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Surveillance actions of violences in primary care, hospital and rehabilitation services in Brazil

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Abstract *This article analyzes how violence monitoring and notification actions are incorporated into different levels of care in Brazil, according to population size and regional belonging. It is characterized by a cross-sectional, descriptive study, combining quantitative and qualitative techniques, with the application of questionnaires in 290 primary care, 128 hospital and 113 rehabilitation services in 379 Brazilian cities. In the qualitative approach, 63 health professionals/service managers were interviewed. The data is analyzed through frequencies by level of care, region and population size. The interviews were analyzed by thematic content. The results show that hospital units stand out in reporting, that primary care services stand out in agreeing flows and disseminating information and that ongoing training actions need to be expanded. The recommendations are integration between information systems, feedback of information in care and surveillance, improvement in the recording of self-inflicted violence and the existence of electronic medical records for integration into the network.*

Keywords *Violence, Notification, Public health surveillance*

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Introduction

Since the historic report on violence and health in the early 21st century, the World Health Organization (WHO) has emphasized the importance of investing in violence surveillance worldwide[1]. In the following years, the focus has turned to case reporting and qualifying information on morbidity, mortality, and economic costs resulting from violence, essential for evidence-based decision-making[2-4]. In Brazil, public policies and some strategies have been implemented since the 2000s, among which the structuring of the National Accident and Violence Prevention Network and the implementation of the Violence and Accident Surveillance System (VIVA) stand out[5-8].

The magnitude of violence in Brazil and the unequal way in which it affects specific groups call on the health sector to act in prevention, epidemiological monitoring, guidance through public policies, and intervention[9,10]. The Global Study on Homicide 2021 Report shows that the global homicide rate is approximately 6.1 per 100,000 inhabitants, with a focus on Latin American and Caribbean regions. The homicide rate in Brazil is around five times higher than the global average, and the country has the second highest rate[11] in South America. Among children, data from the United Nations Children's Fund[12] indicate that one in four children in the world lives in territories with high physical or psychological violence rates. Approximately one in three women worldwide (30%) have experienced physical or sexual violence by an intimate partner or non-partner at some point in their lives[13]. Armed conflicts and violence in war zones continue to be causes of large-scale forced displacement of people.

The data place violence at the center of the public health agenda and stress the need to generate evidence on the problem's magnitude and establish and improve health surveillance and information systems; offer qualified services; raise awareness, and train professionals and managers to respond to the needs of survivors comprehensively and empathetically; to prevent the recurrence of violence through early identification; to provide information on the functioning of services; and to promote appropriate referral and support[13].

Surveillance is an essential guideline of the National Policy for Reducing Morbimortality from Accidents and Violence (PNRMAV)[8], guiding actions for reporting and monitoring events, diagnosing deaths and injuries involving children and adolescents, women, older adults, people with disabilities and mental disorders, and, more recently, attention to ethnic-racial violence and violence against the LGBTQIA+ population was included in the health agenda[7,14]. Reporting violence is mandatory by regulatory and legal acts[15-19].

Recording and systematizing data on this phenomenon allows for characterizing the type of violence committed and the perpetrator's profile, which supports the three spheres of management of the Unified Health System (SUS) at the Federal, State, and Municipal levels regarding the definition of priorities and public policies for prevention and promotion of life[7].

The Policy considers improving information a priority, and from 2009 to 2014, the number of municipalities reporting to *VIVA-Contínuo* grew by 370%, and the percentage of domestic, sexual, or other violence reports increased by 343%, giving visibility to these issues[14]. Minayo *et al.*[14] explain that from the viewpoint of hospital admissions, the aim was to qualify the primary and secondary diagnosis, which helped to identify the procedure used and the primary cause that caused the injuries. They add that, besides mortality, investment was made in the Forensic Medical Institutes to clarify the type of violence that caused death and, thus, reduce the participation of deaths classified as events with undetermined intent.

Despite advances, there are still many weaknesses in the knowledge of how surveillance actions occur in the country's health services, especially in primary care, hospital, and rehabilitation services. This study offers critical elements for planning and allocating resources to improve care for violence cases and evaluate practices and policies. It also highlights the need for support for strategic research, promoting continuing education actions, creating and strengthening intra and intersectoral networks, and raising awareness of professionals and managers to improve the institutional response to violence and the protection and care of victims. This article analyzes how monitoring and reporting violence actions are incorporated into Brazil's different care levels by population size and regional affiliation.

Methods

The study is nested in a national survey from 2020 to 2023 titled "Evaluative Survey of the Implementation of the National Policy for Reduc-

ing Morbidity and Mortality due to Accidents and Violence (PNRMMAV)". Its cross-sectional and descriptive nature characterizes it, combining quantitative and qualitative techniques from its conception of data collection and analysis[20].

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

Quantitative approach

Questionnaires with closed-ended and open-ended questions on accident and violence surveillance were developed based on previous evaluative research[21] and the guidelines recommended by the PNRMMAV[8]. A total of 5,570 online questionnaires were sent to health secretaries and managers of the three care levels (primary, secondary, and tertiary) in all Brazilian municipalities, with questions on the structure of violence care services, the team formation process, training, priority actions, and results. The email addresses were organized based on lists provided by the Ministry of Health. The RedCap platform was used between July and November 2021, with responses from 290 primary care services, 128 hospital services and 113 Recovery/Rehabilitation services, distributed across 379 Brazilian municipalities. The survey, supported by the Ministry of Health, the National Council of Health Secretaries (CONASS) and the National Council of Municipal Health Secretaries (CONASEMS), faced difficulties in obtaining participation from individuals and municipal managers, due to the fact that it was carried out during the COVID-19 pandemic.

The issues analyzed in this article refer to notification, monitoring actions, and the use of information on reported violence, broken down by care level, region, and municipality size (large - 100,000 inhabitants or more; medium and small - up to 99,999 inhabitants). Statistical analysis was performed using SPSS version 24.0[22].

Qualitative approach

In this stage, managers and health professionals were interviewed, especially those working in Accident and Violence Prevention Centers and surveillance services. Professionals working in emergency and primary care were interviewed in their absence. Managers from the Health Surveillance Secretariat of the Ministry of Health, CONASS, and CONASEMS also participated. Sixty-three interviews were conducted with managers and health professionals, distributed across 26 state capitals, the Federal District, and 10 rural municipalities selected by size, region, and PNRMAV implementation level.

The interviews were conducted using semi-structured scripts, addressing the themes presented here, which dialogue with the quantitative data: reporting services for violence cases, reporting barriers, established flows, and information use. The interviews were conducted remotely on Google Meet, lasting an average of one hour. They were recorded and transcribed. The interview analysis procedure was thematic[23], and the categories that addressed case monitoring and reporting were considered along with the categories of relevance indicated by the different stakeholders in their respective roles in the implementation of the SUS.

Results

Notification in primary care, hospital, and rehabilitation services

Hospital services report violence cases the most in the municipalities (87.4%) and rehabilitation services in the capitals (100.0%) (Table 1). Health professionals lead in reporting in hospitals, followed by hospital and social assistance centers, with more prominence in the capitals. The evidence from hospitals is primarily explained by their being reference locations for trauma, which affects recording issues:

The highest number of violence reports derives from hospitals and UPAs and then from SAMU. Primary care accounts for only 2% of notifications (Respondent from Surveillance in Salvador-BA).

Despite reporting fewer cases, primary care services are essential in recording violence cases: 82.9% in the municipalities and 77.8% in the capitals surveyed. The Riverside Population Team Program, Family Health Unit/Center/Clinic, Health Center/Post, Psychosocial Care Center for Alcohol and Other Drugs (CAPS AD), and the *Melhor em Casa* (Better at Home) Program (90.7%) report cases the most; the Oral Health Program (77.3%) and the Family Health Support Center (NASF) (79.9%) are the least cited services, besides the Therapeutic Residential Services (88.6%) and the School Health Program (PSE) (85.7%) in the capitals, albeit all

with high frequency. The profile of reporting services is similar in the different Brazilian regions. However, regardless of the care level, we observed difficulties in reporting whether some cases were suspected or could be confirmed.

The Midwest Region stood out in primary and hospital care service notifications, while the Southeast and South Regions stood out in rehabilitation services' records. Larger municipalities (90.0%-100.0%) stand out in notifications of hospital care for violence victims, while smaller municipalities are less expressive in this regard, albeit with high percentages. Only 2.5% of the primary care services surveyed never report violent events, especially those in smaller cities (Table 1).

Most of the time, monitoring violence cases in the country has been conducted mainly by the individual initiative of a professional who is more aware of the issue rather than by a planned action with financial and human resources assigned. This situation generally overburdens a few people, causes illness, and leads professionals to leave their positions:

[This professional] has been for a long time responsible for reading the notification forms. We don't have the skills to do everything, but for the more severe or apparent cases, she would return to the municipality and provide guidance from there, which is what we haven't done anymore. [The person] ended up getting sick [...] What I've been doing – so as not to say that we don't do anything – is that the cases appearing in the press or the morning paper, I look for them in the form. If they're not in the form, I call the municipality, have them look out, and keep an eye on them (Respondent from the Espírito Santo State Center for Violence Prevention).

Staff turnover and fear of retaliation are obstacles to reporting violence, especially in primary care, due to the health sector's role in these areas. At this care level, in small cities and places with high urban and criminal violence levels, the boundaries between reporting and denunciation are blurred, as identifying alleged situations of violence generally triggers actions to care for victims and hold perpetrators accountable. In light of this, different strategies have been created to support professionals, such as making the unit responsible for reporting.

It is complicated when the professional does not understand that it is a notification and that his name will not be revealed to the community or the faction. We understand that they are threatened; we have places here where people can only go to work if the faction allows it (Respondent from Primary Care in Manaus-AM).

Monitoring actions

Standardized actions for surveillance, agreement, and assessment of violence indicators as part of monitoring are highlighted at all management levels and the municipality's popula-

Table 1. Percentage distribution of violence notifications to SINAN-Net by Primary Care, Hospital Care, and Recovery/Rehabilitation by participating municipalities, capitals, regions, and population size. Brazil, 2021.

Place	Population size	Primary Care				Hospital Care			Recovery/Rehabilitation Care		
		Yes, most services (%)	Yes, few services (%)	They do not notify (%)	N	Yes (%)	No (%)	N	Yes (%)	No (%)	N
Municipalities	-	82.9	14.6	2.5	281	87.4	12.6	111	71.4	28.6	105
Capitals	-	77.8	22.2	0.0	18	85.7	14.3	7	100.0	0.0	7
North Region	Up to 99,999	85.7	14.3	0.0	14	87.5	12.5	8	57.1	42.9	7
	Above 100,000	77.8	22.2	0.0	9	100.0	0.0	3	100.0	0.0	7
Northeast Region	Up to 99,999	82.2	16.4	1.4	73	82.1	17.9	39	72.0	28.0	25
	Above 100,000	85.7	14.3	0.0	7	100.0	0.0	3	66.7	33.3	3
Southeast Region	Up to 99,999	80.8	12.3	6.8	73	83.3	16.7	24	61.9	38.1	21
	Above 100,000	85.7	14.3	0.0	21	90.0	10.0	10	75.0	25.0	12
South Region	Up to 99,999	84.6	13.5	1.9	52	87.5	12.5	8	88.2	11.8	17
	Above 100,000	50.0	50.0	0.0	6	100.0	0.0	3	75.0	25.0	4
Midwest Region	Up to 99,999	94.7	5.3	0.0	19	100.0	0.0	11	33.3	66.7	6
	Above 100,000	85.7	14.3	0.0	7	100.0	0.0	2	66.7	33.3	3

Source: Authors.

tion size. New technologies to qualify information from the form with the automatic detection of errors and inconsistencies in completing information have been recurrent. One example is the Health Surveillance Action Qualification Program (PQA-VS), which encourages an increase in notifications and the correct completion of fields such as ethnicity/skin color:

We have reached 95% of notifications with valid data in the ethnicity/skin color field, but we still have to insist a lot so that invalid data does not appear as unknown or blank. This survey is mandatory monthly, including duplicates. We do this check to see if it is a recurrence or if it really was a duplicate, so we are constantly monitoring and doing this search in all the grievances. When something goes unnoticed by us, the state also signals it (Respondent from Macapá-AP).

Support for improving the quality of information in the SUS is evident in primary care, hospital, and rehabilitation services, with a good frequency of its implementation (once or more times a year) by most services, especially in capitals and municipalities with larger populations. Notably, we observe significant support for improving the quality of information in the private health network that offers hospital care. However, records of toxicological problems and the preparation of files to obtain information on violence, other than those provided by SINAN, are rarely mentioned by hospital care services. Likewise, support for improving the quality of information provided by rehabilitation services in the private sector is rarely mentioned (Table 2).

In general, primary care services implement actions related to the agreement of flows and dissemination of information in municipalities and capitals the most (Table 3). The actions are widespread, and the agreement of intrasectoral flow is evident at all care levels in the regions (above 73.7%), except for large municipalities in the South region (50.0%). In the North and Northeast Regions, the analysis and dissemination of SINAN data are the most cited actions; the agreement on an inter and intra-sector flow is the most relevant in the Southeast Region; and the agreement on an intra-sector flow stands out in the South and Midwest Regions (data not shown).

The intersectoral and intrasectoral flows agreed upon with the protection network aggregate information on violence from different services – healthcare, protection, public security, and justice. Online strategies are used to implement the flows, along with meetings, intra and intersectoral forums, and other communication devices in which discussions, training, and agreement on referrals, protocols, and technical notes that guide care and the production of information in the services' reality.

The flow is established in the municipality. The unit notifies and brings it to the Municipal Health Secretariat. With the pandemic, I opened an email so they could send it scanned. Some units are still sending it this way (Respondent from Primary Care in Porto Velho-RO).

We have our clinical practice guide (PAC) and nursing protocols as tools, which were fundamental in turning the key towards improving reporting. The first step of the PAC is to identify emergencies; from there, it directs the algorithm that will lead to the management and flows in the network. Ultimately, it will always say: "Report the case and forward it to such and such flow". Each professional, doctor, and nurse has a PAC, and they are trained. (Respondent from Primary Care in Florianópolis-SC).

SAMU arrives at the scene. It is always reported as an "accident" [...]. Most of the time, the hospital identifies that it was violence, abuse, and not just any accident. This notification is also made at the hospital entrance when SAMU identifies it. We take it to a professional and call the social service staff upon arrival at the hospital (Respondent from Pre-Hospital Care in São Luís-MA).

Use of information

The use of information on violence generated by monitoring is more significant in capital cities. Primary care services stand out in this regard, followed by rehabilitation and hospital services. Data's usefulness for training and adapting teams of professionals are the purposes most cited by respondents (Table 4). Publicizing information through bulletins, portals, and public domain platforms becomes essential in building visibility on the issue of violence by showing its magnitude and different expressions. However, several reports state that data is not used to produce bulletins, pointing to underutilized information for improving practices and scientific dissemination:

If I don't expose this data, I can't implement or pressure my manager for any resources or assistance for my actions. I tell the teams: "How am I going to go to my Secretary and say, 'We need support, we need these professionals, we need to qualify them". When I look, the production of data on services is deficient. They are not reporting. It's a challenge! (Respondent from Primary Care in Carauari-AM).

Table 2. Frequency of implementation of violence surveillance actions by Primary care, Hospital, and Rehabilitation in municipalities and capitals. Brazil, 2021.

Primary Care								
Monitoring actions	Municipalities				Capitals			
	Once or more times a year (%)	Every two years or more (%)	Never (%)	N Total	Once or more times a year (%)	Every two years or more (%)	Never (%)	N Total
Support for improving the quality of information in the Public Network	76.2	11.5	12.2	286	88.9	5.6	5.6	18
Support for improving the quality of information in the Private Network	50.2	10.8	39.0	287	55.6	11.1	33.3	18
Creation of records/files (different from SINAN) by the municipality to obtain information on violence	33.3	7.4	59.3	285	16.7	11.1	72.2	18
Establishment of standardized epidemiological surveillance actions for cases of morbimortality due to violence, including determining risk factors	58.8	9.2	32.0	284	76.5	11.8	11.8	17
Use of records from the Integrated Emergency Trauma Care Service (Siate), Mobile Emergency Care Service (Samu), Fire Department, and Police	41.8	5.3	53.0	285	72.2	0.0	27.8	18
Use of records from Toxicology Services/Centers	28.5	4.6	66.9	281	27.8	0.0	72.2	18
Hospital Care								
Monitoring actions	Municipalities				Capitals			
	Once or more times a year (%)	Every two years or more (%)	Never (%)	N Total	Once or more times a year (%)	Every two years or more (%)	Never (%)	N Total
Support for improving the quality of information in the Public Network	59.1	10.9	30.0	110	75.0	12.5	12.5	8
Support for improving the quality of information in the Private Network	45.9	8.1	45.9	111	62.5	12.5	25.0	8
Implementation of Ordinance GM/MS nº142/97, which determines the specification of the type of external cause in the AIH	52.7	8.2	39.1	110	57.1	14.3	28.6	7
Creation of records/files (different from SINAN) by the municipality to obtain information on violence	41.3	5.5	53.2	109	37.5	12.5	50.0	8
Establishment of standardized epidemiological surveillance actions for cases of morbimortality due to violence, including determining risk factors	52.8	12.0	35.2	108	62.5	25.0	12.5	8
Use of records from the Integrated Emergency Trauma Care Service (Siate), Mobile Emergency Care Service (SAMU), Fire Department, and Police for monitoring violence	46.4	8.2	45.5	110	62.5	12.5	25.0	8
Use of records from Toxicology Services/Centers for monitoring violence by hospital care	30.0	5.5	64.5	110	62.5	0.0	37.5	8

it continues

Table 2. Frequency of implementation of violence surveillance actions by Primary care, Hospital, and Rehabilitation in municipalities and capitals. Brazil, 2021.

Monitoring actions	Rehabilitation Care							
	Municipalities				Capitals			
	Once or more times a year (%)	Every two years or more (%)	Never (%)	N Total	Once or more times a year (%)	Every two years or more (%)	Never (%)	N Total
Support for improving the quality of information in the Public Healthcare Network	55.7	8.5	35.8	106	57.1	14.3	28.6	7
Support for improving the quality of information in the Private Healthcare Network	39.6	8.5	51.9	106	42.9	14.3	42.9	7
Implementation of Ordinance GM/MS nº142/1997, which determines the specification of the type of external cause in the AIH	46.5	6.9	46.5	101	57.1	14.3	28.6	7
Creation of records/forms (different from SINAN) by the municipality to obtain information on accidents and violence	42.9	9.5	47.6	105	57.1	0.0	42.9	7
Establishment of standardized epidemiological surveillance actions for cases of morbimortality due to accidents and violence, including determining risk factors	48.5	9.7	41.7	103	57.1	28.6	14.3	7
Conducting data analyzes on accidents and violence in Recovery/Rehabilitation units	45.2	12.5	42.3	104	57.1	14.3	28.6	7

Source: Authors.

Table 3. Percentage distribution of implementation of actions related to reporting violence to SINAN-Net by Primary care, in participating municipalities and capitals. Brazil, 2021.

Actions	Primary care			Hospital care			Rehabilitation care		
	Yes (%)	No (%)	N	Yes (%)	No (%)	N	Yes (%)	No (%)	N
Municipalities									
Agreed on an intra-sectoral flow for notification	78.8	21.2	288	55.6	44.4	108	68.5	31.5	73
Agreed on an intersectoral flow with the protection network	73.2	26.8	287	55.0	45.0	109	65.8	34.2	73
Performed analysis and dissemination of data	60.3	39.7	287	50.9	49.1	108	67.1	32.9	73
Capitals									
Agreed on an intra-sectoral flow for notification	94.4	5.6	18	85.7	14.3	7	83.3	16.7	6
Agreed on an intersectoral flow with the protection network	83.3	16.7	18	85.7	14.3	7	66.7	33.3	6
Performed analysis and dissemination of data	100.0	0.0	17	85.7	14.3	7	83.3	16.7	6

Source: Authors.

In recovery/rehabilitation services, the registration of cases according to ICD-10 is the most cited (87.6% in municipalities and 83.3% in capitals), followed by analyses for planning actions (53.6% and 83.3%, respectively), systematic analysis of records (44.8% and 50.0%) and training of personnel for recording and systematizing information (44.2% and 50.0%).

Regional specificities show health services' diverse strategies to improve notifications and monitoring. For example, Palmas-TO created its system (*Notifica SUS*), intended for reporting accidents and violence, which was expanded to other institutions. Recife/PE received an award for its investment in the notification of suicide attempts, cross-referencing data with exogenous poisonings, and encouraging the recording of the ethnicity/skin color item. The state of Espírito Santo improved reporting and monitoring after implementing the care line, with actions to raise awareness about the importance of reporting in the state, especially in urgent/emergency care, the Mobile Emergency Care Service (SAMU), Primary Care, and others. Establishing and implementing a state law called the "Care Law" (No. 11,147/2020 linked to Ordinance No. 204) escalated reporting of violence cases by the health, education, and social assistance sectors, encouraging the guardianship council to be the reporting institution. The Health Secretariat of Porto Alegre-RS has developed a mobile application for use by education professionals to increase the scope of notifications involving students. Data are processed by epidemiological surveillance, which enters them in the SINAN, and the service network is mobilized to monitor cases. In Mato Grosso/MT, despite the progress made in reporting violence in the state, many places have low record numbers, and in-person monitoring is conducted in the municipalities quarterly to make the work more effective.

Table 5 indicates the low implementation level (29.4% to 38.2%, depending on the care level) of ongoing training activities for monitoring violence cases in municipalities. These values are much higher in the capitals, ranging from 58.8% to 83.3%. Brazilian regions show different trends, with slightly lower percentages in some actions in the North and Midwest regions. Most municipalities, especially the capitals, conduct training activities for monitoring accident and violence cases in hospital care and rehabilitation at least once a year (Table 5). Throughout the country, professional training has generally focused on monitoring and reporting violence cases, even in the private sector. Notably, one excuse for not providing complete details of cases on the reporting forms is the time spent filling them out, which is added to the intense work pace required of professionals.

Some managers emphasized that it is necessary to demystify the idea that reporting is just "another piece of paper" or a merely bureaucratic action. Therefore, addressing more sensitive issues such as homophobia, racism, and attention to Indigenous peoples has required training actions focused on the sociocultural issues of violence that reach services:

Table 4. Percentage distribution of purposes for using data generated in the monitoring of accidents and violence by primary care in participating municipalities and capitals. Brazil, 2021.

Data use	Primary care			Hospital care			Rehabilitation care		
	Yes (%)	No (%)	N	Yes (%)	No (%)	N	Yes (%)	No (%)	N
Municipalities									
For the production of bulletins	49.0	51.0	286	42.3	57.7	111	56.6	43.4	106
In formative moments	63.6	36.4	286	40.4	59.6	109	54.3	45.7	105
To adapt the service infrastructure	60.2	39.8	284	49.5	50.5	109	59.8	40.2	107
To adapt professional teams	69.4	30.6	284	56.4	43.6	110	68.2	31.8	107
Capitals									
For the production of bulletins	77.8	22.2	18	71.4	28.6	7	100.0	0.0	7
In formative moments	94.4	5.6	18	83.3	16.7	6	85.7	14.3	7
To adapt the service infrastructure	61.1	38.9	18	57.1	42.9	7	57.1	42.9	7
To adapt professional teams	72.2	27.8	18	71.4	28.6	7	85.7	14.3	7

Source: Authors.

We always discuss ethnicity/skin color with municipalities as an essential indicator. The ethnicity/skin color field brings several analyses of social inequalities to build public policies for the most vulnerable (Respondent from the State Center for the Prevention of Accidents and Violence of Paraíba).

Resorting to remote media was a powerful strategy for training professionals. These actions have been occurring systematically, and their need is guided by monitoring, which indicates low reporting, gaps, and recurring errors in completing the form. In hospitals, these activities must involve a more restricted time due to the professionals' shift schedule, especially in emergency and urgent care, and the difficulty in removing them from the workplace. The need for training in different professional positions, such as social workers, doctors, nurses and nursing technicians, is also reported. The high turnover of professionals and the change in management reinforce the need for constant ongoing training in the five regions, especially in primary and hospital care services:

On-site updating work – in urgent and emergency care – works best. Regarding holding seminars and training sessions, we often can't get professionals out of the service to participate. I talk to the coordinator beforehand to schedule a time that allows me to have more professionals. Usually, one shift is not enough, if possible, until the evening. We always emphasize the importance of having a social worker, a nurse, and a nursing technician because an individual in a situation of violence can end up in any of these professional categories (Respondent from Pre-hospital and Hospital Care in Aracaju-SE).

Recommendations to managers

Among the points of desire for improving monitoring/notification highlighted by managers interviewed in the country are: (1) Integration between information systems with the implementation of the National Health Data Network, whose objective is to access and integrate information from the user; (2) Feedback of information in care and surveillance, which produces an alert in a situation of violence; (3) Improvement of the fields of self-inflicted violence, enabling the recording of suicidal ideas, so that the case can be included in the local care line; and (4) Electronic medical records for coordination in the network, with communication between morbidity and mortality systems and integration between health and work information systems. Completing different specific forms generates repeated information and an overload for health professionals, which perpetuates the difficulty of recording and the quality of information:

We are making adjustments from a surveillance perspective, for example, "suicidal ideas", which is not an event eligible for entry in the SINAN database but is a situation that requires surveillance and referral, monitoring by the network, and monitoring by primary care. We will not wait for the event to trigger surveillance and protection actions. We advise professionals so that they do not miss the opportunity since they are there with the patient who reported suicidal ideas. This information follows the entire care line process but is not entered in the SINAN (Campo Grande-MS Respondent).

Furthermore, monitoring actions proposed, monitored, and evaluated by federal management is highly valued and gives more consistency to the process. The lack of the Ministry of Health's support in proposing, coordinating, and conducting actions planned by the PNRMAV for 2019-2022 was highlighted throughout the research. Many respondents mentioned the impact of the lack of more proactive action at the central level focused on the continuing implementation of the policy.

Discussion

The findings show strategic data on violence surveillance at different care levels, which can support actions to address violence from an intersectoral perspective based on the right to health and life. In general, monitoring violence varies in the country. Some of the principal results are: (1) The marked presence of violence notifications in SINAN, especially by hospitals, which can be explained by their being references in the treatment of trauma whose injuries often conceal violence; (2) Underreporting, especially in primary care, justified by the circumstances of living in areas dominated by factions and with a high turnover of professionals. Turnover hinders training continuity and education update to understand violence; (3) Surveillance of violence's impact on health has not been consolidated to date; it occurs more through individual initiative instead of collectively planned actions; (4) Primary care services stand out for their agreement on flows and dissemination of information; and (5) Few and insufficient ongoing training actions for monitoring cases of vi-

Table 5. Frequency of continuing education actions for monitoring and reporting cases of violence in primary, hospitals, and rehabilitation care in participating cities and capitals. Brazil, 2021.

Conducting ongoing education/training actions to monitor cases of violence	Yes (%)	No (%)	N
Set of Municipalities			
Primary care management implemented actions	38.2	61.8	272
Hospital care management implemented actions	29.4	70.6	102
Rehabilitation care management implemented actions	33.3	66.7	96
Capitals			
Primary care management implemented actions	58.8	41.2	272
Hospital care management implemented actions	83.3	16.7	102
Rehabilitation care management implemented actions	83.3	16.7	96

Frequency of continuing education actions to monitor cases of violence	Every 5 years or more (%)	Every 2 to 4 years (%)	At least once a year (%)	Never (%)	N
Participant municipalities					
Raising awareness among hospital care healthcare professionals about the importance of monitoring - recording and systematization	-	3.3	96.7	-	30
Raising awareness among rehabilitation care professionals about the importance of monitoring - recording and systematization	-	6.5	93.5	-	31
Training of hospital care health professionals for registration and systematization	-	6.7	93.3	-	30
Training of rehabilitation care health professionals for registration and systematization	3.2	3.2	93.5		31
Improving the quality of information in hospital care for epidemiological surveillance	-	6.7	93.3	-	30
Improving the quality of information in rehabilitation care for epidemiological surveillance	-	6.5	93.5	-	31
Capitals					
Raising awareness among hospital care healthcare professionals about the importance of monitoring - recording and systematization	-	-	100.0	-	5
Raising awareness among rehabilitation care professionals about the importance of monitoring - recording and systematization	-	-	100.0	-	5
Training of hospital care health professionals for registration and systematization	-	20.0	80.0	-	5
Training of rehabilitation care health professionals for registration and systematization	20.0	-	80.0	-	5
Improving the quality of information in hospital care for epidemiological surveillance	-	20.0	80.0	-	5
Improving the quality of information in rehabilitation care for epidemiological surveillance	-	20.0	80.0	-	5

Source: Authors.

olence in municipalities, at all levels of services in the public and private networks. However, there has been an improvement in the quality of information on violent injuries and traumas, which shows that efforts to improve surveillance need to continue and become more universal.

In comparison with the diagnostic analysis of the first years of implementation of the PNRMAV by Minayo and Deslandes in 2005[21], many problems regarding monitoring and notifica-

tion actions persist, although progress has been achieved, with moments of pauses and setbacks. Since then, there has been significant growth in the production, strengthening, and qualification of national information systems on violence, primarily driven by activities developed by local Epidemiological Surveillance, technical areas of Noncommunicable Diseases and Injuries, and the Violence Prevention Centers established by the Ministry of Health. Sensitization and training of teams focused on violence prevention promoted by the federal government throughout the national territory promoted a significant awareness movement over a very long period (from 2006 to 2017) and called upon services to recognize the importance of diagnosing, monitoring, and reporting the impacts of violence on health.

However, the lack of clear standards on technical procedures, the weak structure and organization of services, the lack of credibility in the protection network, the fear of legal procedures that could result in blaming health professionals, fear of reprisals by criminal groups, the lack of legal protection mechanisms for professionals responsible for reporting, and the fear of being sued for breach of professional secrecy were the points most cited as obstacles to reporting[24-31].

The epidemiological indicators provided by the notifications cannot be perceived only as statistical data, and their destination needs to be visible. Cezar *et al.*[28] emphasize the need to debate the information through well-founded discussions about the social context and other relationships that permeate situations of violence[32]. Management at municipal, state, and federal levels should use data to plan public policies and interventions consistent with their local particularities[33]. Low compliance with reporting or uncoordinated data causes deficits in the quality of information and contributes to the invisibility of the problem by the managers.

We should underscore that, for more than two decades of PNRMAV, the leadership of competent and committed technicians from the Ministry of Health has been a crucial factor in the continuous development of policy implementation nationally. Thus, we reiterate the persistent challenge of keeping the entire body of health workers aware and trained to delve deeper into the situation of violence harmful to health, especially because this topic crosses social, historical, political, economic, and cultural issues and is on the path that leads the country to respect the rights of all Brazilians. It is necessary to: (1) Invest in training surveillance professionals to adapt to the specificities of each care level and the work routine; (2) Create monitoring indicators appropriate to each context; (3) Pay attention to smaller municipalities, considering local singularities and (4) Integrate existing information, focusing on SUS users.

This study's most significant limitation is that it does not respond to a national reality. The initial goal was to obtain information from all municipalities, which was overshadowed by the emergence of COVID-19. The authors worked with the information they obtained within a climate of fear, tension, and work overload for professionals and managers during the pandemic. However, the essentially descriptive results show an unprecedented profile of the notifications from 379 SUS services regarding the notification of the impact of violence on the health of Brazilians and all the persistent flaws and deficiencies in this construction. We must keep the wheels turning!

Collaborations

JQ Avanci participated in the conception of the study, planning, design, interpretation of statistical analyzes and results, writing of the first version of the article, critical review of the article. QBM Oliveira participated in the qualitative analysis and writing of the results. SG Assis participated in the study design, analysis and interpretation of results, and critical review of the article.

References

1. World Health Organization (WHO). *World Report on Violence and Health*. Geneva: WHO; 2002.
2. World Health Organization (WHO). *Preventing violence: a guide to implementing the recommendations of the World Report on Violence and Health*. Geneva: WHO; 2004.
3. World Health Organization (WHO). *Violence Prevention Alliance. Global Campaign for Violence Prevention: Plan of Action for 2012-2020*. Geneva: WHO; 2012.
4. World Health Organization (WHO). *Draft global plan of action on violence. Report by the Director-General* (Internet). Sixty-Ninth World Health Assembly; 2016 [cited 2023 jun 10]. Available from: http://www.paho.org/hq/index.php?option=com_content&view=article&id=10249%3Apolicies-plans-violence-prevention-response&catid=7476%3Apillars&Itemid=41343&lang=fr.
5. Brasil. Portaria MS/GM nº 1.968, de 25 de outubro de 2001. Dispõe sobre a notificação, às autoridades-competentes, de casos de suspeita ou de confirmação de-maus-tratos contra-crianças e adolescentes atendidos nas entidades do Sistema Unido de Saúde. *Diário Oficial da União* 2001; 26 out.
6. Brasil. Ministério da Saúde (MS). Secretaria de Assistência à Saúde. *Notificação de maus-tratos contra crianças e adolescentes pelos profissionais de saúde: um passo a mais para cidadania em saúde*. Brasília: MS; 2002.
7. Brasil. Ministério da Saúde (MS). Secretaria de Vigilância em Saúde. Departamento de Vigilância de Doenças e Agravos Não Transmissíveis e Promoção da Saúde. *Viva: instrutivo notificação de violência interpessoal e autoprovocada*. 2ª ed. Brasília: MS; 2016.
8. Brasil. Ministério da Saúde (MS). *Portaria GM/MS nº 737, de 16 de maio de 2001. Política Nacional de Redução de Morbimortalidade por Acidentes e Violência (PNRMAV). Diário Oficial da União*; 2001.
9. Pan American Health Organization (PAHO). 48th Directing Council. 60th Session of the Regional Committee. *Preventing violence and injuries and promoting safety: a call for action in the region* [Internet]. Washington D.C.; 29 set-3 out 2008 [cited 2023 jun 10]. Available from: http://www1.paho.org/english/gov/cd/cd48-20-e.pdf?ua=1.
10. Pan American Health Organization (PAHO). WHO Regional Office for the Americas. *Addressing violence and injuries in the Americas. Taking stocking and moving forward*. Geneva: PAHO; 2017.
11. United Nations Office on Drugs and Crime. *Global study on homicide 2021: trends, context, data*. Vienna: United Nations; 2021.
12. UNICEF. *The State of the World's Children 2020: Children, COVID-19 and Remote Learning*. New York: UNICEF; 2020.
13. World Health Organization (WHO). *Violence against women [Internet]*. [cited 2024 set 10]. Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women.
14. Minayo MCDS, Souza ERD, Silva MMAD, Assis SG. Institucionalização do tema da violência no SUS: avanços e desafios. *Cien Saude Colet* 2016; 23(6):2007-2016.
15. Brasil. Lei nº 8.069, de 13 de julho de 1990. Dispõe sobre o Estatuto da Criança e do Adolescente e das outras providencias. *Diário Oficial da União*; 1990.
16. Brasil. Lei nº 10.778, de 24 de novembro de 2003. Estabelece a notificação compulsória, no território nacional, do caso de violência contra a mulher que for atendida em serviços de saúde públicos ou privados. *Diário Oficial da União* 2003; 25 nov.
17. Brasil. Lei nº 11.340, de 7 de agosto de 2006. Cria mecanismos para coibir a violência doméstica e familiar contra a mulher, nos termos do § 8 o do art. 226 da Constituição Federal, da Convenção sobre a Eliminação de Todas as Formas de Discriminação contra as Mulheres e da Convenção Interamericana para Prevenir, Punir e Erradicar a Violência contra a Mulher; dispõe sobre a criação dos Juizados de Violência Doméstica e Familiar contra a Mulher; altera o Código de Processo Penal, o Código Penal e a Lei de Execução Penal; e dá outras providências. *Diário Oficial da União*; 2006.
18. Brasil. Lei nº 10.741, de 1 de outubro de 2003. Dispõe sobre o Estatuto do Idoso e dá outras providencias. *Diário Oficial da União* 2003; 3 out.
19. Brasil. Lei nº 13.146, de 6 de julho de 2016. Institui a Lei Brasileira de Inclusão da Pessoa com Deficiência (Estatuto da Pessoa com Deficiência). *Diário Oficial da União* 2016; 7 jul.
20. Minayo MCS, Assis SG, Souza ER. *Avaliação por triangulação de métodos*. *Abordagem de Programas Sociais*. Rio de Janeiro: Fiocruz; 2005.
21. Minayo MCS, Deslandes SF, organizadores. *Análise diagnóstica da política nacional de saúde para redução de acidentes e violências*. Rio de Janeiro: Editora Fiocruz; 2007.
22. IBM Corp. *IBM SPSS Statistics for Windows*, Version 24.0. Armonk, NY: IBM Corp; Released 2016.
23. Bardin L. *Análise de Conteúdo*. Lisboa: Edições 70; 2007.
24. Silva MMA, Mascarenhas MDM, Lima CM, Malta DC, Monteiro RA, Freitas MG, Melo ACM, Bahia CA, Bernal RTI. Perfil do Inquérito de Violências e Acidentes em Serviços Sentinela de Urgência e Emergência. *Epidemiol Serv Saude* 2016; 26(1):183-194.
25. Egry EY, Apostólico MR, Morais TCP, Lisboa CCR. Enfrentar a violência infantil na Atenção Básica: como os profissionais percebem? *Rev Bras Enferm* 2017; 70:119-125.
26. Saliba O, Garbin CAS, Garbin AJI, Dossi AP1. Responsabilidade do profissional de saúde sobre a notificação de casos de violência doméstica. *Rev Saude Publica* 2007; 41:472-477.
27. Lobato G, Moraes C, Nascimento M. Desafios da atenção à violência doméstica contra crianças e adolescentes no Programa Saúde da Família em cidade de médio porte do Estado do Rio de Janeiro, Brasil. *Cad Saude Publica* 2012; 28(9):1749-1758.
28. Cezar PK, Arpini DM, Goetz ER. Registros de notificação compulsória de violência envolvendo crianças e adolescentes. *Psicol Cien Prof* 2017; 37:432-445.

29. Njaine K, Assis SG, Constantino P, Avanci JQ. *Impactos da Violência na Saúde*. 4ª ed. Rio de Janeiro: Coordenação de Desenvolvimento Educacional e Educação a Distância da Escola Nacional de Saúde Pública Sergio Arouca, ENSP, Editora FIOCRUZ; 2020.
30. Garbin CAS, Dias IDA, Rovida TAS, Garbin AJÍ. Desafios do profissional de saúde na notificação da violência: obrigatoriedade, efetivação e encaminhamento. *Cien Saude Colet* 2015; 20(6):1879-1890.
31. Kind L, Orsini MDLP, Nepomuceno V, Gonçalves L, Souza GAD, Ferreira MFF. Subnotificação e (in) visibilidade da violência contra mulheres na Atenção Primária à saúde. *Cad Saude Publica* 2013; 29:1805-1815.
32. Galvão VABM, Dimenstein M. O protocolo de notificação da violência: entre o risco e a vulnerabilidade. *Mental* 2009; 7(13):1-12.
33. Deslandes S, Mendes CHF, Lima JDS, Campos DDS. Indicadores das ações municipais para a notificação e o registro de casos de violência intrafamiliar e exploração sexual de crianças e adolescentes. *Cad Saude Publica* 2011; 27:1633-1645.

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