Improving the primary health care response to violence against women in low and middle income countries: the case of São Paulo, Brazil.

Background

Violence against women has a high prevalence in Brazil - about 30% of women reported at least one episode of sexual and/or physical violence perpetrated by a intimate partner during their lifetime. Among the users of primary health care (PHC) centres, the prevalence reaches 50% (Schraiber, 2002, 2007). In São Paulo there has been a public health policy for all types of violence since 2001, and since 2015 all healthcare facilities are required to have a 'violence prevention group' (NPV) responsible for: professional education; promoting, preventing and assisting cases of violence; and enforcing epidemiological surveillance (São Paulo 2015). However, the implementation of these policies has been fragmented and inconsistent (Batista, 2017).

Aim of the study

To understand how primary healthcare systems in São Paulo - Brasil can develop and evaluate interventions for domestic violence against women (DVAW) that link with community services, and ultimately ensure better health outcomes for women and their children.

Objectives

1. To evaluate the readiness of primary care services to identify DVAW, respond to survivors needs, and provide referrals to specialized VAW services;
2. To adapt an evidence-based intervention developed in the United Kingdom (IRIS) through the dialogue with stakeholders (professionals, managers and service users) and pilot the feasibility of its implementation in primary health care services

Study Sites

The two PHC centres that participated in the pilot study were assigned through negotiations between the Brazilian HERA investigators and the São Paulo Municipality Health department. The criteria were the local manager's interest in the research and the existence of the NPV team in the services. A PHC clinic downtown and a peripheral one were assigned.

Methods

This mixed methods study was conducted in three phases.

In **Phase 1**, a formative research was conducted aiming to assess the readiness of the PHC centers to deal with the DVAW cases and to absorb the intervention. The data was produced through: bibliographic review on blocks and facilitators for Brazilian PHC to handle DVAW cases; readiness assessment through check list and facility observation; in depth interviews with central level managers (2), PHC facility managers (2) and providers (16), women survivors (17 from previous project); the number of domestic violence against women cases reported to the epidemiological surveillance (2017); Pre PIM (Providers Intervention Measure) and fieldwork notebook. The intervention was informed by the results of the formative phase and agreed with the stakeholders in a meeting, that also discussed the main challenges to overcome.

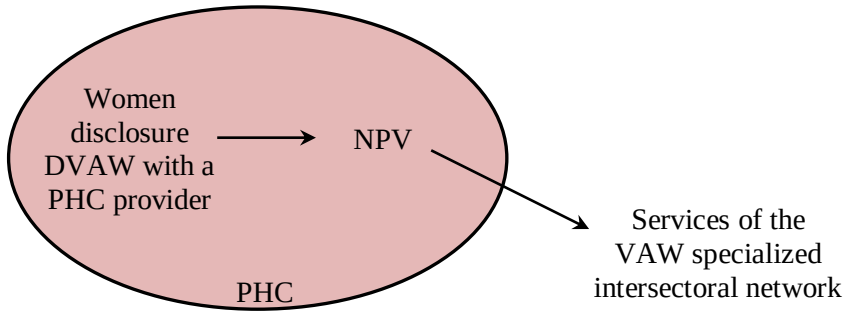
Phase 2 consisted in the intervention implementation in both clinics:

- Propose flow for referral the identified cases aligned with local policies (figure 1)
- Training for all PHC professionals - two sessions of 2h each (April and May / 2018)
- Training the NPV Professionals (June / 2018)
- Monthly Supervision to the NPV through case discussions (July - December / 2018)
- Reinforcement sessions for all PHC professionals - recall the flow of referrals at monthly

meeting (July - December / 2018)

- Intervention agreed at a stakeholders meeting - raised the main problems to be overcome (March / 2018)

Figure 1 – The proposed referral flow



The **Phase 3** consisted in the intervention evaluation. The data was produced through: NPV register table of DVAW cases; Post PIM; field notebook; in-depth interviews with managers (2) and providers (13); number of cases of DVAW reported to epidemiological surveillance after the intervention (2018); cases referred to and which arrived to reference outside the health center.

Main results

- The identification and referral to the NPV increased up to 07 times. The register, however, was not consistent. Not all the cases recorded in the NPV table were reported to the epidemiological surveillance and vice versa.
- Providers, in general, felt more prepared and with a broader range of strategies to care of DVAW cases within the service, also reporting feeling more confident to ask women as they have a clear referral flow.
- The NPV team, which was hardly known before the intervention, gained visibility among the providers. They reported to trust the NPV to be the DV references in the facility.
- The clear flow and the understanding of what to do whenever facing a DVAW case, was reported as important to increase the personal safety of the providers, reduce fear and deal with time constraints.
- The knowledge of the specialized intersectoral network has improved, although there is still a suspicious attitude from some providers to refer the cases to services outside of the PHC. This is mostly based on prior experiences of expectation not reaching what other services can really offer.
- Although important, training is not enough to institutionalize the DVAW care within the PHC services. The manager support was essential to implement and sustain the intervention within the competing priorities of the daily facilities routine.

Challenges for the next steps: the HERA 2

The intervention can raise the identification and referral of domestic violence against women cases in primary health care clinics, but does this really improve women's lives and health and is it sustainable? These are an important research question of the HERA team for next research. Using a similar methodology, the intervention will be adapted and expanded for six PHC services in São Paulo city focusing in reproductive and sexual health care. The new approach will be a qualitative longitudinal follow up of women for one year after the disclosure of DVAW, along with a cost-effective economic evaluation of the intervention.