Esc Anna Nery 2021;25(2):e20200087

Women perception in situations of violence in formal support: scoping review

Percepção das Mulheres em situação de violência sobre o apoio formal: Scoping review

Percepción de las mujeres en situación de violencia en apoyo formal: Revisión de alcance

Marli Aparecida Rocha de Souza[1]
Aida Maris Peres[1]
Lais Fumincelli[2]
Vagner José Lopes[1]
Nen NaLú Alves das Mercês[1]
Marilene Loewen Wall[1]

1. Universidade Federal do Paraná, Programa de Pós-graduação em Enfermagem. Curitiba, PR, Brasil.

2. Universidade Federal de São Carlos, Departamento de Enfermagem. São Carlos, SP, Brasil.

ABSTRACT

Objective: To examine and map the scientific evidence about the perceptions of women in situations of violence regarding formal social support services. **Method:** A Scoping Review, according to the Joanna Briggs Institute, with the following guiding question: "What is the perception of the woman in situations of violence when seeking professional assistance in support services?" Including national, international studies, primary, qualitative, quantitative approaches, mixed methods, English, Portuguese, and Spanish languages, in the period from 2014 to 2019. Searches were carried out in seven databases, 1,557 articles were found and 16 were selected as the final sample. **Results:** The consultations showed active listening, creating bonds and articulating services. As well as lack of reception; feeling of insecurity, fear and humiliation. The training process was established by the articles as a tool for professionals, in promoting a targeted and individualized approach. **Conclusions and considerations for the practice**: The welcoming and bond provided by some support services, resulted in proposals for changes and aroused in women reflection, confidence and the search for an exit from the cycle of violence. The opposite has led to removal of services and consequent permanence with the aggressor.

Keywords: Violence Against Women; Intersectoral Collaboration; Social Support; Review.

RESUMO

Objetivo: Examinar e mapear as evidências científicas acerca das percepções das mulheres em situação de violência quanto aos serviços de apoio social formal. **Método**: *Scoping Review*, conforme Joanna Briggs Institute e a questão norteadora: "Qual a percepção das mulheres em situação de violência ao buscar atendimento profissional nos serviços de apoio?". Inclusos estudos nacionais, internacionais, primários, abordagens qualitativas, quantitativas, métodos mistos, idiomas inglês, português e espanhol, no espaço temporal de 2014 a 2019. Realizadas buscas em sete bases de dados, encontrados 1557 artigos e selecionados 16 como amostra final. **Resultados**: Os atendimentos evidenciaram a escuta ativa, criação de vínculo e articulação dos serviços. Como também a falta de acolhimento; sentimento de insegurança, medo e humilhação. O processo de capacitação foi estabelecido pelos artigos como ferramenta aos profissionais, na promoção de abordagem direcionada e individualizada. **Conclusões e considerações para a prática:** O acolhimento e vínculo propiciado por alguns serviços de apoio resultou em propostas de mudanças e suscitou nas mulheres reflexão, confiança e busca para saída do ciclo da violência. O contrário gerou afastamento dos serviços e consequente permanência junto ao agressor.

Palavras-chave: Violência contra a Mulher; Colaboração Intersetorial; Apoio Social; Revisão.

RESUMEN

Objetivo: Examinar y mapear la evidencia científica sobre las percepciones de las mujeres en situación de violencia con respecto a los servicios formales de apoyo social. **Método**: Revisión de alcance, según el Instituto Joanna Briggs, cuya pregunta guía fue: "¿Cuál es la percepción de las mujeres en situación de violencia cuando buscan asistencia profesional en los servicios de apoyo?". Incluye estudios nacionales, internacionales, enfoques primarios, cualitativos, cuantitativos, métodos mixtos, idiomas inglés, portugués, español, en el período de 2014 a 2019. Se realizaron búsquedas en siete bases de datos, se encontraron 1557 artículos y se seleccionaron 16 como muestra final. **Resultados**: Las consultas mostraron una escucha activa, creando vínculos y articulando servicios. Así como la falta de recepción; sentimiento de inseguridad, miedo y humillación. El proceso de capacitación fue establecido por los artículos como una herramienta para profesionales, en la promoción de enfoque dirigido e individualizado. **Conclusiones y consideraciones para la práctica**: La bienvenida y el vínculo brindado por algunos servicios de apoyo, dieron lugar a propuestas de cambios y despertaron en las mujeres la reflexión, la confianza y la búsqueda de una salida del ciclo de violencia. Lo contrario ha llevado a la eliminación de los servicios y consecuente permanencia con el agresor.

Palabras Clave: Violencia contra la Mujer; Colaboración Intersectorial; Apoyo Social; Revisión.

Corresponding author:
Marli Aparecida Rocha de Souza.
E-mail: marlirochasouza2@gmail.com

Submitted on 04/02/2020.
Accepted on 09/21/2020.

DOI:https://doi.org/10.1590/2177-9465-EAN-2020-0087

INTRODUCTION

Worldwide, violence has been considered a public health problem, in addition to the violation of the human rights of women who are linked to this situation. And in which, the inequality between men and women, mainly that of gender, has in femicide one of the most serious phenomena of this context. And, to cope with it, some strategies related to intervention and prevention have already been set up.[1]

In Brazil, violence against women is based on a patriarchal and androcentric cultural background, which constitutes this inequality and is manifested with a tendency to diminish women in relation to men, which generates their vulnerability.[2] And, when understanding that their confrontation is not only a plan linked to the daily professional practice, but to the management of this process and thus the use of different strategies is essential, among them, the creation of institutions that work in an articulated manner focused on issues socially and intersectorally. Intersectoriality promotes the articulation between different services and favors the attendance of complex phenomena[3] and, in the case of this research, for women in a situation of violence.

Based on this approach, networking, when carried out in an integrated and collective way and not only in the closest contacts, facilitates communication in meeting the needs of these women.[3] Bearing in mind that when these women seek care, the professionals should not limit themselves only to what they are seeing, but turn their gaze to integrality in carrying out a network articulation process, as violence is a complex phenomenon and where a single service does not support it.[4]

Thus, the preparation of these professionals must occur in a manner that integrates in their daily activities, ways of coping and combating violence linked to networking and resoluteness. [4] Since many services that make up the formal social support network are unable to apply means to support these women in their operating context, which fragment their care.[3] Linked to the insecurity of the professional regarding the issue of how to provide care, including the identification of violence, since many do not have apparent injuries.[5,6]

Considering that the professionals who provide this service, they confer difficulties in recognizing the various determinants that involve this phenomenon. Which impacts on services focused on the complaint, or on judgments based on preconceptions, such as references to the use of alcohol, drugs and the indecision to continue the complaint process. Which derives in not investigating other factors that involve the context presented and, as a result, the invisibility of violence.[6]

In the implementation of these strategies., it therefore worth creating a training process, which provides the necessary subsidies for these professionals to act and intervene early.[3,7] At the Sixtieth World Assembly held in May 2014, resolution WHA67.15 was proposed with a focus on creating a global action plan to strengthen the role in the health system, in the face of addressing interpersonal violence and in particular against women, girls and children, having professional training as one of its scopes.[8]

The training process in the formal social support network, for the professionals who provide care to these women, involves, in addition to technical training, a look targeted at their specificities, which includes the knowledge of their family and community. The partnership between the services and the community should focus on autonomy and benefit the decision-making power of these women, considering that there is no standard to be followed, but the best strategies in an intervention process focused on protagonism.[9] Mediated by the services and professionals that are part of this network and highlighted by the literature, as they remain unaware of the totality of this phenomenon and carry out an up-to-date practice.[7]

In this context, the knowledge of what these women have as experience in the search for services included in the formal social support network has the expectation of promoting the direction for the creation of strategies aimed at this service, among them a proposal to work on educational processes aimed at thematic violence against women. Which justifies the interest of this research and aims to examine and map the scientific evidence about the perceptions of women in situations of violence regarding the services that make up the formal social support network.

METHOD

A research study carried out through one of the proposals of the Joanna Briggs Institute (JBI) being referred to as *Scoping Review (ScR).* This is a review method that can be performed when the researcher seeks to answer one or more questions. It is possible to carry out a comprehensive mapping of a given topic and identify the scientific evidence in the literature, regardless of the approach of these studies.[10] To ensure the accuracy of the *ScR,* the *JBI* proposes structures to be used in conducting it, including identifying the research question, identifying relevant studies, selecting studies, organizing data, grouping, synthesizing (analyzing) and describing the results and, as an option, promoting a consultation of the results obtained (specialists).[10]

With this focus, the construction of the guiding question of this review was carried out through the **P***opulation,* ***C****oncept* and ***C****ontext* (PCC) strategy for a scoping review.[10] The following items were defined: P – women in a situation of violence, C – specified the care that they received from the formal social support network professionals, and C - in services of care/coping with violence. In this sense, the following guiding question was established: "What is the scientific evidence about the perceptions of women in situations of violence regarding the formal social support?"

National and international studies were included, with qualitative and quantitative approaches and mixed methods, derived from primary studies; in English, Portuguese or Spanish; in the time frame from 2014 to 2019. Which meets this research in the search for professional assistance in the formal social support network. The exclusion criteria were studies with title and abstract themes that had no reference to the review question.

As for the search strategies described in Chart 1, the databases and information sources used were Cumulative Index to Nursing and Allied Health Literature (CINAHL), Latin American

and Caribbean Health Sciences Literature (LILACS), National Library of Medicine (PubMed), SCOPUS, Embase Search Results (EMBASE), *Web of Science*, and the BVS (*Biblioteca Virtual em Saúde*). The selected descriptors and synonyms are in accordance with the following Health Sciences Descriptors (*Descritores em Ciências da Saúde*, DeCS): "Violência"; "Saúde da Mulher"; "Violência doméstica"; "Apoio social"; "Violência contra a mulher" and, in the Medical Subject Headings (MeSH): "Violence" "Domestic violence" "Violence against women" "Women's health" "Social support". For combining the descriptors, the Boolean operators "*AND"* and *"OR"* were considered for searching these databases and research platforms.

The applied formulas were in accordance with the specificities of each database and two reviewers conducted the search during January 2019, in order to expand the effectiveness and feasibility in the identification and selection of the studies.

For searching and selecting scientific evidence, the PRISMA - *Extension for Scoping Reviews* (PRISMA-ScR) tool[11] was used to guide the research. It is a review tool that has as main objective to support the reviewers in recording the revision process.

The data from the selected studies were extracted by means of an instrument structured by the researchers, which contemplated the following: title of the study, authorship, journal, year of publication, place of the study (country, city, region), objective(s), methodological detailing and sample detailing, main results and conclusions found. For the analyses, the studies were grouped and the results were presented in table formats.

RESULTS

The search resulted in 1,557 selected articles; of these, six were discarded for being duplicated in the databases, leaving 1,551 articles for title and abstract reading. In this new stage, 1,117 were excluded, which resulted in a total of 434 articles for selection as to the inclusion and exclusion criteria. Of these, 19 articles were selected to be read in their entirety, three of which were excluded due to the interpretation of the professionals who provide services to women in situations of violence. Figure 1 shows the search, selection and inclusion process of the selected studies, according to the tool.

In this review, the 16 selected studies (100.0%), are distributed in the years 2014 to 2018. Of these, Brazilian publications stand out in (5/31.25%), being in the years 2015 (1/6.2%), 2017 (2/12.5%) and 2018 (1/6.2%). Years marked by strategies to confront violence against women. Among them and instituted in 2018, the National Judicial Policy to Combat Violence against Women in the Judiciary, in which in Art. 4 line II, there is the determination that the judiciary should give priority to the processes on this theme.[12] The characterization regarding the year of publication, authors, journal, locus and method approached for the selected studies is described in Chart 2.

As for the main socioeconomic characteristics, among the 16 studies, in 14 (87.5%) the mean age among the women ranged

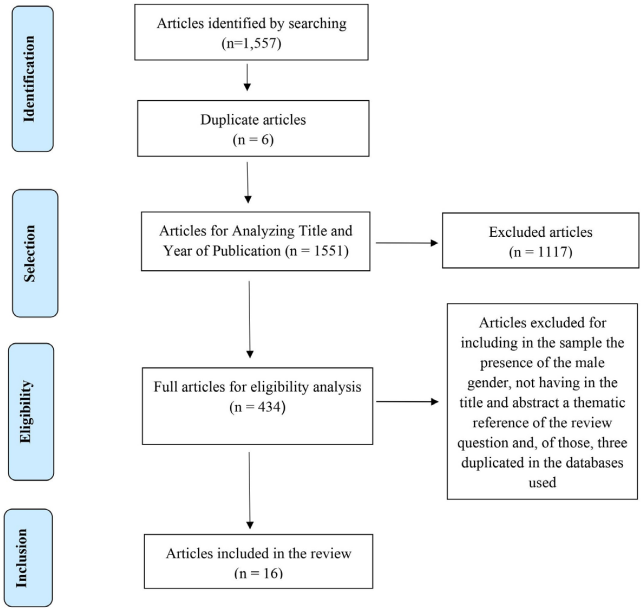

Figure 1. Process for selecting the articles in the databases, adapted from PRISMA-ScR[11]. Curitiba, Paraná, 2019.

Chart 1. Representation of the strategies and search formulas in the databases and in the BVS and platform. Curitiba, Paraná, 2019

BASE	STRATEGY
Pubmed	("Violence"[Mesh]) OR "Domestic Violence"[Mesh]) AND ("Women's Health"[Mesh]) AND ("Social Support"[Mesh])
Scopus	(KEY("Violence") OR KEY ("Domestic Violence") OR KEY("Violence Against Women") AND KEY("Women's Health") AND KEY("Social Support"))
Cinahl	(Violence) AND (Women's Health) AND (Social Support)
Embase	(Violence OR Domestic Violence OR Violence Against Women) AND (Women´s Health) AND (Social Support)
Web of Science	(Violence Against Women) AND (Women's Health) AND (Social Support)
BVS	(Violence OR Domestic Violence OR Violence Against Women) AND (Women's Health) AND (Social Support)

from 12 to 81 years old. Regarding schooling, 11 articles (68.7%) evidenced high school, elementary and higher education, with emphasis on high school (31.2%) and higher education (25%). In terms of income, it was not evidenced in (43.7%) and, in six studies (37.5%), own income prevailed. As for the race, (56.2%) did not characterize it and, among the seven remaining (43.7%), the white race stood out in four (25%) of the studies.

Chart 3 describes the sample of each of the 16 studies on the main socioeconomic characteristics, perceptions, and reports of women in situations of violence. The main results regarding the type of service and professional assistance in the perception of women in situations of violence are described in Chart 3.

Regarding the search for the health services, the studies presented: medical or psychosocial services, and formal social

Chart 2. Characterization of the selected studies according to year, authors, published journal, study locus and method approached. Curitiba, Paraná, 2019.

Study	Year	Authors	Journal	Region/Country	Method
[13]	2018	Machisa et al.	Glob Health Action	Gauteng, South Africa	Quantitative
[14]	2018	Soares and Lopes	Interface	Brazil (no region)	Qualitative
[15]	2015	Vieira et al.	Rev. Latino-Am. Nursing	Brazil, South Region	Qualitative,
[16]	2017	Albuquerque et al.	Texto Contexto Enferm.	Brazil, Rio de Janeiro	Qualitative
[17]	2016	Reis et al.	JCN Journal of Clinical Nursing	Brazil, São Paulo	Qualitative
[18]	2017	Santos and Freitas	Rev Min Enferm.	Brazil, Minas Gerais	Qualitative
[19]	2017	Du Mont et al.	PloS One	Canada, Ontario	Quantitative
[20]	2016	Mantler and Wolfe	Rural and Remote Health	Canada, Ontario	Qualitative
[21]	2017	Loeffen et al.	Eur J Gen Pract.	South Holland, Rotterdam	Qualitative
[22]	2015	Evans and Feder	Health Expect. 2016	United Kingdom Southwest region	Qualitative
[23]	2015	Bahrami et al.	Global Journal of Health Science, 2016	Iran, Isfahan and Shiraz	Qualitative
[24]	2015	Wuest et al.	Research in Nursing & Health	Canada, New Brunswick	Mixed Methods
[25]	2015	Sprague et al.	Global Public Health	South Africa Johannesburg Gauteng Province	Qualitative
[26]	2014	Pratt-Eriksson et al.	Int J of qualitative studies on Health and Well-being	Sweden Stockholm	Qualitative
[27]	2014	Malpass et al.	British Journal of General Practice	Bristol and Hackney	Qualitative
[28]	2014	Ekström	European Journal of Social	Stockholm	Qualitative

Chart 3. Description of the sample of studies on the type of violence reported by the women. Curitiba, Paraná, 2019.

Study	Perceptions of the participating women	Reported Violence
[13]	Social support generated greater resilience and promoted the search for an exit from the cycle by mobilizing the necessary resources, generating a search for formal services and giving continuity.	Physical or sexual
[14]	The first option in the service was drug treatment; the professional did not generate hospitality or show interest in listening; the service generated shame for the violence suffered and non-return to the service to give continuity.	Violence in relationships

Chart 3. Continued...

Study	Perceptions of the participating women	Reported Violence
15	Impersonal care in the health services.	Psychological, physical and moral.
16	Creation of a bond with the professional, and the referrals and support were adequate in the immediate and future needs. The health services, on the other hand, generated withdrawal of the complaint.	Physical, psychological, sexual, moral or patrimonial
17	Multi-professional service focused on physical, psychological and social needs. The police service generated carelessness and a feeling of responsibility for what happened.	Sexual
18	Non-resolution, carelessness, feeling that they should remain with the aggressor. And, when welcomed, they felt encouraged and supported in facing the situation.	Physical, sexual, psychological, controlling behaviors.
19	Adequate and there was disclosure of the service to other women.	Sexual violence
20	The professional generated care beyond function and help in the needs and they did not need to tell their stories more than once.	Violence by intimate partner
21	They had confidence in speaking and were listened to, which generated well-being and strength to continue.	Intimate partner violence
22	Service focused on medication and they felt that this would not solve the problem, because they knew that the problem was in the relationship with the partner.	Domestic violence
23	When they were heard they reflected on their current condition in search of solutions; and when they were not heard it promoted a feeling of impunity for the violence they suffered.	Psychological, Sexual, Moral, Physical and Patrimonial
24	Direction and referrals according to needs, feeling of comfort and support.	Focus on sexual
25	They did not feel comfortable talking to other professionals, because they knew what they were going to talk about the fact.	By intimate partner
26	Disjointed services, frustration by the filing of cases. Guilt, humiliated by having to thank the service received.	Focus on sexual
27	Relief from the help and direction in the situation presented and at ease when speaking and being heard, without feeling of guilt for the fact.	Physical, emotional, verbal, sexual, financial
28	Impunity and no information about what it would happen, under pressure, not heard. In some services, guided and welcomed.	Focus on sexual and physical.

Chart 4. Results of the 16 articles related to professional care in the perception of the women in situations of violence. Curitiba, Paraná, 2019.

Study	Type of formal social support service	Service and professional category	Main Results	Main Conclusions
13	Medical or psychosocial.	Quantitative analysis, without reports.	More serious abuses and difficulty in access generate fewer searches for the services.	Formal services that focused on symptoms generated less resilience.
14	BHU, Police Station, RCWC, PPO.	At the RCWC, good service; Health: The physician focused on medication and did not provide guidance and the nurse was rude; Police Station: Lack of support; PPO: lack of security; Judge: Lack of information and induction to speak.	Positive: By being welcomed, satisfaction and bonding were promoted*; Negative: Focus on disease, lack of: guidance,* welcoming and bond, generating shame and guilt.	Focus on the disease, lack of welcoming and ignorance generated: fear, shame and judgment; Some provided adequate care.

Chart 4. Continued...

Study	Type of formal social support service	Service and professional category	Main Results	Main Conclusions
15	RCWC, TC, school, PM, BHU, LMI, PPO, Emergency mobile service, PA, psychiatric, Church; NGOs, juridical, psychology.	In the secondary formal network it presented: lack of bond and trust and the health professional generated fragility in the service.	The focus was on the disease; in addition to lack of guidance, welcoming and *bond that generated shame, guilt and lack of demand for the services, even in the presence of physical injuries.*	The formal network did not promote ways out of the cycle, demonstrated intersectoriality; and the lack of focus on completeness generated distancing and permanence with the aggressors.
16	Hospitals, health units, PSFW, call centers and forums, schools, SA, justice.	Nurse (BHU) generated bond and direction, physicians, lawyers and public defenders were sensitive and concerned. And S.A. and psychologist generated welcoming, comfort. As well as professors who promoted help. But also places that in health generated silence in women.	The formal secondary network seen as a source of support. And the bond allowed knowing the origin of the complaints, support and referral, adequate. The opposite generated withdrawal in the complaint.	Interaction between services generated effective assistance and bonding, highlighted in Schools, BHU, PSFWs and CEAMs, and appropriate targeting generated distancing from the aggressor. But insecurity generated distancing from the service.
17	Hospitals and PSFW.	Lawyer, nurses and physicians with support and direction; but the Police generated humiliation, lack of support and guilt.	The bond created allowed for support, knowing the origin of the complaints and proper referral. When there was no welcoming and listening, it generated guilt and humiliation.	Negative experiences with the Police Department such as feeling of humiliation, lack of support and intimidation. However, when a bond was created it generated multi-professional referral to the needs.
18	LMI, PD, Health Unit (HU), RCWC.	In the Police Department: lack of information; In Emergency Department: lack of secrecy and ethics and feeling of untruth to the report made; the Psychologist (BHU) did not accept and the Physician was rude and in the RCWC the Psychologist promoted support.	Presented disarticulation of the services: some without referrals, Information, welcoming and humanization; Others with welcoming, support and trust.	Lack of professional preparation, support and welcoming, combined with fragmentation led women to have insecurity. The opposite strengthened confrontation with the situation.
19	Center specialized in sexual violence.	Adequate assistance by the professionals.	The women wanted to recommend the services to others for the service.	Satisfaction with the care and the service.
20	Shelter specialized in women care.	Looking beyond the situation generated satisfaction and the professional created bond and confidence, and facilitated access to another service.	Welcoming generated trust and the direction generated satisfaction, by focusing on the needs.	The integration of the services promoted welcoming, adequate listening and focus on the needs.

Chart 4. Continued...

Study	Type of formal social support service	Service and professional category	Main Results	Main Conclusions
21	Primary care unit for women who have undergone IPV.	Trained professionals provided barrier breaking and bonding. But the medical professional created barriers.	Some professionals generated confidence, openness and wanted to continue the process. Others created barriers and did not identify the needs.	The training of the professionals generated better targeting and articulation in the services and, in the women, better confrontation.
22	Psychological advice and safe housing agency Primary Care.	The Psychologist: Generated perception of self-abuse and the present in its surroundings; The physician (AP) showed that telling the fact was useless.	Active listening generated self-reflection. But inhibition when assisted by the male gender; and the physician focused on the disease.	The support generated reflection on the relationship of violence and better evaluation of the decisions to be taken regarding the fact.
23	Health centers, forensic clinics, counseling center and Police Department.	The actions suggested by the professionals, they could not accomplish, and generated guilt. But being welcomed and supported generated self-reflection. The Police Department generated a feeling of impunity, when hearing the complaint and arresting and releasing the aggressor.	Listening, support and direction promoted empowerment and self-confidence led them to seek ways to overcome. The opposite led them to remaining in the relationship of violence.	The confrontation models that women present must be considered, the professionals must be prepared in their daily practice to welcome each situation in different ways.
24	Primary Health Care (PHC) and service linked to care.	Nurse (First-Aid Clinic) promoted health care by working in partnership with another service professional.	Professionals who were trained, promoted actions that led to satisfaction for knowing how they should perform them.	Promoting bonding and integration led to the referral and strengthening of women in their entirety.
25	Service for women.	The nurses made a joke, with a pejorative name after the service.	The exposure generated led to the search for private services.	Not welcoming generates distancing, and training, welcoming.
26	Shelter for women.	The physicians were rude and focused on the disease and the questions caused humiliation and embarrassment. As well as the SA also generated humiliation.	Feeling of guilty, shame, in addition to not meeting the needs and the male figure caused embarrassment.	Professional ignorance on the theme, generates hopelessness, guilt, insecurity, frustration and invisibility of the violence suffered.
27	AP, Advocacy to Women in DVA.	Physician: listened and generated hope; Attorney: kind, attentive and referred.	The integration of the services generated referral and trained professional generated self-reflection.	Adequate referrals generate trust and decision-making for exiting the cycle.
28	Social workers support center.	Police: loneliness, lack of information, silence and wanting to withdraw the complaint. SA: support and security.	Fragility in the information, pressure and insecurity. Welcoming led to support and security.	Skilled professionals generated better direction in the process of change for these women.

Chart 5. Topics that stood out in the selected studies and were present in the women's speeches, after attending the formal services. Curitiba, Paraná, 2019.

Keywords highlighted	Related studies	Characteristics
Focus on the disease and not on the women's needs.	13-16,25	Service in the immediate search and not in the long run, resulting in no further search.
Disarticulation, lack of bonding, information, support and welcoming.	14-18,25,28	Divergences between professional service with emphasis on the lack of intersectoriality and hopelessness in the formal services.
Welcoming, support, referrals, trust, focus on the needs and self-reflection.	14,16-25,27,28	Actions classified as potential generated self-confidence and reflection on the context experienced and, in some cases, generated the exit from coexistence with the aggressor.
Fear, shame, insecurity, humiliation, embarrassment and guilt.	14,15,17,18,25,26,28	Situations that promoted distancing of these women from the services and made them return to the context of violence.

support network for women in situations of violence, basic health unit (BHU), police department (PD) and police station for women (PSFW), reference center for women's care (RCWC), public prosecutor's office (PPO), tutelary and psychological council, shelter, Legal Medical Institute (LMI), emergency care, hospital, third sector (churches and non-governmental organization), forums, schools, social assistance (SA), specialized center for treatment of sexual violence, forensic clinic and counseling centers and discussed what one had as participation in the care and regarding the perception of the professional and main conclusions in Chart 4.

Chart 5 represents the reports of the women in a situation of violence, after being assisted by professionals in the formal support services. Some present fragilities and other potentialities, as well as what each one represented for them.

DISCUSSION

After analyzing the studies, some characteristics became evident, such as: mean age of 41 years old, and race varying between black, brown, white and indigenous. As for race and ethnicity, 43.7%[13-15,17,20,21,23,24] did not highlighted them and 56.2%[14,16,18,19,22,25-28] classified race or ethnicity, but did not relate this to violence. That is what was found in a 2019 study, in which age, race or skin color, did not show a relationship of greater possibility for women to suffer violence, but the relationship among the women with less schooling and with fewer children.[29]

In this research, 10 studies (62.5%)[13-16,18,21,23-26] highlighted the level of schooling, with a prevalence of high and elementary school and, in eight, higher education (80%). The remaining 37.5%[16,18,19,21,26,27] did not classify. In seven (43.7%)[14-16,18,19,23,25] women's own income stood out; on the other hand, non-income can be an inhibitor for the exit of women from the relationship, for the fear of not being able to sustain themselves or their children. And highlighted in a study in Istanbul,[30] where the risk for the increase of domestic violence was related to the lower index of family income, the non-inclusion of women in the labor market and not permission by their partner.

This is due to the meeting of ideas of control and power of men over women's autonomy and the increase of violence in those who are inserted in the labor market, so at some moments it generates violence and at others it drives the exit, by the achievement of financial autonomy.[30] In this research, a tendency was observed of women with lower income to suffer more violence; however, other analyses are necessary, for the low percentage in the difference.

One of the studies highlighted nurses who provide care to women in a situation of violence, who suffered domestic violence and who did not seek care in the workplace, because they feel embarrassed and discriminated by the lack of secrecy by the professionals. The experience lived in the situation of violence promoted greater focus in their actions to create bond and understand the origin of the violence suffered by other women. [25] Which meets the importance of professional preparation in the care provided to these women, not by the experience, but by the recognition of the importance of this theme.

Lack of knowledge generates unpreparedness and leads to care focused on physiological issues and not on the real need, not always verbalized by women in the search for services. However, training cannot be seen as an isolated situation, but linked to a culture, in which the goal is permanent education applied in a manner so as to become an institutional policy to be maintained and perpetuated.[31]

When conducted, welcoming and bond were highlighted for generating satisfaction and reflection about themselves and in the context if insertion, in contrast when not, provoked dissatisfaction, hopelessness, fear, shame, humiliation and guilt. And it was linked to a weakness in the studies[14-18,25], associated with professional divergence and lack of information.[28] Welcoming is a major step linked to the perception of biological, social and psychological needs and the creation of a bond, in order to understand the situation in its entirety, promote security and support. [31]

In the studies,[14,15] it was demonstrated that the experience of the women when being assisted by professionals linked to the intersectoral collaboration services and that they did not generate a bond, motivated the decision of not returning, even in cases of physical injuries. The literature showed that professionals who work in the network of intersectoral collaboration focused on violence against women demonstrate disarticulation, fragility of the services and in the support for the individual needs of women in situations of violence.[24] This is in line with the findings of this research.

One of the studies[20] highlighted the importance of relationship building, effective connection of the services, community mobilization with health education and awareness of intersectoral work. Others[13,15] that superficial or reductionist services can generate non-demand by these women, mainly in the difficulty in accessing the services. It should be taken into account that the barrier is not always broken immediately, so the bond can guarantee continuity of care. In the studies[19,28] where welcoming and bonding were carried out, reporting and better referrals were favored. In contrast, those who did not did so impacted on fragility, embarrassment and feeling of pressure regarding the reports, even when they presented difficulty and insecurity in verbalization.[18,28]

In addition to the fact that many women do not reflect in their insertion context, because they are used to this way of relating to someone and feel guilty, according to the studies.[22,26] In the study,[22] the emphasis is on the fact that this way of perceiving their context, determines that violence is the only option and they cannot establish the necessary trust in sharing information. And they understand that disclosing the fact can cause harm to the aggressor if he becomes aware, or lose the right to live with his children, which leads to the search for people close to him who are not always able to direct them. And, when they do, the service is restricted to medicalization and disease, highlighted in the studies.[14,15,26]

Which collaborates so that they return to the context of violence and lose the opportunity for exit, as seen in the study[14], it is important that there is co-responsibility and assistance by the professionals who are part of the network of intersectoral collaboration in decision-making, in promoting information appropriate to their empowerment.[15] It is important to emphasize that the subjective evaluation does not disregard the physical condition, but values the search for understanding and continuity of the autonomy process of these women.[15,16] Considering that the feeling of deserving aggression emphasized in one of the studies[26] when having the perception of care with disrespect, incomprehension, humiliation, invisibility and the revival of violence suffered and, as a consequence, lack of demand and discredit in the services.

In opposition to this form of care, one of the studies[19] highlighted that, by identifying these situations, promoting bonding, offering support and adequate direction, generated well-being and search for change in the current condition. Therefore, a service based on welcoming, active listening, support and articulation of the services, benefits these women with strategies of change. As well as the training when promoted as a way to improve approach and direction, and emphasized as generating decision making and strengthening in the continuity in the process of change. Also, the articulation between the services, generated support in the treatments in an integral manner.[16,24] This does not occur when the professionals have a limited view or are unaware of the theme and its cultural context.

In this way, promoting means in which the professional has confidence in the service provided generates knowledge to perform questions directed to the search for the origin of the situation presented. And, when talking about themselves, these women can reflect the context of the relationship and the reasons that made them seek the services and allow the professional to draw up an individual plan, focusing on short- and long-term needs.[31-33] The acquisition of knowledge about each situation favors intersectoral collaboration services, an appropriate referral to the individual needs; the opposite causes a feeling of lack of resoluteness. This fact optimizes women's time when going through these services and will concentrate their time on focused care. This is evidenced in the studies[16,17,19-24,27,28] in which the care provided by professionals with a focus on welcoming, listening and directing, became drivers for these women to continue the search for resoluteness and subsequent distancing from the aggressor.

FINAL CONSIDERATIONS

Women's perception of professional care when they suffer some form of violence was highlighted among the results of this research by lack of bonding, welcoming and networking. In contrast, the reports emphasized that, when the formal support network was linked to intersectoral collaboration services and that prioritized care and included methods that allowed for self-reflection, women were prompted to seek changes.

In the studies analyzed there were reports of guilt, shame, insecurity, non-resolution, impunity, discomfort and humiliation, in parallel to the lack of knowledge in the approach to violence and in the reductionist model focused on apparent injuries, illness and medicalization. And it refers to the biomedical model, in which the biological part is valued, without focusing on women's subjectivity and their specific needs, not always evident in a first approach. And, despite the fact that the care focused on welcoming and active listening is often disseminated in the scientific environment, this research evidenced not to be a reality practiced in all the services, or by all the professionals in the formal social support network, besides as analyzed, it promotes the distancing of these women or their non-adherence to the treatment plan.

Despite the evidence that training promotes resoluteness, it was been fully addressed in the studies as a strategy to confront violence against women. Training is a process that cannot be detached from care, but it is noted that, even though there are specific and frequently implemented policies in the health services, it is still a weakness. Research studies are suggested to evidence which points are necessary in the daily practice, so

that care can strengthen women's autonomy and support them with the necessary tools to make decisions and exit the cycle of violence in which they find themselves.

The contribution of this research and found in the *ScR* was that, in the services where the educational processes were a common point, the women had as reflection the perception of a care with better direction and self-reflection. But also a gap was evidenced, mainly referring to violence in its various aspects, and that can be strategies used in this confrontation. It is suggested that new studies focus on strategies used and themes approached beyond the daily flows and techniques in the educational processes, focused on a historical social context and gender issues and still incipient to those who assist women in situations of violence and reflected in this research, by the women's perception when they are looking for such services.

AUTHOR'S CONTRIBUTIONS

Project design, data search and study selection, project writing, data analysis and interpretation. Marli Aparecida Rocha de Souza.

Project design, review design, study selection, critical review of the intellectual content, discussion of the findings and final approval. Aida Maris Peres.

Review design, project writing, discussion of the findings, relevant critical review of the intellectual content and final approval. Lais Fumincelli.

Data search, project writing, relevant review of the intellectual content and final approval. Vagner José Lopes

Review design, project writing, relevant review of the intellectual content and final approval. Nen NaLú Alves das Mercês.

Review design, project writing, relevant review of the intellectual content and final approval. Marilene Loewen Wall.

Writing and critical review of the manuscript. Marli Aparecida Rocha de Souza. Aida Maris Peres. Lais Fumincelli. Vagner José Lopes. Nen NaLú Alves das Mercês. Marilene Loewen Wall.

Approval of the final version of the article. Marli Aparecida Rocha de Souza. Aida Maris Peres. Lais Fumincelli. Vagner José Lopes. Nen NaLú Alves das Mercês. Marilene Loewen Wall.

Responsibility for all aspects of the content and integrity of the published article. Marli Aparecida Rocha de Souza. Aida Maris Peres. Lais Fumincelli. Vagner José Lopes. Nen NaLú Alves das Mercês. Marilene Loewen Wall.

ASSOCIATE EDITOR

Stela Maris Padoin

REFERENCES

1. Barufaldi LA, Souto RMCV, Correia RSB, Montenegro MMS, Pinto IS, Silva MMA et al. Gender violence: a comparison of mortality from aggression against women who have and have not previously reported violence. Ciênc. saúde coletiva. 2017;22(9):2929-38. http://dx.doi.org/10.1590/1413-81232017229.12712017.
2. Lira KFS, Barros AM. Violência contra as mulheres e o patriarcado: um estudo sobre o sertão de Pernambuco. Rev Ágora. 2018;22:275-97.
3. Couto VA, Rocha RLS, Ribeiro LML, Silveira AM. Intersetorialidade e ações de combate à violência contra a mulher. Rev. Estud. Fem. 2018;26(2):e45859. http://dx.doi.org/10.1590/1806-9584-2018v26n245859.
4. Trentin D, Vargas MAO, Leal SMC, Vargas CP, Ferreira ML, Neves FB. Women in situations of sexual violence: potentialities and weaknesses of the intersectoral network. Rev Bras Enferm. 2020;73(4):e20190856. http://dx.doi.org/10.1590/0034-7167-2018-0856. PMid:32428122.
5. Horwood J, Morden A, Bailey JE, Pathak N, Feder G. Assessing for domestic violence in sexual health environments: a qualitative study. Sex Transm Infect. 2018;94(2):88-92. http://dx.doi.org/10.1136/sextrans-2017-053322. PMid:28778979.
6. Meloni VE, Mariana H. Perceptions of professionals in an intersectorial network about the assistance of women in situation of violence. Interface (Botucatu). 2017;21(60):52-62.
7. Ellsberg M, Arango DJ, Morton M, Gennari F, Kiplesund S, Contreras M et al. Prevention of violence against women and girls: what does the evidence say? Lancet. 2015;385(9977):1555-66. http://dx.doi.org/10.1016/S0140-6736(14)61703-7. PMid:25467575.
8. World Health Organization. Global plan of action: to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. Geneva: WHO; 2016.
9. Cripe SM, Espinoza D, Rondon MB, Jimenez ML, Sanchez E, Ojeda N et al. Preferences for intervention among Peruvian women in intimate partner violence relationships. Hisp Health Care Int. 2015;13(1):27-37. http://dx.doi.org/10.1891/1540-4153.13.1.27. PMid:25741931.
10. Peters MDJ, Godfrey C, McInerney P, Baldini Soares C, Khalil H, Parker D. Scoping reviews. In: Aromataris E, Munn Z, editors. Joanna Briggs Institute Reviewer's Manual [Internet]. Australia: The Joanna Briggs Institute; 2017 [citado 2020 abr 2]. Disponível em: https://reviewersmanual.joannabriggs.org/
11. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D et al. PRISMA Extension for Scoping Reviews (PRISMAScR): checklist and explanation. Ann Intern Med. 2018;169(7):467-73. http://dx.doi.org/10.7326/M18-0850. PMid:30178033.
12. Resolução nº 254 de 4 de setembro de 2018 (BR). Institui a Política Judiciária Nacional de Enfrentamento à violência contra as Mulheres pelo Poder Judiciário e dá outras providências. Diário Oficial da União [periódico na internet], Brasília (DF), DJE/CNJ nº 167/2018, 5 set. 2018, p. 55-9. [citado 2020 abr 2]. Disponível em: https://atos.cnj.jus.br/atos/detalhar/atos-normativos?documento=2669
13. Machisa MT, Christofides N, Jewkes R. Social support factors associated with psychologhical resilience among women survivors of intimate partner violence in Gauteng, South Africa. Glob Health Action. 2018;11(Suppl 3):1491114. http://dx.doi.org/10.1080/16549716.2018.1491114. PMid:30270774.
14. Soares JSF, Lopes MJM. Experiências de mulheres em situação de violência em busca de atenção no setor saúde e na rede intersetorial. Interface (Botucatu). 2018;22(66):789-800. http://dx.doi.org/10.1590/1807-57622016.0835.
15. Vieira LB, Souza IEO, Tocantins FR, Pina-Roche F. Support to women who denounce experiences of violence based on her social network. Rev Lat Am Enfermagem. 2015 out;23(5):865-73. http://dx.doi.org/10.1590/0104-1169.0457.2625.
16. Albuquerque No L, Moura MAV, Fernandes e Silva G, Penna LHG, Pereira ALF. Mulheres em situação de violência pelo parceiro íntimo: tomada de decisão por apoio institucional especializado. Rev Gaúcha Enferm. 2015;36(no. spe):135-42. http://dx.doi.org/10.1590/1983-1447.2015.esp.54361.
17. Reis MJ, Lopes MHBM, Osis MJD. 'It's much worse tha dying': the experiences off emale victimis of sexual violence. J Clin Nurs. 2017;26(15-16):2353-61. http://dx.doi.org/10.1111/jocn.13247. PMid:27140538.
18. Santos WJ, Freitas MIF. Fragilidades e potencialidades da rede de atendimento às mulheres em situação de violência por parceiro íntimo. Rev Min Enferm. 2017;21:e-1048. http://dx.doi.org/10.5935/1415-2762.20170058.
19. Du Mont J, Kosa D, MacDonald S, Benoit A, Forte T. A comparison of Indigenous and non-Indigenous survivors of sexual assault and their receipt of and satisfaction with specialized health care services.

PLoS One. 2017;12(11):e0188253. http://dx.doi.org/10.1371/journal.pone.0188253. PMid:29145501.

20. Mantler T, Wolfe B. A rural shelter in Ontario adapting to address the changing needs of women who have experienced intimate partner violence: a qualitative case study. Rural Remote Health. 2017;17(1):3987. http://dx.doi.org/10.22605/RRH3987. PMid:28298129.
21. Loeffen MJ, Daemem J, Wester FP, Laurant MG, Lo Fo Wong SH, Lagro-Janssen AL. Mentor mother support for mothers experiencing intimate partner violence in family practice: a qualitative study of three different perspectives on the facilitators and barriers of implementation. Eur J Gen Pract. 23(1):27-34. http://dx.doi.org/10.1080/13814788.2016.1267724.
22. Evans MA, Feder GS. Help-seeking amongst women survivors of domestic violence: a qualitative study of pathways towards formal and informal support. Health Expect. 2016;19(1):62-73. http://dx.doi.org/10.1111/hex.12330. PMid:25556776.
23. Bahrami M, Shokrollahi P, Kohan S, Momeni G, Rivaz M. Reaction to and coping with domestic violence by Iranian women victims: A qualitative approach. Glob J Health Sci. 2015 jul;8(7):100-9. http://dx.doi.org/10.5539/gjhs.v8n7p100. PMid:26925908.
24. Wuest J, Merritt-Gray M, Dubé N, Hodgins MJ, Malcolm J, Majerovich JA et al. The process, outcomes, and challenges of feasibility studies conducted in partnership with stakeholders: a health intervention for women survivors of intimate partner violence. Res Nurs Health. 2015 fev;38(1):82-96. http://dx.doi.org/10.1002/nur.21636. PMid:25594917.
25. Sprague C, Woollett N, Parpart J, Hatcher AM, Sommers T, Brown S et al. When nurses are also patients: intimate partner violence and the health system as an enabler of women's health and agency in Johannesburg. Glob Public Health. 2016;11(1/2):169-83. http://dx.doi.org/10.1080/17441692.2015.1027248. PMid:25833744.
26. Pratt-Eriksson D, Bergbom I, Lyckhage ED. Don't ask don't tell: Battered women living in Sweden encounter with healthcare personnel and their experience of the care given. Int J Qual Stud Health Well-being. 2014 fev;9:23166. http://dx.doi.org/10.3402/qhw.v9.23166. PMid:24576461.
27. Malpass A, Sales K, Johnson M, Howell A, Agnew-Davies R, Feder G. Women's experiences of referral to a domestic violence advocate in UK primary care settings: a service-user collaborative study. Br J Gen Pract. 2014;64(620):151-8. https://doi.org/10.3399/bjgp14X677527.
28. Ekström V. Violence against women social services support during legal proceedings. Eur J Soc Work. 2014;18(5):661-74. http://dx.doi.org/10.1080/13691457.2014.951600.
29. Cerqueira D, Moura R, Pasinato W. Participação no mercado de trabalho e violência doméstica contra as mulheres no Brasil. Brasília: IPEA; 2019. Texto para discussão.
30. Aslan E, Bodur G, Beji NK, Alkan N, Aksoy Ö. Exposure to domestic violence in women living in istanbul and aegean regions: a Turkish sample. Ciênc. saúde coletiva. 2019 Aug 24(8):2835-44. https://doi.org/10.1590/1413-81232018248.22952017.
31. Moreira GAR, Freitas KM, Cavalcanti LF, Vieira LJES, Silva RS. Qualificação de profissionais da saúde para a atenção às mulheres em situação de violência sexual. Trab Educ Saúde. 2018 ago;16(3):1039-55. http://dx.doi.org/10.1590/1981-7746-sol00156.
32. Leite FMC, Silva ACA, Bravim LR, Tavares FL, Primo CC, Lima EFA. Victims of violence: perception, complaints and behaviors related to their health. Rev enferm UFPE on line. 2016; ago (Suppl. 6):4854-61. https://doi.org/10.5205/1981-8963-v10i6a11265p4854-4861-2016.
33. Arboit J, Padoin SM, Vieira LB, Paula CC, Costa MC, Cortes LF. Health care for women in situations of violence: discoordination of network professionals. Rev Esc Enferm USP. 2017 abr 3;51:e03207. PMid:28380159.