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Original Article

The attention to women victims of domestic and family violence: care technologies of occupational therapy in basic health care[1]

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Abstract: Introduction: The objective of this work is the construction of care technologies of occupational therapy care in attention to women victims of violence in primary health care. Objective: To identify and analyze occupational therapeutic practices and intervention technologies in attention to these women. Method: The qualitative study adopted the perspective defined by intervention research, with participant observation and semi-structured interviews as the main techniques for data production. For data analysis, the triangulation procedure of Methods was used. Results: The results of the research were systematized in three axes: (a) characterization of the participants; (b) territory data and team action (c) occupational therapy's care practices. Conclusion: It is concluded that Occupational Therapy contributes with its actions of the field of Primary Health Care in the attention to women victims of violence with multiple methodologies and a wide hall of relational technologies of care from the identification, elaboration and confrontation of the situations of violence through interventions in the sphere of women's everyday life and their contexts as well as in the potential for their transformation, with an emphasis on interrupting the cycle of violence.

Keywords: *Occupational Therapy, Primary Health Care, Domestic Violence, Women's Health.*

A atenção às mulheres vítimas de violência doméstica e familiar: a construção de tecnologias de cuidado da terapia ocupacional na atenção básica em saúde

Resumo: Introdução: Este trabalho tem como objeto a construção das tecnologias de cuidado em terapia ocupacional na atenção às mulheres vítimas de violência na atenção básica em saúde. Objetivo: Identificar e analisar práticas e tecnologias de intervenção terapêuticas ocupacionais na atenção à essas mulheres. Método: O estudo, de caráter qualitativo, adotou a perspectiva definidas pela pesquisa-intervenção, tendo a observação participante e as entrevistas semiestruturadas como principais técnicas para a produção de dados. Para análise dos dados foi utilizado o procedimento de triangulação de Métodos. Resultados: Os resultados da pesquisa foram sistematizados em três eixos: (a) caracterização das participantes; (b) dados do território e da ação em equipe (c) práticas de cuidado em terapia ocupacional. Conclusão: Conclui-se que a terapia ocupacional pode contribuir no cuidado às mulheres vítimas de violência com metodologias múltiplas e um amplo hall de tecnologias relacionais de cuidado a partir da identificação, elaboração e enfrentamento das situações de violência por meio de intervenções na esfera da cotidianidade das mulheres e seus contextos bem como no potencial de sua transformação, com ênfase na interrupção do ciclo de violência.

Palavras-chave: *Terapia Ocupacional, Atenção Primária em Saúde, Violência Doméstica, Saúde da Mulher.*

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1 Introduction

Domestic and family violence is one of the many manifestations of gender-based violence that affect women daily around the world. In a society of violence against women in daily and everyday contexts, the occupational therapist can act, contributing to the process of social transformation towards greater equity and social/occupational justice in different fields, and Primary care has increasingly been constituted as a SUS access channel for people victims of violence and a privileged locus for the development of care practices for these people.

However, understanding about the complexity of health conditions, needs and demands in Primary Care has not been enough for the professionals develop necessary and effective tools to build care strategies from professional centers and effectively deploy them into interdisciplinary and cross-sectorial actions, although guaranteeing women a space for access to care, expansion of the social support network and strategic actions of the field.

In the specific case of occupational therapy, these tools are also incipient because of the recently formalized insertion of this professional in Primary Care or because historically this is not a population traditionally assisted by the profession in the health sector.

To meet to demands of this nature, professionals need to be prepared for the development of a more humanized, generalist and cross-sectorial care practice. Identifying violence depends on the mobilization of internal resources, sensitivity and willingness to listen to each other, as well as intense investment in vocational training to receive and act in complex situations (BARALDI et al., 2012).

Therefore, when thinking about health care, we have to be responsible for the quality of care we offer, putting all the technological devices we have in terms of knowledge and techniques, at the service of the patient and their problem situations. Thus, the conception of care technology is the way each professional applies his knowledge to produce a line of care that acts with interest in defense of life, centered on the needs of patients (MERHY; FRANCO, 2003).

Besides the hard technologies, which are already materially structured to objectively meet demarcated demands, the role of light-hard technologies (professional knowledge and techniques) and especially light technologies, which are forms of relational approaches, operate from the encounter between the professional and the patient and their subjective production (MERHY; FRANCO, 2003).

In a national conjuncture and characterized by high rates of domestic and family violence, this study - to build occupational therapy care technologies for the care of women victims of violence - aims to explore how these technologies may come to cope with situations of domestic and family violence in the context of Primary Care, from the perspective of occupational therapists working in this context.

2 Domestic violence IN Brazil and PHC

Gender violence has victimized many women with a rate of 4.8 homicides per 100,000 women. In a group of 83 countries with homogeneous data provided by the World Health Organization, Brazil ranks 5th, showing that local indices far exceed those found in most countries of the world (WAISELFISZ, 2015).

The Maria da Penha Law (Law 11,340/2006), which in 2016 was considered by the United Nations (UN) as one of the three best laws in the world to combat violence against women, in force since August 7, 2006, creates mechanisms to curb and prevent domestic and family violence against women, regardless of class, race, ethnicity, sexual orientation, income, culture, educational level, age and religion (BRASIL, 2006).

From this legislation, Brazil began to indicate the responsibility of each public agency to assist women in situations of violence and to define 5 forms of domestic and family violence against women: physical violence, sexual violence, psychological violence, moral violence, and patrimonial violence.

Even with this law in force, the Map of Violence (WAISELFISZ, 2015), which uses data from the Ministry of Health's Notification Disease Information System (SINAN), reveals that women assisted by the Unified Health System (SUS) in 2014 continue to be victims of various types of violence, including physical violence (48.7% of cases), especially in the young and adult stages of women's life (about 60% of calls). In the second place, the psychological or moral violence has 23.0% of assistance at all stages of development, especially from the young onwards. In third place,

the sexual violence with 11.9% of the assistance, with a higher incidence among children up to 11 years old (29.0% of the assistance) and adolescents (24.3%) (WAISELFISZ, 2015).

The same study showed that physical violence occurs predominantly at the victims' homes, aged between 10 and 30 years old. Up to nine years old, parents are the main agents of these aggressions, and from 18 to 59 years old the main aggressor is the victim's partner or former partner. According to available data, 223,796 victims of various types of violence were treated at SUS during 2014. That is: 405 women demanded care in a health unit for some violence suffered every day of 2014 (WAISELFISZ, 2015). In the Maria da Penha Law (LMP), its articles 22, 23 and 24 lists the urgent protective measures, which should be triggered in situations of violence, and are often unknown to women and health professionals. These measures aim at a set of actions to be taken within 48 hours to ensure the immediate protection of women from their aggressors.

It is noteworthy that the notification of domestic, sexual and/or other violence was implemented in SINAN in 2009, and still has coverage problems (not all locations notify) and underreporting problems (not all cases are reported in the system) (WAISELFISZ, 2015).

The National Policy for Integral Care to Women's Health (PNAISM) aims to strengthen and implement policies that consider women in their diversity. One of the proposed goals is to increase the number of Family Strategy professionals trained in gender specificities and to increase by 20% the number of health services with notification of gender violence (BRASIL, 2013).

According to Schraiber et al. (2002), violence against women has several repercussions for their health and their quality of life. Within the services, domestic and sexual violence has been associated with higher rates of suicide, alcohol and other drug abuse, vague complaints, headache, gastrointestinal disorders, and general psychological distress. Regarding reproductive health, violence against women has been linked to chronic pelvic pain, sexually transmitted diseases, inflammatory pelvic diseases, and unwanted pregnancies.

Numerous studies have shown that basic network services are important in detecting domestic and family violence because in theory, they have a large territorial coverage and close contact with women, and can recognize and receive cases before even more serious incidents even facing difficulties regarding training, capacity building and articulation with the specialized care network on violence against women (SCHRAIBER et al., 2002; KANNO et al., 2012; SIGNORELLI et al., 2013; OLIVEIRA et al., 2015).

According to Reis et al. (2012), with the significant expansion of the Primary Health Care (PHC) and the Family Health Strategy (FHS), there was an expansion of professional categories directly linked to Basic Health Care (BHC), as well as other populations and problematic, which were incorporated as the focus of primary care. Formerly centered on selective follow-up actions for diabetics, hypertensive patients, children and women, this reality has changed, incorporating new demands that emerged with the expansion of care coverage and the bond between the staff and patients. Previously, women's health care was also selective, with the emphasis only on reproductive health aspects.

With this expansion of care and the process of territorialization of PHC, there was also an expansion of the possibilities of action of professionals, including more strongly concerned with the social determinants of the health-disease-intervention process, including coping of situations of violence.

Only in the 1990s, violence against women enters the agenda of health proposals. In 1996, the World Health Organization (WHO) recognizes violence against women as a worldwide public health problem worldwide. In Brazil, primary health care units are recognized as important in detection and coping with domestic violence.

> This level of care has a strong emphasis on health promotion and prevention actions. Also, there is an increase in coverage and recent increase, with an appreciation of going home through the increasing implementation of the Family Health Strategy. This level of care leads to frequent, constant and legitimate access to women throughout their lives, a closer relationship with the community and it is directed to common health problems very associated with domestic and sexual violence against women (D'OLIVEIRA et al., 2009, p. 1040).

The Brazilian primary care services already assist cases of domestic violence against women and children. Although not always presented as

such, these cases are present in the daily routine of services and generate a repeated demand and low resolution according to the data obtained by the Map of Violence (WAISELFISZ, 2015).

The interdisciplinary teams of the primary care teams can contribute to addressing this situation in their actions in the PHC field and also from the development of technologies aggregated to the knowledge and practices of each professional core, emphasizing here the core of occupational therapy.

The history of occupational therapy shows the pathways of practices and professionals to consolidate a field of knowledge that matches the real needs of society, based on guaranteeing rights, respecting diversity and promoting belonging to people who have their daily denied actions.

According to Bassi et al. (2012, p. 444), the gradual expansion of PH coverage produced a scenario of expansion of intervention spaces for the profession, providing the development of core actions in primary care:

> At the end of the 1990s, occupational therapists began to work more in PHC, with proposals for comprehensive care through prevention, promotion, and rehabilitation.

Currently, the insertion of occupational therapists in the PHC occurs in different points of care, strategic for facing violence, such as the Basic Health Units (BHU) and Family Health Units (FHU), Street Clinics and Nucleus of Family Health Support (NFHS).

According to Lancman and Barros (2011), the matrix support is one of the main actions of occupational therapists in PHC, and the NFHS is one of the main fields of work for these professionals, who should act in a shared way with family health teams from the matrix strategy. According to the documentary analysis by the same authors, the insertion and definition of the professional matrix work process, including occupational therapists, are generally presented in guiding documents, without specifications by professional core and low support to the daily work process.

3 Method

This study of a qualitative approach adopted the methodological perspective by the approaches defined by participatory research in the research-intervention modality (PAULON; ROMAGNOLI, 2010).

The formulating process of intervention research deepens the break with traditional research approaches and broadens the theoretical-methodological basis of participatory research, as a proposal for transforming the socio-political reality since it proposes a micro-political intervention in social experience. In intervention research, we do not aim at the immediate change of the instituted action, because the change is a consequence of the production of another relationship between theory and practice, as well as between subject and object (ROCHA; AGUIAR, 2003).

3.1 Field characterization

The field surveyed was the primary care network of a medium-sized city in the interior of the state of São Paulo. All occupational therapists covering the municipal basic health network located in 6 different health units were interviewed.

In 2012, the municipal health secretariat of this municipality committed to intensify and promote the fight against domestic and family violence against women with the signing of the Networking Cooperation Agreement to assist women victims of violence, pursuant to the Federal Constitution and Law 11,340/2006.

There are non-specialized women care services in the city (general hospitals, primary care services, family health program, common police stations, military police, federal police, CRAS/Social Assistance Reference Centers/Specialized Social Assistance Reference Centers/CREAS, the Public Prosecution Service, public defender's offices) and the specialized women's care services (Women's Reference Center, *Casa Abrigo* and the Women's Defense Police Station).

3.2 Research instruments and methodological procedures

For data production, semi-structured interviews were conducted from a script of questions previously built by the researchers and field diaries with the point of view of the researcher.

Therefore, the fieldwork was planned in two stages. **Stage 1** had a specific focus on a health unit, for investigation with the general team and data collection from the PHC field in which occupational therapists were inserted, aiming to identify/map the approach or distance

of the unit's professionals with the theme of "violence against women", promoting the team's sensitization regarding this theme. This stage was important to understand how this team and the PHC field relate to the theme of domestic and family violence in daily work, providing with data about the field in which occupational therapists are inserted.

To record this stage of the research, photographs, and field diaries were used, with the consent of professionals by signing an Informed Consent Form (ICF).

Stage 2 was focused on core aspects of occupational therapy and their contributions to addressing violence against women through interviews with occupational therapists from the PHC municipal network, who agreed to participate voluntarily in the research and to sign the Informed Consent Form. The results of this stage are those presented in this article, based on the analysis and discussion of the data from the interviews.

We contacted 6 occupational therapists (all professionals in this category inserted in the PHC of the researched municipality). Four professionals voluntarily agreed to participate in the research.

The interviews lasted an average of 60 minutes, were audio-recorded and later transcribed and coded with the acronym of the interviewee's professional category (OT) followed by continuous numbering from 1 to 4.

3.3 Data analysis

For data analysis, the method of Triangulation Methods was used (MARCONDES; BRISOLA, 2014) which propose:

I. Analysis of the concrete information raised with the research from the empirical data. In the pre-analysis of the interviews, the following categories of analysis and discussion emerged: (a) characterization of the participants; (b) PHC Field and Territory Data; and (c) Occupational Therapy Core Data; There was a dialogue with the institutional documents and scientific references that deal with issues pertinent to the categories of analysis arising from the narratives and data produced from the technique of interview translation. This technique, originally produced by Kastrup and Passos (2013) for cartographic research, was used in this research because for the authors, cartography is always intervention research and its methodological clues make research committed to producing knowledge combined with the creation of common and heterogeneous worlds (KASTRUP; PASSOS, 2013).

II. Conjuncture analysis, analyzing not only the information obtained but also the context in which the information was generated.

This study was developed in accordance with the guidelines and regulatory standards of research practices, and it was approved by the Ethics Committee on Human Research (CAAE 59307416.2.0000.5504).

4 Results and Discussion

The research results were systematized in three axes: (a) characterization of the participants and their formation for the theme; (b) Actions of the interdisciplinary team in the territory from the perspective of occupational therapists; (c) occupational therapy care practices for women care in primary care.

4.1 Participants characterization

All the 4 professionals interviewed attended public universities and only one has no postgraduate degree. The professional who graduated the longest, graduated in 1986 (OT 3). The professional who graduated less recently completed her degree in 2008 (OT 2). The participants' ages ranged from 30 to 54 years old. Three of the interviewees declared to be white and one declared to be brown. Three of the occupational therapists have been with PHC since 2011 and only one has a recent insertion in 2016.

Regarding the contact of violence, specifically violence against women, all interviewees said they did not adequately discuss the topic during graduation or in other training spaces, which is reflected in technical, personal and social difficulties perceived by professionals when there is a need for a practical approach to the problems of violence against women:

> *Maybe I went through the topic in the OT Social subject, but I can't remember exactly if I saw it or if I had something more specifically for it* (OT 2).

> *No contact. At the time I graduated, I don't know, we didn't talk much about it. It's been thirty years* (OT 3).

> *We had very few conversations about violence related to women, we had a lot of contact with violence as a whole, such as against children, people with special needs, abuse of the elderly people, people with severe mental disorders, autistic children* (OT 4).

In the literature consulted, the fragility of the professional health education focused on gender issues is highlighted, more specifically in violence against women, proving to be one of the greatest difficulties for the implementation of public policies for the prevention and confrontation of violence, and being a reality identified in all health professional categories, including occupational therapy (SCHRAIBER et al., 2002; SALCEDO-BARRIENTOS et al., 2011; KISS; SCHRAIBER, 2011; KANNO et al., 2012; SIGNORELLI et al., 2013; OLIVEIRA et al., 2015).

Regarding the continuing health education, which is one of the objectives of the National Policy Plan for Women (BRASIL, 2013), the interviewed professionals reported lack of offer and participation in activities with this bias in the municipality studied:

> *I've already participated in a discussion* […]. *But nothing like studying, because you review content that sometimes gets lost in the memory, I think leaving these concepts and situations more vivid in mind is always positive. I think it would be interesting* (OT 1).

> *The city hall has never done professional training on this topic, I think.* (OT 3).

According to Freitas, Oliveira and Silva (2013), the discussion on addressing domestic and family violence in PHC require that health work processes be thought of as political processes, not only technical.

However, from the participants' report and the conversation circles with the general team, the incorporation of the theme is discreet and reticent in the formative spaces and in the daily routine of health services. In this sense, the commitment made by the political instances does not seem to directly affect the work of the concrete agents of health practices and health education. Thus, the urgent need for qualification of these professionals in gender relationships is highlighted, especially in violence (KISS; SCHRAIBER, 2011).

About the professionals 'knowledge about LMP, the types of violence that the law covers, the proposal of a care network, the mechanisms to curb and punish domestic and family violence, the testimonies showed that the professionals' lack of knowledge may result in poor health services' resoluteness in supporting law enforcement:

> *I know very little, I never stopped to study the LMP. But I know what it is about, right. But I never stopped to read it. I don't have a deep knowledge of it. I don't know the types of violence that the law covers* (OT 1).

> *I think the more theoretical and contact I had was from its research, I started to pay a little more attention to the types of violence and to think about how it works here in the city* (OT 2).

> *I only know because of hearing about the law, knowing the law, but what it encompasses, the specifics, what you said, I don't know. I don't know* (OT 3).

Since 2005, the Data Senate Institute has been conducting telephone surveys on domestic violence against women. In 2017, the Institute held the seventh edition of the survey, in partnership with the Women's Observatory against Violence. From the data analysis, it was identified that when women are questioned about the *Maria da Penha* Law, all claimed to have heard about the law. Nevertheless, 77% said they know it little, while only 18% know it a lot (INSTITUTO..., 2017).

These data show that the Brazilian population as a whole, including health professionals, has little knowledge about the law, but also reinforces that the lack of understanding of other types of violence distances the victims from specialized services, and naturalizes violence that does not leave visible marks.

When faced with primary care health professionals who are unaware of the law and instruments to protect women's human rights, we understand one of the reasons for the compulsory underreporting of cases from SUS and the fragility of effective cross-sectional care network for women victims of violence in the municipality.

For this reality to change, it is necessary for professionals to have ethical and political training beyond the technical dimension of the work process, bringing part of the responsibility for social transformation and incorporating the practice of making notifications in the daily routine of health services (FREITAS et al., 2013).

Only one of the professionals knew more deeply about the LMP proposal and brought important elements to its discussion:

> *Look I know. But I don't know if I believe it. Particularly, from what women often go through in some situations* [...] *the first thing they talk about is the support and safety after they make the complaint. Another point that I think is prior to the support that will happen later, is the people who receive these women, the relationship they have. Many women say they are very questioned, they really feel, not as a space for defense, but as "Are you sure it was only that? Are you sure you are not guilty of that?" It gives a feeling that the scream and the distress call are questioned. People sometimes when they receive them, look, watch them. I think maybe even pass a value judgment. And depending on who gets it, they often decide there whether or not to continue* (OT 4).

> *The apex of LMP for most of these women is physical violence. The other violence, which is what I follow daily here in Health, they are hidden, they are unnoticed* […] *when we start talking a little about on these issues, women still have difficulty understanding that this is violence, that it is an abusive relationship* (OT 4).

From this, it is essential to discuss access to justice, from three dimensions:

A formal normative dimension, with the recognition of rights by the state and their formalization in-laws; another dimension to the existence of mechanisms and strategies to access to formal justice in real access, with its effectiveness through the organization, administration and distribution of justice; and the third dimension involving the conditions of each citizen to be recognized as an individual of rights and to trigger laws in the protection of their rights (PASINATO, 2015, p. 412).

In the context of the PHC, this law is recognized as a reference for the historical process of building women's rights in Brazil and fulfilling the first dimension of access to the right. When we observe the second dimension, we run into structural problems that often do not help women gain access to their rights (PASINATO, 2015).

The third dimension of access to justice brings up a recurring problem in the population traditionally assisted by the occupational therapy, which is the difficulty to see themselves as individuals of rights, especially the absence of rights that are expressed in daily life.

We live in a society that hegemonically, culturally legitimates everyday violence, for example, by naturalizing women's double-shift or women's sexual, behavioral, material and/or financial control by their partners. This legitimation is repeated when infidelity, authoritarianism or aggression in relationships are incorporated as natural behaviors of man.

For all this, it is easy to understand the report of professionals who point out the difficulty of women to be perceived within a cycle of violence and, moreover, to understand that they have the right not to be in these situations.

4.2 Territory and team action data from the perspective of occupational therapists

To better understand the fields and territories in which each professional was inserted, it was necessary to understand if there were cases of domestic and family violence in the territory, identified and/or accompanied by occupational therapists. Thus, there was consensus on the presence of domestic violence against women in the neighborhoods covered by each unit in which the professionals were linked:

> *It is a neighborhood with violence yes, it is a neighborhood with a very present traffic situation, so there is violence yes* (OT 1).

> *We have many cases of sexual abuse. We have a lot of relationship between parents, stepparents, grandparents, and siblings, who are sometimes involved with alcohol and other drugs* […] *these cases have grown a lot, the relationship of sexual abuse of rape among family members* (OT 4).

Understanding that domestic and family violence is a reality in all research territories, the Basic Health Units (BHU) and the Family Health Units (FHU), as stated in the National Policy of Primary Care (PNAB), has the development of sectorial and

cross-sectorial actions as one of the pillars that have an impact on the situation, conditions and health determinants of the communities that constitute that territory. However, when professionals were asked about the unit's primary violence prevention interventions, reports of a possible deficit of interventions with this focus were identified.

> *In the unit, I see no movement in this direction. What arrives, arrives by the PHC, they are on the street, they are inside the houses, they know the families, they know what happens, even more superficially, they know what is happening. But I have never seen any movement here within the unit to develop some activity in this direction* […] *It would be interesting to explain to everyone this form of prevention, which is violence, which does not have to shut up, to someplace where to run* (OT 1).

> *I cannot tell you what has been done during this period that I am here, I did not see more specific prevention actions. They say that at the time of March 8 they do actions in the queue or in groups or some more specific intervention, but I haven't participated yet.* […] *But I think it's important to talk about, advising about places, how it works, give visibility and know how we can act* (OT 2).

> *Look we always enjoy some time, sometimes there are some students from other universities that appear here, and always involves something. Being pregnant, with the care of the family and the husband present, the use of drink, the issue of abuse. Whenever there is an opportunity we talk, but still in non-collective activities. Particularly, to tell you, a reality here, I see here that domestic violence is a very big taboo subject, it is very little explored* (OT 4).

Regarding the actions to prevent violence against women carried out by professionals in the units, it is necessary to define what is a health basic action and basic health action. Although the terms seem to say the same thing, there is a fundamental difference in content for this discussion.

According to Malfitano and Lopes (2003), basic health actions are the interventions that provide assistance for problems or diseases related to components of clinical health, such as diabetes, hypertension, prenatal and others. The health basic actions are directly related to the demands of that population according to their socio-cultural and economic characteristics.

Domestic and family violence causes health problems for many women, as mentioned earlier. However, it is essential that when we look at this problem, we consider that basic health actions also need to go together, so in fact, it is possible to achieve the goals of comprehensiveness proposed by SUS.

> […] *it is a topic that is not much said, people sometimes feel very ashamed to seek help or even to review with their own team, because sometimes you realize that some things are difficult for the team, that the women on their own team also suffer, sometimes very subtle things* (OT 2).

> […] *We also have an important issue, now that I'm thinking, that we employees also suffer violence. And I can clearly tell you that many healthcare professionals experience violence within their homes* (OT 4).

Such reports showed the delicacy of the theme and the urgent need to break the silence and fear that may result from violence. This challenge is clearly spelled out in occupational therapy and the health sector, composed of most female professionals, as exposed by the World Health Organization (ORGANIZAÇÃO..., 2008) in Figure 1 below:

4.3 Occupational therapy care practices in women victims of violence

Occupational therapy care technologies are uniquely expressed, so each professional applies their knowledge to produce a care line (MERHY; FRANCO, 2003). In this sense, the practices of professionals and statements about their practices express the construction of these care technologies.

Once the cases are identified by the UBS, and the limitations cited by professionals in the field of training and statements about the PHC field, we seek to identify how these cases are approached/received and how they reach (or not) until occupational therapy.

> *Usually the nursing staff welcome them, trying to understand what is happening. They never referred specifically to me. I do not know if they have already sent to CREAS. But I believe this would be what they were going to do* (OT 1).

> *I think it will depend on the case. The day I saw that the injured woman arrived at the unit, the host person called the doctor and sent to the ER,*

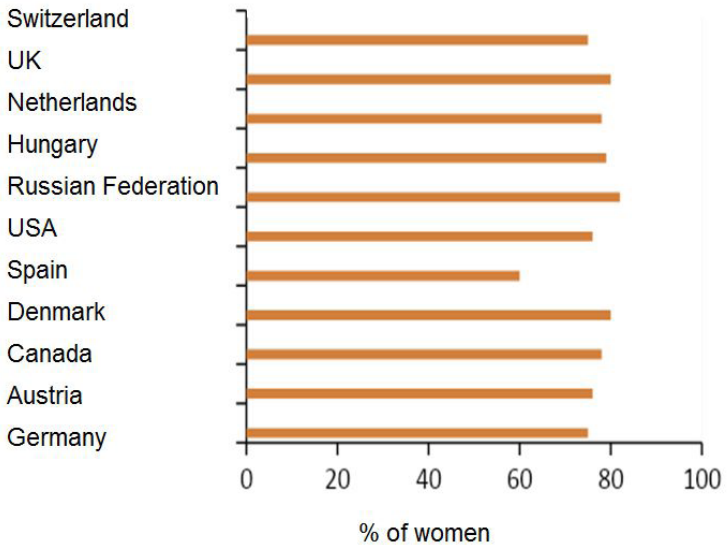

Figure 1. Health workforce distribution by gender.

> *because she was well injured* […] *usually will not reach the OT directly, will come to who is the reference team, to the PHC, to the nurse, to the nursing assistant* (OT 2).

> *In my case, sometimes the nurses identify a case, something that is happening, and then she ends up telling me, if the person doesn't want to talk about it calmly and with someone else, if they don't think it's better to talk more about it in another space, in a more reserved environment. So, there is a referral from the team, or as we told you, the person comes through a situation and we end up observing the violence* (OT 4).

The statements showed that the mediation between women and occupational therapy necessarily or mostly passes through a previous filter (home visits and reception), mainly performed by Community Health Agents (CHA) and the nursing staff, giving clues that these professionals are key elements in understanding what occupational therapy and the sectorial/cross-sectorial network can offer these women.

The moment when a woman decides to share with a professional who is in a violent situation is an important indication that this woman is asking for help, so a quick and effective response is needed. However, we refer not only to a technical response but a technical-ethical-political response.

> *The technique of OT goes very closely with the political position, we always need to be well informed to mobilize for some actions. Things go together, you cannot be a technician and that´s it, you need to have a political background to work in SUS.* […] *If you work in SUS, it is essential that you have some ideologies of what is health, what not it is, what you can do and require from the public service* (OT 3).

> *Look, I think the OT has a very important role because, in her training, she has the ability to work in all sectors: Education, Health, Social area. We work a lot. I believe that in these social and political issues, for example, I am involved in health, but I still have the look of other equipment. So I think we need to improve the cross-sectorial issue a lot, I think we still have this situation of being alone with us. OT can relate to other equipment* […] *but I still believe that we need to improve a lot, study a little more about these issues of violence, including the training of public policies* (OT 4).

Historically, the occupational therapists have engaged in the struggles of workers, patients and family members of mental health services, accompanied the political trajectory of movements of people with disabilities, and the struggle for representativeness and broadening rights of vulnerable populations. Along with the proposals for deinstitutionalization, the struggle for public authority's responsibility for the full care of the excluded part of the population was an ever-present motto in recent decades in the profession (MOREIRA, 2008).

As a result of this historical process of engagement in other struggles, although the findings of the first

stage of the research show the weakness of vocational training specifically to violence against women, the theoretical-practical density of the profession in a set of concepts is notorious and actions that are very relevant to compose the construction of care technologies aimed at the victims. Experiences of care with women victims of domestic and family violence have been a demand that comes to professionals, mainly indirectly in PHC.

> *I met two women who had children with chemical dependence in a group and then the difficulty to deal with this situation because they are mothers and they could stop caring, but they suffered physical violence. They arrived in the handicraft group, it was a group open to the entire population of the neighborhood, but it was focused on mental health* (OT 1).

> *In the six units that I support, I have been attending cases of people who did not come because of a violent situation individually and in a group, but when attending, I discovered a history of violence* […] *a woman I attended started to bring some situations After she knew me 2 months ago, she said "now I think I can tell you". It is very important that the bond, you are available to welcome, to think together and also co-responsible this person* (OT 2).

> *What we see is always violence by men who drink, who come home and beat their wife. They come asking for help with alcohol and not violence, very insecure, feel unable to drive/lead their own life alone* (OT 3).

> *But she comes for another demand, there was no case that came to me with violence explicitly. Sometimes the demand comes in other ways, for example, realizing she is a woman who is more depressed in a group* […] *and then with the bond, you are approaching the case that is unveiling the issue of violence* (OT 2).

In these cases, it is noted that one of the ways that put occupational therapists in contact with the theme of domestic violence in their professional practice in PHC are not mostly specific demands focused on this theme. The meeting with victims occurs mainly from the possible results or effects of violence (such as psychological distress, use of psychoactive substances, sequels related to physical, moral, psychological aggression...) or from daily experiences reported by users that aggregate possible risk or aggravating factors of violence (alcohol and drug abuse, social vulnerability, miserability, occupational injustice, etc.)

According to Rabello and Caldas Júnior (2007), although alcohol and other drug abuse and violence against women are approached as a causal relationship of situations of aggression, this is not the primary cause of the violence suffered but a factor that potentiates and makes women vulnerable to the violent context.

Saffioti (2015, p. 82) reinforces that "It also obscures the understanding of gender violence and the reasoning that pathologizes aggressors". Thus, the mechanism of pathologization ignores hierarchies, gender inequalities, and social contradictions, forgetting that the use of psychoactive substances acts only as another triggering element of violence.

Another fundamental point of this discussion is how professionals have assisted these women, what concepts or which technologies of care in the core occupational therapy can and/or are being used.

> *I start with the individual or home care, then, I take it to the group depending on the situation. But what I realized is the improvement of self-esteem so they can cope with these situations. And then you can work it in anyways and OT has the potential for this* […] *to strengthen this woman in her daily life* […] *I think it is working with this woman: self-esteem, self-sufficiency, issues to strengthen to face this situation in practice* (OT 1).

> *It's up to the OT because somehow it will have interference in that person's daily life, either in her relationships or in her role as wife, worker, finally a series of occupational roles.* […] *When I think of care technologies, I think a lot about these relational, things that are not only specific to the core. To think of spaces that she can share and strengthen, think of social participation. Help this person in her daily life to have a different life, to move in different spaces, in new relationships!* (OT 2).

> *Then we take her life story and everything and start talking a little about her daily life, what she does. And her context turns out to be very impoverished and this impoverished one that I often speak is not because she wants it, but because her husband wants it. And these are very simple things that we, as an occupational therapist, find very easy to identify, help the person to reflect and try to change* (OT 1).

> *They could benefit from OT care, in the sense of empowering, empowering this woman so she can take action. OT could contribute by helping this woman discover her own potential and develop*

> *it in her territory.* […] *using the resources of activities while awakening things for these women, experimenting with new skills, stimulating study and work* […] *Experiencing, doing. Working thinking of income generation, a group that can organize, solidify* (OT 3).

> *I think our activities contributed, the activities of groups mainly. The issue of violence: we always bring one theme and end up leading to another.* […] *Sometimes we identify violence not by the women, but by the figure. This in a way ends up being explored out, so like, "Wow, my son told the therapist or someone else I picked up yesterday." got beat up, my father hit my mother". And then we have a chance, sometimes, to open the issue with this woman come and start talking about it too. And then from the child, we end up assisting the whole family* (OT 4).

Although occupational therapists reported little ownership for LMP and to formal cross-sectorial resources for coping with domestic violence, the interviewees point out ways from the practice that expressed significant contributions from the profession to this specific population.

Synthetically, from the interviews, the occupational therapist's actions towards this population point to at least two major directions (1*) actions from the PHC field shared by other professionals* and (2) *actions from the professional nucleus*.

The actions of the PHC field were better explored from the results of the research in stage 1, which was not the object of this article, but can be summarized here:

The interdisciplinary team in general, considers that PHC is a strategic space in the territory for the implementation of activities aimed at preventing and coping with domestic and family violence, emphasizing the valorization of the family health strategy (FHS) as a model of care that widens the possibilities of identifying and monitoring situations of violence, not only through interventions in families, at home or in individual/group care, but also through actions in schools and cross-sectorial networks, with emphasis on the power of Community Health Agents.

The actions of the PHC field performed by the interdisciplinary team in the care offered to women victims of violence, cited by the participants, include actions such as welcoming, humanization practices, mental health monitoring, home visits and follow-up, qualified listening, general and specific guidance, integrative and complementary practices, networking with other services and sectors, and social support networks.

Regarding the professional nucleus, there is the immersion of the field and interviews that occupational therapy technologies were not explicitly mentioned, developed exclusively for this population that consolidates significant contributions to address violence and possible care technologies to be invested.

From the translation procedure (KASTRUP; PASSOS, 2013) as a procedure specific to some intervention-research modalities, we propose to present some clues provided by the interviewees in the construction of these technologies. According to Kastrup and Passos (2013) to translate is to make the passage from one language to another, in our case, from the language of narrative about the experience to the language of the production of scientific knowledge. In this sense, it is not a question of guaranteeing a correspondence of principle offered by a supposed universality of previously given technologies. However, in the translation procedure, we have to produce equivalents. In terms of intervention research, the equivalence produced is not synonymous with correspondence but occurs as a line that operates the communication between singularities of the actions and individual semiotics of the interviewees and the collective constructions of the profession.

The clues produced are (a) the main intervention spaces of occupational therapists with women victims of domestic violence in primary care from the participants' perspective; (b) the main intervention methodologies of the professionals addressed and (c) the main practices stated by the interviewees.

(a) The main spaces for intervention and meeting between occupational therapists and women victims of violence were the health unit, the domicile and the territory, including its open and institutional spaces.

(b) Among the main methodologies for approaching women were individual care in occupational therapy, group care, income generation workshops, family care, home visits/care, matrix support, and therapeutic follow-up.

The answers found in the participants are in agreement with the study by Cabral and Bragalda

(2017) that states that therapeutic groups and workshops, home visits and matrix support have been the most recurrent forms of performance of these professionals in the field.

The practices stated by the interviewees as experiences that contribute to the construction of care technologies with women/family include:

- The use of activities for the expression, identification, and elaboration of the experience of violence;
- Identification of occupational roles and intervention in aspects of daily dynamics that contribute to the maintenance of domestic and family violence;
- Construction of strategies to deal with the situation of violence with women and their families;
- Construction of other forms of social participation to increase self-perception, self-sufficiency, women's autonomy, including income generation, self-care, therapeutic workshops and strengthening social support networks.

Our findings reinforce Cabral and Bragalda's (2017) thesis that occupational therapy, in the context of PHC, can promote the social participation of these women and their families in the community, focusing on their life projects and meaningful activities.

From the analysis of these actions, a reflection emerged: once the violence shown as a problem that occurs from a daily violence and that produces violated individual and collective bodies, an ethic of care that goes beyond the affirmation or denial of violence emerged as an individual or social problem, or even beyond the understanding of this phenomenon as a problem concerning or not to the health sector.

By affirming that the daily lives of women victims of violence would be the focus of our professional performance, there is a technical-ethical and political commitment to address violence as a problem that focuses on life and life processes, which includes and at the same time goes beyond individual or private care, reaffirmed as a problem of affective, cultural, public and social sphere.

5 Final Considerations

A presente pesquisa teve como objeto o processo de construção de tecnologias de cuidado da terapia ocupacional e buscou identificar e analisar esses processos voltados para a atenção às mulheres vítimas de violência doméstica e familiar, no contexto da ABS.

The objective of this research was the process of building occupational therapy care technologies and sought to identify and analyze these processes focused on the care of women victims of domestic and family violence, in the context of ABS.

From the analysis of the results, in general, a paradox was identified that explains at the same time some weaknesses in the professional training of occupational therapists and PHC professionals about specific conceptual, legal and cross-sectorial aspects of violence against women. At the same time, it makes explicit the powers that occupational therapists and primary care professionals have for the practical confrontation of the cycle of violence, either by the generalist and inclusive training of this professional or by the nature of the capillarized and territorialized attention of the PHC/FHS.

This does not exempt from the need for comprehensive care and gender issues to be explicitly incorporated as references in the training of occupational therapists and for them to be aware of the mechanisms of access to the right, as well as the women's care network victims of domestic and family violence.

Unveiling violence within the services and explaining its consequences through research practices have proved to be a strategic device for the engagement of professionals with the theme and for the academy to correspond with training and knowledge production practices that help to cope of violence and its effects.

The reports of professionals interviewed showed cases of domestic and family violence in the care provided at PHC, being referred to occupational therapists directly and mainly indirectly. The profession has the potential to develop social and care technologies that help women to be perceived in situations of violation of rights and consequently provide strategies for their individual and collective strengthening, breaking the cycle of violence through the creation of concrete conditions of reconstruction/transformation of their daily life.

This research allowed to identify that primary health care units are an important space, not only for identification but mainly for the reception, intervention, and production of support networks for the study population. Thus, occupational therapy and other health professions can focus on the constitution of new forms of professional action or on the strengthening of existing practices, which inaugurate their own technologies of singular care dedicated to women victims of domestic and family violence, demanding the incorporation of the assumptions defended in the National Plan of Policies for Women within the scope of their education and professional performance.

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