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Review

Obstacles and facilitators to primary health care offered to women experiencing domestic violence: a systematic review*

Obstáculos e facilitadores para o cuidado de mulheres em situação de violência doméstica na atenção primária em saúde: uma revisão sistemática (resumo: p. 17)

Obstáculos y facilitadores para el cuidado de mujeres en situación de violencia doméstica en la atención primaria de la salud: una revisión sistemática (resumen: p. 17)

Ana Flávia Pires Lucas d'Oliveira[a]
<aflolive@usp.br>

Stephanie Pereira[b]
<stephaniepereira@usp.br>

Lilia Blima Schraiber[c]
<liliabli@usp.br>

Cecília Guida Vieira Graglia[d]
<cicagvg@gmail.com>

Janaína Marques de Aguiar[e]
<jamaragui@gmail.com>

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[a, c, d, e] Departamento de Medicina Preventiva (DMP), Faculdade de Medicina (FM), Universidade de São Paulo (USP). Avenida Dr Arnaldo, 455, 2º andar, sala 2170. São Paulo, SP, Brasil. 01246-903.
[b] Pós-graduanda do Programa de Pós-Graduação em Saúde Coletiva (Doutorado). DMP, FM, USP. São Paulo, SP, Brasil.
[f] Residente do Programa de Residência Médica, Iamspe. São Paulo, SP, Brasil.

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Systematic review of the literature addressing obstacles and facilitators for the care of women, in situations of domestic violence (DV) in primary health care (PHC) in Brazil. The bibliographic review found 1,048 references. The analysis encompassed 39 articles complying with the inclusion and exclusion criteria. The material was centered on representations and beliefs of practitioners. The main obstacles were related to: conceptualizing DV as a health issue, resulting into difficulties to identify the problem and managing care encounters; lack of training and teamwork; scarce intersectoral network, fear and lack of time. The facilitators were mainly: introducing a gender and human rights perspective, bonding and embracement, teamwork and multisectoral work. Despite the potential of PHC to address the issue, few studies considered perspectives of management and financing, considered as key to overcome the problems pointed out.

Keywords: Violence against women. Primary health care. Health providers.

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Introduction

Violence against women has been a topic of research in Health since 1990[1-6], and accordingly the concerns related to caring for women in situations of violence are also expressive in studies, nationally and internationally[7-12]. Within this angle of research, there are studies that highlight the importance of primary health care (PHC)[13-16]. There are at least three reasons why PHC can be conceived as a privileged area in the path taken by women seeking help for the experienced violence[17].

A first reason is the fact that PHC represents the gateway to the health system and one of the first services to be sought in case of need for assistance.

The second reason resides in that PHC is also the service that works longitudinally with the family and the territorial community that is assigned to it, accumulating experience to deal with situations that occur in that family context. Such situations, mostly perpetrated by partners or ex-intimate partners, represent more than 80% of violence against women[9,18] and in those cases, urgent and emergency assistance services or walk-in clinics, have difficulty in providing a comprehensive response, even though they are key for the care of people who have experienced single-occurrence sexual violence or for the support of physical traumas.

Thirdly, it should be considered that PHC is a service modality that, in the junction of curative assistance with care aimed at prevention and health promotion, offers continuous assistance to women, regardless of demands for interventions in specific pathologies, stimulating to seek service even in the absence of complaints related to already manifest illnesses.

For these reasons, in this study we focused on the response that PHC is able to offer to domestic violence against women (DV), considered as "any action or omission based on gender that causes death, injury, physical, sexual or psychological suffering and moral or patrimonial damage" in the domestic, family or any other intimate relationship of affection[19].

A 2010 review related to the profile of studies on violence against women by an intimate partner from 2003 to 2007 shows that most studies are developed in health services, although not necessarily in PHC[20]. This empirical basis is also reiterated by another review, published in 2016[21] encompassing the publications of Revista de Saúde Pública between 1967 and 2015. This review points out that 86% of the articles that dealt with violence against women addressed violence by an intimate partner.

In the research within the PHC, both the managerial dimension and the clinical care dimension can be individualized. In the latter, it is possible to investigate issues related to professionals, those related to users as well as to the relationship between them. However, there are no reviews that show how the studies are positioned regarding these possibilities. We found no reviews that highlight the research on obstacles and facilitators to this care in PHC.

Thus, the present study aimed at a systematic review of the bibliographic production that addressed the obstacles and facilitators for the care of women in situations of violence in PHC in Brazil.

Method

This systematic review was part of the first phase of the multicenter research HERA 1 (HEalthcare Responding to violence and Abuse). The pilot research aimed to develop, implement and evaluate an intervention to improve PHC's response to domestic violence against women in Brazil and Palestine.

The bibliographic search was conducted in August 2017 in the Lilacs, Pubmed and Scielo databases, and chosen because they contain a significant number of well-indexed Brazilian journals, being a reference in the health area.

The search in the databases was carried out by cross-analyzing the subjects, titles and abstracts, as shown in figure 1. It was decided not to perform a filter for publication dates, in order to retrieve all published works until the search date.

The 1,048 references found were evaluated according to the steps observed in Figure 1. The selection of articles was carried out in two steps. In the first step we selected, using the abstracts, those that met the inclusion criteria: articles from national and international journals, freely accessible, with empirical data regarding the care of cases of DV in PHC in Brazil. In this stage, 977 papers were excluded: theses, monographs, congress annals, documents from the Ministry of Health, articles without free access, repeated articles, theoretical and review articles, articles of prevalence or those that portrayed exclusively the consequences for the health of women.

In the second stage, the 71 selected articles were read in full and 32 were excluded. The main exclusion reason (15) was due to what could be called 'to slice the same study for several publications': they were publications by the same group of authors, referring to the same study (design and general empirical basis, e.g. sample, location and catchment area, exactly the same for the empirical data set), published in subdivisions of partial data groups, not showing substantially different discussions or conclusions among them. In those cases, we chose the one that we considered with more theoretical and methodological consistency and that presented the data and results in a most complete way. Theoretical and methodological consistency is considered as the explicit and coherent relationship between the introduction of the article, the methodological choices and the way of analyzing the empirical data produced[22].

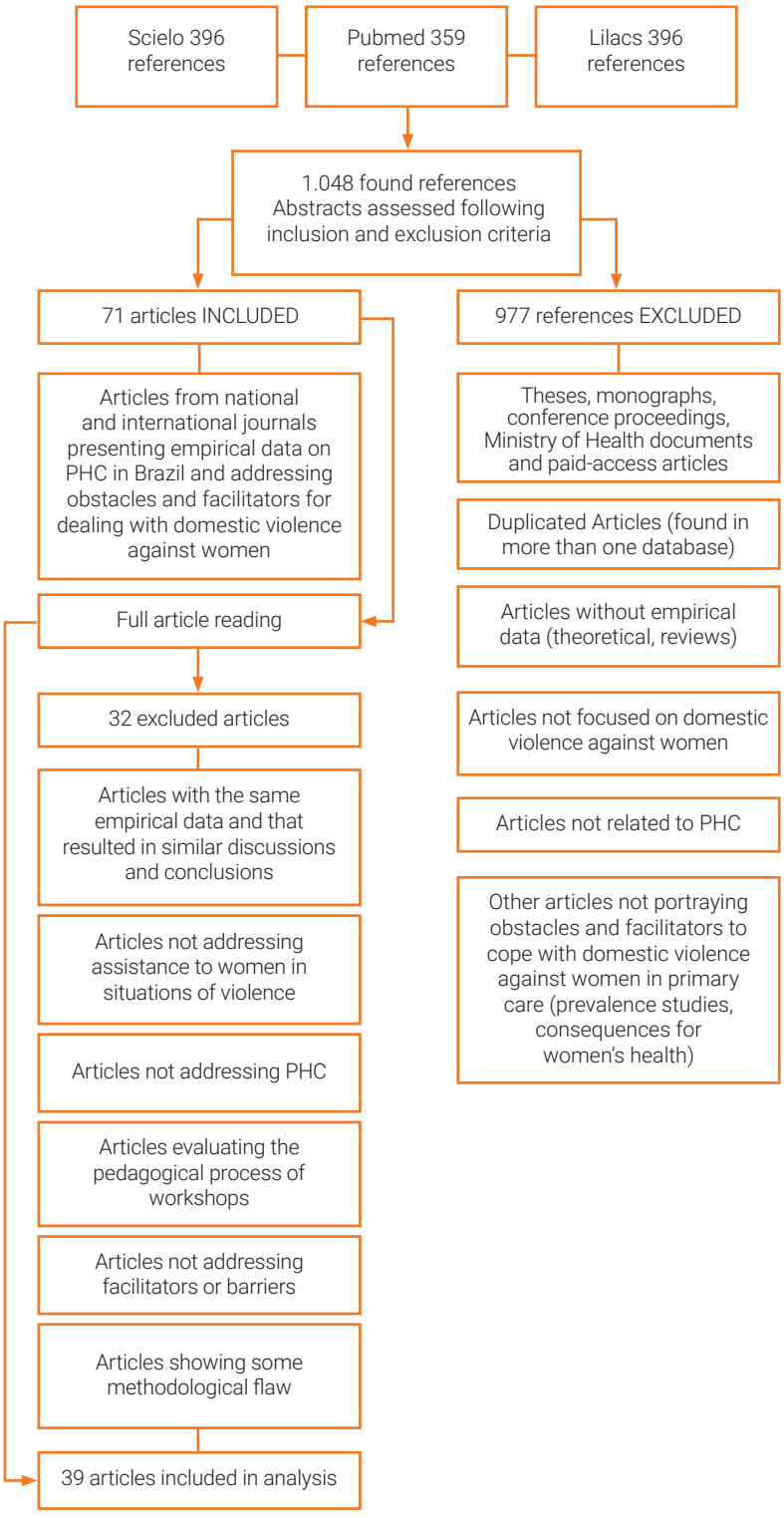

Figure 1. Steps for the systematic review and inclusion and exclusion criteria

We extracted data from the 39 articles on: sex of the first author; Brazilian region where the empirical data was originated; methodology used; study subjects (health professionals, service users or managers); theoretical framework (definition of gender, violence against women and other theoretical frameworks used); obstacles and facilitators for working with women in situations of violence.

Two trained researchers carried out all the steps mentioned above independently; and the disagreements have been compared and discussed by all authors. From this discussion, the following analytical categories emerged, named according to the terms used in the articles and therefore noted in italics: "Belonging to the scope of health", "Professional practice in the care encounter" and "Service management and organization".

Results

The first authors in 37 out of the 39 articles analyzed are women. The Southeast[23-41] was the region with most authors and fields of research data production, but both the Northeast[42-50] and the South[51-61] also account for a significant portion. We observed different scenarios among PHC services, either by geographic location or by care models, with just over half of the articles stating that they studied PHC with a Family Health Strategy[24,26,28,29,31-33,35,42-45,47,48,50,53-56,58,60]. It is interesting to note that this diversity was scarcely reflected in the obstacles and facilitators presented by the studies, and we found more obstacles (157) than facilitators (68). The item showing the greatest variation was women's lack of access to services[49,52].

Most research investigated health professionals, with twenty-eight studies focusing only on health workers[23-31,33,35,36,39-48,50,53,56,58,60,61] three on professionals and women[37,57,59], two exclusively in women[38,49] and one that focused on data from medical records[51]. Managers were interviewed in five studies, comprising direct assistance professionals[32,34,52,54,55]. Some studies focused specifically on doctors[27], Community Health Agents (CHA)[35,56,58], nurses[36,61], but most addressed the professional diversity present in PHC services.

Regarding the methodology, 27 studies used qualitative methodology. Only five studies were exclusively quantitative[23,26,34,40,47] and seven used mixed methods[24,30-32,36-38]. Most studies used semi-structured interviews[25,27,29-32,35,36,38,39,41-43,46,48,50,56-59,61].

In terms of the theoretical framework, 31 of the articles defined violence and 11 defined gender. The legislation known as the Maria da Penha Law[19] was the most used to define violence against women, followed by Brazilian researchers and documents from WHO, PAHO and OAS. In relation to gender, Joan Scott[62] was the most cited author, followed by Heleieth Saffioti[63-66] and other Brazilian and foreign researchers.

Table 1. Number of obstacles and facilitators most cited in the 39 articles analyzed according to analytical categories

		Obstacles	Facilitators
An issue within the scope of health		Not considering violence as a health problem (15)	Promotion of rights as a health role / not blaming women and a gender perspective (6)
		Technicism in care / medicalization (10)	Avoid medicalization, making violence visible (2)
Professional practice issues in the encounter for care		Thinking that it is the woman who should report / woman does not speak out of fear or shame (12)	Creating a good relationship with the woman (bond, listening, embracing) (15)
		Blaming the woman / individualizing the problem. (8)	
		Not knowing what to do (7)	Have priority space in the unit for the entry of cases of violence / service sensitive to violence (3)
		Losing control over the effect of the intervention (6)	
		Not seeing the occurrence reported as violence / naturalizing the problem (5)	
		Being uncomfortable with the topic / Professionals themselves suffer or suffered and do not feel comfortable asking (5)	
		Do not believe that should meddle (4)	Always ask / actively inquire / recognize that it is the professional competence (5)
		Not knowing how to ask (3)	
		Not having a specific protocol (3)	
		Impotence in the face of women's resignation to the violence they suffer (2)	
Service management and organization	Training / qualification and supervision	Lack of training and qualification: at graduation and in service (22)	Have training / qualification (9)
		Lack of supervision (3)	Promote / encourage permanent education policies (1)
		Lack of knowledge of policies and programs for women in situations of violence (2)	
	Teamwork	Do not think that violence is within the competence of the professional category (6)	Teamwork (6)
		Lack of integration in the team / solo work (3)	Having Community Agents on the team (3)
		High turnover of professionals (2)	Carry out home visit (2)
			Having a psychologist / mental health professional on the team (2)
	Intersectoral Network	Lack of awareness of the network services (8)	Having an Intersectoral Support Network (9)
		Not having control over the effects of referral / Disbelief in the network (5)	Interpersonal knowledge among members of the Network (3)
			Having Network meetings to discuss cases (2)
	Fear and lack of time Lack of access	Being afraid of the aggressor and / or reprisals (9)	-
		Lack of time / pressure to attend to other things (10)	
		Lack of access / specialized professionals (7)	
TOTAL		Obstacles 157	Facilitators 68

Domestic violence against women as an issue within the scope of health

A remarkable number of studies[23,25,32-34,37-40,42,43,45,48,51,54] concluded that a very important obstacle in the work with violence against women in PHC is the fact that health professionals fail to approach violence as a health problem. Medicalization, technicism, reducing suffering to pathology, exams and medications are shown and reported in studies as an important obstacle to stop the visibility and work with violence against women[32,33,38,43-46,50,53,60], leading to this difficulty of considering DV as an issue within the health scope.

Among the quantitative studies there is a discrepancy in the data regarding the visibility of the problem. When asked about the identification of cases of DV, the data ranged between 28%[47] and 80%[34] of professionals and 83% of managers[34] reporting that the cases are detected in PHC. However, Osis[34] also showed that women have not recognized PHC as a space capable of embracing this demand, since 65.5% of users who participated in the study reported believing that UBSs do not provide this type of care, and 18.5% stated that they were unaware that UBS could help in cases of violence.

Other studies point to the fact that some professionals already consider DV as pertinent to PHC, which constitutes a change from previous attitudes. Such recognition seems to be related to the perspective of gender and human rights in practice, to the comprehensiveness of care and to the recognition of the role of promotion and prevention that characterizes PHC.

Professional practice issues in the encounter for care

The persistent difficulty in acknowledging DV as a public health problem finds its translation in the beliefs, knowledge and values of professionals. Some studies[25,28,32,36] show a more personal action, such as opinions and advice in cases where visibility occurs.

Policies and laws related to the subject have been scarcely investigated, but the two studies that cite them conclude that professionals know little about them[40,47].

Regarding asking women about DV, professionals say they do not know how to ask; they find it more appropriate to wait for the woman to speak out the situation if so she wishes. They also state that they do not know care protocols[34,47,59], do not know how to approach the question[32,37,43,46,52-54], making them uncomfortable. The violence experienced by the workers was remembered as a possible obstacle[23,24,31,39,48], as well as mentions to the blaming of women made by the professionals[23,27,29,32,41,42,52,57].

On the other hand, the quality of the relationships between practitioners and women as well as the bond created were the most cited facilitators[27,36-38,44,46,50,52,54,56-61], followed by active search and non-moral judgment of women[23,38,40,44,59]. Three studies recommended the existence of a specific and protected space in the unit for cases[30,37,39].

Aspects related to the "management and organization of services"

A large part of the studies inquired at health workers' beliefs, opinions, perceptions and attitudes. None made an assessment of implemented interventions. Compulsory notification of cases of violence has been studied in some articles[31,40,43], demonstrating difficulties in the implementation.

Although listening mostly to the professionals and giving little consideration to the existing policies and the aspects of management and implementation of these policies, issues related to management and work organization aspects were often mentioned as obstacles and facilitators: training, staff, intersectoral network, protection of workers (fear) and care goals and supply/demand ratio (time).

Training / capacity building and supervision

A lot of studies mentioned undergraduate training and in-service training, or permanent education. Training was presented as a solution in most studies[23,25,27,28,30,31,33,34,39-43,46,48,51,53,54,57-59,61]. However, time, didactics or training content were barely addressed. Only one study carried out an assessment before and after training, showing relative success[26].

Lack of *supervision* on site, an important dimension of work, was mentioned as an obstacle by only 3 studies[30,39,57], and continuing education as a facilitator for another[48].

Fear and lack of time [sub-subtítulo]

The fear of retaliation by aggressors appeared in the statements of doctors, nurses and also CHAs[24,31,33,39,40,46,47,57,59], related to work in communities where organized crime is present. An ethnographic study observed threats to professionals during fieldwork, motivated by notification of child sexual abuse[59].

Lack of time, often cited as an obstacle, was linked to work overload derived from care goals, care priorities and the perception that violence is a subject that may take a long time to be cared for[24,26,27,31,40,42,46,48,54,61].

Teamwork

Teamwork was recognized as essential to address violence[33,39,50,51,54,59], even though the way to do it in an integrated manner is still considered a gap[24,32,41]. The lack of role clarity of each professional encourages them to refer cases, as it is not clear what each profession could do[30,32,34,37,40,42]. Differentiated hours and wages, staff turnover and ways of evaluating productivity, with specific goals for professional categories end up hampering team integration[43,54].

Having CHA[49,58,59] or psychologists and mental health professionals[42,55] in the team was highlighted as a facilitator as well as home visits were mentioned as an opportunity to detect cases[33,60].

Intersectoral network

In spite of the professionals reiterating that "violence against women is a public health problem", they also recognize that it is a problem with an important participation of other healthcare sectors. For this reason, the intersectoral network was quoted more for its absence than for its presence.

Insufficiency, lack of knowledge[24,26,27,30,34,39,45,46] or distrust of the intersectoral network[25-27,33,50] was present in the material studied.

At the same time, whenever the network was known, it was understood as a facilitator[24,33,36,39,45,48,50,54,61]. There was an acknowledgement of the value of regular meetings[33,54] and interpersonal knowledge among service members[39,48,51].

Discussion

It was found a significant production of articles, especially in the last decade, compared to international data, showing a review of 46 articles in which 29 were conducted in Brazil[67]. However, concurring with what has already been pointed out in this review, we find the practice of 'slicing' research results, with a consequent expansion of publications, presenting highly heterogeneous quality among the articles in methodological and analytical terms. This issue has been debated internationally as a product of academic pressures for publications[68].

This study provides a clear and consistent picture of what professionals think, and even detects a change: there is a progressive acceptance of the idea of DV as a public health problem.

It is noteworthy that the current review highlighted the challenge of identifying and addressing cases in a way that escapes the medicalized approach to violence, a social phenomenon that has been reduced to pathologies of the body, excluding the socio-cultural dimension that generates suffering and illness. In this sense, the need for intersectoral work becomes invisible and attention is fragmented into specialized services.

Nevertheless, there are considerations regarding the importance of expanding the view of health in the practice of care[69]. Likewise, some articles analyzed emphasized the importance of considering the gender theory in explaining violence, adapting it to the production of care, thus making it possible to criticize the stereotypes that professionals have into their representations about women living with DV, as persons immersed in the same culture that produces the cases. Improvements in the mastery of this theory will also allow for a critical view aligned with non-blaming of women and interested listening for a practice more focused on the defense of social rights and health promotion.

PHC appeared as a favorable place for the visibility and first reception of DV in health, and its consequent referral. The principle of integrality, the understanding of health as a right, home visits and the concept of welcoming, in addition to the Singular Therapeutic Project, were elements identified as facilitators.

On the other hand, there is heterogeneity in training, both at university and in service, as a way to remedy the difficulty of visibility of DV in services or the precarious way of coping with it. While recognizing the lack of knowledge and reflection on the subject on the part of professionals, many articles propose actions of an educational nature, as if what they insistently call 'training or qualifications', often reduced to the transmission of a set of scientific information, automatically resolved the problem. The fact that the studies focused on the opinions and beliefs of health workers, always in demand for more 'training', may have contributed to this finding. An international review that evaluated the effectiveness of educational actions for health professionals on domestic violence showed that training can affect the perception of the problem, but has little impact on changing attitudes in care[70].

On the other hand, an important part of the obstacles encountered by the set of studies has to do with the daily organization of work (time, fear, teamwork, intersectoriality) thus not able to be undone just through educational activities.

There were a few interviews with managers and we did not find studies on the implementation of the various existing policies at the federal level[19,71-74], which were rarely mentioned. Although they are not specific to PHC, these policies establish priorities and consider health as an integral part of the service network. The discussion of management of services by Social Organizations, issues related to financing, productivity goals and work evaluation, were practically non-existent, although such aspects, in terms of health policies and the organization of services in daily practice, are essential for a response towards domestic violence by health systems[75].

Intersectoriality was present in the studies, but little was researched regarding its implementation, with low perception of the network and a lot of mistrust. It was often conceived as something to be achieved by each professional, team or service, and not problematized as a task also by central managers[76]. The principles of SUS and the potential of PHC seem to find a key limit here, but its overcoming has been little discussed.

There was a general absence of protocols and workflows. In fact, there is little scientific evidence regarding possible interventions in PHC, but the international literature seems to agree with the PHC's role of identifying, embracing in a non-judgmental way and forwarding to the intersectoral network[77-79]. The principles of SUS and PHC seem to show a direction that is very close to what has been established internationally[80,81].

It is noteworthy the small presence of studies on users' opinions and experiences, and this should guide future research. In a review on PHC and violence against women, from the 148 articles studied, 64.9% of them referred as "victims"[82]. However, this may have been a limiting factor as a result of our systematic review steps. In any case, obstacles and facilitators seem to be more present in workers' conceptions than in women's experiences, which need to be better known. It is also highlighted that, with the exception of an article that mentions quilombola women[49], those women using SUS were not approached regarding their internal differences regarding other axes of inequality - race, social class, sexual orientation, generation - and their intersection with gender inequality. New studies that address the intersections of the various forms of oppression need to be conducted for a more detailed picture.

Final considerations

PHC is a place with great potential for the care of women in situations of domestic violence. Professionals are already in contact with cases and recognize that the problem is a subject of public health. However, structural issues in working for health, such as a reductionist approach of health needs as pathologies, and structural issues in the organization of services, such as time, lack of security, clear protocols and flows, training, teamwork and recognition of the intersectoral network are important obstacles. While the effective response to cases of violence against women depends on PHC committed to comprehensiveness and care, this same response seeks to contribute in the building of this comprehensive care. In times of cuts in social policies, and censorship of the gender discussion, we need to position ourselves more strongly towards the implementation of policies already achieved, but which will only be implemented with a great effort, including in a fundamental way the component of management and organization of services as well as the social participation and control.

Authors'

Patrícia Carvalho de Sousa[f]
<patricia.carvalho.sousa@gmail.com>

Renata Granusso Bonin[g]
<regranusso@gmail.com>

Affiliation

[g] Pós-graduanda do Programa de Pós-Graduação em Saúde Coletiva (Mestrado). DMP, FM, USP. São Paulo, SP, Brasil.

Authors' contributions

All authors actively participated in all stages of preparing the manuscript.

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Trata-se de uma revisão sistemática da produção bibliográfica sobre obstáculos e facilitadores para o cuidado de mulheres em situação de violência doméstica na atenção primária à saúde (APS) no Brasil. O levantamento bibliográfico encontrou 1.048 referências. Analisamos 39 artigos, conforme critérios de inclusão e exclusão. A produção centrou-se em representações e crenças dos profissionais. Os principais obstáculos foram a constituição da violência doméstica contra a mulher (VDM) como questão do escopo da saúde, traduzida em dificuldades na identificação do problema e manejo no encontro assistencial, ausência de treinamento, trabalho em equipe, rede intersetorial, medo e falta de tempo. Os facilitadores focaram-se na introdução da perspectiva de gênero e direitos humanos, vínculo, acolhimento e trabalho em equipe e multisetorial. Apesar da potencialidade da APS para trabalhar com VDM, houve raros estudos que consideraram a perspectiva da gestão e financiamento, fundamental para a superação dos problemas apontados.

Palavras-chave: Violência contra mulher. Atenção primária à saúde. Profissionais de saúde.

Revisión sistemática de la producción bibliográfica sobre obstáculos y facilitadores para el cuidado de mujeres en situación de violencia doméstica (VDM) en la atención primaria de la salud (APS) en Brasil. La revisión bibliográfica encontró 1.048 referencias. Analizamos 39 artículos, conforme criterios de inclusión y exclusión. La producción se concentró en representaciones y creencias de los profesionales. Los principales artículos fueron la constitución de la VDM como cuestión del alcance de la salud, traducida en dificultades en la identificación del problema y el manejo en el encuentro asistencial, ausencia de capacitación, trabajo en equipo, red intersectorial, miedo y falta de tiempo. Los facilitadores se enfocaron en la introducción de la perspectiva de género y derechos humanos, vínculo y acogida, trabajo en equipo y multisectorial. A pesar de la potencialidad de la APS para trabajar con VDM, fueron raros los estudios que consideraron la perspectiva de la gestión y financiación, fundamental para la superación de los problemas señalados.

Palabras clave: Violencia contra la mujer. Atención primaria de la salud. Profesionales de salud.

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