

Article

The COVID-19 pandemic and cases of domestic violence: perceptions of primary healthcare professionals in the context of social isolation

A pandemia de COVID-19 e casos de violência doméstica: percepções de profissionais da atenção primária à saúde no contexto de isolamento social

La pandemia de COVID-19 y la violencia doméstica: percepción de los profesionales de atención primaria de salud en el contexto del aislamiento social

Maria Carolina Bartos¹

Universidade Federal do Paraná, Curitiba, PR, Brazil

 <https://orcid.org/0009-0009-4259-4071>

 mcarolinabartos@gmail.com

Regiane Matias da Silva²

Universidade Federal do Paraná, Curitiba, PR, Brazil

 <https://orcid.org/0009-0007-6949-6699>

 regianematiassilva@gmail.com

Vanessa de Oliveira Luc chesi³

Prefeitura Municipal de Paranaguá, Paranaguá, PR, Brazil

 <https://orcid.org/0000-0002-8005-189X>

 lucchesi.fono@gmail.com

Clóvis Wanzinack⁴

Universidade Federal do Paraná, Matinhos, PR, Brazil

 <https://orcid.org/0000-0002-1859-763X>

 cloviswa@gmail.com

Marcos Claudio Signorelli⁵

Universidade Federal do Paraná, Curitiba, PR, Brazil

 <https://orcid.org/0000-0003-0677-0121>

 Signore@ufpr.br

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Abstract

Objective: to analyze the perceptions of primary health care professionals in Paranaguá/PR about the relationship between the COVID-19 pandemic and cases of domestic violence in their assigned territories, identifying challenges in the approach, impacts on families and case management.

Methodology: qualitative research was conducted using semi-structured interviews and focus groups with 36 professionals from two primary health care units in Paranaguá, on the Paraná coast. **Results:**

¹ Medical Student at the Universidade Federal do Paraná, Curitiba, PR, Brazil.

² Medical Student at the Universidade Federal do Paraná, Curitiba, PR, Brazil.

³ LL.M in Sustainable Territorial Development at the Universidade Federal do Paraná, Matinhos, PR, Brazil. Speech Therapist at Prefeitura Municipal de Paranaguá, Brazil.

⁴ Ph.D in Regional Development at the Universidade Regional de Blumenau, Blumenau, SC, Brazil. Associate Professor at the Universidade Federal do Paraná, Brazil.

⁵ Ph.D in Collective Health at the Universidade Federal de São Paulo, São Paulo, SP, Brazil. Associate Professor at the Universidade Federal do Paraná, Brazil.

Primary health care professionals unanimously reported an increase in the number of domestic violence cases in those communities, affecting women, children, and adolescents, with the closure of schools identified as an aggravating factor. The main challenges highlighted were the disruption of primary health care services during the peak of the pandemic due to the reallocation of professionals and resources; misinformation about referral processes for domestic violence cases within the intersectoral network; fear among professionals regarding the pandemic and reporting domestic violence cases; and high staff turnover. **Conclusion:** The period of social isolation caused by the pandemic intensified domestic violence cases, according to the perceptions of primary health care professionals in Paranaguá. The dismantling of the intersectoral network further compromised the care of individuals in situations of vulnerability and/or violence. The absence of national guidelines from the federal government left municipalities and primary health care professionals on their own to deal with the issue.

Key Words

COVID-19. Primary Health Care. Social Isolation. Violence Against Woman. Domestic Violence.

Resumo

Objetivo: analisar as percepções de profissionais da atenção primária à saúde de Paranaguá/PR sobre as relações entre a pandemia de COVID-19 e casos de violência doméstica em seus territórios adscritos, identificando desafios na abordagem, impactos nas famílias e manejo dos casos. **Metodologia:** pesquisa qualitativa com entrevistas semiestruturadas e grupos focais com 36 profissionais de duas unidades básicas de saúde de Paranaguá, litoral paranaense. **Resultados:** profissionais da atenção primária à saúde foram unânimes em relatar o aumento no número de casos de violência doméstica naquelas comunidades, com impactos tanto para mulheres, quanto para crianças e adolescentes, sendo o fechamento das escolas um fator agravante. Como principais desafios, foram reportados: a desestruturação da atenção primária à saúde durante o auge da pandemia com deslocamento de profissionais e recursos; desinformação sobre fluxos de encaminhamento nos casos de violência doméstica na rede intersectorial; medo dos profissionais, tanto da pandemia, quanto de denunciar casos de violência doméstica; e rotatividade de profissionais. **Conclusão:** O período de isolamento social causado pela pandemia intensificou os casos de violência doméstica segundo as percepções de profissionais da atenção primária à saúde de Paranaguá. O desmonte da rede intersectorial prejudicou ainda mais o cuidado de pessoas em situação de vulnerabilidade e/ou violência. A ausência de diretrizes nacionais do governo federal deixou municípios e profissionais da atenção primária à saúde à própria sorte para lidar com o problema.

Palavras-chave

COVID-19. Atenção Primária à Saúde. Isolamento Social. Violência contra a Mulher. Violência Doméstica.

Resumen

Objetivo: analizar las percepciones de los profesionales de la atención primaria de salud de Paranaguá/PR sobre las relaciones entre la pandemia de COVID-19 y los casos de violencia doméstica en sus territorios asignados, identificando desafíos en el abordaje, impactos en las familias y gestión de casos. **Metodología:** investigación cualitativa con entrevistas semiestructuradas y grupos focales con 36 profesionales de dos unidades básicas de salud de Paranaguá, en la costa de Paraná. **Resultados:** los profesionales de la atención primaria de salud fueron unánimes al reportar el aumento del número de casos de violencia doméstica en esas comunidades, con afectaciones tanto a mujeres, niños y adolescentes, siendo el cierre de escuelas un agravante. Se informaron los principales desafíos: la interrupción de la atención primaria de salud durante el apogeo de la pandemia con el desplazamiento de profesionales y recursos; desinformación sobre los flujos de derivación de casos de violencia doméstica en la red intersectorial; miedo entre los profesionales, tanto a la pandemia como a denunciar casos de violencia doméstica; y rotación profesional. **Conclusión:** El período de aislamiento social

provocado por la pandemia intensificó los casos de violencia doméstica según la percepción de los profesionales de la atención primaria de salud en Paranaguá. El desmantelamiento de la red intersectorial perjudicó aún más la atención a personas en situación de vulnerabilidad y/o violencia. La ausencia de directrices nacionales por parte del gobierno federal dejó a los municipios y a los profesionales de atención primaria de salud a su suerte a la hora de abordar el problema.

Palabras clave

COVID-19. Atención Primaria de Salud. Aislamiento Social. Violencia Contra la Mujer. Violencia Doméstica.

Introduction

Article 5 of Law 11.340 of August 7, 2006, known as the Maria da Penha Law, states that: “Domestic violence (DV) and family violence against women constitutes any action or omission based on gender that causes death, injury, physical, sexual or psychological suffering and moral or patrimonial damage”, in the sphere of permanent coexistence with people with or without family ties, that is, in their homes; in the family sphere of union by natural ties or considered relatives; and in any intimate relationship of affection in which there was coexistence with the aggressor with cohabitation or not (1).

In this sense, this was the most important legislative initiative, with the function of protecting victims, punishing perpetrators and placing women in territory that was previously practically untouchable. For decades, what happened in the private space, the home, was kept secret, favoring the concealment of domestic violence and the consequent underreporting of this data (2). Until the creation of the law, many previous struggles to combat violence against women had been waged, with women and the feminist movement playing a decisive role in winning rights that cut across the fields of human rights and sexual and gender rights (3-5).

Since 1996, the World Health Organization (WHO) has recognized violence against women as a public health issue (6). It causes physical, mental, sexual and reproductive problems and results in high social and economic costs. Women experiencing DV may suffer from an inability to work, economic dependence and limitations in caring for themselves and their children (7).

To better understand the prevalence of this condition, a study using data from 80 countries showed that around 30% of women who have been in an intimate relationship have suffered physical and/or sexual violence from their partner. The prevalence varied from less in high-income countries to more in developing countries, including Brazil (7).

A Brazilian survey revealed that during the COVID-19 pandemic, approximately 24.4% of women over the age of 16, or about one in four, were victims of violence or aggression in the last 12 months. This represents almost 17 million women who have experienced physical, psychological or sexual violence in this period (8). These figures highlight the devastating impacts of violence against women.

In order to promote peace and prosperity, the UN has included in its Sustainable Development Goals (SDGs) the challenging target of achieving gender equality and empowering all women and girls by 2030 (9). SDG 5 envisages eliminating all forms of discrimination, violence, inequality at work, promoting health, rights and opportunities, among many other goals that seem essential to life, but which are still subjugated in the eyes of a society that culturally perpetuates relations of power and domination of women by men (10).

To achieve this goal, the WHO has established guidelines for public health systems to take the lead in preventing violence against women (11), including establishing clinical guidelines for health professionals in comprehensive care for victims and management of the problem in services (12). Primary health care (PHC) has been identified as the main gateway to health services for women experiencing DV, and is therefore a privileged place to work on prevention and management of the problem (13,14).

Unfortunately, PHC has suffered restrictions and changes in its functioning with the COVID-19 pandemic, decreed on March 11, 2020 by WHO Director-General Tedros Adhanom (15). Faced with the public health emergency, health systems have directed more efforts towards urgent and emergency actions, given the need for ventilatory support for the most serious patients. The threat caused by the virus was accompanied by directives to governments, with social isolation being one of the first measures to prevent the spread of the SARS-CoV-2 virus, which causes the disease. However, social isolation has aggravated the risk of DV for a number of reasons, such as increased time spent in isolation; less contact with a support network, family and friends; financial losses and loss of livelihood, increasing conflicts and subjecting women to a greater risk of economic abuse; limited access to health care services (16).

The effects of confinement have previously been studied in prison populations, submarines and polar expeditions, and the results point to psychopathological consequences such as anxiety, depression, suicidal behavior, substance abuse and violence (17). The lockdown resulting from the COVID-19 pandemic has changed daily activities and routines, representing an important stress factor and putting women and children under the pressure of the coexistence of two pandemics, COVID-19 and DV.

To highlight the reality imposed by the pandemic and the increase in violence within the home, the National Human Rights Ombudsman's Office of the Ministry of Women, Family and Human Rights (MMFDH) has released data on calls received on "Dial 180", the national channel for reporting and dealing with violence against women. Between the 17th and 25th of March 2020, there was an increase of more than 8% in the number of calls received and almost 18% in the number of complaints registered, compared to the data from the 1st to the 16th of the same month (18).

Given this context, the guiding question of this study was: What are the perceptions of PHC professionals in relation to cases of DV during the COVID-19 pandemic? The aim of the study is to analyze the perception of PHC professionals from two basic health units (UBS) in the municipality of Paranaguá (PR) about the relationship between the social isolation of the COVID-19 pandemic and cases of DV in their assigned territories, identifying the impacts of DV on families, challenges in dealing with victims and case management in PHC and in conjunction with the intersectoral network.

Methodology

This study is part of an umbrella research project that led to a master's thesis (19). This exploratory, descriptive and cross-sectional article specifically analyzed the perceptions of 36 PHC professionals about the relationship between the COVID-19 pandemic and cases of DV in their areas of work. The municipality of Paranaguá, on the coast of the state of Paraná, was chosen because of its partnership with the interdisciplinary Research Group on Territory, Diversity and Health (TeDis) and the continuity of previous studies carried out there (20-22). Two BHUs were chosen, one in the Vila

Garcia neighborhood, a more peripheral area, and one in the Serraria do Rocha neighborhood, a more central area of the city, with a total of approximately 60 workers in the two BHUs.

The methodology used was qualitative, focusing on the exploration of a set of opinions and social representations on the subject, thus being able to search for meaning between speeches and actions based on the analysis and interpretation of the process (23).

The semi-structured interviews applied were based on the research by Wild et. al. (24), carried out in East Timor with local health workers and community leaders. The instrument is divided into three categories of thematic questions about: knowledge (7 questions); practices (5 questions) and resources (10 questions). Thirteen interviews lasting around 20 minutes each were carried out in November 2020, recorded anonymously to ensure the confidentiality of the information. The professionals listed for participation had a variety of roles in primary health care, as part of the Family Health Strategy (ESF) or the Family Health Support Center (NASF). In addition to the interviews, two focus groups (FG) were held specifically with community health agents (CHAs), in September 2021, with the participation of 15 and 8 participants respectively, following the same script as the individual interviews. The FGs lasted approximately 90 minutes each. The discussion of issues in FGs allows for an in-depth analysis of behaviors and situations faced based on the exchange of reports that emerge during the debate (25). The CHWs, because they are in direct contact with the community, could contribute with the perspective absorbed outside the confines of the health unit. Only CHWs were included in the FGs because, considering our previous experiences, when higher education professionals are included in the FGs, the CHWs feel embarrassed to take part.

The data set from the interviews and FG was transcribed, coded and analyzed using thematic analysis of emerging categories. The research extracted unpublished data with themes aimed at the impacts of the COVID-19 pandemic on HV. Emerging categories with the greatest impact on the participants' perceptions were selected and compared with the collective health literature.

All the participants were PHC professionals, over 18 years old and signed the informed consent form. The research was approved by the Research Ethics Committee (CEP) of the Federal University of Paraná (UFPR) under Opinion number: 4.433.836. To guarantee anonymity, in this article the participants will only be identified by letters and corresponding numbers.

Results

Among the reports collected from interviews with professionals in different roles (Table 1) in PHC, some opinions stood out, which were considered important for thematic analysis and discussion. Below, the selected clippings plus the content discussed in the FG will be commented on in four categories: 1) cases of violence perceived in the context of social isolation; 2) the challenges in dealing with victims of DV; 3) how professionals identified violence and the impact it had on families; and finally, 4) how cases were managed, the strategies known and used and the relationship with the intersectoral network.

Table 1- Description of the interviewees' age, position, schooling and working time (E).

<i>Identification</i>	<i>Age in Yars</i>	<i>Functions</i>	<i>Education</i>	<i>Length of time working in PHC (in years)</i>
E1	41	ACS	High school	3
E2	-	Occupational therapist	Superior	10
E3	39	Physiotherapist	Superior	16
E4	38	Nutritionist	Superior	15
E5	43	ACS	High school	11
E6	43	ACS	Incomplete high school education	11
E7	29	ACS	Incomplete high school education	3
E8	49	Psicóloga	Superior	6
E9	-	Médica	Superior	2
E10	57	Enfermeira	Superior	1
E11	56	ACS	High school	11
E12	34	ACS	High school	1
E13	29	ACS	Incomplete high school education	3

Source: Authors, 2023.

Domestic violence and social isolation

The perception of an increase in DV during the pandemic confirmed the hypotheses presented in the introduction to this study, as shown below:

During the pandemic, obviously [DV] increased, because the people weren't used to being in direct contact. (E2)

The pandemic has made people stay at home more and has increased stress levels, greatly increasing DV. (E3)

In the territories studied, characterized by pockets of vulnerability, precarious housing is common, restricting space and living conditions, leading to stress and friction between family members. Individuals subjected to isolation can suffer from irritability, anger, insomnia, anxiety and depression (26). There is also financial and social precariousness in a region that faces annual variations (seasonality) in job and income opportunities (2). The low season in coastal regions causes a shortage of resources, which has been intensified by the measures imposed by the COVID-19 pandemic. The lack of employment in both communities was indicated in the FGs as an aggravating factor in family conflicts during the pandemic.

The dismantling of the Family Health Support Centers (NASF) further reduced the supply of PHC services in Paranaguá, and was considered by interviewees to be a negative point for the communities served. In addition, other PHC professionals, such as the reference teams (doctors, nurses and nursing technicians), were momentarily moved away from PHC to work on the front line in the field hospital set up in the city, in the urgent and emergency care network and some, later, in

vaccination. This context jeopardized the link between PHC and its target population and the longitudinal care that is advocated as an attribute of PHC. The interruption in the operation of schools and nurseries was also recalled both as a cause of increased stress among parents, who were not used to living intensely with their children, and as a facilitating factor for neglect and food insecurity.

Challenges in dealing with victims of DV: “moving on”

[...] you try a dialog, you try everything. If not, you have to move on. (E1)

The importance of dialogue in the management of cases of DV identified in PHC was acknowledged by several professionals, while the lack of training was widely admitted, regardless of experience and area of work. When asked how to deal with cases of DV in the context of the pandemic, the flow followed would most often be through referrals to other professionals or other possibly more specialized units.

I don't think I feel empowered enough. I usually seek help either from X [name omitted], who is the unit's psychologist, or from the unit's nurse to refer the case. (E4)

Although referrals exist throughout the comprehensive care of women victims of violence, the ideal reception requires professionals to be aware of the services available and their duties. At this point, the importance of intersectoral coordination and continuing education for network workers is highlighted (27). However, many services in the intersectoral network (such as schools, social assistance centers) were also interrupted during the pandemic, or switched to remote/online mode, which hampered their functioning. Continuing education activities were also suspended, as the priority at the height of the pandemic was to save the lives of people with COVID-19.

It's like I said, we'd have to have training because we don't know if we're going to get to the patient's house and this situation [DV] is happening, if I'm going to call the police, if I'm going to call the police station, what I'm going to do. If I witness a scene, even noticing how to act, I wouldn't know. (E5)

As many services in the network have closed, restricted or changed their format, the flow of care for people in situations of DV has changed, undermining the function of the protection network. Although described in the Maria da Penha Law, victims' rights are not optimally respected when they are initially received by PHC. The law stipulates that victims receive care from a professional specialized in DV, in a private environment, avoiding repetitive testimony and the number of referrals (1). Although they don't directly mention knowledge of the law and victims' rights, the following excerpt reveals the perception of the need for qualified care for this demand:

They should be welcomed by a trained professional who doesn't need to keep repeating the same story over and over again. (E3)

Challenges in dealing with victims of DV: the fear

D'Oliveira, et al. (14), through a systematic review, recognized the fear of reprisals from aggressors as an obstacle in attending to cases of violence against women in PHC. Doctors, nurses and CHWs reported threats to them in communities where organized crime is present.

Fear was the feeling most expressed about the challenges of dealing with and following up cases of DV during the pandemic. In addition to the fear imposed by the pandemic itself (fear of contamination, fear of taking the virus home, fear of death), the fear of providing care in cases of DV or getting involved with the problem emerged, due to reprisals from the aggressor himself and the lack of integration with the public security system. This can be seen in the following excerpts:

You help someone, like in a community that sometimes has violence, right, the residents know where we work and everything (E4)

We would have to call the police to provide better support because we never know what the aggressor is like, we never know what he might do. (E10)

Fear of reporting cases of DV was also reported, especially in the FGs, as well as misinformation about how to fill in the forms in the Notifiable Diseases Information System (SINAN), in addition to phrases of relief about never having reported a case of violence. The behavior is contradictory, but reflects the fear of the aggressor's reaction or that the confidentiality of the notification or the victim in question will be breached. Epidemiological data on violence can be rendered invisible because of this behavior:

People don't usually notify out of fear, out of fear of getting involved, often, or out of fear of making a mistake, right, because sometimes people are just suspicious, they're not sure. (E8)

[...] but I've never made a notification, thank God, I hope I never have to... (E13)

Where to go help?

The health sector is the gateway for many victims of DV, much more so than police stations or other points in the network. Despite the importance of PHC in building an intimate relationship with the user, DV can be identified in any service, even emergency services, based on physical or psychological signs or the patient's own disclosure (2).

Among the needs reported, the lack of training for specific DV care is once again noteworthy. There are notable gaps in the tools and routes known for these cases:

We need support, because here in the unit we don't have it. I don't have specific support, there's no specific professional, someone who has knowledge, because we don't either. (E12)

Nowadays, the path that victims of DV have to follow includes various sectors and professionals, who are not always able to deal with their anguish. The repetition of moments of suffering and the need to go through several different institutions discourages victims from continuing (28).

I think we have to refer them to a specialized body, to be listened to only by qualified people, to prevent this violence from happening again, because with each report, this person feels violated again. (E8)

Therefore, when subjected to an exhausting and fragmented resolution process, the survivor relives the aggression, which ends up being perpetuated by the system. Reports like the one above reflect a position in which PHC professionals are not responsible for care, going against what is recommended in the PHC and SUS guidelines.

According to Menezes (2), although the health sector is the point of entry for victims of violence, coordination with the police, legal and psychosocial sectors has an impact on resolving and dealing with DV. However, integration is limited by the number of professionals available and their lack of training. In addition, there is still a lack of information about support services, resulting in inappropriate courses of action being taken, fragmenting comprehensive care. In the following excerpts, we can see that the need for interaction between the aforementioned sectors is well known, but that the misinformation of professionals and victims interrupts the flow in the search for help:

[Knowing] more about the laws that protect women because we don't know. A welcoming program for them, so they feel safe, a support group so we can direct these women to talk to someone who will listen and help you. (E12)

D'Oliveira, et al. (14) found that a very relevant obstacle in working with DV in PHC is when professionals do not recognize violence as a health problem. In the interviews, professionals gave direct answers to the question: "Do you consider violence against women to be a public health problem?". Most of the answers were in the affirmative, and the professionals were aware that resolving the issue should also involve PHC. However, in the course of the questioning, it became clear that other challenges prevent survivors from receiving optimal care:

It's very difficult for them to report it because they have nowhere else to go. That's what really happens, the aggressor stays at home and the woman has to leave... (E2)

The biggest challenge in working with violence is that the aggressor is usually inside the home. So when you realize it, find out, you have to get the victim out of that environment and that's certainly the biggest challenge. (E8)

Although the Maria da Penha Law states that the aggressor must leave the home and keep his distance from the victim and her family, there is a lack of training for law enforcement officials to welcome survivors in a humane way and advise them of their rights (10). The victim needs to be guided towards a planned and safe escape route. However, when women don't have family ties or a social circle that supports them, it is difficult to find ways to leave the aggressor's environment. In the focus groups, there were reports of professionals paying for victims to stay away from home because there was no place to go. Temporary shelter for the woman and her children is decisive for structuring the withdrawal and giving confidence to the woman seeking help. In addition, the survivor must be trained to find an occupation that frees her from the financial ties that subjected her to the aggressor. These points were discussed and agreed upon as a flaw in the system for receiving patients:

I think that as soon as a woman or a child is a victim of violence, we have to distance the victim from the aggressor. So there would have to be a place to shelter these people

and they would have to be supported, because there is a very strong psychological issue. This person needs their spouse to support them financially, so how are we going to do that? So it's complex, but it's necessary because cases are increasing a lot. (E9)

Reception should be centred on the person and not on the medicalization of symptoms (28). There are cases in which the victim needs curative care, but in order to leave the cycle of violence behind, it is necessary to go beyond the biomedical view, broadening the vision of the victims' needs and interprofessional involvement in the formation of an effective support network.

Staff turnover and the loss of ties with the community

Acosta (10) argues that contact with victims' accounts breaks down barriers to understanding and effective care, highlighting the nursing team's welcoming, sensitive listening and guidance on rights and decisions to be taken. A long-lasting and trusting relationship with a professional who is more present in the victim's reality contributes to the victim reporting their situation when asked about it (28). Thus, any health professional who is in contact with the patient can receive her complaint, but CHWs have a privileged position because they go to these women's homes and have a window of opportunity to create a bond.

The CHW program began in the late 1980s to promote integration between professionals and the community. Their duties include advising families on the correct way to use health services and keeping other team members informed about the community and its needs (29). CHWs live in the same area where they work, and for this reason they can establish bonds of trust and get to know the family dynamics more intimately in order to identify cases of violence and abuse, either through their own perception or through reports received (30). Menezes (2) argues that professionals working in the ESF should play a leading role in monitoring women who are victims of DV, since the proposed territorialization process allows for involvement, recognition and understanding.

The CHW, as a member of the community, carries with him the importance of an intermediary position, linking needs and providers. Despite all the advantages of having a professional within the community to translate needs, there are also negative points related to culturally followed hierarchical models in which, due to affinity, CHWs can differ in the way they treat families or even interfere in an unfavorable way through personal judgments, mixing their private lives with their professional duties (31). The lack of continuing education, care protocols and unpreparedness on the part of the CHWs were mentioned as weaknesses in the program:

So I always say that CHAs have a lot of power, but they don't know how to take advantage of it. (E2)

Arboit (30) has already reported that CHWs are an important tool in developing care practices for women at risk in rural areas. However, there is a lack of multi-professional integration in intervention strategies, as well as specific training in this area. Problems related to access to healthcare and geographical isolation can also be considered for coastal areas, since economic and social relations follow a seasonal cycle.

The field research also pointed to the method of selecting professionals and precarious employment relationships as challenges to managing cases of DV. These issues cause high staff turnover in PHC, damaging the bonds of trust built with the patients who frequent each unit. When professionals don't integrate and understand the health-disease process involved in the demands of a

population, the principle of comprehensive care becomes flawed, making the medicalization of symptoms the focus of action.

As far as health is concerned, we really do have that problem of too many people coming in and too many people leaving. (...) I do training and last year I finished with everyone, this year we had to do it all over again. The fact that the City Hall has this PSS gets in the way too much. If we had a distribution of employees in each unit, who we could train and they could be multipliers, that would be great, but that doesn't exist. (E2)

How professionals identified HV and the impact it had on families

In the focus groups, the CHWs said that they are sometimes called by neighbors who report that a woman in a particular house is suffering violence. Violence was described as the act of a man, who may be a husband, boyfriend or son, who often uses drugs and becomes violent towards the family, but it also happens when they have a "clear head". They also noted that in isolation, conflicts increased and that the children in some of these families ended up being neglected, with overdue vaccinations, bruises and visibly thin. For the participants, the fact that children were out of school during the height of the pandemic didn't just damage their learning, but also the food security of the poorest, as they stopped eating meals, which in many cases were only eaten at school.

We find out through a neighbor, someone, and the person themselves, who is suffering, doesn't speak up, right? (E4)

Among the CHWs, there were reports that the victim herself, in a private confidante, said she was being assaulted. However, according to the professionals, this is the most difficult way of detecting cases of DV, as it is more common for people close to them to alert them that "something is going on" in the house, or for victims to come to the health center with other subjective and frequent complaints.

Signorelli, et al. (13) found in recent research, with more than 34,000 women, that victims of intimate partner violence, when compared to those who do not suffer from violence, have a high prevalence of poor or very poor health conditions. The parameters used to measure this condition were: fatigue, depression, disinterest/lack of pleasure, suicidal thoughts, problems sleeping, and problems eating:

People usually came seeking support for a panic attack, anxiety or depression. A lot of self-mutilation, in all cases, when you investigate you realize that it's very deep pain. And when the person comes with very deep pain, the consequence is usually DV, sexual violence. (E8)

Despite the studies presented so far focusing on violence against women in the family and domestic environment, children and the elderly are also vulnerable to cases and effects of violence, highlighting the need for measures that integrate these family members (32). A consensus in the GF discussions was that DV against children and adolescents was as exacerbated as domestic violence against women in that reality during the pandemic.

According to previous studies, violence and neglect that occur in the family environment are the main factors responsible for the perpetuation of aggression that causes women, children and adolescents to fall ill. Personal, psychological, social, economic and cultural factors and a history of violence in previous generations are possible complications in the occurrence of this condition (32).

I receive more children, because women find it difficult to report (...) usually women and children are the ones who get beaten up, but the ones who come to me the most are children and adolescents. (E2)

The investigation of DV should extend to other vulnerable members, not just the woman. It is up to the PHC professional accompanying the family to notice and record behaviors such as hygiene habits, vaccination schedules, school attendance and unexplained injuries that may be indications of intentional aggression. Child/adolescent abuse can be identified physically by bruises, abrasions, trauma, dislocations and burns. In the long term, the consequences of abuse can lead to psycho-emotional and gastrointestinal disorders, problems with sleep, appetite and delays in physical and intellectual development (32).

In the context of the pandemic, children and adolescents are affected differently from adults. Experiencing this critical period can lead to decreases in biopsychosocial development, and the negative impacts are intensified when added to exposure to neglect and abuse (26). The closure of schools during the period of high transmissibility of SARS-CoV-2 led to reports of children remaining on the streets while their parents were in conflict at home. Considering areas of Paranaguá where crime is high, professionals also pointed out that by staying away from home, children were also exposed to drug trafficking.

Case management, strategies and the intersectoral network

Contrary to popular belief, it is not the public safety network that treats women victims of DV. Through the 2019 National Health Survey, Signorelli, et al. found that 63% of victims are received by the SUS, mainly through primary and secondary care, in contrast to a minority of 26.9% who receive care through the private network (13). After being identified in the community or received at the health unit, survivors need guidance. The impasses narrated by the professionals interviewed will be commented on below:

[...] for sure because I've experienced it in my area [HV], and the person went to the health center to get help, right, so the health center is the first door the person goes to, right. (E6)

At one point in the interview, professionals from the Basic Health Units (UBS) were asked about which agency would be indicated to receive the complaint and proceed with better care, as they would follow a referral plan. The Social Assistance Reference Center (CRAS) was frequently mentioned as a support point in the intersectoral network. Among the functions assigned to CRAS are to provide guidance on rights, social policies, and support and orientation in cases of domestic violence (DV) (33). However, other participants recalled the Specialized Reference Center for Social Assistance (CREAS), whose role is to assist people experiencing situations of rights violations or violence (34). Both places are part of the Unified Social Assistance System (SUAS). The Child and Adolescent Protection Center (NUCRIA) and the Women's Police Station, bodies linked to the Public Security Secretariat, were also mentioned. A gap in the intersectoral network in Paranaguá is the absence of a Women's Police Station, therefore, DV cases end up being reported at the common Civil Police Station, which discourages many victims from filing complaints, according to participants.

Although both CRAS and CREAS deal with cases of violence, they each have their own responsibilities. However, when mentioned by the professionals, it was clear that the functions are not

clearly understood. The dismantling of the NASF was aggravated during the pandemic period (35), which was reported by the difficulty some victims had in accessing services such as a psychologist, which in PHC was done via the NASF.

The lack of recurrent training courses was again pointed out by the FG participants as a possible cause of misinformation about referral flows. Those who have received training point out that they go years without updates and that the service was taught based on "rules" that don't fit the daily reality of the UBS. Others reported that they learned from more experienced staff, from how to carry out services to how to operate the information system.

Conclusion

The period of isolation caused by the COVID-19 pandemic has intensified cases of HV according to the perceptions of PHC professionals in Paranaguá. Difficulties that were already perceived before the pandemic were complicated by the dismantling of local care network services. The perpetrator of violence was described as a man, father, husband or son. The challenges faced in caring for victims were reported mainly through fear, in a comprehensive and multidirectional way, and the lack of ongoing and specialized training for system operators at all levels.

HV was described as a public health problem that affects not only women, but also children and adolescents. After detecting cases, professionals tried to follow a flow of referrals, but this flow was disrupted during the pandemic, and they did not have clear knowledge about the most resolute pathways, highlighting once again that training could improve the quality of care for victims of DV. In the perception of PHC professionals, during the height of the pandemic, not only was PHC care for people in situations of vulnerability and/or violence impaired, but so was the functioning of other points in the intersectoral network, including schools and the services of the SUAS network.

This study had several limitations, such as the fact that it was carried out in just two UBS in a single municipality in southern Brazil, and with a relatively small sample of interviewees. Another difficulty faced in carrying out this kind of face-to-face research was that it was carried out during the height of the pandemic, when vaccines were not widely available. In this sense, conducting FG with several people in one room was a major challenge. The reduced number of professionals, as well as their relocation to other health units to support COVID-19, were recognized as limitations. However, despite these limitations, the study was also an opportunity to understand the challenges faced by PHC professionals in managing DV, a latent problem, which we can postulate from this study as a side effect of the COVID-19 pandemic.

Conflict of interest

The authors declare that there is no conflict of interest.

Authors' contributions

Bartos MC contributed to the conception/design of the article, data analysis and interpretation, writing of the article, critical revision of its content and approval of the final version. Silva RM da contributed to the conception/design of the article, data analysis and interpretation, writing of the article, critical review of its content and approval of the final version. Lucchesi VO contributed to the conception/design of the research project and the article, data collection (interviews and focus groups), data analysis and interpretation, writing the article, critically reviewing its content and approving the final version. Wanzinack C contributed to the conception/design of the research project and the article, data analysis and interpretation, writing the article, critically reviewing its content and approving the final version. Signorelli MC contributed to the conception/design of the study and the article, conducting the field research, analyzing and interpreting the data, writing the article, critically reviewing its content and approving the final version.

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