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Evaluation of an intervention to improve Primary Health Care's response to cases of domestic violence against women - São Paulo, Brazil

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Abstract *The aim was to analyse and improve the Primary Health Care (PHC) response to domestic violence against women (DVAW) by developing, implementing and evaluating an intervention. A pilot study evaluating the before and after of intervention implementation, using mixed methods and carried out in three phases – formative, intervention and evaluation – between August 2017 and March 2019 in two Basic Health Units (UBS) in the city of São Paulo. In this paper, we present the details and evaluation of the intervention, carried out six to twelve months after its implementation. The intervention was developed based on the findings of the formative phase and in line with the health policy that establishes the Violence Prevention Nucleus (NPV) and consisted of stablishing a care pathway; general training for all workers and specific training for the NPV; drawing up educational material and monthly case discussions over 6 months. The evaluation showed acceptability among the workers, increased identification and repertoire for caring for cases of DVAW, strengthening internal referral and the intersectoral network. We identified obstacles to the full implementation and sustainability of the intervention.*

Key words *Primary Health Care, In-service training, Policy evaluation, Violence against Women, Domestic Violence*

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Introduction

In 2016, the World Health Organization (WHO) member states adopted a global action plan to strengthen the role of health systems to respond to violence against women, girls and children within a multisectoral response[1]. Properly trained primary health care (PHC) providers can provide a supportive environment in which to identify women experiencing violence; provide medical care for associated health problems and put them in contact with the appropriate services. This includes specialist violence against women (VAW) services that can help to decrease the risks and increase the wellbeing of women and their children.

The evaluation of interventions to improve the response of PHC services to domestic violence against women (DVAW), the most prevalent form of VAW, has been expanding as a field of knowledge[2]. A systematic review of interventions in PHC showed positive results, such as increased use of safety behaviours and increased referrals to other services in the multi-agency network[3].

Despite the existence of specific public policies and training initiatives for providers[4,5], the Brazilian health care system still does not seem prepared to respond adequately to DVAW. This low response of services is partly due to obstacles already identified in the literature and include the understanding of DVAW as a health problem, affecting identification and the provision of proper support to women[6]. It is believed that the training of providers, an important facilitator of better responses, has not achieved good results to match what this type of service can do[7].

There has been a history of municipal policies and programs in the health sector developed by the city of São Paulo since 2001, aimed at confronting violence. However, these policies have suffered discontinuities at each change of administration[4] and have been impacted by the practice of out-contracting services through different Social Health Organizations (OSS) as well as by the austerity policies that decreased funding for social policies.

In 2015, the municipal administration implemented the Comprehensive Care Pathway for People in Situations of Violence[8], aimed at caring for all forms of violence. This policy provides for the implementation of the Nucleus for the Prevention of Violence (NPV) in all health services. The NPVs, according to the document, must encompass at least four health providers, preferably with a multi-professional composition and with the participation of the management. The NPVs are responsible for training the other members of the team and for coordinating cases, either internally or in the multi-agency network.

Considering this background, the present study aimed to analyse and improve the PHC response to DVAW by developing, implementing, and evaluating an intervention convergent with the Municipal Care Pathway[8]. This study is part of a multicentric research programme[9].

Methodology

This is a before and after pilot study of a Primary Health Care intervention to improve the response to DVAW, using mixed methods and carried out in three phases between August 2017 and March 2019. Two PHC Clinics (UBS) of the Municipality of São Paulo participated in the research. The selection criteria of the services and their characteristics in terms of care model, administration, as well as the set of data on the territory of coverage and health workers were published elsewhere[10].

In the first phase, a formative study, the findings pointed to a number of barriers including precarious implementation of the NPVs in terms of membership, group functions, and poor recognition of their work by all workers in the clinics; vague protocol for providing DVAW care; staff members fear of retaliation, and lack of time to attend to DVAW cases adequately. The latter was found to be linked to the care goals of the OSS management contracts, that mostly prioritize number of consultations and have no performance indicator for violence[10].

Based on the formative phase findings, we developed and implemented an intervention (phase 2) based on two proposals published in the literature regarding care of women in situations of violence: the Brazilian model CONFAD[5] and the British model IRIS[11], both aligned with the guidelines of the World Health Organization[12]. In the third phase of the study, we surveyed records of DVAW cases identified by the NPVs and reports of DVAW to Epidemiological Surveillance, comparing the 12-month period prior to the intervention (2017) and 12 months after the intervention (2018); and conducted semi-structured interviews, with fifteen health workers who were appointed by the management of the UBS in order to ensure professional diversity.

The interviews were audio recorded, tran-

scribed, checked, and the data were analysed using thematic content analysis[13].

This research received ethical clearance from the Research Committee of the School of Medicine of the University of Sao Paulo (opinion number 2.056.530) as well as by the Research Committee of the Sao Paulo Municipal Health Secretariat (opinion number 2.142.949). Both interviewees and interviewers were guaranteed support in case of mental suffering resulting from the research.

In this paper, we present the details of this intervention development (phase 2) and the last phase of the research, which was the evaluation, carried out 6 to 12 months after the intervention.

Results and discussion

The intervention and the results of the evaluation phase are presented and discussed below, based on the findings of the interviews and organised in three distinct themes: 1. Visualising and then making it happen: domestic violence against women as an object of work in PHC services; 2. Expanding from technical effectiveness to practical success; 3. Brief reflections on organisational and management aspects.

The interviewees from this evaluation phase are presented in Table 1.

Since this research is inside, about, and for health services[14] and seeking to increase the impact and effectiveness of their results, the intervention was developed and agreed upon with a Research Support Committee - made up of the researchers, managers of the Municipal Health Secretariat, the Regional Health Coordinators and Technical Health Supervisors of the territory of the UBSs; managers and members of the NPV of the two UBSs; and representatives of the intersectoral network of assistance to violence against women.

The intervention consisted of the development of actions and a flow of care for cases of DVAW, in which all staff members were trained in: 1. The identification of DVAW and first response; 2. Referral of women to the NPV of the unit for further support and potential external referrals; 3. Documenting DVAW cases through compulsory notification and an internal chart to follow up on them. 4. The research team designed and delivered educational material for health care providers[15] and also specialized materials[16] for the NPV. 5. Reinforcement training in clinic team meetings, involved recalling the flow and specific professional roles. A sixth activity involved the professionals of the NPV holding monthly discussions on the care of the cases identified, which was facilitated by the research team.

In total, 99 workers were trained in the two UBSs, 37 of which were university-trained level. The "general training", conducted by researchers in the UBSs, involved two sessions of two hours each, with a 1-month gap between each session, to enable critical reflection. Of the total, 48 workers participated in both sessions while the others participated in only one, for various reasons: scheduling difficulties, holidays and due to be summoned for other activities. The training included group dynamics, role-play and short classes.

Although it was not foreseen in the initial proposal, we identified in the formative phase the need for a "specific training" for NPV professionals, who claimed they did not have the necessary tools to handle the cases, despite having received monthly training for two years by the São Paulo Municipality (2016 and 2017). Fifteen NPV representatives from the two UBSs participated in the specific training, as well as representatives from Women's Defence and Coexistence Centres, VAW specialised centres (CDCM) and the specialized Public Defender's Offices, in order to bring the UBSs closer to the multi-agency

Table 1. Characteristics of the workers interviewed during the evaluation.

Characteristics	Interviewees (n=15)
Sex	
Male	2
Female	13
Profession	
Social Worker	3
Community Health Agent	3
Nurse	2
Manager	2
Physician	2
Nursing Technician	2
Psychologist	1
NPV member	
Yes	4
No	11
Interviewed in phase 1	
Yes	8
No	7

Source: Authors.

network services. Subsequently, the researchers participated for six months in the monthly meetings of the NPV of each UBS to discuss the cases. The specific training was based on the Brazilian CONFAD[5] model, using in-depth conversation techniques guided by principles of non-judgment based on personal values; non-victimization; privacy and secrecy; and shared decision making.

We will use "intervention" to refer to the proposed flow, educational material, general training of professionals and the NPV, and monthly meetings for monitoring the cases.

Visualising and then making it happen: domestic violence against women as an object of work in PHC services

In the formative phase of the research, the vast majority of interviewees recognised DVAW as a health problem, but the action in cases seemed to go beyond the possibilities of offering care, therefore challenging the biomedical logic in the actions of the services[17]. As there was no clear care pathway for DVAW in a protocol, the DVAW was not an object of intervention, leading to a low identification of cases (Table 2).

Integrating care DVAW cases in the organization of the services involved the delimitation of violence as an object of work. We identified during the formative phase that both the acts of violence and the effects of gender inequality on women's lives were understood by providers as one and the same problem, underpinned by socio-historical and structuring constructions of relationships[18,19], leading to feelings of powerlessness to deal with cases, although most of them vehemently condemned DVAW. The intervention addressed this issue by delimiting acts of violence within a gender and human rights perspective; discussing the trivialisation and naturalisation of DVAW; and articulating the care of DVAW in everyday health practices This helped health care providers to make sense of and incorporate DVAW as an object for intervention. Such discussions resulted in a better understanding of the object that would be addressed during the intervention.

First: the perception of what violence is, what domestic violence is. There are some things I can already perceive in a way I didn't before. [...] It was happening so frequently that we couldn't see it as something different or as violence. [...] Now, I ended up realizing that it is not normal, that it shouldn't happen (Community Health Agent CHA, UBS 2).

Setting the boundaries to DVAW as a work object, in order to integrate the organization of care in the service, also demanded the definition of a purpose, an assistance end point as a product of professional action. This implied developing a care pathway capable of foreseeing a potential result for the care of cases, and for which the appropriate instruments and knowledge would also be defined, as should occur in any work process in health[20].

The purpose of the work with DVAW cases in PHC is to seek the most appropriate ways for the woman to deal with her own domestic situation, respecting her will within the existing range of possibilities. This work process also qualified as a care committed to integral health care[5] i.e., in the consideration and visibility of health problems beyond symptoms and their translation into medical diagnoses, incorporating social, psychological and political aspects of health issues to the biomedical dimension. In this way the potential results of the assistance to be provided are the quest for women's strengthening through this type of care project, but also enabling the access to services and rights in order to ensure a life without violence and, as a final purpose, reorienting the repetitive and inefficient use of health services[21].

Regarding the instruments and knowledge, it was necessary to develop an operational knowledge for the care of cases in line with such purposes[22]: a type of knowledge capable of integrating theoretical/scientific knowledge, well grounded in the understanding of gender inequalities and the contexts in which such inequalities are transformed into violence[23] in the technical action for the care of each case, in addition to considering the practical lore of the providers in the care encounter, resulting from their previous experiences, whether with other cases of violence, or with their personal situations[24]. To this end, the intervention proposed dramatization dynamics – such as role-playing – based on women's personal stories and on signs and symptoms recognised by the literature on DVAW[25] and techniques for ap-

Table 2. Cases of DVAW identified 12 months before and after intervention.

Service	Before	After
UBS 1	8	18
UBS 2	3	12
Total	11	30

Source: Authors.

proaching these women: how to ask and perform the first welcoming, in accordance with the literature, and with personal experiences. The activity was well received:

I found it very cool and very practical [...] how you presented the questions: what to ask; what to talk about (Manager, UBS 1).

Once workers were more confident to identify and offer a first response to women, it was necessary to redefine the internal flow for care – previously centralized in the figure of the psychologist and/or social worker – and the forms of interaction between the team in the operation of this flow[5,20].

In contrast with the UK IRIS[11] model, in which all professionals were trained to identify women experiencing DV and refer them to an external service, the Brazilian intervention considered cultural and structural specificities of the services, such as: the proposal of NPV[8]; the presence of a multi-professional team beyond doctors and nurses; the difficulty of accessing specialised services due to a quantitative shortage and distance from the territory; and acknowledging the value of longitudinality, of the link between women and the PHC service and the singularity of the cases. The flow was established so that all providers had a role in identifying women experiencing DV and referred them to the NPV professionals, who would offer a specially qualified listening[5] and referrals to external services, if necessary, always according to the needs of the woman.

The intervention resulted in increased identification of cases (Table 2), a feeling of greater confidence about what to do when facing a disclosure of DVAW, a decrease in fear of the unknown, as well as the relativization of the lack of time as an insurmountable obstacle.

The fear decreases due to the fact that we are better equipped, the approach, and all what I have as support tools. It is natural. You are often afraid of what you don't know. When you begin to know what you have available, whether in terms of facilities, instruments, or team, the fear decreases (Nurse, UBS 1).

Additionally, another important result was the consolidation of NPVs in terms of organization, function and expansion of the team. However, the specific conditions of each unit brought different results with regard to the organization of the nuclei.

The NPV was strengthened and included the participation of five university-trained professionals in UBS 1, covering the entire period of daily operation of the unit divided in shifts, enabling care on the same day for women who were identified as experiencing violence. The strengthening of the NPV was important for legitimising their role, increasing their visibility, establishing a single flow, and increasing healthcare providers' confidence in referral:

Because before the training, or even before the NPV, these events would go unnoticed. They [the providers] know of the existence of the NPV [after the intervention], that we were qualified to provide care. So the cases have been coming more to us. (Social Worker 1, NPV, UBS 1).

When I already identified some type of suffering, of aggression, I would go directly to the clinic, and they [NPV] always had someone to welcome us. So, I found [the flow] very practical, very timely (Physician, UBS 1).

In UBS 2 the NPV, which before the intervention was composed of only one social worker (SW), aroused the interest of Community Health Agents (CHA) and mid-level professionals. Still, the NPV remained more personified in the SW.

Previously, I would talk to the social worker [...]. Now, with the other members, as I do not know then, I would be more [insecure]... (Physician, UBS 2).

The role of the CHA in caring for women in situations of violence is widely discussed in the literature, being highlighted by their double link to the service both as workers and users[26]. Although they recognize theoretical and practical limitations[27,28], the authors emphasize CHAs as key workers for identifying DVAW and responding to it[27,29]. However, based on the experience of CHA as members of the NPV in UBS 2, we highlight some limitations to their work.

The lower authority of these workers within the multi-professional team resulted in a poor recognition of them as capable of caring for women experiencing DV, and because of their close link to the community, they were less trusted in the team with regards to confidentiality of cases, in spite of their greater proximity with the cases. In addition, it was noteworthy that the CHAs had less autonomy for the management of their agendas, aggravated by the lack of protected time for issues related to the NPV, and their work being linked to home visit quantitative goals.

With regard to the organization of care in the service, it is essential to expand the flow of care beyond the walls of the PHC Clinic, articulating health care with other services of the multi-agency network of care, capable of responding to the multiplicity of demands of the cases of DVAW.

Specialized training was able to broaden knowledge about the existence and care vocation of network services[30,31], helping providers, and especially those from the NPV, to be more comfortable in caring for cases. Even so, shared care with other services remains a challenge in PHC, especially due to health care providers holding expectations that were beyond the concrete possibilities of the services.

One of my wishes is to get to know better our facilities and services. To have more contact, in fact to know how far that service can go. Because sometimes we also have a false impression that... It will always work out. And, you know, it's not always like that! (Social Worker 1, NPV, UBS 1).

Expanding from technical effectiveness to practical success

Before the intervention, the cases of VAW that occasionally emerged were answered with opinions and advice based on personal values[32], often centred on pressure to separate from the aggressor and reporting to the police. Women were rarely taken as subjects in the meetings, and their wishes and life projects were little explored and, on the contrary, such meetings were tainted with conceptions that blamed the woman for the violence suffered.

If violence was assumed as being within the professional scope, care was reduced to its biomedical aspect. There was a prevailing quest for a technical type of success in dealing with the cases, and this success was only based on biomedical expectations, the other dimension being absent, which can be termed 'practical success'[33,34] broadening the purpose of the intervention towards what women want and can accomplish given their living conditions. In this sense, an instrumental relationship prevailed in which the staff had an expectation that women should accept their vision of solving the problem, focused on the care of complaints and symptoms, culminating in practices of medicalization of the violence experienced[17].

In order to promote a shift from this normative horizon to a dialogical care that includes knowledge of women's lives, their wishes and goals, the intervention sought to integrate a communicative ethical action to the care meetings, seeking to emphasize not only the instrumental character of the care to obtain a technical success, but, above all the interactive character of care, making it possible to also achieve a practical success[33].

This way, the specific operational knowledge required for the type of care meeting that occurred between professionals and women already considered before, should be articulated to the construction of interactive relationships with the women. In these relationships, the health care worker must value women's perspectives, without judgment based on personal values, considering the experiences and expectations of women.

This aspect was developed during the training courses through an interactive game in which the professionals were invited to put themselves "In her place"[35] and make decisions they deemed necessary to deal with the violence suffered, in addition to other group dynamics. This particular moment allowed providers to value 'being in the other's place', and enabled them to experience the empathy, leading to deeper reflections on their interactions with women in the production of care actions.

As a result, the interviewees recognised the need to respect the women's choices and times, avoiding the expression of personal values in care:

In cases of violence, I may also have a more neutral look, without judging, I found it very helpful [...] you can't judge, because the person doesn't want that, right? If you judge, the person already closes up and from there; they don't open up to us anymore (CHA, UBS 1).

Sometimes we thought we were helping and we were creating problems for the person [...] I thought it was good [the intervention]! Because I think you help the person more approaching her the right way. [...] We no longer see the kind of conversation that we used to have, like a friend with the patient, saying: "Ah, I think you shouldn't do that" - advice (Nursing Technician, UBS 2).

The intervention was not received by health care providers as a strict protocol of conduct, but as a motivation to think: the broadening in their repertoire of actions and referrals allowed professionals to consider different possibilities for action, regarding the different needs that each women may have. It also encouraged workers to create their own strategies, taking into account the concrete contexts in which the work takes place.

By taking into account the practical wisdom of the women themselves in dealing with their situations, we approached practical success in the care of cases, and the conception of what is a good professional practice was shifted towards a purpose of care that values the wellbeing of the users, their emancipation and access to rights

and resources of the multi-agency network of specialized services.

I used to think just about the process of getting sick, as if it were a pathology. [...] I think that [the intervention] expanded the view, not only on getting sick as a pathological process, but getting sick... in a broad way. [...] It was something that I practically did not approach in clinical practice, and after the intervention I started to look for this more frequently. [...] The importance [of care], precisely, is to improve the quality of life of the person (Physician, UBS 1).

You perceive the emotional side of the person... [...] It was mainly because we were accompanying [the woman] regarding her life project. [...] They come here and say: "Oh, it's good that I made it. I'm feeling good". That happened with some women (Social Worker, NPV, UBS 2).

Even looking for the inclusion of a dialogical perspective of care, the biomedical and technical foundation of doctors and nurses remained at the core of their working process. The care for DVAW cases was not integrated into traditional forms of care, and kept being understood as something apart from their performance, and many professionals thought that the care of these cases was something that "goes beyond" the assistance they traditionally provided.

So, we leave physical part to the doctor, or nurse. But that's where the problem lies. She won't only take care of the physical part. A gynaecologist, for example, talking about all this interest, she is not only finding breasts, a possible breast cancer. And then, what is happening behind this woman? If she acts only as a doctor, she will only look at breast cancer there from... the guidance about the chemical part of the process. But when she approaches her thinking: "what is this woman experiencing?", now she is going beyond. (Social Worker, NPV, UBS 2).

The interviewees narratives show that the different professional categories are perceived by their stereotypical specificities linked to training: the psychologist listens, the social worker deals with rights and benefits, the doctors and nurses deal with the physical body and its health needs, the CHAs make contact with the community and the manager gives support to anything that needs to be done, but the interviewees also made considerations that everyone should go beyond and 'help' the cases, although it is not clear what this means.

It is interesting to note that, even though the intervention increased the visibility of the cases in the services and improved the care offered, a certain "technological refusal"[24] remains in the professional discourse. Having said this, we would like to emphasize that even though DVAW is recognized as a health problem - both by the providers and by existing proposals for health care intervention; and also considering that the intervention has delimited DVAW as a work object with established purpose, instruments and knowledge capable of integrating the care of DVAW cases together with the other interventions in the daily routine of PHC services, we found that in the conceptions of the professionals all of these new instruments and knowledge still do not appear to them as presenting an adequate health technology. Or, in the words of Schraiber and d'Oliveira[24], "neither as good nor as competent as the other interventions in this field".

Brief reflections on organizational and management aspects

Management demonstrated a key role in the implementation of the intervention, both in the service and in the other levels of the hierarchical organization of the Municipal Health Secretary (SMS). Issues related to the organization of the health structure itself in the city of São Paulo, such as the outsourcing of PHC services, managed by OSSI, emerged as obstacles to the integration of care for DVAW provided in the services. A first issue to be problematized concerns the contracts established between SMS and OSSs, based on productivity goals as a condition for financial transfer. Since there is no indicator for the care of DVAW cases, the issue is considered lower priority in the services.

[...] We are turning primary care into a panel of indicators. Whatever is an indicator, you mobilize the team and you make it happen, whatever is not an indicator, falls into limbo (Manager, UBS 1).

The support of the manager in integrating the intervention into the routine of the PHC Clinic also proved to be of great importance, and was found to be partly responsible for the fact that the flow and the work of the NPV was more consolidated in BHU 1. As foreseen in the intervention proposal, the reinforcement of the general training took place on two occasions in BHU 1. In BHU 2 there were no team meetings, which made this reinforcement unfeasible, because these spaces in the providers' schedule was non-existent.

But... I don't know if in practice [NPV] is working. I think we really need to have general team meetings, right? (Psychologist, UBS 2).

The general team meetings proved to be important for the dissemination of the process, the exchange of information and experiences among team professionals, the discussion of cases and even allowing all professionals of the unit to learn about the existence and functioning of the NPV. Some interviewees stressed the need to keep institutional spaces for discussion of the topic – such as strengthening the training and monthly discussion of cases – as a way to remember the content and because of the rotation of workers in the service:

Just like I told you: every time I get in touch, I remember: "Guys, I have to stay more...". [...] So, I think that if there was a space, once a year, or twice a year, to, you know, update us in relation to this [...] It wakes you up a little. So I think that if there was more incentive in relation to this, I think it would be better... until this becomes routine, right? It should be routine, it should be part of the anamnesis (Doctor, UBS 1).

As already discussed, care of DVAW cases in PHC services challenges the predominantly biomedical logic enacted in the day-to-day routine of services and requires continuous investment for its incorporation, not limited to isolated trainings. Although the intervention has expanded the knowledge and repertoire of actions in confronting cases of DVAW, it is already known that specific training on the subject may positively change the perception of the problem. However, without articulation with other actions, in the long term it will have little impact on concrete attitudes towards DVAW[36].

It is noteworthy that in the year following the departure of the research team from the field, consequently ending the monthly spaces for discussion of cases, the number of notifications of DVAW decreased in both PHC Clinics, remaining close to what was recorded in the baseline. This suggests not only the need for long-term supervision activities in order to encourage and guide professionals, but also that changes in the care culture must be motivated and accompanied for longer periods than those intended only for specific training.

Final considerations

The implementation of an intervention convergent with the policies in force for the confrontation of DVAW in the Primary Care Clinics showed acceptability among the staff, increasing the identification and referral of cases, both internally to the service through the established flow of care, and externally through an extended recognition of the services of the multi-agency network of care for women suffering violence.

Although the intervention proved to be capable of improving the response of services to the care of DVAWor cases, there were obstacles to its full implementation in PHC. Those obstacles are linked especially to the organisation of the PHC services in the municipality and their peculiarities in the public-private interaction; and to the internal culture of care within the services as well.

The role of managers at different hierarchical levels and the influence exerted by the research team on the results need to be explored in greater depth in future research in order to improve the intervention and move it towards a sustainable phase.

Collaborations

All authors participated in data analysis, critical review of intellectual content and final approval of the version to be published. S Pereira, LB Schraiber and AFPL d'Oliveira participated in the conception and writing of the article and are responsible for all aspects of the work in guaranteeing the accuracy and integrity of any part of the work.

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