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Care for women in situations of violence: construction of a model of permanent health education

Atenção às mulheres em situação de violência: construção de modelo de educação permanente em saúde

Atención a mujeres en situación de violencia: la construcción de un modelo de educación permanente para la salud

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ABSTRACT

Objective: To propose a Permanent Health Education Model with strategies linked to the Five Disciplines framework for the development of competencies of professionals who work in direct care for women in situations of violence.

Method: A qualitative research carried out by the focus group technique, with professionals who are part of an intersectoral network in Curitiba-PR, from August to October 2019. Data analyzed by content analysis in the thematic modality, in the light of the theoretical framework of the Five Disciplines: personal mastery; mental model; shared vision; team learning and systems thinking.

Results: The Five Disciplines were evidenced in the categories, as well as strategies to be used for competence development. A diagrammatic representation was used to be covered during the learning process.

Conclusion: The strategies suggested by professionals who work in the care for women in situations of violence supported the proposition of a Permanent Health Education Model based on the adopted theoretical framework.

Keywords: Learning health system. Competency-based education. Education, continuing. Interprofessional education. Violence against women.

RESUMO

Objetivo: Propor um Modelo de Educação Permanente em Saúde com estratégias vinculadas ao referencial das Cinco Disciplinas para o desenvolvimento de competências dos profissionais que atuam na atenção direta às mulheres em situação de violência.

Método: Pesquisa qualitativa realizada pela técnica de grupo focal, com 16 profissionais que integram uma rede intersetorial em Curitiba-PR, de agosto a outubro de 2019. Dados analisados por análise de conteúdo na modalidade temática, à luz do referencial teórico das Cinco Disciplinas: domínio pessoal; modelo mental; visão compartilhada; aprendizagem em equipe; e, pensamento sistêmico.

Resultados: As Cinco Disciplinas foram evidenciadas nas categorias, bem como estratégias a serem utilizadas para desenvolvimento de competências. Utilizou-se uma representação diagramática a ser percorrida durante processo de aprendizagem.

Conclusão: As estratégias sugeridas pelos profissionais que atuam na atenção às mulheres em situação de violência apoiaram a proposição de um Modelo de Educação Permanente em Saúde baseado no referencial teórico adotado.

Palavras-chave: Sistema de aprendizagem em saúde. Educação baseada em competências. Educação continuada. Educação interprofissional. Violência contra a mulher.

RESUMEN

Objetivo: Proponer un Modelo Permanente de Educación en Salud para el desarrollo de competencias de los profesionales que trabajan en la atención directa a mujeres en situación de violencia.

Método: Investigación cualitativa realizada por la técnica de grupo focal, con profesionales que forman parte de una red intersectorial en Curitiba-PR, de agosto a octubre de 2019. Datos analizados por análisis de contenido en la modalidad temática, a la luz del marco teórico de las Cinco Disciplinas: dominio personal; modelo mental; visión compartida; aprendizaje en equipo y pensamiento sistémico.

Resultados: Las Cinco Disciplinas fueron evidenciadas en las categorías, así como las estrategias a ser utilizadas en el desarrollo de competencias. Una representación diagramática fue utilizada para ser cubierta durante el proceso de aprendizaje.

Conclusión: Las estrategias sugeridas por los profesionales que actúan en el cuidado de la mujer en situaciones de violencia sustentaron la proposición de un Modelo de Educación Permanente en Salud a partir del referencial teórico adoptado.

Palabras clave: Aprendizaje del sistema de salud. Educación basada en competencias. Educación continua. Educación interprofesional. Violencia contra la mujer.

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INTRODUCTION

Gender violence is a theme addressed worldwide, as it is considered a phenomenon present in different places and social classes, attended at different levels of health care. Among the types of violence, there is violence against women, based on several social relationships such as sex/gender and constructed by models in which violence is reproduced by the superposition of men over women[1].

In some countries, violence against women grows consecutively, like Singapore and Cyprus, with an increase of more than 30% in telephone calls asking for help. In Brazil, there was a 30.7% increase in deaths in women between 2007 and 2017, compared to previous years, as published in the statistics of the Atlas of Violence[2–3].

In order to cope with violence against women, some initiatives were taken in the country, including the National Policy for Integral Attention to Women's Health (*Política Nacional de Atenção Integral à Saúde da Mulher* – PNAISM) in 2004 and the Maria da Penha Law (LMP) in 2006, with emphasis on the organization of interconnected networks, together with the articulation of the actions carried out between the services that constitute them[4]. The organization of an intersectoral network cannot be related to a plot in which actions are articulated only in some aspects, but to be a provider of common care, in which professionals recognize the existence of actions of other services and develop effectively communication and articulation, to ensure the rights and autonomy of these women[4–5].

The networked organization must seek actions that promote comprehensive care for women in situations of violence and the identification of their peculiarities. Thus, and for it to happen in a multidimensional way, the training and interconnection of services are necessary, and also evidenced their gaps that can compromise this attention[5].

The articulation between the services, in addition to strengthening and breaking down barriers in communication, generates trust and security by sharing information among professionals, given that knowledge about the phenomenon of violence and the diverse factors that involve it are not known to everyone. Consequently, the preparation of these professionals must occur in order to integrate ways of welcoming women and promoting the articulated and resolute confrontation of violence in their daily work[6]. Permanent Health Education (PHE) stands out as a model used in professional qualification at different levels of care. However, it is evident that the professionals have little prepare on the theoretical and practical concepts necessary in the care for women in situations of violence, which makes the PHE an indispensable strategy to be inserted in the professional performance on a continuous basis[7].

The core of the elaboration and structuring of a PHE model is the identification of the problem and the creation of planned means to approach the services, with a view to promoting comprehensive and effective care. The use of the concept of PHE as a strategy refers to incorporating teaching and learning into the daily life of organizations in social and work practices, as well as raising and qualifying personal potentialities in the development of ethical and humanistic skills so that, in addition to knowledge, it promotes effective attitudes towards the population, as pointed out in the National Policy for Permanent Health Education (*Política Nacional de Educação Permanente em Saúde* – PNEPS)[8]. A learning process is carried out with the development of competences in a model in which the professional is considered an apprentice and learning is shared. The construction of new knowledge, skills, experiences and especially self-knowledge, linked to organizational learning techniques, are aligned with the described problem and can be considered practices that change the individual when perceiving himself from the individual to the collective[9]. In this study, the term competence was used from an act linked to the functions that integrate knowledge into action, namely: knowing, learning, having oneself, situating oneself, positioning oneself and performing/transforming something into one's reality or assess the need for change at a given moment[10].

Among these techniques, it stands out the use of the Five Disciplines: personal mastery, mental model, shared vision, team learning and systems thinking[9]. Such disciplines focus on organizations characterized as learning, and in their components the improvement of their skills, which allows thinking about the future in order to recreate it through actions taken together. Thus, they propose as a goal the awareness of the team, in an act that allows personal questioning and the creation of an environment in which others can do the same[9].

Regarding the intersectoral networks already implanted and, among them, those that focus on caring for women in situations of violence, the literature describes that the professionals that are part of them feel unprepared. This fragility is justified by the lack of approaches during training on specific themes related to the different types of violence against women, as a way of generating reflections on the dimensions of care and professional transformation, still seen as fragile and not continuous[7].

PHE as a model of care, links the learning and professional training needs with those of the population, not to

adjust processes, but in the reflection about the needs of the population, in search of alternatives to the reality presented and to be adapted to each level of care and specificity[8]. That said, the present research aims to propose a Permanent Health Education Model with strategies linked to the Five Disciplines framework for the development of competences of professionals who work in direct care for women in situations of violence.

METHOD

It was opted for a qualitative study for the elaboration of a proposal that considered perceptions, opinions and the products of the interpretations constructed, thought and experienced by the participants. Thus, this approach was related to the present concepts, to the deepening of actions and relationships, in a not so explicit or visible side[11], and anchored by the theoretical framework of the Five of Disciplines: personal mastery, mental model, shared vision, team learning, and systems thinking[9].

The research was conducted in the city of Curitiba-PR, in August and October 2019, with professionals who work in the services of the Network of Attention to Women in Situations of Violence at Curitiba (*Rede de Atenção às Mulheres em Situação de Violência de Curitiba* – RAMSVC). RAMSVC was implemented in 2002, and in its dynamism, it has incorporated the setup of several services, as occurred in 2016, with the inauguration of the House of the Brazilian Woman (*Casa da Mulher Brasileira* – CMB), a space designed to assist women who suffer violence and need social, psychological and legal support[12].

In data collection, it was used the Focus Group (FG) technique, as it allows participants to explore and reflect on some social phenomenon, through the formulation of questions and the search for answers in their insertion reality[13]. In performing the FG, it was invited a representative of each service that participates in RAMSVC, to know the desire and rethink in the discussions, and allow proposals and suggestions from the participants, in the development of actions to be implemented in the existing educational processes.

In this context, and inserted in the *Casa da Mulher Brasileira*, the place chosen for the research, the professionals compose services such as: Reception, Screening and psychosocial support, Women's Police Station, Maria da Penha Patrol, Military Police, Public Prosecutor's Office, Court of Domestic and Family Violence against Women and Public Defender's Office. In addition, the invitation was extended to other services that compose the network, such as the Social Assistance Reference Center (*Centro de Referência de Assistência Social* – CRAS) and the Specialized Reference Center for Social Assistance (*Centro de Referência Especializada de Assistência Social* – CREAS), Health, Education and for Non-Governmental Organizations (NGOs) that are linked to it.

The inclusion criteria were: professionals from non-governmental organizations working at RAMSVC and professionals working in the services that compose RAMSVC, regardless of their professional category and level of training, working directly with women in situations of violence for at least six months. And, as exclusion criteria: unavailability to participate in at least one of the meetings, being an intern or resident in a professional training course or on leave regardless the reason, or under 18 years of age.

Two meetings were held with an interval of 45 days, conducted by the main researcher, who was assisted by two researchers to take notes during the meetings and support the recordings. The meetings lasted 1h30min and were held at the CMB, with prior authorization and scheduling. The CMB was chosen because it is a space where monthly meetings occur between the services that compose the intersectoral network. In the first meeting, 16 professionals participated and 11 in the second, identified as "NP" (network participants).

Initially, a moment of relaxation was provided, with clarification of doubts about the research and its objectives, with the intention of improve the level of contributions in the discussions. Next, the participants were invited to sit in chairs in U formation, so that they could have a view of the other participants, as well as the researchers. The questions were conducted by the main researcher, who returned to the center of the discussions when the lines dispersed to parallel themes, without, however, causing embarrassment or discouraging contributions, but with the intention of optimize the time agreed with the participants.

The first meeting focused on the existing fragilities in the network from the point of view of the participants. In the second, the fragilities pointed out in the previous meeting were validated by the participants and, from there, the discussions focused on the suggestions for implementation in the educational processes and the ways to enhance them.

After the transcriptions of the recordings by the main researcher, the data analysis was carried out through content analysis, which starts from the reading in a foreground of speeches or statements, to later go to a deeper level and overcome the level of common sense[11]. This technique was chosen in an attempt to go beyond the communication carried out in the interviews, to an interpretative depth regarding the theoretical framework used.

Among the modalities of content analysis, the one chosen was thematic, as it aims to discover the nuclei of meaning

that make up communication. Therefore, the thematic analysis unfolded in three stages: pre-analysis, exploration of the material, treatment and interpretation of data[11]. The pre-analysis, carried out by fluctuating reading of the transcribed material, was characterized as a stage in which the theoretical framework of the Five Disciplines allowed the definition of the thematic pre-categories personal mastery, mental model, shared vision, team learning and systems thinking[9]. The thematic categorization of the participants' speeches, arising from the two meetings, was aligned with the pre-categories brought by the theoretical framework. This step was followed by the exploration of the material, described in the composition of the five categories. Subsequently, the results obtained by the interpretation stage were treated, which advanced following the propositions and inferences of a qualitative approach.

At this stage, to synthesize the proposals presented in the other four disciplines, it was used the concepts that rule the fifth discipline, systems thinking, integrating the participants' suggestions with the strategies proposed by the theoretical framework, resulting in the elaboration of a Permanent Health Education Model (PHEM), supported by the strategies suggested by the participants, and mediated to their execution, in the theoretical framework of the Five Disciplines.

The Five Disciplines were chosen because they consider individual thinking first, followed by interaction and collective learning, focusing on the transformation necessary for the learning process. A process that occurs when people come to see how their actions contribute to the reality in which they find themselves, perceive their attitudes and seek changes to favor the whole, recreating their reality[9].

In this context, the personal mastery that reflects on virtual reality is seen as an ally in the organization that learns, and in which, the knowledge of the actions performed and the impact on the other, becomes the essence when promoting commitment, sense of comprehensiveness and responsibility for the service performed. The mental model is the discipline that signals the need to work on the ability of reflection and inquiry together. Cooperative learning is favored when the individual searches for the best alternative in a given situation and, in this way, expands their field of knowledge[9].

The shared vision develops the exhibition of ideas, debates, with opportunities for recognition and restructuring of what is ingrained in people. It does not ignore personal vision or generate imposition, but is developed in a favorable mood to its stimulation. In team learning, the "I" does not reflect its complexity, the collective view cannot be managed by words in which the professional acts correctly, but the service does not. This allows the individual to defend the actions taken and prevent his view of systemic problems. Dialogue in this discipline is suggested to promote this learning[9].

The fifth discipline is defined as the basis for the others, as it mediates the whole that goes beyond the sum of the parts. In this way, it connects to the shared vision because it encourages long-term commitment; to mental model, for allowing openness to reveal the limited ways of looking at the world; to team learning, by developing team skills to see the whole of the organization; and to the personal mastery, for allowing continuous learning in the observation of the actions taken and the impact on the collective.

The research was carried out in compliance with Resolution nº 466 of December 12, 2012, of the National Health Council, submitted and approved by the Ethics Committee of the *Universidade Federal do Paraná* (UFPR) and the Ethics Committee of the Municipal Department of Curitiba, CAAE 476401500000031.

RESULTS

The thematic categories were defined according to the disciplines composed by the theoretical framework, in connection with the speeches and suggestions in the two meetings. The participants were part of a network composed by several services, which were represented by professionals such as: nurse, delegates, municipal police officer, nursing technicians, psychologists, social workers, social educator, sociologist, professors, and prosecutor's office adviser.

Category 1 – Personal mastery

The statements showed the importance of looking at everyday deficiencies, among them, the concern that the daily experience is not the whole in this performance. As well as, fragility in the knowledge about the actions of the services that compose the network and in the communication.

> *Because they imagine that we are very qualified, so in the day-to-day practice we learn a lot, but we don't know everything* [...]. (NP3)
>
> [...] *we had an information that the police station cites the aggressor* [...] *the police station does not, who will cite will be the Judge, the officer.* (NP3)
>
> *Actually, it is lack of communication.* (NP14)

In the questions about participation in network training, it was identified the absence of invitation to all services, as well as the participation of all professionals who

are part of it, which generated suggestions for strategies in this enhancement.

> *We don't have training in this area, we receive invitations from institutions, anyway, not from the city hall, we don't receive periodic training* [...] *we promote internal training, but in an organized way it doesn't exist. We also don't see health professionals involved in these discussions.* (NP7)
>
> *I think we have to make some differences, when you plan the training, for example, the doctor is very difficult to come* [...] *how do we get to this professional, there's not just one way to get there, but there are health teams [. . .] you can work on a case-by-case basis, discuss cases [. . .] sometimes it has to be practical* [...]. (NP1)

Category 2 – Mental model

The professionals, when contextualizing the existing problems in the services and in the performance of some professionals, highlighted that, even after the educational processes already carried out, some situations remain:

> *And then we are drying ice, because it's actually the so-called bad problems that we end up talking about, we keep changing the nomenclature, we keep saying different, but we keep saying the same thing!* (NP3)
>
> *[. . .]the question of the medical practice of interdisciplinarity itself and that we are only now reaching, questions that we have been working on this for how long?* [...] *And these difficulties were the same* [...] *they have not changed, it is impressive, we have an impressive difficulty with this!* (NP6)

Another relevant point was the reflection about the importance of inclusion in educational processes, of the theoretical approach in relation to the culture experienced by these women. Likewise, the historicity of the theme of violence, with a focus on generating subsidies in daily action, so that professionals understand the needs of women, their limitations and how to direct them:

It is important to realize how much this person can reach and go, because many times, professionals want them to go beyond what they can, or what they can, and then I think it ends up being another violence to want the person to go! Go! And he/she doesn't realize it! (NP18)

Sometimes the person is able to go further, but they need more time and sometimes we want to take shortcuts, because we already know where they are going [...] *so we have to try to look through their eyes, we can't give our solution, one because the solution may be inadequate* [...]. (NP8)

Thus, the participants also reflected about the inclusion of methodologies in which professionals expose how they feel in their work. For them, the lack of self-perception, of those who work with these women, and lack of reflection on the structural model present in society, affects individual and/or collective care:

> *I think that training proposal has to merge between studies of texts and more theoretical aspects, but also the emotion of each, because health professionals are within this society, they reflect and are microcosms of this society and that often do not see themselves that way, when they go to the service, they reproduce things from their own history* [...]. (NP1)
>
> *I feel a little guilty about the reason the woman allows it, why she lets it, why she doesn't do it, much more of wanting to judge the person than really understanding it as a social problem* [...]. (NP18)

Category 3 – Shared vision

The statements revealed the perceptions about the care provided by professionals who are working in services where they would not like to be in, as well as the experience of procedures performed in some services and that were positive:

> *Exactly, from the professional himself, enormous difficulty* [...]. (NP6)
>
> *One thing that I think was cool* [...] *they put a list with who wanted* [...] *it was successful, the staff liked it and they adapted well to the service* [...] *because then the person doesn't come obliged.* (NP2)
>
> [...] *So we started, before saying anything, we gave each one a piece of paper to write* [...] *what was the old memory that she had the most pleasant in her childhood and which was the worst* [...] *I went to analyze later* [...] *so it was an interesting tool because they entered the training already asking themselves, realizing themselves* [...]. (NP1)

When debating about the notification, it was evidenced that the existing work processes in the services are experienced in a sectoral and non-intersectoral way:

> *But then it is a specific case* [...] *when we receive the cases* [...] *reports of domestic violence are all notified* [...] *we make the notification* [...] *the notification is done anyway*

[...] *it is specific to each equipment, right, but we don't see this difficulty anymore!* (NP14)

I don't know in other places [...] *we had an expressive increase* [...] *yes, there was a big technical difficulty for us to notify* [...] *we ended up not doing this notification form, so it comes underreporting!* (NP6)

Category 4 – Team learning

When the questioning was linked to the fragilities of the services, they sought to highlight their service, however, there were questions about the performance of the collective in the network.

[...] *I don't complain about mine* [...] *we can dialogue a lot!* (NP16)

Each does its own but does not communicate with the other! (NP4)

However, when talking about the strategies implementation, it was possible to consider that they miss the participation of some professionals in the educational processes and the impact of absences as network:

[...] *we do not see the medical professional in these meetings, they are invited, they are not invited, or they do not participate* [...] *because we see a lot of nurse!* (NP7)

[...] *we are feeling a little distancing from the medical team, because it ends up being more focused on the prescribing part of the exams and medication* [...] *and we always ask for their insertion in this service, so in this part we are being flawed!* (NP16)

When asked about the frequency with which they discuss cases multidisciplinary, the answers were unanimous about the non-occurrence, as well as suggestions about the implementation in the network of a determination for this.

No, it's not done. (NP13)

[. . .]I think if it happened in an informal way this communication between the agencies, but there is no periodicity, it is not scheduled, this is not official [...] *if there was a need to comply with a schedule it would help a lot!* (NP6)

Also highlighted, the interest in team learning, including feedback from professional performance as a way to improve network communication:

How do people perceive the service? So reporting cases is the way the professional will perceive it and it would be a very rich source to address failures and welcoming situations [...]. (NP7)

To see where we got it right, or where we got it wrong, what can we improve, right? [...] *that's what we're talking about, the lack of communication between the areas, then it gets there at the end, the judge doesn't understand* [...] *you see that something happened somewhere, but you don't know where it was or what to do!* (NP4)

Category 5 – The fifth discipline: systems thinking

This category was represented in Chart 1 and elaborated with the synthesis of the participants' statements, as it is considered the connection between the previous four. In view of this, the suggestions were connected to those described in the theoretical framework, which allowed to establish the competencies required in the proposition of the PHE Model.

Chart 2 presents the PHEM, composed in its structure by: assumptions, theory, four central concepts and a diagram that guides its applicability.

In Figure 1, as a suggestion for the applicability of PHEM, the diagram represented and designated "The U-Process" is suggested, as part of the theoretical framework already used by organizations that have implemented the Five Disciplines in their learning processes, but without evidence in the health area. It represents the four disciplines in the ascent and descent of the U leg, and has at its center, as a way of potentiating them, systems thinking in the transformation of the individual to the collective.

Discipline	Strategies suggested by the participants and proposal based on the theoretical framework	Mastery/ Competence
Personal Mastery	Participants: Provide spaces for reflection for professionals to spill out their feelings. Proposal: Moments in which the professional writes down his ambitions, in search of what he really wants, promoting reflection on his writing and proximity to what he wants. Characterized as removing "layers" that involve aspects of personal vision and questioning "self" and "being", without abandoning the individual vision, but how it contributes or not to the whole.	**Knowledge** Organize care
Mental Model	Participants: Discuss social historical context, gender, sexist culture in professionals. Proposal: Ladder of inference, each step with dynamics of reflections in the search for knowledge that professionals have about other services. Together with discussions and conducting knowledge about the vision they have among themselves, later about the care, including topics on the historical context of the theme of violence against women and actions of the intersectoral network.	**Competence:** Promoting person-centered care
Shared Vision	Participants: Discuss the comprehensiveness of services in the care for women in situations of violence Proposal: Allow people to share their expectations and tasks. The goal is that when participating in a shared vision, they are likely to listen, discuss other ideas and recognize difficulties. Discussion not imposed, but with the use of horizontal communication.	**Attitude** Assertive communication; Work in an intersectoral way.
Team Learning	Participants: Promote communication between services and learn about the actions that each one performs at RAMSVC Proposal: Focus the dialogue using three basic conditions: 1. Suspension of individual assumptions, leaving them aside for analysis of opinions and not facts; 2. View the other as a colleague; 3. Mediator who knows the dialogue strategy. Necessary principles: conduction that makes the other feel secure in speaking even in the presence of authority; avoid dispersion and encourage maximum discussion; direct the speech to the center of the group; allow an idea to be experienced, until the team becomes independent, and where complex issues culminate in decision making. As well as the participating professionals, promote in their services an extension of learning.	**Knowledge** Work collaboratively; Plan resolutive actions. **Attitude** Decision making.

Chart 1 – Strategies for implementing the PHEM in the development of professional competences for those who work in the care of women in situations of violence. Curitiba, Paraná, Brazil, 2021
Source: Research data, 2020

PHEM structure
Assumptions: PHE as a resource used in work management and as a tool for educational processes with a focus on training in articulation with the needs of the population. The development of competences and the use of an organizational learning process generate in the individual knowledge about comprehensiveness. The articulation between the services in an intersectoral way involves the participation of professionals as articulators of this process, in which the actions will be carried out collectively.
Central concepts: Interprofessional: professionals who compose the intersectoral network and promote care beyond the biological. The **environment:** the intersectoral network itself, which focuses on its formation, an attention directed to women to get out of the cycle of violence. The **human being:** women in situations of violence, with institutionalized rights capable of generating better opportunities in their needs. **Health/disease**, represented by the context of violence itself, as a phenomenon that affects different levels at these women's health.
Theory: Using the referential of art and practice of the learning organization: The fifth discipline, composed by: Personal mastery, mental model, team learning, shared vision and systems thinking.
Diagram and its applicability: "U" process

Chart 2 – Presentation of the Permanent Health Education Model (PHEM). Curitiba, Paraná, Brazil, 2021
Source: Research data, 2020

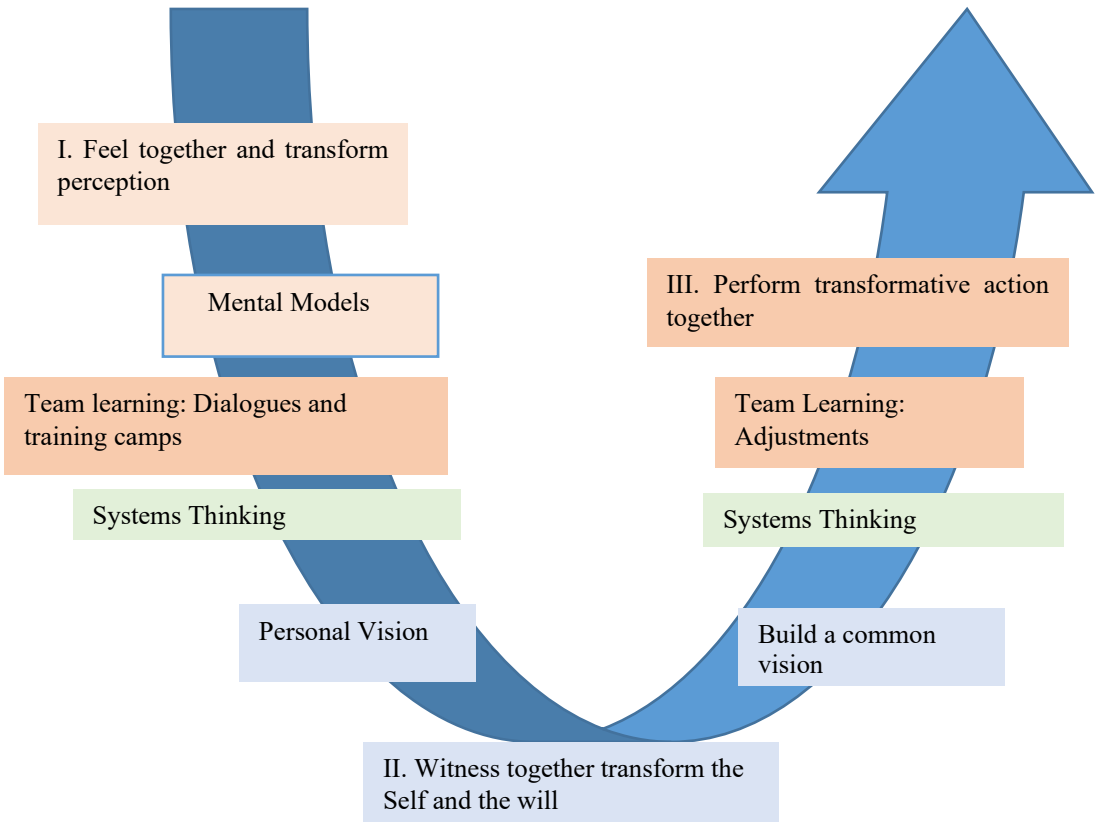

Figure 1 – The "U" process and the Five Disciplines. Curitiba, Paraná, Brazil, 2021
Source: Senge, 2018

DISCUSSION

In this research, it is considered that the learning process is continuous, as people change places and services, as well as knowledge, protocols and flows. Therefore, when creating a strategy that is maintained even with the arrival of new members, new knowledge is learned, which is consistent with the PHE, in which knowledge is not ready, but generated and solutions built in the everyday practice[14].

Among the suggestions made by the participants, that of implementing means in which those who work in the care for women in situations of violence can talk about how they feel, is in line with what has been described on the theme of competences, in which the individual, when confronting their values in their environment, promotes reflection and meaning to their actions, understood as subject to change and adaptation in the face of adverse situations[15].

When referring to the need for greater knowledge about the actions performed between the services, they refer to a context of fragmentation of information, which hinders collective work and does not follow the concept of intersectoriality as an instrument for health promotion. Teamwork promotes the exchange of knowledge, as each profession has its knowledge and, when thinking about articulated care, these are shared, which facilitates networking[16]. Thus, it becomes one of the challenges for management to implement actions that promote effectiveness in intersectoral work.

Intersectoral work involves processes that are frequently updated, given the complexity surrounding the theme of violence against women. In this way, the turnover item reflected among the participants has a direct impact on the daily performance between the services that are part of the care network. This led to the suggestion that, with the arrival of new professionals, they should be effectively involved in educational processes, focusing on the guidelines of the PMV and RAMSVC. This suggestion is reinforced by the theoretical framework of the Five Disciplines, in which a learning process does not end, but always restarts[9].

When citing the importance of professionals' participation in educational processes, the participants suggested that those designated to represent the services, when returning to their respective workplaces, promote actions to share what was learned for those who were not present. Such strategy is in line with the discipline of the personal mastery, which aims to generate the development of activities in connection with others, in addition to themselves, so that changes occur from the individual to the collective[9].

In medical education, still accompanied by the paradigm that emphasizes the disease and classified as a biomedical model, there is a challenge under construction so that the curricular guidelines of this profession include methodologies that promote humanization in care[17]. This fragility in training makes it difficult to diagnose violence with the identification of the real needs of these women, not only biological and not always manifested immediately, leading to the invisibility of violence.

Therefore, it is prioritized surveillance by the health team in the consultations, considering that, even in cases of visible physical injury, the woman does not reveal what happened. Thus, educational processes that focus on improving the team in identifying cases include multiprofessional discussion incorporated in clinical practice, in order to mediate the process of identifying women in situations of violence[18].

Knowledge about the population served promotes reflection about ways to change the situations presented. However, it is not enough for the professional to have this or other skills if he/she does not know how to apply them, but it is necessary to "know how to act" with pertinence, beyond practical execution, take initiative and seek to understand the presented situation, anticipating it[10].

The patriarchal culture is present in society, mainly in the fact that female and male roles are accepted as certain, in which the role of women is in the domestic space and that of men in the public space[19]. This conjuncture, directly linked to the questioning of the participants when citing the importance of including in the educational processes of themes related to the historical context of violence, so that the professional look does not generate blame, but seeks the reasons that make these women don't leave the cycle of violence in which they are inserted.

The formation of intersectoral networks was linked to strategies for the promotion and integration of professionals and services, with an emphasis on improving care for these women[4]. However, they do not generate by themselves a care process focused on integrality, but rather, the implementation of educational processes linked to PHE, that lead to a professional transformation. By showing this fragility, the participants understand a path to be followed as members of a network with an emphasis on intersectoriality, which demonstrates an interest in promoting a shared vision.

Even in countries where laws are punitive for professionals who do not report or comply with institutionalized protocols, underreporting prevails. Therefore, training improves knowledge on the theme, ways of identifying violence, safety in the workplace and appropriate directions, which will support and favor these professionals in an action focused on problem-solving[20]. The circumstance cited is in line with this research, in which the participants reflected on the lack

of knowledge of some professionals during consultations, the impact on daily performance and the importance of implementing existing processes.

They also presented strategies for building an educational process based on their experiences and knowledge, with a focus on improving the whole as an intersectoral network. In the discipline of team learning, such event is considered important, in the search for learning from the individual to the collective[9] – a fact evidenced in the discussions developed about the potentialities and fragilities present in the network and in the proposition of directed care.

Systems thinking is considered as the cornerstone among other disciplines; the shared vision for encouraging long-term commitment; to mental models for allowing openness in revealing the limited ways of looking at the world; team learning by developing team skills to see the whole of the organization; and to the personal mastery for allowing continuous learning, in the observation of the actions taken and the impact they have on the whole[9].

Thus, by linking the proposal of the applicability of the PHEM using the "U" process, this research has the proposition that the descent of the "U" leg should focus on knowing the reality of each service or the interaction in care for women in situations of violence. In this way, it is considered that each service has a vision and thus, the descent is composed by the exhibition of the existing mental models and, from there, their amplitude. The use of strategies focused on sharing will trigger these actions, as well as the use of team learning in situations experienced as a network, as a form of knowledge that generates dialogue, discussion and reflection.

As a probable limitation, it is mentioned that, despite a representativeness of more than 80% of the services and professional categories representing the intersectoral network, there was not all the services that compose it. As potentiality, there is the elaboration of the PHEM, achieved based on the suggestions of professionals who provide direct care for women in situations of violence. This fact allowed important reflections through the knowledge of their experiences and the fragilities that trigger non-resolutive processes.

CONCLUSION

The strategies suggested by professionals who work in the care for women in situations of violence promoted the elaboration of a PHEM that concomitantly with the use of the theoretical framework of the Five Disciplines, allowed proposing strategies to be implemented in organizations that learn, to trigger a learning process, focused on developing the competences of professionals working in this intersectoral network.

Among these strategies, it stood out as a suggestion of the participants, the knowledge about the personal culture of the professionals and how they feel in relation to the care of women in situations of violence. In this way, it is suggested to the managers of the services that are part of the network a look in search of knowing the personal perspectives of the professionals who work in it, in favor of a care with comprehensiveness, otherwise the action may be influenced by the judgment of the personal culture of the professional and not of the woman's needs.

In this context, the PHE was considered a resource and strategic tool that permeates educational processes, focusing on professional qualification to transform the workplace, in articulation with the population's needs, through attention to women in situations of violence that result in effective actions. Therefore, among the suggested competences, the following stand out: organize care; promote person-centered care; assertive communication; Work in an intersectoral way; work collaboratively; plan resolutive actions; decision making; knowledge; competence and attitude.

It is considered that, even though they are not specific competences of professionals who work in the context of care for women in situations of violence, they are a priority for team learning. As a contribution of this study, the PHEM elaborated with strategies linked to the phenomenon of violence, with specific themes on this subject, fills a gap in the literature and evidenced by the participants.

As an innovation, it is highlighted the use of the theoretical framework of the art and practice of the organization that learns, permeated by the Five Disciplines that compose it, as indispensable factors in the continuous learning process. It is suggested that the PHEM can be implemented not only in the researched network, but also by other networks that have services linked to the care for women in situations of violence.

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