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A DINÂMICA PROCESSUAL DOS ATENDIMENTOS DE MULHERES EM UMA REDE PROTETIVA BRASILEIRA

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ABSTRACT

The present study aimed to analyze the procedural dynamics of the non-specialized protective network that provides assistance to women experiencing violence in Viçosa, Minas Gerais, based on the coordination established among different municipal organizational sectors. Data collection was conducted through documentary research, in-depth interviews, and direct observation, with systematic records in a field diary. The results indicate that the women most frequently assisted by the protective network were predominantly Black and Brown, with educational levels ranging from incomplete to complete elementary and secondary education. Regarding age distribution, there was a predominance of women between 25 and 59 years old, corresponding mainly to young and adult women. In most cases, the episodes of violence occurred within the home environment and were generally perpetrated by current or former partners. Physical and psychological violence were identified as the most prevalent forms. Although violence against women occurs across diverse social contexts and life circumstances, its higher incidence is closely associated with situations of social vulnerability experienced by these women. In this context, the performance of the protective network guided by the provision of humanized and supportive services through the coordinated work of institutions and professionals combined with the woman's willingness to interrupt the abusive relationship, may be decisive for the outcome of the process and for effectively breaking the cycle of violence.

Keywords: Organizations. Network. Gender. Institutional Collaboration.

RESUMO

O estudo em questão teve por objetivo analisar a dinâmica processual da Rede Protetiva não especializada de atendimento às mulheres em situação de violência, em Viçosa-MG, a partir das articulações estabelecidas entre os diferentes setores organizacionais municipais. Sendo adotados como instrumentos para a coleta de dados, a pesquisa documental; entrevista em profundidade e observação direta, com registro em diário de campo. Assim, entre a mulheres mais atendidas pela Rede Protetiva, estavam as pretas e pardas; com escolaridade entre o ensino fundamental e médio completo e incompleto; faixa etária com predominância de mulheres entre 25-59 anos, ou seja, jovens e adultas; sendo que, normalmente, em seus próprios lares que as agressões aconteciam, perpetradas pelos companheiros ou ex-companheiros. E a violência física e psicológica são as predominantes. Apesar da violência ser verificada em diversos contextos e realidades de vida distintas, a sua maior incidência está atrelada à situação de vulnerabilidade social vivenciada pelas mulheres. O desempenho da rede, dentro da proposta de propiciar um atendimento humanizado e acolhedor, por meio da atuação das organizações e dos profissionais; e a disposição da mulher de interromper o relacionamento abusivo, pode ser determinante para o desfecho, em relação à ruptura com a situação de violência.

Palavras-chave: Organizações. Rede. Gênero. Articulação institucional.

1. INTRODUCTION

Gender inequalities commonly present in society are still naturalized and reproduced, being perpetuated and reinforced both by individuals and within institutional spaces. This social construction surrounding the sexes, which privileges a supposed male dominance, has in violence against women (VAW) its most perverse manifestation among many harmful societal impacts, often masked within power and domination dynamics.

The understanding that VAW represents a severe violation of human rights is a recent achievement, as explained by Bandeira (2014). This deconstruction has helped demystify the idea that violence against women is inherently linked to masculinity and femininity, an assumption that has historically justified and perpetuated unequal hierarchical relationships within families and broader social settings through asymmetrical power dynamics based on the presumed superiority of men over women. Consequently, biological differences continue to be socially invoked to rationalize oppressive and abusive behavior by men toward women (Bandeira, 2014).

In Brazil, the enactment of the Maria da Penha Law (Law No. 11,340/2006) expanded the understanding of different types of violence, classifying them as physical, psychological, sexual, patrimonial, and moral violence. This explicitly established that manifestations of violence are not limited to physical and sexual harm, and that all forms identified under the law require accountability mechanisms within society to curb such acts. Further concrete progress was achieved through the National Pact and Policy to Combat Violence Against Women in 2007, where network-based approaches were introduced as viable strategies for federal, state, and municipal implementation, dividing care services across various sectors to comprehensively address the needs of women experiencing violence.

At the municipal level, the city of Viçosa initiated efforts in 2010 to combat VAW through a partnership formed between the Interdisciplinary Center for Gender Studies (NIEG) at the Federal University of Viçosa (*Universidade Federal de Viçosa* - UFV), the Municipal Council for Women's Rights (*Conselho Municipal dos Direitos da Mulher* - CMDM), and the Public Defender's Office (*Defensoria Pública*). This partnership enabled the creation of the extension project Women's House (*Casa das Mulheres*), focusing on two main lines of action: providing support and shelter to women experiencing violence, and offering free legal counsel to guide them through the reporting process.

It also led to the establishment of the Non-Specialized Protective Network for Care to Women Experiencing Violence (*Rede Protetiva Não Especializada de Atenção às Mulheres em Situação de Violência*), composed of public entities and civil society organizations.

One of the main obstacles to implementing this work effectively was the lack of data on the volume of violence cases and their demographic breakdown by race, social class, education, and other indicators. The partnership with the university enabled the structuring of research to address this gap through the Education through Work Program for Health (PET-Saúde). With UFV's support, statistics on VAW gained visibility, as the data revealed the severity of the issue, recording 742 cases in 2013 and 620 in 2014, which were the peak years for reported incidents and coincided with numerous anti-violence initiatives in Viçosa.

The primary arm of this collective effort to combat VAW was the direct care provided to women by the Protective Network. Centered on the day-to-day reality of these services, this study examines the profile of these women, the different paths they navigate, and the obstacles they encounter in their search to break the cycle of violence to which they are exposed.

2. THE MANIFESTATION OF GENDER-BASED VIOLENCE IN THE FAMILY ENVIRONMENT AND IN INSTITUTIONAL SPACES

Gender-based violence, also referred to as violence against women, results from gender-based violent action that causes or has the potential to cause psychological suffering, physical injury, or sexual abuse to women, and can be perpetrated in public or private settings. It affects women across different social classes, races, and regions of the world, constituting a highly complex phenomenon (Silva & Oliveira, 2014).

In Brazil, the manifestation of violence against women is not only recurring but chronic, whether perpetrated by family members or by the State itself. There is, therefore, an overlap of different forms of violence. In the case of institutional violence, it occurs through misplaced actions or through direct omission. Thus, the State, which should serve as the guarantor of rights, becomes a promoter of violence; that is, it acts as another perpetrator, contributing to the sustenance of the cycle of violence against women rather than its rupture, leading to revictimization (Scheffer & Stolz, 2018).

As highlighted by Villela et al. (2011), the often misguided behavior of professionals leading organizations responsible for supporting women in violent situations reproduces prejudiced and sexist attitudes, reinforcing and naturalizing inequalities between men and women. Consequently, interpersonal violence exacerbates the vulnerabilities experienced by the women served, whereas institutional violence is expressed through the barriers they face when accessing services, including the biases of professionals, which further hinder efforts to break the cycle of violence.

Two initiatives in Brazil were particularly significant, providing opportunities to materialize targeted actions to combat violence against women: the enactment of the Maria da Penha Law in 2006 (Law No. 11,340/2006), an essential instrument for guiding and shaping action by legitimizing public entities and civil society to seek ways to restrict and report violence (Oliveira, 2012); and the National Pact and Policy to Combat Violence Against Women in 2007.

Within the scope of public policies to combat VAW, guidelines were implemented primarily through the delivery of specific programs and services. To achieve this, coordinating priority sectors, such as health, justice, social assistance, public safety, education, income generation, and psychosocial support, is essential to address service demands (Cavalcanti et al., 2014).

This inter-agency integration was proposed through the structuring of a support network for women in situations of violence. Junqueira (2004) adds that coordination among different organizations is a rational strategy to optimize scarce resources, given that complex social realities transcend the scope of a single social policy. In this sense, intersectoral and network-based care requires collaborative arrangements among organizations to effectively address the demands of diverse social actors.

As emphasized by Kiss, Schraiber, and D'Oliveira (2007), network-based operations involve distinct and sometimes conflicting operational rationales. This makes shared work imperative, requiring the building of inter-institutional communication and interaction, alongside active State participation to support these frameworks.

Throughout this process, the involvement and participation of various social actors, organizations, and institutional mechanisms shape the approach built around these services. As D'Oliveira and Schraiber (2013) note, specifically regarding intimate partner violence, there is a very distinct context involving a woman's entire network of social relations and acquaintance, along with varying degrees of access to community and social resources. Combined with the cultural weight of their environment, these factors shape the decisions and actions women take when seeking to end a violent relationship. Whether professionals recognize these specificities during care delivery directly dictates how effectively the demands presented by these women are resolved.

3. METHODOLOGY

This study adopts a mixed-methods (qualitative-quantitative) approach, utilizing document research, in-depth interviews, and direct observation recorded in field journals as data collection instruments[1].

To conduct the interviews, representatives from the organizations identified in the Protocol for Care for Women Experiencing Violence as belonging to the Non-Specialized Protective Network in Viçosa, Minas Gerais, were contacted and invited to participate in the study. All invited representatives agreed to participate, resulting in a total of 16 interviews conducted during the first semester of 2019. The interview script comprised 25 questions (Appendix I). To facilitate the analytical process, each question was organized into a dedicated file. Following this initial systematization, the questions were subsequently grouped into thematic categories, bringing together complementary and interrelated contents. This structure was organized around five main analytical axes: operation, network management, communication, information, and training. Table 1 presents the list of organizations responsible for providing care to women experiencing violence in Viçosa, MG.

1 This study was approved by the Institutional Review Board (Ethics Committee) of the Federal University of Viçosa under protocol number 03194018.8.0000.5153. The interviews were recorded with the participants' authorization after signing an Informed Consent Form, prepared in accordance with research ethics standards.

Table 1 | List of organizations responsible for providing care to victims of violence, Viçosa-MG, 2019

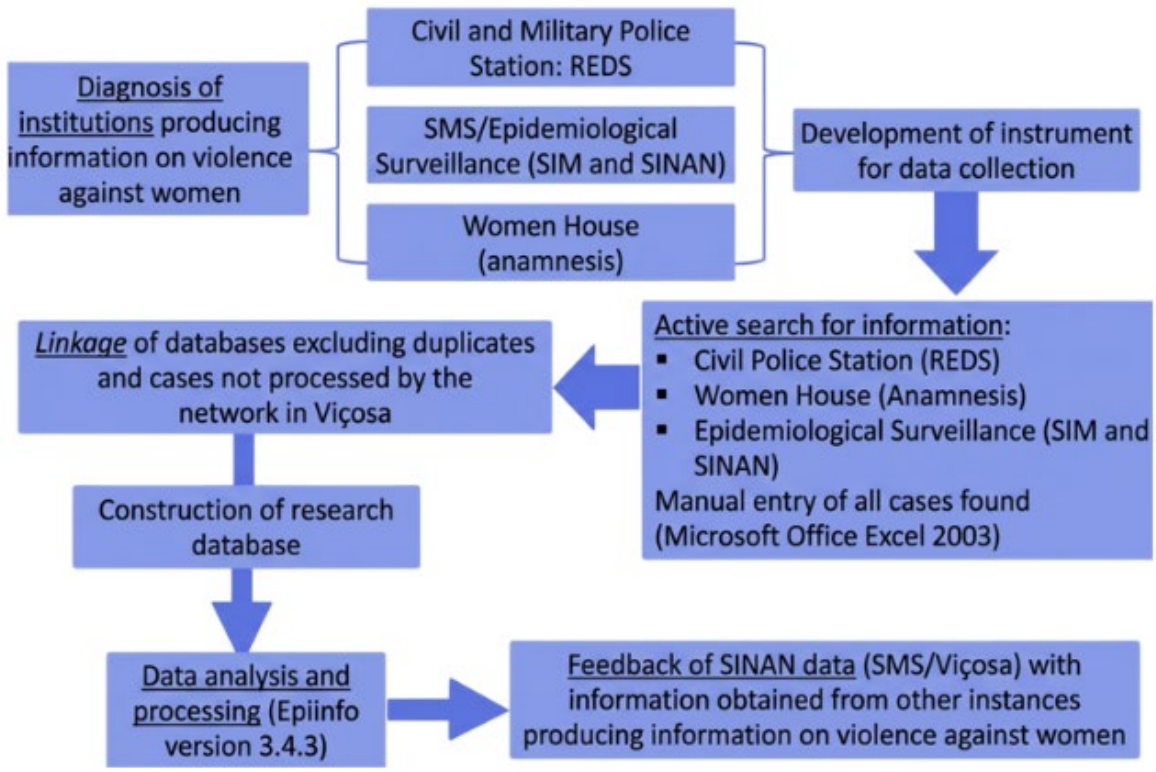
Area	Organizations
Health	Family Health Program (*Programa Saúde da Família* – PSF), São Sebastião Hospital (*Hospital São Sebastião* – HSS) / STI Support Group (*Grupo de Apoio às DSTs*), São João Batista Hospital (*Hospital São João Batista* – HSJB), State Specialized Care Center (*Centro Estadual de Atenção Especializada* – CEAE), and the Health Division of the Federal University of Viçosa (*Divisão de Saúde* / UFV).
Social Assistance	Social Assistance Reference Center (*Centro de Referência de Assistência Social* – CRAS) and Specialized Social Assistance Reference Center (*Centro de Referência Especializado de Assistência Social* – CREAS).
Justice/Rights Protection	Women's House Program (*Programa Casa das Mulheres*), Public Defender's Office (*Defensoria Pública*), and Guardianship Council (*Conselho Tutelar*).
Public Safety	Civil Police / Forensic Medical Institute (*Polícia Civil* / *Instituto Médico Legal* – IML) and Military Police (*Polícia Militar*).
Psychosocial	Psychosocial Care Center (*Centro de Atenção Psicossocial* – CAPS), Family Health Support Units (*Núcleos de Apoio à Saúde da Família* – NASF) / Psychology Sector, and the Psychosocial Division of the Federal University of Viçosa (*Divisão Psicossocial* / UFV).

To analyze the network-based care service delivered, it was necessary to understand the profile of the women served and the aspects regarding the occurrence of violence. To outline this profile, the following variables were considered: age group of the women served, race/ethnicity, educational level, and marital status. Additionally, to complement the analysis and expand the scope of understanding, other variables were included, such as: type of violence, motivation for the violence, relationship to the victim, location of occurrence, recurrence of violence, time of occurrence, day of the week, sex of the perpetrator(s), and alcohol use by the perpetrator(s). Document research was conducted for this data collection.

Regarding the document research, two different databases were consulted: the *Casa das Mulheres* Intake Form (*Anamnese*), which corresponds to the form completed by interns based on accounts gathered during consultations, and the Observatory on Violence Against Women, to obtain the socioeconomic profile of the women served by the Protective Network.

Regarding the Observatory, three distinct databases were combined: the aforementioned Intake Form (*Anamnese*); the Social Defense Event Records (*Registro de Eventos de Defesa Social-REDS*), provided by the Civil and Military Police through Incident Reports (*Boletins de Ocorrência – BO*); and the Information System for Notifiable Diseases (*Sistema de Informação de Agravos de Notificação-SINAN*) alongside the Mortality Information System (*Sistema de Informação sobre Mortalidade-SIM*). These latter systems receive notification forms on violence against women from health organizations and compose the database of the Municipal Health Department (*Secretaria Municipal de Saúde-SMS*)/Epidemiological Surveillance (*Vigilância Epidemiológica*), as shown in the flowchart in Figure 1.

Figure 1 | Flowchart of the violence database construction process in the municipality of Viçosa-MG



Source: PET-Saúde/VS-UFV, 2010-2015 (PINTO, 2016).

The flowchart details how this active search is conducted and how the data are organized, feeding into the database of the Observatory on Violence Against Women (*Observatório da Violência contra as Mulheres*), which presents an annual overview of violence in Viçosa. This action was crucial for designing targeted public policies for women and establishing various work fronts.

The analysis of the interviews was carried out by categorizing the materials according to content analysis guidelines, which, according to Bardin (1994), consists of three phases: a) pre-analysis, b) exploration of the material, and c) processing and interpretation of the data.

Following the transcription of all interviews, the responses were grouped into 25 distinct files, corresponding to each question included in the interview script, along with their respective content analyses. Continuing with the exploration of the material, the questions were then grouped under the six main themes present in the interview script.

Regarding the document analysis, the materials were organized into folders in chronological order of publication, covering information from the Observatory on Violence Against Women between 2015 and 2019, as well as the Intake Form (Anamnese) data file corresponding to the years 2017 and 2018. Table 2 below presents a compilation of all data collection instruments used and their respective sources consulted.

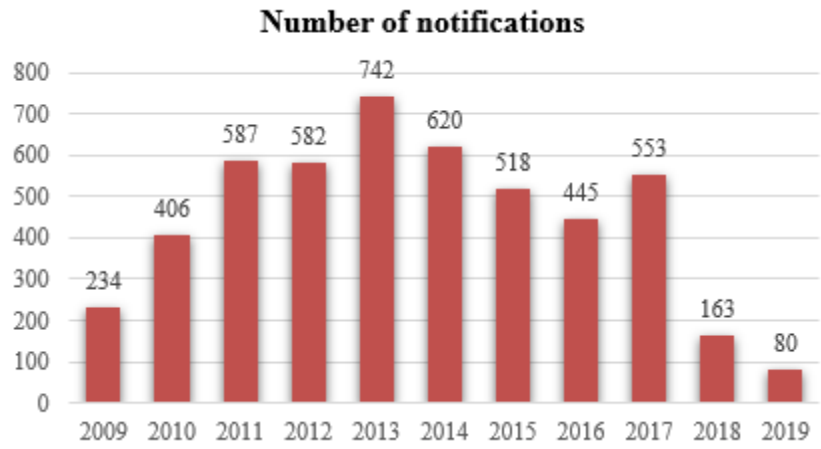
Data collection instruments	Research Participants / Documents	Description
In-depth interview	With representatives from non-specialized Protective Network organizations serving women in situations of violence, as listed in the Care Protocol.	**Health**: Family Health Program (*Programa Saúde da Família* – PSF), São Sebastião Hospital (*Hospital São Sebastião* – HSS) / STI Support Group (*Grupo de Apoio às DSTs*), São João Batista Hospital (*Hospital São João Batista* – HSJB), State Specialized Care Center (*Centro Estadual de Atenção Especializada* – CEAE), and Health Division / UFV (*Divisão de Saúde* / UFV). **Social Assistance**: Social Assistance Reference Center (*Centro de Referência de Assistência Social* – CRAS) and Specialized Social Assistance Reference Center (*Centro de Referência Especializado de Assistência Social* – CREAS). **Justice/Rights Protection**: Women's House Program (*Programa Casa das Mulheres*), Public Defender's Office (*Defensoria Pública*), and Guardianship Council (*Conselho Tutelar*). **Public Security**: Civil Police / Forensic Medical Institute (*Polícia Civil* / *Instituto Médico Legal* – IML) and Military Police (*Polícia Militar*). **Psychosocial**: Psychosocial Care Center (*Centro de Atenção Psicossocial* – CAPS), Family Health Support Units (*Núcleos de Apoio à Saúde da Família* – NASF) / Psychology Sector, and Psychosocial Division / UFV (*Divisão Psicossocial* / UFV).
Document research	Care Protocol for Women in Situations of Violence	Document developed through a participatory process among representatives of the non-specialized Care Network for women in situations of violence, Viçosa, MG.
	Casa das Mulheres Intake Form (*Anamnese*)	Corresponding to the form filled out by the interns of the Casa das Mulheres Program based on the accounts provided during support sessions with women in situations of violence.
	Observatory on Violence Against Women	Data obtained from clinical intake forms (*Anamnese*), the Social Defense Event Records (*Registro de Eventos de Defesa Social* – REDS), and the Civil and Military Police through filed Police Reports (*Boletins de Ocorrência* – BO), alongside the Notifiable Diseases Information System (*Sistema de Informação de Agravos de Notificação* – SINAN) and the Mortality Information System (*Sistema de Informação sobre Mortalidade* – SIM) which receive notification forms regarding violence against women from health organizations and constitute the database of the Municipal Health Secretariat (*Secretaria Municipal de Saúde* - SMS) / Epidemiological Surveillance Unit—made it possible to analyze the socioeconomic profile of the women served by the Protective Network.
Direct observation	Field Log Entries	Notes on ambient observations and participants' statements gathered during the interviews.

4. RESULTS AND DISCUSSION

4.1. PROFILE OF WOMEN SERVED BY THE PROTECTIVE NETWORK SERVICES

In Viçosa, data from 2009 to 2019 indicate that the number of notifications underwent significant changes, as shown in Figure 2.

Figure 2 | Relationship between the number of notifications and the year of occurrence, Viçosa, MG



Source: SINAN/SMS2/PMV3, 2009-2019

Over these ten years of work, the years following 2009 were marked by an increase in notifications, particularly up to 2017. This rise can be explained by the response actions launched in Viçosa, which expanded support services for women through the Protective Network, as well as by ongoing active case-finding efforts. The years 2018 and 2019 point to a slowdown in these response efforts, marked by the halt or even closure of certain work streams, primarily driven by the lack of call for proposals from funding agencies, given that the resources secured from the municipal government were insufficient to maintain the broad scope of actions, barely allowing for the minimal continuation of the Protective Network's operations.

According to the observatory database for the years 2015 to 2018, the women served by the network were predominantly between 25 and 59 years old, consistently accounting for over 70% of support cases[4]; followed by those aged 18 to 24. A shift occurred in 2019, with a drop in cases within

2 Municipal Health Secretariat (*Secretária Municipal de Saúde-SMS*),
3 Municipal Government of Viçosa (*Prefeitura Municipal de Viçosa - PMV*).
4 With the exception of 2018, at 69%.

the 25-59 age group[5], to 58%. This decrease is likely linked to the suspension of certain work streams, which led to a reduction in services provided to women, as previously mentioned.

Regarding self-reported race/color, despite a notable increase in support provided to white women, showing a 10-percentage-point rise from 2018 to 2019 (from 24% to 34%), a predominance of Black and Brown (*parda*) women was observed. Combined, their percentages accounted for 71% of support cases in 2018 and 60% in 2019. Violence against Black and Brown women was predominant at the national level. Due to their skin color, these women endure multiple forms of violence, including restricted access to public services such as healthcare; negative stereotypes directed at Black women; discrimination against African culture and beliefs; retaliation produced by security forces on the part of the State on one hand, and by militias and organized crime on the other; greater exposure to narcotics; among other violations present in their daily lives (Carneiro, 2017).

In this regard, as Waiselfisz (2015) points out, one cannot fail to mention the widespread culture of segregation and selectivity in violence that still exists in Brazil. Violence against women is no different, showing a constant upward trend in rates against Black women alongside a reduction or decrease in incidence among white women. It must be made clear that while violence occurs because of one's gender, it is compounded by other intersectionalities, such as race and class.

Returning to the analysis of Viçosa, the observatory data demonstrated that low educational attainment is a persistent reality among the women served by the Protective Network between 2015 and 2019. Over 70% of support cases involved women with either completed or incomplete elementary, middle, or high school education. Women with completed or incomplete higher education also sought services from the network, but this group did not exceed 20%. As Campos and Almeida (2016) emphasize, violence is a reality in the daily lives of diverse women, regardless of social markers such as race, social class, origin, marital status, age, educational level, or sexual orientation. The data support this assertion while also highlighting a higher prevalence among specific social groups, such as women with low income and limited education.

5 The Observatório da Violência Contra a Mulher analyzes the incidence of violence across the following age groups: 0–17, 18–24, 25–59, and 60 and older.

Married women and those in consensual unions were among those who most frequently sought out network services to report abuse or seek support to break the cycle of violence. However, there was also significant demand for services among single women, accounting for 37% of cases in 2018 and 43% in 2019. Among these cases, data demonstrate that in the vast majority of instances, these acts were committed by male perpetrators. The most recent data from 2018 and 2019 revealed that in 53% and 34% of cases, respectively, acts of violence were committed by current partners, followed by abuses committed by former partners, such as ex-boyfriends or ex-spouses. Although women reported that the perpetrator consumed alcohol, this was not a predominant factor across the accounts provided by those served. Another finding was that the violence occurred in their own homes in over 70% of cases. Furthermore, data revealed that more than 50% of the cases involved recurring violence.

There is a clear distinction in the settings where violence occurs. Violence against men takes place predominantly in public spaces, whereas violence against women occurs not only in public settings but also, and more frequently, within private and domestic environments. In these contexts, women are subjected to humiliating situations and acts of violence perpetrated by intimate partners or family members, that is, individuals with whom they live and who belong to their primary or close social networks (Campos; Almeida, 2016).

It was found that the alleged motivation for the violence was associated with sexism, defined as prejudice or discrimination based on a person's sex or gender, which accounted for 58% and 35% of cases in 2018 and 2019, respectively. The reports also identified other motivations, including violence arising from generational conflicts, homelessness, disability, homophobia, lesbophobia, biphobia, and transphobia.

The data further revealed that violence occurred predominantly at night, with significant occurrences also during the afternoon, happening most frequently on weekends. Support was overwhelmingly provided to women residing in vulnerable areas, specifically the peripheral neighborhoods of the municipality.

The most frequently reported form of violence during service interactions was psychological violence, accompanied by a high incidence of physical violence. A single woman may experience multiple forms of abuse, and other types of violence, such as sexual, patrimonial, and institutional violence, are also frequently present in the daily provision of services across the organizations that comprise the network.

Thus, the profile of women most frequently served by the Protective Network comprised Black women (the combined total of Black and Brown/*parda* individuals); those with complete or incomplete elementary, middle, or high school education; and predominantly young and adult women aged 25 to 59. The aggressions typically occurred in their own homes, committed by current or former partners, with physical and psychological violence being the most prevalent forms. Although violence is observed across various contexts and distinct life realities, its highest incidence is closely linked to the situation of social vulnerability experienced by these women.

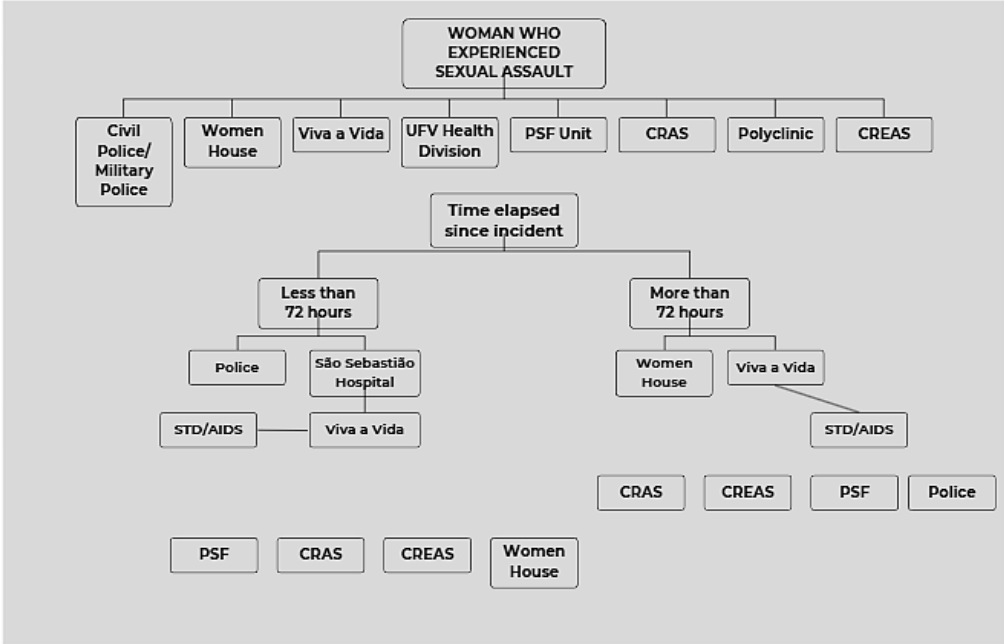
4.2. THE PROTECTIVE NETWORK AND THE VARIOUS GATEWAYS FOR SUPPORTING WOMEN EXPERIENCING VIOLENCE

To understand the operation of the Protective Network for Women Experiencing Violence requires examining how workflows are established among its constituent organizations, particularly how support services are organized and structured to enable women to access and navigate the available resources.

The definition of these workflows was determined through a participatory process involving representatives from the network's member organizations, leading to the creation of the Municipal Protocol for Care for Women Experiencing Violence in 2014. In addition to establishing these workflows, the protocol delimited the function and role of each organization in supporting women.

The protocol outlines two distinct care workflows based on the type of violence encountered: one specifically for sexual violence and another for other forms of violence, such as psychological, moral, patrimonial, and physical abuse, each offering various referral pathways, as shown in Figures 3 and 4 below.

Figure 3 | Flowchart of support services for female victims of sexual violence, Viçosa, MG



Source: Protocolo Municipal de Atenção às Mulheres em Situação de Violência (Lei de Iniciativa Popular 2417/2014)

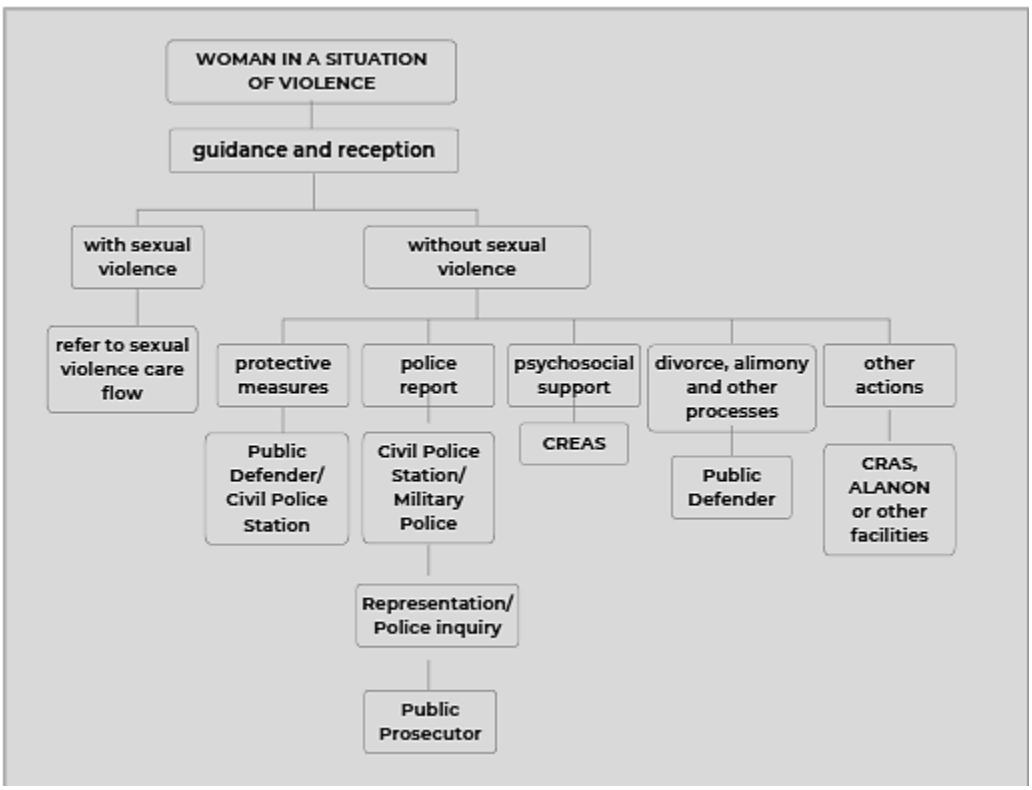
As illustrated in the flowchart, there are distinct sectors among the services provided by the network across various areas: Healthcare, including the São Sebastião Hospital (HSS), São João Batista Hospital (HSJB), Centro Estadual de Atenção Especializada (CEAE), Divisão de Saúde/UFV, and Programa Saúde da Família (PSFs); Social Assistance, Centro de Referência de Assistência Social (CRAS) and Centro de Referência Especializado de Assistência Social (CREAS); Public Security, via the Civil Polícia Civil/ Instituto Médico Legal (IML) and the Polícia Militar; Justice, Casa das Mulheres and the Defensoria Pública; Psychosocial Care, Divisão Psicossocial /UFV; and Rights Guarantee, Conselho Tutelar.

As shown in Figure 6, the intake point for victims of sexual violence can occur across various organizations; however, regardless of where the woman enters the system, there are two possible referral paths. If less than 72 hours have elapsed since the incident, healthcare receives primary priority. Thus, prior to any legal or police/IML procedure, the victim is referred to the hospital, as this constitutes a more urgent matter. Conversely, if more than 72 hours have passed since the sexual violence occurred, the referral pathway changes, with the victim generally being directed to the

Women's Center (*Casa das Mulheres*) if she wishes to initiate legal proceedings[6] and subsequently, she is advised to seek assistance at Viva Vida (currently the CEAE) to receive the necessary medical care. Further referrals are then made based on the victims' specific needs, which explains the absence of interconnecting lines at the bottom of the diagram. This workflow displays greater uniformity regarding referral pathways, as described, owing to the specific characteristics of the care provided.

Regarding support for other forms of violence, excluding sexual violence, the care workflow can follow various paths depending on the victim's needs, as illustrated in Figure 4; consequently, women may navigate distinct referral routes.

Figure 4 | Flowchart of support services for women experiencing violence, Viçosa, MG



Source: Protocolo Municipal de Atenção às Mulheres em Situação de Violência (Lei de Iniciativa Popular 2417/2014).

6 As of 2012, the Federal Supreme Court empowered the Public Prosecutor's Office to initiate criminal proceedings in cases of violence against women regardless of the victim's decision to press charges, irrespective of the severity of the physical injuries.

In both flowcharts, structures were presented based on the idealized operational framework of a support network for women experiencing violence, in accordance with the parameters established in the National Pact and Policy to Combat Violence Against Women (Pacto e Política Nacional de Enfrentamento à VCM).

Although the Protocol represents an important initiative toward organizing the functioning of the Protective Network, particularly under the premise of providing more comprehensive and humanized care, the implementation of these efforts must consider the specific type of violence and the demands of these women.

As previously noted, violence can be sexual, physical, psychological, moral, or patrimonial; thus, the ways in which women navigate the network must be critically examined. Consequently, initial access to a service depends significantly on the specific form or forms of violence to which the woman was subjected, as she may be facing multiple types simultaneously, and which demand is most urgent at the time of care.

Notably, despite the existence of prescribed flows established by the Protocol to guide victims, a woman's path through the network is linked to two key factors: the entry point she chooses when seeking support and her decision to proceed with the services available across the network. When seeking help, a woman may opt for a service with which she is already familiar, viewing the organization or a specific practitioner as a point of reference, or she may be advised by family members and friends, relying on her primary social network to seek assistance. As Portugal (2007, pp. 237–238) points out:

> The different types of networks aim to address the fundamental features that mark individuals' social relationships. When we examine reality, there are no 'pure' models, nor is any of these relational models entirely exclusive of the others, each individual's network intersects diverse elements

Thus, it is not possible to establish a fixed route, given the demands presented by the women and the professionals' understanding of the workflows outlined in the protocol, which determine which organizations should be activated. Consequently, despite the existence of a planned workflow described in the protocol, adaptations may become necessary in daily practice to address the specific demands and characteristics of individual cases. Even the flows shown in the previous flowcharts leave referrals open-ended: in Figure 3, certain connections are omitted, while in Figure 4, several

organizations listed in the Protocol as responsible for network care are not included.

Regarding these demands, even if a woman is advised by her primary or secondary social network to file a police report (*Boletim de Ocorrência* – BO), for example, this may not reflect her wishes at that moment; she may instead require a specific service tailored to her priorities, as reported by a network professional:

> "(...) another thing is trying to convince this woman to file a police report and initiate legal proceedings. Not all of them want to file a report—in fact, the majority do not, that is the truth" (Interview No. 2).

In certain situations, the expectation of the woman receiving care may simply be to end the abusive relationship, being willing to initiate divorce and child support proceedings, while feeling uncomfortable taking legal action against her partner. Pressure exerted by a practitioner can discourage or even deter a woman from breaking the cycle of violence, producing the opposite effect and resulting in secondary victimization (revictimization). As Soares and Lopes (2018) point out, addressing violence encompasses actions that are not limited to a single dimension, but are multifaceted; within this multiplicity lies the recognition of the woman's autonomy in the decision-making process.

Returning to the guidelines in the Protocol, although it outlines workflows and offers direction for referrals, and was cited in interviews as an important supporting document, personal factors and professional rapport among the individuals leading these organizations can also prove decisive in choosing referral pathways. As noted by Rezende and Andrade (2014) in their analysis of Viçosa's Protective Network (*Rede Protetiva de Viçosa*) during its first year of operation, the network relied more on individuals than on organizations, which raised concerns about the effectiveness and continuity of its actions, particularly in the context of high staff turnover and precarious employment relationships.In other words, despite the crucial role of practitioners and their commitment to their work, operational reliance anchored more in personal commitments than institutional frameworks can impair performance, proper communication, and coordination among services.

In this regard, concerning the implementation of the Protocol by network professionals, two interviewees made the following comments:

> (...) and regarding this issue of each institution's protocol defining its duties very clearly, as well as where to refer and what to do, failures or similar issues sometimes happen that we need to iron out (Interview No. 1).

> (if the practitioner) does not implement the protocol the way it should be implemented, it creates loopholes that prevent the work from being fully consolidated and from truly guaranteeing this woman's right to care" (Interview No. 3, emphasis added).

This concern regarding proper referral pathways for women within the network enabled the organization of the Protocol Monitoring Committee (*Comitê de Acompanhamento do Protocolo*), which met monthly to discuss service delivery and assess whether women were navigating the network in accordance with the protocol's provisions and in response to their presented demands. The comments presented above highlight several breakdowns in the protocol's applicability within daily practice. These findings reveal the gap that can emerge between the guidelines set forth in official documentation and what is actually achieved in the day-to-day operations of network-based intervention. Ultimately, this may be an inevitable realization; although the protocol is essential for offering direction and clarifying the responsibilities of each organization within inter-agency efforts, practitioners on the front lines must make necessary adjustments to ensure the flow of care depending on the scenario presented, making static predictability around referral pathways impossible.

Another factor that can impact the comprehensiveness of care is the assumption by practitioners that they have already addressed all the needs presented by the woman, reflecting a sector-bound view of service delivery that lacks proper coordination with other agencies. As Silva and Miguel (2016) point out, traditional, verticalized modes of operating under hierarchical structures hinder the execution of work that is more holistic, horizontal, and cross-cutting, characteristics essential to the operational dynamics of a network if it is to achieve the fluidity and responsiveness required when supporting women.

Thus, as has been observed up to this point, care provision is not dictated solely by the type of violence, but is also grounded in the woman's self-stated demands and the resulting referrals executed by professionals in response to those requests. A woman may arrive at an entry-point organization within the network without having clearly defined care needs; in such cases, it falls upon the practitioner to offer recommendations in accordance with the Protocol. On the other hand, when a woman presents with a more specific demand, she may navigate a pathway that does not fully correspond to the workflows set forth in the Protocol, as illustrated in the following passage:

> Not only according to the violence suffered, but primarily according to the woman's own demand. Because sometimes we might hear an account that we consider more severe or serious, yet a woman with a milder account might have a greater need for psychological support, for example. So yes, it will depend on the violence, but also on the woman's demand. In cases of sexual violence, there is this well-defined protocol, which prioritizes medical care first before addressing other issues; but in other cases that do not involve recent sexual violence, it will depend on this, the account of violence and her demand, whether for psychological care or social assistance, so it depends on each case (Interview No. 1, emphasis added).

The account presented demonstrates that rigidity regarding referral workflows is untenable, considering that key elements dictate how these referrals materialize, such as qualified listening, proper reception (*acolhimento*), and a thorough understanding of the woman's care needs, all of which represent decisive steps in determining her pathway through the network. In other words, the route a woman navigates within the network depends not solely on its institutional functioning and operational dynamics, which are themselves tied to various factors, but also on the rapport established between the practitioner and the client.

Furthermore, a woman's pathway is closely linked to the specific type of violence she experienced, the organization she first approached, and the practitioner's response to the situation; specifically, whether, within the referral framework set forth in the Protocol, the practitioner will guide her toward other network services or determine the necessity of directing her elsewhere in response to her presented needs. These diverse possibilities for care delivery, reflecting the multifaceted nature of violence against women, arise from the following aspects, as emphasized by Hanada, D'Oliveira, and Schraiber (2010, p. 35):

> health services (for the treatment and prevention of physical, emotional, and sexual/reproductive health harms), legal guidance and assistance (for separation proceedings, child custody disputes, guidance on property rights, and criminal matters), police assistance (for reporting crimes, filing complaints, protection in high-risk situations, and removing the perpetrator from the home), shelter services (in situations involving life-threatening risks to the woman and/or her children), social assistance (for guidance on welfare benefits that help improve living conditions and/or contribute to overcoming violence), and psychosocial support (for processing the violent family situation, building new life plans, and developing healthy patterns of emotional relationships) (Hanada, D'Oliveira, & Schraiber, 2010, p. 35).

Thus, even if a woman initially approaches a specific organization, she will likely be directed to others. For instance, if she first visits the Civil Police (*Polícia Civil*) and requests a divorce or child support proceedings, she may be co-referred to the Women's House (*Casa das Mulheres*) in coordination with the Public Defender's Office (*Defensoria Pública*). If, during this process, she requires psychological support, she can be referred to the Specialized Social Assistance Reference

Center (*CREAS*) and, similarly, to other organizations depending on her multifaceted care needs. Familiarity with the workflows established in the protocol allows for better guidance of women across the network; however, adjustments remain necessary to accommodate the daily realities of service delivery.

On the other hand, sharing care responsibilities across these various sectors addresses the range of needs that arise when a woman is in a situation of violence. Certain sectors must intercommunicate and maintain ongoing dialogue to enable effective guidance for women within the network and steer their trajectory, preventing them from bouncing from one service to another without having their demands properly addressed. A woman must navigate a critical pathway that enables her to break the cycle of violence to which she is subjected.

Sagot and Carcedo (2000) explain that the critical pathway begins when a woman decides to break the silence surrounding the violence,usually disclosing it first to individuals within her primary social and informal networks, such as relatives, friends, or neighbors. Depending on the social responses received, both at the familial and institutional levels, these initial disclosures can either encourage or discourage breaking the cycle of violence. Consequently, the sequences of decisions made and actions taken throughout this process are crucial along this route.

According to Meneghel (2011), this pathway actually begins, that is, formally, upon the public disclosure of violence, which most often occurs through the filing of a police report (*Boletim de Ocorrência* – BO) at a police station. Within this critical pathway, both facilitating and inhibiting factors were identified in the studies by Sagot and Carcedo (2000) as well as Meneghel (2011). Among the facilitating factors, personal aspects are highlighted, such as receiving death threats; the cumulative toll of years of violence; trust in the enforcement of the Maria da Penha Law; and the quality of service provision alongside the promptness of certain procedures. Regarding inhibiting factors, feelings such as guilt, fear, and shame are frequently cited, as are family pressures to remain in the relationship; financial constraints; institutional inertia; difficulties in understanding specific instructions and processes; the fragmentation of network services; the absence of a centralized reference point for comprehensive care; and criticisms regarding the performance of the security and legal sectors (Meneghel et al., 2011). In one interview, the following account was shared:

> Why do many women not report it? Because sometimes a neighbor or a friend says: 'Look, don't go, because I've been there and it doesn't solve anything.' And this applies more to domestic violence, not sexual violence—we don't see a resolution for it. At the Council, we hear various comments from the council members as they help a victim, and you don't see a police follow-up or any interest. Is it complicated? It's extremely complicated. Let's work on this network so that it actually functions for both sexual and domestic violence, because it's no use saying it's working when it reaches a point where the woman sees there is no resolution (Interview No. 2).

And the interviewee continues, emphasizing that:

> The burden is heavy, and we also have to know how to cope with that, because some patients no longer want to talk about the subject, so they prefer not to return, and we must respect the patient's decision. Actions are needed to alleviate this suffering, such as building this shelter home (Interview No. 2).

These two excerpts highlight, on the one hand, the practitioner's concern regarding obstacles to the proper functioning of the network due to the lack of commitment from certain organizations. On the other hand, they reveal the subjective and emotional toll that professionals experience when supporting women in situations of violence, as well as the subjectivity of the women themselves, who may not wish to relive the experience and therefore choose to remain silente, at times choosing to no longer access services altogether.

As Schraiber et al. (2012) point out regarding care networks, it is impossible to establish a uniform set of services or a single flowchart for referrals, as the structure is far from static. On the contrary, there is a constant need for reconfiguration, creating distinct arrangements and varied relational diagrams depending on the specifics of each case and the shared decision-making among practitioners across the available services. Neither the entry point nor the pathways are fixed, unlike in traditional, hierarchical systems of assistance.

The contribution of Schraiber et al. (2012) further demonstrates that if a network configuration were drawn for each individual woman, the result would be a series of unique diagrams, as the specificities of each case map out distinct routes within the universe of possible workflows. These diagrams would likely reveal a higher frequency of referrals to specific organizations, highlighting their central role. In the present case study, interview accounts demonstrated that active participation within the Protective Network centers heavily on the Women's House (*Casa das Mulheres*), operating collaboratively with the Public Defender's Office (*Defensoria Pública*), Hospital São Sebastião, the Civil Police/Police Station (*Polícia Civil/Delegacia*), the State Specialized Care Center (*Centro Estadual de Atenção Especializada - CEAE*), and the Specialized Social Assistance Reference Center (*Centro de Referência Especializada de Assistência Social - CREAS*). In other words, care delivery is largely concentrated within the security, legal, and health sectors.

5. FINAL CONSIDERATIONS

The manifestations of violence against women in the municipality of Viçosa revealed that cases occurred primarily within the victim's own domestic sphere, perpetrated chiefly by current or former spouses/partners. Psychological/moral and physical violence predominated, committed mainly against young women (aged 30-39) with low levels of education who reside predominantly in peripheral neighborhoods, underscoring the condition of social vulnerability experienced by the victimized women.

Regarding the dynamics of service provision for women within the Protective Network, pathways were dictated primarily by the self-stated demands of the women in accordance with the type of violence experienced, as well as the intervention styles of the practitioners leading these organizations, operating through adjustments to the protocol based on the lived reality of each individual case.

The critical pathway that women must navigate is fraught with obstacles and setbacks, extending from the initial decision and the act of reporting itself to the ultimate realization of breaking the cycle of violence. Along this journey, enabling factors can facilitate the entire process and serve as decisive turning points; conversely, inhibiting factors can demand perseverance and determination from women as they move forward. Consequently, the performance of the network, guided by the objective of offering humanized and supportive care through its agencies and practitioners, coupled with a woman's resolve to end an abusive relationship, can prove decisive in determining whether the cycle of violence is successfully broken.

Thus, despite advancements in protective measures through the enactment of laws that safeguard and grant rights to women, a long road remains ahead. Dismantling structures of male dominance along with the naturalization and reproduction of patriarchal behaviors means that violence against women is still often addressed in a covert and biased manner, frequently victimizing the perpetrator and blaming the victim. This reality underscores the urgent need for addressing violence against women through continuous, integrated, and comprehensive actions.

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APÊNDICE I: ROTEIRO DE ENTREVISTA

UNIVERSIDADE FEDERAL DE VIÇOSA

CENTRO DE CIÊNCIAS HUMANAS, LETRAS E ARTES

PROGRAMA DE PÓS-GRADUAÇÃO EM ECONOMIA DOMÉSTICA

Research Project: Intersectoral Network for Institutional Coordination in Addressing Violence Against Women, Viçosa–MG.

Researcher: Palloma Rosa Ferreira

Research Subjects: Representatives of organizations within the non-specialized protective network for women experiencing violence, the Coordinator of Public Policies for Women, and the Coordinator of the Municipal Council for Women's Rights.

OBJECTIVES		RESEARCH QUESTIONS
Operation	1	How are women received and referred within the network?
	2	Is there feedback regarding case resolution provided to the organizations involved in the care process? That is, is there counter-referral for the services rendered.
	3	Is there any form of follow-up for the victim as she navigates the network? If so, what kind?
	4	Following care, to which organization or service are women generally referred? Is this destination related to the specific type of violence experienced?
	5	Are there any obstacles or challenges in providing care to victims of violence?

Network Management	6	As an organization belonging to the Protective Network, what actions does your organization implement to combat violence against women?
	7	What criteria does your organization use to assess the quality of the work performed? Is there any evaluation mechanism for the work developed by your organization and by the Protective Network?
	8	Is there any mechanism for supervising the work carried out by the network?
	9	How does your organization integrate or coordinate with the other organizations in the Protective Network?
	10	Which regulations govern the Protective Network?
	11	How is the management or governance of the Network carried out?
Communication	12	Can you outline what you consider to be the negative and positive aspects of the Protective Network?
	13	How is dialogue established with other professionals across the different organizations of the Protective Network? What is the most frequently used medium of communication?
	14	Are meetings held with professionals from the organizations that make up the Network? With what frequency?
	15	What type of guidance or information is provided to women by your organization?
Information	16	Is there an information system or database used to record the care provided?
	17	If so, how are these recorded data used?
	18	Are you aware of any official system that records data on violence against women in the municipality? If so, which system is it? Have you ever accessed the information in this system?
Capacity building	19	Is training provided to professionals on the topics of gender inequality and violence against women? What about approaches to network collaboration?
Other	20	Is there a good relationship among the organizations that comprise the Protective Network?
	21	Do you consider network-based collaboration to be important? Why or why not?
	22	How do you evaluate the performance of the Protective Network in Viçosa? Do you have any suggestions, and if so, what are they?
	23	What does the Protective Network mean to you?
	24	If the Protective Network did not exist, how significantly would that impact the Policy for Combating Violence Against Women? Why?
	25	Do you believe the municipal government recognizes the importance of network-based collaboration?

Note: at the conclusion of the interview, ask each organizational representative to provide a sketch (a drawing of the network) depicting how they perceive its structure and operation from their specific institutional standpoint.

NETWORK MAPPING – REFERRALS (FLOWS BETWEEN ORGANIZATIONS)

Intersectoral Network for Institutional Articulation for Combating Violence Against Women (*Rede Intersetorial de Articulação Institucional em Torno do Enfrentamento à Violência Contra as Mulheres*) Viçosa-MG

Name of Organization _____

Intersectoral Network – Existing Network Referral Pathways and Workflows

The information to be collected through the following table addresses the following aspects: the organizations responsible for providing care to victims that participate in the Protective Network; the frequency with which contact is established with other network organizations; the type of violence addressed and, based on this information, the referral procedures utilized; the occurrence or non-occurrence of counter-referrals (feedback/follow-up loops) within the referrals carried out across the network; and the duration of participation in the Protective Network.

Nº	**Organization**	**Frequency of Contact**				**Type(s) of Violence**	**Counter-Referral**		**Duration of Network Membership**
1		1	2	3	4		Yes	No	
2		1	2	3	4		Yes	No	
3		1	2	3	4		Yes	No	
4		1	2	3	4		Yes	No	
5		1	2	3	4		Yes	No	
6		1	2	3	4		Yes	No	
7		1	2	3	4		Yes	No	
8		1	2	3	4		Yes	No	
9		1	2	3	4		Yes	No	
10		1	2	3	4		Yes	No	

Type of Violence

1	Sexual
2	Physical
3	Psychological
4	Moral
5	Patrimonial

Frequência

1	Once a month
2	Once every two weeks
3	Once a week
4	Daily

Lista de Organizações

1	São Sebastião Hospital (*Hospital São Sebastião - HSS*)
2	São João Batista Hospital (*Hospital São João Batista - HSJB*)
3	Family Health Program (*Programa Saúde da Família - PSF*)
4	State Specialized Care Center (*Centro Estadual de Atenção Especializada - CEAE*)
5	Health and Psychosocial Division (*Divisão de Saúde e Psicossocial*) /UFV
6	Reference Center for Social Assistance (*Centro de Referência de Assistência Social - CRAS*)
7	Specialized Reference Center for Social Assistance (Centro de Referência Especializado de Assistência Social - CREAS)
8	Public Defender's Office (*Defensoria Pública*)
9	Public Prosecutor's Office (*Ministério Público*)
10	Guardianship Council (*Conselho Tutelar*)
11	Civil Police (*Polícia Civil*)
12	Military Police (*Polícia Militar*)
13	Medico-Legal Institute (*Instituto Médico Legal – IML*)
14	Women's Shelter (*Casa das Mulheres*)
15	Municipal Council for Women's Rights (*Conselho Municipal dos Direitos da Mulher -CMDM*)
16	Coordinating Office for Women's Policies (*Coordenadoria de Política para as Mulheres*)

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