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ORIGINALES

Practical dimension of the community health agents' social representations about domestic violence against women

Dimensão prática das representações sociais de agentes comunitários de saúde sobre violência doméstica contra a mulher

Dimensión práctica de las representaciones sociales de los agentes de salud comunitarios sobre la violencia doméstica contra la mujer

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ABSTRACT:

Objective: To understand the practical dimension of the social representations of community health agents about domestic violence against women.

Methodology: This is a research study with a qualitative approach grounded on the Theory of Social Representations and carried out in Family Health Units in a municipality from the inland of Bahia, with participation of 30 community health agents. Data production took place through the technique of in-depth interviews and lexical analysis; the IRAMUTEQ (*Interface de R pourles Analyzes Multidimensionales de Textes et de Questionnaires*) software was used and the data were processed by means of the Descending Hierarchical Classification method.

Results: It was revealed that the care practices for women in situations of domestic violence are based on the technical dimension through home visits; on the relational dimension anchored in listening, bonding and trust; and on the guidance dimension by the ability to establish an information exchange and management process. They presented conceptions about services and professionals that comprise the care network for women in situations of violence, revealing weaknesses at work that hinder development of actions.

Final considerations: It is understood that community health agents are important professionals in the prevention, identification and confrontation of domestic violence against women and need multiprofessional and intersectoral support to meet the demands of these women.

Keywords: Violence Against Women; Community Health Agents; Family Health Strategy; Gender and Health; Nursing.

RESUMO:

Objetivo: Compreender a dimensão prática das representações sociais de agentes comunitários de saúde sobre violência doméstica contra a mulher.

Metodologia: Trata-se de investigação de abordagem qualitativa apoiada na Teoria das Representações Sociais, realizada em Unidades de Saúde da Família de um município do interior da Bahia, com a participação de 30 agentes comunitários de saúde. A produção de dados ocorreu a partir da técnica de entrevista em profundidade e análise lexical; utilizou-se o *software* IRAMUTEQ (*Interface de R pourles Analyses Multidimensionneles de Textes et de Questionnaires*) e os dados processados pelo método de Classificação Hierárquica Descendente.

Resultados: Revelaram que as práticas assistenciais às mulheres em situação de violência doméstica são pautadas nas dimensões técnica através da visita domiciliar; relacional ancorada na escuta, vínculo e confiança; orientação pela capacidade de estabelecer um processo de troca de informações e gerencial. Apresentaram concepções sobre serviços e profissionais que compõem a rede de atenção à mulher em situação de violência desvelando fragilidades no trabalho que dificultam o desenvolvimento de ações.

Considerações finais: Entende-se que os agentes comunitários de saúde são profissionais importantes na prevenção, identificação e enfrentamento da violência doméstica contra a mulher e necessitam de apoio multiprofissional e intersetorial para atender às demandas dessas mulheres.

Palavras-chave: Violência contra a mulher; Agentes Comunitários de Saúde; Estratégia Saúde da Família; Gênero e saúde; Enfermagem.

RESUMEN:

Objetivo: Comprender la dimensión práctica de las representaciones sociales de los agentes comunitarios de salud sobre la violencia intrafamiliar contra la mujer.

Metodología: Se trata de una investigación de enfoque cualitativo sustentada en la Teoría de las Representaciones Sociales, realizada en Unidades de Salud de la Familia de un municipio del interior de Bahía, con la participación de 30 agentes comunitarios de salud. La producción de datos se realizó mediante la técnica de entrevista en profundidad y análisis léxico; Se utilizó el software IRAMUTEQ (Interface de R pourles Analyzes Multidimensionales de Textes et de Questionnaires) y los datos fueron procesados por el método de Clasificación Jerárquica Descendente.

Resultados: Reveló que las prácticas de atención a mujeres en situación de violencia intrafamiliar se basan en dimensiones técnicas a través de visitas domiciliarias; relacional anclado en la escucha, la vinculación y la confianza; orientación por la capacidad de establecer un proceso de intercambio y gestión de información. Presentaron concepciones sobre los servicios y profesionales que integran la red de atención a las mujeres en situación de violencia, revelando debilidades en el trabajo que dificultan el desarrollo de las acciones.

Consideraciones finales: Se entiende que los agentes comunitarios de salud son profesionales importantes en la prevención, identificación y enfrentamiento de la violencia intrafamiliar contra la mujer y necesitan un apoyo multidisciplinario e intersectorial para atender las demandas de estas mujeres.

Palabras clave: Violencia contra la mujer; Agentes de salud comunitarios; Estrategia de salud de la familia; Género y salud; Enfermería.

INTRODUCTION

The theme of Domestic Violence Against Women (DVAW) has been discussed worldwide, presenting high prevalence and impact in the health services. In this study, DVAW is defined as any gender-based action or omission that results in their death, injuries, mental, sexual or psychological distress, and moral or patrimonial harms, both in the public and private scopes[1].

DVAW is built from the relationships between men and women that are permeated by social and hierarchization inequalities between them[2]. Thus, violence translates the gender social construction that attributes men power in the relationship and the figure of a virile provider, while women remain as submission objects[3].

It is estimated that 35% of the women are victims of physical or sexual violence in the world[4]. A study developed in Spain indicated that low-schooled and unemployed women are at a higher risk of being victims of intimate partner violence, with 24.8% prevalence of women who suffer the problem[5].

In Brazil, a research study conducted by the Brazilian Public Security Forum revealed that, out of 10 women, three are victims of violence; this is synonymous to saying that 16 million Brazilian women suffer some type of violence, with most of them experiencing it in their homes (42%) and the boyfriends/spouses/partners being indicated as the main perpetrators, with 23.8%[6].

DVAW requires dialog between several sectors of society for its confrontation and prevention, with investments in political, social and economic actions by the governments, the institutions that assist women and the entire society[7]. In the health sector, the Family Health Strategy (FHS) presents itself as a field for communication, organization and flow of users, as well as it enables initial care for women in situations of violence. Consequently, it stands out for playing a fundamental role in the Care Network for Women in Situations of Violence (*Rede de Atenção à Mulher em Situação de Violência*, RAMSV)[8].

In this way, FHS health professionals are involved in the process to cope with DVAW, where this activity requires professionals to have a view of the world and of care practices that contemplates gender issues[9,10]. Community Health Agents (CHAs) stand out among the FHS health professionals, as they enjoy the possibility of knowing the family dynamics for living in the same area and of establishing dialog and trust with the women and family members, in many cases with the opportunity to identify the DVAW situations from their very observations and act as a link between the family and the FHS team[9].

In this context, the research topic chosen was “The practical dimensions of the CHAs' social representations about DVAW”, which implies recognizing the social representations (SRs) as a joint guide and definition regarding the different aspects of everyday reality, in order to ease interpretation, decision-making and a defensive stance before them[11]. Consequently, the objective is to work on the health professionals' SRs and acknowledge the existence of knowledge that relates common sense wisdom and its links for the constitution of specific technical-professional knowledge, aimed at objects arising from the everyday professional practice of the work process itself[12].

It is believed that unveiling the CHAs' care practices for women in situations of violence based on their SRs about DVAW raises reflections about the development of actions that contemplate these women's needs in the FHS, as well as devising strategies that improve articulation between this health service and the other sectors of the RAMSV.

Consequently, the objective of this study is to understand the practical dimension of the CHA's social representations about domestic violence against women.

METHODOLOGY

A research study grounded on the Theory of the Social Representations (TSR), through which it can be understood how speeches, communication instances, images and messages show the other's opinion on a given topic, representing what each individual experienced in relation to the subject matter in the social environment in which they are immersed[13].

The research was developed in 11 Family Health Strategy (FHS) units from the municipality of Jequié, Bahia, Brazil, based on the following inclusion criteria: urban area units with double or single teams and full teams according to the Ministry of Health's protocol during the data collection period.

The research participants were the CHAs working in the FHUs, selected for convenience. Based on the contact established with the supervising nurse, the researcher requested a meeting with all the CHAs working in the FHU team so that she could invite them to participate in the study and schedule a day and time for data collection. As an inclusion criterion, the CHAs had to be active in their functions and having worked for more than six months in the FHU; the exclusion criterion consisted in CHAs who were on holiday, leave-bonus, or undergoing health treatments during the data collection period. Thus, 107 CHAs attended the first meeting with the researcher and, of these, 48 provided their telephone number for subsequent contacts.

Data collection took place from May to August 2019, by means of in-depth interviews guided by a form that contained sociodemographic aspects and a script with three blocks of questions about the theme (DVAW, types and precipitating factors of DVAW, and the CHAs' practices for women in situations of domestic violence). The interviews were conducted individually by the researcher herself in a room made available at the FHUs where the CHAs worked, using an audio recorded and lasting a mean of 50 minutes. Theoretical saturation of the interviews occurred from the 26th interview, when noticing repetition of contents and absence of new occurrences; however, another four interviews were conducted in order to reinforce the perception. Consequently, the study participants were 30 CHAs from the 11 FHUs.

All 30 interviews were transcribed and organized in the *Open Office 4.0.0* software, assembling the *corpus* for lexical analysis that was processed in the IRAMUTEQ (*Interface de R pourles Analyses Multidimensionneles de Textes et de Questionnaires*) software, *version 0.7 alpha2*, in the interface from the Descending Hierarchical Classification (DHC) or Reinert's methods. From the original *corpus*, DHC allows identifying and organizing the Text Segments (TSs) into groups of statistically significant words from each interview. The chi-square test is used to verify the association of the TSs with a given class; the higher the value, the greater the association[14]. Thus, the analysis *corpus* consisted of 30 lines corresponding to the interviews, processed and analyzed in the software in 39 seconds.

All the participants were informed about the study objectives, reason, risks and benefits and signed the Free and Informed Consent Form. The research project was approved by the Research Ethics Committee of the State University of Southwestern Bahia, complying with Resolutions No. 466/2012 and No. 510/2016 of the National

Health Council. Seeking anonymity, the participants' speeches were identified with the word *Participant*, followed by an Arabic number corresponding to the order in which the interviews were conducted.

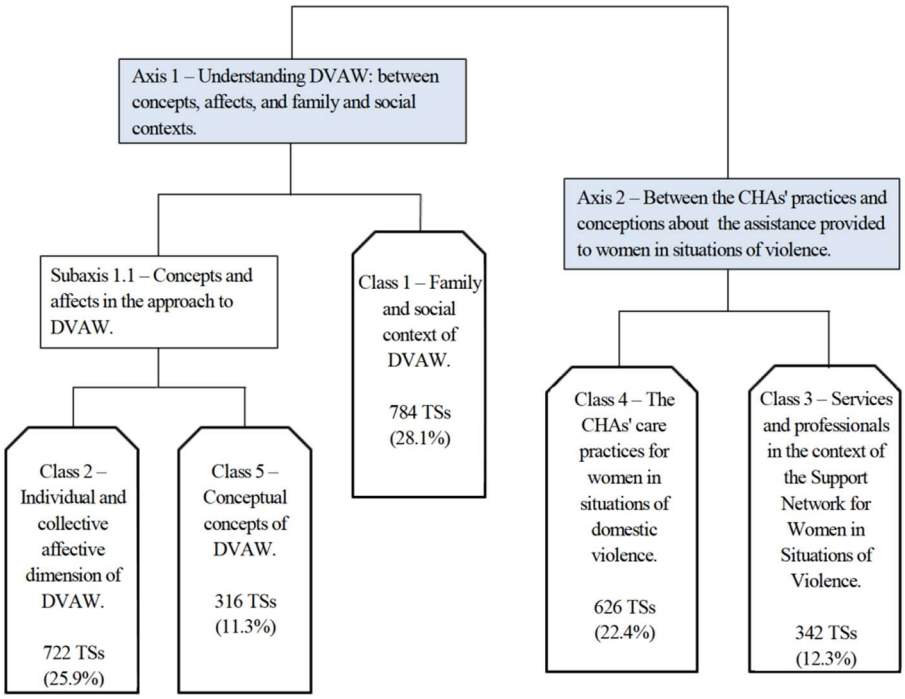
RESULTS

Only one of the 30 CHAs participating in the study was male, their age varied from 32 to 57 years old with predominance of the age group between 32 and 45 years old, with 17 participants; 19 self-declared as brown-skinned, 15 were married, 14 had complete Higher Education and 24 indicated mean family incomes from 1 to 3 minimum wages.

Lexical analysis of the interviews in the IRAMUTEQ software yielded 3,058 TSs, of which 2,790 were analyzed, representing 91.24% leverage. The *corpus* presented 5,531 forms, with 106,739 occurrences, and word lemmatization obtained a total of 3,207, with 3,020 active word forms and 12 supplementary forms. After sizing and classification in DHC, the text segments were defined as belonging to five classes distributed into two axes, according to Figure 1.

Figure 1 shows the classes organized based on the DHC dendrogram, which must be read from left to right. The *corpus* was divided into two subgroups (axis 1 and axis 2); axis 1 was further subdivided into subaxis 1.1 giving rise to classes 5 and 2 and to class 1: this division indicates that classes 5, 2 and 1 are content related, whereas classes 5 and 2 are even closer to each other for being structured in the same subaxis. Axis 2 generated classes 3 and 4, which, even sharing the same axis, have contents that differentiate them and justify their separation into different classes.

Figure 1: Distribution of the thematic classes into axes according to DHC, Jequié, BA, Brazil, 2019.



Source: Adapted from IRAMUTEQ (2019).

This study will deal with the presentation and discussion of axis 2: “Between the CHAs' practices and conceptions about the assistance provided to women in situations of violence” comprised by class 4: “The CHAs' care practices for women in situations of domestic violence” and by class 3: “Services and professionals in the context of the Care Network for Women in Situations of Violence”.

The general content of axis 2 allowed understanding the practical dimension of the CHAs' SRs about DVAW, as it mainly shed light on these professionals' care process for women in situations of violence and on the convictions about the RAMSV services and professionals.

Class 4 - The CHAs' care practices for women in situations of domestic violence

Class 4 represented 22.4% of the *corpus* analyzed with 626 TSs, and the most significant words in this class were as follows: talk ($x^2 = 177.82$), nurse ($x^2 = 123.95$), seek ($x^2 = 112.42$), here ($x^2 = 112.32$), speak ($x^2 = 100.04$), help ($x^2 = 96.1$), DEAM ($x^2 = 88.49$) and support ($x^2 = 81.49$), among others.

The study findings evidenced that the CHAs grounded their practices through the technical dimension with the home visit, the relational dimension anchored in listening, bonding and trust, and in the guidance dimension by the ability to establish a process to spread diverse information and knowledge that may allow women to live without violence.

The CHAs reported developing their care practices for women in situations of violence from the home visits based on dialog and on the guidelines that they consider important to interrupt the cycle of violence, such as improving self-esteem. However, they acknowledge having weaknesses in the development of their actions and in resoluteness regarding the problem, which generates a feeling of sadness, as can be verified in the following reports:

> *Sometimes you don't even have a chance to take down notes, I arrive for the home visit and the person sometimes just wants to talk and I'm going to feel that I'm a better professional if I offer this assistance of at least listening and talking* (Participant 16: Score: 412.31).

> *Then it's necessary to provide guidance, listen and improve her self-esteem* (Participant 18; Score: 443.93)

> *I try to do what I should in a way that I know is very superficial, providing guidance, talking, speaking, making the person see herself in a new way, but I have my limitations all the same* (Participant 28; Score: 425.11).

In the meantime, the CHAs participating in the current study also showed that they need assistance and support of the FHU nurse in developing their care practices for women in situations of violence. Consequently, they stated the importance of the link established with the nurse, as they understand that this professional is a reference in case of doubts and in the best possible targeting of their actions.

> *I always pass things on to the nurse here, so that she can interact and help, I schedule the conversation and she provides guidance* (Participant 7; Score: 669.90)

> *There is guidance, the bond in bringing them here to the unit, for our nurse to try to do a home visit and provide better guidance* (Participant 29; Score: 592.34)

In their psychosocial thinking, the study CHAs evidenced understanding that their care practices and those of the Family Health team go far beyond the relationships established with the women, as they include the managerial dimension about the problem, such as the importance of notifying and referring the cases that need support from other instances of the RAMSV, such as the Specialized Police Stations for Women (*Delegacias Especializadas no Atendimento a Mulher*, DEAMs).

> *Notifications are a constant here, when I get here she can trust, and I try to help her, then advising to seek some official instance, referring her somewhere* (Participant 01; Score: 455.34).

> *What I do for her is asking and guiding her to seek the DEAM.* (Participant 08; Score: 474.38).

Class 3 - Services and professionals in the context of the Care Network for Women in Situations of Violence

Class 3 presented 12.3% of the *corpus* analysis with 342 TSs, and the following words can be found in its constitution: health ($x^2 = 239.5$), unit ($x^2 = 224.72$), group ($x^2 = 155.27$), psychologist ($x^2 = 123.44$), therapy ($x^2 = 120.31$), work ($x^2 = 85.09$), community agent ($x^2 = 80.21$), duty ($x^2 = 76.95$), public ($x^2 = 75.39$) and training ($x^2 = 70.66$), among others. This class presented the CHAs' conceptions about the difficulties encountered in the development of their care practices for women in situations of violence due to the absence of intersectoral articulation between the FHUs and the other services comprising the RAMSV. For these health professionals, this network does exist; however, the services are not able to articulate the activities with the health units, as noticed in the following statements:

> *I think that this existing network needs to be more connected, we need such presence, knowing that they (services) are there, they need to appear more here in the health unit, more interaction with us is necessary* (Participant 12; Score: 622.26).

> *And the areas that really work with this, the DEAM and the CREAS, could really offer more support to the units* (Participant 17; Score: 323.46).

The CHAs showed the importance of the relationships that must be established and the need for the participation of professionals that are not part of the Family Health team, such as psychologists and social workers, in coping with DVAW and that, even in isolation from the FHU, they have been developing activities such as Community Therapy Groups. Consequently, it is noticed that, in these health professionals' social imaginary, there is understanding of the psychosocial dimension, as well as of the

women's psychological and social aspects that need to be valued and articulated to the co-accountability of all the RAMSV professionals.

> *The health units lack social workers and psychologists, if we had them it would all improve a lot, make things easier, a psychologist would help* (Participant 19; Score: 730.32)

> *There's therapy, we bring her to the community therapy group, there are women who vent here and cry* (Participant 4; Score: 428.56).

Based on the reports, it was noticed that the CHAs consider themselves as important and essential health professionals due to the bond established with the women, as well as it was evidenced that they are key actors in the communication between the users and the health units. However, they stated lacking the necessary knowledge to develop actions to cope with DVAW, emphasizing lack of training in the Family Health team as a limitation in the work developed in the RAMSV context.

> *The community agent plays a very important role, we feel important because we're important inside the unit, we're the people who bring the problems back and forth* (Participant 15; Score: 695.93).

> *Health professionals need to trained to work with violence, there's no such thing, I never had, I've been a community health agent for 22 years now and I've never been trained to work on or deal with the issue of violence against women* (Participant 19; Score: 414.23).

DISCUSSION

In the CHAs' social imaginary, it is revealed that the assistance provided to women in situations of violence includes a technical dimension, a relational dimension and a guidance dimension, although there is also a managerial dimension that assumes an interaction practice and sharing of actions among the professionals, in an attempt to favor comprehensive care for these women.

Home visits are an opportunity for the health professionals to observe the women's living conditions, such as injuries in the body, the home environment, the relationship with the family members and diverse complementary information in the identification of situations of domestic violence[15]. While conducting the home visits, health professionals develop practices such as communication and active listening, which enhance the bond and facilitate the guidelines that can contribute to alleviating and calming down women in situations of violence[16].

In this sense, based on their work process, the CHAs develop identification and intervention strategies in relation to DVAW. Home visits strengthen the CHAs' presence in the home environment, the space where they can establish a boding and trusting relationship with the women by assuming the role of social articulators and mediators[9]. The guidelines are aimed at helping to awake in the women the knowledge about their rights, protection, appreciation as human beings and empowerment so that they can enjoy a violence-free life[16].

In the context of DVAW, the home space is an example of patriarchal domination; gender inequality is not something natural, it is imposed by the cultural tradition, by the power structures and by the agents involved in the social relations weave, and this will only be overcome by empowering these women, which means attributing power to them, improving their self-esteem, for example[2].

In the SRs, it is noticed that the CHAs presented a critical attitude and tried to minimize the women's anguish and doubts through the guidance they provided. Consequently, they assume the position of main actors in identifying and coping with DMAW[7]. However, a research study conducted about the CHAs' care practices for rural women in situations of violence showed that these health professionals feel powerless in solving the DVAW cases; therefore, they need a professional nurse to guide them in their actions[9].

Proximity between the health services and the community becomes an important instrument that allows for more effective care to be provided, which is strengthened by establishing links comprising a network which allows for a more targeted perspective in the face of DVAW situations[17]. Consequently, the CHA's everyday care practice favors the construction of a bond-based relationship, most of the times being the first professional to whom the women report the violence experienced and ending up representing one of the main contacts of these women with the health field and the other care services[9,17].

Nurses play a singular role in the assistance provided to women in situations of violence; in the FHU, they are the professionals responsible for offering support to the nursing technicians and CHAs, in order to solve the cases, in addition to integrating the team, preparing training activities to identify and refer users who are victims of violence, among others[18].

In addition to that, a study developed in the United Kingdom/England with women in situations of domestic violence showed that they acknowledge the importance of the role of those nurses working in Primary Health Care (PHC) in the support provided, planning of the referrals to the ancillary services and guidance about the safety of these women[19].

Thus, it is fundamental for the CHAs to devise strategies aimed at modifying the DVAW situations with the purpose of overcoming fragmentation of the work process, of strengthening the bond with the nurses, and of achieving common goals.

In the meantime, the data generated by the notifications support actions and foster public policies for coping with violence and, by notifying the DVAW cases, health professionals show their commitment and understanding of the magnitude of the problem. Many health professionals acknowledge notifications as a tool to ensure the rights and protection of women in situations of violence; however, they find difficulties notifying the cases due to unpreparedness, fear of retaliation and insecurity resulting from lack of skills in dealing with the diversity of consequences inherent to this context[20].

The FHU health professionals notice that the interventions in the Primary Health Network not always contribute results, and that it becomes necessary to refer the cases to other services for continuity of the care provided to the women[16]. it is noted

that, in 2014, in the Unified Health System (*Sistema Único de Saúde*, SUS) scope, half of the appointments with women who were victims of violence had some type of referral, with the general police stations, DEAMs, the Public Prosecutor's Office and the Specialized Social Assistance Center (*Centro Especializado de Assistência Social*, CREAS) standing out[21].

Articulation between the care services for women in situations of violence needs to be permeated by collective dialog and contact with the professionals, involving the institutional definitions about the roles that each one of them can perform in the network[22]. Disarticulation of the RAMSV results in the professionals' dissatisfaction and impairs care continuity, as DVAW can present care demands in several sectors for the actions to be effective[23].

The CHAs' representational content about the work-related difficulties in the RAMSV is correlated to the different pieces of knowledge built by the group, both based on reified knowledge about how to cope with DVAW and on the technical-professional knowledge that governs the theoretical and experiential proposals that come into action when developing the everyday professional practices[12].

The health professionals' sensitivity in working based on the biopsychosocial perspective of the health-disease process is fundamental, considering the complexity of DVAW[10]. The health professional's commitment in referring the necessary cases to other professionals from the network services reflects that they expect assistance, support and care continuity so that women may build a violence-free life perspective[16].

The CHAs' representational contents encourage articulation of actions between the teams, in an attempt to allow for the integration of diverse professional knowledge in the face of the needs related to the assistance provided to women in situations of violence. Thus, multiprofessional performance needs to rest upon a practice in which professionals from various services work together.

Considering the need for psychological and/or social support, most of the women victims of violence that are treated in the FHS should have the support of a psychologist and/or social worker from the Family Health Support Center (*Núcleo de Apoio à Saúde da Família*, NASF). Based on the interdisciplinary approach and on matrix support actions, the NASF professionals strengthen the health care practices in the FHS through planning, continuing education and health promotion[24], even in relation to coping with DVAW.

Thus, the care provided to women in situations of violence is permeated by collective reconstruction through the diverse knowledge represented by the different services; however, one of the obstacles for articulation of the services in the care network is the professionals' lack of knowledge about functioning of the services. The interaction process between several sectors that comprise the network will only be consolidated by means of mutual knowledge, which involves diverse information about their duties, location, referrals and counter-referrals[22].

Corroborating the current study, a survey conducted with CHAs in the city of Palmas/TO showed that there is lack of knowledge in these professionals regarding the adequate course of action in the face of DVAW, as well of appropriate targeting in

the RAMSV for the assistance to be provided to women in situations of violence, with the need for update courses on the theme[25].

In the international scenario, insufficient training of the health professionals in relation to DVAW is also cited; in a research study conducted in Turkey with family physicians and nurses, it was identified that these professionals mention lack of knowledge to deal with intimate partner violence situations, showing deficiencies in notification and referral of the cases[26].

Unpreparedness to deal with DVAW generates difficulties identifying the cases and how to intervene in the situations; unawareness about networking can isolate the women and hinder the critical route, that is, women can be referred to services where they will not find answers to their needs. Consequently, it is necessary to adopt practices to update knowledge about the problem, discuss the cases and understand the flowchart of the services that comprise the RAMSV for the promotion of effective changes in the assistance provided to women in situations of domestic violence[27].

FINAL CONSIDERATIONS

This study allowed understanding the practical dimension of the CHAs' SRs about DVAW, appropriating what is stated in reified knowledge, common sense and technical-professional knowledge ancillary to the guidance on actions in the face of the problem.

In their social imaginary, the CHAs brought up that home visits are both a care practice and a strategy to approach DVAW, appropriating the technical dimension. In this sense, during the home visits, the CHAs resort to the relational dimension supported on active listening and bonding as essential tools that favor good quality of their assistance, and the guidance dimension is used a way to exchange information about DVAW and autonomy development with the women. They also reflected on the importance of notifying the DVAW cases and of the referrals to the services that comprise the RAMSV, when they included the managerial dimension of the care practices for women in situations of domestic violence in their thinking.

In general, the CHAs' care practices in the face of DVAW are supported by the FHU nurses for the various knowledge and experience exchanges about the problem, indicating these professionals as responsible for the targeting of their actions.

By revealing the weakness found in networking, the CHAs also presented their conceptions about the services and professionals that comprise the RAMSV. The results pointed to certain disarticulation between the health services and other specialized services that comprise the RAMSV, difficulties that the Family Health team encounters when developing some care practices due to the absence of psychologists and social workers who offer support to the women's psychosocial aspects and to the lack of professional training on the theme of DVAW and networking. It is also emphasized that the municipality where the study was conducted does not have any Family Health Support Center (NASF) that might minimize this gap.

Consequently, it is understood that the CHAs are important professionals in DVAW prevention, identification and coping and need multiprofessional and intersectoral

support to meet the demands of women in situations of violence. It is understood that the study contributes benefits for the RAMSV professionals, as well as for teaching and research in Health and Nursing, as it consists in providing diverse evidence about the CHAs' care practices and conceptions for women in situations of violence and the weaknesses found in the professional behaviors in the care network context. Thus, there is an evident need to appropriate the theme of DVAW through reflection spaces for the CHAs, professionals from the different areas, managers and universities, in an attempt to attribute new meanings to the professional practices in the FHS and RAMSV context.

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