ORIGINAL ARTICLE *DOI:10.4025/cienccuidsaude.v16i3.35348*

POTENTIAL AND LIMITS OF HOME VISITS TO IDENTIFY AND ADDRESS WOMEN IN SITUATION OF VIOLENCE

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ABSTRACT
This study aimed to capture the potential and limits of home visits to identify and address women in situation of violence. It is a participant research with 38 professionals (nurses, nursing and community health agents) of six teams from the Family Health Strategy of a municipality located in the northwestern region of Rio Grande do Sul, Brazil. The data production occurred between November 2015 and March 2016, from six educational workshops. Data were analyzed by means of thematic analysis. The home visit is potential to identify situations of violence against women and observe the marital and family relations at home. The limits of the research were the presence of the aggressor and relatives, the workload in the unit and short time to address the issue. To overcome them, professionals identified that creating a private and secure atmosphere can be a proposal to be carried out through persistent and planned visits. Including the home visits as hard-light technology geared to women in situation of violence as a routine in the Family Health Strategy, may be a technique to approach the problem.

Keywords: Home visits. Violence against women. The Family Health Strategy.

INTRODUCTION

Violence against women is a recurrent problem in societies that mainly occurs by historical constructions of gender, in which the male is considered superior to the female in a relationship in which the latter is in a subordinate position[1]. The aggression that takes place at home is, in most of the cases, repeated and experienced for a long time, as a way of solving conflicts within the family. And, in these cases, violence against women is often "invisibilized"[2].

The experience of violence takes women to health services due to illness and, in this context, the Family Health Strategy (FHS) is considered to be a suitable service to receive women and to follow up a therapeutic project. The proximity and the bonds between the professionals and women tend to facilitate the report of the problem, which can be done at home[3].

This way, woman care through the visit shared with the FHS team is based on criteria of the families' risk and vulnerability, including violence against women[2]. In this way, professionals can know the environment in which the individual lives and the family dynamics, which assists in planning the actions with a larger perspective of the concept of health[4]. Socio relational diagnosis of the family is the basis to define the approach of each situation of violence, provoking discussion and organizing the actions of the team[2].

Thus, the practice of home visit is considered essential to identify situations of violence against women, since the professionals enter in the domestic space, the arena of violence. There are, in this practice, challenges related to the complexity of the specific situations of violence that professionals need to handle[3].

In this context, addressing violence against women in the home visits require the presence of light technologies (relational and knowledge) and hard-light (technical expertise), as well as the technological orientation of care related to an assistance model strongly supported by the relational base[5]. In the technological knowledge it is included the knowledge of gender to address violence against women[1].

Home visits can also give visibility to the

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problems of violence against women in territories where the FHS acts to initiate a therapeutic project and include the situation as a health demand in order to accompany the families and the impact of the interventions[2]. It is also the space in which the healthcare professional may conduct an active search, plan and execute health care promotion[6], which are considered essential in situations of violence against women.

International studies have also highlighted the key role of home visits to women who experience violence, by providing multiple opportunities to explore their experiences of violence, as well as the collective construction of the support these women need[7,8].

However, there are challenges to be overcome in view of the complexity of this problem, which requires more than investigative actions with a curative nature, educational and guidance are also needed. In addition, home care through visits of FHS is not fully incorporated into primary health care.

Considering the above, meeting and identifying the potential and the limits of home visits to women in situation of violence in the FHS brings the possibility to contribute to the discussion and qualification of the practice based on theoretical principles of gender[2] and relational care technologies[5]. It is shown that when these professionals seized the concepts, violence is understood and can promote more effective interventions during home visits[1].

Thus, this study aimed to capture the potential and limits of home visits to identify and address women in situation of violence.

METHODOLOGY

The study was carried out through the participative research (PR) method, which promotes the group analysis of knowledge and the manner in which it will actually be used; examines critically the reality; establishes the causes of the problems, the possibilities of a solution; and offers referrals[9]. It is organized in four stages[10] described below.

First phase: institutional and methodological construction of participative research

First, there was a meeting between the research team, the Health Secretary, the Technical Coordinator of the basic attention and members of the Management Board of the municipality where the study was carried out to discuss and plan the research project. After the approval of the Committee of Ethics in Research (CER), the group met and decided that the six educational workshops (data generation technique) will occur on Friday mornings, in the Centre of Reference and Expertise in Occupational Health.

Nurses, nursing technicians and community agents of seven teams from FHS were invited to participate in the study. The inclusion criterion was: having worked in a FHS unit for more than six months; the exclusion criteria: being on leave or on vacation. 38 out of the 65 professionals invited accepted to participate in the study. We highlight that the number of participants in the workshops varied.

Second phase: preliminary study of the population and the region involved.

In the first workshop, attended by 25 professionals, the introductory seminar occurred where the research project was presented, the informed consent (TCLE) and a demographic questionnaire handed to the participants, who read, filled and returned them. After that, the participants formed four groups so-called “Rose”, “100% ACS”, “Hosts” and “Facing violence”. In these groups the following inducing issues were discussed: “How do you manage the home visits with women in situation of violence in your daily work?” and “In which moment of your daily work do you perform home visits?”. After that, the groups expressed their ideas making posters.

Third phase: critical analysis of priority issues the research participants wish to study.

In the second workshop, which was attended by 31 professionals, the groups discussed and presented their ideas about the factors that limit and enhance home visits to women in situation of violence in the context of the FHS.

The third workshop was attended by 19 professionals who pondered and discussed the causes, solutions and actions to minimize the limiting factors of home visits to women in situation of violence.

The fourth workshop was attended by the 19 professionals that have attended the previous one.

They watched a Power Point presentation which addressed the potential and the limits of home visits. This presentation was built by the research team based on previous discussions and allowed the participants to define the priority problem, which is: "the home visit with the presence of relatives and aggressors and the difficulty the women have to talk about the situation of violence". Given this, it was planned to discuss and theorize "home visits to women in situation of violence".

The **fourth stage** is to program and implement a plan of action that contributes to the solution of the problem found.

During the fifth workshop, the groups read articles, solved situation-problems and discussed ways of approaching women in situation of violence in the home visits. 29 professionals took part in this workshop.

The sixth workshop was held under the following evaluation questions: "what are your impressions about the way in which the home visits to women in situation of violence occurred?" and "what is the contribution of the experiences offered by the workshops to implement the home visits to women in situation of violence?". 37 professionals participated.

The study was carried out from November 2015 to March 2016, in a municipality located in the northwestern region of Rio Grande do Sul. The empirical material of the workshops, which were recorded (audio), and the diary were transcribed and submitted to thematic analysis[11]. To this end, first, the material transcription was done in a text editor; then, the material was read individually and, later, the group reviewed the material and determined the corpus of analysis. After, this corpus was read, and registration units defined based on themes and meanings.

These approaches were read in groups and reclassified in units of record according to the units of meaning. The registry and units of meaning were read again and grouped together giving rise to thematic categories: potential of home visits: to identify, witness and observe the environment; limits of home visits: the presence of the aggressor, overload of work and short time; and actions to promote a private and secure atmosphere in the home visit.

The study complied with the standards of resolution No. 466/2012[12] and was approved by the CEP at the Federal University of Santa Maria under the opinion paragraph 1,290,392. To guarantee the anonymity of the participants, we used the letter P for participant, followed by the numerical sequence as the first participation in the workshops.

RESULTS AND DISCUSSION

27 out of the 38 participants were community health agents, seven were nurses and four Nursing technicians. About the characteristics of the participants, 35 were female; 30 were white; 38 were Brazilians; 20 were Catholics; 27 were married; 20 had completed secondary education; 26 received one to two minimum wages; and 12 had worked for two years in the health service.

Potential of home visit: to identify, witness and observe the environment

Home visits allow the professional to identify situations of violence against women and observe some events that don't happen in the FHS. It is taken by professionals as an opportunity to observe not only the injuries present in the woman's body, but also the home environment, conditions and integrity. It also allows to obtain additional information about intimate relations.

> It's a chance for us to detect things {violence} in a quieter way too. [...] I've already gone to a house where she {women} had recently given birth and he was aggressive. I saw this during the home visit. [...] this man wouldn't go the clinic, he wouldn't be there with her (P24 UR1).

> The home visit is a scenario where you see whether there is something broken in the house and you can also observe the injuries (P5UR1).

In general, to be inside the users' house helps to identify the real cause of illness, which in the FHS unit would not be possible. When it comes to situations of violence against women, the possibilities of observing the environment, culture, habits are enhanced, which helps to extend the knowledge about the problems and needs of women and their families and to promote better interaction between them and the professionals, which may facilitate the development of a therapeutic project[13].

In this context, it is imperative to adopt light

technologies such as listening, host and bond during home visits, since these elements can help building a trust relationship between the woman and the health team. Their home is the place where the FHS professionals have the opportunity to listen, engage, interact more with the users[2], which tends to enhance the continuity of care in situations of violence against women.

On the one hand, witnessing violence against women during home visit potentializes care follow up. On the other, the FHS professionals may feel afraid and insecure of the risks facing a situation of conflict which sometimes needs an immediate action, like prevent the aggressor to threaten or mistreat their wife, which is not always possible[3]. Women, in turn, are afraid to receive the professional visit, because they fear the repercussions of the aggressor if they find out that they talked about the violence[7].

The professionals related that when home visits are scheduled, they feel more secure and calm to deal with the woman in the situation of violence.

> [...] you have that time for the visit [...] it's quieter, there aren't those queries (you have in the unit) (P24 UR2).

> [....] you have the time for the visit, because it is a time that you dedicate to make that visit (UR4 P24).

The scheduled home visit may be more suitable for approaches that require listening/dialogue demands like violence against women, and their home is where the professional can give them more attention. The proximity between the professionals, women and families promotes interaction and communication in a private atmosphere, which considers the possibilities of the users' participation in the care program[14].

Home visit may be scheduled in advance, however, in this case, actual relations may be hidden. And, when not scheduled, you can witness the reality of the relations, which in situations of violence against women can be very likely to occur[3].

About the professional who performs home visits, the community health agent is the most important, because they live in the community and experience situations of violence daily. In general, this is the FHS professional that has a closer contact with the users and, sometimes, more consolidated ties with the population[15].

In this context, the community health agents identify women in situation of violence, they inform the nurses and together discuss the care and plan interventions in a team meeting[16]. So, home visits made by the community health agent promotes the women in situation of violence access to the health team and service, where she will be received and the problem addressed. Thus, home visits facilitates the user's access to health services[17].

With regard to home visits carried out by other professionals of the FHS team, as a doctor, nurse or Nursing technician, they are defined according to the needs of the users and scheduled depending on these professional's availability and the demands in the unit[18].

Limits of home visit: presence of the aggressor, work overload and short time

The results showed that the presence of the aggressor and relatives at home during the home visit are limits for professionals to develop listening through dialogue with the woman, safely and privately. In this way, the professionals believe that a woman should be alone during the visit.

> In the home visits we see the privacy a problem, in the case of the aggressor presence [...] in most cases, if she really suffers aggression, he tries to be together so that she doesn't say anything, doesn't report what happens (P8UR1).

> In home visits the presence of other people seems to be the problem (P9UR1).

> [...] the presence of the aggressor also causes limits like fear [...] sometimes the place is not appropriate because they are not alone (P6UR2).

Home is the intimate universe of the couple and should be a place where the "security, trust, harmony, equilibrium, affection, empathy, complicity and respect for autonomy"[14:628] are needed for good marital and family relations. The fact that the aggressor is present at the time of the home visit can mean, among other things, that he doesn't want the woman to speak with the professionals on the subject. In this respect, the violence represented by a male domination relationship, hampers the woman's possibilities of growing and developing autonomy[14], which limits their right to come and go, to express themselves and connect with others, especially with the health professionals.

On this composition, it is necessary to consider that home and families who live there are

constituted by different and multidimensional realities, cultures, values and beliefs, and considering these conditions it is possible to develop a care plan for the user, based on negotiations that look for success[6]. And, when it comes to situations of violence against women, it is crucial to understand the context in which these and their families live, to achieve success.

Although the social network of women who experience violence is composed of mothers, mothers-in-law and sons, they rarely threaten the power of the partner/aggressor[19]. Thus, the participation of FHS health professionals at home may promote to establish a relationship of trust and bond with this woman, which tends to encourage her to talk about the violence lived, creating possibilities for coping with it. It should be noted that the bond and trust encourage the woman to expose the violence openly[7], which she wouldn't do without this relationship.

Another limit of home visits to women in situation of violence mentioned by the professionals, was the overload of work due to excessive demand and lack of time. These conditions limit the realization of the visit, especially when it comes to the professional nurse. The time of the visit in which the woman would talk about the violence was not considered enough.

> You know you need to go to a home visit with the community health agent but can't leave because there's a lot of people in there {unit} (P11UR2).

> [...] a very strong factor, raised by the nurses, is the time, the workload [...] sometimes you end up not giving attention {to home visits} (P6UR3).

> [...] time is short for the woman to expose all the problem [...] (P15UR4).

The excessive work in the unit limited by the time, prevents the nurse to leave the unit, which is a reason why they do not visit women in situation of violence more often when compared to community health agents. It is noted that this situation is recurring in the FHS reality, where the intense demand of activities makes the nurses to prioritize nursing consultations instead of home visits, showing a model of assistance based on biological risks and programmatic actions[17]. This model determines a health service organization based on rules, timetables, scheduled appointments, which prevent the professionals to establish other forms of customer service/relations with the users[5].

With respect to the home visit length, it varies according to the needs of each family. However, it is necessary to determine a period of time, considering the number of visits that each professional must perform. A study shows that nurses dedicate from two to four shifts for planned visits with the team, while community health agents perform from eight to ten visits a day[17].

In home visits to women in situation of violence, the time of the visit will depend on the conditions of the woman. Therefore, it is appropriate to exploit better the time factor, because it could mean that professionals are not sufficiently prepared to meet the social demands of health, including violence against women.

Actions to promote a private and secure atmosphere in the home visit

The professionals considered the need to find a secure location, protected from the aggressor and family in which them and the woman in a situation of violence can start to program a therapeutic project.

> [...] we have to give preference to a reliable place; in the case of the woman, alone (P15UR4).

Such conceptions are according to the assumptions of the humanized service, which looks to ensure the privacy and confidentiality of information in an environment of trust and respect[20]. This environment is critical, given that the dialogue established on a visit to the woman in a situation of violence can mobilize feelings of shame, anger, fear and awe. On the other hand, a dialogue, well conducted by a caring, honest professional in a conversation devoid of judgment and stigmatization[7], shows the interests of the service to support the women situation[20].

The dialogue and listening during an individual conversation with the women can make them think about their experiences and give a new meaning to them so they may be able to tackle the problems. The professional support is a help to initiate a process of resilience[14]. A study shows that talking about violence during the home visit impacts positively on the women self-esteem, as well as increases their awareness about the services to which they are entitled as victims of violence[7].

The persistence of professionals in home visits and their planning at a time in which the aggressor is not in the house were pointed out by

professionals as actions to promote a protected environment for women in situations of violence.

> [...] we have to persist in the visits, because one day he {the aggressor} won't be home [...] I believe that he will not always be there (P8UR2).

Home is the place where the woman suffers violence[2]. So, we need to consider the specific characteristics of each situation, finding out the best time for the woman to receive the team and paying attention to the family environment. In this logic, the importance of using relational technologies arise, to produce a bond between the woman and the professional that ensures the production of care[5] considering the biopsychosocial aspects of the health/disease process of this woman. Bonds and listening are powerful technologies for women in situation of violence in the FHS[1] and may help to guide about the safety and security services to women in this situation.

The essence of care that home visits represent lies on the way the professionals work outside the FHS unit, which creates a unique possibility of freedom to manage their actions. Their relationship with women and their families and the knowledge of their contexts of life, promote the development of collective alternatives and, perhaps, more appropriate to care them and producing autonomy. Relational technologies offered during care are the basis to understand the families' needs in the domain of the home space, and go far beyond the transmission of information that can assist to tackle their problems[2].

FINAL CONSIDERATIONS

The home visit, as a hard-light technology, can become a strategy for addressing violence against women. Also, the adoption of light technologies represents a conversation through a dialogue with an appropriate and sensitive language that allows to know the subjectivity of women in situation of violence, who live in a marital and family environment dominated by the male figure.

Home visits to women in situation of violence implies to overcome a range of challenges related to the conditions that the problem requires, that go beyond a systematization of objective and subjective data observed in family relationships and the home environment.

Although home visit has been seen by professionals as a potential to identify situations of violence and better apprehend what is not possible in the FHS, the presence of the aggressor and family members during the visit, the workload in the unit and the short time to address the problem are evidences of the limits of this practice.

Providing a private and secure atmosphere through persistent and planned home visits by the professionals will help to overcome that limits together, with the ability of the FHS professionals to interact at home through efficient relational technologies, looking for alternatives that can transform this space of care, in order to expand the autonomy of women and their families.

The inclusion of home visit routines in the FHS as a hard-light technology, dedicated to women in situation of violence, makes it possible to improve it as a technique of approaching the problem. In this sense, thinking on social gender constructions may help the professionals to qualify this practice, since it is important to consider these spaces are genderized.

POTENCIALIDADES E LIMITES DA VISITA DOMICILIAR PARA IDENTIFICAR E ABORDAR MULHERES EM SITUAÇÃO DE VIOLÊNCIA

RESUMO

Este estudo objetivou apreender potencialidades e limites da visita domiciliar para identificar e abordar mulheres em situação de violência. Trata-se de uma pesquisa participante da qual participaram 38 profissionais (enfermeiros, técnicos de enfermagem e agentes comunitários de saúde) de seis equipes da Estratégia Saúde da Família de um município localizado na região Noroeste do Rio Grande do Sul, Brasil. A produção dos dados ocorreu entre novembro de 2015 e março de 2016, a partir de seis oficinas pedagógicas. Os dados foram analisados mediante análise temática. A visita domiciliar é potencial para identificar situações de violência contra as mulheres e observar as relações conjugais e familiares no ambiente doméstico. Como limites, constatou-se a presença do agressor e de familiares, a sobrecarga de trabalho na unidade e pouco tempo para abordar a questão. Para superá-los, os profissionais apontaram a criação de uma atmosfera privada e segura como proposta a ser efetivada através da persistência e planejamento das visitas. Incluir a visita domiciliar como tecnologia leve-dura voltada às mulheres em situação de violência como rotina na Estratégia Saúde da Família possibilita aprimorá-la como técnica de abordagem do problema.

Palavras-chave: Visita Domiciliar. Violência Contra a Mulher. Estratégia Saúde da Família.

POTENCIALIDADES Y LÍMITES DE LA VISITA DOMICILIARIA PARA IDENTIFICAR Y ABORDAR A MUJERES EN SITUACIÓN DE VIOLENCIA

RESUMEN

Este estudio tuvo el objetivo de comprender potencialidades y límites de la visita domiciliaria para identificar y abordar a mujeres en situación de violencia. Se trata de una investigación participante de la cual hicieron parte treinta y ocho profesionales (enfermeros, técnicos de enfermería y agentes comunitarios de salud) de seis equipos de la Estrategia Salud de la Familia de un municipio ubicado en la región Noroeste del Rio Grande do Sul, Brasil. La producción de los datos ocurrió entre noviembre de 2015 y marzo de 2016, a partir de seis talleres pedagógicos. Los datos fueron analizados por medio de análisis temático. La visita domiciliaria es potencial para identificar situaciones de violencia contra las mujeres y observar las relaciones conyugales y familiares en el ambiente doméstico. Como límites, se constató la presencia del agresor y de familiares, la sobrecarga de trabajo en la unidad y poco tiempo para abordar la cuestión. Para superarlos, los profesionales indicaron la creación de una atmósfera privada y segura como propuesta para llevarse a cabo a través de la persistencia y planificación de las visitas. Incluir la visita domiciliaria como tecnología blanda-dura dirigida a las mujeres en situación de violencia como rutina en la Estrategia Salud de la Familia posibilita perfeccionarla como técnica de abordaje del problema.

Palabras clave: Visita domiciliaria. Violencia contra la mujer. Estrategia Salud de la Familia.

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Submitted: 10/02/2017
Accepted: 13/10/2017