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DOMESTIC VIOLENCE AGAINST WOMEN: EXPERIENCES OF PRIMARY HEALTH CARE PROFESSIONALS

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ABSTRACT

Objective: to analyze how Primary Health Care professionals experience domestic violence against women.
Method: qualitative research, conducted from January to June 2023, through interviews with 20 Primary Health Care professionals, in a medium-sized municipality in the state of São Paulo, Brazil. The data obtained were interpreted using the Content Analysis Technique, thematic modality.
Results: professionals emphasize the need for a sensitive approach and early identification, expressing feelings of perplexity and powerlessness during care. The impacts of violence are perceived by the victims, families, and society, causing physical, psychological, and social consequences. Challenges include lack of training, fear of reprisals, and lack of institutional support. The limitations faced by women in confronting violence are linked to lack of information, financial and emotional dependence, generating fear and insecurity.
Conclusion: professionals experience the complexity of providing health care to women who are victims of domestic violence, and it is inferred that investments in professional training, institutional protection, and the creation of spaces that can support women are necessary to prevent re-victimization.

DESCRIPTORS: Primary health care. Violence against women. Domestic violence. Women. Health staff. Nursing.

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VIOLÊNCIA DOMÉSTICA CONTRA AS MULHERES: VIVÊNCIAS DOS PROFISSIONAIS DA ATENÇÃO PRIMÁRIA A SAÚDE

RESUMO

Objetivo: analisar como os profissionais da Atenção Primária à Saúde vivenciam a violência doméstica contra as mulheres.
Método: pesquisa Qualitativa, desenvolvida no período de janeiro a junho de 2023, por meio de entrevistas com 20 profissionais da Atenção Primária à Saúde, em um Município de Médio Porte do Interior Paulista. Os dados obtidos foram interpretados pela Técnica de Análise de Conteúdo, modalidade temática.
Resultados: os profissionais enfatizam a necessidade de abordagem sensível e identificação precoce, expressando sentimentos de perplexidade e impotência durante o atendimento. Os impactos da violência são percebidos pelas vítimas, famílias e sociedade, causando consequências físicas, psicológicas e sociais. Os desafios incluem falta de capacitação, medo de represálias e carência de apoio institucional. As limitações enfrentadas pelas mulheres no confronto com a violência estão ligadas à falta de informação, dependência financeira e emocional, gerando medo e insegurança.
Conclusão: os profissionais vivenciam a complexidade que representa o cuidado em saúde às mulheres vítimas de violência doméstica e, depreende-se que são necessários investimentos na capacitação dos profissionais, proteção institucional e criação de espaços, que possam acolher as mulheres, evitando assim a revitimização.

DESCRITORES: Atenção primária à saúde. Violência contra a mulher. Violência doméstica. Mulheres. Pessoal de saúde. Enfermagem.

VIOLENCIA DOMÉSTICA CONTRA LAS MUJERES: EXPERIENCIA DE LOS PROFESIONALES DE LA ATENCIÓN PRIMARIA DE LA SALUD

RESUMEN

Objetivo: analizar cómo los profesionales de Atención Primaria de Salud viven la violencia doméstica contra las mujeres.
Método: investigación cualitativa, desarrollada de enero a junio de 2023, a través de entrevistas a 20 profesionales de la Atención Primaria de Salud, en un Municipio Mediano del interior de São Paulo. Los datos obtenidos fueron interpretados mediante la Técnica de Análisis de Contenido, modalidad temática.
Resultados: los profesionales enfatizan la necesidad de abordaje sensible e identificación temprana, expresando sentimientos de perplejidad e impotencia durante la prestación de cuidados. Los impactos de la violencia son percibidos por las víctimas, los familiares y la sociedad y provocan consecuencias físicas, psicológicas y sociales. Los desafíos incluyen la falta de capacitación, el miedo a represalias y la falta de apoyo institucional. Las limitaciones que afrontan las mujeres quando se enfrentan con la violencia están vinculadas a la falta de información y a la dependencia financiera y emocional, lo que genera miedo e inseguridad.
Conclusión: los profesionales experimentan la complejidad que representa la atención de la salud para las mujeres víctimas de violencia doméstica advirtiéndose la necesidad de inversiones en formación profesional, protección institucional y creación de espacios que puedan acoger a las mujeres y evitar la revictimización.

DESCRIPTORES: Atención primaria de salud. Violencia contra las mujeres. Violencia doméstica. Mujer. Personal de salud. Enfermería.

INTRODUCTION

Violence against women poses a serious global public health problem, with ramifications that reverberate in their citizenship and quality of life, challenging human rights principles and perpetuating gender discrimination[1]. However, the issue is susceptible to prevention and eradication, constituting one of the sustainable development goals of the United Nations (UN)[2].

In the context of Brazilian health policies, the definition adopted for violence follows the parameters proposed by the World Health Organization (WHO), which conceives it as the intentional use of force or power, in a real or threatening manner, directed at oneself, another person, a group, or a community, with the potential to cause injuries, death, psychological trauma, developmental disabilities, or deprivation[3]. Estimates point to a global prevalence of 27% for physical, sexual, or both types of violence occurring at least once in the age group of 15 to 49 years[4].

In Brazil, Law 11.340/2006, known as the Maria da Penha Law, has become an important legislation in combating domestic violence against women, proposing measures for prevention, punishment, and eradication to ensure the physical, psychological, sexual, patrimonial, and moral integrity of women, promote gender equality, and raise awareness in society about their rights. Therefore, it provides for the application of urgent protective measures to ensure their safety and integrity, prohibition of the aggressor's approach, removal from the home, restriction of contact, and other necessary measures to protect the victim[5].

However, despite the significant impact of the Maria da Penha Law on Brazilian society and the increased visibility given to the issue of domestic violence against women, the rates of women facing violence remain high. This becomes more evident considering that the data released in 2023 show that the average of Brazilian women who have experienced some form of violence by an intimate partner was 33.4%, higher than the global average[6].

The construction of a care pathway in the field of violence has been proposed to organize resources, facilitate access, promote care comprehensiveness, and protect individuals in situations of violence, qualifying Primary Health Care (PHC) as one of the appropriate settings for the care of women facing violence[7].

PHC professionals have knowledge of the local reality, allowing them to identify women at risk and/or experiencing violence through a person-centered approach, qualified listening, and bond establishment, providing psychosocial support to empower women and interrupt the cycle of violence[8–9]. Additionally, the strategic role of PHC in preventing violence against women provides power devices such as promoting discussions on gender equality, raising awareness about women's rights, and implementing educational strategies in the community. It is added that these professionals can make use of a care network with specialized services and meet the needs of these women[9–10].

However, it is evident that there is a certain reductionist view among primary health care professionals regarding domestic violence against women, which may result in the unfeasibility of implementing necessary action plans to reduce the number of violence cases, reaffirming the biomedical model in health care[10]. Furthermore, the effective actions of PHC are still limited to the identification of cases and poorly articulated referrals, which, although appropriate actions, are insufficient due to the complexity of this phenomenon, which requires interdisciplinary and intersectoral actions for its care[11].

In light of the above, it becomes unequivocal that domestic violence against women is still a persistent challenge, as well as the weaknesses in their care by PHC. Thus, the aim is to understand the experiences of this violence from the perspective of professionals in this setting, starting from the following question: "how do professionals experience domestic violence in their daily work?" The objective was to analyze how primary health care professionals experience domestic violence against women.

METHOD

This is a qualitative research, guided by the assumptions of the Consolidated Criteria for Reporting Qualitative Research (COREQ) ensuring credibility, transferability, reliability, and confirmability. The data obtained were interpreted using the Content Analysis Technique, thematic modality[12].

This study is part of a section of the Research Project entitled: Domestic violence against women: experiences and repercussions of the request for revocation of urgent protective measures. The research was conducted in a medium-sized municipality in the state of São Paulo, Brazil, which had an estimated population of 237,629 people in 2022. Women aged 20 to 59 years accounted for 65,796 of the population, representing 27.54%[13]. The municipality has 55 health units, including 9 traditional Basic Health Units (UBST) and 46 Family Health Units (USF).

Data collection took place from January to June 2023. For the selection of units, telephone contact was made with primary health care supporters, who portrayed the municipality's panorama, resulting in the selection of ten USF from different peripheral regions, for convenience. The professionals were selected intentionally considering availability, with the inclusion criterion being having at least one year of practice in PHC. Those who were on vacation or on leave were excluded. The first approach was made throuhg a telephone call to the Unit, and there were no refusals. Thus, twenty interviews were conducted, ten with nurses and ten with Community Health Agents (CHA) as they are professionals with lower turnover in the Units and who were willing to participate in the study.

For the interviews, a script was used containing sociodemographic data including gender, age, profession, and years of practice in primary health care, and the following open questions: 1. "Describe how the care for women victims of violence occurs." 2. "What are the implications of domestic violence against women for the PHC team?". 3. "Mention your understanding of domestic violence and family functionality".

The interviews were conducted by two researchers, one an undergraduate nursing student and the other a doctoral candidate in nursing. They underwent training and conducted pilot interviews to refine the interview script. The interview locations were the Healthcare Units, in a noise-free environment and without interference from other people, on days and times previously agreed upon according to the participants' availability. The interviews were audio-recorded using an MP3 player and lasted an average of 10 to 15 minutes without repetition. They were transcribed verbatim by the researchers to facilitate a closer examination of the material obtained.

Data collection was carried out until data saturation, which was decided upon by consensus among the researchers. The data saturation technique[14] refers to an approach used in exploratory-qualitative research to collect data until reaching saturation, and therefore, new information no longer adds relevant insights or new knowledge to the study. It should be noted that there was no need to repeat the interviews. After transcription, the data were validated by five participants.

For the qualitative analysis, the Thematic Analysis technique was chosen[15], which is a qualitative analytical method used to identify, analyze, and report patterns (themes) from qualitative data and interpret various aspects of the research theme through six distinct phases, precisely so that some decisions, traditionally implicit, become evident at the moment of analysis: 1. Familiarization with the data, which involves immersion through in-depth and extensive readings of the content. 2. Production of initial codes. 3. Search for themes, where the focus of the analysis is adjusted to more comprehensive themes. 4. Review of themes considering internal homogeneity and external heterogeneity criteria. 5. Definition and naming of themes. 6. Production of the report with final analysis and report writing.

In the operationalization of thematic analysis, a qualitative analysis tool, the NVIVO Plus software, version 11, was used. The use of software in qualitative research has been strongly

recommended, as it contributes to the processing of information based on a set of rules, ensuring the necessary scientific rigor[16].

The interviews were identified with the code “e,” followed by Arabic numerals in ascending order, from “e1” to “e20.”

This research was approved by the Ethics and Research Committee with Human Beings, after authorization from the Municipal Health Department.

RESULTS

Regarding the sociodemographic characterization of the 20 participants, it is observed that 18 declare themselves as female, with an average professional experience of 13.5 years and a prevalent age group between 40 and 50 years old.

In the analysis of the interviews, 52 codes were identified, which, after review, composed six themes and 29 subthemes as presented in Chart 1.

Chart 1 – Composition of themes and subthemes carried out with the support of NVIVO Plus software, version 11. Marília, SP, Brazil, 2023.

Topics	Subtopics
(1) Concept of violence beyond physical violence	Lack of respect Impediments and limitations Patrimonial (economic) violence Psychological violence Sexual violence
(2) Team actions towards women victims of violence	Welcoming, listening, and guidance Support in reporting Team discussion and team support Referrals after identification Identification or recognition of violence Home visit
(3) Different feelings that permeate PHC professionals in attending women in situations of violence	Powerlessness Indignation Fear and concern regarding the reported Sensitization Tension and sense of risk Sadness
(4) Consequences of violence	For the aggressor For the children For the entire family Repetition through generations
(5) Team difficulties	Lack of training or humanization Lack of support for coping
(6) Limits of women in coping with violence	Financial dependence Lack of dissemination of the Maria da Penha Law Lack of recognition of women in society Lack of social support Inefficient care flows Inefficient judicial measures

Source: Self-prepared with the support of NVIVO Plus software, version 11, 2023.

Concept of violence physical violence

It was evidenced an understanding of violence that goes beyond the physical, although recognizing that this type is easier to identify. They assume, therefore, the existence of various forms of violence, rooted in social structures and relationships that permeate our culture and society. They mention, as violence against women, the impediments and limitations imposed on women in the family context, lack of respect; sexual violence; economic violence; psychological violence, besides considering it certain that CHAs have already witnessed situations of violence, given their high frequency.

[...] *I also think the way of speaking, thinking that the person is a slave, in the sense of having to do everything, at the moment she wants* (e5). [...] *and they are all diverse, physical, psychological, of all types, verbal, all types of violence you can imagine. I doubt there is a community health agent who has not experienced* (e17).

[…] *domestic violence is any type of violence, it doesn't need to be physical, but it is psychological pressure, isn't it? It is lack of respect, consideration* (e11). [...] *it is not just physical violence, torture, sexual violence, physical* [...] *that's it* (e9). [...] *belittling the person, saying that she is useless* (e8).

Actions of the team towards women victims of violence

The health professionals interviewed emphasized the crucial role they play in identifying or recognizing violence through a sensitive and welcoming approach. They utilize resources such as observations during home visits, team discussions, medical history, and physical examinations. It is also essential to offer support and appropriate referrals, including the possibility of intervention through reporting via the Disque 100 [Call 100] hotline.

[...] *we arrive at the visit, try to talk as much as possible, always observe very closely what is happening regarding that family* (e17). [...] *so we have to have a different and broad view of the situation, a sensitivity. It is the link, our tool is ourselves* (e15).

[...] *and even reporting, if necessary, do you understand? Because we have the Disque 100 hotline"* (e10). [...] *but our daily work, we, in the community, have to present all means to try to get out of that situation* [...] *and seek other professionals from the unit to support us. Everything to assist the family* (e2).

Different feelings that permeate PHC professionals in assisting women in situations of violence

The feelings arising from the complexity of violence situations, as expressed by the professionals, include perplexity; indignation and complete helplessness; difficulty in finding solutions to the situation; breaking the cycle of violence; and ensuring the safety of these women. Furthermore, they put themselves in the place of these women, which causes sadness, frustration, fear of the situation and the aggressor himself, tension, and a sense of being at risk.

[…] *The first feeling I had was one of total and complete powerlessness* (e17). [...] *God, I am perplexed because when you see a child hitting the mother, making her suffer. I was at a loss, not knowing what to do* (e11).

[...] *powerlessness, I think it is common, isn't it? And a feeling of fear... fear for that woman, of the situation that may happen* [...] *but I think powerlessness is the worst* (e18). *so it's complicated, because you're looking for help but treading lightly so that nothing gets out of control, what will happen? Will he turn against us? So, my biggest concern is the reaction* (e1).

Consequences of violence

In the perception of PHC professionals, the consequences of domestic violence encompass the victims, their children, families, and also society, due to the transgenerational nature of violence, considering the different dimensions of the physical, psychological, social, and economic impacts of this repetition of violent behavior. Furthermore, they understand the need to mitigate these harmful effects and broaden the focus of attention to caring for the aggressor.

[...] *I believe that it hinders this woman, if she has children, school-age children, this hinders school, hinders learning, hinders development. Certainly, in the future, these children also become protagonists of violence* (e14). […] *the family becomes psychologically disoriented. This child will not develop well in school, will not perform well, will not be able to respect the teacher and classmates.* (e11).

[...] *I think it creates a very disharmonious, troubled, and confusing family environment.* I *think it must be a mess, it becomes a mess in the children's minds* (e3). [...] *the person who commits the aggression is also someone who is ill, who would also need help, including psychological assistance and more* (e8).

Team difficulties

One observes the lack of specific training and fear of reprisals, as well as the lack of solid institutional support, such as clear protocols and service flowcharts, resources, and management and higher-level support, even though this is a condition experienced in the daily lives of PHC professionals, especially CHAs.

[...] *to what extent can we get involved or not? Because normally there is no support, and unfortunately, we, community health agents, experience this every day* (e17). [...] *how far can I go to avoid reprisals? From the aggressor, I mean* (e1).

[...] *there is no protection for healthcare professionals in this sense, I feel alone* [...], *I miss having a reference* (e8). [...] *look, I know that in the municipality we have a flow of child violence* [...] *but the issue of violence against women, I think it is not discussed as much.* Here we do not have training, promotion, there is no workflow.

Limits of women in facing violence

The limits faced by women in addressing domestic violence involve structural barriers, including lack of information about laws protecting women's rights, financial and emotional dependence, limited social recognition of women, and weaknesses in social, legal, and healthcare support. Consequently, they are unable to see possibilities for empowerment and overcoming violence, which leads to fear and insecurity, according to these professionals' perception.

[...] *there was a time when the Maria da Penha law was talked about a lot. Today there is not as much publicity, I think it should be more publicized, shown to women that they have rights* (e3). [...] *I think that women who are more independent, they can leave, those who depend on their husbands, they end up staying and accepting the situation as it is*.

[...] *sometimes society is a bit sexist, prejudiced, isn't it? So, sometimes people are afraid to tell us. This woman has no support, nowhere to go* [...] *I think what is lacking is support after they report, that's why many women do not report* (e8). [...] *because the woman with this emotional, economic dependence, right? She becomes weakened, out of fear, she does not ask for help*. (e10)

DISCUSSION

It is understood that violence against women transcends into a wide range of individual, family, and societal repercussions. The data in this research lead to the view that physical violence is only the most visible and readily identifiable facet of violence against women, extending to other types of violence of psychological, economic, and sexual domains[17].

Domestic violence is known for involving various forms of violent behavior that occur in the family context, often perpetrated by the intimate partner, a cyclical pattern of behavior that results in a dynamic of domination and submission, putting the victim in a position of constant vulnerability and fear[18]. In this context, healthcare services emerge as formal support instances, often sought by women in situations of violence. However, spontaneous disclosure rarely occurs, making it the responsibility of professionals to carefully observe signs of violence, transcending strictly technical knowledge to act as catalysts, as noted by participants in the present study[17–18].

From this perspective, PHC, as the gateway for women experiencing violence, must establish a skillful and coherent strategy for emergency reception and implementation of the organizational principles of the healthcare system, such as accessibility, territorialization, comprehensiveness, longitudinality, bonding, and care coordination within the healthcare network. This facilitates the early identification and prevention of cases of violence against women[19]. It is agreed that, for this purpose, a care network is necessary, one that addresses the complexity of these situations with sensitivity and competence, fostering a coordinated and integrated response[20].

In this perspective, it is identified that the actions of the team towards women victims of violence need to be permeated by the humanization of care, active and empathetic reception, which involves a sensitive technical competence, both in the various care provided within the health facility and in home visits aimed at early intervention. A study involving primary healthcare professionals in Turkey revealed that the stance adopted by these professionals regarding domestic violence against women directly influences the reporting of violence cases and their perception of their own readiness to deal with the situation[21].

However, as observed in the findings of this study, healthcare professionals often find themselves inadequately prepared, lacking support and training to deal with individuals exposed to domestic violence situations. The absence of adequate training impacts not only the confidence and ability of professionals to assess contexts where violence occurs but can also compromise the integrity and safety of the victim, resulting in missed opportunities for comprehensive care for women[22–23].

The active involvement of community teams can promote a positive impact on individual attitudes and behaviors related to violence against women. It is recommended that the issue be addressed in different contexts, through so-called power devices, such as community radio programs, group meetings, in order to optimize resources and increase the effectiveness of intervention initiatives. In this sense, it is up to healthcare professionals to establish active listening and meet the needs of women, aiming to effectively combat this issue[9,24].

The fragility in identifying and reporting domestic violence against women by intimate partners is linked to the follow-up of the biomedical or curative model by health services, requiring a break from hospital-centric and exclusively clinical-centered behaviors[23]. In addition to this, there's difficulty in addressing topics seen as delicate and intimate, with arguments of lack of time, lack of continuity of care, personal discomfort, counterproductive attitudes, often perpetuated by negative parental patterns, normalization of violence, and culturally entrenched gender disparities[17,25].

Therefore, it becomes essential for healthcare institutions to commit to training their professionals, developing protocols and flowcharts regarding the intersectoral network, promoting not only identification

and reporting but also referral care to specialized services when necessary[24–25]. These services are an effective strategy as they go beyond local assessment[20].

It's relevant to emphasize the importance of healthcare professionals being aware of the resources available for the care of women in situations of violence, as addressing this issue requires interdisciplinary and intersectoral actions. Training professionals in sensitive communication skills, empathy, and cultural competence is also essential for establishing trust and providing appropriate support[9].

Regarding the team's difficulties in providing adequate care for these women, it is worth noting that the insufficiency of allocated resources and evident discrepancies in current policies and protocols result in feelings of helplessness among healthcare professionals, potentially impacting their willingness to intervene effectively[25]. Therefore, it is imperative that organizational initiatives be undertaken to reassess policies and protocols governing the identification and treatment of cases of domestic violence against women, as these are key elements in promoting awareness of social norms that promote equity and break the cycle of violence[24–25].

An approach aimed at providing greater support to healthcare professionals would be the implementation of group supervision sessions, primarily for the exchange of experiences and mutual learning through shared experiences. Additionally, these sessions would provide tools for managing the suffering that can manifest in these circumstances[22]. Analyzing community intervention strategies or network approaches that encourage resilience and empowerment of women and professionals is essential[9,25].

The analysis of healthcare professionals' experiences highlights that the multifaceted nature of violence elicits intense emotional reactions. Sadness emerges as a natural response to exposure to the pain of victims, as well as the frustration and helplessness inherent in the barriers to breaking the cycle of violence and the hostile environment, especially when women do not proceed with legal procedures, even though they know about protective laws, exposing the stereotype of submission to the situation. This corroborates with the data, which indicate that even when current or former intimate partners are their main aggressors, these women do not always report them[26–27].

There are different reasons why many women do not report their abusers, which limit the actions of PHC professionals. Among them are economic and emotional dependence, pre-judgments by family members, concern for children, and conceptions of the interactional dynamics present in these contexts. There is a great dilemma immersed in an even larger range of feelings when it comes to the parental role of the perpetrator[27]. It is understood that the reports made by these women do not seek to intentionally end the relationship, but rather to cease the violence, resulting in the continuation of abusive relationships and/or hesitance to proceed with legal processes, as referenced by the interviewed professionals[26].

Referring to seeking help in these situations of violence, it is highlighted that apprehending the diversity of factors based on cultural norms is implicated in the search for assistance, which primarily manifests through informal assistance or primary healthcare services[27]. Considering the historical-social aspect of women, it is inferred that there is a certain stereotype of passivity, submission, and defenselessness of women victims of domestic violence, which tends to nullify the impacts of the set of delicate choices involved in managing her and her children's risk situation[28]. In addition to the constant fear of the aggressor, economic tension and economic abuse, which as a form of domination and power, present themselves as elements of hopelessness and the maintenance of the violent relationship[29].

For the participants of the study, the negative configuration of parental roles contributes to the normalization of violence and the perpetuation of gender disparities. In this context, it is relevant to mention that individuals who developed rigidity due to parental interactions during childhood tend to

manifest patterns of marital relationships characterized by insecurity. These patterns, in turn, unfold into conflicting family dynamics, thus consolidating the cycle of violence. The implications of this cycle go beyond family boundaries, reverberating throughout society as a whole[30].

It is worth noting that these perceptions are mentioned with greater authority by the CHAs, who bring longitudinal aspects of their experiences and greater mobilization in seeking solutions to this problem[25]. Therefore, it is an indication of the importance of investments and support for these professionals to promote educational activities for the empowerment and resilience of women, preventing violence and/or revictimization, whether in household, community spaces, or through programs, exemplifying the Health in Schools Program (PSE).

There is a strategic position for PHC professionals in the fight against domestic violence against women, which is to advocate for and increase awareness about socially accepted norms that perpetuate tolerance towards violence[9]. Thus, primary healthcare assumes a critical dimension within the healthcare system, being co-responsible for actions that prioritize the promotion of quality of life, in the pursuit of a society free from violence and discrimination. Although challenging, this emerges as an explicit commitment of the global development agenda. However, there is an urgent need for adequate allocation of resources, ensuring access, and intersection with mental health services and legal support.

The limitations of the study relate to the high turnover of workers in primary healthcare, resulting in the participation of only two categories of team professionals.

CONCLUSION

In the experiences of the interviewed professionals, there is recognition of different types of violence against women in the domestic sphere, which are often perpetrated by intimate partners. These professionals become sensitized and exhibit intense emotional reactions, such as fear, sadness, and indignation. Although they make attempts to support the victims and the family context, they face various challenges, such as the lack of preparation and training for professionals to transcend identification; the reception and guidance of women and families victims of violence; as well as the lack of policies; vague and poorly articulated protocols, and the absence of structural resources capable of effectively supporting women and removing them from the aggressor.

It is worth noting that the teams perceive the need for professional practices aimed at the comprehensive care of women, identify the need for greater institutional support and training of the professionals involved, enabling broad and effective responses to promote the health and rights of these women and strengthen family relationships, in order to break the intergenerational cycle of domestic violence. Therefore, it is suggested to invest in the training of professionals, especially CHAs, institutional protection, and the creation of spaces that can support women, thus avoiding revictimization.

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