DOI: 10.1590/1413-81232020256.19332018

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

Carolina Siqueira Mendonça (https://orcid.org/0000-0002-2697-4992) [1]
Dinair Ferreira Machado (https://orcid.org/0000-0003-3006-7110) [1]
Margareth Aparecida Santini de Almeida (https://orcid.org/0000-0002-4603-2513) [1]
Elen Rose Lodeiro Castanheira (https://orcid.org/0000-0002-4587-7573) [1]

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*

[1] Programa de Saúde Coletiva, Departamento de Saúde Pública, Faculdade de Medicina, Universidade Estadual Paulista Júlio de Mesquita Filho. Av. Prof. Mário Rubens Guimarães Montenegro s/n, Campus de Botucatu. 18618-687 Botucatu SP Brasil. siqueira.carol@uol.com.br

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[1-3].

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[1,2,4].

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[5].

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 (PNRMAV[6], 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[7].

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*[8]); the Maria da Penha Law[9]; the National Policy for Addressing Sexual Violence against Women (*Política Nacional de Enfrentamento à Violência Sexual contra as Mulheres*[8]); and the National Plan for Addressing Sexual Violence against Children and Adolescents (*Plano Nacional de Enfrentamento à Violência Sexual contra Crianças e Adolescentes*[10]).

These and other policies in Brazil[11-16] are implemented in coordination with specific legislation[6-10,17-19] 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[20-22].

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[22,23], it is important to recognize successful, albeit isolated, experiences within PHC[24].

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 in-

tegrative 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.

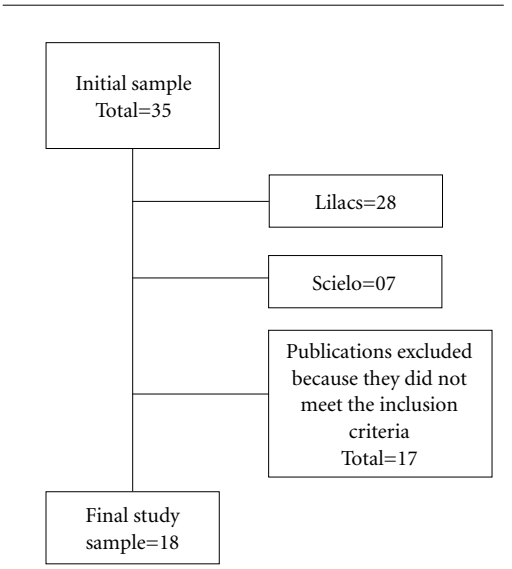

Figure 1. Flowchart showing sample composition.

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.

Periodic	Year/ Country (Code)	Title	Main Author	Main results
General Violence - VG				
Physis	2014/ Brazil (VG1)	Domestic and sexual violence within the sphere of the Family Health Strategy: professional practice and barriers to tackling violence	Porto[38]	Difficulty in identifying cases and symptom-centered approach.
Violence against women - VCM				
Ciência e Saúde Coletiva	2015/ Brazil (VCM1)	Public health agendas for tackling violence against women in Rio Grande do Sul, Brazil	Costa[39]	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.
Cadernos de Saúde Pública	2013/ Brazil (VCM2)	Underreporting and (in) visibility of violence against women in Primary Health Care	Kind[40]	Underreporting of violence against women. Low number of records of notification in health center.
Cadernos de Saúde Pública	2013/ Brazil (VCM3)	Domestic violence against women and professional practice in Primary Health Care: an ethnographic study in Matinhos, Paraná, Brazil	Signorelli[41]	Care centered on "biologizing" principles, focusing on physical injuries and drug therapy.
Revista Brasileira de Ginecologia e Obstetrícia	2013/ Brazil (VCM4)	Prevalence of violence perpetrated by male partners among women using the PHC network in the State of São Paulo	Mathias[42]	Prevalence of violence perpetrated by intimate partners (VPI) was 55.7% (53.8% psychological, 32.2% physical, and 12.4%, sexual).
Revista Gaúcha de Enfermagem	2012/ Brazil (VCM5)	Impacts of the Maria da Penha Law on tackling domestic violence in Porto Alegre	Alves[43]	The law promoted changes in violence prevention, the provision of assistance to women, and punishment of perpetrators, leading to greater visibility of the phenomenon.
Revista de Saúde Pública	2012/ Brazil (VCM6)	Violence between health center users: prevalence, perspective, and conduct of managers and professionals	Osis[44]	Violence against women is not routinely investigated. Only 5% of women reported having sought services.
Interface (Botucatu)	2009/ Brazil (VCM7)	Actions directed at tackling violence against women in two PHC centers in Rio de Janeiro	Borsoi[45]	Professionals showed themselves to be more prepared for identifying the problem when it was not explicit.
Ciência e Saúde Coletiva	2009/ Brazil (VCM8)	Comprehensive care for female victims of gender violence – a primary healthcare alternative	D'Oliveira[46]	Discussed aspects relating to the connection between the health sector and intersectoral assistance network and its main difficulties.
Interface (Botucatu)	2009/ Inglaterra (VCM9)	Violence against women: perceptions of doctors working in health centers in Ribeirão Preto, São Paulo	Ferrante[47]	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.

it continues

Chart 1. Publications analyzed by the study by population group in reverse chronological order of publication.

Periodic	Year/ Country (Code)	Title	Main Author	Main results
Violence against children and adolescents - VCCA				
Ciência e Saúde Coletiva	2014/ Brazil (VCCA1)	Factors associated with reporting maltreatment of children and adolescents in primary care services	Moreira48	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.
Saúde e Sociedade	2011/ Brazil (VCCA2)	Studies of domestic violence against children in health centers in São Paulo, Brazil	Ramos[49]	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.
Revista Baiana de Saúde Pública	2011/ Brazil (VCCA3)	Working practices in primary healthcare in relation to the identification and notification of violence against children and adolescents	Lima[50]	Community health agents nursing technicians identified cases of violence during home visits. Identification was positively associated being female and having previous training.
Violence against the elderly - VCI				
Caderno de Saúde Pública	2013/ Brazil (VCI1)	Professional approach to family violence against elderly people in a health center	Wanderbroocke[51]	Professionals experienced difficulties in identifying violence and believe it is impossible to tackle the problem. Institutional factors hinder detection and assistance.
Ciência e Saúde Coletiva	2012/ Brazil (VCI2)	Meanings of family violence against elderly people from the perspective of primary health care professionals	Wanderbroocke[52]	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.
Caderno de Saúde Pública	2008/ Brazil (VCI3)	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	Moraes[53]	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.
Violence against men - VCH				
Revista Saúde Pública	2013/ Brazil (VH1)	Violence and mental suffering among men in primary health care	Albuquerque[54]	Mental suffering was associated with suffering recurring physical and/or sexual violence throughout life.
Revista Brasileira de Epidemiologia	2012/ Brazil (VH2)	Men, masculinity and violence: a study in primary health care services	Schraiber[55]	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.

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[28].

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[29,30]. 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[31].

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[29,31], understanding the health work process as a setting

Ciência & Saúde Coletiva, 25(6): 2247-2257, 2020

that is alive and person-centered, considering the mobility of the multiple subject accompanied by the instabilities of the social *loci*[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[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[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[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[20,21,30].

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[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[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[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[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[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 signified 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.

Ciência & Saúde Coletiva, 25(6): 2247-2257, 2020

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

1. Brasil. Ministério da Saúde (MS). *Temático Prevenção de Violência e Cultura da Paz II*. Brasília: OPAS; 2008.
2. Minayo MCS, Souza ER. Violência e Saúde como Campo Interdisciplinar e de ação coletiva. *Hist Cien Saude* 1997; 4(3):513-531.
3. WHO Global Consultation on Violence and Health. *Violence: a public health priority*. Genebra: WHO; 1996.
4. Brasil. Ministério da Saúde (MS). *Diretrizes nacionais para a atenção integral à saúde de adolescentes e jovens na promoção, proteção e recuperação da saúde*. Brasília: MS; 2010.
5. Dahlberg LL, Krug EG. Violência: um problema global de saúde pública. *Cien Saude Colet* 2007; 11(Supl.):1163-1178.
6. Brasil. Ministério da Saúde (MS). *Política Nacional de Redução de Morbimortalidade por Acidentes e Violência*. Brasília: MS; 2001.
7. Brasil. Ministério da Saúde (MS). *Rede Nacional de Prevenção da Violência e Promoção da Saúde e a implantação e implementação de Núcleos de Prevenção à Violência em Estados e Municípios*. Brasília: MS; 2004.
8. Brasil. Secretaria de Políticas para Mulheres. *Política Nacional de Enfrentamento à Violência Contra as Mulheres*. Brasília: Secretaria de Políticas para Mulheres; 2011.
9. Brasil. Lei nº 11.340, de 7 de agosto de 2006. Lei Maria da Penha. *Diário Oficial da União* 2006; 9 ago.
10. Brasil. Secretaria Especial dos Direitos Humanos (SEDH). *Plano Nacional de Enfrentamento da Violência Sexual contra Crianças e Adolescentes (PNEVSCA)*. Brasília: SEDH; 2013.
11. Brasil. Ministério da Saúde (MS). *Política nacional de atenção integral à saúde da mulher: princípios e diretrizes*. Brasília: MS; 2004.
12. Brasil. Ministério da Saúde (MS). *Política Nacional de Atenção Integral à Saúde da Criança*. Brasília: MS; 2015.
13. Brasil. Ministério da Saúde (MS). *Política Nacional de Atenção Integral à Saúde da Pessoa Idosa*. Brasília: MS; 2006.
14. Brasil. Ministério da Saúde (MS). *Política Nacional de Saúde da Pessoa com Deficiência*. Brasília: MS; 2010.
15. Brasil. Presidência da República. Secretaria Especial dos Direitos Humanos (SEDH). *Plano Nacional de Promoção da Cidadania e Direitos Humanos de Lésbicas, Gays, Bissexuais, Travestis e Transexuais*. Brasília SEDH; 2009.
16. Brasil. Ministério da Saúde (MS). *Política Nacional de Atenção Integral à Saúde do Homem*. Brasília: MS; 2008.
17. Brasil. Lei nº 8.069, de 13 de julho de 1990. Estatuto da criança e do adolescente. *Diário Oficial da União* 1990; 14 jul.
18. Brasil. Lei nº 10.741, de 1º de outubro de 2003. Estatuto do idoso. *Diário Oficial da União* 2003; 2 out.
19. Brasil. Lei nº 13.146, de 6 de julho de 2015. Estatuto da Pessoa com Deficiência. *Diário Oficial da União* 2015; 7 jul.
20. Brasil. Ministério da Saúde (MS). *Acolhimento nas práticas de produção de saúde*. Brasília: MS; 2010.
21. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. *Linha de Cuidado para Atenção Integral à Saúde de Crianças, Adolescentes e suas Famílias em Situações de Violências*. Brasília: MS; 2010.
22. Schraiber LB, D'Oliveira AFPL, Couto MT, Hanada H, Kiss LB, Durand JG, Puccia MI, Andrade MC. Violência contra mulheres entre usuárias de serviços públicos de saúde da Grande São Paulo. *Rev Saude Publica* 2007; 41(3):359-367.
23. Mascarenhas MDM, Andrade SSCA, Neves ACM, Pedrosa AAG, Silva MMA, Malta DC. Violência contra pessoa idosa: análise das notificações realizadas no setor de saúde – Brasil, 2010. *Cien Saude Colet* 2012; 17(9):2331-2341.
24. d'Oliveira AFPL, Schraiber LB, Hanada H, Durand J. Atenção integral à saúde de mulheres em situação de violência de gênero: uma alternativa para a atenção primária em saúde. *Cien Saude Colet* 2009; 14(4):1037-1050.
25. Mendes KDS, Silveira RCCP, Galvão CM. Revisão Integrativa: método de pesquisa para a incorporação de evidências na saúde e na enfermagem. *Texto Contexto Enferm* 2008; 17(4):758-764.
26. Ganong LH. Integrative reviews of nursing research. *Res Nurs Health* 1987; 10(1):1-11.
27. Knafl K, Whittemore R. The integrative review: updated methodology. *J Adv Nurs* 2005; 52(5):546-553.
28. Bosi ML. Pesquisa qualitativa em saúde coletiva: panorama e desafios. *Cien Saude Colet* 2012; 17(3):575-586.
29. Schaiber LB, Nemes MIB, Mendes-Gonçalves RB. *Saúde do adulto: programas e ações na unidade básica*. 2ª ed. São Paulo: Hucitec; 2000.
30. Pinheiro R, Luz MT, organizadores. *Construção da integralidade: cotidiano, saberes e práticas em saúde*. 4ª ed. Rio de Janeiro: IMS/UERJ – CEPESC – ABRASCO; 2007.
31. Machado DF, Mclellan KCP, Murta-Nascimento C, Castanheira ERL, Almeida MAS. Abordagem da Violência contra a Mulher no Ensino Médico: um Relato de Experiência. *Rev Bras Educ Med* 2016; 40(3):511-520.
32. Oliveira JR, Albuquerque MCS, Brêda MZ, Barros LA, Lisbôa GLP. Concepções e práticas de acolhimento apresentadas pela enfermagem no contexto da atenção básica a saúde. *Rev Enferm UFPE* 2015; 9(Supl. 10):1545-1555.
33. Favoreto CAO. *A narrativa na e sobre a clínica na atenção primária: uma reflexão sobre o modo de pensar e agir dirigido pelo diálogo à integralidade e ao cuidado em saúde* [tese]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2007.
34. MS, Backes DS, Sousa FGM, Erdmann AL. A emergência da integralidade e interdisciplinaridade no sistema de cuidados em saúde. *Rev Eletr Quadr Enferm* 2009; 17.
35. Dalmolin BB, Backes DS, Zamberlan C, Schaurich D, Colomé JS, Gehlen MH. Significados do conceito de saúde na perspectiva de docentes da área da saúde. *Esc Anna Nery* 2011; 15(2):389-394.

36. Noronha JC, Pereira TR. Princípios do sistema de saúde brasileiro. In Fundação Oswaldo Cruz. *A saúde no Brasil em 2030 - prospecção estratégica do sistema de saúde brasileiro: organização e gestão do sistema de saúde*. Rio de Janeiro: Fiocruz/Ipea/MS/Secretaria de Assuntos Estratégicos da Presidência da República; 2013. p. 19-32.
37. Brasil. Secretaria da Saúde. *Violência Doméstica contra a Pessoa Idosa: Orientações Gerais. Coordenação de Desenvolvimento de Programas e Políticas de Saúde*. São Paulo: Secretaria da Saúde; 2007.
38. Porto RTS, Bispo JJP, Lima EC. Violência doméstica e sexual no âmbito da Estratégia de Saúde da Família: atuação profissional e barreiras para o enfrentamento. *Physis* 2014; 24(3):787-807.
39. Costa MC, Lopes MJM, Soares JSF. Agendas públicas de saúde no enfrentamento da violência contra mulheres rurais - análise do nível local no Rio Grande do Sul, Brasil. *Cien Saude Colet* 2015; 20(5):1379-1387.
40. Kind L, Orsini MLP, Nepomuceno V, Gonçalves L, Souza GA, Ferreira MFF. Subnotificação e (in)visibilidade da violência contra mulheres na atenção primária à saúde. *Cad Saúde Pública* 2013; 29(9):1805-1815.
41. Signorelli MC, Auad D, Pereira PPG. Violência doméstica contra mulheres e a atuação profissional na atenção primária à saúde: um estudo etnográfico em Matinhos, Paraná, Brasil. *Cad Saúde Pública* 2013; 29(6):1230-1240.
42. Mathias AKRA, Bedone AJ, Osis MJD, Fernandes AMS. Prevalência da violência praticada por parceiro masculino entre mulheres usuárias da rede primária de saúde do Estado de São Paulo. *Rev Bras Ginecol Obstet* 2013; 35(4):185-191.
43. Alves ES, Oliveira DLLC, Maffacciolli R. Repercussões da Lei Maria da Penha no enfrentamento da violência doméstica em Porto Alegre. *Rev Gaúcha Enferm* 2012; 33(3):141-147.
44. Osis MJD, Duarte GA, Faúndes A. Violência entre usuárias de unidades de saúde: prevalência, perspectiva e conduta de gestores e profissionais. *Rev Saúde Pública* 2012; 46(2):351-358.
45. Borsoi TS, Brandão ER, Cavalcanti MLT. Ações para o enfrentamento da violência contra a mulher em duas unidades de atenção primária à saúde no município do Rio de Janeiro. *Interface* (Botucatu) 2009; 13(28):165-174.
46. d'Oliveira AFPL, Schraiber LB, Hanada H, Durand J. Atenção integral à saúde de mulheres em situação de violência de gênero: uma alternativa para a atenção primária em saúde. *Cien Saude Colet* 2009; 14(4):1037-1050.
47. Ferrante FG, Santos MA, Vieira EM. Violência contra a mulher: percepção dos médicos das unidades básicas de saúde da cidade de Ribeirão Preto, São Paulo. *Interface* (Botucatu) 2009; 13(31):287-299.
48. Moreira GAR, Vieira LJES, Deslandes SF, Pordeus MAJ, Gama IS, Brilhante AVM. Fatores associados à notificação de maus-tratos em crianças e adolescentes na atenção básica. *Cien Saude Colet* 2014; 19(10):4267-4276.
49. Ramos MLCO, Silva AL. Estudo sobre a violência doméstica contra a criança em unidades básicas de saúde do município de São Paulo - Brasil. *Saude Soc* 2011; 20(1):136-146.
50. Lima MCCS, Costa MCO, Bigras M, Santana, MAO, Alves TDB, Nascimento OC, Silva MR. Atuação profissional da atenção básica de saúde face à identificação e notificação da violência infanto-juvenil. *Rev Bahiana Saúde Pública* 2011; 35(Supl. 1):118-137.
51. Wanderbroocke ACNS, Moré CLOO. Abordagem profissional da violência familiar contra o idoso em uma unidade básica de saúde. *Cad Saúde Pública* 2013; 29(12):2513-2522.
52. Wanderbroocke ACNS, Moré CMOO. Significados de violência familiar contra o idoso na perspectiva de profissionais da Atenção Primária à Saúde. *Cien Saude Colet* 2012; 17(8):2095-2103.
53. Moraes CL, Apratto Júnior PC, Reichenheim ME. Rompendo o silêncio e suas barreiras: um inquérito domiciliar sobre a violência doméstica contra idosos em área de abrangência do Programa Médico de Família de Niterói, Rio de Janeiro, Brasil. *Cad Saúde Pública* 2008; 24(10):2289-2300.
54. Albuquerque FP, Barros CRS, Schraiber LB. Violência e sofrimento mental em homens na atenção primária à saúde. *Rev Saúde Pública* 2013; 47(3):531-539.
55. Schraiber LB, Barros CRS, Couto MT, Figueiredo WS, Albuquerque FP. Homens, masculinidade e violência: estudo em serviços de atenção primária à saúde. *Rev Bras Epidemiol* 2012; 15(4):790-803.

Article submitted 27/02/2018
Approved 25/09/2018
Final version submitted 27/09/2018