

MISSED OPPORTUNITIES IN THE CARE OF WOMEN EXPERIENCING VIOLENCE

Ana Pereira dos Santos

Instituto René Rachou - Fiocruz Minas / Pontifícia Universidad Católica de Minas Gerais,
Belo Horizonte, Brazil

© ana_pereira.santos@fiocruz.br |  <https://orcid.org/0000-0003-2758-845X>

Lívia Pereira de Souza

Universidade Federal de Minas Gerais, Belo Horizonte, Brazil

© liviapsz@gmail.com |  <https://orcid.org/0000-0002-4822-288X>

Kênia Araújo Pires

Instituto René Rachou - Fiocruz Minas, Belo Horizonte, Brazil

© kenia.arj@gmail.com |  <https://orcid.org/0009-0008-3232-1470>

Kate Aparecida Rocha Lacerda

Instituto René Rachou - Fiocruz Minas, Belo Horizonte, Brazil

© kate.lacerda@fiocruz.br |  <https://orcid.org/0000-0003-3453-9533>

Janete Gonçalves Evangelista

Instituto René Rachou - Fiocruz Minas, Belo Horizonte, Brazil

© janete.evangelista@fiocruz.br | <https://orcid.org/0000-0002-8610-5350>

Isabella Vitral Pinto

Instituto René Rachou - Fiocruz Minas, Belo Horizonte, Brazil

© isabella.pinto@fiocruz.br | <https://orcid.org/0000-0002-3535-7208>

Carmem Sant Fruchman

Swiss Tropical and Public Health Institute, University of Basel, Basel, Switzerland

© c.santfruchman@swisstph.ch |  <https://orcid.org/0000-0002-5276-3515>

Daniel Cobos Munoz

Swiss Tropical and Public Health Institute, University of Basel, Basel, Switzerland

© daniel.cobos@swisstph.ch |  <https://orcid.org/0000-0002-5920-1304>

Paula Dias Bevilacqua

Instituto René Rachou - Fiocruz Minas, Belo Horizonte, Brazil

© paula.bevilacqua@fiocruz.br |  <https://orcid.org/0000-0003-0015-2154>

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ABSTRACT: This study investigates how territory, as a social marker of difference, influences the care of women experiencing violence within Primary Health Care (PHC). Using a qualitative and intersectional approach, the study explored the experiences of health professionals, women experiencing violence, and activists from social movements connected with five Basic Health Units (BHU) in the municipality of Belo Horizonte, Minas Gerais, Brazil. The findings revealed that territory, beyond a geographic space, is also a political arena in which power dynamics imposed by armed groups establish norms of conduct based on hegemonic masculinities, thereby reshaping health care practices. Fear emerges as the central category, weakening the relationship between professionals and the community. Territorial violence imposes challenges to the protection of women, silencing complex demands and hindering the implementation of public policies.

KEYWORDS: Health Policies; Primary Health Care; Women's Health; Territory; Gender

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OPORTUNIDADES PERDIDAS EN LA ATENCIÓN A MUJERES QUE SON VÍCTIMAS DE VIOLENCIA

RESUMEN: Este estudio analiza la manera en la que el territorio, como marcador social de la diferencia, influye en la atención brindada a las mujeres que son víctimas de violencia en el ámbito de la atención primaria de la salud (Primary Health Care, PHC). Mediante un enfoque cualitativo e interseccional, el estudio analizó las experiencias de profesionales de la salud, mujeres que son víctimas de la violencia y activistas de movimientos sociales vinculadas a cinco Unidades Básicas de Salud (UBS) en el municipio de Belo Horizonte, en el estado de Minas Gerais, Brasil. Los resultados del estudio revelan que el territorio, además de ser un espacio geográfico, es también un ámbito político en el que las dinámicas de poder impuestas por los grupos armados establecen normas de conducta basadas en masculinidades hegemónicas, lo que reconfigura las prácticas de atención de la salud. El miedo se perfila como la categoría central, lo que debilita la vinculación de las profesionales con la comunidad. La violencia territorial dificulta la protección de las mujeres, silencia las demandas complejas y obstaculiza la implementación de políticas públicas.

PALABRAS CLAVE: Políticas de salud; Atención primaria de la salud; Salud de la mujer; Territorio; Género

OPORTUNIDADES PERDIDAS NO CUIDADO DE MULHERES EM SITUAÇÃO DE VIOLÊNCIA

RESUMO: Este estudo investiga como o território, enquanto marcador social de diferença, influencia o cuidado de mulheres em situação de violência na Atenção Primária à Saúde (APS). Utilizando uma abordagem qualitativa e interseccional, o estudo explorou as experiências de profissionais de saúde, mulheres vítimas de violência e ativistas de movimentos sociais vinculados a cinco Unidades Básicas de Saúde (UBS) do município de Belo Horizonte, Minas Gerais, Brasil. Os resultados revelaram que o território, além de espaço geográfico, é também uma arena política na qual dinâmicas de poder impostas por grupos armados estabelecem normas de conduta baseadas em masculinidades hegemônicas, remodelando, assim, as práticas de saúde. O medo emerge como categoria central, fragilizando a relação entre profissionais e comunidade. A violência territorial impõe desafios à proteção das mulheres, silenciando demandas complexas e dificultando a implementação de políticas públicas.

PALAVRAS-CHAVE: Políticas de saúde; Atenção Primária à Saúde; Saúde das mulheres; Território; Gênero

INTRODUCTION

Understanding the determinants of violence against women and developing strategies to address it based on the analysis of social markers of difference¹ remains a significant challenge for both academia and public policy, in Brazil and globally. From this perspective, we assume that social phenomena, as well as individuals, are shaped by systems of social classification operating through markers such as race/ethnicity, class, age, sexuality, territory, among others, producing inequalities in their multiple dimensions.

Among these systems of classification, *territory*—understood as a space of residence, the production of subjectivities, and social interaction—is a fundamental marker for the formulation and implementation of care and social protection strategies. In Brazil, the organization of Primary Health Care (PHC) adopts territory as a structuring axis for service provision, operationalized through the Family Health Strategy (FHS) and the Community Health Agents Program (Ministério da Saúde 2011).

As a theoretical category, beyond its geographic dimension, *territory* can be understood as a space of social practices, a dimension of belonging sensitive to political, economic, and cultural changes, and a stage for the construction of social relations (Santos 2005). Thus, it is not

¹ *Difference* is understood as an analytical category that conceives experience as a site of contestation—a discursive space in which different subject positions and processes of subject formation are constructed, valued, or discriminated against (Brah 2006, Zamboni 2014). Thus, social markers of difference are classification systems that organize experience by identifying certain individuals with specific social categories (Zamboni 2014: 13). These frameworks allow territory to be understood as a social marker that produces ways of being and acting, articulating strategies of power which, like class and gender, may assign the social subject a position of recognition that places them under conditions of oppression and discrimination.

possible to separate individuals, institutions, families, and communities from their primary space of social life and its forms of creativity, agreements, and rules.

In this sense, the legal and technical framework for the protection of women experiencing violence is shaped by the conditions determined by the territories in which it is implemented. Violence associated with organized crime and its effects on service provision and on health professionals has been an increasingly studied topic. In Latin America, this problem is associated with the processes of colonization and social inequalities, resulting in high homicide rates and a scenario that, although not officially classified as a war zone or civil conflict, exhibits comparable characteristics (Ribeiro, Andrade, Dias and Almeida 2023; Vargas, Vélez-Grau, Camacho, Richmond and Meisel 2022).

In this context, PHC is frequently and directly affected by such violence, a phenomenon intrinsically linked to its logic of territorialization. Different studies address the effects of urban violence on the use of outpatient and hospital health services (Vargas *et al.* 2022), on health professionals and their work processes (Vargas *et al.* 2022; Vieira-Meyer, Morais, Santos, Yousafzai, Campelo and Guimarães 2022), including PHC (Almeida, Peres and Lima 2019; Bellas, Jatobá, Bulhões, Koster, Arcuri, Burns, Grindrod and Carvalho 2019; Signorell, Taft and Pereira 2018; Vieira-Meyer, Albuquerque, Guimarães, Ferreira, Aguiar, Pequeno, Morais, Forte, Farias, Vieira, Silva Júnior and Yousafzai 2025), as well as the communities served (Signorell *et al.* 2018; Vargas *et al.* 2022). However, few studies analyze PHC responses to women experiencing violence in territories under the control of organized crime.

Given this gap, this article aims to examine violence against women from a territorial perspective. We are particularly interested in analyzing the relationship between territorial violence, associated with organized crime, and the health care provided by PHC to women experiencing violence. From an interpretative standpoint, we argue that the violent socialization of men, which underpins cohesion and action within criminal groups operating in territories marked by significant

vulnerabilities, undermines and delays the protection of women experiencing violence. Furthermore, such violent socialization structures contingent and highly controlled forms of social relations, in which male dominance over women extends into state policies and practices.

This hegemonic masculinity, manifested in bellicose, intimidating, explosive, exhibitionist, and performative forms, is rhizomatic in nature, shaping subordinated subjectivities among women, activists, and workers, and dominant ones among men (whether or not they are linked to organized crime) (Connell 2016, Segato 2003).

For the interpretations presented, we understand gender as a relational dimension, problematizing male domination as an ordered social practice (Vigoya 2018). In other words, hegemonic masculinity, collectively learned and producing a violent sociability (Silva 2004), constitutes an everyday practice with sufficient force to penetrate and sustain patriarchal structures, even in political-institutional contexts where resources of various kinds are formally ensured for the protection of women's rights.

This study derives from research conducted using mixed methods in Belo Horizonte, Minas Gerais, Brazil, through a partnership between the René Rachou Institute (Fiocruz Minas) and the Swiss Tropical and Public Health Institute. The research investigated the nature, magnitude, and determinants of missed opportunities to identify, provide care for, and refer women experiencing violence within PHC. In this article, we discuss data from the qualitative component of the study, which point to interrelated determinants that lead to missed opportunities in responses aimed at the protection of women and girls experiencing violence.

METHODS

For the qualitative component of the study, we employed focused ethnography (Correa Junior, Paraizo-Horvath, Teles, Santana and Sonobe 2023), participant observation, and individual as well as group inter-

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views with women experiencing violence (and those not experiencing violence), PHC workers, and activists from social movements.

Fieldwork was conducted between 2022 and 2023 in five Basic Health Units (BHU) located in the city of Belo Horizonte. These units were selected based on the following criteria: i) homicide rates calculated for 2018 at the neighborhood level, selecting locations with higher rates; ii) proximity to or distance from specialized services for women experiencing violence; iii) BHU serving different population groups, such as people experiencing homelessness and transgender women and *travestis*; iv) the existence (or absence) of women's groups addressing violence within the local territory; v) the researchers' prior knowledge of the territories where the BHU were located; and vi) recommendations from managers of specific sectors within the organizational structure of the Municipal Health Secretariat of Belo Horizonte (SMS/PBH), such as the Primary Health Care and Care Integration Directorate and the Health Promotion and Epidemiological Surveillance Directorate, obtained through exploratory and stakeholder alignment interviews conducted prior to the study.

To meet the requirements of focused ethnography and ensure a targeted perspective in the field, the researchers engaged in extensive discussions regarding the conditions for conducting the study, including entry into the field, the building of relationships, and the selection of key informants and settings to be observed. Additionally, the interview guides were pre-tested, allowing for the revision and refinement of the research instruments.

Individual interviews were conducted with professionals from FHS teams within the BHU, typically composed of a physician, nurse, community health worker, and nursing assistant.² We also interviewed

² The FHS was conceived with the aim of reorganizing PHC in Brazil by expanding, consolidating, and strengthening it in accordance with the principles of the Brazilian Unified Health System (SUS). As a mode of practice, the FHS aims to promote a reorientation "of the work process with greater potential to deepen the principles, guidelines, and foundations of primary care, to enhance problem-solving

professionals from the Family Health Support Center (NASF), including pharmacists, physicians, psychiatrists, psychologists, occupational therapists, speech-language pathologists, and physical education professionals.³ In some BHU, we also interviewed professionals (psychiatrists, social workers, and psychologists) who were part of the unit but were not formally linked to a specific FHS team. Group interviews involved women experiencing violence who were service users, as well as members of women's collectives active in the territories where the BHU were located.

To broaden the observation of daily work practices, one to two health teams in each BHU were observed. The following spaces within the units were observed: reception, waiting rooms for consultations, staff dining areas, and spaces designated for patient intake and appointment scheduling. Additionally, we participated in health team meetings and matrix support meetings (*matriciamento*) between FHS and NASF teams, as well as activities focused on health promotion and meetings organized by the Municipal Social Assistance Policy, involving the health sector to promote intersectoral collaboration within the territory, spaces referred to as “network meetings.”⁴

capacity and impact on the health status of individuals and communities, in addition to ensuring cost-effectiveness” (Ministério da Saúde 2011: 2).

³ The NASF was established by the Ministry of Health as a multiprofessional support structure within PHC, with the aim of supporting, expanding, and enhancing the problem-solving capacity of PHC. It consists of multiprofessional teams that incorporate professionals with backgrounds distinct from those of Family Health Teams (FHTs) and operate in an integrated manner with these teams. The composition of NASF teams is defined by municipal managers and must take into account local health needs as well as the needs of the FHTs they support (Ministério da Saúde 2011: 3).

⁴ Matrix support, or *matriciamento*, refers to the process of shared construction between two or more teams for the implementation of health interventions, considering both pedagogical and therapeutic dimensions. Matrix support is an innovative experience in the field of mental health practice, promoting collaborative care between mental health services and PHC (Gonçalves, Ballester, Chavierini, Tófoli, Chazan, Almeida and Fortes 2011: 13).

Data analysis followed a reflexive approach (Bertaux 2010), incorporating elements of content analysis (Bardin 2011), seeking data saturation and generating inferences through weekly meetings among the researchers for the exchange of impressions, interpretations, and theoretical discussions, generating hypotheses through the articulation of data and concepts (Charmaz 2019).

The research procedures were reviewed and approved by the Research Ethics Committee of the René Rachou Institute (Fiocruz Minas), the Research Ethics Committee of the Municipal Health Secretariat of Belo Horizonte, and the National Research Ethics Commission (CAAE: 53271621.7.0000.5091). The terms “professional” and “woman” were used to refer to participants in order to preserve their identities.

RESULTS

Spectacularization of Violence and the Objectification of Women

In all studied territories, drug trafficking was present to varying degrees, characterizing violent contexts that impacted gender relations and the health sector’s response to violence against women. A professional who had worked for 15 years in one of the BHU stated:

This is a territory marked by frequent conflicts between gangs from the neighborhood itself and from outside. And, specifically, violence against women is really very present, right? Once you have intense drug activity within the neighborhood, active drug trafficking, this consequently impacts the issue of violence against women. Where there are drugs, there is violence in general—between parents and children, between siblings, between gangs, between neighbors. So it is a highly vulnerable neighborhood (Health professional).

Two scenes drawn from the data highlight the issue of the “spectacularization of violence” against women in territories dominated by masculinist dynamics linked to drug trafficking. In one of the field sites, a man severely beat his partner in front of the BHU, under the gaze of several onlookers, including health professionals. The silence, as a consequence of fear, had a clear explanation: the aggressor was one of the local drugs trafficking leaders, meaning that he was not only involved in drug trafficking but also part of the leadership structure of the criminal organization, which made him even more intimidating. The woman was subsequently treated at the BHU, vomiting blood and with several broken teeth.

In another field site, a worker reported that a drug trafficker severely beat his sister in the middle of the street, breaking four of her teeth. In the same territory, a woman who used drugs was beaten to death in the street by drug traffickers. Like her son, who was also killed by drug traffickers, the woman had to be buried in a closed casket due to the condition of her body. The reason for the killing was unknown; however, people connected to the territory believed that she may have been an ineffective *olheira* (lookout) and failed to warn the *movimento* (drug operation within the trafficking network) about the police entering the area, or that she owed money to the drug trade.⁵

In episodes such as those described above, the street appears as an extension of the home and vice versa. In other words, violent sociability is exercised both within the domestic sphere and in public spaces, contributing to the construction of the image of the “criminal” and reaffirming domination. According to one of the interviewed women who survived violence, it is not possible to expect that a man who is violent in the street will be *tchutchuco* at home. The term *tchutchuco*, a widely used Brazilian slang term referring to an affectionate man, also implies a docile and gentle demeanor.

⁵ The terms *olheira* and *movimento* are used by residents in some of the studied territories to designate, respectively, an informant for drug trafficking and the activities carried out within the drug trade.

In this context, highly regulated by norms of conduct arising from shared sociability in the management of drug trafficking, state action is limited, resulting in most cases of violence being resolved within the territory itself. Police presence is perceived as a threat to local dynamics, challenging the prerogatives of the Maria da Penha Law, a legal instrument that stipulates, through the application of protective measures, the removal of the aggressor from the victim (Congresso Nacional 2006).⁶ In one of the studied territories, there is an implicit agreement: local traffickers must be consulted before any police intervention is requested. This warning allows for the reorganization of the territory, including the concealment of drugs and members of the criminal organization. Police interventions not authorized by the local drug trade frequently result in punishment of those who requested it.

Consequently, the effectiveness of protective measures is compromised. Women experiencing violence are compelled to submit to local power arrangements, seeking protection from their aggressors through the *meninos do movimento* (young men associated with the local drug trade), or, ultimately, abandoning the territory and losing their community ties and support networks.

An interviewed activist illustrates this scenario. Her neighbor sought her help due to the violence she was experiencing, reporting that psychological violence (largely tolerated) had escalated into physical assaults and death threats. Despite having a protective measure in place, the military police did not respond to calls reporting violations of the judicial restraining order. Without state protection and under constant fear, the victim chose to move to another city within the state.

⁶ Measures that impose obligations on the aggressor, such as removal from the household and prohibition of contact with the victim, as well as measures that ensure the protection of the victim and her children, such as referral to official protection programs or escorting the victim to her residence (Congresso Nacional 2006).

She left the neighborhood. This was very distressing for her and her daughter. The daughter was left with many lasting traumas, as she did not understand why her mother was leaving home [...] Today she has a normal life: she is pregnant [...] But with many traumas. We spoke recently, and she said: “If I had to give advice to someone, I would say: stay with the aggressor.” Strange, isn’t it? (Social movement activist).

The term *meninos do movimento* was used during the interviews. When we asked health professionals about the nickname *meninos* used to refer to traffickers, they explained that these leaders are increasingly younger, making the drug trade more violent due to traits such as impulsiveness and a sense of urgency associated with youth. According to the reports, the conciliatory and patient stance of former trafficking leaders has been replaced by a more aggressive, impulsive, and ambitious dynamic, centered on financial gains and positions of power and decision-making within the criminal organization. This may also be one of the reasons underlying the strategy of the spectacularization of violence, through the enactment of a bellicose masculinity in public spaces.

Conflicts are mediated internally through locally established practices within the community’s prevailing social structure, in which drug trafficking leaders hold the authority necessary to intervene in situations of violence that may generate disorder. In one of the research sites, there was a report of a pregnant woman who was being assaulted by her partner and sought help from *meninos do movimento*. The *meninos* spoke with her partner and, following this intervention, the man changed his behavior and even began “cooking for the family.”

One of the study sites was particularly important for understanding the dynamics between armed groups and violence against women. Most residents live in conditions of extreme poverty, and drug trafficking permeates territorial dynamics and the lives of the population in multiple ways, including high levels of violence not only against women but also against children and other groups. The health teams at the local BHU are affected by the violence in the area: professionals

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are exhausted, heavily medicated, and disillusioned about the possibility of finding solutions for the cases of violence they deal with, in particular, and for engaging with the territory as a basis for implementing the PHC model.

In this region, a woman who had survived violence used the term *kit nóia* to refer to the objects used by crack users. The kit, in this case, consists of the “rock” (crack cocaine), a pipe, steel wool (used to heat the drug), and a woman. According to this informant, women engage in sexual relationships with male users to avoid suffering violence. In other words, although objectified, they find a form of protection when engaged sexually with male users. Other reports from the same territory describe women being beaten, with injuries occurring predominantly on the face, as well as having their hair forcibly shaved by traffickers. Thus, violence is not limited to the physical act itself but communicates punishment directed at women, targeting body parts with strong social meanings associated with femininity, such as the face, mouth, and hair, becoming sites upon which violent masculinity is imposed to destroy the feminine.

Women Experiencing Violence in Violent Territories: Naturalization and Secrecy

In the study settings, violence is pervasive, forming the backdrop of everyday life. It constitutes a language through which everyday relationships operate and is therefore naturalized and readily assimilated. Violence against women thus appears as one among many other forms of violence occurring within the community. An interviewed professional, who was born and raised in one of the studied territories, stated:

I was raised indoors because, when I was a child, I would go outside and every day I saw a brain on the ground, literally. This is not an exaggeration. It was either from [expression used by the health professional to refer to young women from the community], or from people leading

the drug trade, or from a stray bullet hitting someone. I grew up with this trauma (Health professional).

Violence against women is highly prevalent in these territories, but it is often not reported, partly due to shame or naturalization, but also due to fear of retaliation and escalation of violence. Fear of the aggressor, given his ties to the territory, is a common feeling among residents, health professionals, and women victims. One of the consequences of this process of intimidation is a pronounced sense of isolation among women experiencing domestic violence.

He became deeply involved in drug trafficking, I was afraid and ashamed for my family to know what was happening to me at home, for my neighbors to know that he was assaulting me [...] I did everything so that no one would find out. Then I became pregnant, and at seven months he beat me for the first time, while I was pregnant [...] I was pregnant with twins, and he beat me so severely that I lost one of the babies [...] he beat me with a belt and I did not tell anyone (Woman experiencing violence).

A health professional who lives in the territory referred to the widely known saying “*em briga de marido e mulher não se mete a colher*” (“one should not interfere in disputes between husband and wife”) to reflect “I have seen people interfere and die. Because I lived this, I saw it in childhood. So, you should not interfere, because I have seen people die for interfering, you understand?”

Therefore, due to the social organization of these territories and fear of retaliation, violence occurring within the domestic sphere is often kept as a “secret,” both by the community and by health teams.

The interviewed women perceive the health unit as a space subject to the same rules that govern the territory and the conduct of those who live there. Many reported feeling unsafe disclosing experiences of violence to health teams. They also pointed to the lack of

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training on violence against women for health professionals, which has not been adequately addressed by municipal authorities:

I think it really depends on whether the staff member has empathy; most of them don't. And when they don't have empathy, they're not specialists, right? They treat us in a rude way, like we're crazy, you know? What we need is proper care and support. And they just say: "There's nothing we can do here, you have to go to the women's police station" (Woman experiencing violence).

Regarding women with abusive partners, one interviewed health professional stated that men involved in drug trafficking "are the most violent, because they see themselves as owners of girls and women. And they don't have just one woman, they have one, two, three women." According to the professional, these men constantly threaten their partners, subjecting them to psychological terror by threatening to kill loved ones if the women leave them.

Many women blame themselves for the violence they experience, justifying, to themselves and to others, that they deserved the abuse for having violated the "rules of the drug trade" or for having "disrespected" their partners in some way. For some professionals interviewed, women involved with traffickers may gain certain advantages from maintaining these relationships, such as social status and financial stability. This perception contributes to the acceptance and naturalization of violence, reinforcing the belief that women may benefit from remaining in abusive relationships, advantages they would not be able to achieve on their own.

Silencing in the face of violence against women characterizes the work of professionals operating in these territories. Intervening in cases of violence, in addition to the risk of exposing women and potentially exacerbating the violence, may also pose risks to workers themselves, who feel intimidated and fear retaliation from groups linked to drug trafficking. This situation significantly affects the es-

establishment of relationships of care between health teams and women who use these services.

Territorial violence requires health professionals to weigh the decision between discussing cases of violence within their teams, thereby enabling the development of care strategies, and remaining silent in order to protect both themselves and the women affected. This reasoning also takes into account the need to build trust between health teams and the population served. For these professionals, addressing or questioning experiences of violence may expose connections between such experiences and the partner's network of sociability within the drug trade. In some cases, if the partner has already had contact with the police, another consequence may follow: the worsening of the aggressor's legal situation if additional crimes are reported. Furthermore, when drug trafficking operates as a systemic structure within the territory, reporting one's partner may also place their associates within criminal groups at risk of arrest.

In the case of the woman assaulted in front of the BHU, mentioned in the previous section, health workers witnessed the episode. One worker, who showed an intention to intervene, was discouraged by another, who warned her of the personal risks involved in intervening in a situation involving that aggressor/trafficker. Regarding this case, a professional reported:

The guy beat the woman right here at the entrance of the BHU. But since he was a trafficker, what could we do? He knew that we had witnessed it, and she came into the unit after being assaulted. And if we reported it, he would immediately know it was us (Health professional).

Within PHC, the situation is even more complex for Brazilian Community Health Agents (CHAs), as many of these professionals reside in the same territory where they work. As such, they are a professional group familiar with community dynamics and local events, and often have family members entangled in situations of violence, or are themselves experiencing violence. One CHA stated:

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Regarding violence against women, we cannot get these women to open up, and we are also afraid. For example, if he (the aggressor) suspects that we reported something, offered guidance, or referred them to services, they won't allow us to work in the territory anymore, they threaten us. We would have to be transferred to another BHU. We also have to protect our own lives, not only those of the users. That's why we don't get too involved (Community health agent).

Cases of violence against women are known, concealed, and handled with extreme caution. They are often communicated among professionals through a strategy referred to as *rádio peão* (term used by workers to describe informal communication about violence against women within the health unit). Although widely known, these cases are rarely discussed officially and are not addressed as a health issue. When they do surface, they highlight a distressing gap in professional training and institutional resources for intervention.

Conversely, there is reluctance among professionals regarding the limits of the health sector's role in cases of violence, particularly in contexts marked by higher levels of criminality. Professionals tend to rely on improvised interventions, and demands arise as emergencies. In this sense, we observed that such cases are not understood as strategic actions to be incorporated into health teams' work processes, nor are they addressed considering the support of specialized service networks and intersectoral collaboration.

As a consequence, several PHC responsibilities in responding to cases of violence are neglected, beginning with detection and case management. Many women experiencing violence seek BHUs for routine consultations and other procedures, thereby creating opportunities for early screening of potentially abusive relationships. Missed opportunities for detection, in turn, impact case reporting within the health information system (Notifiable Diseases Information System [Sistema de Informação de Agravos de Notificação], Sinan), an important tool for planning actions, as it supports the definition of priorities and the evaluation of interventions (Ministério da Saúde 2023: 44).

For most professionals, care —and more specifically reporting to Sinan— is understood as equivalent to reporting a crime, rather than as part of a health care process that includes referral pathways and intersectoral work. In this sense, reporting is framed within a policing-oriented logic, perceived as intimidating, coercive, and potentially retaliatory for all those involved, including health workers.

Conversely, when violence is identified by health teams, it is often approached from an individualizing perspective, understood as an experience confined to the private sphere, with decision-making responsibility placed almost exclusively on the woman. As observed in the study settings, within the institutional dynamics of BHUs, psychology and social work services are more frequently mobilized to address cases of violence against women. When handled by these professionals, cases tend to be treated either from a clinical perspective (psychology) or as a social issue (social work), often lacking integration with one another and with the broader scope of health care. Depending on the case, some social workers refer women to the Women's Care Reference Center (CRAM) or to the Specialized Social Assistance Reference Center (CREAS).⁷ This constitutes an effective and institutionally supported strategy in light of the inability to manage such cases within BHUs, due to fear, lack of technical training, and limited awareness of possibilities for network-based action.

⁷ The Brazilian National Social Assistance Policy (PNAS) organizes service delivery according to levels of complexity, prioritizing territorial action as a fundamental principle. It is divided into basic protection, for cases of vulnerability, and special protection, for cases involving rights violations. For the former, the reference facility is the Social Assistance Reference Center (CRAS), and for the latter, the CREAS (Ministério do Desenvolvimento Social e Combate à Fome 2014).

DISCUSSION

An intersectional analysis that takes into account different social markers of difference is a key analytical tool for exploring alternative perspectives on social phenomena, grounded in a decolonial stance and a systemic approach to our objects of inquiry. In this sense, the concept of intersectionality serves as an analytical lens for recognizing the structural consequences and dynamics arising from the interaction of different axes of subordination, mechanisms that reinforce discriminatory systems and create or intensify inequalities and oppressive structures affecting different groups (Crenshaw 2002).

Intersectional analysis, therefore, requires more than the recognition of these markers; it demands an analytical approach that fosters complex thinking, attentive to singularities while simultaneously bringing forward new, critical elements that challenge dominant norms. In this study, we applied the concept of intersectionality not only as a theoretical framework but also as a methodological lens, enabling us to access and interpret the data in an integrated manner, thereby avoiding fragmented and decontextualized understandings.

To this end, territory, understood as a social marker of difference, was mobilized to analyze PHC responses to cases of violence against women, taking into account the contexts of violence present in these territories and shaped by the actors operating within them. In the Brazilian public health context, the notion of *territory* guides the organizational logic of the SUS. That is, the territorialized model of care enables the decentralization of health actions and ensures a political framework for care organized into integrated networks coordinated by PHC (Faria 2020). Within PHC, the FHS constitutes the main model for organizing actions and services, gradually replacing a model centered on curative and fragmented care (Ministério da Saúde 2011).

Territorialization, a structuring principle of the FHS, involves delimiting, recognizing, and analyzing the territory under a health team's responsibility. In this context, territory extends beyond geographic boundaries to a socially produced space shaped by social relations and

living conditions, influencing the health-disease process. Through territorialization, teams register households, map resources, identify vulnerabilities and risks, and assess health needs, guiding integrated actions in health promotion, prevention, surveillance, care, and rehabilitation (Ministério da Saúde 2011). Additionally, proximity to the territory and families fosters relationships, continuity of care, and context-specific interventions, helping reduce health inequities (D'Oliveira, Schraiber, Hanada and Durand 2009).

At first glance, viewing territory as a means of ensuring proximity and access to PHC services for women experiencing violence may facilitate case detection, care, and referral, reducing missed opportunities and enabling entry into the health system. However, findings show that, alongside other social markers, territory can also generate challenges that hinder women's protection, particularly through health policies.

In these territories, violence against women is not isolated but embedded in broader dynamics where violence organizes social relations. Common across Latin America, territories dominated by drug trafficking rely on collective life shaped by rigid codes, pacts and logics of brotherhood (Feltran 2018, Segato 2005). In this context, violent sociability (Silva 2004) explains force as a language of power, replacing political mediation in the public sphere. This is intensified in marginalized areas, where weak social protection enables parallel powers to compete with the State through coercion.

Although Silva (2004) does not prioritize a gendered analysis, violent sociability operates through a pedagogy of cruelty (Segato 2005). Within this framework, control over women's bodies and bellicose masculinity underpin brotherhood pacts and territorial governance. Shaped by dominant models of masculinity, men assert authority over women as a form of emancipation (Vigoya 2018). While they defy state order, creating their own territorial regulations, they simultaneously reinforce patterns that sustain gender inequality through violence. Thus, violent territories intensify violence against women, both by normalizing force and distancing from state norms.

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In Latin America, the construction of masculinities occurs within a context of historical, structural, and everyday violence and is grounded in a bellicose logic as a guiding principle through which men engage with social conflicts (Vigoya 2018). These elements strengthen patriarchal systems and sustain a sociopolitical order in which domination ensures control over the sexuality, freedom, and autonomy of women and girls through violent performance in both public and private spheres. As a result, we observe delays in the protection of women even in territories with significant institutional and community facilitators, such as the presence of PHC. In other words, violence against women in Brazil, despite having only recently gained legal frameworks and technical guidelines recognizing it as a human rights violation, is once again framed as an intimate experience (Angelim and Diniz 2009), in which strategies for ensuring protection and promoting health are reduced to the woman's individual capacity for decision-making, often under conditions of isolation.

Intimidated by the effects of systems of masculinity production, health professionals establish limited connections between women's illness and the presence of violence, thereby restricting their role as social actors embedded in the territory (Almeida *et al.* 2019, Signorelli *et al.* 2018). Reports of fear and threats experienced by workers—as well as the perception that certain interventions in cases of violence against women are interpreted as formal reporting of a crime, such as notification in Sinan, or the need to negotiate rules of coexistence within the territory in order to carry out team activities—are also findings reported in other studies (Almeida *et al.* 2019, Signorelli *et al.* 2018).

Different studies point to the influence of urban violence in shaping aspects of work and the establishment of relationships between FHS teams and the community. Notably, one of the most affected professional groups in this dynamic is that of community health workers (CHWs), whether due to their intrinsic relationship with the territory, as they are usually residents of the communities (Signorelli *et al.* 2018; Zanchetta, Pinto, Galhego-Garcia, da Cunha, Cordeiro, Fagundes-Filho,

Pinho, Voet, Talbot, Caldas, de Souza and Costa 2015), or due to the particular nature of their work, centered on home visits, which are often contingent upon the daily context of the territory (Bellas *et al.* 2019, Signorelli *et al.* 2018).

In the daily routine of health teams, urban violence imposes restrictions and “rules of coexistence” that, according to Almeida *et al.* (2019), make negotiation channels more limited and home visits dependent on informal authorization from criminal groups controlling the territory. Thus, CHWs, who should function as a trusted link, have their practice constrained by fear, thereby silencing complex demands.

Another aspect affected by this dynamic is that certain topics are either not addressed or are approached with restrictions, for example alcohol consumption and other drug use, imposing implicit or even explicit constraints on team practices (Almeida *et al.* 2019). Similarly, the approach to violence follows these restrictions, as it is considered a matter confined to the domestic sphere, a “secret” which serves to safeguard workers, most of whom are women, as well as the women receiving care, given that potential professional interventions may further exacerbate the violence experienced (Almeida *et al.* 2019).

As a result, professionals organize their work in a manner detached from a broader social practice, resulting in health care primarily grounded in a biomedical and medicalizing perspective. Consequently, violence against women becomes doubly rendered invisible, first through the silence and secrecy surrounding it, and second through its medicalization, often based on superficial diagnoses such as depression. Within this dynamic, violence is neither recognized nor interpreted, even when it manifests physically through psychosomatic illness.

Another important aspect concerns the lack of emotional and institutional support experienced by health workers, which compromises their capacity to respond effectively to cases of violence and, more broadly, weakens the very essence of the PHC model. Engagement with the territory, which is expected to be grounded in sustained relationships and territorial presence, comes to be perceived as a source of risk, undermining care strategies and limiting

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possibilities for community-based intervention. This scenario illustrates what Signorelli *et al.* (2018) describe as a “profound gap” between public policies aimed at addressing violence and the practical reality of Basic Health Units, where theoretical frameworks are not supported by the realities of everyday practice.

From the perspective of gender relations and efforts to address violence against women in peripheral territories, the performance of masculinity constructed from hegemonic ideals of virility and strength, combined with the use of violence to control subordinated bodies, including those of women, constitutes a significant obstacle to the implementation of public policies addressing violence against women (VAW) in vulnerable communities.

The reports presented demonstrate the articulation between gender-based violence, violent territorial control, and the production of violent masculinities, highlighting how violence perpetrated by partners involved in drug trafficking extends beyond the sphere of intimate relationships and is embedded within a territorial logic of domination. The assertion that these men perceive themselves as “owners” of girls and women makes explicit the naturalization of possession and female subordination as constitutive elements of a masculinized regime of power, in which territorial authority is projected onto women’s bodies and lives.

Threats directed not only at intimate partners but also at their family members constitute a mechanism of control that operates through fear and psychological terror (Almeida *et al.* 2019), limiting women’s ability to leave violent relationships and seek institutional protection. This finding reinforces the understanding of territory as a social marker of difference, as women living in territories controlled by armed groups experience specific and intensified forms of violence, characterized by the overlap between domestic violence, criminal violence, and territorial coercion.

In this sense, the findings of this study indicate that violence against women and girls cannot be analyzed exclusively through individual or family dynamics but must be understood as a territorialized

phenomenon, shaped by local power relations and by models of masculinity that legitimize violence as a strategy of social control.

For PHC teams, recognizing these dynamics is essential for ethical and contextually grounded practice. If PHC functions as a key entry point for cases of violence, particularly through the rhizomatic and continuous work of health teams, it is necessary to acknowledge and engage with the specific social and relational conditions of territories, as well as the power and economic relations established within them, thereby enabling the development of effective network-based protection strategies.

FINAL CONSIDERATIONS

The study highlights the importance of an intersectional perspective for understanding violence against women, taking into account the different social markers involved in the production of this phenomenon. In particular, we examined territory as a social marker and an effective analytical lens for understanding the protection of women in vulnerable settings, especially those dominated by violent groups and characterized by multiple forms of inequality.

In the absence of state regulation, or even regulation promoted by civil society, that ensures norms and rules of conduct based on respect, gender equality, and justice, there is a risk that violence against women will be normalized as part of a system of social organization grounded in violent sociability, which is highly detrimental to women. In such contexts, women may be easily objectified in territories where the gender system is sustained by the violent socialization of men, which, in turn, sustains illegal economies and reinforces social positions of power and control.

This territorialized dynamic creates severe barriers to the institutionalization of PHC, which, although it may function as a strategic entry point for women experiencing violence, ultimately fails to identify them, resulting in numerous missed opportunities for detection,

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care, and intra- and intersectoral referral. Thus, understanding territory not merely as a geographic base, but as a field of forces that shapes and contests subjectivities, is essential to ensuring the right to health and to life for women in contexts of extreme vulnerability.

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