REME • Rev Min Enferm. 2017;21:e-1048
DOI: 10.5935/1415-2762.20170058

RESEARCH

WEAKNESSES AND POTENCIALITIES OF THE HEALTHCARE NETWORK FOR WOMEN IN SITUATIONS OF INTIMATE PARTNER VIOLENCE

FRAGILIDADES E POTENCIALIDADES DA REDE DE ATENDIMENTO ÀS MULHERES EM SITUAÇÃO DE VIOLÊNCIA POR PARCEIRO ÍNTIMO

FRAGILIDADES Y POTENCIALIDADES DE LA RED DE ATENCIÓN A MUJERES EN SITUACIÓN DE VIOLENCIA POR SU COMPAÑERO

Walquiria Jesusmara dos Santos [1]
Maria Imaculada de Fátima Freitas [2]

[1] RN. PhD student. Assistant Professor. Federal University of São João del-Rei – UFSJ, Dona Lindu Center-West Campus – CCO, Nursing Course. Divinópolis, MG – Brazil.
[2] RN. PhD in Educational Sciences. Full Professor. Federal University of Minas Gerais – UFMG, School of Nursing – SN, Department of Maternal and Child Nursing and Public Health. Belo Horizonte, MG – Brazil.

Corresponding author: Walquiria Jesusmara dos Santos. E-mail: waljsantos@hotmail.com
Submitted on: 2017/05/29 Approved on: 2017/08/15

ABSTRACT

The objective was to know how the interaction between women in situation of violence and the services of the institutional network of assistance to violence takes place in a Brazilian capital and know the weak and strong points of these services. A qualitative study was developed with 12 women in situation of domestic violence perpetrated by intimate partner, followed up at a Reference Center for Women's Health, in Belo Horizonte, Minas Gerais. The analysis of the interviews resulted in categories related to the weaknesses of the healthcare network services, the difficulties encountered by women in the search for assistance, and the aspects that facilitated their insertion into the network that constituted the strong points of the services in the care of this population. The results show the importance of the articulation between the healthcare network services and the professional qualification for the assistance to these women, as well as the interlocution of the reference service analyzed with other institutions.
Keywords: Violence Against Women; Domestic Violence; Social Networking; Intersectoral Collaboration.

RESUMO

O objetivo foi conhecer como ocorre a interação de mulheres em situação de violência com os serviços integrantes da rede institucional de atendimento à violência numa capital brasileira e as fragilidades e potencialidades desses serviços. Estudo qualitativo desenvolvido com 12 mulheres em situação de violência doméstica perpetrada por parceiro íntimo, acompanhadas em centro de referência no atendimento à mulher, em Belo Horizonte, Minas Gerais. A análise das entrevistas resultou em categorias relativas às fragilidades dos serviços da rede de atendimento, às dificuldades encontradas pelas mulheres na busca por assistência e aos aspectos que facilitaram sua inserção na rede e que se constituíram em potencialidades dos serviços na assistência a essa população. Os resultados mostram a importância da articulação entre os serviços da rede de atendimento e da capacitação dos profissionais para a assistência a essas mulheres, bem como a interlocução do serviço de referência analisado com outras instituições.
Palavras-chave: *Violência Contra a Mulher; Violência Doméstica; Rede Social; Colaboração Intersetorial.*

RESUMEN

El objetivo fue conocer cómo ocurre la interacción de mujeres en situación de violencia con los servicios integrantes de la red institucional de atención a la violencia en una capital brasileña y las fragilidades y potencialidades de estos servicios. Estudio cualitativo llevado a cabo con 12 mujeres en situación de violencia doméstica cometida por su compañero íntimo, atendidas en un centro de referencia de atención a la mujer en Belo Horizonte, Minas Gerais. El análisis de las entrevistas resultó en categorías relativas a las fragilidades de los servicios de la red de atención, a las dificultades encontradas por las mujeres en dicha búsqueda y a los aspectos que facilitaron su inserción en la red y que se constituyeron en potencialidades de los servicios en la atención de esta población. Los resultados muestran la importancia de la articulación entre los servicios de la red de atención y de la capacitación de los profesionales, así como la interlocución del servicio de referencia analizado con otras instituciones.
Palabras clave: *Violencia Contra la Mujer; Violencia Doméstica; Red Social; Colaboración Intersectorial.*

How to cite this article:
Santos WJ, Freitas MIF. Weaknesses and potencialities of the healthcare network for women in situations of intimate partner violence. REME – Rev Min Enferm. 2017[cited ____ ___ ___];21:e-1048. Available from: ________________ DOI: 10.5935/1415-2762.20170058

INTRODUCTION

Violence against women is a worldwide phenomenon, resulting from socially accepted cultural norms of power relations where men dominated women,[1] a gender-based violence defined as "any action or conduct based on gender that causes death, injury or physical, sexual or psychological suffering of women".[2,3]

The family institution is the main scenario for gender-based violence. About 70% of perpetrators are current or former partners of women.[1] Intimate partner violence (IPV) stands out among the forms of violence against women and includes acts of physical aggression, sexual coercion, psychological abuse or controlling behavior, with frequent association between different types of violence.[4]

IPV is considered a public health problem. Injury, trauma and death or long-term impacts that affect quality of life are products of IPV.[1]

Since the 1970s, international agreements and covenants have been adopted in to assure the women's rights and to eliminate violence have resulted from feminist protests and movements.[3]

In Brazil, until 2002, the guidelines for actions to combat violence against women were based on support for the construction of shelters and specialized police stations. Since 2003, public policies in this area have gained a new dimension with the creation of the Secretariat for Women's Policies and the implementation of other specialized services, such as women's reference centers and women's advocacy centers.[3,5] In 2006, the Law 11.340/06, known as the Maria da Penha Act, was specifically enacted to address domestic and family violence against women. This law establishes measures for the protection of women's physical integrity, rights and care, and demands that attention to women in situations of violence be given in an integral way from multiple care sectors.[2]

Social network is defined as the network of relationships that involve the subjects, such as people, institutions or social movements, and presents itself as an alternative to approach the dynamics of social relations that women in situations of violence develop with their environment.[5,6] This network may consist of family members, friends, co-workers, school or community members, including health care services, neighbors and persons who share, for example, the same religious belief, who provide help and support to reduce the effects of a crisis.[7]

Health care is a key component of the social network for women in situations of violence. It is composed by the articulated governmental and non-governmental institutions aimed at improving the quality of care, adequate referral and effective prevention strategies, including health, public safety, social and legal assistance, among others.[8]

Health services are part of the institutionalized network and are often sought by women in situations of violence who usually come to these services with vague complaints, avoiding to openly reveal their situation. Nonetheless, health professionals have difficulty dealing with social and cultural issues such as violence, as they are not directly related to illness but yet can lead to health damage.[9]

Knowledge about the ways in which socio-institutional networks are organized and interact to approach and assist women in situations of violence, as well as the ways in which women experience such situations, opens the possibility to understand the complexity of the social life involved in IPV.

The objective of this study was to know how the interactions between women in situations of violence and the healthcare network take place, and also to know the weak and strong points of these services that directly interfere in the effectiveness of the assistance from the perspective of women.

The results of the present study may contribute to the in-depth discussion about the interlocution of services that make up the healthcare network to women in situations of violence and provide integral attention to this population. It may also encourage further reflection on situation of women and on the public policies against such violence.

METHODS

Study with qualitative approach, based on concepts of Goffman's interactionism[10] and in the perspective of comprehensive sociology proposed by Petitat[11].

In the view of Goffman,[10] people live in a world of social encounters and they tend to develop patterns of verbal and non-verbal acts with which they express their opinions and their assessment on themselves and on the other participants. The perception of subjects on the social role they play establishes the symmetry of the communication process and sets the stage for the game of information.

For Petitat,[11] the individuals are ruled on biological bases of living beings, from birth to the most complex ways of human beings, to establish the connection between their inside and outside, to show or hide, to open or to conceal from others, by means of conventional signs, respecting or transgressing them. Each person can travel, virtually, through three axes of interaction: a) the possibility of expressing or not their thoughts and representations; b) the possibility of authentically expressing what he thinks or, on the contrary, expressing distortions in this respect; c) the possibility of respecting or not the conventional rules of exchange. Subjects pass between the poles of trust and distrust between each other, made explicit in the different ways of revealing and hiding, as something necessary and natural of the interactions of human beings.

Social interactions are established through the individuals' perception of themselves and their place in society. The social world is created and recreated by the interactions, through

mutual interpretations that provoke the adjustment of the social actors to each other.

Firstly, it was necessary to know the services that belong to the socio-institutional network of the municipality, the study scenario, in its objective, institutional, functional, structural and symbolic aspects, as proposed by Castoriadis.[13] These aspects are the substrate for the analysis of the social experiences of women in situations of violence, when confronted with the testimonies of the participants of the research. In order to know the institutional network, the researchers personally visited the State Coordination of the Network of Combat of Violence against Women and contacted the management and the coordination of the main services by telephone calls, asking on issues related to the operation of the services and the flow in the network. In order to complement the data, information available on the service's *websites*, public folders and public archives, and publications about the service network in the municipality were consulted. The services of the institutional network included several sectors, such as health, judiciary, public security and social assistance sectors.

The study scenario was a Reference Center for Women's Health linked to the municipality of Belo Horizonte, Minas Gerais. The data collection period comprised the interval between July 2015 and June 2016, and the project was approved by the Research Ethics Committee (REC) of the Federal University of Minas Gerais under Opinion nº 1,138,006, CAAE: 43697515.8.0000.5149. The research participants voluntarily accepted the invitation to participate in the study and signed the Informed Consent Term.

Twelve women who met the following inclusion criteria participated in the study: being over 18 years of age, having had at least one episode of IPV at some point in their lives, and in case of mental illness or drug use, being out of crisis and having conditions to dialogue. The number of participants was not defined *a priori* and the criterion of exhaustiveness of the data on the object researched was the basis to terminate the collection, considering that, in qualitative research, data must be collected during field research until saturation.[14]

To contact the participants, the interviewer attended the service on days previously scheduled by the management office. The invitation to participate in the survey occurred after the professional assistance given at the service. The interviews were scheduled for the next return consultation scheduled by the service, in the case of first visits, or on a date of preference of the participant. The mean duration of the interviews was 60 minutes. There was a formal presentation of the research in relation to the ethical aspects and the participants were informed about the research objectives, confidentiality of data, and the voluntary nature of the participation. Each participant was identified with the letter R (of respondent) followed by the number corresponding to the increasing order of each interview (I1, I2, ...). In order to collect data, a predetermined script was prepared to identify the participant's socio-demographic situation and material life context, followed by an open and in-depth interview, with the following guiding instruction: "I would like you to tell me your story, and describe the events of violence in your life and the services you sought in these situations". Eventual additional questions were included, when necessary, to help clarify situations and relevant aspects to the topic, especially with regard to respondents' assessments of the services that assisted them.

The interviews were audio-recorded and later transcribed verbatim for analysis.

Data were organized and analyzed using NVivo10©, based on the method of structural analysis of the speeches described by Demazière and Dubar.[15] For these authors, the interview is a moment of reflection of the interviewees in the interaction with the interviewer, which allows them to present their version of the facts, including justifications and feelings toward them, as well as people who have any relevance in these facts and feelings. This narrative takes place in a path of comings and goings, in a construction of meaning for oneself and toward others that is defined in sequences by object of speech.

The analysis is divided into four stages, according to a technique proposed by Blanchet and Gotman.[16] The first stage, called vertical reading, corresponds to the exhaustive analysis of each interview, searching for their individual overall meaning, which results in the knowledge of the "tone" of the interview and the identification of the themes present in it. In the second stage, called horizontal reading, the "deconstruction" and "reconstruction" of each interview is performed. The set of the text is sequenced by the subject treated and the sequences numbered in ascending order, listing the facts (F), the explanations, feelings or justifications (J), as well as the characters (C) present in the narrative. Then, sequences dealing with the same subject are grouped and are given a denomination that explains the central object of that speech, resulting in a first categorization of the individual narrative. In the third stage, the so-called transversal reading, the preliminary categories of the totality of the interviews are compared among themselves to unveil common and discordant points and to categorize the meanings explained in the final corpus, resulting in the final categories. The last stage of the work is the in-depth interpretation of categories constructed upon the theoretical reference and literature pertinent to each category.

RESULTS AND DISCUSSION

The participants of the research were in the age group between 35 and 61 years. The majority (seven) were separated from

the partner at the time of the interview. The level of schooling varied, with women with incomplete elementary education and others with postgraduate education, but the majority (10) had complete or incomplete elementary education. The same variation was seen with respect to family income, varying from one up to more than five minimum wages, considering the minimum wage in force of R$ 788.00. Ten interviewees declared themselves of brown color, and one black; 11 reported following a religion, being six evangelicals. They all had children, and the number ranged from one to four; nine of them were using controlled medications. The sociodemographic data showed thus a great variability in the age, education and income of the interviewed women compatible with the profile of Brazilian women in situations of violence, according to Senate Data,[17] as violence is considered a phenomenon that affects different age and social groups. This same study shows that the majority of women in situations of violence professes some religion and indicates a growth in the homicide rate of Brazilian black women.

The qualitative analysis of the interviews showed that the variability of the socioeconomic profile is not relevant with regard to interactions and resulted in categories related to the interactions of women with people and institutions in the search for care in the institutional network of care for violence, highlighting the weaknesses and potentialities of this network, which represent important and essential aspects for breaking away from the situation of violence.

Fragilities of network services

The interviewees highlighted the "(dis)articulation among the network's services" is one of the main reasons for discontentment, which may impair the continuity of care:

> *They told me I had to go there in the MLI for examination of evidence of crime by the aggression, but the MLI was far and I had no car. Then I spent the whole night waiting… I was interviewed there in the Specialized Court too, you have to go to several places; you end up very confused. You say, "I'm being assisted there in the reference center" and they say: "we have nothing to do with that reference center, we are a state institution, and that center a municipal institution" […] Then, you call the police and say: "My ex-husband is calling me and threatening me, I have to make a police report" and they say, "Yeah, I'm going to do the report of the incident, but it is the civilian police that makes the inquiring, what is the civilian police doing?" I say, "I do not know". We get very discouraged (I1).*

The diverse demands of women in situations of violence go beyond the solving power of a single sector; an articulated set of intersectoral actions is rather necessary.[18] The interactions leave the main interested person powerless, debilitated, which is absolutely necessary for them to survive, physically and emotionally, to the event and to have autonomy to make decisions. Lack of information and solidarity can aggravate the situation. The clear definition of flows, i.e. the agreement on what will be done by each service, seems to be a key factor for networking, to draw the flows and disseminate the information among all the actors involved. This would allow professionals to know exactly what to do and where to direct the cases.[19]

The process of interaction between the various sectors that make up the network is only possible through mutual knowledge, with information about their competencies, attributions, locations, internal and external processing, as well as hours of operation.[18] The availability of transport between the services is another aspect that could ensure not only the reception but also the flow of referral when the services are geographically distant. Traveling these distances by public transport, in a time of emotional, physical and, in many cases, financial fragility can be very difficult.[19]

Professional unpreparedness for reception of women

The interviewees reported on experienced facts that revealed unprepared service professionals, lack of humanization in care, not to mention lack of resolution, with interactions that do not encourage confidence, do not protect women, but rather expose and weaken them:

> *I showed that my arms were scratched. I was all bruised; my knee had a band and all. Limping. Then she said: "You're saying you're in pain, but it's no use. Is it really injured under that?" "No, ma'am, he twisted my leg and shifted it, it's inside." Then she said: "I'm not seeing your pain, you're the one saying it, I don't know if you're telling the truth or a lie". That was how she treated me (I7).*

> *When I arrived with the report at the health center, the psychologist there turned to me and said she could not help me. Besides, she put me in a very uncomfortable situation at the health clinic, because everyone knew my story … Because the pastor's wife works at the clinic. That became the subject of gossip there (I8).*

Based on Petitat,[11] we can say that these interactions are unequal in nature, but they are professional relations between users and professionals and, therefore, should happen with maximum trust between the parties, licit attitudes, with discreet disclosure, secrecy between the actors and within the

institution, as well as respect for the expression of the other, regardless the so-called "evidence of aggression suffered". Reception must be characterized by ethical stance, taking on the responsibility of "sheltering" others in their demands. This conception is in line with the concept of transversality of care, which aims to place the users and their needs at the center of attention, configured by the articulated actions within a service or between services in the same intersectoral network.[8]

Studies[9,20] have revealed that inadequate information and unacceptable attitudes and moral judgment are frequent in the trajectories of women in situations of violence, in a route called "critical route", because the decisions and actions of women to break up the cycle of violence are made ineffective when they are inadequately hosted or blamed for the event, rather reiterating the violence.

It is noteworthy that part of the reports on the difficulties met in the reception of women refers to the attitudes of health professionals:

> *There in the health center everyone knows [the situation of violence], but no one has ever talked to me about it. I went there once because I was nervous. Then I gasped, felt like faint, the doctor even cursed me. Because I had a health insurance plan, right? He said, "What are you doing here? You do not have to come here, you have health plan". The service was terrible. Very bad. It was not the first time that this happened (I6).*

Violence is a very peculiar object in the health field. In the professional sense, these issues are regarded as objects belonging to social sectors such as the Judiciary or Public Security, thus falling outside the scope of the health sector. The "invisibility" of violence in health services, or even their stigmatized or prejudiced visibility, shows the importance of integration between health actions and those of other sectors of social production.

Failure in service resolution

The speeches reveal that the demand of women seeking support in the network services is often unmet:

> *When I went to the police station for women's protection, I did not get an answer, so I went back home. Then I said, "My God! There is no other way out, the way out is this; I'm already in this life". So, you have to bear it and keep on [in the relationship with the partner], it's the way I have it, try to live, accept it! (I5).*

> *He is still coming into the house because the protective warn has not yet reached his hands. They did not find him. And he says thus: "there is no document that forbids me coming in, I'll come in whenever I want" (I10).*

The credibility and resolution of specialized network services, in addition to the support of family and friends, favor the search for professional help.[21] As explained in the lines, the opposite can also happen. When the demands of women are not welcomed and they do not feel supported in social or institutional networks, they may simply remain in the situation of violence.

Thus, the feeling of impunity of the aggressor and the lack of resolution of the services lead the woman to distrust the protection and security system:

> *The protective warn does not mean that ... it gives you a backup... he is not allowed to contact me on the phone, he cannot approach me closer than 200m, he cannot attend my work or my residence. If he does it, I'll call the police and they'll arrest him, but if I provoke something, I'm going to die, do you understand? So it helps, but it does not help much (I1).*

Corroborating the data of the study, Boira[22] emphasizes the permanent sensation of impunity as a factor that can influence the decision to denunciate the aggressor, because impunity undermines the confidence in the institutions and leads the violated woman to the false or true confirmation that their feelings and experiences have no social value.

Despite the progress made by public policies and the social organization and distribution of services specifically aimed at violence against women, many difficulties still persist with regard to both the quality of care offered in each services and the capacity to respond to the search for help of women on their routes to deal with the violence they experience.[9]

However, although meeting objective demands and the hosting by the services are important, the answers to IPV cannot be centralized in these components, because this issue is part of a culture that reproduces relations of subordination and is inserted in the quotidian life. In this sense, it is necessary to incorporate new ways of doing and weaving the support network for women, allowing a flow between institutions and significant actors in the women's environment. Mapping the social networks of women in situations of violence can be a privileged strategy for the identification of existing forms of mediation, favoring the proposition and planning of specific public policies.[6]

Potentialities of healthcare services to women in situations of violence

This category includes the narratives that show feelings of appreciation of the assistance received in the components of

the network, which is configured in the potential of these services because it positively impacts the empowerment of these women, which can be a crucial factor for the rupture with the situation of violence.

Reception, qualified listening and creation of bond between professionals and users

In the same way that the failures in the reception represent a difficult aspect of the persistence of women in the care network, the perception of support and reception was a positive aspect found in the narratives on the search of care in public agencies. Among the services that offer reception and bond with professionals, the reference center was highlighted. This center functions as articulator of the network's services and its actions aim to contribute to the reassurance of women in situations of violence who search for their rights as citizens, by means of permanent follow up:

> *I arrived here defeated. And I was welcomed. It was a very important moment in my life to have arrived here. And then I found support in the reference center, right? Today I say that here is my space (I5).*

In the scenarios of violence, the reception based on the principle of integrality, on the part of professionals, introduces possibilities of intervention and action, favoring the person's self-perception and the reflection on what to do and how to act in life. Therefore, the respectful and careful treatment of professionals who assist women in situations of violence conveys commitment to users of services. The way in which the relationships between women and the actors of the institutions that support them are established influences the way in which this support is perceived. As the women realize the existence of an extended listening for their needs, there is a higher possibility of connection with the service and of breaking up with the violence[5], as explicit in the speech of I8:

> *Here in the reference center I have a good relationship and I even asked to be assisted only by P. We created a bond. When I'm in trouble I'll call her. And I call every five minutes until I can speak to her. I feel comfortable talking to her. I try to tell her everything, better than making something silly (I8).*

The bond allows the establishment of trust between the women in situation of violence and the professionals, which is essential for these women to break with stigma and verbalize their situation and feelings, allowing them to escape the anguish that can lead to death ("doing something silly").

In order to understand the reasons why women were exposed or remain in situations of violence, it is necessary that professionals try to understand their experiences and feelings. Therefore, empathy is one of the main mechanisms of humanized care and it is necessary for the construction of a link to provide effective care, generate referrals, guidelines and possibly prevent the recurrence of other violent acts.[23]

Empathy is the basis for reliable interactions and is a therapeutic tool that allows a form of subjective exchange and qualified listening to be established in the reception of each user who needs care.[24]

However, the results of the present study, including the strategies for reception of women in situations of violence and the way they are treated, show that empathy varies according to the service. This depicts the fragmentation of the network. The results reinforce what was found by Lettiere and Nakano,[8] when they affirm that the perspectives adopted by the institutions that make up the healthcare network are directed towards the specialization of care of each institution, without integral and transversal attention, ultimately hindering the quality of the assistance.

It should be emphasized that primary healthcare services were not a specific and in-depth subject of the present study and this represents a limitation of the study, because it is assumed that women who have established ties with family health teams receive more qualified care in regard to listening on the axis of integrality. However, these services need to be articulated with the health network and support to women in situations of violence in order to enable the continuity and effectiveness of the actions, which was not mentioned as a rule by the interviewees.

Something that needs also to be mentioned is that, despite the saturation of data without new elements that should be further analyzed in the collection, not all the realities of women living in situations of violence perpetrated by intimate partner in Brazil were treated here, also representing a limitation of this study. There are different contexts and the unpredictability of violence that can lead to other impositions and conflicts that should be taken into account by professionals who serve this population.

FINAL CONSIDERATIONS

Domestic violence perpetrated by intimate partners is a worldwide phenomenon and is influenced by cultural norms based on patriarchal ideas and gender inequality. Women's decisions and actions to maintain themselves or to break up with a situation of violence can be influenced by a number of factors, including the support received from their network of individual relationships, community resources and institutionalized network services. Because of the complexity of the phenomenon, women in situations of violence may have demands for

care in various sectors: health, judicial, public security, social assistance, among others.

The narratives of women in situations of violence in the search for care in services of the healthcare network made it possible to unravel how the interactions for the assistance to women take place, providing either more or less effectiveness. Weak and potential points of the services were detected, opening opportunity for the improvement of care.

As the main weaknesses found in the services, the interviewees mentioned the disarticulation between the network services, the professional unpreparedness for the reception and the failures in the resolution of the service.

Reception, qualified listening and creation of bond between professionals and users were cited as aspects that stimulated the insertion of women in the healthcare network, facilitating their confrontation and the search for rupture with the situation of violence.

The analysis of the results shows a fragmentation in the attention to women in situations of violence, demonstrated by the lack of articulation between services of the institutional network, in which each component restricts itself to the specific assistance provided in the sector, and have unprepared professionals. These aspects can combat or push women into the submission logic imposed by the partner and now by the institution.

Health services should act more efficiently in detecting situations of violence and be more actively articulated with other sectors, since they are important components of the institutionalized network and one of the main entry points for women in situations of violence.

In order to strengthen the healthcare network and guarantee integral assistance to women served by the various sectors of the network, it is essential to establish effective communication between services, with the definition of flows and responsibilities, as well as an interdisciplinary and transversal view of all the services and professionals involved.

We hope that the present study contribute to broadening the knowledge about violence against women and promote new reflections on the conditions of women in situations of violence, through an understanding of their experiences and their interactions with services of the institutionalized network. Furthermore, studies addressing the experiences and points of view of people living such serious social problems can contribute to the development of public policies against violence, as well as open space for new debates and research on the subject. In the area of health care, these studies may allow for in-depth reflection on the performance of health services as an important part of the institutionalized network and organization of care for these women and their families, with a focus on health promotion and integral care.

REFERENCES

1. Ambriz-Mora MI, Zonana-Nacach A, Anzaldo-Campos MC. Factores asociados a violencia doméstica en mujeres mexicanas vistas en primer nivel atención. *SEMERGEN* - Medicina de Familia. 2015[cited 2017 Jan 15];41(5):241-6. Available from: https://medes.com/publication/101153
2. Ministério da Saúde (BR). Lei Maria da Penha: Lei nº 11340 de 7 de agosto de 2006. Cria mecanismos para coibir a violência doméstica e familiar contra a mulher. [cited 2017 Feb 02]. Available from: http://www.planalto.gov.br/ccivil_03/_ato2004-2006/2006/lei/l11340.htm
3. Presidência da República (BR). Secretaria Especial de Políticas para as Mulheres. Política Nacional de Enfrentamento à Violência contra as Mulheres. Brasília: Presidência da República; 2011.
4. World Health Organization - WHO. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva: World Health Organization; 2010.
5. Dutra ML, Villela WV. O setor saúde e a configuração da rede social de mulheres em situação de violência doméstica. *BIS Bol Inst Saúde*. 2012[cited 2017 Jan 15];14(3):266-73. Available from: http://periodicos.ses.sp.bvs.br/scielo.php?script=sci_arttext&pid=S1518-18122013000400003&lng=pt&nrm=iss
6. Dutra ML, Prates PL, Nakamura E, Villela WV. A configuração da rede social de mulheres em situação de violência doméstica. Ciênc Saúde Coletiva. 2013[cited 2017 Jan 15];18(5):1293-304. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232013000500014&script=sci_abstract&tlng=pt
7. Krenkel SM, MORE CLOO, Motta CCL. The significant social networks of women who have resided in shelters. Paidéia (Ribeirão Preto). 2015[cited 2017 Jan. 15];25(60):125-33. Available from: http://www.scielo.br/scielo.php?pid=S0103-863X2015000100125&script=sci_abstract&tlng=pt
8. Lettiere A, Nakano AMS. Rede de atenção à mulher em situação de violência: os desafios da transversalidade do cuidado. Rev Eletrônica Enferm. 2016[cited 2017 Jan. 18];17(4). Available from: https://www.revistas.ufg.br/fen/article/view/32977
9. D'Oliveira AFPL, Schraiber LB. Mulheres em situação de violência: entre rotas críticas e redes intersetoriais de atenção. Rev Med (São Paulo). 2013[cited 2017 Jan 15];92(2):134-4. Available from: https://www.revistas.usp.br/revistadc/article/view/79953
10. Goffman E. A representação do eu na vida cotidiana. 9ª ed. Petrópolis: Vozes; 1999.
11. Petitat A. Secret et morphogenèse sociale. In: Petitat A. Secret et formes sociales. Tradução de Maria Imaculada de Fátima Freitas para fins didáticos, com autorização do autor. Paris: PUF; 1998. p. 139-160.
12. Le Breton D. L'interactionnisme symbolique. Paris: Puf; 2004.
13. Castoriadis C. A instituição imaginária da sociedade. Tradução Guy Reynoud. 2ª ed. Rio de Janeiro: Paz e Terra; 1982.
14. Driessnack M, Souza VD, Mendes IAC. Revisão dos desenhos de pesquisa relevantes para Enfermagem: part.2: desenhos de pesquisa qualitativa. Rev Latino-Am Enferm. 2007[cited 2017 Jan 17];15(4). Available from: http://www.scielo.br/pdf/rlae/v15n4/pt_v15n4a25.pdf.
15. Demazière D, Dubar C. Analyser les entretiens biographiques: l'exemple de récits d'insertion. Paris: Nathan; 1997.
16. Blanchet A, Gotman A. L'enquête et ses méthodes: l'entretien. Paris: Nathan; 1992.
17. Senado Federal (BR). Secretaria de Transparência. Coordenação de Controle Social. Serviço de Pesquisa do Data-senado. Violência Doméstica e Familiar contra a Mulher. Brasília: DATASENADO; 2015.
18. Menezes PRM, Lima IS, Correia CM, Souza SS, Erdmann AL, Gomes NP. Process of dealing with violence against women: intersectoral coordination and full attention. Saúde Soc. 2014[cited 2017 Jan 15];23(3):778-86. Available from: http://www.scielo.br/scielo.php?pid=S0104-12902014000300778&script=sci_arttext&tlng=en

19. Brigagão JIM, Santos FBP, Spink PK. A sustentabilidade e a continuidade de redes de articulação: o caso do Iluminar Campinas. Saúde Soc. 2016[cited 2017 Jan 15];25(2):361-8. Available from: http://www.scielo.br/pdf/sausoc/v25n2/1984-0470-sausoc-25-02-00361.pdf
20. Sagot M. Ruta crítica de las mujeres afectadas por la violencia intrafamiliar en América Latina: estudios de caso de diez países. Washington: PAHO; 2000.
21. Silva RA, Araújo TVB, Valongueiro S, Ludermir AB. Enfrentamento da violência infligida pelo parceiro íntimo por mulheres em área urbana da região nordeste do Brasil. Rev Saúde Pública. 2012[cited 2017 Jan 15];46(6):1014-22. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102012000600011
22. Boira S, Carbajosa P, Méndez R. Miedo, conformidad y silencio. La violência en las relaciones de pareja em áreas rurales de Ecuador. Psychosocial Intervention. 2016[cited 2017 Jan 15];25(1):9-17. Available from: http://www.sciencedirect.com/science/article/pii/S1132055915000381
23. Visentin F, Vieira LB, Trevisan I, Lorenzini E, Silva EF. Women's primary care nursing in situations of gender violence. Invest Educ Enferm. 2015[cited 2017 Jan 15];3(3):556-64. Available from: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0120-53072015000300020
24. Abritta SD, Roque FCF, Ramos MEC. A importância do acolhimento e do aquecimento em grupos sem demanda no contexto da Justiça. Rev Bras Psicodrama. 2015[cited 2017 Jan 15];23(2):6-15. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S0104-53932015000200002

CC BY This is an open-access article distributed under the terms of the Creative Commons Attribution License.