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PERCEPTION OF HEALTHCARE PROFESSIONALS REGARDING PRIMARY INTERVENTIONS: PREVENTING DOMESTIC VIOLENCE[1]

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ABSTRACT: The purpose of the study was to learn about the perception of Family Health Team professionals from the Violence Prevention Program regarding primary interventions to prevent domestic violence. The study was linked to the research "Primary and secondary intervention in domestic violence from the perspective of primary healthcare professionals". The approach of this research was qualitative and exploratory. Data were collected from semi-structured interviews. The participants were four nurses and four physicians. Three categories emerged in the analysis of the theme: knowledge of primary interventions to prevent violence; execution of primary intervention actions to prevent violence - ease and difficulties; and acknowledgement of the importance of primary interventions and the care provided. The professionals were previously aware of the main primary interventions, and some were already taking place in the multidisciplinary work.

DESCRIPTORS: Domestic violence. Delivery of health care. Public health. Nursing.

PERCEPÇÃO DOS PROFISSIONAIS DE SAÚDE FRENTE ÀS INTERVENÇÕES PRIMÁRIAS: PREVENINDO A VIOLÊNCIA INTRAFAMILIAR

RESUMO: Buscou-se conhecer a percepção dos profissionais das Equipes de Saúde da Família, da área do Programa de Prevenção à Violência, acerca das intervenções primárias, a fim de evitar a violência intrafamiliar. O estudo esteve vinculado à pesquisa Intervenção primária e secundária frente à violência intrafamiliar sob a ótica dos profissionais atuantes na Atenção Básica à Saúde. A abordagem foi qualitativa, exploratória. Os dados foram coletados por meio de entrevista semiestruturada. Participaram quatro enfermeiros e quatro médicos. Ao realizar a análise temática, emergiram três categorias: conhecimento das intervenções primárias de prevenção à violência; realização de ações de intervenção primária de prevenção à violência – facilidades e dificuldades; e importância da realização de intervenções primárias e o atendimento prestado. Os profissionais conhecem as principais intervenções primárias, considerando que algumas já ocorrem no trabalho multiprofissional.

DESCRITORES: Violência doméstica. Assistência à saúde. Saúde pública. Enfermagem.

PERCEPCIÓN DE LOS PROFESIONALES DE SALUD FRENTE A LAS INTERVENCIONES PRIMARIAS: PREVINIENDO LA VIOLENCIA INTRAFAMILIAR

RESUMEN: Se objetivó conocer la percepción de los profesionales de los Equipos de Salud Familiar de la zona del Programa de Prevención de la Violencia, sobre las intervenciones primarias con el fin de prevenir la violencia familiar. El estudio está vinculado a la investigación: Intervenciones primaria y secundaria frente a la violencia doméstica desde la perspectiva de los profesionales que trabajan en la Atención Primaria de la Salud. El enfoque fue cualitativo y exploratorio. Los datos fueron recogidos a través de entrevistas semiestructuradas. Los participantes fueron cuatro enfermeras y cuatro médicos. A través del análisis temático, se revelaron tres categorías: conocimiento de las intervenciones primarias de la prevención a la violencia; realización de acciones de intervención primaria para prevenir la violencia – facilidades y dificultades; y importancia de realizar intervenciones primarias y de la atención recibida. Los profesionales conocen las principales intervenciones primarias, mientras que algunos ya se producen en el trabajo multiprofesional.

DESCRIPTORES: Violencia doméstica. Prestación de atención de salud. Salud pública. Enfermería.

INTRODUCTION

In contemporary society, domestic violence is becoming more and more frequent, as it becomes a growing problem associated with the social, economic, and cultural context in which it emerges. Considered a serious healthcare issue because of the physical and psychological damage that it causes, the violence experienced in the family environment affects individual and collective health, and results in losses that are not only momentary but affect every aspect of life.[1]

Among the many forms of violence, incidents of domestic violence as well as violence experienced in extrafamilial contexts, such as in the community and in schools, have drawn the attention of the media, the authorities, teachers, and researchers because of how often they occur and the repercussions they have not only in Brazil but in several other countries as well.[2] Described as an act or omission that hurts the wellbeing, physical and psychological integrity, and right to a full development of a family member, domestic violence exists even when it happens outside the victim's home, whether caused by the biological parents or by someone acting as the parent. With respect to violence against children and teenagers, it is defined as every act or omission by parents, relatives, and any other person or institution capable of causing physical, sexual, and/or psychological damage to the victim.[3]

It is understood that childhood and adolescence are times in which vulnerability to health problems and economic and psychosocial factors is at an all-time high. In situations of violence, the central family no longer provides a framework of protection for the child or teenager.[4] Violent acts do not occur solely in a certain population, class, or age group; however, it is known that women, children, teenagers, and the elderly are the primary victims.[5] Because of the psychosocial consequences that it creates, violence has been considered a healthcare issue that compromises health and quality of life.[2]

In Brazil, violence against children became more visible and started to receive attention from the government in the 1980s, understood as a relevant matter. This was especially true following the implementation of The Child and Adolescent Act (ECA, in Portuguese) and the Federal Constitution (art. 227), which consider it an obligation of the family, society, and the state to guarantee, with absolute priority, that all individuals have the right to life, health, food, education, leisure, professionalization, culture, dignity, respect, freedom, and to live with family and in the community, in addition to being safe from any form of negligence, discrimination, exploitation, cruelty, or opression.[6]

In terms of violence, there is physical violence, which occurs most often because the victim, who is still developing, is helpless when compared to the aggressor. Psychological violence can be characterized as every action or omission that causes or intends to cause harm to the self-esteem, identity, or development of a person and creating intense mental suffering, including the threat of abandonment. Child sexual abuse is characterized by a form of violence that involves the use of power and often leaves invisible marks, making it hard to prove, especially when small children are concerned. Negligence is characterized by the absence of the family or their care with respect to the child.[7]

In order to have a broader application of the resolution and its impact on people's health, the Basic Units of the Family Health Strategy (UBESF, in Portuguese) were instituted, in which healthcare professionals must be ready to detect situations of the risk of violence in the community, as well as

to identify families that are more vulnerable to it.[8] These professionals are more closely related to the eco-social cultural context of the population they assist and, therefore, they are better equipped to detect domestic violence early.

The actions to prevent violence conducted by the professionals of UBESF are: primary level interventions, which include orientation strategies about family planning, and proper assistance in prenatal care; information, orientation, and support to family programs; campaigns to provide information to the media; and any other action to the communities and families and raise awareness.[9] Among these actions, we also have community diagnosis of those families who live in a situation of social vulnerability.

At the municipal level, in July of 2009, the city of Rio Grande in the Rio Grande do Sul state signed a membership application with the Violence Prevention Program (PPV, in Portuguese) of the state government of Rio Grande do Sul, by means of the Structuring Programs for Our Cities, in partnership with the United Nations Organization for Education, Science, and Culture (UNESCO).

The main goal of the program is to reduce domestic violence by using social support networks in order to identify the problems within a given community and look for solutions.

The purpose is to promote greater involvement between private institutions and the public, as well as to promote governmental and non-governmental actions to try to reduce the health problems in the population caused by violence. Another goal of the PPV is a 20% reduction in the number of episodes of violence in the 50 cities of the state of Rio Grande do Sul, which has the highest number of deaths caused by external factors such as homicides, suicides, and traffic accidents.[6]

Knowing the connection between and the important role played by the health professionals who work at the UBESFs in the city with the communities they assist, the purpose of this study was to understand the perception of the Family Health Teams in the PPV area regarding primary interventions to prevent domestic violence.

METHODOLOGY

This is a qualitative and exploratory study built on data from the research entitled Primary and secondary intervention in domestic violence from the perspective of primary healthcare professionals.

The study was developed in three UBESFs in the city of Rio Grande, Rio Grande do Sul state, which are part of the PPV area. The study units were Castelo Branco I, Castelo Branco II, and Santa Rita de Cássia. Two units were made up of a team with one physician and one nurse, and the other had two teams.

The study participants were eight healthcare professionals, four nurses and four physicians, and they comprised the family health teams in the areas covered by the PPV. Data collection was done from August to September 2011 by means of a semi-structured interview that was scheduled in advance with the healthcare professionals, according to their availability.

The interviews were recorded and transcribed to be analyzed afterwards. A content analysis was performed, and it included a pre-analysis by means of a floating reading of the data, exploration of the material with the coding of the information obtained in the interviews, treatment of the data by grouping the similar themes into categories, and their interpretation.[10]

The health professionals involved in the study signed a free and informed consent form. The research was approved by the Health Research and Ethics Committee of the Federal University of Rio Grande in Opinion n. 102/2011. To preserve the identity of the participants, the reports were identified with the initial letter corresponding to the profession of each professional; thus P1, P2, P3, and P4 were physicians, and N1, N2, N3, and N4 were nurses.

RESULTS AND DISCUSSION

After the data analysis, three categories emerged: knowledge of the primary interventions to prevent violence; execution of primary intervention actions to prevent violence ease and difficulties; and acknowledgement of the importance of primary interventions and care provided.

Knowledge of the primary interventions to prevent violence

When asked about what the primary interventions to prevent violence were, one of the professionals said that he did not know the meaning, two demonstrated knowledge on the theme with conviction, and the others expressed uncertainty about the concept, as can be seen in their statements:

I don't know what primary intervention is (P3).

I believe primary interventions are those that we care directly for the patient who comes to us. They bring some information to us (N1).

primary is the first care that is from the health unit; we evaluate, see what we can solve (N3).

I don't know specifically. I don't know it with these words. In the matter of the primary interventions I believe that we already work with it. It is one of our main roles, to prevent, work with prevention, even with those types of violence that we are able to identify inside the family (N2).

I think primary intervention would be for us to act before it happens, so, on the part of education, by preventing it (N4).

Most of the professionals who work at the UBESFs are able to understand the meaning of the concept of "primary health interventions" when they mention the relevance of intervention with the community, creating a dialogue, and the several types of orientation for health - in summary, education for health, including psychoeducation. Psychoeducation is understood in this study as one of the psychosocial rehabilitation models, which includes the development of a group of programs and services to facilitate the lives of individuals with some mental health condition. It can be done individually or in groups by any healthcare professional who has received training for that purpose.[11]

Some of the statements given by the healthcare professionals demonstrate a lack of knowledge or fragmented knowledge about primary interventions. This context reinforces a primary assistance model that is rooted in cure-based care rather than prevention, whereas prevention is the pillar of UBESF. This perspective may be connected to the academic background of the healthcare professionals, which was more guided toward learning about cure-based assistance instead of learning about prevention. However, one of the participants brought up the essence of primary health interventions when he said that this takes place with specific actions to prevent domestic violence.

Regarding what they think about primary interventions that are able to prevent domestic violence, we can highlight the following statements:

so, in primary interventions, I believe in the matter of education. [It is] *also a matter of intervening, of having a greater surveillance over the families, that they know there is a healthcare service that can also watch that. The school* [needs to] *be a partner of the healthcare unit; they cannot work separated* (P1).

primary intervention I believe is the home visit [done] *by the healthcare community agent, by the follow-up done by the team... a prevention factor* [is when] *the child goes to school. So then all institutions would be protecting this child, a child that would be monitored by the healthcare* [team] *as well as the education* [team] (P2).

I see that it is a primary intervention by means of groups, of education with family members who take care of children, who take care of the elderly. I believe it is about this education in general terms (P3).

[...] [with] *primary* [intervention] *what we can do is watch the family itself, by means of a community agent, in visits, done on a routine basis, and also home visits by the team. Then we are able to evaluate and guide this family as well* (N3).

The PPV professionals, although they do not clearly know the primary health intervention in conceptual terms, showed in the statements above a knowledge of the term as, in practice, they talk about actions that must be done to prevent domestic violence, chief among them the follow up and monitoring of the families by the healthcare teams and by the education teams. When they refer to these families, they possibly make reference to those that are most vulnerable, that is, those in which risk factors for violence predominate.

The statements revealed how closely allied the healthcare system and the community are by means of the presence of UBESF, and how this became an important instrument for more effective care and a wider coverage of the needs of the families. This is strengthened when it creates links with other entities in the community, building actual networks that provide a more concrete outlook on the situations that might trigger domestic violence.

The close relationship of the UBESF team with the community seems to be a crucial element for the process to come into play. The different perspectives of the UBESF professionals about the community enable them to gather knowledge about the family relationships in multiple ways. The sum of these perceptions makes it easier to spot the situations in which there might be domestic violence, as well as the risk factors.

The different ways these professionals work, in view of their education and of the work field at UBESF, may intervene in a positive or negative way in the development of primary interventions. However, this aspect does not seem to be a barrier when the work done individually happens with a common purpose and in harmony. Nevertheless, when it is necessary to use other psychosocial sup-

port services, the lack of communication tools such as reference and contra-reference actions makes it difficult to continue to provide care, especially if the risk factors are intense or if there is a history of domestic violence.

In this study, the risk factors were understood as individual and/or family conditions that increase the risk for the problem to occur. The factors most commonly found to trigger violence are: families that are going through a crisis or who have suffered from losses such as the couple splitting up, unemployment, or death; when dialog among the family members is difficult, creating lack of control and aggressiveness; and families in which there is substance abuse.

When talking about this, the professionals said that it was important to first do a community diagnosis, which is considered the basis for planning and scheduling violence prevention measures, and represents the technology necessary to organize the work process of the multidisciplinary teams who have to face problems that are poorly structured, complex, heterogeneous, and with different needs, and especially cases of extreme social vulnerability.[12]

Execution of primary intervention actions to prevent violence—ease and difficulties

Regarding the primary actions to prevent violence and the way they are carried out, the professionals described their experiences within the boundaries of their daily practice:

[...] *we try to accomplish a few things, we create orientation groups about violence, how to report an issue to the authorities, who to report* [...]. *The community agents also have a group*. [...] *There are always questions about this* [...] *We tell them that any report of an abuse or physical violence must be taken to the oversight authority in the form of an anonymous tip* (P1).

I think all the teams here one way or another end up doing this. Even by means of the visits. When a baby is born, we start this moment to see how the family deals with this birth and how to deal with situations of violence. I think that was it (P3).

We use groups a lot. I think that is where we do this, not only women's groups but also groups of teenagers, the elderly. In all of these groups we preach and we talk about the rights, you know, such as the Maria da Penha Law, like another type of - how do you say it? - the child and teenager act, the elderly act. We discuss them as rights, you know, that everybody has. So we bring prevention by means of this extended education system (N1).

Still, when they talk about the practice, it is clear that to these professionals prevention is directly related to the orientations given in groups about human rights by means of multidisciplinary work. Another aspect refers to the value given to every moment with the community as something unique and extremely important to prevent violence by means of proximity and orientation. It is beneficial to provide early monitoring of the developing families, in particular those that already show risk factors, and also an orientation to all of the members of the family with respect to how to look for help in situations of violence.

In this context, the following aspects facilitate the actions:

[...] *the facilitator is the fact that there is access. The community-based worker is a very big facilitator, he brings you the case in loco, he brings it very early on, many times even before the patient himself does it* (P1).

[...] *facilitating factors, I think it is the bond, the first thing, the bond is something that helps.* [...] *the multidisciplinary action* (P2).

[...] *facilitator? I think it is the groups* [...] *and the nursing care that we provide, in the case of my profession. And this bond that we have with each other. Even now we also have the support from Active Life, of the school itself that is being created here, close to the gymnasium, which is also from PPV, and takes many children out of the situation. I can offer them better working and education conditions. I think it helps a lot* (N1).

I think it is the bond. The connection, the fact that we know that the person knows that we are open for them to come and talk and clear a few things out. Because it is a network. It is the city, it is everybody working together, but everyone doing his own thing, and our follow up has a lot to do with it (N4).

For the healthcare professionals, one of the factors that facilitated the most in the case of the primary prevention actions against violence was the work of the community-based healthcare workers on the healthcare team, who were always present in people's homes. Because they were from the community, they knew the local reality and, generally, they were the first to have contact with families in a vulnerability situation or who were already experiencing domestic violence. In view of this, they offered important information to the team to design the therapeutic project to be implemented with each of these families, as well

as those who were seen as a potential threat and, therefore, needed continuous monitoring.

Another point to mention is the importance that the healthcare professionals assigned to building and strengthening the bonds with the families in terms of the proximity between the healthcare institution and the community. Because of how close they were to the families and the communities, the family healthcare teams are a strategic tool to cope with several forms of mental suffering.[13]

On the other hand, the professionals also mentioned factors that made primary prevention actions difficult:

not having access to these families, that is, families that do not allow us to visit. Families that do not use the service or that refuse to accept the service. I think this is a factor that makes it difficult (P2).

what really makes it difficult is not having a support network. Today there is a lot of talk about the existence of CRAS [the Reference Center for Social Work], CREAS [the Specialized Reference Center for Social Work], *the Guardianship Council, but actually I think this is an issue that is still regarded as a taboo. Also, the families, because there is low income, because they depend on the person perpetrating the violence, it is also difficult* (P4).

what makes it difficult? Sometimes we don't know what is really happening, right? This makes it difficult, when it is not seen by the family, you know? Like a violence that he is suffering from. This is what makes it difficult (N1).

I believe it is fear, the fear the family has of opening up the door, you know, of showing the reality inside their home. [...] *It is difficult to make a decision alone or not having this understanding of looking for a professional. But in most cases it is fear that holds these people back, and it makes us unaware of what is going on* (N2).

Regarding the factors that make primary prevention actions against domestic violence difficult, the professionals mentioned the families that do not seek out UBESF and do not accept the presence of the healthcare team or any professional at their homes, because these actions could allow their reality to result in an intervention and could bring disorder to the family.

Another aspect that was mentioned was the fact that some families subjected themselves to violence because the aggressor was the one who financially provided for the family. This situation reinforces submission, especially from women, from being financially dependent on the husband, and they end up accepting situations of violence and exposing the other members of the family to these situations. In addition, there is difficulty with the actual work of the social support network, which does not enable those who suffer from violence or who are in a risk situation to be seen by an expert team. There is also the difficulty of detecting and confirming cases where violence is suspected by the authorities, which prevents a more assertive action.

In a study conducted in Rio de Janeiro, it was found that although it is possible to identify domestic violence, some professionals still had difficulty considering the violence as a demand for a specific action from the healthcare sector, which certainly had repercussions in his involvement and consequent intervention.[14] This reinforces the possible lack of professional training to work on a primary healthcare level, which prevents early solution-based assistance from occurring in these situations.

The importance of primary interventions and the care provided

The following opinions reveal what the professionals think about the importance of primary interventions to prevent violence:

I think it is important; I think this is the essence of PPV. It is about having a general reduction so that there are no greater consequences afterwards (P3).

for sure, for the quality of life of these families, the follow up, and also because of a future disruption (P2).

I think so. It is important to do and maybe most important still would be that when we as professionals talk in our team meetings, in NASF meetings, which is the center of support for family health, that we really need to build this network and that it is effective (P4).

We are an area of PPV and we are really an area of great vulnerability, so this is one of our main works. To work on preventing violence, try to minimize these situations of violence. So, yes, it is extremely important for our work (N2).

You're not going to see violence and stand still and cross your arms. Somehow you'll have to act. It is trying every way possible, trying your best not to expose yourself, too (N3).

The primary intervention action is important, because it makes it possible to listen to claims about violence in its complexity, work with the extended concept of the health-sickness process, and create skills to deal with issues that go beyond

the biomedical paradigm.[15] Everyone who was interviewed considered the primary interventions as having great relevance for professional practice and to prevent violence, and they value the implementation of PPV. The statements show the concern of these professionals with the quality of life of the families they assist, and they contemplate assertive intervention as a way to prevent the possible consequences of violence. These also reveal a professional commitment to preventing violence and searching for ways in which to prevent these situations from being repeated.

When asked about the care provided in their work units with regard to primary interventions to prevent violence, we heard:

I think in general the care provided is good. I think it is a support of the strategy, especially from the PPV area for these families (P3).

We started not long ago in PPV. What I saw, and what they've done were educational campaigns that have happened from time to time at the gymnasium. They have done a walk for peace; they are all educational movements, but in our unit we still have not done anything different that I could tell you (P4).

I believe it is good, but we still have to build better qualities because we still have few professionals in the area, like psychologists, engaged in the system. I think it needs more support, you know? There is a lot of demand. Sometimes we don't have – it takes a little while to give help. Be we keep on going (N1).

what we have is, sometimes, a certain fear of taking cases forward, as we have had before. Not only with children and teenagers, but also with the elderly. You get exposed and the person who heard the report knows who it was. It makes your job very difficult. It had to be something more confidential but it is not. So we are afraid (N3).

Healthcare professionals considered the implementation of PPV as either "very good" or "good," but they showed a certain discontent with slow-paced actions in terms of the implementation of the program, especially when referring to the increased number of professionals working in the area and the inclusion of other professionals - among them a psychologist.

What also caused many concerns were the ethical issues, which are generally not considered in their professional work, causing fear for the team because they become totally exposed when they try to break the cycle of domestic violence, and it intimidates them. But it is possible to notice the commitment of the team when they execute the activities that their professional practice allows them to do, trying to reduce these cases.

FINAL CONSIDERATIONS

Based on this study, it was possible to understand the perceptions of UBESF healthcare professionals with regard to primary interventions to prevent domestic violence. Because it is UBESF, the professionals are closer to the families, which allow them to get to know them, especially by means of the information given by the community-based healthcare workers, who are inserted in the community, live the local daily reality, and are able to better detect when there are domestic violence cases.

Even with their difficulty in understanding and using the concept of "primary intervention to prevent violence," most professionals had the idea of the main actions that must be executed for it to occur, associating them with their availability to embrace the families, the creation of a connection between UBESF and the community, tracking the social groups that are vulnerable, and educating them about their human rights and their right to education and health.

The data showed that some actions of primary intervention to prevent domestic violence already take place in the daily activities performed by UBESF, in a multidisciplinary manner, by means of the nursing and medical visits, individuals, groups formed with the clients, orientation with respect to their rights as citizens, education for health, and the use of every moment with the community to strengthen ties.

The factors that facilitated the preventive measures against domestic violence were: the work of community-based healthcare agents; the ties to the community; and the partnership among schools. The factors that made this practice difficult were: the lack of access to the families that were afraid of a possible interference in their domestic environment; and the fact that there wasn't an actual authority in the teams' investigative actions to confirm suspicious cases, as well as lack of consideration of the ethical issues when the professionals reported cases in daily work life.

The importance of conducting primary interventions to prevent violence was mentioned by all who were interviewed, who referred to them as extremely relevant for their professional practice. The professionals in this study regarded the actions proposed by PPV and carried out by the

healthcare units as "very good" and "good." However, they showed a certain discontent toward the insufficient number of professionals available to do this job, as well as not having professionals in other areas, among them a psychologist, to provide a more specific type of care.

The interest of the professionals in committing to the interventions to prevent violence was also clear, as well as their commitment to reducing the cases of domestic violence. However, it is understood that they have not yet received the necessary training by the PPV to act in a safer and more effective manner according to the primary intervention intent of the program; this is probably why it was hard for them to understand the concept and to clearly define which actions should be prioritized.

This situation is understandable because, when the interviews were conducted, PPV had only been implemented for two years in the town and one year at the UBESFs, that is, at a time of adjustments toward the new proposal.

For healthcare professionals to be able to effectively prevent domestic violence, it is necessary to go deeper on this theme, starting with professional education and then the active participation in training as they work, which would allow for a performance based on results when facing situations of violence.

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