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Intersectoral assistance to victims of accidents and violence from the perspective of Primary Care managers and professionals

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Abstract *This article examines the implementation of the interdisciplinary and intersectoral assistance guideline for victims of accidents and violence, as outlined in the National Policy for Reducing Morbidity and Mortality from Accidents and Violence (PNRMAV), within Primary Health Care. This is research based on the triangulation of quantitative and qualitative methods, analyzing questionnaires and interviews with managers of primary care services in selected capitals and cities. The health network, social assistance services, and the guardianship council are the primary entities with which Primary Health Care coordinates care for cases of accidents and violence. There is a high frequency of flows and protocols for referring cases of violence and accidents, which are generally well-regarded. However, attention to accident victims is more limited. Progress has been observed in intersectoral coordination for providing care to victims of violence and accidents across all regions of the country. The main challenges identified are insufficient training and high staff turnover. The study concludes that the implementation of the PNRMAV in primary because its role is very important in itself and in conjunction with other services for the quality of life of users and the construction of peace.*

Key words *Violence, Accidents, Primary Health Care, Intersectoriality*

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Introduction

The structuring and organization of the Unified Health System (SUS) services network is a fundamental guideline for the reception, diagnosis, treatment, and referral of accident and violence victims in the country. PHC acts as a regulator of the health network in the country and is the main gateway to the SUS. It is based on a proposal for comprehensive care and within the principles of reception, humanization, care continuity, and territorialization. Primary care is strategic for the prevention of diseases, identification, notification, and coordination of care in general, including for people suffering violence and accidents who resort to the system. This care level is privileged because it reaches the health of individuals, family members, and neighborhood groups and fits the context[1]. The primary care nature that provides PHC knowledge close to users' reality also allows coordinating with other sectors such as education, social assistance, and justice and understanding socioeconomic, cultural, family, community, individual, and gender factors that interfere with health, and in the case studied here, in cases of violence and accidents[2]. According to data from the Primary Health Care Secretariat of the Ministry of Health, about 76% of the Brazilian population was covered by primary care and 63.6% by the Family Health Strategy (ESF) in December 2020. Regarding the country's regions, the percentages of primary care coverage ranged from 82.33% in the Northeast to 68.53% in the Southeast[3].

Regarding cases of violence and accidents that reach services, establishing bonds in the care offer enables more in-depth knowledge to identify underlying causes, service, and follow-up. For example, the literature reveals that about half of the people who commit suicide attended a medical appointment within six months before death, and most of them were attended by a generalist PHC doctor in the month before the episode, with diverse, nonspecific, and vague clinical complaints[4]. A similar scenario occurs in cases of domestic violence against children, adolescents, women, or older adults. In general, attentive professionals can act in the victims' identification, care, and referral and avoid aggravation to the individual's physical and emotional health.

The preventive and health promotion nature of PHC enables continuous care regardless of demands for interventions in specific pathologies, encouraging people to seek the service even in the absence of complaints linked to already manifest illnesses. This feature is relevant in situations of violence that usually occurs in systemic and intergenerational fashion, requiring comprehensive care[5-7] and triggering an extensive intrasectoral and intersectoral care network since violence and accidents are not exclusive events that affect the health sector[8].

Interdisciplinary and intersectoral care to accident and violence victims underpins the seven guidelines of the Ministry of Health's National Accident and Violence Morbimortality (PNRMAV), promulgated in 2001[9]. In this document, the idea of intersectoriality is connected to the notion of networks and partnerships with various services that do intrasectoral health management and social problems such as social assistance, education, public security, traffic, and justice[10]. However, this coordination requires a new vision of work culture and arrangements for institutional practices[11-13].

This article examines the implementation of the Interdisciplinary and Intersectoral Care Guidelines for PNRMAV accident and violence victims by the primary health care teams. As stated, the research is justified by the importance of PHC in the prevention and care to these events.

Methods

The study is nested in a nationwide survey conducted in the 2020-2023 period entitled "Evaluative Survey of the Implementation of the National Policy to Reduce Morbidity and Mortality due to Accidents and Violence" that uses quantitative and qualitative methods and several data collection and analysis techniques[14-17].

The National School of Public Health of Fiocruz Research Ethics Committee approved the research with CAAE 27932820.7.0000.5240, and all participants signed the Informed Consent Form.

Quantitative approach

This study is nested in extensive evaluative research on implementing the PNRMAV in all Brazilian municipalities. Regarding the issue of intersectorality in Primary Care, professionals and managers from 290 services were interviewed, including 18 from capital cities (Chart 1).

For this study, questions were extracted from the extensive survey that focused on two

themes: (1) coordination of networks and services to which primary care refers accident and violence cases and (2) flow type for coordinating primary care with other health services for accident and violence cases. The most significant emphasis was given to the analysis by Brazilian regions. The quantitative analysis was performed using the statistical package SPSS 24[18].

Qualitative approach

Individual interviews were conducted with 11 PHC managers and professionals from the following Brazilian capitals and cities: Manaus-AM, Recife-PE, Belo Horizonte-MG, São Paulo-SP, Florianópolis-SC, Porto Alegre-RS, Carauari-AM, Santarém-PA, Rio Tinto-PB, São Tomás de Aquino-MG, and Arroio do Tigre-RS (South). These cities were selected through 14 indicators constructed from PNRMAV guidelines[9]. The interview asked about intrasectoral actions and articulations in assisting people in violence and accidents and the processes and results of implementing the PNRMAV in PHC. All interviews were conducted remotely via the Google Meet platform, lasting an average of one hour. They were recorded and transcribed by specialized professionals. Thematic analysis techniques were used to give relevance to the main contents[19].

Chart 1. Number of participating services in municipalities and capitals of Primary Care by Region and Federation Unit. Brazil, 2021.

Region	Federation Unit	Participating municipal services (N)	Participating capital services (N)
North	Acre	4	0
	Amapá	1	1
	Amazonas	3	1
	Pará	8	1
	Rondônia	2	1
	Roraima	3	1
	Tocantins	2	1
Northeast	Alagoas	2	1
	Bahia	19	0
	Ceará	11	1
	Maranhão	3	1
	Paraíba	19	0
	Pernambuco	7	1
	Piauí	11	0
	Rio Grande do Norte	7	1
	Sergipe	3	0
Southeast	Espírito Santo	8	0
	Minas Gerais	42	1
	Rio de Janeiro	10	1
	São Paulo	39	1
South	Paraná	13	0
	Rio Grande do Sul	18	0
	Santa Catarina	28	0
Midwest	Federal District	1	1
	Goiás	9	1
	Mato Grosso	7	1
	Mato Grosso do Sul	10	1
Total		290	18

Source: Authors.

Results

Referral and flows of PHC with other services

The Health Network (99.3%), the Guardianship Council (98.2%), the social assistance network (97.8%), and the Public Prosecutor's Office (84.9%) are the main services to which primary care refers cases of violence. In turn, the LGBTI+ Rights Council (20.5%), the specialized reference center for other sectors (21.5%), and the Police Station for People with Disabilities (21.9%) are rarely mentioned. The scenario does not differ between the participating units (Table 1).

Aligned with the quantitative data, the professionals and managers interviewed also mentioned sharing cases with other health services, the Social Assistance Reference Center (CRAS), the Specialized Social Assistance Reference Center (CREAS), the Guardianship Council, and the Public Prosecutor's Office. Coordination, in general, is conducted in favor of the care of women, children, adolescents, older adults, and pregnant women as violence victims. The professionals highlighted joint actions with schools, non-governmental organizations, legal councils, universities, and community associations to prevent violence. In some locations, managers and professionals highlighted the support of regional institutions. A North Region manager showed a very positive view of the referrals of violence cases attended to by primary care:

We worked very well with the people from the Department of Justice to improve the flow. We understand that everyone needs to speak the same language, besides coordinating with services from the Social Welfare Secretariat, such as CRAS and CREAS.

In the Northeast, a professional who works in Recife-PE highlighted:

We have some partnerships: from a prevention perspective, we have been working with the Women's Movement, some NGOs, the Public Prosecutor's Office, the Family Court, and all the control agencies, such as CRAS and CREAS. So, we talk a lot about these cases of violence. We were trying to work with the University of Pernambuco because there is a center that studies violence. However, the pandemic started then.

Table 1. Networks and services to which Primary Care refers cases of violence in participating municipalities and capitals.

Networks/Services	Municipalities % (n)	Capitals % (n)
Health Network	99.3 (280)	100.0 (17)
Social assistance network	97.8 (279)	100.0 (17)
Education network	63.5 (277)	70.6 (17)
Women's Service Network	50.5 (277)	100.0 (17)
Tutelary Council	98.2 (279)	100.0 (17)
Elderly Council	67.1 (280)	94.1 (17)
Elderly Service Station	30.5 (272)	62.5 (16)
Human Rights Reference Center	24.0 (275)	64.7 (17)
Public Prosecutor's Office	84.9 (279)	88.2 (17)
Specialized Child and Adolescent Protection Station	36.6 (276)	88.2 (17)
Women's Service Station	44.9 (276)	88.2 (17)
Other Stations	77.6 (272)	52.9 (17)
Child and Youth Justice	49.3 (278)	70,6 (17)
Public Defender's Office	67.0 (276)	70,6 (17)
Child and Adolescent Rights Council	65.5 (278)	76,5 (17)
Disabled Persons' Police Station	21.9 (274)	41,2 (17)
Disabled Persons' Rights Council	32.2 (273)	70.6 (17)
LGBTI+ Persons' Rights Council	20.5 (273)	47,1 (17)
IML - Forensic Medical Institute	58.8 (277)	62,5 (16)
Specialized reference center outside of health	21.5 (274)	52.9 (17)
Other services	7.8 (245)	0.0 (17)

Source: Authors.

The School Health Program (PSE) is cited as an essential strategy in preventing violence by administrators in several cities nationwide. It aims to contribute to the comprehensive education of students in public schools through health promotion, prevention, and care actions to address the vulnerabilities that impact the full development of children and young people in public schools. Reducing morbimortality due to accidents and violence is one of the actions planned by the PSE[20]. One of the respondents from a small city in the Northeast exemplifies this coordination, although it is restricted to campaign periods:

Health professionals, along with those in care, would go to schools to talk a little about the types of violence. Usually, in May, we would address sexual abuse and exploitation, and at other times, we would also talk about physical and psychological violence. In short, we would talk much in schools. This activity decreased significantly since we had to stop due to the pandemic (Rio Tinto-PB).

Primary care managers and professionals in a capital city in the South highlighted the potential of networking, which enables coordination with public bodies, community institutions, and associations.

We have Integration Management, which is part of our Board of Directors here. It interfaces a lot with these other sectors. With Social Welfare, especially looking at the issue of vulnerability in some more specific situations. Pregnant women who are exposed to homelessness. Interface with the university itself and with State services. Primary Care also has a robust intersectoral interface within the territory. The local manager is encouraged to work with the School Health Program there. [We] encourage people to look at their social facilities in the territory and from there observe the possibilities for [themselves] to work on issues of violence in the territory (Florianópolis-SC).

One of the managers of a capital city in the South highlighted the importance of mobilizing and enhancing a broad network that includes resources already available in the territory, such as community associations:

They are not just institutional either. Some networks form much more in favor of community issues and associations that become an essential experience. Of course, this must continuously be strengthened and thought of institutionally. However, I always believe that finding good dialogues with networks is also possible. I come from important experiences in this regard, [of valuing] what already exists in communities as a provision of spaces and care. These themes also derive from and permeate the issue of violence (Porto Alegre-RS).

In some capitals of the Southeast, health professionals mentioned the existence of Intersectoral Centers that receive, discuss, and coordinate the care of cases of violence with representatives from different areas, sharing complex cases.

Intersectoral centers sometimes involve education, social assistance, and education. Also, when a child is identified as behaving differently, and someone begins to suspect a violation of rights, someone contacts the Health Center or refers the case to this so-called Regional Intersectoral Center (NIR), where these cases are discussed. There is crucial intersectoral coordination, and we make these referrals to the Elderly Councils and the Guardianship Council through the Regional Administration Office with notification and protective forms. We also often receive requests from child protection agencies, such as requests for monitoring this individual or family (Belo Horizonte-MG).

The availability of referral flows and protocols for accident and violence cases is relevant in implementing comprehensive care. Around 60.0% of the municipalities surveyed and a little over 80.0% of the capitals have an agreed flow for coordinating primary care units with other networks and health levels in violence and accidents. Generally, when they are in place, the flows are institutionalized and regulated by normative acts. This level of organization was more prominent in the Southeast in cases of violence and the Midwest in situations involving accidents. The South and Midwest had more weaknesses in regulating flows involving violence. The referral flows of accident cases were less mentioned in the South and Northeast.

The state network stands out regarding intersectoral coordination for addressing violence and accidents. Intersectoral actions are rarely mentioned in the private network not affiliated with the SUS and the federal network. A much greater availability of agreed flow and network coordination is found in the public services of the capitals (Table 2). Qualitative data show that links and referrals are more consolidated for the care of children, adolescents, women, and victims of sexual violence and suicide attempts. There is a consensus among professionals and managers that the complexity of violence and accident cases requires inter and multiprofessional and intersectoral action.

In the South, professionals from a capital highlighted several violence prevention initiatives and emphasized the importance of integration and flows.

Underreporting may be our worst enemy because, without the correct information, it is challenging to design public policies to prevent violence. We are now cross-referencing information with that of the Health Management, the Municipal Security Secretariat, and other municipal governance sector and social services. We are attempting to reduce the gap in underreporting. The health sector and the education sector must be part of this group. We are working with preventive policies in municipal schools in the most socially vulnerable areas of Porto Alegre, on the outskirts. They serve a population that suffers from institutional, structural, racial, gender, and sexual violence, besides prejudice. We are facing some resistance from the security sector, which does not have the same understanding (Porto Alegre-RS).

In the rural area of this region, a primary care professional highlighted the availability of an intra and intersectorally well-articulated technical group in his municipality.

We contacted the CRAS and the Guardianship Council. If necessary, the Public Prosecutor's Office. We created a network among ourselves [to assist victims of] violence. We have a technical group to combat violence, which meets compulsorily once a month. The technical group comprises nurses from the units. Our person in charge of the violence policy is a social worker. We extended the invitation to several entities that address the same problems. Some do not attend the meetings, but the group is substantial. All type of violence is brought up there: against children, older adults, and self-inflicted violence (Arroio do Tigre-RS).

Also, another municipality in the rural area of the South has a broad intersectoral articulation and well-defined referral flows.

Nossa rede de proteção ela é instituída através do Conselho Municipal dos Direitos da Our protection network is established through the Municipal Council for the Rights of Children and Adolescents. It permeates all councils: the health council, the social welfare council, and the education council. So, the flows we agreed upon and the protocols are passed on to all councils. This group of councils created a working group with representatives from each public policy, health, welfare, municipal and state education, the guardianship council, and public security. So, prevention is done through this planning, through joint actions,

Table 2. Percentage distribution of the availability of a flow for coordinating Primary Care units with other health services of different spheres for cases of violence and accidents in the participating municipalities and capitals.

Flow for coordinating and institutionalizing Primary Care with other health services	Violence		Accidents	
	Municipalities % (n)	Capitals % (n)	Municipalities % (n)	Capitals % (n)
Agreed flow for coordinating municipal Primary Care units with other health services from different governmental and non-governmental spheres to address cases of violence	59.7 (273)	82.0 (17)	64.3 (280)	88.2 (17)
Federal Network	16.7 (252)	20.0 (15)	19.4 (252)	40.0 (15)
Institutionalized/regulated by a normative act	82.9 (41)	100.0 (3)	85.1 (47)	83.3 (6)
Under construction	5.3 (207)	8.3 (12)	5.6 (195)	22.2 (9)
State network	62.2 (259)	94.0 (17)	62.2 (263)	93.8 (16)
Institutionalized/regulated by a normative act	74.2 (159)	69.0 (19)	76.9 (169)	80.0 (15)
Under construction	4.2 (96)	0	8.2 (85)	0 (1)
Private/philanthropic network affiliated with the SUS	36.5 (260)	41.0 (17)	37.5 (261)	50.0 (16)
Institutionalized/regulated by a normative act	73.9 (92)	86.0 (7)	83.9 (93)	87.5 (8)
Under construction	2.5 (163)	10.0 (10)	8.9 (158)	12.5 (8)
Private network not affiliated with the SUS	1.03 (253)	19 (16)	13.0 (254)	26.7 (15)
Institutionalized/regulated by a normative act	59.4 (32)	100.0 (3)	56.7 (30)	75.0 (4)
Under construction	1.9 (215)	7.7 (13)	2.8 (215)	0.0 (11)
Other network	9.0 (245)	19.0 (16)	6.7 (238)	13.3 (15)
Institutionalized/regulated by a normative act	63.6 (22)	100.0 (3)	66.7 (15)	100 (2)
Under construction	2.6 (192)	7.7 (13)	6.8 (205)	7.7 (13)

Source: Authors.

and this is how the institutions and civil society organizations we have here in our municipality are organized (Dois Irmãos-PR).

We use the radio, and now we have Instagram and Facebook. Within our protocol, we assist victims with their health needs. The assistance policy, CREAS, supports the victims and their families. So, each segment has its role and perspective, and each promotes this organization and actions to prevent and curb violence differently (Dois Irmãos-PR).

Managers' assessment of primary care service flows with other networks

Graph 1 shows the good evaluation by municipal managers and health professionals regarding the quality of the articulations and flows of primary care services with other networks (66.7%) and with the private network not affiliated with the SUS (59.4%) for the care of cases of violence by the respondents to the questionnaire. The federal network was the best evaluated in the capitals (Graph 1).

In the analysis by region, in the North, the evaluation of the primary care service network flows was fair, especially in the case of the private network and that associated with the SUS. In the Northeast, the positive evaluation of the flow of PHC to other networks prevailed, including in cities with smaller populations (100.0%) and the federal network. The participating municipalities in the Southeast also positively evaluated the flow between the federal network and other partners in the care of violence cases. In the South, the flow to the private network not affiliated with the SUS received an excellent evaluation. However, the same does not occur with the federal network in the region, which was considered poor, especially in smaller municipalities. In smaller locations in the Midwest, the flow to the state network (60.0%) received a good evaluation (data not presented).

Regarding accidents, private and philanthropic units affiliated with the SUS and other networks stood out with good evaluations regarding the quality of the articulations and flows of primary care services in the municipalities and capitals. The coordination with the federal network was fair. The private network not affiliated with the SUS received the worst evaluation. The evaluation of the coordination by the state network focused on the "fair" concept by the managers of the capitals (Table 3).

PHC managers and professionals rarely mentioned actions related to intersectoral care to assist accident victims. Accident victims only arrive at PHC units if they are of low severity, such as minor burns, small cuts, bruises, and the like. More severe victims start using PHC services later after the acute phase, which is generally treated in hospital emergency services. Traffic and other accidents can leave temporary and permanent after-effects that require care from a complex care network that includes PHC services.

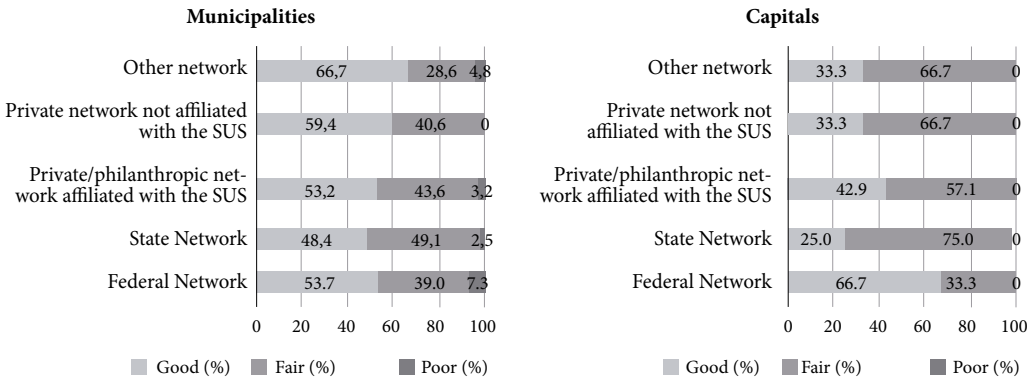
We hardly have any demand within the unit regarding traffic accident victims. Indeed, we will have to do this later to monitor the person who suffered and needs to be monitored. For example, because the person was bedridden or we need to monitor some process at home, which is when we are called in. However, at this stage, when the issue of traffic violence occurs, the patient is usually referred to an emergency service (Manaus-AM).

Again, in the North, a manager of a rural city of Amazonas spoke about the accidents that arrive at primary care: bites by venomous animals, older adults' falls, and traffic and work accidents. These situations require a level of care that the municipality cannot count on since no medium or high-complexity services are available in small cities:

We have to request an ICU. Here, we don't have doctors to perform intubation. So, it's very complicated when you come across fractures: it's a scientific demand. Here in the rural area, it's very complicated for us. So, we say: "It's better to prevent than to treat the consequences of these accidents" (Carauari-AM).

The *Vida no Trânsito* Program (Life in traffic, PVT) was mentioned by some respondents due to its essential role in strengthening policies to prevent traffic injuries and deaths. The PVT's main feature is intersectoral and joint work between stakeholders directly and indirectly linked to this issue. A manager from Recife explained how the PVT's intersectoral work works in the city:

[Recife] is one of the capitals covered by the project. We have regular meetings to analyze deaths, analyze data, and the like. This is done together, in conjunction with the State Health Secretariat. It is a partnership from the State Health Secretariat along with intersectoral actions. So, the CTTU, which is the city's traffic authority, often even the Forensic Medical Institute, when we need to go deeper, the fire department, data from SINATT. Here in Recife, we have access to it and can look within our territory the roads with the most accidents, the profile of victims, and related factors. Thus, this well-established partnership is



Graph 1. Percentage distribution of the assessment of the flow for coordinating Primary Care units with other health services from other networks to address cases of violence in all participating municipalities and capitals.

Source: Authors.

Table 3. Percentage distribution of the assessment of the flow for coordinating Primary Care units with other health services from other networks for handling accident cases in all participating municipalities and capitals.

Networks	Municipalities				Capitals			
	Good (%)	Fair (%)	Poor (%)	Total (N)	Good (%)	Fair (%)	Poor (%)	Total (N)
Federal Network	43,8	52,1	4,2	48	40,0	60,0	0,0	5
State Network	50,6	46,4	3,0	166	26,7	73,3	0,0	15
Private/philanthropic network affiliated with the SUS	59,1	38,7	2,2	93	57,1	42,9	0,0	7
Private network not affiliated with the SUS	48,5	45,5	6,1	33	25,0	50,0	25,0	4
Other network	56,2	37,5	6,2	16	50,0	50,0	0,0	2

Source: Authors.

robust in the action of accidents with the State (PHC Manager, Recife-PE).

In the state of São Paulo, a manager from the capital commented that the PHC has been working with other institutions to map the occurrence of traffic accidents through the project "*Vida Segura*" (Safe Life), which has already shown promising results.

Look, we have a project with CET [Traffic Engineering Company]. It's called Vida Segura. So, we have identified the most common motorcycle accidents. Then, we put this on the map, identifying at least 10 units where these fatal events occur the most. We are doing this study now, and it's fascinating (PHC Manager, São Paulo-SP).

Although the managers participating in the qualitative stage of the study acknowledged and valued intersectoral work in the context of providing care to people in situations of violence and accidents, some difficulties and challenges were highlighted. The most damaging aspects were the complex dialogue between the different sectors and institutions and ongoing monitoring. The barriers arise from accumulated work, discontinuous actions, and the turnover of professionals involved in the services.

I think we still need to make much progress with the Guardianship Council. It is a relationship that still requires clear roles, and we need to know the health sector's responsibilities. I see that it is often not a very easy relationship. We do not have a space to build emblematic cases, and sometimes, the Guardianship Council is absent, which I think is essential (Belo Horizonte-MG).

Because of so many demands, we say, 'No, I'll pass it on to CREAS. CREAS will talk to the police station.' Alternatively, 'I'll pass it on to the Guardianship Council. The Guardianship Council will talk to the Public Prosecutor's Office or the police station. Often, this feedback doesn't happen the way it should. I believe that this counter-referral is still really fragile. The victim of violence goes away and doesn't come back often (Rio Tinto-PB).

Discussion

In comparison with the diagnostic analysis of the first years of implementation of the PNRMAV conducted by Minayo and Deslandes[21], significant progress was observed in primary care in addressing the several forms of violence and accidents as health problems, with increased awareness of care and the creation of strategies to report and ensure healthcare. This fact is mainly due to increased awareness among professionals and professional qualifications promoted by the Ministry of Health and other institutions, besides the expanded instruments for institutionalizing flows and care.

The findings of this article highlight the strategic role of primary care services in preventing and caring for people in situations of accidents and violence, especially regarding intra- and intersectoral coordination. In all regions of the country, progress has been made concerning these coordination actions in the care of victims, which is essential in implementing the PNMRAV. There is a consensus on understanding violence and accidents as complex events that require efforts from several sectors and institutions in society to overcome fragmented views and practices. Furthermore, tackling violence and accidents depends on the adequate coordination of flows and organization of work in a network to achieve a better and more complete provision of care[22,23].

Despite the privileged place of PHC services in preventing and responding to situations of violence and accidents, the demands of individuals and their families do not end at this care level. On the contrary, they require activating a complex network of services that exceed the health network. However, this dialogue is not always easy and requires ongoing work. Mafioletti *et al.*[24] warn of the challenges imposed by the culture of sectorized, hierarchical, and verticalized work in public institutions, which hinders work in intersectoral networks, whose paradigm is integration, horizontality, connectivity, and complementarity, requiring swift and effective communication in referrals and the decentralization of decisions[25]. Some partnerships are already established with the Guardianship Council, CRAS, CREAS, and the Public Prosecutor's Office to act in the prevention, promotion, and care of health, in general, and in particular, in the impacts of violence and accidents. However, it is necessary to strengthen the coordination with other sectors that care for vulnerable groups, such as the LGBTQIA+ Persons' Rights Councils and specialized centers.

Available flows in the coordination of PHC units with other health services for cases of violence and accidents show the progress of the institutionalization of the policy in the country over the last few years. All efforts aimed at creating clear flows and protocols for caring for victims, agreed upon by different teams and services, allowing for faster and more assertive responses by professionals and offering greater treatment effectiveness. Some types of violence, such as sexual violence, self-inflicted violence, and violence involving women, children, young people, and older adults, are the types for which there are the most prepared people and care protocols[2].

The best intersectoral organization and referral and counter-referral flows stand out in the state network, which generally has the potential for broader action. The weakest connections are found in the private network not affiliated with the SUS and in the institutions of the federal network.

Recent initiatives to provide care to the LGBTQIA+ population in situations of violence must be strengthened, including the creation of specialized care services. The implementation of these services is essential for the consolidation of the National Policy for Comprehensive Health for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals (LGBT)[26]. In the case of Primary Care, it is necessary to develop strategies for this population and people with disabilities[2].

PHC professionals are not yet sufficiently aware of accidents, especially regarding the care of urgent cases of low severity and complexity, as provided by the National Emergency Care Policy[27]. Likewise, after discharge from the hospital after severe accidents, accident victims are referred to primary care for rehabilitation. The availability of primary care professionals to assess and direct users according to their specific needs is very characteristic and peculiar and contributes to greater rationality in the use of medium and high complexity[28].

The results of this research corroborate what the limited literature on the subject emphasizes about the role of PHC in preventing violence and accidents. In this sense, we comment on the limited literature on accident prevention in PHC. On the contrary, there are many more studies on violence prevention. Studies conducted with PHC nurses show that there is little training available for these professionals to work, especially in cases of domestic and traffic accidents involving children[29,30]. We should underscore that accidents are the leading cause of death among children in Brazil. Preventive measures appropriate for child development must be learned and transmitted to families when monitoring this group.

Equally important is preventing accidents that occur more frequently in older adults, mainly falls. It is estimated that around 28% of people aged 65 or over fall each year, causing severe consequences for their health[31]. The occurrence of falls is multifactorial and requires support from several areas, such as traffic engineering, maintenance of safe sidewalks, better training and behavior of public transport drivers, care at home, and creating safe conditions in bathrooms and traffic stops[32]. However, although it requires low-cost initiatives, actions to prevent domestic and transport accidents among older adults are pretty limited[33].

It is essential to invest in training people who work in PHC so that they can plan and implement actions that prevent violence and accidents and lead in promoting intra- and intersectoral initiatives[1]. Along with such initiatives, managers must be aware of team turnover, one of the main obstacles to implementing protocols and flows. As D'Oliveira *et al.*[13] point out, comprehensive care is only effective when coordinated actions are put into practice between professionals in the intra and intersectoral network so that the result is the construction of intervention projects that produce capacity at each point in the network.

The principal limitation of this study is the insufficient amount of information collected by the research that gave rise to it. We have already clarified that this is chiefly because the work occurred during the COVID-19 pandemic. Going into the field was impossible, and professionals and managers were overwhelmed with providing care to those affected by the disease. However, despite its descriptive nature, this article presents unprecedented findings that place Primary Care at the forefront of care for people in situations of violence and recovery from accidents and traumas, which was not found in the first diagnostic analysis in 2005. Therefore, in specific action and intra and intersectoral articulation, investing in this level of care is crucial to implement and strengthen the PNRMAV.

Finally, even considering the progress made in implementation, the health sector's adoption of the PNRMAV is not yet fully guaranteed or universalized. This process will only occur with due recognition of the importance of this policy, the appreciation and collaboration of workers and managers who, from Primary Care, act as enhancers of health promotion and prevention of diseases that harm the quality of life, and the construction of peace!

Collaborations

The authors participated equally in all stages of the elaboration of the article.

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