saúde EM DEBATE

ORIGINAL ARTICLE

Driving and restraining forces in a Specialized Care Service for People Experiencing Sexual Violence

Forças impulsoras e restritivas em um Serviço de Atenção Especializada às Pessoas em Situação de Violência Sexual

Fuerzas de conducción y contención en un Servicio de Atención Especializada para Personas en Situaciones de Violencia Sexual

Eduardo Araújo da Silva[1], Michelle Tavares Barbosa dos Santos[1], Juliana Bastoni da Silva[1], Dayana Sales Rodrigues[1], Wyttória Régia Neves da Conceição Duarte[1], Leonora Rezende Pacheco[2], Leidiene Ferreira Santos[1]

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ABSTRACT Sexual abuse is growing exponentially in both the number and complexity of cases, constituting a serious global public health problem. Specialized care units represent an important tool for welcoming and assisting people in situations of violence. Therefore, this study aimed to identify and describe the forces that drive and constrain work processes in a Specialized Care Service for People in Situations of Sexual Violence (SAVIS), based on the Force Field Theory. This is a qualitative research study, approved by an Ethics Committee (CAAE 72696123.5.0000.5519), in which healthcare professionals were interviewed and the transcribed data were subjected to Content Analysis. The results show that the work of SAVIS is influenced by numerous factors, some intrinsic to the unit itself and others reflecting the organization of the other services that make up the network. Negative forces such as prejudice, misogyny, sexism, violence as a tolerated phenomenon, and weaknesses in the network indicate the need for public policies to address sexual abuse to be implemented, with financial and human investment in actions that contribute to the prevention and management of cases, with a focused direction on welcoming people in situations of violence and training network professionals.
KEYWORDS Violence. Violence against women. Sex offenses. Health services.

RESUMO *O abuso sexual cresce exponencialmente em quantidade e complexidade dos casos, configurando-se em grave problema de saúde pública mundial. As unidades especializadas no atendimento representam uma ferramenta importante para o acolhimento e a assistência às pessoas em situação de violência. Assim, este estudo objetivou identificar e descrever as forças que impulsionam e restringem os processos de trabalho em um Serviço de Atenção Especializada às Pessoas em Situação de Violência Sexual (Savis), a partir da Teoria do Campo de Forças. Trata-se de uma pesquisa qualitativa, aprovada por Comitê de Ética (CAAE 72696123.5.0000.5519), em que foram entrevistados profissionais de saúde e os dados transcritos submetidos à Análise de Conteúdo. Os resultados mostram que o trabalho do Savis é influenciado por inúmeros fatores, alguns intrínsecos à própria unidade e outros reflexos da organização dos demais serviços que integram a rede. Forças negativas como preconceito, misoginia, sexismos, violência como fenômeno tolerado e fragilidades na rede, indicam a necessidade de que sejam efetivadas políticas públicas de enfrentamento ao abuso sexual, com investimento financeiro e humano em ações que contribuam para a prevenção e o manejo dos casos, com direcionamento atentivo para o acolhimento das pessoas em situação de violência e qualificação dos profissionais da rede.*
PALAVRAS-CHAVE *Violência. Violência contra a mulher. Delitos sexuais. Serviços de saúde.*

RESUMEN *El abuso sexual está creciendo exponencialmente tanto en cantidad como en complejidad de casos, constituyendo un grave problema de salud pública mundial. Las unidades de atención especializada representan una herramienta importante para acoger y asistir a personas en situaciones de violencia. Por lo tanto, este estudio tuvo como objetivo identificar y describir las fuerzas que impulsan y restringen los procesos de trabajo en un Servicio de Atención Especializada para Personas en Situaciones de Violencia Sexual (SAVIS), basándose en la Teoría del Campo de Fuerzas. Se trata de un estudio de investigación cualitativa, aprobado por un Comité de Ética (CAAE 72696123.5.0000.5519), en el que se entrevistó a profesionales de la salud y los datos transcritos se sometieron a un Análisis de Contenido. Los resultados muestran que el trabajo de Savis está influenciado por numerosos factores, algunos intrínsecos a la propia unidad y otros que reflejan la organización de otros servicios que conforman la red. Las fuerzas negativas como los prejuicios, la misoginia, el sexismo, la violencia como fenómeno tolerado y las debilidades de la red indican la necesidad de políticas públicas eficaces para combatir el abuso sexual, con inversión financiera y humana en acciones que contribuyan a la prevención y gestión de los casos, con una orientación atenta para el apoyo a las personas en situaciones de violencia y la cualificación de los profesionales de la red.*
PALABRAS CLAVE *Violencia. Violencia contra la mujer. Delitos sexuales. Servicios de salud.*

[1] Universidade Federal do Tocantins (UFT) – Palmas (TO), Brasil.
leidienesantos@uft.edu.br

[2] Universidade Federal de Goiás (UFG) – Goiânia (GO), Brasil.

Introduction

Violence is a complex and multifaceted phenomenon. Understanding its various forms as a human and social manifestation requires a thorough analysis of the society that produces them, particularly regarding its social and economic structure and socio-historical context[1].

Globally, violence is a serious public health problem, especially due to its high incidence and devastating consequences for individuals and society[2]. Specifically, sexual violence – defined as any act in which an individual, abusing a position of power and using physical force, coercion, intimidation, or psychological influence, with or without weapons or drugs, compels another person, regardless of sex or age, to engage in, witness, or participate in any form of sexual activity, or to use their sexuality in any way for profit, revenge, or other motives[3] – primarily affects women and girls, with increasingly significant numbers[4].

Current data show that, worldwide, one in eight women or girls has experienced rape or sexual assault before the age of 18, totaling more than 370 million people. When including forms of sexual violence without physical contact, such as online or verbal abuse, the number rises to 650 million, or one in five women or girls[5].

Sexual violence is widespread and transcends geographical, cultural, and economic boundaries. Sub-Saharan Africa has the highest number of victims, with 79 million girls and women affected (22%), followed by 75 million in East and Southeast Asia (8%), 73 million in Central and South Asia (9%), 68 million in Europe and North America (14%), 45 million in Latin America and the Caribbean (18%), 29 million in North Africa and West Asia (15%), and 6 million in Oceania (34%)[5].

Given this reality, the need for actions to prevent sexual abuse, as well as support and assistance services for people experiencing violence, is clear. In Brazil, public policies and various strategies have been implemented within the Unified Health System (SUS), including the establishment of the National Network for the Prevention of Accidents and Violence, the implementation of the Violence and Accidents Surveillance System (VIVA), and the creation of Specialized Care Services for People in Situations of Sexual Violence (SAVIS)[6].

Nationally, the presence of specialized units for assisting victims of sexual assault demonstrates a commitment by the public sector to provide qualified care. Another important aspect is the availability of abortion services, prevention of Sexually Transmitted Infections (STIs), and emergency contraception, offered in some of these institutions[7].

However, recent research shows that challenges remain in keeping network workers sensitized and trained to address sexual violence[7-9]. Many professionals are unaware of the existence of specialized services, and there are weaknesses in identifying and reporting cases, as well as in reception, referral, and continuity of care.

From this perspective, considering the importance of services for women, men, children, adolescents, and the elderly in situations of sexual abuse – especially regarding the preservation of life, the provision of comprehensive health care, and the promotion of coordinated care within the SUS[6], the following research question was posed: 'What factors contribute to and what factors hinder the work processes in a SAVIS center?'.

The research aimed to identify and describe the forces that drive and restrain work processes in a SAVIS, based on Force Field Theory[10].

The aim is to highlight the factors that positively and negatively influence the actions developed in and by SAVIS, to support decision-making, problem-solving, behavioral change, overcoming obstacles, and improving the quality of assistance offered to people at risk and in situations of sexual violence.

Theoretical framework

In the health field, several authors[11-13] have described the use of Force Field Theory as a valuable tool for identifying the weaknesses

and potential of services and interventions, supporting the development of actions that effectively contribute to improving aspects of work, both collective and individual.

According to this theory, throughout life, each person synthesizes their experiences and interactions with their environment in a unique way. Thus, every individual has their own dynamics, interprets experiences, and perceives things, people, and situations in a particular manner. It is understood, therefore, that each individual's behavior results from the totality of facts and events coexisting in a given situation, and the interrelation between the facts and events experienced by each person creates a field of forces that represents their psychological environment – the life space that contains them and everything that surrounds them[10].

This field is represented by positive valences (driving forces) and negative valences (restraining forces), that is, aspects that help or hinder work processes and personal interaction, and these are distributed across three dimensions: SELF, OTHER, and ENVIRONMENT[14].

The SELF dimension includes factors related to the individual, such as motivation, talents, and shyness. The OTHER dimension covers factors related to relationships with other people, such as leadership, competence, conflicts, and empathy. Finally, the ENVIRONMENT dimension includes elements related to space and physical structure, material resources, and organizational dynamics[14].

Thus, knowing the vectors that form a given force field makes it possible to understand behaviors and infer implications for how to mobilize actions to achieve established objectives[15-17].

In this research, the field of forces was designed based on valences that affect the work processes of SAVIS. For this purpose, the health professional of the service was considered as the SELF vector; social actors external to the unit and institutions of the network as OTHER; and the living space of SAVIS (team and infrastructure) as ENVIRONMENT.

Methodological approach

This qualitative research study was conducted in accordance with the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ)[18]. Professionals from a SAVIS unit, located in a capital city of the Legal Amazon, were interviewed.

The SAVIS unit is a state-level reference center that operates continuously. It is located within a maternity hospital and provides urgent/emergency and outpatient care. Twenty-four healthcare professionals worked at the unit, including five doctors (two obstetricians, one pediatrician, one psychiatrist, and one general practitioner), six nurses, five psychologists, seven social workers, and one nursing technician. All were invited to participate in the research via telephone contact, specifically through a WhatsApp message.

For data collection, a semi-structured interview was conducted by a healthcare professional, guided by the following questions: 'Tell me about how SAVIS works'; 'Tell me about the activities you carry out at SAVIS'; 'In your opinion, are there factors that facilitate the functioning of SAVIS? If so, tell me about them'; and 'In your opinion, are there factors that hinder the functioning of SAVIS? If so, tell me about them'.

The interviews were audio-recorded and conducted by one of the study's researchers. They took place at SAVIS between May and August 2024, in a private room with only the interviewer and interviewee present, scheduled according to the professionals' availability. Each interview lasted between 16 and 27 minutes.

To ensure the accuracy of the participants' testimonies, the interviewer transcribed the interviews within two days of data collection, making spelling adjustments to facilitate understanding without altering the meaning of the statements, thus forming the corpus for analysis. The transcriptions were sent to the participants in digital document format via WhatsApp for comments or corrections. No changes were requested.

To understand the facts and phenomena presented by SAVIS professionals during the interviews, Content Analysis was used, following Bardin's assumptions[19], without software. The process began with free reading of the material to grasp and organize ideas in an unstructured way. Subsequent readings allowed for the systematization of ideas into recording units.

Next, categories and interpretations were structured through statements that encompassed the themes, according to their degree of intimacy or proximity, and which, through analysis, expressed important meanings and elaborations, considering the object of study[15]. A priori categorization was used, meaning theoretical categories were constructed from the theoretical framework adopted in this research, Force Field Theory[10].

The inclusion criterion was being a healthcare professional working in SAVIS and providing direct care; the exclusion criterion was having less than one year of experience in that unit.

To designate each speech fragment and preserve participant anonymity, the generic term 'Interviewee' was used, represented by the letter 'I' followed by an Arabic numeral according to the chronological order of the interviews.

This research complies with the precepts of Resolution No. 466/12 of the National Health Council (CNS)20, and was approved by the Research Ethics Committee on Human Beings (CAAE 72696123.5.0000.5519) and by the State Health Secretariat. Opinion Number: 6.387.076.

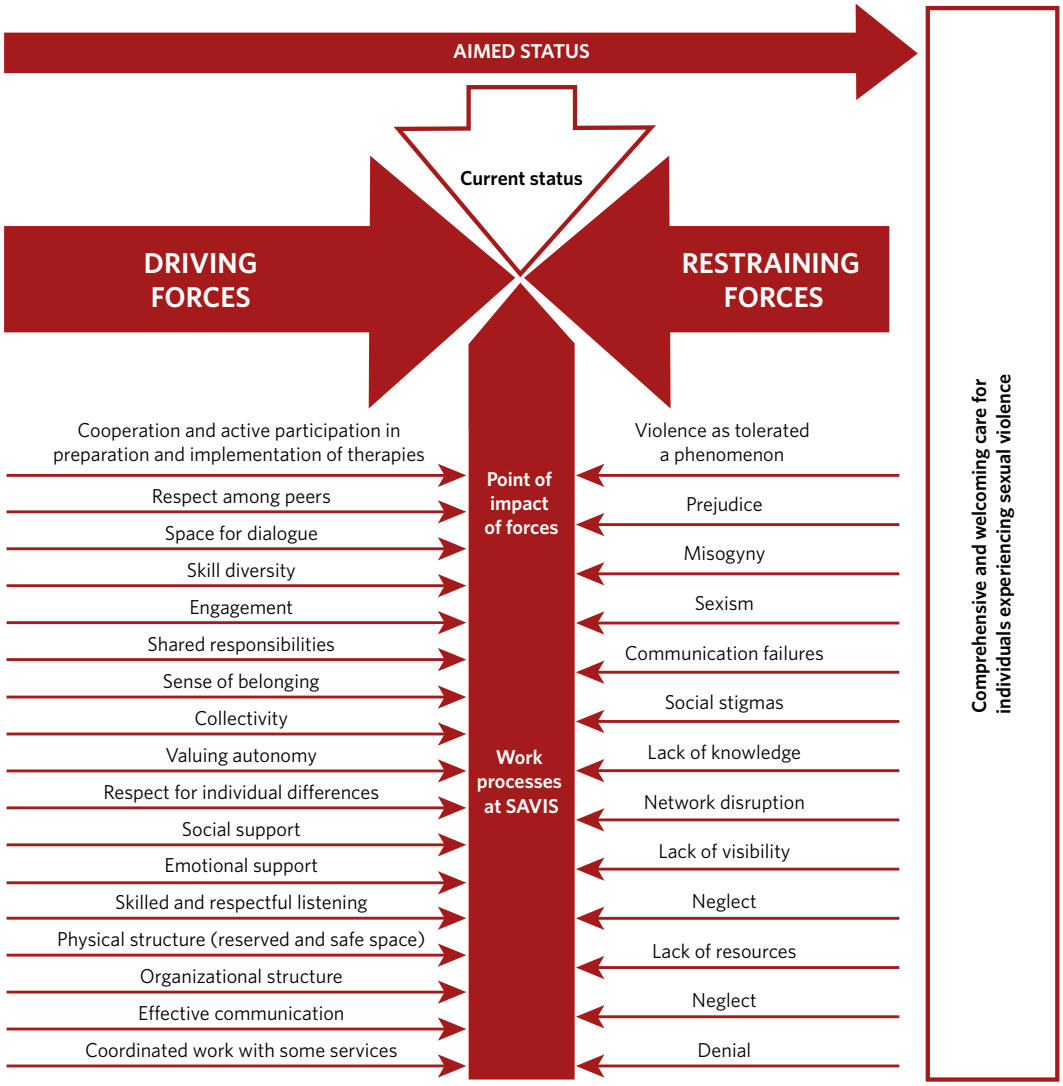
Results

Seventeen healthcare professionals agreed to participate, including two doctors, six nurses, five psychologists, and four social workers. Two individuals were excluded (one nursing technician and one social worker, as they had been with the service for less than two months), two refused to participate (one social worker and one doctor), and three professionals were on leave or vacation (one social worker and two doctors).

All interviewees had completed higher education and had at least three years of experience at SAVIS. The majority were female (13; 76.5%), and their ages ranged from 33 to 55 years, with an average of 45.

Based on the testimonies, it was identified that numerous forces contribute to the assistance provided at the unit and to the implementation of external actions. However, factors that compromise and weaken the work developed by SAVIS were also observed. Thus, the categories 'Driving forces acting on SAVIS' and 'Restraining forces acting on SAVIS' illustrate the field of forces present in the unit (*figure 1*).

Figure 1. Representation of the forces influencing work processes at SAVIS. Palmas, Tocantins, Brazil. 2024



Source: Created by the author.

Driving forces at play in SAVIS

The following subcategories encompass the strengths that drive the activities developed in and by SAVIS: collaborative work, comprehensive care for people experiencing sexual violence, networking, and external outreach, described below.

COLLABORATIVE WORK

Based on the statements, it was observed that services at SAVIS are provided by professionals from various fields who work collaboratively, creating opportunities for dialogue and the collective development of care.

> *[...] there is this vision of the social worker, the psychologist, the nurse, and the doctor. Everyone speaks, everyone evolves, and everyone makes decisions for this patient* (I2).

> *The possibility of discussing cases as a team, conducting case studies, and having the dynamic of being together is valuable. Formal team meetings to discuss cases also help a lot* (I3).

> *[...] we have an engaged team. We care for this as we would our own home; the work becomes part of us to the point that we fight for it, defend it, and work hard to ensure it succeeds* (I4).

> *[...] we approach it as if it were a decision for individual treatment. We create an individual and collective treatment plan* (I12).

At SAVIS, collaborative work results from positive values operating within the vectors of SELF and ENVIRONMENT, including respect among peers, cooperation and active participation in developing and implementing therapeutic plans, space for dialogue, diversity of skills, engagement, shared responsibility, and a sense of belonging and collectivity.

HUMANIZATION IN THE CARE OF PEOPLE EXPERIENCING SEXUAL VIOLENCE

The testimonies revealed that the actions of professionals at SAVIS go beyond purely curative practices. They address not only biological aspects but also value autonomy, individual characteristics, and the social, economic, family, and cultural context of people experiencing sexual violence.

> *We provide care as a team and seek to learn about the patient's life story, social environment, needs, socioeconomic situation, and health status* (I7).

> *[...] every day of the week, we have a full team on duty. This team practices active listening and empathetic listening* (I8).

> *[...] we approach the patient holistically and consider the consequences of this event* [sexual abuse] *in the person's life* (I16).

> *[...] social experiences, social relationships, family interactions, and whether the victim has supportive care are important factors to understand about these patients. It is important to know how coexistence is at school and at church. We seek to determine if their rights are being respected* (I17).

The care provided at SAVIS goes beyond biological issues by also considering people's life experiences. Psychosocial aspects are addressed through strong emotional and social support, as well as qualified and respectful listening, which are present in the SELF and ENVIRONMENT vectors. The environment also serves as a positive influence by promoting a welcoming and humanized approach to care.

> *[...] a more welcoming and isolated environment compared to the rest of the hospital, so much so that it is further removed from the usual care areas, such as the emergency room. This creates a calmer, more tranquil setting where better care can be provided* (I6).

> *[...] today we already guarantee an appropriate physical space to provide quality listening – a private, safe, and non-hostile space* (I8).

> *[...] we have a very valuable benefit that I always praise: the reception. When someone arrives and says they want to talk about violence, the reception staff do not ask for additional information; they simply take the documents and bring the person to us. This streamlined process has greatly reduced the dropout rate among users, as they feel welcomed from the moment they arrive* (I9).

It is thus noted that aspects of the physical structure (calm, private, and safe space) and organizational structure (free and unbureaucratic entry, and respectful and discreet receptionists) of SAVIS act as driving forces, present in the ENVIRONMENT vector.

NETWORKING

The testimonies reveal that effective communication and coordinated work between services are strengths within the OTHER vector, enhancing SAVIS's performance.

> *The network makes things easier because we already have a good relationship with it. We have many opportunities to speak there* (I4).

> *We have very close contact with the guardianship council. It is a partner as we seek ways to ensure that the user's rights are respected* (I7).

> *Communication within the network itself, between the police station, the Forensic Medical Institute, and SAVIS, facilitates the development of activities* (I12).

Various institutions can help prevent sexual violence and provide support and protection to abused individuals. Collaboration between sectors, services, and social actors within these spaces creates a network of care, helping to guarantee rights and reduce harm to people experiencing suffering and vulnerability.

EXTERNAL ACTIVITIES

In addition to assisting people who have suffered sexual abuse, the SAVIS team also conducts educational activities in schools and other sectors of the community:

> *[...] we give lectures at schools and prepare documents for the Public Prosecutor's Office* (I2).

> *We have already received teenagers who came here after learning about the service through a school lecture. Increasing the service's visibility will unfortunately raise the number of cases, but if it means providing care, we believe it is worthwhile* (I7).

> *We provide guidance to schools, support groups, and the police. We also offer guidance on procedures* (I17).

The implementation of external actions by SAVIS professionals serves as a positive force in the OTHER vector, as it provides visibility to their work, promotes integration and partnerships with other institutions and services, and offers people experiencing violence the opportunity to learn about the unit's existence.

Restrictive forces operating at SAVIS

The subcategories prejudice, violence as a tolerated phenomenon, and weaknesses in the network encompass the forces that operate as negative valences, restricting the activities developed in SAVIS, and are presented below.

PREJUDICE

Stigmas related to people experiencing sexual violence were identified, extending to professionals working in the SAVIS. Prejudice, neglect, and lack of support and empathy are forces acting on the OTHER vectors, making the professionals' work more difficult and compromising the humanization of care in the unit.

> *The maternity staff themselves have this prejudice against the SAVIS staff because we also perform abortions permitted by law. So, there is even this religious prejudice from others* (I11).

> *[...] prejudice, even from professionals who work in the maternity ward. We needed a doctor on the weekend for a patient's admission, and it took a long time to get that care. There are various forms of prejudice from professionals, patients, and family members* (I16).

> *[...] they call us an island here; they say we are restricted and closed off, but we are not. They create this obstacle as if we were independent. They say we should have specific beds, but the patient is from the SUS, from the hospital. We always provide training during the year, but many people do not participate. People's judgment is horrible* (I17).

Social stigmas, imposed by families, other patients, and even healthcare professionals, contribute to revictimizing individuals experiencing sexual violence and making their path even more difficult, as well as exposing professionals working in the unit to expressions of violence, such as prejudice and discrimination.

VIOLENCE AS A SOCIALLY TOLERATED PHENOMENON

The accounts show a clear sociocultural influence on the practice and acceptance of certain forms of violence, both by society and by those working in various social assistance and health services. This influence can weaken the effectiveness of the protection network, lead to blaming victims, and contribute to revictimization.

> *[...] the way the professional was raised will affect both the professional and their interpretation, including whether they perceive the seriousness of violence that is reported and how they approach it* (I2).

> *[...] we have cultural issues that greatly influence the demands we address here. We live in a culture, and we need to acknowledge this, where women are not validated in their accounts of violence* (I3).

> *[...] most violence occurs within families. In some cases, we observe that the abuser remains at home* (I7).

> *[...] the professional's subjectivity will interfere. Whether they have been a victim of violence or not, and whether violence in their environment was validated or not, all of this will lead them to have varying interpretations regarding the seriousness of the violence, which can impair their work with the victim* (I9).

Denial, sexism, misogyny, impartiality, invisibility, and the normalization of certain forms of violence act as negative valences in SAVIS, present in the vectors SELF, OTHER, and ENVIRONMENT. Violence is present in people's daily lives and is primarily practiced within family life and tolerated in various institutions and services.

WEAKNESSES IN THE NETWORK

According to those interviewed, society and other institutions lack awareness about the existence and functioning of SAVIS, which contributes to people experiencing sexual violence not being referred to or seeking out the service. As a result, they may not be properly welcomed or guided and may not receive timely treatment.

> *[...] sometimes servers from other sectors are aware that SAVIS exists, but if you ask them what SAVIS is for, they do not know* (I5).

> *What often makes things difficult is the lack of information or dissemination about the service* [SAVIS] *in other sectors and environments in the city. Sometimes, a person seeks help long after experiencing such violence, perhaps because they were not informed or did not know how the service worked. That is a challenge* (I6).

> *We have an underserved audience, which is the LGBTQI+ population, because people assume that motherhood is only for women and children. So, this other audience – those who are not women, including men – also experience situations of sexual violence and do not know where to turn for help* (I8).

> *Patients have little knowledge about our service, and there is not much demand for it. People suffer this type of violence and do not know where to seek help. Often, the network does not know where to refer them, which hinders our service* (I13).

Furthermore, limitations in the knowledge of professionals working in the network, regarding the treatment and referral of people in situations of violence, and the lack of financial, material, and human resources, act as negative forces:

For example, when you go to the police stations, they do not know how to refer you; child protection services do not know how to process the requests; and doctors do not know how to refer you either (I1).

Difficulties with prophylaxis are also a recurring issue. The medical staff do not know how to refer or administer prophylaxis. Hospitals of a certain size (two years old) do not have prophylaxis for victims of sexual violence, which is the same as for accidents with sharp objects, and this reflects a lack of awareness across the entire network. We see that it is not prepared (I3).

[...] so it is very difficult. For example, the person has to leave [the municipality more than 500 km from SAVIS] *every week to come for this psychological care, because there is none there* (I4).

[...] the patient is in a difficult financial situation without assistance from the municipality for transportation, since many municipalities do not want to take responsibility for the transfer (I17).

The invisibility of SAVIS and the lack of preparedness among professionals and resources within the network are negative forces present in the OTHER vector and can significantly compromise assistance to people experiencing sexual violence, from initial reception to the maintenance and continuity of treatment.

Discussion

Sexual violence is a serious crime that causes profound and persistent suffering, with significant negative impacts on health and well-being[21]. Therefore, it is essential that health professionals, particularly those working in specialized services for individuals exposed to this form of violence, receive adequate training to provide care that effectively supports victims and helps prevent revictimization, including institutional revictimization[7]. Such training can contribute to the development of a field of forces in which vectors aimed at promoting health and safeguarding rights predominate.

From this perspective, it is essential that care be delivered collaboratively[22], as this model enables professionals from different disciplines to work together and implement interventions grounded in the principle of comprehensive health care, while considering the needs of patients and their families and respecting the singularities and autonomy of those involved[23]. Therefore, professionals must be prepared to provide prompt and effective care and be willing to engage in teamwork. These competencies are fundamental to interprofessional practice, facilitating the integration of diverse forms of knowledge and the delivery of coordinated, patient-centered, and timely care, thereby helping to overcome reductionist approaches[22].

In this research, respect among peers, opportunities for dialogue, engagement, the collective development of therapeutic plans, a sense of belonging, and collective responsibility emerged as a set of driving forces oriented toward collaborative practice within SAVIS.

Such attitudes can contribute significantly to improving the actions carried out by the institution, as understanding the specific roles of each profession enables the recognition of what should be shared among all team members, as well as how the practices of one professional may influence the effectiveness of the care provided by another[22]. In this way, collaborative work enhances the quality of care delivered to individuals in situations of sexual violence and constitutes a set of values strongly aligned with efforts to confront and prevent violence.

Furthermore, individuals experiencing sexual violence must receive comprehensive and humanized care through qualified listening and respect for their dignity[24]. These actions were identified as driving forces within the SAVIS field of forces and are reflected in practices such as facilitating access to the service without unnecessary bureaucracy, exposure, or embarrassment, promoting

autonomy from the first consultation, during which individuals may choose one or more professionals from the team to listen to them, and developing individualized therapeutic plans jointly constructed by health professionals and the patient.

The work carried out outside SAVIS, particularly by some units that are part of the network for the protection of individuals experiencing violence, also emerged as a positive valence within its field of forces. This aspect highlights the importance of integrated actions among the various social actors and sectors involved in the care network, contributing to the qualification and continuity of care[25]. Furthermore, welcoming practices, humanization, and collaboration among services and professionals can help individuals feel supported, empowered, and motivated to break free from the cycle of violence[26].

It is noteworthy that welcoming practices, humanization, and collaborative, network-based work operate as driving forces that help shape the SAVIS field of forces, both in terms of frequency and intensity. In this context, it is important to emphasize that the greater the number and strength of positive vectors, the greater the potential for promoting health and safeguarding the rights of individuals experiencing violence[27].

Nevertheless, although the findings of this study point to a field predominantly composed of driving forces, current evidence[7-9] indicates that, despite the existence of laws and guidelines aimed at improving care for individuals experiencing sexual violence in Brazil for more than a decade, assistance is still often not provided in accordance with recommended standards[7].

In this scenario, it is important to recognize that violence is a culturally tolerated phenomenon embedded in social life, contributing to the invisibility of this harm. This reflects a historically constructed process grounded in the logic of justifying the crime and blaming those who have experienced it, whether by society at large or by the criminal justice system itself[28]. Such dynamics configure a field of forces marked by restrictive vectors that weaken care provision and compromise the protection of the dignity and rights of individuals exposed to abuse.

In turn, sexual violence constitutes a cruel and persistent manifestation of gender-based violence, characterized by an intersectional nature and strongly influenced by social determinants, disproportionately affecting women and girls[4,5]. In addition to these groups, the LGB+ population also requires particular attention, as its members face multiple restrictive factors when seeking support and care following sexual violence[29].

In Brazil, LGB+ individuals are nearly five times more likely to experience sexual violence than heterosexual individuals[30]. Moreover, access to healthcare remains marked by inequalities, stigma, and prejudice. Care practices are often structured around heteronormative assumptions and, particularly in the case of transgender people, may be influenced by processes of pathologization, creating additional barriers to accessing comprehensive and respectful care[31].

These findings reinforce that sexual violence is closely associated with macrostructural factors embedded in society, including racism, patriarchy, misogyny, and sexism[32]. Furthermore, the subtle yet effective silencing of abuse is sustained by a process of collective irresponsibility through which violence becomes normalized[28].

In this context, it is essential to recognize the persistent weaknesses within the care network for individuals experiencing sexual violence. These weaknesses are related not only to structural limitations and resource shortages but also to the actions and attitudes of the social actors involved in care provision[33]. Social representations held by professionals shape their perceptions of violence and directly influence how interventions are planned and implemented[34].

The values, knowledge, feelings, perceptions, and power relations of professionals

working within the care network often shape practices that are limited and marked by disrespect for the rights and dignity of the individuals assisted[25]. It is evident, therefore, that services are influenced by forces that can significantly compromise the quality, comprehensiveness, and effectiveness of the care provided[7,8].

Furthermore, insufficient knowledge among professionals about the service network and the role of each sector results not only in difficulties in communication and coordination but also in inappropriate referrals[33]. These aspects were observed in the SAVIS field of forces as restrictive vectors, negatively influencing the articulation of care and the quality of assistance provided.

It is also important to recognize that the underfunding of the health sector contributes to unequal access to care and limits the capacity of the SUS to respond equitably to users' needs, particularly those of the most vulnerable populations[33]. In the present study, some patients were required to travel more than 500 kilometers each week to receive follow-up care from the SAVIS team. These findings illustrate how socioeconomic factors can hinder both access to support networks and adherence to therapeutic plans[7].

It is therefore evident that the numerous barriers to assisting individuals who have experienced sexual violence in Brazil constitute a field of forces marked by negative valences, significantly compromising work processes across the care network. Nevertheless, it is important to emphasize that services also have the potential to support recovery and resilience, particularly when individuals are received with validation, affirmation, dignity, and respect[35]. These elements were identified as positive valences within the SAVIS field of forces.

Furthermore, the pursuit of improved outcomes and the provision of dignified, high-quality care for individuals experiencing sexual violence requires ongoing training and capacity building for health professionals. Such efforts can facilitate the implementation of interventions, taking into account the characteristics and demands of each level of care and the realities of professional practice[8].

One limitation of this study is the exclusion of the perspectives of individuals assisted by SAVIS, as their experiences could have provided additional insights and reflections regarding the care received. Nevertheless, the proposed objective was achieved, making it possible to understand the factors within the work process that facilitate or hinder health promotion and the protection of the rights of individuals experiencing sexual violence.

Final considerations

The work carried out by the SAVIS team is influenced by numerous factors, some intrinsic to the unit itself and others reflecting the organization of other services that make up the network for protecting people in situations of violence.

Among the forces that positively influence the work process at SAVIS, the following stand out: opportunities for dialogue, the collective construction of care, respect among peers, engagement, a sense of belonging within the team, the valuing of professional autonomy, qualified listening, and respect for individual differences as well as social, economic, family, and cultural contexts. Together, these elements indicate that SAVIS provides welcoming, humanized, and collaborative care to individuals experiencing violence.

Regarding the forces that negatively affect the work process at SAVIS, several limitations were identified, including insufficient knowledge among professionals within the care network, particularly regarding appropriate and timely management of cases; failures in referral processes; shortages of financial, material, and human resources within health services; limited public and institutional awareness of specialized centers for the care of individuals experiencing sexual violence;

and manifestations of prejudice, racism, patriarchy, and misogyny. These factors affect not only the individuals receiving care but also the professionals involved in providing assistance, including those working within the broader care network.

Corroborating current evidence, this study demonstrates that violence remains a culturally tolerated phenomenon, particularly when directed against women and girls. This finding underscores the urgent need for training and capacity building of professionals, both through academic education and continuing professional development, to better address this issue. Such efforts are essential given that the quality and nature of care are strongly influenced by the sociocultural values, beliefs, and attitudes of the professionals who comprise the healthcare network.

Furthermore, it is essential to strengthen public policies aimed at combating sexual violence through adequate financial and human resource investments in prevention, protection, and care initiatives. Such efforts should support the effective management of cases while ensuring comprehensive, timely, and compassionate assistance for individuals who have experienced this serious violation of human rights.

Authorship contributions

Santos LF (0000-0002-2969-6203)*, Silva EA (0009-0003-5453-3734)* and Santos MTB (0000-0002-0831-8940)* contributed to conceptualization, data curation and analysis, research, methodology, project management, development, supervision and writing, revision and editing of the manuscript. Silva JB (0000-0002-6642-8910)*, Rodrigues DS (0009-0000-7536-0084)*, Duarte WRNC (0009-0003-3699-9450)* and Pacheco LR (0000-0001-6048-3911)* contributed to conceptualization, data curation, data analysis, methodology and writing, revision and editing of the manuscript. ■

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*Orcid (Open Researcher and Contributor ID).

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Editor in charge: Maria Lucia Frizon Rizzotto, State University of Western Paraná (Unioeste), Cascavel (Paraná/PR), Brazil. Lattes: http://lattes.cnpq.br/7877904356698023 – Orcid: https://orcid.org/0000-0003-3152-1362 – e-mail: marialuciarizzotto@gmail.com