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THEORETICAL-EXPLANATORY MODEL OF THE CARE PROVIDED TO WOMEN IN SITUATIONS OF VIOLENCE IN PRIMARY HEALTH CARE

Jordana Brock Carneiro[1]
Nadirlene Pereira Gomes[1]
Luana Moura Campos[1]
Fernanda Matheus Estrela[2]
Natália Webler[1]
José Luís Guedes dos Santos[3]
Amâncio António de Sousa Carvalho[4]

[1]Universidade Federal da Bahia, Escola de Enfermagem. Salvador, Bahia, Brasil.
[2]Universidade Estadual de Feira de Santana, Departamento de Saúde. Feira de Santana, Bahia, Brasil.
[3]Universidade Federal de Santa Catarina, Programa de Pós-graduação em Enfermagem. Florianópolis, Santa Catarina, Brasil.
[4]Universidade de Trás-os-Montes e Alto Douro, Escola Superior de Enfermagem, Departamento de Enfermagem de Saúde Mental e Comunitária. Vila Real, Portugal.

ABSTRACT

Objective: to develop a theoretical-explanatory model of the care provided to women in situations of intimate partner violence in the context of Primary Health Care.
Method: a study with a qualitative approach, whose theoretical-methodological contribution adopted was the updated Straussian strand of the Grounded Theory. Between February and December 2019, individual interviews were conducted with 31 professionals who worked in Family Health Units in the Health District of a capital from northeastern Brazil, members of the minimum team (first sample group) and of the Expanded Family and Primary Care Health Center (second sample group). The data were organized using an analytical tool called Paradigmatic Model, consisting of three components: condition, action-interaction and consequences.
Results: the theoretical-explanatory model of the phenomenon called “enabling the empowerment of women in situations of intimate partner violence” allowed understanding the meanings attributed by the professionals to the care offered to women in situations of intimate partner violence within the scope of the Family Health Strategy.
Conclusion: the model of care provided to women in situations of intimate partner violence, based on identification of the problem and intervention in the cases, is limited due to the characteristics of the organization of the services. In this sense, the study points to the importance of managerial actions to achieve favorable outcomes for female empowerment and consequent confrontation of violence.

DESCRIPTORS: Women’s health. Intimate partner violence. Health personnel. Forensic Nursing. Family Health Strategy. Health care. Grounded Theory.

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MODELO TEÓRICO-EXPLICATIVO DO CUIDADO À MULHER EM SITUAÇÃO DE VIOLÊNCIA NA ATENÇÃO PRIMÁRIA

RESUMO

Objetivo: elaborar um modelo teórico-explicativo do cuidado à mulher em situação de violência por parceiro íntimo no âmbito da Atenção Primária à Saúde.
Método: estudo com abordagem qualitativa, cujo aporte teórico-metodológico adotado foi a vertente straussiana atualizada da Teoria Fundamentada nos Dados. Entre os meses de fevereiro e dezembro de 2019 foram realizadas entrevistas individuais com 31 profissionais que atuavam em Unidades de Saúde da Família do Distrito Sanitário de uma capital do Nordeste brasileiro, integrantes da equipe mínima (primeiro grupo amostral) e do Núcleo Ampliado de Saúde da Família e Atenção Básica (segundo grupo amostral). Os dados foram organizados por meio da ferramenta analítica denominada modelo paradigmático, composto por três componentes: condição, ação-interação e consequências.
Resultados: o modelo teórico-explicativo do fenômeno "viabilizando o empoderamento da mulher em situação de violência por parceiro íntimo" permitiu a compreensão dos significados atribuídos pelos profissionais aos cuidados ofertados à mulher em situação de violência por parceiro íntimo no âmbito da Estratégia de Saúde da Família.
Conclusão: o modelo de cuidado à mulher em situação de violência por parceiro íntimo, pautado na identificação do agravo e intervenção diante dos casos, encontra-se limitado em decorrência das características da organização dos serviços. Nesse sentido, o estudo aponta para a importância de ações da gestão para o alcance de desfechos favoráveis para o empoderamento feminino e o consequente enfrentamento da violência.

DESCRITORES: Saúde da mulher. Violência por parceiro íntimo. Pessoal de saúde. Enfermagem forense. Estratégia saúde da família. Atenção à saúde. Teoria fundamentada.

MODELO TEÓRICO-EXPLICATIVO DE LA ATENCIÓN PROVISTA A LAS MUJERES EN SITUACIONES DE VIOLENCIA EN EL ÁMBITO DE LA ATENCIÓN PRIMARIA

RESUMEN

Objetivo: elaborar un modelo teórico-explicativo de la atención provista a las mujeres en situaciones de violencia conyugal en el ámbito de la Atención Primaria de la Salud.
Método: estudio de enfoque cualitativo, donde se adoptó el aporte teórico-metodológico de la vertiente Straussiana actualizada de la Teoría Fundamentada en los Dados. Entre los meses de febrero y diciembre de 2019 se realizaron entrevistas individuales con 31 profesionales que se desempeñaban en Unidades de Salud de la Familia del Distrito Sanitario de una capital del noreste de Brasil, integrantes del equipo mínimo (primer grupo muestral) y del Centro Extendido de Salud de la Familia y Atención Básica (segundo grupo muestral). Los datos se organizaron por medio de la herramienta analítica denominada Modelo Paradigmático, conformado por tres componentes: condición, acción-interacción y consecuencias.
Resultados: el modelo teórico-explicativo del fenómeno denominado "Viabilizar el empoderamiento de las mujeres en situaciones de violencia conyugal" permitió comprender los significados atribuidos por los profesionales a la atención ofrecida a las mujeres en situaciones de violencia conyugal en el ámbito de la Estrategia de Salud de la Familia.
Conclusión: el modelo de atención a las mujeres en situaciones de violencia doméstica, basado en la identificación del problema y en la intervención frente a los casos, se encuentra limitado como consecuencia de las características de la organización de los servicios. En este sentido, el estudio señala la importancia de acciones de gestión a fin de lograr resultados favorables para el empoderamiento femenino y el consiguiente afrontamiento de la violencia.

DESCRIPTORES: Salud de la mujer. Violencia doméstica. Personal de salud. Enfermería forense. Estrategia de Salud de la Familia. Atención de la salud. Teoría Fundamentada en los Datos.

INTRODUCTION

Intimate partner violence, a complex phenomenon that impacts the lives of women all over the world, leads to a search for social, legal and health care services, among others. In the preventive context, for representing the coordinating axis of care, Primary Health Care (PHC) needs to be organized to ensure care for women in situations of violence, given the presence of women experiencing intimate partner violence who are users of these services. A study conducted with 470 women in the PHC network of a Brazilian municipality showed that, in the last 12 months, 12% of them suffered sexual violence; 26%, physical violence; and 42.8%, psychological violence perpetrated by their intimate partners[1].

The women's illness process resulting from intimate partner violence leads to impairment of their physical and psychological health. Physical impairment is revealed through the harms to the body caused by the aggression process, which can manifest in the form of abrasions, lacerations, bruises and fractures, among others. In addition to compromising physical integrity, marks are left in the psychological field, which are manifested through feelings such as sadness, fear and anxiety, reverberating in depressive behavior, post-traumatic stress disorder, and attempted and consummated suicide[2]. These conditions require that the professionals find strategies to identify the problem and intervene in the cases.

In the current context, the extraordinary character of the COVID-19 pandemic, which refers to social distancing and home reclusion, intensifies the consequences resulting from the problem, as it exposes women to remain in contact with the perpetrator for a longer period of time. This situation, in line with the difficulty accessing the health services and with lack of professional care aimed at their demands, makes them vulnerable to death situations[3].

By experiencing these illness processes at some level, women resort to the health services in an attempt to find a solution to their demands. In this search for specific care to treat the consequences related to violence, the hospital context is more evident, given that it serves more serious situations, usually resulting from physical injuries such as bruises and burns, among others. A Brazilian study, carried out with 7,132 women who were admitted to emergency services, revealed that 30.9% of them were treated for issues related to violence, having their current or former intimate partners as aggressors[4].

Although the cases are presented more explicitly in urgency and emergency services, it is in the Family Health Strategy (FHS), in the context of PHC, where the professionals have a favorable context to identify the occurrence and to confront the problem, especially in early-stage cases. However, although the FHS has the advantage of being inserted in the community context, and the professionals have a close relationship with the users, a number of studies (both national and international) have pointed out that care for women in situations of violence is not carried out in an institutionalized manner, with pre-defined flows and protocols, which undermines comprehensive assistance to this population[5–6].

Thus, weaknesses are observed in this process of care for women immersed in a scenario of intimate partner violence, mainly due to the limited training of the FHS professionals for prevention and health promotion[5–6], which signals the importance of a management that institutionalizes a theoretical-explanatory model of care. Thus, the following research question was outlined: how is care provided to women in situations of marital violence within the scope of Primary Health Care? The following objective was defined: to develop a theoretical-explanatory model of the care provided to women in situations of intimate partner violence within the scope of Primary Health Care.

METHOD

This is a study with a qualitative approach, whose methodological approach adopted was the Grounded Theory (GT), Straussian strand, which proposes to explain certain complex phenomena based on human experiences, considering, above all, the social aspects involved, such as personal behaviors and interactions. From this perspective, an explanatory theory about the reality under study is elaborated, based on the behavior of a group of people who experience it, valuing interactions and meanings that permeate their experiences[7].

The study setting consisted of 22 Family Health Units (FHUs) in a Health District from northeastern Brazil. This district comprises 35 neighborhoods and 2 islands, and is located in a peripheral area. In 2015, the PHC coverage in this district was 74.1%, with 64.4% of the population served by the FHS[8].

The Health District in this study is characterized by disorderly urban growth, linked to low socioeconomic conditions. Added to other social markers, these factors contribute to the increase in crime, making the region socially vulnerable. It is noteworthy that, between 2005 and 2015, the overall mortality rate in this district varied from 4.47 to 5.29 per 1,000 inhabitants, being higher in men, despite most of the population being female. Specifically regarding domestic violence, the data reveal an increase from 43.46 per 100,000 inhabitants in 2010 to 101.52 in 2015, signaling the vulnerability to which these women are exposed[8].

The GT directs the study design to allow defining the participants through the theoretical sampling logic, which establishes that sample groups must be investigated, as long as they encompass relevant experiences about the phenomenon under study. It is noted that theoretical sampling enables the elaboration of concepts which direct the researchers to new questions and to the outlining of hypotheses that can be answered with a new data collection process. Following the GT precepts, the constitution of this sampling is procedural and cannot be established before the data collection and analysis process[9].

Following the assumptions of the Straussian strand of the GT, it is up to the researchers to define the participants of the first sample group, in order to conduct the theoretical model that is being elaborated[9-10]. Taking into account the study objective, selection of the participants who were part of the first sample group used the following as inclusion criteria: being a health professional with higher education level and having worked in the health unit's minimum team for at least six months. With regard to the second group, social workers and psychologists who had been working for a period equal to or greater than six months in a team from the Expanded Family and Primary Health Care Center (*Núcleo Ampliado de Saúde da Família e Atenção Básica*, NASF-AB) were included. In both groups, workers on medical leave were excluded, as well as those on vacation during the collection period or who missed more than three interviews without reporting the absence.

Considering the large contingent of professionals who worked in the minimum teams of the FHS and NASF-AB under study, approximately 214 active employees, a representative sample of professional performance in the provision of care was chosen. In this way, at least one professional from each coverage area was invited. Thus, 31 health professionals were intentionally interviewed, 26 of whom were members of the FHS minimum team and five who worked in the NASF-AB. It is to be noted that, among all the possible participants, only one psychologist refused to participate in the study, because he felt uncomfortable with the topic.

The established criteria allowed the methodological proposal to be taken into account. Thus, the first sample group was assembled, consisting of 26 health professionals from the FHS minimum team: 17 nurses, five physicians and four dentists. Subsequently, through a process of constant comparative analysis, it was possible to elaborate the following hypothesis: "the professionals of the FHS reference team share the understanding that psychologists and social workers are better

prepared to provide care to women in situations of intimate partner violence", which pointed to the need for continuity of the research and directed it to the second sample group. This was composed of professionals who were members of the NASF-AB, totaling five participants: two social workers and three psychologists.

Data collection took place from February to December 2019. The participants were approached through conversation circles about gender inequality and women's health. Subsequently, they were invited to participate in the study, being interviewed individually by two PhD students with experience in qualitative research. To such end, a script was used containing closed questions, referring to socioeconomic data, and open questions, directed by a guiding question: how is care provided to women in situations of marital violence in the context of Primary Health Care? The interviews lasted between 20 minutes and 1 hour and 40 minutes. All were recorded with the aid of a smartphone and later transcribed in full. Theoretical data saturation was achieved after collection of the second sample group, with no need to search for new information to support the phenomenon under study.

After the interviews transcription stage, all the material obtained was organized and coded using the NVivo 10 software, which contributed to the data analysis process. Throughout this analytical process, memos and diagrams were also used as strategies to help identify and illustrate the articulation between the concepts and the analytical categories.

In the GT, the data analysis process takes place in three interdependent stages: Open Coding, Axial Coding and Integration. In Open Coding, the data obtained are separated, examined, compared and conceptualized. For each fragment of the interview, a sentence that becomes a preliminary code is assigned. These preliminary codes are grouped by similarities and differences and constitute subcategories, entitled according to the theme they deal with[7–8]. Thus, the substantial codes are identified, as well as their properties and dimensions.

In turn, Axial Coding enabled the development of concepts and the creation of subcategories necessary for data comparisons. During this stage, a preliminary code becomes a conceptual code, migrating to subcategories or categories. Even after a code has been considered a category or subcategory, after consecutive assessments and readings of the data, it may or may not regress to a conceptual or preliminary code[8–9].

During the axial coding stage, the paradigmatic model is used as an analytical tool. This model is structured in three components: conditions, which refer to the reasons given by the participants for the occurrence of a certain fact, as well as explanations about the reasons why they respond to an action in a certain way; actions-interactions, understood as responses given by the participants to problematic events or situations; and consequences/outcomes, which refer to the anticipated or actual results of the actions and interactions. Finally, during the Integration stage, a model that represents the central category of the study is structured, entitled Research Phenomenon[7–8].

In this study, data analysis was guided by the current theoretical framework on collective health, gender and intimate partner violence. It is noted that validation of the theoretical model was carried out by three researchers with expertise in the method and by three study participants. In the validation process, it was sought to verify methodological rigor and deepen the theme, based on its application to Nursing and to the scientific field.

It is highlighted that the matrix project was approved by the Research Ethics Committee. The researchers obtained the participants' consent through their signing of the Free and Informed Consent form (FICF), in compliance with the ethical precepts contained in Resolutions No. 466/2012 and Nº. 516/2016 of the National Health Council (*Conselho Nacional de Saúde*, CNS). The procedures set forth in the Declaration of Helsinki (1964 and its reformulations, the last dating from 2000) were also respected. All the participants were advised that the content of the interviews would be filed in virtual folders and excluded five years after the research has been developed.

It is noted that confidentiality was ensured and that the participants' anonymity was guaranteed, since the interviews were conducted in a private room. The names of the professionals were replaced by the following code: letter E for Interviewee ("*Entrevistado*" in Portuguese) followed by the numeral that represents the order of the interview and the G1 or G2 combination, depending on the sample group they belonged to.

RESULTS

The theoretical sample of this study consisted of professionals aged between 28 and 65 years old, who had worked for a mean of nine years in the FHS. Most of the participants (n=25) had a *lato sensu* graduate degree in Family Health or Public Health.

Data analysis and integration allows understanding about the care that has been offered to women in situations of intimate partner violence within the scope of the FHS, revealing the phenomenon called "enabling the empowerment of women in situations of intimate partner violence", represented in Figure 1. The theoretical-explanatory model of this care was delimited based on the aforementioned phenomenon, which comes from the interrelation of the three components of the paradigmatic model - Consequence, Condition and Action-interaction - expressed in the following categories: "identifying situations of intimate partner violence; Intervening in cases of intimate partner violence; Limiting care due to the characteristics of the organization of the services; Favoring confrontation of intimate partner violence through women's empowerment; Impairing confrontation of intimate partner violence due to lack of care". Therefore, such theoretical-explanatory model can be configured as a strategy to direct actions to identify the problem and intervene in the cases, with a view, above all, to women's empowerment to confront the problem.

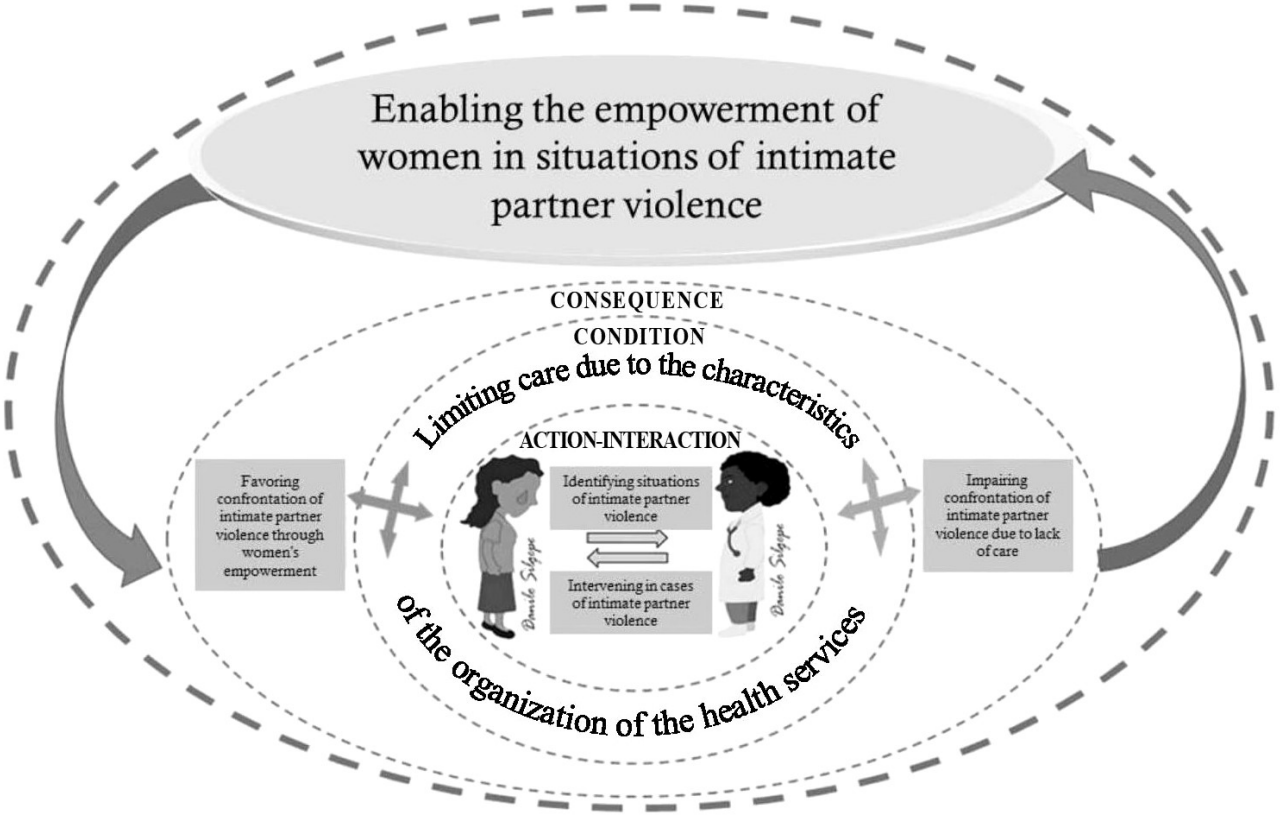

Figure 1 – Theoretical-explanatory model, Salvador, Bahia, Brazil, 2020.

As pointed out in the professionals' statements, the care provided to women in situations of intimate partner violence permeates the user-professional action-interaction process, represented by two categories. The first, entitled "Identifying situations of intimate partner violence", shows that the following is necessary for the care provided to women who experience the problem: investigation of the intimate relationship, establishment of a bond with the user, and articulation with other professionals from the team.

[…] *Generally, from the moment I welcome her and establish a relationship of trust, she's able to speak* [...] *I also get suspicious when I notice signs of sadness, anxiety, introspection and physical injuries* [...] *I also seek information from other professionals, such as the nurse and the community agent* (E25 G1).

[…] *The bond is fundamental. All the professionals in the unit must be prepared to create bonds with these women* [...] *Sometimes they come here to deal with other matters and I realize they're not doing well. I stop to listen to them, and they end up telling me that they experience violence in the relationship* [...] *When they are suspicious, the employees tell us, so that we can investigate* (E2 G2).

Also during the action-interaction process, as pointed out in the "Intervening in cases of intimate partner violence" category, in addition to identifying the situations of intimate partner violence, it is essential that the professionals working in PHC provide assistance to the women immersed in this context under the multidisciplinary perspective, as well as that they notify the cases and refer the women to other services, when necessary.

[…] *When I treat a situation of violence, I take care of the woman together with other professionals from the unit itself, such as a psychologist and social worker from the NASF. Some referrals are external, such as to the Emergency Unit and the referral center, although there's no counter-referral* [...] *I fill in the notification form* (E19 G1).

[…] *Together with the team, we prepare a care plan. In primary care, we share care. I notify the problem and then make the necessary referrals to the Specialized Police Service for Women and, in cases involving sexual violence, we forward them to the Service for People in Situations of Sexual Violence* [...] *I schedule a return visit with me to be able to monitor the case* (E4 G2).

The *condition* component of the theoretical-explanatory model, in turn, was represented by the "limiting care due to the characteristics of the organization of the services" category. What was exposed by the professionals indicates that the organization of the services is a *sine qua non* condition for the viability of the care provided to the victims of intimate partner violence in the FHS setting, which encompasses time of care, sizing of human resources, professional training to deal with situations of violence, and establishment of a flow for intersectoral referrals.

[…] *Even when I see some signs, I find it difficult to ask women about violence. I don't master the theme and there's no guidance on how to carry out this investigation and conduct the cases* [...] *in addition to that, the time for consultation is scarce, so I end up dwelling on the main complaint* (E6 G1).

[…] *Our NASF has two women professionals to support the nine teams. Even though I feel qualified to handle marital violence cases, I'm only in the unit once a week, and the professionals from the minimum team wait for that day for us to make the referrals. They need to be trained, as they don't feel able to manage the cases* (E1 G2).

The results of the "*action-interaction* process" were represented by the *Consequences* component through two categories. The first, entitled "favoring confrontation of intimate partner violence through women's empowerment", reveals the importance that being prepared to investigate and intervene in these cases is linked to the strengthening of women immersed in a context of violence and to female empowerment, factors that favor rupture of the abusive relationship and point to the essentiality of the care actions aimed at the aforementioned population.

[…] *When I create a bond, and the woman reveals that she experiences violence, I can help her with guidelines and referral to a psychologist and police station* [...] *so that violence may decrease and she may no longer suffer aggressions* (E2 G1).

[…] *We told her about her rights and she decided to report* [...] *she left her home and rented a house for her and her children. I know that the way we handled the situation helped her to overcome that life of frequent aggressions* (E5 G2).

On the other hand, when care is not provided, the "*consequences"* are linked to negative outcomes, as indicated in the second category: "impairing confrontation of intimate partner violence due to lack of care". In the professionals' statements, it is observed that inefficiency to organize identification and intervention strategies to face the problem reverberates in the woman's permanence in the intimate relationship, which favors worsening of physical and psychological harms resulting from violence, even making her susceptible to death.

[…] *I don't know much about how to identify or approach a woman when I suspect violence. This can make her keep coming back here several times, with me not being able to find the cause of the problem* [...] *the consequences are for her life and her physical and mental health and for that of the people around her, especially the children* (E7 G1).

[…] *Lack of guidelines contributes for her return to a life of violence* [...] *The professionals aren't concerned about taking care of that woman; they just want to pass the case on* [...] *This neglect worsens women's health situation, who can even die due to violence* (E3 G2).

DISCUSSION

The study revealed that the care provided to women in situations of intimate partner violence within the scope of PHC takes place from the action-interaction between the health professionals and the users, in order to identify and intervene in the cases. Regarding recognition and/or suspicion of an experience of violence by the women, the participants' statements point to the importance of establishing a professional-user bond, an essential course of action given the women's difficulty in sharing something of their intimacy, understood as a problem private scope problem.

A study carried out with women who experienced violence in New Zealand identified that they felt ashamed to share their intimate experiences, in addition to being afraid of being exposed to society[11]. A number of Brazilian female researches also draw the attention to the women's difficulty in verbalizing the forms of violence suffered, even in the care network spaces[12–13]. Thus, bonding with women can be configured as a strategy that allows them to feel safer to share intimate issues, in order to favor disclosure of the problem in the health setting. Hence the importance of the health professionals being prepared to establish bonds with the women.

In the interactional process, the statements also alert that a close relationship with the user contributes to the professionals' awakening to a possible experience of violence, even when the search for the service takes place for different reasons. This reality is also pointed out nationally and internationally in studies that reveal different Primary Care spaces, such as appointments and family planning, as strategic environments for the investigation of cases of violence, regardless of the reason that led the woman to seek care[14–15]. Thus, physical marks, as well as subtle signs of violence, such as sadness, introspection and anxiety, are revealed as signs to suspect violence and investigate marital daily life with the woman or other professionals from the team.

In view of the identification of the cases, the findings point to the indispensability of notification as a stage in the assistance process, although some care professionals mistakenly only perform it in confirmed situations, which evidences the need for them to be informed and trained to fill out this form[16]. It is important to mention that notification of violence against women, even if suspected, has a compulsory character, constituting a legal obligation of the professionals who work in health services.

Therefore, the management must be concerned with promoting training for this. In this regard, Law Nº.10,778/2003 determines that the suspected or confirmed cases of violence must be notified by the health professionals, in addition to reinforcing the importance of the management to enable in-service training[17]. Such initiative is expressed as a successful strategy for the notification of cases.

The findings also point to the need for intervention in the face of the physical, psychological and social demands of each woman. Therefore, through matrix support, the professionals meet to share and discuss the cases, developing a multidisciplinary care plan whose needs go beyond the care limits of the unit, demanding referrals to other services and, consequently, intersectoral articulation. This teamwork modality is pointed out in a Brazilian study, which places PHC as a central element for the communication of the Health Care Networks, including monitoring the agreements made with other network services and directing care, which requires integrated actions with management support[18].

Also from the perspective of actions of interest to the management, the statements revealed the need to reorganize the work processes, as well as to assess the possibility of making the time devoted to the appointments more flexible in situations such as cases of intimate partner violence. This is because, due to the complexity of the phenomenon, the process of approaching women can demand time and subjectivity, as indicated by an international study[19]. On the other hand, research shows that management models aimed at productivity, time optimization and greater number of visits make it difficult to investigate cases of violence[20].

However, it is important to point out that the time limitation can be overcome through approaches that supplant consultation spaces, such as interactions in educational groups, home visits and waiting rooms. These findings are corroborated by a research study carried out in Rome, Italy, revealing a successful experience in identifying and caring for cases of violence in PHC, through the creation of groups by health professionals in extramural areas of the unit, for example, street drama and dance. These activities, aimed at quality of life, expand the therapeutic possibilities aimed at women in situations of violence[21].

For this performance, it is indispensable that the training processes focused on the theme of violence are built since graduation, given that, in this research, the professionals reported lack of preparation to approach and conduct the cases. Due to this lack of preparation, they tend to refer the women to the NASF-AB, as they believe this team is better prepared to act in these cases. The national literature points out that, in cases of violence identified in the PHC services, the team, mainly composed of physicians and nurses, is guided to refer the situations to specialized teams which offer support, especially for the psychological and social issues, favoring the handling of situations that are difficult to resolve[22].

The performance of this center, however, does not exempt the minimum team professional from providing care to women in situations of intimate partner violence. This is ratified in a national study, which points out the obligation of the FHS minimum team working in comprehensive care of women in situations of violence, also in articulation with the multidisciplinary team[23]. Although the work carried out by this center is valued, the professionals' performance becomes limited due to underestimation of human resources, as portrayed in the study. Thus, although the NASF-AB provides specialized backup in health actions, improving care resoluteness in primary care, a study shows a reality of understaffed teams, inadequate physical structure for the appointments and, consequently, a fragmented modality of the health care provided to the assisted population[24].

These weaknesses in the provision of care, identified in this study, make it difficult to confront the problem, contributing to the woman's permanence in the relationship, which can worsen the process of physical and mental illness, both for her and for the people who live with her, such as the children. A similar situation was revealed in research studies conducted with women in situations of intimate partner violence in Brazil and Palestine, which revealed that lack of support from the professionals

regarding legal-police, social and health care reverberates in their physical and mental illness, as well as in that of their children[2,25].

Staying in an abusive relationship can even culminate in femicide. An example of this, in the social isolation scenario resulting from the COVID-19 pandemic, women, in permanent contact with the aggressors, are even more susceptible to being fatal victims of their partners. This situation is evidenced in an international study that pointed out how the social isolation rules, by favoring women's permanence for a longer time with their intimate partners, contribute to intensifying conflicts and increasing the number of femicides[26]. This context of confinement of women with their partners, in addition to mitigating their empowerment resources, especially support, due to social distancing, points to the urgency of a special plan for the management of the care offered to women in situations of violence, with digital technologies being an important strategy in this process.

In order to promote institutionalized care for women within the scope of the health services, this study shows that the professionals are responsible for the care and base their praxis on sensitive and welcoming listening, as well as offering information about their rights. National and international studies reveal that the support provided by the professionals, whether based on interpectoral referrals such as legal-police services, inclusion in an employment and income generation program, participation in reflective groups, or in other ways, contributes to women becoming stronger and leaving violent relationships[27–29]. This professional course of action leads to female empowerment and, consequently, favors rupture of violent relationships.

This research was limited for having investigated the experience of professionals working in a single health district of the municipality, which can undermine the representativeness of the results, considering that, in PHC, care is organized according to specificities of the population and is influenced by the district coordination office. Despite this, the study represents and advance, as it embodies a theoretical matrix illustrating the care provided to women in situations of intimate partner violence within the scope of FHS, whose substantial model can guide managerial plans and equip professionals in the FHS context to deal with the situation. It is believed that its development in other health care settings and/or levels can contribute to a broader understanding of the theoretical-explanatory model herein presented.

CONCLUSION

The study points to a theoretical-explanatory model of the care provided to women in situations of intimate partner violence, which is related to actions aimed at the identification of the problem by the FHS professionals, favored by the establishment of a bond, investigation of the marital routine, and articulation with other professionals from the team. They also intervene in the cases, through notification, assistance provided to the women in the unit and referral to the network devoted to confronting violence against women.

Although many professionals recognize the different possibilities for conducting cases of violence, the data that emerge from the model point to the need to involve the management in the preparation process for conducting the cases, considering the multiplicity of factors that interact with the phenomenon and which need to be considered during this process. Within the scope of PHC, although limited due to the characteristics of the organization of the services, care consists in identifying the problem and intervening in the cases.

It is noteworthy that, in the professionals' perception, the women who did not receive care were susceptible to unfavorable outcomes, including death; while those who did receive it were empowered to break with the violent relationships. Thus, the study points to the importance of an integral role of the health professionals with this population, representing a possibility of working to confront the problem.

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NOTES

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CONTRIBUTION OF AUTHORITY

Study design: Carneiro JB, Gomes NP, Campos LM, Estrela FM, Webler N, Santos JLG, Carvalho AAS.
Data collection: Carneiro JB, Campos LM, Webler N.
Data analysis and interpretation: Carneiro JB, Gomes NP, Campos LM, Estrela FM, Webler N, Santos JLG.
Discussion of the results: Carneiro JB, Gomes NP, Campos LM, Estrela FM, Webler N.
Writing and/or critical review of content: Gomes NP, Santos JLG, Carvalho AAS.
Review and final approval of the final version: Carneiro JB.

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CORRESPONDING AUTHOR

Jordana Brock Carneiro
jordanabrock@yahoo.com.br