics in Research Committee of the Nursing School of Ribeirão Preto, under the protocol nº 266/2013.

The data collection was conducted at the institutions, during December of 2013 and March of 2014. To secure anonymity when presenting results, testimonials were coded by the letter (S) followed by Arabic digits of one to seven, following the order of interviews conducted.

The testimonials were obtained through semi-structure interview, as the report allows dialogue with the real complexity, and the speech allows to express the multiplicity of the perceived phenomenon[13]. To attend the interest of the empirical material production, an interview script was built with open questions contemplating the information to characterize participants: age, education, occupation, time of service and function or position exercised. The questions were about the perception of the phenomenon reported about the offered services and driven by the institutions.

The testimonials were recorded, fully transcribed and analyzed through the interpretation of meanings[14], following the steps: comprehensive reading, aiming to see the whole and to apprehend particularities that serve as basis for interpretation; exploring the material, which is the ability to go beyond the speeches, characterized by the identification and problematizing and by the dialogue between ideas, as information provided by other studies about the subject and the theoretical reference; and finally, the creation of an interpretative synthesis, characterized by the articulation between the objectives of the study, the theoretical basis adopted and the empirical data.

RESULTS AND DISCUSSION

The group of seven key-informants was composed by three professionals of the Institution 01, two from Institution 02 and, two from Institution 03, all of them were females. Their mean age was 34 years, and it varied from 29 to 54 years. Regarding participant's education, one completed high school and six graduated in social services, psychology, and law. In relation to their function, four were social assistants, one was psychologist, one was chief police officer, and one was police clerk. The time working at the institution varied from one to 20 years exercising in the function.

While analyzing testimonials, the central category emerged: **Self echo-organizing system of Institutions**, denominated as such because the institution is highlighted through the environment and it is distinguished by its autonomy and individuality, and at the same time, it is connected to it by the increase of its opening and exchange that accompanies all complexity progress[8]. From this category, two meaning nucleuses were identified: a) Care axis and b) Functionality of the institution while attending women in situation of violence.

Regarding the **Care axis**, Institution 01 pertains to psychosocial care. Regarding care vocations, actions conducted are of basic orientation, creation of projects and development of public policies to the city. In this institution, the offered services are in majority, guidance and referrals to care network, and the professionals composing the multi-professional team are psychologists, social assistants, lawyers, hosting agents and coordinators.

[...] to guide the paths that women should follow when found in situation of violence. [...] a service of support and strength (S2 – Institution 01).

This functional structure presented at Institution 01 corroborate with the data of a study that mapped the care network for women in situation of violence in other

metropolitan regions[2]. Thus, the Institution 01 gathers characteristics of a place to provide services of basic guidance about their rights and about other network services and the formulation of Public Policies for matters of rights, citizenship, gender and women's health[2].

The care axis of Institution 02 is health care, and its care vocation is characterized by actions of health and psychosocial fields. The offered services are, in its majority, medical and psychosocial care. The professionals composing the multi-professional team are social assistants, physicians, psychologists, administrative officer, and the institution's director.

[...] psychological care, we have psychiatric care, we have medical care for infectious diseases and pediatrics for our children…[...] gynecology and obstetrics ambulatory that attends women and infectious contagious diseases (S4 – Institution 02).

In the health field, such institutions develop activities to care for women in situation of violence, especially sexual violence and mental health matters, mixing medical activities with psychosocial actions, therefore social and/or psychological care[2].

Although the nursing category does not compose the team of participating institutions, studies[15-16] highlight that in healthcare services, nurses are the first professionals to get in touch with women in situation of violence. Their ability to manage cases and care, make them responsible to articulate between other professionals and services, and it is a key-professional to care for these women[15-16].

The Institution 03 provides public safety care and its care' vocation is characterized by actions in the police field. The services offered are accident report, case investigation, guidance, and referral to the care network. The professionals composing the team are police chiefs, clerks and, investigators. Thus, the institution provides police assistance, attending women in terms of complaints' registration, investigation and compliance with court decisions[2].

[...] triage attention [...] I support, guide and I do the referral. [...] the accident report. There are investigators, when the case is a bit more severe… (S6- Institution 03).

Regarding the assisted clientele, Institutions 02 and 03 attends women as well as children and adolescents. The Institution 01 attends only women, however, if there are children/adolescents involved in the dynamics of family violence, the service also care for the family and refers children/adolescents.

Thus, the auto echo-organizer principle has holographic value, that is, not only the part is in the whole, but also the whole is in the part. This principle holds true for the society and institutions that have functionality rules[8].

In the second meaning nucleus, the **Functionality of the institution** is developed based on the institutional vocation that is different at the three studied institutions. However, they have in common the fact that each institution tries to capture the women's demands from their assistencial vocation, and the first triage action is the basis of the institution's dynamic.

So we work a lot with demands brought promptly on that day (S1 – Institution 01).

When the service requested by the woman is not offered at the institution, the care continuity happens through referrals to the care network, focused on the need to follow and to insert equipment, as observed on the following pieces:

For some psychological support services, at the Universities, at psychology clinics. For the Public Defense... [...] punctual sexual violence, that does not have to do with the family dynamic, we refer to the reference service (S3 – Institution 01).

We have the coordinating body that we refer to. The referral service...There is the guardianship council when involves minor and the Public Defense... (S6 – Institution 03).

The triage, which should constitute a primordial and fundamental step in care for women in situation of violence, in a sense to be the moment practice hosting through an action plan respecting the woman's decision[17], ends up restricting actions while verifying if it is a compatible case with the service vocation. Thus, it was identified that the triage is a practice of punctual conduct and, when it is not compatible with the care vocation of the institution, the woman is redirected to other equipment of the network, searching for access channels and following the case.

Therefore, it is identified the expressed meaning by the participants not contemplating what is conceived for hosting and transversality of care. Hosting is characterized by the ethical posture and implicates the sharing of knowledge, taking for itself the responsibility to "host" others in their demands, with responsibility and resoluteness, guiding when needed the subject and the family, in relation to other services, to continue the assistance and establishing articulations with these services to guarantee the efficacy of these referrals[18]. This hosting conception corroborates with the concept of attention transversality, aiming to put the user and its needs in the center of attention and it is configured by articulations of actions in the same service or between services of the same sectorial or inter-sectorial network[2].

The triage leads to responsibility weakening, once each one tends to be responsible not only by its specialized task, but also solidarity, as it does not notice the bonds with their fellow citizens and professionals[8]. Thus, the path leading to inter-sectorial approach stumbles on the referral without compromise with follow up and articulation of cases.

One singular condition of this attention can be identified on Institution 02, when discussing a case with the multi-disciplinary team. The group discussion aims to decide the type of care requested and to delimitate what is considered of their competence or not. Although shyly, these professionals have a view of the women's care transversality, when proposing to discuss the case particularities, in conformity with the service actions, putting it in the care network context.

[...] the woman passes through the social service that does the triage, then there is the case discussion with the team…to know what will be the referral, if she is going to individual attention, if she is going to group therapy or if she continues mental healthcare that it is already performed, if she demands to go to CREAS, then it is during this case discussion that we will decide what will be done with that case… (S5 – Institution 02).

The demands of a woman in situation of violence are diverse and it is necessary to broaden the view over their needs. Thus, it is important to understand the context in which violence is present, it can involve diverse family members at the same time. Thus, professionals who share this conception try to stimulate inter-sectorial activities to sustain transversality, as observed in this part:

[...] our objective is to provide health care for that woman, but when dealing with woman suffering from violence, we have to understand that all members of that family are suffering with violence, so all those members need to be seen and need accompaniment. [...] the bonds are fragile, the access to rights of that person is fragile…so, for this reason, the network needs to be prepared and strong to host, in a sense to host the needs presented by that family, but in a way to empower the rights, the strengthening and the insertion on the equipment...So we have to have this look over this woman who is getting strong and how this community is ready to deal with this support (S5 – Institution 02).

Professionals from this study considered the institution as having its autonomy and internal work organization, but, facing the complex reality of work permeating the violence relationships, they need the environment and other institutions to contextualize the work object[8].

Thus, the violence against woman is configured as a multifaceted phenomenon, and how each woman will deal with this situation, given the social, community or family contexts in which they are inserted, requires diverse and complementary care, demanding attention in network to produce efficient answers[2].

The transversality of care also contemplates care for the aggressor. However, this care is absorbed by the institution coming from the woman's demand, as seen in the following testimonial:

Sometimes, there is that issue that the partner have drug problems… and she does not want to separate, but she wants him to get treated. So what we can and do, is to refer this man…(S1 – Institution 01).

This conception of care for the aggressor is also discussed by operators of public safety and justice, marked by the change in how to conceive the attention not as punishment, but as something recoverable through a restoration measure.

[...] instituting something called restoration justice. [...] you give him a sentence that he will have not only to follow but that will also restore him, that is why the name (S7-Institution 03).

The law Maria da Penha allows the judge to determine the mandatory presence of the aggressor in recovery and re-education programs. These measures, in a certain way, recognize that to intervene in the violence cycle, actions that will also include men needs to be implemented[18]. However, this proposal still finds gaps due to lack of clear definition of how this structure and the organization of attention centers providing education and recovery actions should be, as they do not allude about prevention actions for the male population[19].

Although not all participants in the study share this contextualized view of the phenomenon, some testimonials show the need to develop the inter-sectorial activity as strategy that can strengthen the network and leverage the coping and the breakage of the violence cycle. Thus, the results of this study confirmed the assumption that the adopted perspective of the institutions composing the care network for woman in situation of violence has been directed to adjustments of interventions to culture and in the vocations of care from each institution, being an integral and transversal care, making difficult the quality of it.

The mismatches between professional's tasks, linked to care vocations and women's needs, that sometimes is not asked by professionals, produce a conflictual and truncated assistance, far from an integral and transversal care[2]. Thus, it is central to recognize the women's needs in situation of violence to organize care and to transform the praxis, considering violence a phenomenon that determines needs in diverse sectors[20]. Thus, allied with the inter-sectorial policy, professionals need to add themselves to other sectors to produce the promotion and the improvement of quality of life[21] of these people.

In this sense, it is needed to understand the necessity to not restrict the work organization in the logic of rationality and functionality, but to implement strategies in the sense of facing the gaps. Therefore, the work in net should have not only the ability to adapt, but also to apprehend, invent and create. Facing the institutional organization, the stiffness and the sequence of pre-determined actions allow effectuation of the institution, but when the institution cannot answer the demands brought by complex phenomenon, tends to fail. In rigid institutions, reflection is not needed and everything is done automatically, but in institutions where development of strategies is allowed, these allow to absorb elements capable to contribute for the work

development. Thus, the possibility of flexibility and adaptation favors sclerosis on bureaucratic phenomenon[8].

Finally, sustained in the complex thinking, it is noteworthy that knowledge is always unfinished[8] and dynamic, therefore, this study aims to indicate paths to be built. Thus, to guarantee inter-sectorial actions, it is needed to have monitored assessment proposals and systematic supervision to qualify the services provided, and these information should be used to guarantee public policies and improve the answers of institutions. Thus, a view searching for care transversality and work in net connected to existing services, is the development of management in networks, an inter-sectorial coordination to establish referral ways and continuity of care[3].

CONCLUSION

In this study, it was identified that regardless of advances obtained on past years, the "mismatch" persists in networks of care for women. In the teams of each participating institution, the problem is partially coped, focused on the specificity of each sector. In the functionality, work processes still permeate centralized on a hierarchical model, with consequent care fragmentation.

Facing the complexity of the problem, this study is only a first diagnostic step; therefore, it still represents gaps facing the proposition of concrete strategies that are viable and applicable. It is suggested for new studies to make viable the implementation of information system broad to all institutions that conduct care to women in situation of violence. It is suggested protocols and referral fluxes for domestic violence with risk classification and vulnerability to build conducts that are more assertive. Finally, the development of studies mapping processes for a qualified network management.

Thus, in a sense to contribute with health and nursing care, it is important that professionals dealing with these women to have new knowledge of diverse fields, as well as the inter-disciplinary and inter-sectorial discussions to subsidize and improve their practices. Thus, it will be only possible to institute integral and transversal care in network when a considerable transformation occur in how to think, *how to do it* and the *common how to do it.*

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Received: 11/26/2014.
Accepted: 08/12/2015.
Published: 12/31/2015.