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VIOLENCE AGAINST WOMAN AND THE FAMILY PSHYSICIAN APPROACH: INTEGRATIVE LITERATURE REVIEW

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ABSTRACT

Objective: to identify in the literature how the Family Physician approach is used in the detection and referrals related to female domestic violence. This is an Integrative Literature Review of articles published between 2010 and 2016, using the terms "violence", "women" and "public health".

Results: 39 articles published in English and Portuguese were analyzed, of which 15 were included because they met the study objective. It has been observed in most studies that doctors do not feel empowered to care for women victims of domestic violence, and that, violence is still invisible to most doctors, making it difficult to get referrals. It was observed that there is no intersectoral articulation and no reports of violence are made regarding referrals.

Conclusion: the literature points to the need for training Physicians in detecting hidden cases of violence and proceed with appropriate referrals.

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INTRODUCTION

Violence is a social problem that accompanies the whole history of humanity. It is inserted as a priority in the Health Promotion Policy and as such deserves attention of professionals, especially the Family Doctor (Malta *et al*., 2016). The United Nations defines violence against women as: "Any act of violence based on gender difference resulting in physical, sexual and psychological harm and suffering of women," including "threats of such acts, coercion and deprivation of liberty, whether in public or private life" (Duncan *et al*., 2013). In Brazil, violence was observed in a higher prevalence in the female sex, being considered a public health problem and proving the occurrence of gender's violence in all geographic regions and in different population groups in Brazil (Mascarenhas *et al*., 2017).

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Despite the high frequency, there is a possibility that these rates are even greater, since psychological aggressions (verbal and behavioral manipulation, insults, blackmail and isolation) are rarely perceived as violence because they are not immoderate and / or cruel acts that leave severe physical damage (Barreto *et al*., 2009). Often, this violence is not recorded, does not generate care, and is underreported, characterizing the invisibility of violence against women (Garcia, 2016). Within the scope of the Unified Health System (SUS), the services that comprise Primary Health Care (PHC), like the Family Health Strategy (ESF), are one of the entry points for the Network of Care for Women in Violence Situation, created to give full assistance to women. In its operationalization, it must take into account the complexity demanded and the need for intersectoral actions that are articulated to face the critical route of violence against women (Brazil, 2011). The Network Assistance is conceptualized as an "articulated action between governmental, non-governmental institutions and the community, aiming the expansion and improvement of the quality of care; the

identification and appropriate referral of women in situations of violence; and the development of effective strategies prevention" (Brazil, 2011). Recognizing violence against women requires a high degree of sensitivity, awareness of being secure and confidentiality between battered women and health professionals. Therefore, attention and better training is needed for all levels of professionals in the community, being them community health agents, nurses, psychologists and physicians, putting the politics of humanization in practice to better manage violence against women (Melo *et al*., 2017, Signorelli *et al*., 2017). In a study of domestic violence against women from the perspective of community health agents, 12 of them affirmed that there is no standardization in the care and there is dismantling of services for the protection of women victims of violence, as well as lack of knowledge about appropriate behavior (Lima and Pacheco, 2016). In this context, the Family Doctor, in his / her area of activity, should attend to any warning signs during the care, both in the anamnesis and in the physical examination. Among the warning signs, the following stand out: rigid and unequal distribution of power and authority, lack of role differentiation, permanent conflict, low level of autonomy development of family members, closed structure without opening for external contacts, families in situation of crisis and loss, presence of a violent family model in the history of people involved, alcohol and other drug abuse, criminal backgroun story, psychological or psychiatric impairment of individuals, economic or emotional dependence, and low self-esteem (Duncan BB *et al*. 2013). Thus, the National Policy to Combat Violence against Women seeks in its main objectives, to cover all spheres of action that somehow interfere with the effectiveness of violence control in all its consequences. This policy has been consolidated by the National Pact for Confronting Violence against Women, launched in August 2007, involving the federal government, states and municipalities (Brazil, 2011). Violence against women has also been presented as an economic problem, since millions of dollars are spent on the treatment of depression and anxiety, without considering other psychiatric disorders of victims of violence. As the Brazilian Ministry of Health points out, the problems are even greater, as they affect women emotionally, causing loss of self-esteem, depression, phobias, nightmares, distress crises, psychoses, fear of sexual relations, among others. About 35% of the complaints from women presented in the health services are associated with some type of violence (Brazil, 2005).

Whether within or outside the domicile, violence against women is named as a problem of global proportions in the area of health, as it interferes with the life process of the individual and the community and has profound social repercussions (Coelho et al., 2014). Building on debates, conferences, and conventions, Brazil has instituted public policies that address intimate partner violence. These policies to combat violence, especially against women, gained strength between 1992 and 2012, during which a series of legal and institutional measures were adopted throughout the country. These measures include the creation of the Centers for Prevention of Violence and Health Promotion in 2004 by the Ministry of Health, which represented a framework from which compulsory notification was established for acts of violence against women (Law 10.778 / 2003, art 1º) (Brazil, 2003). According to the provisions of this law, when providing care for a woman with injuries caused by domestic or sexual violence, the health professional must issue a notification to the Epidemiological Surveillance Service or the Municipal Health Department to form an integrated database on violence and to outline a profile of victims and perpetrators. Another relevant achievement for women was Law 10,886 / 2004, which makes personal injury a special type of domestic violence (article 129, § 9) (Brazil, 2004). In 2006, one of the most important laws that supported the elaboration of public policies was sanctioned: The Maria da Penha Law (Law 11.340 / 2006) (Brazil, 2006), based on civil and criminal provisions. This law refers to the protection of women beyond the punishment of the aggressor, creates mechanisms to restrain and prevent violence in the family (article 226 § 8). It is an innovation to ensure assistance during the police and judicial phases of the investigation. In article 7th of this law, definitions are defined for physical, psychological, sexual, patrimonial and moral violence, helping, more and more, the identification of women who are exposed to such violence (Brazil, 2006). According to the World Health Organization (WHO) 2015 manual, one of the targets for the next 15 years is to significantly reduce all forms of violence against women, as well as the death rates related to them everywhere. This goal stems from the fact that violence against women is closely related to their state of physical and mental health (World Health Organization, 2015). In addition to reducing violence against women, there is a great need to address this issue with the commitment to promote women's health in an integral way, making possible the planning of public policies that modify this reality (Silva and Oliveira, 2015). It is observed that there are few published works on the theme of violence against women and the referral given by the Family Doctor. Thus, it became important to know how these issues have been addressed in the PHC and, based on the knowledge of this reality and the difficulties recorded in the literature, make possible the reorganization of the reception of these women, as well as the accomplishment of necessary referrals in an agile and efficient way.

MATERIALS AND METHODS

Integrative literature review study (Galvão TF and Pereira MG, 2014) whose guiding question was: how does the Family Physician's approach to detect and refer the occurrences of domestic violence occur?

As inclusion criteria were established: having the text available, dated 2010 to 2016 and being in an article format. The texts should refer to female violence and the Family Physician's approach to the occurrence, as well as to the referral of the victim. Thus, the methodological plan of this study consisted of a scientific search conducted from May to December 2016. The databases for the review were the Virtual Health Library (VHL) and SCIELO (Scientific Electronic Library Online). These bases were chosen because they specifically addressed issues involving the health area. The descriptors used for the search were: "violence" AND "woman" AND "public health". The articles were selected and organized into a framework of studies. After being analyzed, they were classified according to the levels of evidence for the indicated conducts. The criteria of Stetler *et al*. (1998), which ranks in: level 1 - evidence resulting from meta-analysis of multiple controlled and randomized clinical studies; level 2 - evidences obtained in individual studies with experimental design; level 3 - evidence from quasi-experimental studies; level 4 - evidence from descriptive (non-experimental) studies or qualitative approach; level 5 - evidence from case or experience reports and level 6 - evidence based on expert opinions.

RESULTS

In the initial search, 572 articles were found in the Virtual Health Library (VHL). After filtering for the LILACS and MEDLINE databases, 117 articles were obtained. In SCIELO, after the same filtering of 227 articles, 44 were left. All abstracts of the 161 papers selected were excluded and 110 were excluded because they dealt with different themes or were duplicitous. A total of 51 articles were selected, of which 37 were from the VHL and 14 from the SCIELO. However, a VHL text was not available, one was repeated and 10 from the SCIELO were duplicated as well (Figure 1), according to Moher D *et al*. (2009).

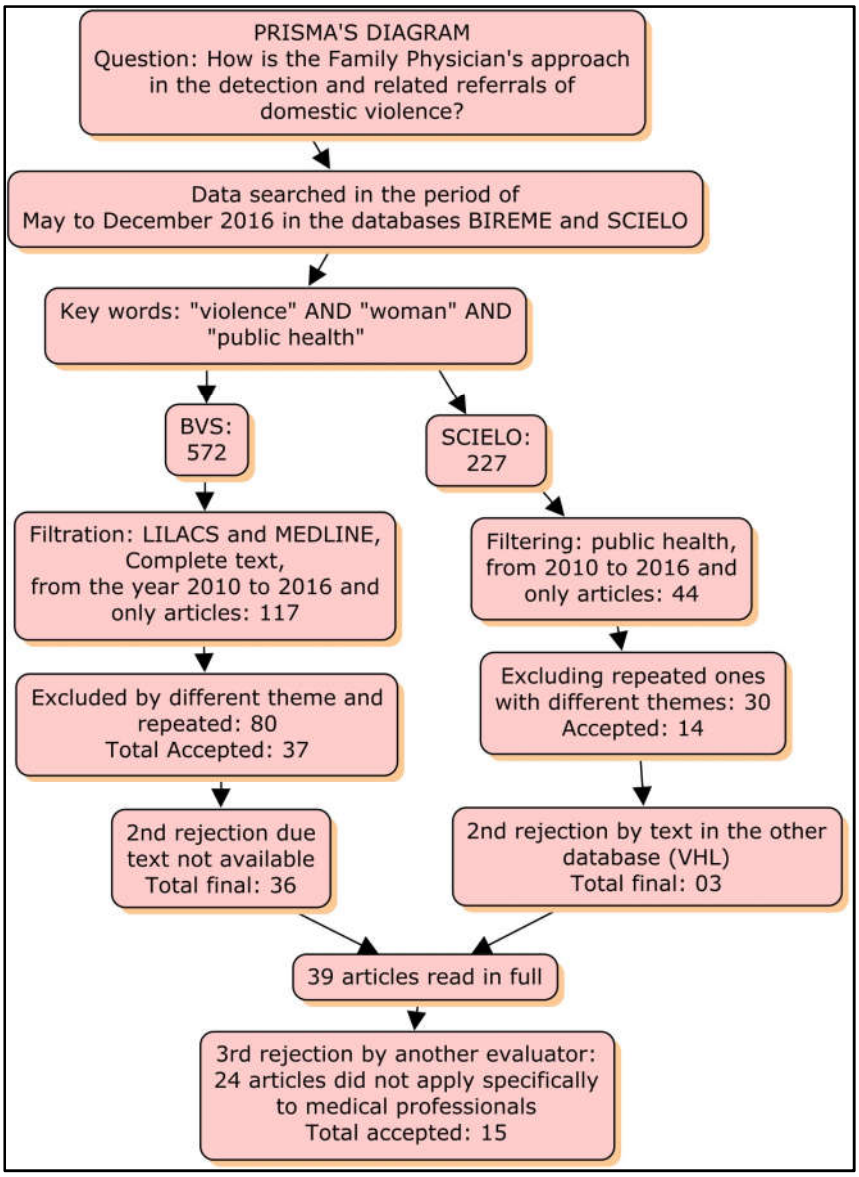

Figure 1. Fluxogram (PRISMA model) of the methodological way of the literature review. São Paulo, Brazil, 2017

The 15 selected articles were read in full and also evaluated by a second researcher, seeking to identify if they respond to the guiding question of the research on the conduct of medical professional, regarding the detection of the occurrence of domestic violence and referrals. Twenty-four articles were excluded because they dealt with specific professional segments, and did not address the medical professional. The classification analysis of the levels of evidence was therefore performed with 15 articles. The magazine that most published this theme was the "Cadernos de Saúde Pública" (4) and, subsequently, the "Revista Latino Americana de Enfermagem" (3), the rest were distributed with only one publication. As to the year of publication, of the works selected, five (33.3%) were from 2014 and another five (33.3%) were from 2013. Subsequently, there were three (20%) of the year 2011 and one (6.6%) in 2012 and another in 2015. No eligible articles were found in the years 2010 and 2016. All these papers analyzed answered the research question. Of the articles selected, two dealt with violence outside the country, one article on the practices of professionals in Angola and one article on the experience of women served in the United Kingdom. The following 13 articles, with relevance on the theme, described several regions of the country: six (40%) articles from São Paulo, two (13.3%) from Rio Grande do Sul, two (13.3%) articles from Bahia. Following, there was one article from Santa Catarina, one from Minas Gerais and one from Rio de Janeiro (6.6%).

As to the level of evidence of the studies (Stetler BC *et al*., 1998), all articles accepted for analysis were classified as level four: descriptive and / or qualitative approach (Table 1).

Table 1. Published studies that answer the question: how does the Family Physician approach, when it detects female domestic violence? Integrative Revision, São Paulo, 2017

Data base	Authors	Article's title	Resource and year of publication	Study's tipe and objective	Sample	Variables	Results
1 - BVS	Nascimento, Ribeiro, Souza.	Perceptions and practices of health professionals in Angola on violence against women in the marital relationship	Cad. Saúde Pública, 2014; 30(6)	Qualitative. To identify the perceptions and practices of health professionals in Angola regarding violence against women in the marital relationship.	13 health professionals from 3 national hospitals in Luanda, 1 manager, 3 nurses, 3 doctors, 3 psychologists and 3 nursing technicians	Perception of professionals regarding violence and their performance	In their practices, health professionals in the attention to women in situations of violence, prioritize the treatment of physical injuries without contemplating the subjectivity and the complexity of these situations.
2-BVS	Gomes, Erdmann	Marital violence in the perspective of professionals of the "Family Health Strategy": public health problem and the need of care for women.	Latino-Am. Enfermagem, 2014; 22(1)	Qualitative. Building a matrix from the practices and care of women in situations of violence in the FHS (family health strategy)	2 professionals from Sta. Catarina 17 nursing technicians, 13 nurses, 12 physicians, 10 NASF professionals (core family health support)	Meaning and process of care of conjugal violence, causes of violence, preparation of professionals	Recognition of conjugal violence as a public health problem and the need to manage women's care
Data base	Authors	Article's title	Resource and year of publication	Study's tipe and objective	Sample	Variables	Results
3-BVS	Facuri, Fernandes, Oliveira, Andrade, Azevedo.	Sexual violence: a descriptive study on the victims and care in a university reference service in the State of São Paulo, Brazil.	Cad. Saúde Pública, 2013; 29(5).	Descriptive, quantitative. To characterize the population of women who suffer sexual violence, and describe the characteristics of the aggression and the care provided in a university service of reference.	687 women victims of sexual violence, attended at the women's hospital in Campinas SP	Age, profession, religion, care dispensed within the first 24 hours.	Early care for almost 90% of women, introducing prophylactic measures.
4-BVS	Kind, Orsini, Nepomuceno, Gonçalves, Souza, Ferreira.	Subnotification and (in) visibility of violence against women in primary health care.	Cad. Saúde Pública, 2013;29(9).	Quantiqualitativo. Map violence indicators and identify health professionals' difficulties in reporting.	270 professionals from the ESF and NASF of Belo Horizonte MG.	(in) visibility of violence, reasons for not reporting violence.	Violence as a public health problem, preventing its confrontation due to (in) visibility and notification as a complaint.
5-BVS	Guedes, Fonseca, Egry.	Limits and evaluation possibilities of the family health strategy for gender violence.	Rev.esc.enferm. USP, 2013; 47(2).	Qualitative. Understand the limits and the evaluation possibilities of the FHT in the recognition and coping of the health of women who experience violence.	22 professionals from ESF and 13 women users of the service who experienced gender violence in São Paulo.	Visibility of violence in the daily life of health work. ESF practices, limits and potentialities.	The medical and nursing consultation were the most mentioned spaces of recognition of violence in the prenatal consultation.
6- BVS	Osis, Duarte, Faúndes.	Violence among health unit users: prevalence, perspective and conduct of managers and professionals.	Rev. Saúde Pública, 2012; 46(2).	Descriptive. Transversal Estimate the prevalence of violence in women if they were detected and the treatment by primary care professionals.	14 Coordinators 2379 users 75 managers 375 professionals from the state of São Paulo	Type of violence. Experience of violence Characteristic of the care. Referrals, Notification, Protocol, Trained Professionals.	Almost three quarters of the professionals said they did not investigate the experience of violence among the users. 15% reported some training to investigate violence.
7 BVS	Oshikata, Bedone, Papa, Santos, Pinheiro, Kalies.	Characteristics of sexually abused women and adherence to outpatient follow-up: trends observed over the years in a referral service in Campinas, São Paulo, Brazil.	Cad. Saúde Pública, 2011; 27(4).	Longitudinal. To evaluate the evolution of the adherence of women victims of sexual violence to the outpatient segment.	642 Women who suffered sexual violence and who chose to do an outpatient segment after emergency care.	Use of prescribed medications Appearance of sexually transmitted diseases Serological follow-up. Pregnancy Psychological profile evaluation. Assessment of social and legal needs.	70% of women attended the first 24 hours after being beaten. There was an increase in outpatient adherence, with a decreased dropout rate. Increased psychological segment over the years. Increased use of illicit drugs among women. There was a change in the form of intimidation and a decrease in the prescription of emergency.

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8- BVS	Malpass, Sales, Johnson, Howwell, Davies, Feder.	Women's experiences of referral to a defender of domestic violence in the UK primary care settings: a collaborative user service.	Br J Gen Pract. 2014;64(620):151-158.	Qualitative. Understand women's experience of disclosure of domestic violence and abuse in primary care settings and subsequent referral to a violent advocate.	12 Women who had experienced domestic violence and abuse and were referred to a violent advocate.	Age, Time of abuse, Type of abuse (s), Continuity with the abuser.	General practitioners and nurses can play an important role in identifying victims of domestic violence and directing them to advocacy for guidance.
9- BVS	Silva, Padoin, Vianna.	Violence against women: limits and potential of care practice.	Acta paul. enferm. 2013;26(6).	Participant research. To analyze the limiting and potentiating situations of the assistance practice of Family Health teams to women in situations of violence.	30 ESF professionals, among the 67 that participate in the teams, in the northwest of the state of Rio Grande do Sul.	Reception, Bonding, Home visit, Notification, Attendance.	Welcoming, bonding and home visits are potentialities for practice. Compulsory notification, attendance by reporting and outburst are limits to practice.
10- BVS	Berger, Giffin.	Health services and violence in pregnancy: perspectives and practices of professionals and health teams in a public hospital in Rio de Janeiro.	Interface (Botucatu); 2011;15(37).	Action research. Promote the identification and reception of women who suffer violence during pregnancy.	23 professionals, of which: 1 techn. Nursing, 11 doctors, 2 nurses, 4 nursing assistants, 3 social workers, 2 psychologists.	Gender perceptions. Conception and reasons associated with violence in the lives of the interviewees and in the health service.	The limits and responsibilities appropriate to the situation of violence against women in pregnancy and the working conditions of the professionals have been identified.
11-BVS	Villela, Vianna, Lima, Sala, Vieira, Oliveira.	Ambiguities and Contradictions in the Care of Women Who Suffer Violence.	Saúde Soc. São Paulo. 2011;20(1):113-23.	Qualitative. Identify the institutional dynamics that frame the professional relationship violated woman.	23 professionals from 2 hospitals, 3 health units and 2 police stations for women from SP.	Physical space Flow of care The vision of the professional about its user	In the health units there is no specific flow for women with a complaint of violence. In the hospital, cases of sexual violence are referred to the emergency room.
12-BVS	Gomes, Bonfim, Barros, Silva Filho, Diniz.	Confronting conjugal violence within the family health strategy.	Rev. Enferm UERJ, 2014;22(4): 477-81.	Qualitative. Identify elements that contribute to the confrontation of conjugal violence.	14 ESF professionals, 2 doctors, 2 nurses, 2 dentists, 4 social workers, 3 health workers and 1 technician. Nursing.	Identification Notification, Perception Intersectoral articulation of conjugal violence for health in the municipality of Bahia.	Identifying, notifying, perceiving, and having intersectoral articulation are elements that contribute to coping with violence, directing health actions and raising awareness among professionals.
13 - SCIELO	Barrientos, Miura, Macedo, Egry.	How Basic Care professionals face violence in pregnancy.	Rev. Latino-Am. Enfermagem 2014;22(3):448-53.	Qualitative How FHS professionals recognize and face the phenomenon of domestic violence during pregnancy.	14 professionals from the ESF, with 7 doctors and 7 nurses from the eastern zone of São Paulo.	Ease and difficulty in attending pregnant women.	The professionals had no training related to coping with domestic violence and did not consider themselves prepared.
14- SCIELO	Gomes, Silveira, Diniz, Paixão, Camargo, Gomes.	Identification of violence in the marital relationship based on the Family Health Strategy.	Texto contexto-enferm. 2013; 22(3).	Qualitative. To analyze the process of identification of marital violence by professionals of the Family Health Strategy of São Francisco do Conde Salvador-Bahia.	22 professionals of higher level being 5 doctors, 4 nurses, 5 social workers, 8 dentists.	Identification Perception Complexity of conjugal violence.	There is a need for better professional preparation, which will allow greater visibility of the problem and the adoption of coping strategies.
15- SCIELO	Gomes, Silva, Oliveira, Acosta, Amarijo.	Domestic violence against women: representations of health professionals.	Rev. Latino-Am. Enfermagem, 2015; 23(4):718-724.	Qualitative. To analyze the representations about violence against women among professionals from the Family Health Units in the city of Rio Grande, state of Rio Grande do Sul.	64 professionals, 13 nurses, 12 technicians. Nursing, 12 doctors, 27 health agents from 19 units.	Work time, Course completion time, Vocational training, Marital status, Training on violence.	All professionals presented a negative connotation regarding domestic violence. There are feelings set in the victims and in the professionals.

DISCUSSION

In the study carried out with health professionals from Angola, which included health professionals from three hospitals in Luanda considered as a national reference, the authors noted that in low- and middle-income countries such as Angola, there is a lack of information on violence against women, which contributes to the invisibility of violence (Nascimento *et al*., 2014). Other studies also point to the invisibility of violence (Gomes and Erdmann,, 2014; Guedes *et al*., 2013, Osis *et al*., 2012; Berger and Giffin, 2011; Vilella *et al*., 2011; Gomes *et al*., 2014; Barrientos *et al*., 2014; Gomes *et al*., 2013). Violence against women has rarely been identified and addressed in care, which hampers prevention initiatives. It is important to emphasize the importance of public policies, increasing the attention offered to protect women victims of violence, going beyond diagnosis for the care of physical and emotional injuries (Nascimento *et al*., 2014). It is clear from the aforementioned study that, even in the spontaneous reports of women about violence, referrals are not made, since there is no system of reference and counter-reference with definite flows and articulations in Angola. There is still the idea that marital violence is an intimate and private problem of the couple, in which professionals should not get involved because of privacy issues. Violence records are deficient, made in a local book and there is no mention of notification (Nascimento *et al*., 2014).

In Brazil, even if there is notification, it is often not performed due to the fear of reprisal or lack of knowledge of the professionals (Guedes *et al*., 2013; Gomes *et al*., 2014; Kind *et al*., 2013). The studies show that the practice of professionals is more focused on specialties and that this condition makes it difficult to act in situations of violence in which so many variables are involved. Medicine is fragmented and deficiencies are justified by the reduced number of professionals, as well as the lack of a qualified multidisciplinary team (Nascimento *et al*., 2014; Guedes *et al*., 2013; Berger and Giffin, 2011; Vilella *et al*., 2011; Kind *et al*., 2013). In the qualitative researches, it was unanimous among the interviewees that the lack of training represents the greatest difficulty in acting in situations of domestic violence. The professionals refer in several studies, unprepared for the care of women victims of violence (Nascimento *et al*., 2014; Gomes and Erdmann, 2014; Gomes *et al*., 2014; Barrientos *et al*., 2014; Gomes *et al*., 2013). The authors report in their studies that the perceptions of health professionals about violence against women emerge from a cultural construction, loaded with prejudices based on the supposed male superiority. Man is assigned a condition of domination and the woman is counted the responsibility for the aggressions that suffer in this relation. In practice, professionals who provide care to victims, most of the time, prioritize the treatment of physical injuries and do not contemplate the complexity of the situation. Some believe that violence issues concern only the psychologist and the social worker (Nascimento *et al*., 2014). In the survey carried out with ESF professionals in Santa Catarina, the interviewees showed that they consider marital violence an important health problem for women, with implications for the health sector and for economic productivity. The study records that the professionals of the ESF teams, in identifying women in situations of violence, refer them to the Family Health Support Center (NASF), but these support professionals, because they are linked to several units, are unable to attend the demand, compromising the care to the woman. The authors also stress the need to identify marital violence as a cause associated with repeated search by health services and stress the importance of exercising qualified listening (Gomes and Erdmann, 2014). Other studies also make clear the need for intersectoral actions (Gomes and Erdmann, 2014; Osis *et al*., 2014; Gomes *et al*., 2014). In the study carried out in Campinas, State of São Paulo, 687 women victims of sexual violence, assisted in emergency and multidisciplinary outpatient care (gynecologist, nurse, psychologist, social worker and psychiatrist) were studied. This program aims to prevent unwanted pregnancies, Sexually Transmitted Diseases (STDs) and promote the physical, psychological and social recovery of women and pregnancy care due to rape. The authors of the study reported that 2/3 of the women who arrived at the service reported within the first 24 hours after sexual violence and that 87.6% of the women who were seen within the first 72 hours were prescribed antiretroviral prophylaxis, vaccination / immunotherapy for hepatitis B, antibiotics, emergency contraception and outpatient follow-up with good adherence (Facuri *et al*., 2013).

It has also been observed that many women need support from mental health services, after suffering sexual violence and, that, if they are not followed up they may develop sequelae (Facuri *et al*., 2013; Oshikata *et al*., 2011). Other studies mention the recording of statements that highlight the impotence felt by professionals in the approach to gender violence, given the complexity of this subject. Another aspect that draws attention also relates to the report of some women users of health services, who do not recognize as only the competence of the health servisse, the reduction of violence (Guedes *et al*., 2013; Osis *et al*. 2012; Berger and Giffin, 2011). In a participatory research on the limits and potential of professional practice, with regard to violence against women, the authors pointed out the importance of the reception with qualified listening, aiming the creation of bond and the home visit as resources to detect violence (Silva *et al*., 2013). The Massachusetts Medical Society Committee on Violence recommends a direct question, which often increases the chance of detecting violence: "Have you ever caught, kicked, or been mistreated in any way by your partner?" (Duncan *et al*. 2013). Inadequate attitudes of professionals reproduce prejudice and perpetuate inequalities between genders, fueling a vicious circle between interpersonal and institutional violence. It should be noted that transforming the woman who suffers violence into a victim, treating her with indifference or insensitivity is to participate in the process (Vilella *et al*., 2011).

In a study of the social representations of 64 health professionals, including 12 physicians, these participants demonstrated negative feelings about violence against women, expressing terms such as fear, revolt, submission, low self-esteem, abuse and abuse of power (Gomes *et al*., 2015). Finally, in a single article of this integrative review, it was found that in an interview with 12 women who suffered domestic violence in the United Kingdom and were referred to a defender of violence, it can be observed that general practitioners and nurses could play an important role in identifying the victims of domestic violence and directing them to advocacy for guidance (Malpass *et al*., 2014). It is necessary to build networks attention with a focus on primary health care and the training of professionals to care for women in situations of violence in a comprehensive care perspective (Oliveira PS *et al*., 2016). The present study had as limitation

the absence of more robust studies relating female violence and the medical professional's referral to properly conduct their victims. It would be important to follow a group of women who suffer violence and how effective the referrals are used by the medical team.

Conclusion

It has been observed in selected studies that physicians are not prepared to address or detect domestic violence against women in primary care. Studies present violence as invisible. Regarding the referrals made by APS physicians, it was observed, according to the majority of the studies evaluated, that there is no integrality in the assistance offered, being the exception in two services that provide assistance in cases of sexual violence, in which the studies registered the supply of a comprehensive care that includes prevention and follow-up protocol, offering its own reference sites. In these two studies, these women were referred to the public defender's office and / or to a constant psychological outpatient follow-up. The studies also point out, disarticulation and absence of a care network. It is necessary to consolidate intersectoral policies so that there is equity and effectiveness in the care of women in situations of violence. The notification, although compulsory, as already mentioned, is also highlighted as deficient. The reason for not notifying itself is often the lack of preparation of the professional who regards the notification as a complaint, thus compromising epidemiological data. It is necessary to train APS physicians to be able to detect violence and make appropriate referrals. In addition, one could encourage the insertion of the theme in academic circles; broadening the interprofessional debate, as well as raising the awareness of managers in the area of public security and destigmatizing the problem, mobilizing and empowering civil society in general.

To that end, it would be urgent to restructure the health care network to ensure improved care, aiming at the quality of life of these women, especially in those groups that are less financially privileged because they have fewer resources, and are more exposed to violence. Lastly, this review can serve as a tool for reflection on the professionals that integrate the Family Health Strategy and Family Health Support Center teams, for expedited and more adequate referrals, in order to restore dignity, reduce vulnerability and bring protection and empowerment to women in situation of violence.

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