ABSTRACT
Objective: to analyze the collective construction of a municipal service network for prevention and referral of victims of violence through primary care. Method: this is a qualitative study based on action research, conducted with 24 professionals from a basic health unit in Mossoró, Rio Grande do Norte, Brazil. Data were produced with the focus group, workshop, and semi-structured interview and they underwent the content analysis technique after approval by the Research Ethics Committee of the Federal University of Rio Grande do Norte (UFRN), under the CAAE 0176.0.051.000-10. Results: we found out fear and lack of knowledge to prevent and refer cases of violence; actions to prevent and fight violence are not effectively performed. Participants received training on the use of the violence notification form. The commitment to notify possible cases in the area concerned was declared. Conclusion: the network was partially implemented, requiring monitoring along with the staff at the unit. Descriptors: Nursing; Network; Violence; Primary Care.

RESUMO
Objetivo: analisar a construção coletiva de uma rede de serviços municipais para prevenção e encaminhamento das vítimas de violência a partir da atenção primária. Método: trata-se de estudo qualitativo baseado em pesquisa-ação, realizado com 24 profissionais de uma unidade básica de saúde em Mossoró (RN). Os dados foram produzidos com o grupo focal, oficina e entrevista semiestruturada e submetidos à técnica de análise de conteúdo após a aprovação pelo Comitê de Ética em Pesquisa da Universidade Federal do Rio Grande do Norte (UFRN), sob o CAAE n. 0176.0.051.000-10. Resultados: foram constatados medo e desconhecimento para prevenir e encaminhar os casos de violência; ações de prevenção e combate à violência não são desenvolvidas efetivamente. Os participantes receberam capacitação sobre o uso da ficha de notificação da violência. Foi declarado o compromisso de notificar possíveis casos na área de abrangência. Conclusão: a rede foi parcialmente implantada, requerendo monitoramento junto à equipe da unidade. Descriptors: Enfermagem; Rede; Violência; Atenção Primária.

RESUMEN
Objetivo: analizar la construcción colectiva de una red de servicios municipales para la prevención y el direccionamiento de las víctimas de violencia desde la atención primaria. Método: esto es un estudio cualitativo basado en la investigación-acción, llevado a cabo con 24 profesionales de una unidad básica de salud en Mossoró, Rio Grande do Norte, Brasil. Los datos fueron producidos con el grupo focal, taller, y entrevista semi-estructurada y sometidos a la técnica de análisis de contenido después de la aprobación por el Comité de Ética en Investigación de la Universidad Federal de Rio Grande do Norte (UFRN), bajo el CAAE 0176.0.051.000-10. Resultados: se constató miedo y desconocimiento para prevenir y direccionar los casos de violencia; acciones de prevención y combate a la violencia no se llevan a cabo con eficacia. Los participantes recibieron capacitación acerca del uso de la forma de notificación de violencia. Se declaró el compromiso de notificar posibles casos en el área de alcance. Conclusión: la red fue parcialmente implantada y requiere un monitoreo por parte del equipo de la unidad. Descriptores: Enfermería; Red; Violencia; Atención Primaria.
INTRODUCTION

When thinking through the historical and social content and the pandemic proportions that violent events and their consequences bring to the victimized groups, it is argued that violence is a complex, conflictive, multivariate, and worrying phenomenon, particularly for the health sector. Violence itself consists in a social problem, non-specific to the health field. It affects those involved both due to the deaths, injuries, and traumas caused and to the impact generated on living conditions and health status. This impact requires the formulation of specific policies and the organization of practices and peculiar services. Violence currently constitutes, along with the chronic and degenerative illnesses, a new epidemiological profile in the Brazilian health context. The phenomenon starts requiring an approach with which the health system is not accustomed and trained to deal.1

Depending on the requirements and complexity of violence as a phenomenon, working within networks has been proposed. The Health Care Networks are conceptualized as: “organizational arrangements of actions and health services, with various technological densities, which, interconnected by means of technical, logistical, and managerial support systems, seek to ensure a comprehensive care”.2

Networks, as a way of acting, not only have the task of large-scale protection, but also of leading violence, its causes and consequences to be recognized as a problem that affects individuals and the collectivity, even if violence involves an abominable and wicked nature, this phenomenon has a cure.3,12,30

Among the possible strategies for working in networks, the importance of the Family Health Strategy (FHS) has been discussed, which favors getting closer and bonds between community and health team. Scholars have shown the effectiveness of FHS in the prevention, identification, and referral in face of situations of violence, enabling guidance in conflicts and ways of coping.4

In the context of FHS, although health professionals occupy a strategic position to identify cases of violence, this practice faces challenges, low professional qualification with regard to the theme and to the denunciation procedures stand out. In the domain of primary care, the profession has redesigned its actions so that it can meet users' health needs, being not limited to the medical-curtative reasoning.5

The findings exposed in face of the magnitude of the problem contributed to outline the following questions: “How do primary care professionals act to prevent and refer the cases of violence?”; “What are the prospects for change in the work of primary care professionals by means of educational activities?”.6

Given the above, it is assumed that violence must be seen in a network, which articulates the interpersonal relationships in families, in the streets, in the health services as a means of prevention, strengthening work in primary care and, on a priority basis, that of nursing. Indeed, the study on violence, from the perspective of prevention, will result in the need and ability to develop concepts and theories and try a comprehensive way to provide nursing care. Thus, this study aims to analyze the collective construction of a network of municipal services for prevention and treatment of victims of violence through primary care.

METHOD

This is a study with qualitative approach from the perspective of action research. It was conducted at the Family Basic Health Unit in the neighborhood Carnaubal, in the town of Mossoró, Rio Grande do Norte, Brazil. The study sample consists of 24 professionals from the two family health teams working at the said unit; only 1 professional refused to participate. Among the participants, we have: 2 physicians (PHY), 2 dentists (DEN), 2 nurses (NUR), 7 community health agents (CHA), 3 nursing technicians (NTech), 2 dental office assistants (DOA) and, also, support professionals, i.e. 2 receptionists (REC), 1 facility manager (FM), 1 administrative agent (AAG), 1 social worker (SW), 1 pharmacy assistant (PA), and 1 nursing technician (NTech).

In the inclusion criteria, the professionals described were included and the students holding a scholarship and the employees who spontaneously decided to do not participate during the study were excluded, as well as those in sick leave or vacation.

We adopted as techniques for producing data: the focus group, workshop, and interview. Data were collected from February to October 2011.

We explained the research proposal to the participants and the confirmation of participation took place by signing the free and informed consent term. All steps were recorded in digital media, stored in a

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database and, later, transcribed and analyzed.

Data analysis was performed by means of thematic analysis guided by the theoretical framework of Paulo Freire, through the liberation pedagogy, who claims that learning “is, first of all, learn to read the world and understand its context.”

During the analysis we performed, then, a detailed reading of all the answers by the research subjects. At this stage, there was a text division, selecting words and sentences that appear more frequently or with more emphasis. Through the words or expressions grouped by thematic richness, we defined the generating themes for analysis.

We obtained the approval by the Research Ethics Committee of the Federal University of Rio Grande do Norte (UFRN), under the Opinion 158/2010 and the CAAE 0176.0.051.000-10.

**RESULTS AND DISCUSSION**

The implementation of the network begins with the situation analysis, characterizing the research participants and identifying their views on violence.

The 24 participants were aged between 27 and 61 years. Regarding the length of professional experience, most of them work for over 10 years. It is highlighted that professionals with more training and experience can be resistant to the change that the FHS proposes and, as a consequence, to the actions to be performed in this context; among these actions, stands out the prevention and fight against violence, reflecting the training process derived from previous curricula driven by sickness and poorly aimed at public health.

Thus, we asked the participants about violence within the unit’s area. If the option is liberating and humanizing, “[...] we cannot start with our generating words, but, on the contrary, we have to conduct a survey among people in order to know their words [...]”.

Participants demonstrate to know the types of violence and the proportions of this phenomenon. They emphasize as generating theme the domestic violence, often concealed or regarded as a way to educate, and the violence against women.

*It is very frequent that a child comes to the unit along with her/his mother who does not allow her/him to talk. Children and women are silent for fear of further ill-treatment.* (CHA)

It is emphasized that the mother is also a victim of violence, both directly and indirectly, as she accompanies the suffering of her children. Studies conducted in some developing countries indicate a strong correlation between violence against women and violence against children.

Participants demonstrate to be aware of the effects and harmful consequences of violence on people’s lives.

*Either a physical or mental aggression, it leaves scars for the rest of life and emotional disorders. (NUR)*

*Violence is strong nowadays, both physical and psychic, leading people to convey violence among themselves and leaving marks.* (PA)

When participants were asked about what actions to prevent and fight violence were performed at the unit, we found out that thematic violence requires a multidisciplinary, intersectoral, inter-institutional work with an emphasis on health education. They do not point out effective actions, justifying with the point that health professionals cannot act alone with regard to the cases, requiring support from other institutions, although they indicate the needed and indispensable interface to solve the problem, i.e. health education.

*There is a need for a multidisciplinary approach and support from the community, police, school, so that there is awareness on the part of the family and everyone.* (NUR)

This way, it becomes evident that care for the victims need to be grounded on multiprofessional knowledge, with teamwork and cohesion, in order to avoid the risk of individual and omnipotent care, which, although seeming to be virtuous, is ineffective and dangerous for everyone involved.

Health education constitutes one of the main working tools at the FHS and, although permeating the professionals’ discourse, there is at the services a gap between the education practice and the health promotion proposal.

These findings expressed by most professionals reflect silence, the lacunar aspect of violence as an object of health practices, either by work overload or fear to denounce, as well as the apparent lack of qualification to deal with the violence situations and referral of victimized subjects. These factors contribute to the invisibility of violence, making it a problem that involves a difficult intervention.

We infer about the viewpoint adopted by some professionals working at primary care that working from the perspective of preventing/identifying/minimizing violence or promoting health is not within their scope, commitment, or responsibility.
There are explanatory models for the distance, silence, and unspoken face of violence, among them, for the purposes of this study, stands out work overload, consistent with our findings. In health services, the indirect effects of violence at the workplace, such as discouraging to work, poor conditions of service provision, among others, represent an important and invisible cost of violence. If, on the one hand, violence can make the service worse, on the other hand, it can also be caused by users' dissatisfaction with regard to the quality of care, creating a vicious cycle that could feed back into the problem.12

People attribute to the lack of professional training the inexperience to intervene in violence situations, making professionals lack confidence and be uncommitted to the fact. Thus, understanding that the complexity of this problem requires intervention measures specific to each case, that is why some individuals believe in the development of protocols with guidelines, routines, and ethical-legal, theoretical-practical procedures to drive professional practice, even recognizing that, in addition, the professional must break with the socially constructed barriers and those conveyed in the form of taboo, prejudice, and omission.

As a result of this viewpoint distant from violence, we observe a fragmented, individualized, and curative work, where violence itself, the conception of victim, the aggressor, the body site affected, and the victimization condition restricted to a specific social context, therefore known, reflects strong emotional and affective load. Perhaps, it contributes to the legitimization of violence and its consequences.

The focus group proved to be successful to address this problem. Therefore, it is recommended that the focus group constitutes a powerful space for discussion, learning, and fight against the problem and that it can and should be shared by professionals, managers, association leaders, and others, in order to establish a dialogical relationship in face of the issues inherent to violence. Thus, the focus group is legitimized as a dialogic space, where suggestions and solutions may be thought and agreed in the local context of victimization in order to minimize/eliminate violence from the daily life of communities, without disregarding the ministerial recommendations about this issue, but understanding in loco the multiple causes of this problem.

Beforehand, people knew about the shy actions undertaken that raised the doubt with regard to what they believe to be needed to put into practice the prevention and referral of violence. Mostly, the professionals express the need for structural changes and training.

Nothing will provide results only, then, what is lacking, indeed, is a intersectoral network of services, working together to cope with violence. (AAG)

We observed in the speech the need for intersectoral work. There emerges the relation of violence to health, translated into an approach from the perspective of the formation of networks. Health care networks are health service organizations, connected to each other, having common goals by means of a cooperative and interdependent action.13

The organizational arrangement into networks in health care allows us to offer a continued and comprehensive care to a given population with low budget and financial cost and an emphasis on the quality of care actions, in a humanized, equitable, decentralized, universal, and comprehensive way, taking into account commitment and sanitation, economic, social, and political accountability, able to generate value, beliefs, and affirmative attitudes towards the population.

It is agreed that, alone, no level of health care systems has all the resources and skills needed to meet the population's health needs, since it implies the urgent need to constitute interconnected networks, recognizing and appreciating the interdependence and, often, the conflicts between social actors and various organizations in shared power situations.14

Regarding training, one professional states that there is a need to:

Organize workshops, training sections with regard to violence are among the most relevant strategies, they take a look at what we can and cannot do on the issue of violence. (SW)

Some professionals claimed that risking themselves in order to prevent violence is not among their duties.

I realize it in the area, but, for fear of reprisals, I keep silent. (CHA)

I do not realize it, but, if I noticed it, I would have the courage to denounce it. (CHA)

The disengagement tone, emanated by most participants, raises a concern with regard to the proposals to solve this problem, where fear of coping in health and of the unknown and complex world of violence make them unable to find means and ways to prevent and refer the cases of violence occurring within the area where they work,
and, mostly, the professionals felt victims of occupational violence, having in mind the proportions that violence have reached in the unit’s area.

For us, health professionals, fear of working with violence still stands out. We see that we are working in an area of much risk, we get to the point of making a home visit and being rejected because the household has a drug-addicted adolescent. (NUR)

[It is] like defending ourselves at the workplace, because the user arrives here with the knife hitting the counter. (NTech)

Given the concern deriving from participants’ emotions and feelings, exemplified in the last speeches above, we started a discussion to grasp the next steps of the study from Freire’s perspective. We claim that the directions are possible projects and, as a consequence, awareness does not involve only knowledge, but choice, decision, and commitment.  

Collectively, we selected as a priority through the understanding and need to modify the reality of violence and the new field of health care, conducting a workshop to train professionals on the use and handling of the violence notification form. After this pact agreed by all workshop participants, there emerged the need to assess in a procedural way. Thus, we demonstrated the positivity of group discussions, as a dialogic space able to express, capture, drive, and evaluate doubts, anxieties, defenses, insights, and provide with visibility the problems experienced at the FHS, going beyond the objective of this study, recognizing and legitimizing the productive and emancipatory potential of the group.

The first step to form the network: workshop for using the compulsory notification form of domestic, sexual, and/or other kinds of violence.

The notification form as a tool in the prevention and referral of cases of violence is the key object of this discussion. Therefore, we addressed its objectives and importance for the work at the FHS and the instructions for adequate filling of the form.

In the context of coping with juvenile violence, this action represents an important public policy instrument, since it enables measuring the phenomenon, evaluating the investment needs, by means of the surveillance and assistance centers, as well as it allows conducting researches and increasing knowledge on the problem. The act of notifying may be understood as a crucial element in the timely action against violence, in the global political action, and in the understanding of this phenomenon.  

We emphasized the need to notify as an instrument for the publicizing of cases of violence in the area where the team operates, comparing the disclosure of cases that echo in the media. Notification was stressed as a way to contribute to the development of public policies to act against the problem and, also, that information of a health problem is not an act of denunciation.

In this regard, notification goes beyond the scope and boundaries of the health service, since it calls for institutional partnerships, becoming indispensable to the area.  

Paradoxically, obligation and non-compliance with this requirement, as a means of notifying cases in all life cycles on the part of surveyed professionals, reflect the downgrading and disengagement with the legal and ethical compliance obtained in the process of preventing and fighting against violence and that their failure is foretold in article 66 of the Decree Law 3,688, enacted in 1941, as a criminal misdemeanor involving a failure of the health professional who does not communicate a crime of which she/he became aware through her/his work.  

I thought the notification was only in order to let the Health Ministry know, I did not know it had legal implications. (NUR)

The Children and Adolescents’ Statute (ECA) provides for the specific role of the health and education sectors, making them accountable as privileged spheres of protection, with power to notify violence situations, in search of solutions to protect the victim and support her/his relatives. It also addresses the requirement that doctors and other health professionals, teachers, or individuals in charge of teaching institutions notify the (suspected or confirmed) cases for the competent authorities, providing a fine from 3 to 20 reference wages in cases of omission.

Through the introduction of the notification form, the discussions were driven by questions made by the participants and the reports of situations experienced within the unit’s area.

Who will notify? (SW)

Is there telephone notification or just through the form? (CHA)

Where is this form available? (AAg)

After filling it, where do we send it to? (DOA)

Is this notification confidential or the professional’s name has to be informed? (CHA)

Thus, it was clarified that filing the notification form is a responsibility of all professionals at the FHS, thus, the ability to do that is a requirement. It is assumed that,
after the workshop, all the unit’s staff has become able to use it, because the notification is not characterized as a denunciation, but as an information about a health problem. The record also aims to generate a profile of problems and demands and, this way, provide means for the proper planning of care for the victims in the basic units and in the system as a whole.16

We called the attention, after filling the form, for the important and needed actions, i.e. refer to the competent municipal agency and inform the Child Guardianship Council by phone, in the case of violence against children and adolescents. We stressed that the notification is confidential, the professional does not need to sign, but only register the code of the National Register of Health Care Facilities (CNES). This notification is also named “faceless” notification, because it does not identify who notified.

In the workshop, we explored all items of the notification form in detail. Faced with doubts, questions, and clarifications, we chose and asked for the description of a case where violence was suspected as a way to drive the explanations on the typology of violence. Thus, the case below was intended to clarify through a concrete situation the kind of violence:

There is a child, she is 3 years old, her mother locks her outside home early in the morning, she puts water in a bowl and biscuit in another one, goes out and sometimes just goes back in the afternoon. The neighbors have called the police, which broke the gate open and took the child; when the mother arrived, she was informed of what had happened, came to the police station and brought the child back. She spent a few days without doing this, but now she is doing that again. (CHA)

There is a case within the area that the mother took the boy out of the school to beg. (CHA)

We observe, through the nature of their working process, that the CHAs identify cases of violence situations. It was clarified that the cases fall under the guilt criteria, because the essential tripod is involved: recklessness, malpractice, and negligence, along with abandonment; in all cases, the occurrence of negligence is attributed, therefore, the professional is required, addition to notify, to inform the Child Guardianship Council so that appropriate measures are taken.

As expected, through the case expressed, other doubts emerged on the form regarding the filling of a field concerning the way how the injury was caused, exemplified below:

Do we notify the attempted murder by knife or gun? (NTECH)

It was explained that the victims are adults, aged from 20 to 59 years, therefore, there is a need for filling the form because this kind of violence has other notification sources, such as police stations specialized in homicide.

The strategy of presenting situations derived from professional practice has led to questions about filling that deal with sexual violence, becoming key to the discussion of participants, since they classify as more difficult to detect:

People arrive with a nervous breakdown, so, we notice it before the physical features. (NUR)

Here, there were emergency contraceptive pills, but they expired and we threw them away because they were not used. (FM)

We find out the recognition of the sexual violence situation and the victimization condition, as well as guilt and worthlessness among those seeking health services, just as they recognize the lack of training to deal with victims. We stressed the unit’s role in such cases, although the emotional and affective loads brought by the victim are not less important and significant, which is providing the emergency contraceptive pill before referring patients. We called attention to the emergency contraceptive pills with regard to deadline and validity, avoiding waste due to their distribution.

Regarding the filling, we emphasized the need to register the code of the health care facility in CNES, even not signed by the professional, the importance of closing the cases and, also, the use of notification as the first step to curb cases of violence. After the explanations, filling itself began through the study of a fictional case, prepared by the instructor.

The case study reported the situation of an adolescent who came to a health service accompanied by her stepfather, barely communicating, with bruises in various stages, throughout her body and scars on her back and arms. In addition to a fracture in her right hand and punctate burn on her back. The case was reported to the Child Guardianship Council and she was taken to hospital for treating the fracture.

The professionals showed to be able to use the notification form, filling it with ease. By reading the case, the participants pointed out that the victims of violence seek more the hospital than the unity. We stressed the obligation of health services with regard to
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the notification, in which the hospital is included.

At the end of the workshop, we assessed learning about the notification form:

> It was very good, it became clear how to use the form and do not get exposed. (CHA)
> It is a way to do our part against violence. (NUR)

Learning was great, but I do not believe in notification confidentiality. (CHA)

Through the speeches, it is possible to notice the positivity of workshop, but fear keeps emerging as a hindrance for taking actions against violence. By discussing the professionals’ reluctance with regard to denunciation and notification of cases of violence, it is claimed to be based on the thought that the responsibility to act in face of the problem is an exclusive task of the legal agencies; on the uncertainty about suspicion; on the belief that action concerns only the treatment of injuries; and on the disbelief with regard to the actual intervention possibilities in cases of violence.18

Assessment of the actions taken

By fulfilling the steps of action research, we assessed the actions taken through the application of a semi-structured interview to participants. We asked about change in professional practices after the workshop, and generating themes emerged, such as the recognition of risks, the way how to act in face of violence and the need for commitment on the part of professionals:

> I increased my knowledge about violence and learned to identify when it is a situation of risk for violence. (NTech)

> I am observing the families more closely during home visits and providing guidance so that they are careful with regard to violence. (CHA)

The actions were great, they influenced our look to work on violence, but I regard as a negative aspect the fact that not all professionals participated in the meeting, the physician, the dentist should also take part in the work against violence. (FM)

The speeches express the importance attributed by the team to the research actions, and this fact is crucial to the continuity of work. Involvement becomes important, since the key problem of changing the care model lies on reorganizing the work process, where the subjects remain in a physician-driven practice, they keep taking their actions by producing procedures instead of producing care, without interconnecting their practices to those adopted by the team.19

Finally, we asked about the prospects to keep working to fight violence, highlighting the formation of partnership and continuing what has been learned:

> We hope that the community, the school, and other agencies can be our partners, helping to work on violence within the unit’s area. (SW)

> I want to put into practice what I have learned in the workshop, keep looking carefully and, if I suspect anything, I will notify. (CHA)

It is inferred that, after the workshop, there emerged the prospect for a change in the practice of these professionals. We bet on this fact as a likely beginning to form networks to prevent and refer violence against children and adolescents. It is emphasized that a network of this kind may be formed by spontaneous initiative of a group of people, not depending on legal or government agencies.

We agree that to overcome the persistent effects of fragmentation in the network of health services of the Unified Health System (SUS), there is a need to potentiate the FHS, i.e. prioritize it, besides empowering it as a preferred gateway. Network’s success depends on the interconnection of all resources available through workflows and protocols, able to guarantee safe access to the technologies needed for providing attention, through a production line of care driven by primary health care and a service management that enables the continuity of care.19

**FINAL REMARKS**

We think that this study partially achieved the proposed objectives, as it was able to identify the health team’s work against violence, took the first steps towards the implementation of a network, and evaluated the actions taken. Among the findings, stood out the impossibility of a professional working alone, she/he requires help from other instances. Through the establishment of this partnership, takes place the formation, on a minimal basis, of a service network to prevent and fight against violence. We revealed the recognition and appreciation of networking strategies, also expressing awareness with regard to the continuity of implemented actions. In this sense, we think that for nurses, social workers, community health agents, administrative agents, and the service management, the problem had greater impact due to the simple fact of having greater and longer contact with the population within the area.
We recognized the limitations, as well as the difficulties for conducting the research. The non-adhesion of some professional categories stood out, such as physicians and dentists; carrying out the study at a single basic health unit requires its reappraisal at the other ones in the town under analysis; the difficulty to discuss and evaluate aspects of violence; lack of taking personal risks; partial implementation of the network, since this constitutes a process of continuous improvement and progress along with the unit’s staff.

It is recommended that the work of each health professional must be committed to deploying the network to fight against violence, as this is a legitimate action field, therefore, indispensable, becoming qualified and competent to ensure the quality of care provided to victims of violence.

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