Violence and Primary Health Care in Brazil: an integrative literature review

Abstract  Violence is a challenge for health services in Brazil, especially within primary care. This study analyses national publications on violence and Primary Health Care. An integrative literature review was conducted resulting in a final sample of 18 articles. The most predominant theme was violence against women (nine articles), followed by violence against children and adolescents (four articles), and violence against the elderly (three articles). The population group that accounted for the least number of publications was men, with two articles. The studies show the invisibility of violence in primary healthcare services in Brazil and the need to reorganize the work process beyond a complaint-based approach towards a sociocultural approach based on intersectorality. Comprehensiveness and intersectorality are essential elements of an effective violence care network.

Key words  Violence, Primary Health Care, Health services
Introduction

Violence is a major social problem in Brazil and is recognized as a demand for health care services and comprehensive care. This complex and multidimensional phenomenon in historical, social and cultural terms, has a direct impact on health, quality of life, and public spending. The impacts of violence are felt in different spheres of life and human and social relations, including the health-disease process. Examples of impacts of violence include potential years of life lost, temporary or permanent incapacity resulting from trauma, increased public spending on rehabilitation, as well as fear and suffering, which besides leaving an immeasurable mark on lives, are a significant force in the social process of production and reproduction.

All population groups are vulnerable to violence to a greater or lesser degree, depending on gender, age, socioeconomic status, and the type of violence that each group is more or less exposed to.

With respect to interpersonal violence, exposure to gun violence is greatest among young men in urban areas, while women are more vulnerable to gender-based violence, which permeates social relations, and sexual and physical violence and emotional abuse perpetrated by intimate partners. Children on the other hand are more likely to be exposed to neglect and sexual and physical violence in the home, while older persons and people with disabilities are more exposed to physical and patrimonial violence and emotional and psychological abuse, mostly at the hands of carers.

The recognition of the impact of violence on the Brazilian population and the need for action to tackle this problem led to the introduction of the National Policy for the Reduction of Morbidity and Mortality due to Accidents and Violence (PNRMAMV, acronym in Portuguese) in 2001, followed by the creation of the National Network for Violence Prevention and Health Promotion in 2004 and Violence Prevention Centers in states and municipalities.

As a result of advances made in discussions and as part of the mechanisms to tackle violence, a number of different policies and legislation directed at violence have been adopted, including: the National Policy for Addressing Violence against Women (Política de Enfrentamento da Violência contra a Mulher); the Maria da Penha Law; the National Policy for Addressing Sexual Violence against Women (Política Nacional de Enfrentamento à Violência Sexual contra as Mulheres); and the National Plan for Addressing Sexual Violence against Children and Adolescents (Plano Nacional de Enfrentamento à Violência Sexual contra Crianças e Adolescentes).

These and other policies in Brazil are implemented in coordination with specific legislation and join forces in acknowledging that preventing and combating violence is a social demand, seeking to strengthen intra and intersectoral strategies aimed at promoting more comprehensive and resolutive care, and being directly or indirectly aimed at addressing the problem of violence. In other words, they join forces to enhance and integrate equipment, professionals, and ways of acting in a pursuit to provide singular and effective responses under a broader lens that respects, upholds, protects, and promotes human rights.

Within this context, primary health care (PHC) plays an important role as the point of entry to Brazil's Unified Health System (SUS, acronym in Portuguese) and in proposing comprehensive care delivered through healthcare networks. Its underlying principles, such as the humanization of healthcare, continuity of care, and territorialization make PHC a key component of a network geared towards the prevention, identification, notification, and coordination of the treatment and care of victims of violence.

PHC plays a central role in bringing together partnerships between various sectors, including health, education, social assistance, and justice. It is able to address the wide range of structural factors for violence (socioeconomic, cultural, family, community, individual, and gender) by promoting a comprehensive approach to preventing and tackling this problem.

Although working in networks is still incipient and the capacity of primary care services to promote violence prevention and reporting and deliver appropriate care to victims of violence generally remains limited, it is important to recognize successful, albeit isolated, experiences within PHC.

In light of the above, is it appropriate to explore how the scientific literature produced in Brazil addresses the interface between violence and PHC in order to contribute to the implementation of new initiatives and enhance strategies to tackle violence? In other words, how does the national scientific literature address the inclusion of this issue as a healthcare demand and the role of PHC in preventing and tackling violence? This article presents the results of an investigation...
integrative literature review that sought to answer these questions.

Methods
An integrative literature review was conducted, which focused on selecting and systematizing studies with different methodological approaches, thus gathering and combining theoretical and empirical data to provide a deeper understanding of the object of study.25-27

The review was conducted in five stages according to the recommendations in the literature: 1. Problem definition (definition of the theme of the review in the form of a question or primary hypothesis); 2. Sample selection, based on inclusion and exclusion criteria; 3. Characterization of the studies (definition of the characteristics or information to be collected from the studies using clearly defined criteria); 4. Results analysis (identification of similarities and contrasts); 5. Presentation and discussion of the findings.25-27

Given that the study opted to analyze Brazilian research, searches were performed of the following databases: Scientific Electronic Library Online (SciELO) and Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS - Literature on Health Sciences in Latin America and the Caribbean). The searches were conducted using the following controlled descriptors and boolean operators: (violência OR violence OR violencia) AND (atenção primária OR primary health care OR atención primaria OR atenção básica).

The inclusion criteria were articles based on studies conducted in Brazil and full-text version of periodicals available in either Portuguese, English, or Spanish. The exclusion criteria were: Master’s dissertations, doctoral theses, repeated studies, and studies that did not encompass the object of study. The searches were performed between January and March 2016 without stipulating a time frame, resulting in 35 publications, of which 18 were selected based on the abovementioned criteria, as shown in Figure 1.

Violence and PHC: characterization of the selected studies

Violence against women was addressed by nine of the 18 publications, followed by violence against children and adolescents (four articles) and a set of three articles that deal with violence against the elderly. The population group that accounted for the least number of publications was men, with two articles. There was also one article that did not address any population group in particular, focusing on the approach to violence from the perspective of PHC professionals.

It is important to stress that the search failed to find studies involving people with disabilities and homosexuals, bisexuals, transsexuals, transgender or intersex.

The articles analyzed by this study are shown in Chart 1. To facilitate visualization and analysis, the articles were classified by population group and presented according to the periodical, year of publication, author, title, objectives, and main results.

With regard to forms of violence, the majority of articles addressed family and domestic violence, regardless of population group. This finding highlights the importance of developing actions within PHC services that enable the recognition of vulnerability to violence in the context of family relations and the need to consider the sociocultural and historical context of the family, as well as the importance of exploring alternatives for activating social support networks.

With respect to methodology, there was a predominance of qualitative methods with greater explanatory power, the majority of which aimed to give voice to the study participants (people exposed to violence and PHC professionals). Eleven
Chart 1. Publications analyzed by the study by population group in reverse chronological order of publication.

<table>
<thead>
<tr>
<th>Periodic</th>
<th>Year/Country (Code)</th>
<th>Title</th>
<th>Main Author</th>
<th>Main results</th>
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<tbody>
<tr>
<td><strong>General Violence - VG</strong></td>
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<tr>
<td>Physis</td>
<td>2014/ Brazil (VG1)</td>
<td>Domestic and sexual violence within the sphere of the Family Health</td>
<td>Porto48</td>
<td>Difficulty in identifying cases and symptom-centered approach.</td>
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<td>Strategy: professional practice and barriers to tackling violence</td>
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<td><strong>Violence against women - VCM</strong></td>
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<tr>
<td>Ciência e Saúde Coletiva</td>
<td>2015/ Brazil (VCM1)</td>
<td>Public health agendas for tackling violence against women in Rio Grande do Sul, Brazil</td>
<td>Costa49</td>
<td>Lack of local agendas directed at violence against women in rural areas. Managers face challenges in defining health management lines of action guided by the guidelines and principles of the SUS.</td>
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<tr>
<td></td>
<td></td>
<td>Underreporting and (in) visibility of violence against women in Primary Health Care</td>
<td>Kind46</td>
<td>Underreporting of violence against women. Low number of records of notification in health center.</td>
</tr>
<tr>
<td>Cadernos de Saúde Pública</td>
<td>2013/ Brazil (VCM2)</td>
<td>Domestic violence against women and professional practice in Primary Health Care</td>
<td>Signorelli41</td>
<td>Care centered on “biologizing” principles, focusing on physical injuries and drug therapy.</td>
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<tr>
<td>Revista Brasileira de Ginecologia e Obstetricia</td>
<td>2013/ Brazil (VCM3)</td>
<td>Prevalence of violence perpetrated by male partners among women using the PHC network in the State of São Paulo</td>
<td>Mathias42</td>
<td>Prevalence of violence perpetrated by intimate partners (VPI) was 55.7% (53.8% psychological, 32.2% physical, and 12.4%, sexual).</td>
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<td>Revista Gaúcha de Enfermagem</td>
<td>2012/ Brazil (VCM5)</td>
<td>Impacts of the Maria da Penha Law on tackling domestic violence in Porto Alegre</td>
<td>Alves44</td>
<td>The law promoted changes in violence prevention, the provision of assistance to women, and punishment of perpetrators, leading to greater visibility of the phenomenon.</td>
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<tr>
<td>Revista de Saúde Pública</td>
<td>2012/ Brazil (VCM6)</td>
<td>Violence between health center users: prevalence, perspective, and conduct of managers and professionals</td>
<td>Osix44</td>
<td>Violence against women is not routinely investigated. Only 5% of women reported having sought services.</td>
</tr>
<tr>
<td>Interface (Botucatu)</td>
<td>2009/ Brazil (VCM7)</td>
<td>Actions directed at tackling violence against women in two PCH centers in Rio de Janeiro</td>
<td>Borsoi43</td>
<td>Professionals showed themselves to be more prepared for identifying the problem when it was not explicit.</td>
</tr>
<tr>
<td>Ciência e Saúde Coletiva</td>
<td>2009/ Brazil (VCM8)</td>
<td>Comprehensive care for female victims of gender violence – a primary healthcare alternative</td>
<td>D’Oliveira46</td>
<td>Discussed aspects relating to the connection between the health sector and intersectoral assistance network and its main difficulties.</td>
</tr>
<tr>
<td>Interface (Botucatu)</td>
<td>2009/ Inglaterra (VCM9)</td>
<td>Violence against women: perceptions of doctors working in health centers in Ribeirão Preto, São Paulo</td>
<td>Ferrante47</td>
<td>Doctors are capable of identifying and making women exposed to violence feel comfortable and welcome. Highlighted the need for integrated network-based actions and investment in professional training.</td>
</tr>
</tbody>
</table>
### Chart 1. Publications analyzed by the study by population group in reverse chronological order of publication.

<table>
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<tr>
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<tbody>
<tr>
<td><strong>Violence against children and adolescents - VCCA</strong></td>
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<tr>
<td>Ciência e Saúde Coletiva</td>
<td>2014/ Brazil (VCCA1)</td>
<td>Factors associated with reporting maltreatment of children and adolescents in primary care services</td>
<td>Moreira48</td>
<td>Professionals feel unprepared and unprotected when it comes to caring for and meeting the demands of children suffering from domestic violence. Gaps reported in relation to intersectorality, comprehensiveness, and resolvability.</td>
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<tr>
<td>Saúde e Sociedade</td>
<td>2011/ Brazil (VCCA2)</td>
<td>Studies of domestic violence against children in health centers in São Paulo, Brazil</td>
<td>Ramos49</td>
<td>Reports were made by 56.9%, 17.8% by professionals; 45.2% by child protective services; 33.6% were made in police stations. Community health agents and ESF professionals played an important role in identifying cases of violence.</td>
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<tr>
<td>Revista Baiana de Saúde Pública</td>
<td>2011/ Brazil (VCCA3)</td>
<td>Working practices in primary healthcare in relation to the identification and notification of violence against children and adolescents</td>
<td>Lima50</td>
<td>Community health agents nursing technicians identified cases of violence during home visits. Identification was positively associated being female and having previous training.</td>
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<tr>
<td><strong>Violence against the elderly - VCI</strong></td>
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<tr>
<td>Caderno de Saúde Pública</td>
<td>2013/ Brazil (VCI1)</td>
<td>Professional approach to family violence against elderly people in a health center</td>
<td>Wanderbrooke51</td>
<td>Professionals experienced difficulties in identifying violence and believe it is impossible to tackle the problem. Institutional factors hinder detection and assistance.</td>
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<tr>
<td>Ciência e Saúde Coletiva</td>
<td>2012/ Brazil (VCI2)</td>
<td>Meanings of family violence against elderly people from the perspective of primary health care professionals</td>
<td>Wanderbrooke52</td>
<td>Family violence goes against the principle of the family as support and protection. Meanings of family violence against elderly people were based in the “frail and dependent” notion of elderly, limiting the visibility of cases that do not fall into this definition.</td>
</tr>
<tr>
<td>Caderno de Saúde Pública</td>
<td>2008/ Brazil (VCI3)</td>
<td>Breaking the silence and its barriers: household survey of domestic violence against the elderly in the area covered by the Family Doctor Program in Niterói, Rio de Janeiro, Brazil</td>
<td>Moraes53</td>
<td>Prevalence was greater among younger elderly people, those who lived with a greater number of individuals, those with a joint disease, and those who has a history of diabetes. Frequency of serious violence was greater among individuals with a higher level of schooling and those who had memory problems.</td>
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<td><strong>Violence against men - VCH</strong></td>
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<tr>
<td>Revista Saúde Pública</td>
<td>2013/ Brazil (VH1)</td>
<td>Violence and mental suffering among men in primary health care</td>
<td>Albuquerque54</td>
<td>Mental suffering was associated with suffering recurring physical and/or sexual violence throughout life.</td>
</tr>
<tr>
<td>Revista Brasileira de Epidemiologia</td>
<td>2012/ Brazil (VH2)</td>
<td>Men, masculinity and violence: a study in primary health care services</td>
<td>Schraiber55</td>
<td>The prevalence of violence (any type of violence and perpetrator) was 79%. In 14.2% of cases there was an overlap between suffering violence at the hands of an intimate partner and perpetrating violence.</td>
</tr>
</tbody>
</table>

Source: Authors' elaboration.
studies used a qualitative approach (VG1, VCM1, VCM2, VCM4, VCM5, VCM6, VCM8, VCM9, VCCA1, VCCA2, VCI1, VCI2), four used a quantitative and qualitative approach (VCM3, VCM7, VCCA1, VH2), and three used a predominantly quantitative approach (VCCA3, VCI3, VH1).

The predominance of qualitative methods shows that authors sought to understand the theme from the sociocultural perspective of the interviewees. In this respect, since violence is a social and historical phenomenon, it differs across different contexts and is therefore better understood when researchers interact with the life stories and worldview of study participants.

Studies that used a more quantitative approach tended to focus on the prevalence of violence, the most common forms of violence, the most vulnerable groups, and outcomes associated with exposure to violence in relation to PHC (VCM2, VCM9, VCCA1, VCCA3, VCI3, VH2).

**Violence and PHC: advances, potentialities, and challenges**

One of the most significant aspects in the literature analyzed by this study is the importance of PHC and the reorganization of the health work process to tackle violence.

There is a consensus that the different forms of violence and their impact on the health-disease process demand new approaches to addressing this problem, entailing the redesign of the work process and organization in networks to effectively implement the measures envisaged in national policy.

The primary health care approach should therefore ensure intersectorality and comprehensive care. The phenomenon is not just a health problem and, as such, actions designed to address violence are not exclusive to the health sector and should therefore not end at PHC (VG, VCM, VCCA, VCI, VH).

Although tackling violence requires an intersectoral approach, according to the authors, PHC is uniquely positioned to address this problem, given that services are located in territories, favoring a more horizontal and dynamic dialogue with users, lasting relationships and a concern with bonds, as well as partnerships based on active listening, the recognition of the value of autonomy, and co-responsibility in healthcare (VG1, VCM1, VCM2, VCM3, VCM7, VCM8, VCM9, VCCA1, VCCA2, VCCA3, VCI1).

PHC professionals are key players in violence identification, prevention and early intervention and it is vital that they receive continuing training (VG1, VCM3, VCM7, VCM8, VCM9, VCCA2, VCCA3, VCI2).

Another strength of PHC highlighted by the studies is the important role it plays in coordinating network-based care through the Family Health Strategy (ESF, acronym in Portuguese), creating the capacity to tailor local interventions to address violence to the specific health needs of the local population. In this respect, the literature highlights that ESF plays a key role in promoting reflective spaces and strategic coordination with the victim assistance network (VG1, VCM3, VCM7, VCM8, VCM9, VCCA2, VCCA3).

The same studies that emphasize the key role of PHC and the ESF in tackling violence also highlight that there is a significant gap between health and victim assistance policies and practice (VG, VCM, VCCA, VCI, VH).

The studies reaffirm that if health professionals in general are unable to grasp that violence is a public health problem and the role primary care can play in tackling this problem, then service users are even less likely to understand this, resulting in the constant invisibility of violence at this level of care (VG1, VCM3, VCM7, VCM8, VCM9, VCCA2, VCCA3, VCI2). The barriers tend to outweigh the potentialities of PHC and health professionals end up delivering complaint-based, piecemeal care where it is expected that "violence will come knocking on the health center’s door", thus failing to turn PHC into a legitimate space that provides a welcoming and comfortable environment (VG1, VCM, VCCA, VCI, VH).

The articles analyzed by this study corroborate the claims of other studies that PHC is a setting where forms of creation and appropriation of the production and reproduction of life are expressed, assuming a role as a space of practices that induce change in everyday life, and gaining political and social materiality as a component of the victim assistance network. That being the case, the main challenge highlighted by the studies is raising awareness among ESF and PHC professionals, education and training, and capacity building.

In this respect, health professionals’ will only open their eyes to violence if there is a change in the work process, that is, being close to the individual and community, in itself, does not guarantee that their peculiarities will be recognized. It is necessary to establish care models that apprehend subjects and their customs and needs in an interactive and dynamic manner, understanding the health work process as a setting
that is alive and person-centered, considering the mobility of the multiple subject accompanied by the instabilities of the social loci\textsuperscript{30}.

Viewed from this perspective, the work process requires a broader conception of violence and the deconstruction of certain paradigms that remain ingrained in the field of health, beginning by unveiling, denaturalizing, “debiologizing”, and “desmedicalizing” violence and its impacts, resignifying it as a sociocultural issue that impacts not only mental health and public security, but also public health. As some authors have highlighted, healthcare should not be restricted to the effects of violence, but rather focus on the person and his/her worldview, customs, habits, and values acquired throughout life (VG1, VCM1, VCM3, VCM7).

Breaking paradigms implies more humanized practices, tailored to and immersed in local reality, given that the role of healthcare in addressing violence goes beyond symptom and medication-based interventions, encompassing prevention, comprehensive care, and working in networks\textsuperscript{32-34}.

From this perspective, healthcare practices, particularly PHC practices, should be guided by three dimensions of comprehensiveness applied to the work process: the interface between the individual and the group, which is the central element of a broader conception of health which enables understanding of subjects and violence-associated demands within ways of being, producing, and reproducing life in its uniqueness and multiplicity\textsuperscript{35}, continuity of care, where PHC is responsible for the provision of ongoing care for patients and families in a given territory; and intersectorality, which recognizes the need to coordinate health policy with education, public security, social assistance and other policies to maximize the effectiveness of health actions\textsuperscript{35}.

Comprehensive care implies recognizing the other as a subject and protagonist of his/her own care and the delivery of continuous, network-based care encompassing all dimensions of the subject’s life. This dimension requires the development of unique treatment plans with tailored goals to resolve the problem. For this, the care relationship should be developed within a broad perspective of health and interaction between living, active and co-responsible social subjects (professionals and users), which in turn requires an interdisciplinary approach. (VG1, VCM1, VCM3, VCM7).

Comprehensiveness engenders health promotion, prevention, protection and recovery, ensuring that victims of violence receive wide-ranging care at all levels. Continuity of care brings focus to the central role of PHC in caring for individuals, the family, and community. In other words, victims of violence should be treated at the different levels of care according to the complexity of their case, while maintaining the PHC professionals they are allocated to as a point of reference\textsuperscript{30,21,30}.

The following violence prevention strategies are highlighted by the studies: actions expanded across the territory; promotion of dialogue and establishing bonds between health professionals and patients; adoption of democratic and non-repressive practices in health services; combating institutional violence and debureaucratizing care; violence awareness raising actions; promoting rights and strengthening and emancipating users and workers (VG, VCM, VCCA, VCI, VH).

The group approach and home visits were suggested as ways of enhancing the work process of PHC professionals in relation to tackling violence, particularly violence against women. While the group approach gives users a voice and enables identifying processes, often facilitating the disclosure of abuse, home visits afford direct contact with the patient’s reality and foster bonding and listening in a private, safe environment, aiding the early detection of violence (VG1, VCM3, VCM7, VCM8, VCM9, VCCA2, VCCA3, VCI2).

While the authors stress that continuing training enhances the work process with more humanized, broader-ranging, resolutive, and better quality health practices, they also suggest that the main difficulty faced by health professionals when dealing with violence lies precisely in the lack of education and training in holistic approaches to deal with the social factors that influence the health-disease process.

Although comprehensiveness, one of the guiding principles of primary care, adopts a broader concept of health to promote health and prevent disease, practices remain based on diagnosing physiological symptoms and drug therapy\textsuperscript{31}. Thus, without awareness raising and appropriate training to perceive the sociocultural factors associated with violence, its impacts, and the life experiences of those involved in violence, professionals will be unable to act in accordance with other violence prevention policies\textsuperscript{22,23}.

PHC professionals need to assimilate the role of PHC and incorporate it into their daily practice, adopting a reflexive and proactive stance, breaking reductionist barriers and focusing on
the multiple dimensions of life in a dialectic manner\textsuperscript{33,34}.

With respect to intersectorality, the studies recognize that because violence is a social phenomenon affecting the health-disease process, tackling this problem cuts across health settings and requires integration with social assistance, public security, and other policies with common target audiences (VG1, VCM3, VCM7, VCM8, VCM9, VCCA2, VCCA3, VCI2).

It is therefore necessary to engage in dialogue with different services and professionals who operate these policies so as to promote the integration of public services and avoid overlaps\textsuperscript{34,36,37}.

The creation of intersectoral care networks and lines of care directed at specific population groups (women, children and adolescents, the elderly, people with disabilities, LGBT, and men) are the best strategies for this problem, so much so that they are advocated by the policies directed at these groups\textsuperscript{6-8,10,37}.

However, the studies highlight challenges in establishing these networks due to difficulties in convincing service managers and health professionals to share knowledge and experience in pursuit of learning that lead to advances in the production of new meanings and ways of living that restore rights, foster comprehensive care, and make violence visible (VG1, VCM3, VCM7, VCM8, VCM9, VCCA2, VCCA3, VCI2).

Actions directed at specific groups should be founded on co-responsibility for care between health services, users and other services that deal with this demand, in order to ensure the provision of comprehensive, intersectoral care and assistance to these individuals.

**Final considerations**

This literature review allowed us to analyze recent publications on violence in the context of primary care in Brazil and the construction of associated concepts and theoretical bases.

Notwithstanding the uniqueness of the different forms of violence and specificities of care associated with each type of population group, the main challenges faced by PHC were shown to be the detection of violence and the delivery of continuous care that goes beyond the physiological perspective, given the fact that violence is sociocultural phenomenon.

From a health perspective, the object of study remains grounded and signifies within hegemonic, rationalizing, and “biologizing” concepts, which fail to address the origins of violence and neutralize more wide-ranging, humanized, and comprehensive practices that are often more effective.

There is a large gap between policy and work process, particularly with respect to building bonds, the different dimensions of comprehensive care, continuity of care, the recognition of violence as a health problem, and, consequently, health promotion and prevention.

Investing in changes in work process is a way of ensuring comprehensive care and intersectorality and enabling a violence care network. These changes will only be possible when violence is understood as a social process expressed in the health of different age groups and with the promotion of adequate training and capacity building for professionals aimed at fostering greater understanding of this phenomenon and the adoption of violence prevention and protection strategies that employ technologies that facilitate dialogic relationships between health professionals and users.
Collaborations

CS Mendonça participated in study conception and design, data analysis and interpretation, drafting and critical revision of the article, and approval of the version to be published. DF Machado participated in study conception and design, in the critical revision of the article, and approval of the version to be published. MAS Almeida participated in the critical revision of the article and approval of the version to be published. ERL Castanheira participated in the critical revision of the article and approval of the version to be published.
References


