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Advances and difficulties of the National Accident and Violence Reduction Policy: the implementers' point of view

Maria Cecília de Souza Minayo (https://orcid.org/0000-0001-6187-9301) [1]
Kathie Njaine (https://orcid.org/0000-0003-3250-2331) [1]
Edinilsa Ramos de Souza (https://orcid.org/0000-0003-0903-4525) [1]

Abstract *A qualitative study analyzes advances and challenges in implementing the National Policy for Reducing Morbidity and Mortality from Accidents and Violence from the perspective of 63 implementers from the Brazilian regions. Aspects of institutionalizing complex public policies that require inter-organizational coordination are discussed. The results show that Primary Care is the level that most developed the Policy guidelines, and the Rehabilitation sector is the least engaged. From national coordination, the following stand out: training processes, formalization of commitments at all levels, decision, and negotiation mechanisms, permanent consultancy, creation of prevention centers, strengthening information systems, and financial subsidies. Of the local coordinations, the following stand out: actors from the prevention and health surveillance centers; leadership capacity to promote training and integration with other areas to carry out local diagnoses and choose priorities; networking; creating mechanisms for routinizing procedures. Obstacles to the implementation of PNRMAV are also addressed, which today can be seen as a glass half full and half empty. However, the country has sufficient capacity for it to be institutionalized.*
Key words *SUS, Health policies, Assessment*

[1] Departamento de Estudos sobre Violência e Saúde Jorge Careli, Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz. R. Leopoldo Bulhões 1480, Manguinhos. 21041-210 Rio de Janeiro RJ Brasil. maria.cecilia.minayo@gmail.com

Introduction

This article discusses the implementation process of the National Policy for Reducing Morbimortality from Accidents and Violence (PNRMAV)[1] to understand and analyze this movement from the perspective of health professionals and managers responsible for putting it into practice. This year marks the 23rd anniversary of this Policy and this analysis is conducted at the Ministry of Health's request to determine how the SUS is absorbing and institutionalizing it.

As Barbosa[2] states, implementation is a phase of the public policy cycle, the challenge of transforming intentions and proposals into actions and results. The implementation process generally involves stakeholders from different levels of government and organizations with different interests, expertise, and institutional formats. Its implementation occurs through interorganizational arrangements. Its structure and forms of interaction influence its performance[2].

The governance of a public policy concerns the regulation of relationships through mechanisms that include authority and coordination. Authority is the law transformed into governance. Coordination is an aspect of this governance, but it does not constitute it entirely because its role is executive. However, according to Kooiman[3] and Barbosa[2], coordination is crucial in complex contexts that require the integration of interdependent stakeholders who need to adapt to each other[3].

The perspective of researching the ongoing PNRMAV implementation[1], enacted by the Ministry of Health on May 16, 2021, through Ordinance No. 737/2001, focuses on managing the interdependencies between the implementers that make up the interorganizational arrangement. This Policy represented a considerable advance against what had been addressed by the health sector through the "external causes" heading. It brought a significant challenge: introducing a highly relevant social issue into the field's theoretical, methodological, and practical framework, which is violence. Although considered a public security issue, the PNRMAV[1] understands that violence impacts the quality of life and is currently the third leading cause of death in the country. The health sector is the outlet for its consequences. Accidents, yes, appeared more clearly among the injuries and causes of death. However, they also began to occupy a place – along with violence – in health promotion topics, and both are the object of care in Primary Care, Pre-hospital and Hospital Care, and Recovery and Rehabilitation.

The implementation of PNRMAV[1] in all the sector's levels, because it necessarily coordinates social and health problems, has always been slow and the subject of controversy and resistance. Some barriers were reduced in 2002 when the WHO released a document, the "World Report on Violence and Health"[4], reinforcing the PNRMAV[1]. As the result of collective construction and discussion, this health policy has to prevent violence and accidents, with its prevention and promotion instruments and in interaction with other agencies and civil society. It focuses on protecting life.

Six years after the PNRMAV[1] was enacted, Minayo and Deslandes[5] analyzed its implementation in five capitals of different Brazilian regions (Manaus, Recife, Rio de Janeiro, Curitiba, and the Federal District). They found some progress in its internalization but also much resistance and difficulties. For example, they found that the topic was lacking at the Primary Care level.

In 2012, Souza *et al.*[6] evaluated the Centers for Violence Prevention and Health Promotion, designed as one of the main strategies for consolidating the implementation of the PNRMAV[1]. This study also identified the proposal's potentialities and difficulties in its feasibility. For example, the authors observed that more than half of the municipal centers performed well under the criteria established for the analysis. However, 42.7% of them showed many deficiencies in the training of their members, the adequacy of the activities, and the shortage of professionals.

More than 23 years later, a new study examines the state of implementation of the PNRMAV[1]. This article is part of this latest investigation and aims to understand what worked and the difficulties and obstacles in its implementation from the implementers' perspective.

Methods

Data on progress and difficulties in implementing PNRMAV[1] were analyzed by care level in the central regions and capitals. We interviewed 63 people from the 26 capitals and the Federal District responsible for implementing the Policy: managers from the municipal, state, and federal spheres, members of the municipal and state prevention centers, and members of the surveillance sector.

The qualitative approach was accompanied by a quantitative study that this article will not discuss. In the comprehensive approach to the implementation of PNRMAV[1] from the perspective of the main stakeholders involved in the action, the semi-structured interview technique was used based on a joint roadmap, adapted per the specificities of each principal stakeholder: (1) What was the historical trajectory of implementation of PNRMAV[1] in their location; (2) Whether the use of notification and information forms about these conditions was adopted; (3) How was the care for victims structured; (4) How has the training of professionals occurred; (5) What prevention actions, monitoring of events, and treatment means are being developed; (6) What are the advances, difficulties and prospects regarding the implementation of the Policy.

All conversations with respondents occurred remotely due to the impossibility of face-to-face communication since the research was conducted during the COVID-19 pandemic. The conversations were held via the Google Meet platform and recorded with the respondents' consent, who signed and sent the informed consent form they had previously received to the research coordinating team.

The audio recordings of the interviews were sent to a company specializing in transcription for implementing this operation. The collection was processed and subjected to content analysis in the thematic modality, as proposed by Minayo[7]: (1) Organization of the collected material; (2) Categorization of relevance, emphasizing the meaning of the respondents' statements; (3) Interpretation of the data and its comparison with the theoretical framework, composing a narrative regarding two issues: the state of implementation of the PNRMAV[1] and the obstacles and difficulties in this process.

The ENSP/Fiocruz Ethics Committee approved this study under Opinion No. 4.732.884, dated May 25, 2021. Considering the information collected, it presents a possible and entirely plausible view.

Results

We opted to present the results by region since the testimonies converge despite the detailed research. Greater emphasis was given to the issues raised by those practicing the Policy in the field since their statements contain the most substantial reflections.

Advances in the respondents' view

In the *North*, managers spoke the least about implementing the PNRMAV[1]. However, those who did speak out praised its importance, recognizing the weight of violence and accidents in the morbimortality profile and the demands generated by these injuries in the sector. However, technicians working in this region's centers were much more eloquent when recounting their experiences.

The main advances mentioned by the technicians were their awareness of reducing traffic accidents, supporting people in situations of violence, and the relevance of networking. The social groups most often mentioned as targets of care were women and children. Managers from several centers reported an increase in intersectoral work through joint actions with education, social services (Social Assistance Reference Centers - CRAS and Specialized Social Assistance Reference Centers - CREAS), and guardianship councils. The *Vida no Trânsito* (Life in Traffic) Program was the most mentioned initiative, highlighting its effectiveness in the positive results of reducing deaths and injuries. In partnership with the World Health Organization (WHO), this program started in Brazil in 2010 in five capitals: Palmas, Teresina, Belo Horizonte, Campo Grande, and Curitiba. Today, it is found in most capitals and has expanded to cities with more than one million inhabitants.

Professionals working in the pre-hospital, hospital, and rehabilitation areas in the North hardly mentioned the actions provided for by PNRMAV[1] that exceed curative care.

In the North, Belém and Manaus stood out for their ability to implement the Policy. In Manaus, the technician interviewed highlighted the integration between the people who work with the topic and the support they receive from the managers. The Belém center also mentioned the institutional support and training provided to each new technician who joins the program. Relevant signs of progress are seen in the other capitals. In Palmas and Macapá, the people interviewed highlighted the reinforcement of surveillance actions, reporting, and data organization. Also, in Macapá, people mentioned monitoring cases of violence against women, children, and older adults based on a fruitful partnership between the municipality and the state and investment in the training of technicians. The information about Boa Vista also shows the same direction.

In Rio Branco, the topic was introduced in schools, services, and the training of life sciences students during their undergraduate studies. The respondent from this capital commented that the Prevention Center coordinator said that she promoted training for teachers in schools in this capital in 2019 with the support of the Municipal Health Secretariat. Thus, "*teachers are already aware of PNRMAV[1], they issue notifications, and request intervention from the Guardianship Council when necessary: they are also multipliers*" (Professional from Rio Branco-AC). In Rondônia, a state surveillance technician emphasized that the way forward was conducting integrated work. She mentioned two networks for combating violence against women and children in the capital that support each other, the inclusion of an individual from the School Health Program (PSE) in the surveillance sector, and highlighted the effort to improve notification: "*Today we are already achieving 80% of notifying municipalities*" (Technician from Rondônia-RO).

In the *Northeast*, respondents considered the advances in the implementation of PNRMAV[1] as many and relevant: "*We are at another level in the institutionalization of the policy that has placed accidents and violence on the public agenda as a problem for the individual and society*" (Professional from Recife-PE). The respondents highlighted the creation of reference centers, establishing case referral flows, increasing scientific production and production of educational material, and organizing surveillance to consolidate data. The relevance of the *Vida no Trânsito* Program was also mentioned, with interaction between health professionals, education professionals and DETRAN, and practical effects on reducing accidents. Likewise, all respondents praised the fact that they had learned to work intersectorally, which was also highlighted by professionals from the North and Midwest. One of the aspects that differentiates the situation in the Northeast from the other two is that more people are working on the topic and an institutionalization process with more apparent elements.

In the municipal surveillance department of Recife-PE, one of the professionals interviewed said that the most remarkable advances were improved notifications, the establishment of referral flows, networking, coordination with reference services, and investment in continuing education. This respondent commented that the capital has many social facilities, such as CRAS and CREAS, which facilitate the creation of an intersectoral public policy. This technician considered the performance of the surveillance sector in conjunction with pre-hospital services to be a success. Another technician commented that she always discusses violence and health in her committees. Both emphasized that today, the PNRMAV[1] has excellent visibility, regardless of the obligation to notify, as the Policy has dramatically strengthened the focus on the situation of women and children and other vulnerable groups such as the LGBTQIA+ population, people with disabilities, and Indigenous people.

Focusing on the crucial point of institutionalization, the technician interviewed from Rio Grande do Norte considered that her center received support from the administration and has a communication channel at the State Secretariat. She assessed that one positive side of the pandemic was that it incorporated the discussion of violence and reinforced the role of intersectoral actions. However, she believes there is still a lot to be done: "*In some regions, we have to pressure even to provide training. [...] there are more than 30 municipalities, and we have to integrate several stakeholders, qualify the perception and relevance of violence surveillance*" (Professional from Natal-RN).

In Paraíba, the institutionalization movement is also powerful. One respondent said the combination of institutional and personal coordination has been very successful: "*Sometimes it's not working in public management, and we call on a partner who is already part of that service*" (Professional from João Pessoa-PB). This technique highlights that actions designed as a network have enabled the collective construction of instruments, booklets, and guides for women, and there is a focus on Black women, which has gained space in municipal and state management.

Two Aracaju-SE professionals interviewed assessed the progress of the policy in the Municipal Prevention Center and the urgent care network. The Center's professional said PNRMAV[1] highlighted the tragic impact of accidents and violence on the SUS. She also highlighted that the center has focused on the information they obtain and work on to better plan actions. A respondent in the urgent care sector praised the Prevention Center's work, going to hospitals and trying to sensitize professionals to improve care and notifications. Both commented that the state center has not yet been formalized by ordinance.

In Piauí, the people interviewed cited the structuring of the mobile pre-hospital service,

SAMU, the implementation of the *Vida no Trânsito* Program, the remote training sessions for professionals in the municipalities discussing accidents and violence, and the dissemination of data on these topics in the state's bulletins as advances in the Policy. A professional from Teresina/PI affirmed that a critical achievement was raising issues of violence and accidents in different spaces, even on television: "*I no longer only talk to health professionals, but also to the police; we manage to talk*" (Professional from Teresina-PI). The number of services to support victims, especially women, has increased. Another action that she believes has been progressing is greater attention to self-inflicted violence.

A technician who works in surveillance in Maceió-AL emphasized that this service has advanced in being closer to the professionals on the front lines. She commented that she monitors, together with them, the people in the violence and accident care network. She emphasized that she has received much support from the managers. However, her team is small: "*We try to build a project that gathers all sectors, such as the secretariat for women, children and adolescents, older adults, and the PSE*" (Technician from Maceió-AL).

The Ceará state surveillance agency pointed out the creation of an observatory for external causes as one of the successes of PNRMAV[1]. It cited other activities aimed at women, children, and adolescents who are violence victims. It also highlighted the partnerships with the state university to create strategies to combat violence and accidents in the municipalities and implement notification forms in several schools. In Fortaleza-CE, the respondent from the epidemiological surveillance agency stated that a positive point had been the actions of the Traffic Accident Committee, which involved many partners and activities on the streets.

In the State of Bahia, the most significant gain that PNRMAV[1] had, as mentioned by one technician, was establishing working groups that gave visibility to violence and accidents. She highlighted the *Vida no Trânsito* Program, mentioned the importance of implementing, maintaining, and expanding pre-hospital services in the territory, and underscored the role of surveillance in understanding the specific contexts of violence and accidents, intersectoral work, and partnerships. This professional affirmed that the State of Bahia has gathered multipliers and shared experiences in these 20 Policy years.

We can conclude that the states of the Northeast are committed to institutionalizing the PNRMAV[1], mainly due to the technicians assigned to the Centers and the Surveillance sector, despite all the health professionals' difficulties in accepting the topic. There is a notable commitment to offering care and prevention services to the population. As in the North and Midwest, little information about Pre-Hospital, Hospital and Rehabilitation services is available.

Investments were made in implementing PNRMAV[1] in all states of the *Southeast*. Information on the region and the capitals was analyzed. One person interviewed in Espírito Santo assessed the implementation of accident and violence surveillance as a specific sector feature, the incorporation of the notification form, and the opening of communication with health units and other sectors of society. She commented that working across sectors was the most positive aspect. This respondent emphasized that partners are informed about the types of events and the most common profiles of violence and accidents in the training courses they offer annually: "*We managed to think outside the healthcare box and go outside, and we do this very well; we are a reference*" (Professional from Vitória-ES). She emphasized that managers from the education and justice sectors often call to discuss cases and ask for guidance: "*So, I think we are recognized and receive demands. That involves trust and credibility*" (Professional from Vitória-ES). The Espírito Santo State Center consolidated partnerships with partners from the Public Prosecutor's Office, the Public Defender's Office, the Legislative Assembly, and Universities.

In the State of São Paulo, the surveillance team assessed that investment in information qualification together with partners has been one of the main advances regarding the PNRMAV[1]. One professional highlighted that the availability of the digital Tabnet (DATASUS Generic Data Tabulation System) was a huge gain and resulted from a consistent team's work. This respondent assessed that the feedback from interlocutors regarding data systematization has been excellent, and "*most understand that this is a guideline for them to start appropriating the data and transforming it into information*". Another person on the team considered that the consistency of the work has to do with actions' continuity since the current communication channel is a tremendous facilitator.

In São Paulo, the capital, a professional from the city's surveillance sector mentioned notification as a significant step forward: "*It facilitated discussing violence within the healthcare system,*

as a health problem as well, which was essential" (Professional from São Paulo-SP). The respondent recalled that managers were reluctant to talk about violence and reporting these events at the beginning because they did not consider it a problem for the sector. Another point she considered crucial is the creation of Violence Prevention Centers. She stressed that this line of work needs to continue and be strengthened, "*we must have those responsible for the coordination in the states and the municipalities*" (Professional from São Paulo-SP). São Paulo stands out for organizing services related to the topic in the 32 sub-prefectures and promoting an integrated flow between the different sub-secretariats and the government organizations working in the same line.

Belo Horizonte had a broad movement to sensitize professionals, especially regarding the impoverishment of families, child labor, and violence against children, adolescents, and women. The people interviewed reported that they work intersectorally and with a focus on young people. They reported that the city has full coverage of Primary Care. In more socially vulnerable neighborhoods, the team, the city government, and the Social Assistance Reference Centers have developed actions such as sports and leisure for young people at risk.

In Rio de Janeiro, the capital, the person responsible for this policy highlighted that one of the main advances was the creation of articulating groups in several areas of the city. This strategy is based on constructing diagnoses of the territory in a more agile and timely fashion, working in partnership instead of a hierarchical relationship. The responsible considered that politics triggered the debate, and today, the problem is one of the most discussed topics in the media and by health professionals as a social issue and a concern for how to refer and address cases in the health sector. Likewise, decentralization to the municipalities through the computerized Notifiable Diseases Information System (SINAN Net) is a significant advance, as was the creation of Prevention Centers in both the capital and the rural area.

The *South* has also successfully institutionalized the PNRMAV[1] through very concrete actions and with the support of the State and Municipal Secretariats. A Rio Grande do Sul State Center respondent assessed that their efforts have been recognized. She also said that most municipalities request support and advice and have made progress in partnerships with various sectors. There is collective work with the support of "*this entire intersectoral network, especially in the issue of combating suicide, which is a significant advance for the PNRMAV*" (Professional from Rio Grande do Sul-RS).

A security professional from Porto Alegre/RS affirmed that the advances related to PNRMAV[1] are evidenced in the "*cross-sectional and intersectoral line of care for violence*" (Professional from Porto Alegre-RS). Regarding accidents, she assessed that the *Vida no Trânsito* Program is well-known in the capital and that she has worked with these actions for 10 years. Both the PVT and the issue of violence surveillance are recognized by the state administration and other municipalities in the state, "*we can say that we have a methodology that works, that prevents and that accidents are decreasing*" (Professional from Porto Alegre-RS).

Primary care professionals in Florianópolis-SC assessed that sensitizing health teams regarding accidents and violence is an important step forward. The technician interviewed said that professionals can now look at these events, make a situational diagnosis, and build care flows. The maturity of the care network has allowed for a deeper discussion about such problems and improved work strategies and professional training.

A Paraná State Center for Violence Prevention manager considered that "*the state has made great progress since implementing the Policy*" (Professional from Paraná-PR). This respondent affirmed that her state has an organized structure with a "*focus on prevention, health promotion, and a culture of peace*" (Professional from Paraná-PR). She praised the pioneering teams that structured the work and assessed the results as positive: the design of intersectoral networking; the creation of reference services for people in sexual violence situations; pregnancy termination services; preparation of protocols, thematic notebooks, and epidemiological bulletins with data on violence and accidents; and training that the Secretariat has developed with the entire protection network.

Two professionals from the Municipal Center for Violence Prevention in Curitiba-PR highlighted the progress of a protection network for children and adolescents, consolidated and a reference for other states and municipalities. Other successes achieved by this team over the 20 years of PNRMAV[1] were participation in the Violence and Accident Surveillance (VIVA) surveys and the Continuous VIVA Survey, expanding the perspective of records of violence against women, girls, and older adults. These re-

spondents believe that everything was possible with the federal government's support and the academic institutions that built the PNRMAV[1]. One of the professionals from this Center who works directly in the protection network reported one of the achievements, in partnership with a state forum for preventing child labor: creating a forum for recyclable waste collectors. The partners trained the health units so that all collectors in the territory could be registered. "*We managed to reach 70 health units. It was a cool experience because then we managed to get these units to expand their perspective on that territory*" (Professional from Curitiba-PR). The action aimed at identifying children who were working on the streets as recyclable waste collectors covered the entire protection network, including schools, and "*it was a significant experience that is also within the scope of SDG*[8]*. It's all connected*" (Professional from Curitiba-PR).

In the *Midwest*, creating health promotion groups with positive results in actions related to accidents and violence was cited as an advance in the PNRMAV[1]. Regarding accidents, in Mato Grosso, monitoring and training actions were conducted in some municipalities on traffic, installation of signs, pedestrian crossings, and activities with motorcyclists. Concerning violence, support centers for female victims and police stations were created, and the teams that lead the implementation of the Policy rely on media collaboration.

A surveillance technician for Noncommunicable Diseases (NCDs) in Cuiabá-MT highlighted that health professionals and professionals from other areas are trained to work with violence through online courses. She also mentioned improved care for victims, which gained visibility through social media, television, and other campaigns. This technician also recalled the increasing support for research in the state.

In the Federal District, the Center's coordinator believes they have already established a protection network there: "*We managed to establish much more assertive communication with other secretariats because it is not just about health*" (Professional from Brasília-DF). In alliances with public security, justice, and the Women's Secretariat, the Center seeks to strengthen reporting and better understand violence cases to provide adequate care to people in proposals developed independently of the governments in power. In other words, this person is talking about institutionalizing the Policy.

The Goiânia-GO Surveillance Center mentioned the increased visibility of violence within the health sector and how much this impacts actions. There and in Campo Grande, the technicians mentioned the increase in training sessions, the recognition of problems by health services, and improved notifications; understanding these actions is fundamental for planning care. The respondents stated that they see an increase that reflects their commitment when they look at the historical series of notifications. Another positive point mentioned by one of the respondents from Campo Grande is the sustainability of the Prevention Center. It was officially established and is part of the management organization chart. "*It has its little box; it is a service*" (Technician from Campo Grande-MS). The *Vida no Trânsito* Program was also established by decree, as was the intersectoral committee that directs it and the data analysis group. This respondent highlighted that sustainability through legislation ensures that actions continue even with changes in government. She also highlighted the importance of intersectoral work and research: "*I think three or four professionals here are doing family health residency, only studying violence, in their master's degree, and so on*" (Technician from Campo Grande-MS).

In short, the Midwest also saw visible investment in dissemination, training, coordination with other areas and stakeholders, surveillance, and reporting. The idea of a network, interdisciplinary action, and searching for official strategies so that PNRMAV[1] can be institutionalized are particularly notable.

Two important points: First, all respondents from all locations mentioned the *Vida no Trânsito* Program's success, a proposal involving a significant investment. Second, we should underscore that the Ministry of Health's supervision of the PNRMAV stagnated under the previous government starting in 2019. All respondents regretted this standstill, which may have led to setbacks, especially for locations and centers still in the early stages of activity.

Implementing difficulties from the respondents' perspective

The most urgent references to the difficulties in implementing PNRMAV[1] are concentrated in the *North*: few professionals to serve people living in very remote areas; high turnover of teams and managers; lack of renewal of teams; other priorities alleged by managers who do not see violence as a topic to be addressed by the health sector; lack of a specific indicator to val-

ue services; lack of organization and integration of health services among themselves and with other sectors; resistance of professionals to report violence; lack of understanding in society regarding violence and accidents as preventable events; lack of structure for proper care; lack of financial resources; loss of specific Ministry of Health's funding.

In the *Northeast*, the most mentioned problems were the difficulties in conducting integrated intra and intersectoral work, lack of structure to work, the fact that professionals have to work in armed conflict-affected areas, lack of proposals that consider some specific vulnerable groups such as older adults, Blacks, LGBTQIA+ and people with disabilities; lack of understanding among professionals about the importance of notification and, aligned with the North, having reduced teams to address such complex issues that affect so many social segments.

In the *Southeast*, the main complaints were a lack of state and municipal management's understanding regarding accidents and violence; lack of specific funding for the PNRMAV at federal, state, and municipal levels; difficulty in working with the homeless population and drug users; drug traffickers (and militiamen) in the outskirts, which makes the health sector's work less effective; work overload; blatant machismo, including within health units, especially regarding the situation of women who suffer abuse and LGBTQIA+ groups.

In the *South*, the people interviewed also reported a lack of political and financial support to implement the PNRMAV[1], high staff turnover in the health sector, a shortage of professionals, poor intra-sectoral and inter-sectoral coordination; family silencing situations of violence, the fact that those most affected by violence, young people, are those who least seek services; a lack of rehabilitation services for people with after-effects; society's lack of understanding of the fact that violence and accidents are preventable events; an increase in the number of homeless people and those who use alcohol and other drugs; and a lack or inefficiency of mental health and suicide prevention services.

In the *Midwest*, the biggest complaints were the lack of personnel, lack of infrastructure to work and monitor people, lack of material and human resources for training, the realization that there are bedridden people without access to rehabilitation, some people have mental issues, have suicidal thoughts, and attempt suicide without care; and the lack of private space for care. One respondent affirmed, "*The challenges are huge*".

Discussion points

All the work described here can be considered an inquiry into the path toward institutionalization of the PNRMAV[1]. Institutionalization refers to the process by which norms, values, practices, and organizational structures are established in a standardized manner in a given society or a specific organization: in the legal sphere (formulation of laws and legal documents), institutional sphere (preparation of guidelines, regulations, protocols, and programs), cultural sphere (incorporation of new principles and values), and budgetary sphere (allocation of resources) and are transformed into consistent actions[9-11].

Implementers believe that the evaluation process allows us to conclude that the PNRMAV[1] has reached all Brazilian regions, albeit with different adherence and intensity. The problems stated by technicians and managers are enormous. Thus, this Policy cannot be considered institutionalized in any region, state, or municipality, although there are essential differences in where it has been made official.

The merit of proposing the Policy and its Guidelines was the work of many hands. However, the strategies created by the Ministry of Health with the support of states and municipalities escalated from 2006 to 2018 and enabled the local organization of its operationalization. This movement can be seen in the leading role of the Accident and Violence Prevention Centers and the organization of Health Surveillance with the implementation of notification forms for these conditions, with the Ministry's funding, supervision, and coordination. These two initiatives played (and still play) a crucial role in the PNRMAV[1] internalization process.

None of this would have been possible without competent national coordination of this process. In agreement with Klijn[12], Hill[13], Barbosa[2], and Miranda[10], good coordination is crucial to guide complex and inter-organizational processes. The following were essential for implementing the PNRMAV[1]: the organization of training processes; the formalization of commitments at all management levels; decision-making and negotiation mechanisms; intensive, present, and recurrent advisorship in the creation of centers and strategies for monitoring and action; the strengthening of informa-

tion systems and financial subsidies. However, in isolation, none of these aspects explains the excellent performance; instead, their confluence[2,11] is successful.

Regarding local management, some mechanisms were essential, such as the leadership capacity, including people and promoting training to address the issue; integration with other local subsystems; conducting local diagnoses and choosing priorities; intra- and inter-sectoral and network work; creating mechanisms for routine procedures to institutionalize them and research for action. These characteristics were mentioned mainly by coordinators of the Prevention Centers and by Health Surveillance professionals. These two professional segments stand out in all locations and bodies.

The analysis of the difficulties does not show, at first glance, any personal inefficiency on the part of the national and local coordinators. What does appear repeatedly are the enormous challenges that persist and need to be considered by the managers responsible for institutionalizing the PNRMAV[1]. These points had already been identified by Minayo and Deslandes[14] and Souza *et al.*[6]: (1) Because this is a complex, interdisciplinary and interorganizational Policy, it requires permanent coordination and officially agreed action protocols; (2) a specific funding source for this Policy must be established at the federal and local levels; (3) it is necessary to agree on some indicators for action that can be controlled by local centers and valued in the assessment of professionals; (4) special attention should be given to the regions with the most significant difficulties in implementing the Policy; (5) it is necessary to pay attention to complaints from all locations – many of which operate through the personal commitment of employees – about the lack of institutional support, structure, and personnel; (6) It is necessary to invest in strategies that engage the pre-hospital, hospital and rehabilitation segments in the implementation of the Policy. The Primary Care level is currently the one that has assimilated it best. Echoing Minayo and Deslandes[14], attention to rehabilitation remains the weakest point in the link of actions provided for in the PNRMAV[1].

In short, the implementation of the PNRMAV[1] must be considered a priority, both because of the high mortality rates due to accidents and violence and because of the widespread discomfort it spreads, causing physical, mental, and social problems. After a political hiatus in which the Ministry of Health's oversight strategies for this Policy were weakened, it is time to resume agreements and strengthen strategies that formalize its existence in the organizational charts of health institutions, financing them and supporting the recommended actions.

Collaborations

The three authors participated equally in the collection, organization and analysis of data, as well as in the design and preparation of the article.

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