

Instruments for articulating the network of attention to women in situation of violence: collective construction



Instrumentos para articulação da rede de atenção às mulheres em situação de violência: construção coletiva
Instrumentos para articulación de la red de cuidado de mujeres en situación de violencia: construcción colectiva

Laura Ferreira Cortes^a
 Stela Maris de Mello Padoin^b
 Daniela Dal Forno Kinalski^b

How to cite this article:

Cortés LF, Padoin SMM, Kinalski DDF. Instruments for articulating the network of attention to women in situation of violence: collective construction. Rev Gaúcha Enferm. 2016;37(spe):e2016-0056. doi: <http://dx.doi.org/10.1590/1983-1447.2016.esp.2016-0056>.

doi: <http://dx.doi.org/10.1590/1983-1447.2016.esp.2016-0056>

ABSTRACT

Objective: This paper aims at identifying all the necessary information to build instruments which are designed to facilitate the professional integration of services to women in situation of violence with a view to the establishment of a network of attention.

Method: Qualitative study, convergent, whose information has been produced from February to August 2015 by 10 group meetings, with 32 participants from the Integrated Working Group to Confront Violence in Santa Maria-RS, located at the Universidade Federal de Santa Maria. Using thematic content analysis.

Results: It defined the flow direction; the points to compose the network; what it would take to communicate among services: identification of wife and family, report on the situation and the continuity of care.

Conclusions: There is a need for an institutional formalization of constructed devices. The articulation between the services requires communication, involvement and commitment of the professionals to ensure the continuity of care.

Keywords: Women's health. Violence against women. Delivery of health care. Intersectoral action. Interdisciplinary communication. Professional practice.

RESUMO

Objetivo: Identificar as informações necessárias para a construção de instrumentos destinados a viabilizar a articulação de profissionais de serviços de atendimento com mulheres em situação de violência com vistas à constituição de uma rede de atenção.

Método: Estudo qualitativo, convergente assistencial, cujas informações foram produzidas de fevereiro a agosto de 2015 por meio de 10 encontros grupais, com 32 participantes do Grupo de Trabalho Integrado de Enfrentamento às Violências de Santa Maria-RS, situado na Universidade Federal de Santa Maria. Utilizou-se a análise de conteúdo temática.

Resultados: Definiu-se o direcionamento do fluxo; os pontos para compor a rede; o que seria preciso comunicar entre os serviços: dados de identificação da mulher e da família, relato acerca da situação e a continuidade do cuidado.

Conclusões: Há necessidade de formalização institucional dos dispositivos construídos. A articulação entre os serviços requer comunicação, envolvimento e compromisso dos profissionais para garantir a continuidade do cuidado.

Palavras-chave: Saúde da mulher. Violência contra a mulher. Assistência à saúde. Ação intersetorial. Comunicação interdisciplinar. Prática profissional.

RESUMEN

Objetivo: Identificar el contenido necesario para construir instrumentos para facilitar la integración de profesionales de servicios a mujeres en situación de violencia con miras a la creación de una red de atención.

Método: Estudio cualitativo, convergente, cuya información se produjo de febrero a agosto de 2015, durante 10 sesiones de grupo, con 32 participantes del Grupo de Trabajo Integrado para Contrarrestar la Violencia de María Santa-RS, que se encuentra en la Universidad Federal de Santa María. Se utilizó el análisis de contenido temático.

Resultados: Se definió la dirección del flujo; los puntos que componen la red; lo que se necesitaría para comunicar entre servicios: identificación de mujer y familia, informe sobre la situación y la continuidad de la atención.

Conclusiones: Existe una necesidad de formalización institucional de dispositivos construidos. La articulación entre los servicios requiere comunicación, participación y compromiso de los profesionales para asegurar la continuidad de la atención.

Palabras clave: Salud de la mujer. Violencia contra la mujer. Prestación de atención de salud. Acción intersectorial. Comunicación interdisciplinaria. Práctica profesional.

^a Universidade Federal de Santa Maria (UFSM), Programa de Pós-Graduação em Enfermagem, Grupo de Pesquisa Cuidado à Saúde das Pessoas, Famílias e Sociedade. Santa Maria, Rio Grande do Sul, Brasil.

^b Universidade Federal de Santa Maria (UFSM), Residência Multiprofissional Integrada em Sistema Público de Saúde Grupo de Pesquisa Cuidado à Saúde das Pessoas, Famílias e Sociedade. Santa Maria, Rio Grande do Sul, Brasil

■ INTRODUCTION

Violence against women is a complex and multidimensional phenomenon, since it involves different disciplines, social, psychic and cultural dimensions marked and determined by gender inequalities. Thus, it transcends typical situations of the health and disease process marked by the biomedical paradigm.

Due to the complexity of the problem, its confrontation requires the joint action of several sectors involved as: health, public safety, justice, education, work, housing, social assistance, among others.

These should propose actions that deconstruct inequalities and fight gender discrimination, interfering with sexist cultural patterns; they should promote the empowerment of women; and guarantee a qualified and humanized service⁽¹⁾.

The work that occurs in an interconnected way between the different sectors and set of services is attributed to the network qualification⁽²⁾.

The network of care or attention to women in violence situation is composed of a set of actions and services from different sectors, which aim at increasing and improving the quality of care; identification and appropriate referral of women, as well as the integrality and humanization of care. The network is made up of non-specialized, or general and specialized services⁽³⁾.

Non-specialists usually constitute the woman's entry point into the network: general hospitals, primary care services (healthcare units), police stations, military police, federal police, Social Assistance Referral Centers (SARC), Specialized Reference Centers for Social Assistance (SRCSA), Public Ministry and public defenders. Specialists attend exclusively women, having expertise in the subject. They are: Reference Centers for Assistance to Women (Passage Houses), Specialized Police Offices for Women (SPOW), Centers for Public Defender, Specialized Prosecutor's Offices, Special Courts for Domestic and Family Violence against Women, Women's Assistance Center (Call 180), Ombudsmen, healthcare services for cases of sexual and domestic violence, among others.⁽³⁾

The intersectoral perspective represents a challenge insofar as it requires a break with the traditional model of public management, which tends to departmentalization, disarticulation and sectoralization of public policies and actions. For that reason, it is fundamental that services work from the perspective of intersectorality, so that they can define service flows that are compatible with local realities, taking into account the demands of women in their diversity⁽³⁾.

These services compose a large mosaic, which is still little interrelated. Networking requires a specific operation mode, which is not only due to the existence of a set of services or just juxtaposed services whose performance does not necessarily establish some assistance integration. In this configuration, services do not recognize each other as institutions that reinforce their interventions and that may actually have something to share. This reinforces women's critical path⁽⁴⁾. When women look for support, it is often a late or ambivalent decision, and when they find isolated assistance, with varying responses to their demands, they tend to interrupt their routes⁽²⁾.

Studies demonstrate that the network is seen as fragmented, inaccessible and distant from the reality lived by women⁽⁴⁻⁶⁾. However, some professionals report the will to transform the forms of intervention, with a view to creating mechanisms for the approximation of actors and the flow organization⁽⁵⁾. Often, services are not recognized as effective help for their social and health demands⁽⁶⁾. The success trajectory of these women in services requires that the institutions work as support and facilitation instruments in the process of overcoming the violence experienced⁽⁴⁾.

This fragility has also been pointed out by professional nurses who recognize the need for multiprofessional and articulated healthcare with other services. However, they mention difficulties in monitoring and implementing communication among the services⁽⁷⁾, which has a negative repercussions regarding the healthcare of women, since these are at the mercy of the personal availability of the professional. The lack of specific flows forces women to wait for the appointment to be scheduled, which may discourage them. It is possible to carry out a bureaucratized service, but it is directed at the women needs. However, it is necessary to rethink the use of generalizing protocols that fragment service that tends to pathologize and medicalize the body, which can lead to women going through different types of services⁽⁸⁻⁹⁾.

In this sense, there is a need for studies that go deep into the aspects to contribute to the transformation of this reality and create interdisciplinary intervention tools in order to contribute to the articulation of the services to compose the service network. With this perspective, this study presents the following guiding question: "What is the necessary content to build instruments in order to make possible the articulation among professionals of services of assistance to women in situation of violence with a view to the creation of a network of attention?". It aims at identifying the necessary information for building instruments designed to enable the articulation among professionals of services of assistance to women

in situation of violence with a view to the constitution of a network of attention.

METHOD

It is a qualitative study of the convergent type of care, from a doctoral thesis entitled "Women in a situation of violence: collective construction of instruments for the construction of the network service"⁽¹⁰⁾, of the Post-Graduation Program in Nursing of the Universidade Federal de Santa Maria. The Convergent Care Research (CCR) has been chosen as a methodological reference because of the possibility of developing joint research and assistance actions in order to direct the researcher to solve or minimize problems and/or to introduce innovations in health practices⁽¹¹⁾. This scenario gives the participants autonomy for transformation, thus justifying the choice of this method.

The CCR has been developed after the approval of the Committee of Ethics in Research with Human Beings of the Institution, CAAE: 40350315.1.0000.5346, with the opinion nº 935.978. The ethical procedures have been respected in

all the steps and moments of the research, considering the Resolution No. 466/2012 of the National Health Council.

CCR's development scenario was the Santa Maria-RS Integrated Working Group to Combat Violence (IWGCV), which is an intersectoral group composed of health, social assistance and public safety professionals. The IWGCV meets at the Universidade Federal de Santa Maria, with no room scheduled every fifteen days, and its coordination is linked to the Hospital Universitário de Santa Maria. The previous insertion of the researcher in the IWGCV and some professional experiences with members of the group determined the choice of space, characterizing a selection for convenience. It has been established as an inclusion criterion: to be a professional or an academic and to participate in the IWGCV. The exclusion criterion was: to be absent from work during the information production period, which was from February to August 2015. 32 people participated actively, three of them are academic, from the social service or psychology courses and 29 are professionals: social worker, psychologist, nurse, nursing technician, pharmacist, doctor and police officer.

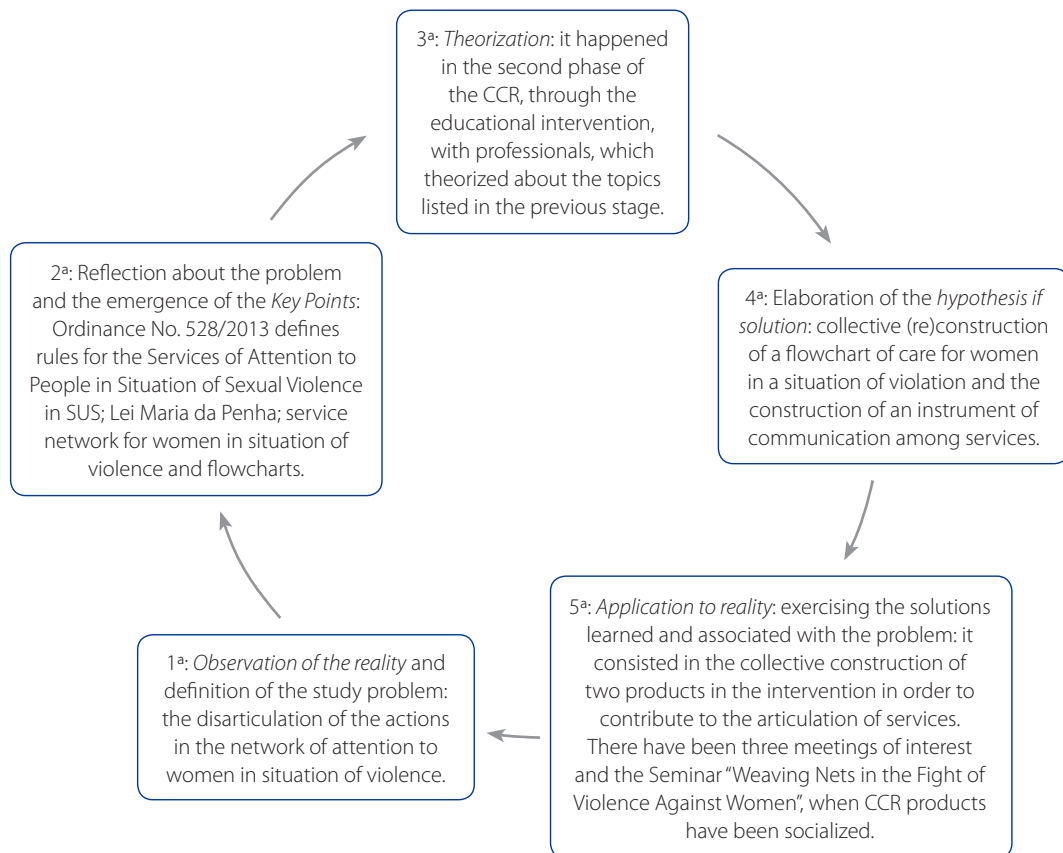


Figure 1 – Application of the Problem Methodology in the Study

Source: ⁽¹²⁾

In order to produce the information, the convergent group (CG) technique has been used as well as the field journal. The CG has been used in the CCR with the objective of implementing assistance practice projects and making abstractions of this practice in order to build knowledge about regarding themes⁽¹¹⁾, being recommended by the authors of the method. Ten meetings have been held every fifteen days in a room previously scheduled, lasting approximately two hours according to the participants agreement. The research team consisted of the main researchers, a doctorate student, a counselor and three research assistants.

The group meetings have been planned and developed taking as reference the Methodology of Problematization (MP). It has been used in studies in the areas of education, health and nursing and its application is based on the Charles Maguerez's Arch⁽¹²⁾. Developed in five stages (Figure 1).

For the analysis of the data, the analysis of the thematic content⁽¹³⁾, composed by the phases of pre-analysis, exploration of the material and treatment of the obtained results has been developed. Chromatic coding of the findings has been performed, being identified the common ideas and the relationship of the categories among each other: 1) Flowchart for women in situation of violence as a strengthening device for the construction of the attention network and 2) communicative articulation for the construction of the network. For the interpretation, the material has been articulated with the literature indexed in the data base.

■ RESULTS E DISCUSSION

This study presents content which has emerged from the group of participants in the construction of the flowchart of care for women in situations of violence in the city of Santa Maria-RS, and an instrument to promote the articulation among professionals of care services to women in situation of violence with a view to establishing a network of attention.

Flowchart of care for women in situation of violence as a strengthening device for the constitution of the care network

The collective (re)construction of the flowchart has been carried out based on the understanding of the need to materialize an established course that could represent the access of the users to the care services. It has been identified in the professionals' speech the understanding that the flowchart is a strengthening device for the con-

struction of the network of attention. However, they have understood that only this drawing is not enough for the network to be built. For the participants, the network has a focus on care, in an intersectorally way.

Draw the flow and: Make it work! Does not work. (P5/Hospital)

It is necessary to establish a flow in this network [...] she came from the Basic Unit, what does she need then? Where does she go? And to get to that other place, she still has another place she has to go. [...] To establish a network, it is necessary to think about care and to go through all the sectors that have to do with that problem, because everyone has the knowledge that is refined, right? Including the personal relationship, because it is a construction. (P3/SES)

Make a routine, so that everyone who comes by knows what to do. (P14/SMS)

The participants have demonstrated an understanding of the importance of continuity of care. In addition to understanding that the flowchart can represent the path of women and direct the organization of the network service. The flowchart descriptor is used in health to capture ongoing processes so that it can provide enough substantive data and information that validates certain analyzes and contributes to planning. It consists of the graphic representation of the work process, and seeks to perceive the paths covered by the user and their insertion in the service, when looking for assistance. It allows a sharp look at the existing flows at the time of health care production, and it allows the detection of their problems. Applying it is as if throwing light into areas of shadow, not yet perceived, that operate in the opposite direction of the user-centered attention⁽¹⁴⁾.

The service flowchart is considered a strategy that favors referrals. Primary health care professionals point out that the establishment of a flow and its knowledge contributes to directing the paths to be followed and the search for support in the social network⁽¹⁵⁾. Knowledge regarding the services is determined through existing information and communication flow⁽¹⁶⁾. In order to facilitate the referral, care and protection of women, it is necessary to assimilate how much the network incorporates the partnerships and interconnections. It is necessary to look for strategies for disseminating the services that integrate the network, taking their knowledge to the population, through written, spoken and/or televised media⁽¹⁷⁾.

When problematizing, during the meetings, what would be the aspects to compose the flowchart, it was

necessary to define which services provide care for women in situation of violence in the city. The professionals mentioned social services: SRCSA and SARC; The police station, the school, the hospital, the Health Units. In addition, they mentioned that the construction of the network includes sectors such as culture, housing, work, infrastructure, justice, among others.

The SARCs, the education. Often they arrive at school or the school can contribute to this case understanding. And the police station. (P1/SMS)

It is the network as a whole; the hospital is part of it. (P3/SES)

[the network] goes beyond health, it goes for housing, for planning, for the city's infrastructure, sanitation [...]. (P4/Hospital)

It is intersectoral [...] culture; justice comes in. [...] it is not very fixed, [...] it does not work alone to address the issue of violence. [...] you have to come to the discussion, to rethink what you did and try to improve what is being offered. [...] I make a phone call and e-mail the copy of the notification. [...] (P5/Hospital)

[...]A shelter [service that works in the fighting of violence] this is the cool thing [...]. So I think that when we know it, it's important to be part of this group [WG] that we really do networking, it's not just the question of city, state, no, it's all the others that form it. (P7/Hospital)

This finding is in line with a study carried out in Bahia, with professionals from the areas of security, legal, psychosocial and health, in which the participants highlighted the importance of intersectoral articulation to enable the process of fighting the violence against women. In addition, they have highlighted that, in order to share the problems and knowledge, it is necessary to create strategies such as encounters and systematic meetings to overcome the deficiency of intersectoral communication, suggesting that these are the ones that favor the strengthening of the network. In the study city, there is also a Working Group (WG) to deal with violence, which is considered an alternative for the consolidation of the care network. These are considered spaces for dialogue that act as structures for the visibility and consequent resoluteness⁽¹⁷⁾.

The construction of the network is a new action strategy; therefore, it requires investing in training and incentive of the participants, so that all can communicate in a clear and agile way. This is a great and permanent challenge,

which requires the participation of broad social sectors such as the media, education, health and community movements. It is necessary to provide information that enables transformation, not only through formal knowledge, but also through the promotion of the citizenship as a way of fighting the violence⁽¹⁶⁾.

The professionals collectively reflected about the complexity of the situations of violence, mainly because of the affective relationship in which the woman is involved. This process of collective redefinition of the flowchart was a productive moment that demanded reflection from the group about their understanding of the entrance door of women in the care services. Thus, they could perceive the need of redefining the beginning of the flow as the "doorway" of the woman in the services, that is, any service that the woman has previously accessed. And from that, the flow would be directed according to each type of violence identified.

[...] Doorway, we cannot put health ... but it can be the police station ... it can be all the sectors, to school, any service and from the door to where each type of violence goes. The sexual goes where? The physical? Then we have to see what kind of violence it is, and the doorway can be any. [...] (P14/SMS)

I understand that these are the ways this woman can go until she finds the right place. (P15/Hospital)

In this sense, the entrance door, which has been centralized in the Women's Police Station, was constituted by: health services, social assistance services, education and public security: UBS, ESF, Hospitals, UPAs, WFP, schools, SRC-SA and police stations in general.

In order to strengthen the construction, the types of violence have been studied, since the (re)construction of the structure had emerged from the five types: physical, psychological, patrimonial, moral and sexual violence defined in the Maria da Penha law. With this perspective, the flowchart has been structured from the types of violence.

It should be highlighted that, in order to deal with cases of violence, the network is the most accepted model in the literature, and in it, "the entry door can take place at any point, the circulation of cases being a braid among the various points of this group (the different services), among which there is no hierarchy, but a horizontal placement in relations among themselves"^(9:1048).

The collective reconstruction has been permeated by knowledge of the different areas involved, represented by the different services, each with their own views about the flowchart.

It should be highlighted that questions arose regarding the most appropriate points to define as a sequence of referrals and services to be performed. At the same time, communication needs were emerging with other services and even institutional articulations between Secretaries such as Health and Social Assistance, Women's Police Station, Legal Medical Department, school clinics, in order to combine aspects to be modified according to the possibilities of each service. Thus, the statements pointed to the need for professionals to interact and, from the contact and communication, to know the work of the different services.

We have to talk to the other SARCS [...] talk to the team and see how they are doing [...]. (P16 / Department of Social Assistance)

We have to know which is the coverage area of SARCS, which regions [...]. (P2/SMS)

I am there in the social service attending the woman, then she shows me an injury [...] Can I refer her to the basic unit? [The] professional person has to know how to assess that situation and know where it goes. [...] The issue is the notification, network stuff, monitoring. (P5/Hospital)

One of the obstacles to the referral of women is the lack of knowledge about the functioning of services. This has been verified in a study carried out with professionals who demonstrate little knowledge about the work done in the Reference Center and the SPOM, as well as about the articulation between them⁽¹⁵⁾. The process of interaction between the different sectors that integrate the network will only be consolidated through mutual knowledge. It involves information about their assignments, location, internal and external processing, as well as the opening hours⁽¹⁷⁾. Therefore, overcoming this barrier of communication requires a movement of exchange among services. This movement needs to be guaranteed and made possible by the management team.

By following the process of organizing the flowchart, they understood that, based on the need of the woman assisted in the service, the professional would need to identify directly or indirectly the situation of violence. If he did not identify by the report, the situation could be identified by the clinical aspects of the violence, inserted in the flowchart as warning signs, to mention: burns, bruises and fractures, any head or neck injury; lesions of the oral, anal and vaginal mucosae, urinary and/or vaginal infections and pregnancy. Late manifestations such as pain in the lower abdomen, hypertension, digestive disorders, insomnia,

nightmares, lack of concentration, irritability; shock, panic attack, anxiety, confusion, self-doubt, insecurity, guilt, alcohol and drug abuse, depression, suicide attempts, sexual dysfunctions, among others.

It was possible for the professionals to make a reflexive movement in order to imagine possible practical situations to apply the flowchart and thus verify the possibilities of using it according to the attributions of each service. In this exercise, they suggested the inclusion of school clinics, places linked to teaching and providing psychological, social and legal assistance, along with other services, such as mental health. It has been observed the convergence of the research and intervention proposed with the need of change and appropriation of the professionals about the process of collective construction. They expressed their satisfaction with the process.

[...] I think now we're going to complete this flow and then we'll have to start tying these partnerships. [...] We as WG, what we will have to do is tie this flow with the management and with these partnership. (P2/SMS)

[...] We are preparing, thinking, reading material, putting our heads to work [...]. So that little ant job, it does not seem to work, but you see it does. (P5/ Hospital)

And it is a sign for us that we are evolving, if we can look at that from a long time ago and see that there is failure, it is because today we can see better. (P14/SMS)

The construction of a network demands complex steps, a new look at the same problem, the utopia to plant solutions and the overcoming of the sectoralized and verticalized way of work⁽¹⁶⁾. In this sense, the group has discussed the need to guarantee some form of communication among services and collectively built an instrument in an attempt to formalize and articulate the work between services.

The communicative articulation for the construction of the network

In order to reflect about the communication among the services and the possibility of building an instrument that would facilitate articulation, some questions have been raised regarding the content needed to facilitate the dialogue among the services of care for women in situation of violence. The participants have concluded that it is necessary to communicate to the other service, that is, the reference, transfer of care: the identification data of the woman and family, as well as a report about the

situation and the care provided, and also when the woman arrives at the service. Regarding the aspects that need to be known after the referral to the other service, the counter-referencing referred to the services accessed and the continuity of care.

Identification data of the woman (name, age, address, telephone number - hers and relatives'. (P5/hospital; P13/hospital; P15/hospital; P4/hospital; P17/ Department of Social Assistance; P3/SES; P1/SMS; P2/SMS; P9/SMS)

Brief report of the case and care: what has been done, what has been identified; which professional has performed the care/reception; service care that has been provided. (P5/hospital; P13/hospital; P15/hospital; P4/hospital; P17/ Department of Social Assistance; P3/SES; P1/SMS; P2/SMS; P9/SMS)

Procedures that have been performed and referrals to the other network services as needed. If the woman arrived, if she has been attended, what has been done, if the treatment has been followed. (P5/hospital; P13/hospital; P15/hospital; P4/hospital; P17/ Department of Social Assistance; P3/SES; P1/SMS; P2/SMS; P9/SMS).

The articulation among services needs to be permeated by the dialogue and contact among professionals. When questioned about how to do this so it could be instituted by the services, they pointed out the need for institutional agreements. In this sense, it has been verified the need to continue the organization of the service network, based on what has been built during the CCR by the IWGCV. They have demonstrated the commitment to the continuity of the work triggered from CCR.

[...] it's a lot of what we do, if we just send a document, and it does not communicate, it does not dialogue, we're doing what we do not want to happen with this instrument. [...] So I think we have to go to the services and talk, get to know people. [...] it's not ready, we are building it. (P1/SMS)

The instrument is a complementation of the contact. It gives transparency, reaffirms the agreement between the parties [...]. Otherwise it gets bureaucratic. [...] The document is also a way of saying that it has already had an intervention, and other people, right after us, will access it and know the history. (P9/SMS)

[...] the instrument formalizes it, it is a document, a record of what has happened, because it is not only the contact.

[...] But the contact is essential; I will not receive an instrument without a connection. [...] (P13/Hospital)

You do not have to write an extensive report, putting what has been done in a line, to identify where and who have passed by. [...] Telephone number is the minimum that it need to contain. [...] (P17/ Department of Social Assistance)

[...] I think that the communication roadmap could be a protocol [...]. The protocol has to do, regardless of whether it's SARCS, whether it's me or it. [...] (P13/Hospital)

[...] we have to sit with our peers [...]. At the moment when the [name of the hospital] is organized as a micro network, we have to organize ourselves in a way that the discussion takes place, what, in fact, does not happen today ... to define what is up for each service, and in which way things will be routed [...]. It has to be tied up, of course, and described, because things work only when they are very clear, defined, written on paper [...] what is up for each one [...]. (P2/SMS)

The need of building the network was explicit in the lines, just as the professionals have demonstrated that this is a collective task that needs to involve services through dialogue and institutional definitions about the roles that each one can play in the network. Even if they did not know exactly how to operationalize this construction, they made it clear that they appropriated that understanding, which is one of the important results that have been revealed by the study. In this sense, it is understood that to advance in the construction of a powerful network for the continuous service to these women, it is necessary the involvement of the management team and the different sectors involved. In order to do so, it is imperative to propose affirmative actions, mechanisms of intersectoral communication and articulation which is coordinated by cities.

The composition of a network requires the articulation between the particular actions of each service, which will only happen when the assistance production is minimally shared by the different services. For this, there is a need for institutional definitions that can dialogue with each other, services organized in service dynamics that can also converge to shared aspects of this assistance, as well as communication and interaction among the various professionals involved. In this way, the network will be the operation mode in which each service will reinforce and add actions promoting an intervention project that is common to the services. In this perspective, the networks and the relationships linked to it are also thought from the flows of information, objects and people that pass through it⁽²⁾.

It is necessary to overcome the logic of referral without the commitment to follow up the cases and to guide professional and institutional actions in the intersectoriality. To do so, one must learn how not to restrict the organization of work in the logic of rationality and functionality. Networking, in addition to adapting, requires seizing, inventing and creating. When the institution fails to meet the demands of complex phenomena, such as violence against women, it tends to fail⁽¹⁸⁾.

The concept of integrated and intersectoral work is linked to the understanding that this task is a constant construction. The constitution of a network usually requires a more intense and continuous movement, to integrate different actors and social equipment, either through a computer network or not. There is a need to share the same communication code, which means having the same understanding of different forms of violence. It is necessary that the members of the network act in synchrony with the urgent demand for intervention. The formalization of the networking is not enough to maintain the interconnections. Communities need to recognize the role of partnerships in connection. The implementation of a network does not require large investments from the public or private sector, but a change of look and a more attentive view of the professionals, aiming at integrating the existing services, with sensitized and committed people⁽¹⁶⁾.

The guarantee of intersectoral actions is determined by the monitoring of proposals with systematic evaluation and supervision in order to qualify the services provided. This information needs to be used to ensure public policy and improve institutions' responses. To look for a network that integrates existing services is to develop network management, based on an intersectoral coordination that establishes the routes for referrals and the continuity of the attention⁽¹⁹⁾.

It should be highlighted that the creation of protocols and referral flows for violence against women, based on criteria of risk classification and vulnerabilities, are recommended by the literature as strategies for the construction of more resolute behavior. In order to contribute to health and nursing care, it is important to appropriate new knowledge in several areas of knowledge so that the professionals who take care of these women take ownership of knowledge, interdisciplinary and intersectoral discussions. The institution of integral, transverse and networked attention is conditioned to the transformation in the way of thinking and the know-how to do in common⁽¹⁸⁾. In this sense, the importance of collective and interdisciplinary spaces such as the WG, the study scenario, as well as the need for institutionalization of collective, intersectoral pro-

cesses of discussion and work reinforced. It is necessary to guarantee these moments from the training in health and other areas, so that teaching and service can create new strategies, resources and technological tools that can innovate and contribute to the construction of the network of attention to women in situation of violence.

■ FINAL CONSIDERATIONS

It has been verified that there is a need for institutional formalization of the devices built in this CCR, just as the articulation among the services that requires the involvement and the commitment of the professionals with the communication and the guarantee of the continuity of the care. Regarding the situation of violence, the family, the services provided and the services covered is essential for follow-up.

The content produced by the CCR subsidized the change in health practices and other sectors involved with the issue in question, since it contributed to the empowerment of the WG professionals regarding the theme and the need to organize spaces of articulation of the WG with other services involved in women care. Currently, these instruments have been incorporated into a Nursing Care Protocol for Women's Health that is under construction in the city in question.

In the educational area, the contribution to the need to create interdisciplinary spaces in health education that can dialogue about complex issues such as violence. These need to involve the knowledge of the social sciences, humanities and even the area of communication, information technology and computer science, since working on the logic of building networks requires integrated efforts of different areas, which can enable communication between the sectors involved. The study presents as a limitation the delimitation of the local scenario and the difficulty in maintaining the focus on some meetings, since the participants were from different sectors, and the meetings permeated by the interaction.

■ REFERENCES

1. Presidência da República (BR), Secretaria de Políticas para as Mulheres. Relatório anual socioeconômico da mulher. Brasília (DF); 2013.
2. Schraiber LB, d'Oliveira AFPL, Hanada H, Kiss L. Assistência a mulheres em situação de violência: da trama de serviços à rede intersetorial. Athenea Digital. 2012 [citado 2016 out 10];12(3):237-54. Disponível em: <http://atheneadigital.net/article/view/v12-n3-schraiber-pires-hanada-et-al/1110-pdf-pt>.
3. Presidência da República (BR), Secretaria de Políticas para as Mulheres. Rede de enfrentamento à violência contra as mulheres. Brasília (DF): Secretaria Nacional de Enfrentamento à Violência contra as Mulheres, Secretaria de Políticas para as Mulheres; 2011.

4. Sagot M. The critical path of women affected by family violence in Latin America: case studies from 10 countries. *Violence Against Women*. 2005;11(10):1292-318.
5. Meneghel SN, Barrios F, Mueller B, Monteiro D, Oliveira LP, Collazol ME. Rotas críticas de mulheres em situação de violência: depoimentos de mulheres e operadores em Porto Alegre, Rio Grande do Sul, Brasil. *Cad Saúde Pública*. 2011;7(4):743-52.
6. Vieira LB, Souza IEO, Tocantins FR, Pina-Roche F. Apoio à mulher que denuncia o vivido da violência a partir de sua rede social. *Rev Latino-Am Enferm*. 2015;23(5):865-73.
7. Cortes LF, Padoin SMM, Vieira LB, Landerdahl MC, Arboit J. Cuidar mulheres em situação de violência: empoderamento da enfermagem em busca de equidade de gênero. *Rev Gaúcha Enferm*. 2015;36(spe):77-84.
8. Signorelli MC, Auad D, Pereira PPG. Violência doméstica contra mulheres e a atuação profissional na atenção primária à saúde: um estudo etnográfico em Matinhos, Paraná, Brasil. *Cad Saúde Pública*. 2013;29(6):1230-40.
9. d'Oliveira AFPL, Schraiber LB, Hanada H, Durand J. Atenção integral à saúde de mulheres em situação de violência de gênero: uma alternativa para a atenção primária em saúde. *Ciênc Saúde Colet*. 2009;14(4):1037-50.
10. Cortes LF. Mulheres em situação de violência: construção coletiva de instrumentos para a construção do atendimento em rede [tese]. Santa Maria (RS): Universidade Federal de Santa Maria; 2017.
11. Trentini M, Paim L, Silva DMGV. Pesquisa convergente assistencial: delineamento provocador de mudanças nas práticas de saúde. 3. ed. Porto Alegre: Moriá; 2014.
12. Berbel NAN, Gamboa SAS. A metodologia da problematização com o Arco de Maguerez: uma perspectiva teórica e epistemológica. *Filosofia e Educação*. 2012 [citado 2016 out 10];3(2): 265-87. Disponível em: <http://ojs.fe.unicamp.br/ged/rfe/article/view/2363/2635>.
13. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 13. ed. São Paulo: Hucitec; 2013.
14. Franco TBF. O uso do fluxograma descritor e projetos terapêuticos para análise de serviços de saúde, em apoio ao planejamento: o caso de Luz - MG. In: Merhy EE, Franco TB, organizadores. *O trabalho em saúde: olhando e experienciando o SUS no cotidiano*. São Paulo: Hucitec; 2003. p. 161-98.
15. Gomes NP, Erdmann AL, Mota LL, Carneiro JB, Andrade SR, Koerich C. Encaminhamentos à mulher em situação de violência conjugal. *Mundo Saúde*. 2013;37(4):377-84.
16. Njaine K, Assis SG, Gomes R, Minayo MCS. Redes de prevenção à violência: da utopia à ação. *Ciênc Saúde Coletiva*. 2007;11(Supl):1313-22.
17. Menezes PRMM, Lima IS, Correia CM, Souza SS, Erdmann AL, Gomes NP. Enfrentamento da violência contra a mulher: articulação intersetorial e atenção integral. *Saúde Soc*. 2014;23(3):778-86.
18. Lettiere A, Nakano AMS. Rede de atenção à mulher em situação de violência: os desafios da transversalidade do cuidado. *Rev Eletr Enf*. 2015 [citado 2016 out 10];17(4):1-8. Disponível em: <http://dx.doi.org/10.5216/ree.v17i4.32977>.
19. García-Moreno C, Hegarty K, d'Oliveira AFL, Koziol-MacLain J, Colombini M, Feder G. The health-systems response to violence against women. *Lancet*. 2014 [cited 2016 Sep 28];385(9977):1567-79. Disponível em: [http://dx.doi.org/10.1016/S0140-6736\(14\)61837-7](http://dx.doi.org/10.1016/S0140-6736(14)61837-7).

■ **Corresponding author:**

Laura Ferreira Cortes

E-mail: lferreiracortes@gmail.com

Received: 12.26.2016

Approved: 04.18.2017