



CARE TO WOMEN IN SITUATIONS OF MARITAL VIOLENCE IN PRIMARY CARE O CUIDADO À MULHER EM SITUAÇÃO DE VIOLÊNCIA CONJUGAL NA ATENÇÃO PRIMÁRIA ATENCIÓN A LAS MUJERES EN SITUACIONES DE VIOLENCIA CONYUGAL EN ATENCIÓN PRIMARIA

Nadirlene Pereira Gomes¹, Alacoque Lorenzini Erdmann², Talita Castro Santos Garcia³, Cláudio Claudino da Silva Filho⁴, Rosana Santos Mota⁵, Telmara Menezes Couto⁶

ABSTRACT

Objective: to understand how to caring of women in situations of domestic violence in primary care. **Method:** a qualitative study was developed with the support of Grounded Theory, with 47 professionals interviewed linked to the Family Health Strategy in a municipality of Santa Catarina/SC, Brazil. The analysis of the data was done at the same time of the collection, from the open coding process, axial and selective, comparative form and constant. The research project was approved by the Ethics Committee in Research, CAAE 01291412.3.0000.0121. **Results:** on suspicion or identification of domestic violence, women are referred for care at the psychologists and social assistants of the Support Center for Family Health. Psychosocial support is essential in the process of empowering women to confront the domestic violence, being important to reflect the greater availability of psychologists and social assistants within primary care. **Conclusion:** signals to the importance of teamwork in transdisciplinary perspective, especially for coping effectively complex problems, such as domestic violence. **Descriptors:** Violence Against Women; Family Health; Comprehensive Health Care; Women's Health.

RESUMO

Objetivo: compreender como se dá o cuidado à mulher em situação de violência conjugal na atenção primária. **Método:** estudo qualitativo, desenvolvido com o suporte da Teoria Fundamentada nos Dados, com 47 profissionais entrevistados vinculados à Estratégia de Saúde da Família em um município de Santa Catarina/SC, Brasil. A análise dos dados, concomitantemente à coleta, deu-se a partir do processo de codificação aberta, axial e seletiva, de forma comparativa e constante. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE 01291412.3.0000.0121. **Resultados:** diante a suspeita ou identificação de violência conjugal, as mulheres são referenciadas para atendimento junto a psicólogos e assistentes sociais do Núcleo de Apoio à Saúde da Família. O apoio psicossocial é essencial no processo de empoderamento das mulheres para o enfrentamento da violência conjugal, sendo importante refletir a maior disponibilidade de psicólogos e assistentes social no âmbito da atenção primária. **Conclusão:** sinaliza-se para a importância do trabalho em equipe na perspectiva transdisciplinar, sobretudo para enfrentamento eficaz de problemáticas complexas, como a violência doméstica. **Descritores:** Violência Contra a Mulher; Saúde da Família; Assistência Integral à Saúde; Saúde da Mulher.

RESUMEN

Objetivo: entender cómo dar atención a las mujeres en situaciones de violencia marital en la atención primaria. **Método:** estudio cualitativo, desarrollado con el apoyo de la Teoría Fundamentada en los Datos, con 47 profesionales entrevistados vinculados a la Estrategia de Salud de la Familia en los municipios de Santa Catarina/SC, Brasil. El análisis de los datos, de manera concomitante a la recolección, se llevó a cabo en el proceso de codificación abierta, axial y selectiva, de forma comparativa y constante. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación, CAAE 01291412.3.0000.0121. **Resultados:** de la sospecha o la identificación de la violencia doméstica, las mujeres son referidas para la atención a los psicólogos y los trabajadores sociales del Centro de Apoyo a la Salud de la Familia. El apoyo psicossocial es fundamental en el proceso de empoderamiento de las mujeres para enfrentar la violencia conyugal, siendo importante para reflejar a la mayor disponibilidad de los psicólogos y los trabajadores sociales en la atención primaria. **Conclusión:** las señales de la importancia del trabajo en equipo en una perspectiva transdisciplinaria, especialmente para hacer frente a los problemas con eficacia complejos, como la violencia doméstica. **Descriptores:** Violencia contra la Mujer; la Salud Familiar; Atención Integral a la Salud; Salud de la Mujer.

¹Nurse, Professor Post-Doc, Department of Community Nursing/Post Graduate Program in Nursing, Federal University of Bahia/PGENF/UFBA. Salvador (Bahia), Brazil. E-mail: nadirlenegomes@hotmail.com; ²Nurse, Professor, Department of Nursing/Post Graduate Program in Nursing, Federal University of Santa Catarina/PEN/UFSC. Florianópolis (SC), Brazil. E-mail: alacoque@newsite.com.br; ³Nurse, Specialist in Family Health, Health Department of the State of Bahia/SESAB. Salvador (Bahia), Brazil. E-mail: taly_garcia1986@hotmail.com; ⁴Nurse, PhD in Nursing, Post Graduate Program in Nursing, Federal University of Santa Catarina/PEN/UFSC. Florianópolis (SC), Brazil. E-mail: claudiocfilho@gmail.com; ⁵Nurse, Master of Nursing, Assistant Nurse of the Maternity Tysilla Balbino. Salvador (Bahia), Brazil. E-mail: rosana17santos@yahoo.com.br; ⁶Nurse, Professor, Department of Community Nursing, Federal University of Bahia/UFBA. Salvador (Bahia), Brazil. E-mail: telmaracouto@gmail.com

INTRODUCTION

Violence against women is an interlocutory appeal in Brazil, with sociopolitical and economic repercussions. In 2009 and 2010, there were 100.849 reported cases of domestic violence, sexual and/or other violence across the country.¹ In the first half of 2012, there were 388.953 attendances of violence against women by Call 180, and in 70,19% of cases, the perpetrator is the victim's spouse or partner. When added other affective ties (ex-husband, boyfriend and ex-boyfriend), this figure rises to 89,17%.²

As the Inter-American Development Bank (IDB), violence against women has high financial costs. About 10% of the Gross Domestic Product (GDP) is used annually as a result of this violence, which represents US\$ 84 billion in annual costs that involve the health system, with treatment of injuries to health, police and judicial process and medical costs for licenses as a result of violence.³

In addition to the economic consequences, there are the social and health. Studies indicate that health services most wanted by women victims of sexual and domestic violence are the emergency rooms and primary care services, which, despite being directly involved in this demand, continue to present fragmented care and poor solutions.⁴⁻⁵

With respect to primary care, the bond and closeness with the community, the family health teams working in the Family Health Strategy (FHS) are in prime position to recognize the situations of violence. The link-building and accountability between professionals and users over time reduces the ignorance of life histories and care coordination.⁶ Considering these precepts, one must be a constant attempt to contemplate the complex reality of the health of populations included.

In order to supplement the care of patients seen by primary care through the ESF, the Ministry of Health through Ordinance 154 of 2008 created the Center for Health Care for the Family (NASF), consisting of teams of professionals in different areas knowledge. Thus, in order to expand the scope of work and the solvability of primary care, the NASF appears to support the inclusion of the ESF network services supporting the specialties not covered by the minimum specified in the Policy team early. Thus, the work processes of family health teams, with the support of NASF, enable addressing situations not previously recognized as a health problem, such as domestic violence against mulher.⁷⁻⁸

The NASF has the basic precept interdisciplinary work and matricial, that constitutes a privileged space for the permanent formation of teams, which can be exchanged and learning by supporters matrix that experience to apply their knowledge in a context fraught with variables that are not always a specialty alone could manage, nor is accustomed to deal.⁸ matrix support is a work methodology complementary to hierarchical systems, which seeks to provide backup care professionals and specialized teams in charge of care for health problems , sometimes complex. In the case of situations of domestic violence against women, the matricial health team family psychosocial knowledge is fundamental,⁹ signaling for integrating professional psychologists and social workers in NASF.

Considering the magnitude of domestic violence against women and the need for its confrontation of different and complementary knowledge and practices, such as the performance of the NASF, this study showed the following question: What are the meanings attributed by professionals working in the ESF on the process of care to women in situations of domestic violence? This stemmed from the question of the study: What are the meanings of actions and interactions experienced by professionals on the practice of nursing and health care for women in situations of domestic violence in the context of primary health care?

OBJECTIVE

- To understand how the care of women in situations of domestic violence in primary care.

METHOD

Article compiled from the Report Postdoctoral << Women in situations of domestic violence: building practices of nursing and health in FHS >> presented to the Graduate Program in Nursing of the Federal University of Santa Catarina/UFSC. Florianópolis - SC, Brazil. 2012

The study was developed with the support of Grounded Theory, also known as Grounded Theory (GT).¹⁰ While qualitative methodology, PDT furthers our understanding of the interactions and actions experienced by the subjects, revealing, therefore the proper object of study proposed.

Linked to post-doctoral project entitled "Women in situations of domestic violence: building practices of nursing and health in ESF", and under funding from the Research

Foundation of the State of Bahia (FAPESB), the study was conducted in a municipality in the state of Santa Catarina, Brazil. Had as a backdrop, 16 health teams five local health units that comprise a particular Sanitary District. The choice of the health district was made because the units are placed in communities with different socio-economic contexts, allowing a broader understanding about the care of women in situations of domestic violence.

It was considered as a criterion for selection of subjects, be professional working in the FHS of the municipality. The subjects were defined as recommended by the PDT, respecting the principles of theoretical sampling. The first group was composed of 17 nursing technicians, 13 nurses and 12 doctors. The purpose of this group was to get answers on the question: How is the care to women in situations of domestic violence within the ESF? Analyses were concurrent with data collection, enabling us to discover and understand the codes and the initial categories of analysis.

The data in the signal the importance of investigating the relations of Family Health with the NASF specialties: psychiatry, psychology and social work that, for cases of domestic violence were considered by the members of the first group as more prepared to approach and care the woman. This fact led us to formulate hypothesis and new issue, resulting in the composition of the second sample group. This was composed by professionals Psychiatrists (2) Psychologists (2) and social worker (1) comprising the NASF district under study. The objective of this group is to better understand the process of care to women in the experience of violence by these professionals.

As sampling technique was used to interview opened, allowing the subject to speak freely on the topic introduced by the researcher. This freedom to express him allows a broad exploration of their content.¹¹ Data collection was conducted between May and August 2012, in the physical space of the units in a private room, indicated by the professional in order to ensure your privacy and confidentiality of information. The interviews were recorded and transcribed with the support of the *Microsoft® Office Word*. The data were organized from the *NVIVO®*.

The analysis of data was done through a process of open coding, axial and selective, occurring concurrently with the collection of the same, in a comparative and steady as prescribed PDT. In the encoding process, were

assigned to each idea a code, which constituted the primary categories, which were compared for similarities and differences thus elaborating the conceptual data. In axial coding, these codes or concepts were regrouped in subcategories related to each other, giving rise to the categories. The categories and subcategories are still related to each other, in selective coding, when it was based the model paradigm that guides connections between categories based on the identification of those showing the context, causal conditions, intervening conditions, strategies action/interaction and the consequences, allowing you to find the core category: the phenomenon.¹¹

The relationships and interactions led to the formulation of the phenomenon: "Recognizing marital violence as a public health problem and the need for management to comprehensive care to women." This paradigmatic model was validated by professionals working in the health district, the locus of the study and subsequently by 10 researchers with expertise in PDT.

It is noteworthy that the 47 professionals were informed about the purpose and relevance of the study and invited to constitute themselves subject, signing the Instrument of Consent in which ethical contain registered in order to comply with the resolution n. 196/96 of the National Health Council for the confidentiality of information, the subjects were identified by the initials of the professional category, followed by an Arabic numeral. The project was approved by the Ethics Committee of the Federal University of Santa Catarina (opinion n. 21560/2012, CAAE 01291412.3.0000.0121).

RESULTS

In the context of care for women in experience of domestic violence within the ESF, we present the category "Describing the process of care to the woman," which includes the following subcategories: Nurses and physicians referring to psychologist and social worker NASF; Referring on contributions of the psychologist and social worker and NASF; Describing the interaction process reference team and NASF.

◆ **Nurses and doctors referring to psychologist and social worker of NASF**

The study indicates that, given the suspicion experience of domestic violence by women, nurses and doctors who work in teams of reference seek support from a psychologist and social worker NASF:

[...] We say: "You want to support? It psychologist. "We offer support, leads the psychologist [...] and we will know then that there was a particular problem with her and her husband. Sometimes I could not scoop it, but then she reveals. So suspicious, since the psychologist forwards NASF. (E6) Perhaps the social worker knows more. [...] I think it gives more security to address and do not pass up the cases that sometimes will not directly bring violence. So when I suspect I do I forward to a psychologist or social worker (M3)

As talk of health, confirmation of the history of domestic violence sometimes occurs only with the support of social workers or psychologists. Thus, women in when identifying the experience of domestic violence, the study shows that nurses and doctors refer to the psychosocial care with professionals that comprise the NASF, as illustrated in the following lines:

[...] Whenever I caught one such case, I at least I forward for the psychological and social assistance. (E12)

We have social workers, psychologists NASF. Then, the support group helps a lot in that time. [...] That part of violence stays more with the social worker and psychologist. (M3)

◆ Speaking on the role of the psychologist and social worker of NASF

The consultation of women in situations of domestic violence can happen only with a psychologist or social worker or together with professionals from the reference, as illustrated by the lines:

Sometimes we care integrated with a psychologist or social worker, with a doctor and nurse. (M10)

That day, I made along with the nurse and staff nurse technician, who were the ones who called me. Sometimes, we also trigger the welfare of their own NASF. (Pc1)

Health professionals interviewed both nurses and medical staff reference as psychiatrists, psychologists and social workers the NASF report that psychosocial support empowers women to break with the violence experienced.

With respect to psychological support, the lines point to the importance of the psychologist in the rescue process, construction of women's empowerment:

The psychological part because she could help build other outputs. [...] To locate the situation, you get to see it from another angle; I got out of the situation of victims of violence. (M1)

[...] We evaluate what has happened in relation to it. [...] She goes on a binding dependency that the other will meet me in anything, but she thinks she cannot live alone [...] then she is subject to this situation. (Pc1)

Social support to women experiencing intimate partner violence as means to the interviewees, assist in referrals to cope with the situation, either for specific services or to integrate them in stocks for income generation. To illustrate such support, follow the excerpts from speeches:

We're seeing the socioeconomic conditions of her and tries to help [...] see the housing situation, knowing the family. (PC2)

You need social support to help her find a job [...] stimulate go after, so she can be independent. (E2)

If you need to change locations of the city, the social worker to see where she can go, where she will make this support. Also refer to reference house or police station (Pc1).

◆ Describing the process of matricial to psychologists and social workers of NASF

When you detect or suspect cases of marital violence, nurses and physicians surveyed refer matricial with professionals psychologists and social workers the NASF. This process of interaction between staff and NASF reference is given as follows:

[...] We have our day mapping cases. On the day, we separate the cases I find most important and discuss with them. From my story: they do visit, they do an investigation, they call for service. (E12)

When demand requires a faster, we sometimes end up doing the matricial outside the meeting. (E7)

During the matricial, professionals discuss the case with others of different areas, which allows to draw a more comprehensive care plan to the demands made by women and also to accompany her in the process.

At the meeting, we are looking for is seeing if she returned to present another violent framework. For this, we discussed at the meeting, who are all professionals involved from the pharmacist, psychologist, and social worker, nurse and community health workers. (M10)

At the staff meeting, where are all professionals, we take the case of the user to the meeting and discuss with the professional which is the situation: they are case studies and develop strategies with respect to that patient, and ideally, all patients could spending. Here we receive guidance on how to cope. (E7)

The study indicates further for understanding by the professional team of reference for its responsibility to monitor the

woman, although there matricial next to the psychologists and social workers NASF.

We still always watch, even if the psychologist or you are with the social worker. [...] Always continues with the staff team family health nurse and doctor, which makes coordination of care and have to know what each is doing and we end up having meetings with all of them. (M3)

Not so: "The patient comes here and ready! Serve and never see. "We have everything on record. So to see the psychologist care of her, I see [...] I know the continuity that is being given to my work. I am responsible for her care. (E12)

DISCUSSION

Considering the cases of domestic violence, professionals who work in family health teams seek psychosocial support among professionals of the NASF. The difficulties encountered by nurses and medicine to meet women in situations of domestic violence are also backed studies with health professionals, revealing that they do not feel able to provide care to women, limiting itself to treating physical injuries and refer them to the police sector.¹²⁻⁴

Health professionals have difficulty identifying the experience of domestic violence. A study of women in this situation revealed that there is a difficulty for health professionals in recognizing the violence experienced by women. Even recognizing violence against women as a serious and important, health professionals have little knowledge about what to do in these cases, there is a tendency to reductionism biologist and fragmented in the health of women.^{5,12,14} Another study of nurses who work in family health units revealed that they do not feel prepared to serve this clientele, although pointing experiments show that the presence of this reality services.¹³

It is worth mentioning the importance of matricial because it facilitates the linkage between the two teams. This occurs more commonly from conducting consultations and joint interventions, and 9 must exist for effective coping violence since disciplines and knowledge alone are not enough to care for women raped.¹⁵

The study also reveals the contributions that these professionals can enable the woman in order to assist them in the process of preventing and coping with the phenomenon, and providing opportunities for women perceive themselves as subject. The technical-scientific evidence to prove that the psychologist worked synergistically with the

family health team favors another look at the subjectivities of users SUS, so that reframe the disease process, and empower to exercise better self-care.¹⁶ Thus, in the context of domestic violence, this work to empower the woman herself to find outlets for a life free of violence, perceiving themselves as subjects of rights.

Thus, it is clear the importance of psychosocial support to women victims of violence. Health professionals interviewed both nurses and medical staff who reference as part of the NASF also agree that care by psychologists and social workers empower women to break the violence experienced. Although in specific cases, the professional NASF can schedule appointments or other activities of specialized interventions,⁹ as recommended work processes NASF team, the individual and specific care should be the minimum possible and referrals should not be performed frequently and / or a part of the flow unit (Decree 154, 2008).⁷ Given this assumption and the importance of psychosocial support to women in situations of domestic violence suggests the inclusion of psychologists and social workers in the reference teams.¹⁶⁻⁷

It is worth noting that the team is up while NASF team matricial and therefore you're doing should be to equip the professionals of the health team to deal with family violence cases, as well as create together with the FHS strategies to address the problem, in order to reduce damage and improve the quality of care of the most vulnerable groups. Considering the referencing of women in situations of domestic violence to psychologist and social worker NASF, the study provides a better understanding the process of interaction between reference staff and professionals of NASF, which occurs most commonly in regular meetings with the entire group the matricial professionals.⁸ is another opportunity to discuss a plan of care individualized to the situation of the woman who supports her to break the cycle of domestic violence, free from moral judgment or giving faults to the permanence of women in the experience of violence.

From the discussion of complex cases-such as violence, support matrix enables the NASF team action, together with the team of family health, the development of unique therapeutic projects, allowing the collective appropriation, violence situations.^{8,9,18} thus became evident as soon as the matrix support implies the construction of an integrated treatment plan between the healthcare team and family team NASF.

The construction project is a unique therapeutic space for the realization of actions multidisciplinary, transdisciplinary and exercise shared responsibility.^{7,9} In this context, the study reveals the importance of spaces for dialogue of knowledge and consequently the matricial the care of women, especially when the NASF integrates psychosocial professionals with knowledge to face the marital violence.¹⁶⁻⁷

The model of care outlined by the FHS team requires constant interaction between professionals and the knowledge available to the care of individuals. Sharing in team situations/problems allows the development of alternative coping and enabling the participation of fundamental knowledge to the case at hand. Therefore, staff meetings, while indispensable tool in the work process into healthcare family, are not only moments to the distribution of tasks and should be understood as a dialogic space and pleasurable, where everyone has the right to voice and opinion.¹⁹ Study shows the importance of NASF in the process of effecting the exchange of knowledge and guidelines between teams as well as assessment of cases and reorientation of conduct.⁹

It is noteworthy that even that has the matricial NASF of professionals, nurses and doctors on the team are responsible for minimum care, should take responsibility for monitoring the longitudinal case of conjugal violence and thus conduct care plan individual, family and collective. The reference staff is critical to enhance accountability, formation of therapeutic relationship and comprehensiveness of care, offering a treatment dignity, respect, and quality care.¹⁹

CONCLUSION

Based on the meanings attributed by professionals working in the FHS from the municipality , the care of women in situations of domestic violence requires psychosocial support, so that the suspect or identify such a situation, nurses and medical teams comprising reference the women to meet with psychologists and social workers the NASF.

It is noteworthy that in the spaces systematic meetings, nurses and doctors indicate cases in which it needs the support of psychology and/or social service, when the matricial schedule, which is often performed in conjunction with one or more members of the core team. In the meeting, both define the need for continuity of care specific, which should, however considering the low supply of these professionals, since they are not unique

to particular ESF. In the case of the municipality locus, two psychologists and a social worker are responsible for 16 local health teams studied. This situation represents an important limitation regarding the quality of care to women in situations of violence, committing the care and overall contributing to the permanence of masking the problem in the community.

Psychosocial support was considered essential in the process of empowering women to confront the domestic violence, particularly by seeking to restore the autonomy of women and the referrals to care services and/or programs for income generation. However, it is important to reflect on the situation and limitations of professionals within the NASF, which should support the professional reference staff alone and do not assume such consultations, ensuring, for the constitutional principle of full accountability and guidance provided in the National Humanization. In this context, it signals to the reflection on the need for inclusion of psychologists and social workers in the reference teams.

For Nursing, the study indicates the importance of teamwork in transdisciplinary perspective, especially for coping effectively complex problems such as domestic violence. Implies the need to listen to other studies, the health managers involved in the formulation and execution of policies for primary health care in order to understand how mean marital violence as object of activity of the ESF, and soon, as prioritize formative processes for raising these social actors.

FINANCING

Study carried out with financial support from the Research Foundation of the State of Bahia (FAPESB).

REFERENCES

1. Ministério da Saúde [BR]. Vigilância de violências e acidentes (VIVA). Violência doméstica, sexual e/ou outras violências. Brasília (DF): MS [Internet]. 2011 [cited 2012 June 13]. Available from: <http://dtr2004.saude.gov.br/sinanweb/tabnet/dh?sinannet/violencia/bases/violebrnet.def>

2. Secretaria de Políticas para as Mulheres (SPE). Balanço Semestral - Janeiro a Junho/ 2012. Ligue 180- Central de Atendimento a Mulher. Brasília (DF) [Internet]. 2012 [cited 2012 Dec 20]. Available from: <http://www.sepm.gov.br/publicacoes-teste/publicacoes/2012/balanco-semester-ligue-180-2012>

3. Superintendência de Política para Mulheres (SPE). Violência contra a mulher custa 10% do PIB brasileiro. Salvador (BA) [Internet]. 2011 [cited 2012 Nov 18]. Available from: http://www.spm.salvador.ba.gov.br/index.php?option=com_content&task=view&id=405&Itemid=2
4. D'Oliveira AFPL, Schraiber LB, Hanada H, Durand J. Comprehensive health (care) services to women in gender violence situation - an alternative to primary health care. Ciênc saúde coletiva [Internet]. 2009 July/Aug [cited 2013 Feb 14];14:1037-50. Available from: <http://www.scielo.org/pdf/csc/v14n4/a06v14n4.pdf>
5. Santi LN, Nakano AMS, Lettiere A. Domestically abused Brazilian women's perceptions about support and received support in its social context. Texto & contexto enferm [Internet]. 2010 July/Sept [cited 2012 Oct 14];19:417-24. Available from: <http://www.scielo.br/pdf/tce/v19n3/a02v19n3.pdf>
6. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica [internet] 2012 Brasília: Ministério da Saúde [cited 2013 Feb 17]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_atencao_basica.pdf.
7. Brasil. Ministério da Saúde. Portaria 154 de 2008. Cria os Núcleos de Apoio à Saúde da Família - NASF [internet]. 2012 Brasília: Ministério da Saúde [cited 2013 Feb 17]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2008/prt0154_24_01_2008.html.
8. Mangia EF, Lancman S. Núcleos de Apoio à Saúde da Família: integralidade e trabalho em equipe multiprofissional. Rev ter ocup [Internet]. 2008 May/Aug [cited 2012 Dec 12]; 19(2): i-i. Available from: <http://www.revistas.usp.br/rto/article/view/14030/15848>
9. Campos GWS, Domitti AC. Matrix support and reference team: a methodology for interdisciplinary health work management. Cad saúde pública [Internet]. 2007 Jan/Feb [cited 2012 Dec 15]; 23(2):399-407. Available from: <http://www.scielo.br/pdf/csp/v23n2/16.pdf>
10. Strauss AL, Corbon J. Pesquisa Quantitativa: técnicas e procedimentos para o desenvolvimento da Teoria Fundamentada. Porto Alegre: Artmed; 2008.
11. GIL AC. Como elaborar projetos de pesquisa. 4th ed. São Paulo: Atlas; 2009.
12. Lettiere A, Nakano AMS, Rodrigues DT. Violência contra a mulher: a visibilidade do problema para um grupo de profissionais de saúde. Rev esc enferm USP [Internet]. 2008 Sept [cited 2012 Nov 18];42(3):465-71. Available from: <http://www.scielo.br/pdf/reeusp/v42n3/v42n3a07.pdf>
13. Bezerra IMP, Nascimento WL, Machado CA, Machado MFAS. Enfermeiro da estratégia saúde da família frente à violência conjugal: analisando o processo de trabalho em saúde. Sau & Transf Soc [Internet]. 2012 [cited 2012 Dec 17];3(2):67-74. Available from: <http://periodicos.incubadora.ufsc.br/index.php/saudeettransformacao/article/view/1493/1773>>.
14. Vieira LB, Landerdahl MC, Padoin SMM. Identification and Referrals Given to Situations of Violence Against Woman by Health Professionals Those Work in a Teaching Hospital. Rev enferm UFPE [Internet]. 2010 Apr/June [cited 2012 Nov 17];4(2): 722-9. Available from: <http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/viewArticle/893>
15. Gomes NP, Diniz NMF, Silva Filho CC, Santos JNB. Enfrentamento da violência doméstica contra a mulher a partir da interdisciplinaridade e intersetorialidade. Rev enferm UERJ [Internet]. 2009 Jan/Mar [cited 2012 Nov 12];17(1):14-7. Available from: <http://www.facenf.uerj.br/v17n1/v17n1a03.pdf>
16. Costa DFC, Olivo VMF. New meanings for the psychologist practice in the Family Health Program. Ciênc saúde coletiva [Internet]. 2009 Sept/Oct [cited 2012 Nov 12]; 14(1):1385-94. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232009000800011&lng=en.
17. Ribeiro RS. O trabalho do assistente social e sua inserção no processo de trabalho em saúde: um olhar sobre a atenção primária e a estratégia saúde da família. Libertas [Internet]. 2008 Jan/June [cited 2012 Feb 10];8(1):91-109. Available from: <http://www.editoraufjf.com.br/revista/index.php/libertas/article/view/1781>
18. Oliveira GN. O projeto terapêutico e a mudança nos modos de produzir saúde. São Paulo: Hucitec; 2008.
19. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Humanização - Formação e intervenção [internet] 2010 Brasília: Ministério da Saúde [cited 2013 Feb 17]. Available from:

http://bvsmms.saude.gov.br/bvs/publicacoes/cadernos_humanizaSUS.pdf

Submission: 2013/01/10

Accepted: 2013/10/09

Publishing: 2013/11/15

Corresponding Address

Nadirlene Pereira Gomes

Rua Jardim Vera Cruz / Quadra 05 / Lote 08

Bairro IAPI

CEP: 40340-590 – Salvador (BA), Brazil