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Institutionalizing the theme of violence within Brazil's national health system: progress and challenges

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Abstract *This article reflects on the evolution of the theme of violence within the field of public health. It provides an overview of the strategies and actions developed within Brazil's Unified Health System developed in response to the country's main guiding policy on violence, the National Policy for the Reduction of Morbidity and Mortality due to Accidents and Violence, drawing on baseline documents, national and international research, data from the country's main violence information systems, and the firsthand experiences of the authors from their participation in the abovementioned actions. Violence against children and adolescents, women, and older persons have assumed a prominent position on the health agenda, while other forms of violence, such as child labor, human trafficking, homophobic and racial violence, and violence against street dwellers and people with disabilities, who are deprived of their liberty, are gradually finding their way onto the agenda. Despite undeniable progress in institutionalizing the theme, there is a need for greater investment in various areas including out-of-hospital emergency, rehabilitation, and mental health services. It is also necessary to incorporate the theme into the training and development of all of healthcare professionals and intensify continuing training to enhance capacity for detecting and reporting violence and delivering adequate care to victims.*

Key words *Violence, Health policy, Morbidity, Mortality*

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Introduction

This article reflects upon the incorporation of the theme of violence into the field of public health. To do so it provides an overview of the strategies and actions developed within Brazil's Unified Health System (*Sistema Único de Saúde* – SUS), drawing on the country's main guiding policy on violence, the National Policy for the Reduction of Morbidity and Mortality due to Accidents and Violence (*Política Nacional de Redução da Morbimortalidade por Acidentes e Violências* - PNRMAV)[1].

We trace the evolution of the theme within the health agenda in Brazil stemming from the homologation of the PNRMAV[1] and public debate surrounding specific vulnerable groups and topics. We then go on to discuss the actions developed in response to the guidelines set out in this policy, demonstrating the progress made in each area and limitations in the 16 years since it came into force. The narrative draws on baseline documents, national and international research, data from the country's main violence information systems, and the firsthand experiences of the authors from their participation in the abovementioned actions. Finally, we present some considerations regarding progress and limitations in light of the current economic, political and social crisis that plagues the SUS.

Bringing the theme of violence into the field of public health

Violence affects both individual and collective health, causing death, injury, and physical and mental traumas. It also decreases the quality of life of individuals and the community and creates an increased burden on healthcare services, revealing the need for an interdisciplinary, multiprofessional, intersectoral, and socially-engaged approach to treatment and prevention. However, the emergence of this theme in health care practice and research is recent.

Violence was officially placed on the health agenda in Brazil in 2001, with the promulgation of the PNRMAV[1], 13 years after the creation of the SUS and five years after the World Health Organization (WHO) made the issue a public health priority at the Forty-ninth World Health Assembly in 1996[2]. Both the domestic and international agendas were preceded by a vast body of accumulated knowledge in the area, both in Brazil[3] and the rest of the world[4].

The core themes of Brazil's progressive agenda were: violence against children and adolescents; gender-based violence; violence against older people; road traffic violence; workplace violence, and, more recently, ethnic violence, violence against people with disabilities, and violence against LGBT people.

Violence against children and adolescents was placed on the agenda through the hands of pediatricians, psychiatrists, social workers and other health professionals that deal with this age group. This group of actors, following in the footsteps of Kempe et al.[5], drew attention to the effects of violence on children's growth and development and physical and mental health, highlighting that it can often bring about suicidal behavior[6,7]. In Brazil, the Regional Child Abuse Cares Centers (*Centros Regionais de Atenção aos Maus Tratos na Infância* - CRAMI) in São Paulo, Brazilian Multiprofessional Association for the Protection of Children and Adolescents (*Associação Brasileira Multiprofissional para Proteção das Crianças e Adolescentes* - ABRAPIA) in Rio de Janeiro, and Brazilian Association for the Prevention of Child Abuse and Neglect (*Associação Brasileira de Prevenção de Abusos e Negligências na Infância* - ABNAPI) in Minas Gerais were pioneers in conducting research, developing activities, and supporting the formulation of social policies. This group of organizations and professionals engaged in child protection played a central role in building Brazil's Child and Adolescent Statute[8]. The prevention of child violence has drawn the interest of researchers and activists alike over the last 40 years[9]. Led by health professionals and social movements, primary and secondary prevention programs and interventions began to find a place on the agenda of public and private institutions and nongovernmental organizations. The initiatives developed in Brazil have always been in tune with the international movement.

The following pieces of legislation may be considered central pillars of the legal framework for the protection of children and adolescents: Law Nº 12.015/2009, which deals with heinous crimes and abuse of children and adolescents, defining rape and sex crimes against the vulnerable; Law Nº 13.010/2014 (the "Bernardo Boy Law"), which establishes that children and adolescents have the right to be educated and taken care of without the use of physical punishment and other cruel or degrading treatment. It is also important to highlight the Line of Care for Comprehensive Healthcare for Children, Adolescents and their Families in Situations of Violence (*Linha de Cuidado para a Atenção Integral à Saúde de Crianças, Adolescentes e suas Famílias em Situação*

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de Violência)[10], which provides guidelines for the effective provision of continuous comprehensive healthcare for children, adolescents and their families in situations of violence.

The second core theme is gender-based violence, which appears in the Comprehensive Women's Healthcare Program (*Programa de Assistência Integral à Saúde da Mulher* - PAISM) created in 1983. This initiative incorporated women's rights to sexual and reproductive health and emphasized the problem of gender violence, following the trends within the feminist movement[11]. This them can also be observed in various documents produced by the WHO[2,12]. In 2004, the PAISM was transformed into the National Policy for Comprehensive Women's Healthcare[13], which prioritizes caring for women and adolescents exposed to violence. Significant advances have been made in legislation, including: the promulgation of the Maria da Penha Law[14], a political milestone marking a paradigm shift in tackling gender-based violence; the law that provides for mandatory reporting of gender-based violence in sentinel services[15]; the decree that establishes guidelines for the provision of mandatory humanized care for victims of sexual violence by public security professionals[16]; and the Femicide Law[17], which treats this type of homicide as a heinous crime, among various other plans and programs that followed.

With respect to violence against older people, Brazil's Statute for the Elderly, which has the force of law, was promulgated in 2003[18]. Old persons' movements, care professionals and calls made by international movements played an essential role in its creation. The National Elderly Health Policy came into force in 2006[19], creating norms for the prevention of violence against older persons in hospitals, clinics, and long term care facilities.

This theme emerged in the international arena in 1975[20], gradually being incorporated into research and government agendas. A particularly important player in this area is the *International Network for the Prevention of Elder Abuse*[21]. Created in 1997, it promotes advocacy, research and policy development. An important milestone at the international level was the Madrid Declaration, in which the prevention of violence against older persons is treated as a priority by the UN. In Brazil, the reporting of violence against older persons became mandatory with the creation of the Statute for the Elderly[18].

National Policy for the Reduction of Morbidity and Mortality due to Accidents and Violence

Health professionals from various areas with experience of treating the effects of violence in urgency, emergency and rehabilitation, and support services, supported by social movements and academic knowledge accumulated in the country since 1970[3], played an essential role in the formulation of the PNRMAV[1], which came into force in 2001.

Soon after, the Ministry of Health created a technical area to oversee the implementation of the policy whose first initiative was a road traffic accidents and deaths prevention program. At the time, the main focus was the provision of emergency assistance to victims of accidents and violence, with the creation of the National Policy on Emergency Care and the Mobile Emergency Care Service (*Política Nacional de Atenção às Urgências e o Serviço de Atendimento Móvel de Urgência* - SAMU)[22].

Various measures followed designed to improve the reporting of deaths and injuries, including the introduction of standardized technical guidelines for diagnosing traumas and injuries, the classification of events, and the general reporting of cases involving children, adolescents and women, people with disabilities, mental health problems, the elderly, and others.

In 2003, with the creation of the Office for the General Coordination Noncommunicable Diseases (*Coordenação Geral de Doenças e Agravos não Transmissíveis* - CGDANT) within the Ministry of Health, the focus of actions to tackle the various expressions of violence turned more towards surveillance and prevention.

The following section complements this brief overview of the history of the incorporation of the theme of violence into the field of public health by highlighting some of the main actions undertaken in response to the guidelines set out in the policy.

• *Promotion of the adoption of safe and healthy behaviors and environments*

In 2004, the National Violence Prevention and Health Promotion Network and Violence Prevention and Health Promotion Centers (Brasil, 2004) were created, encompassing states and municipalities. The implementation of this system was most intense between 2005 and 2006, after the promulgation of the National Health Promotion Policy[23]. In this period, the Ministry of Health also created a group of 15 Academic

Centers chosen to be Collaborative Centers. The above network came to cover 1,300 municipalities and was funded by the Ministry of Health between 2006 and 2012.

The WHO's World Report on Road Traffic Injury Prevention[24], published annually since 2004, has drawn attention to the epidemic of road traffic injuries and deaths in developing countries, the overwhelming majority of which involve motorcyclists, cyclists and pedestrians. In 2009, at the first global conference on the theme held in Moscow, the UN declared 2011 to 2020 the "Decade of Action for Traffic Safety". Brazil and other countries participated and made commitments. The second global conference was held in Brasília in 2015, showing that the majority of countries had failed to meet the targets set at the first conference[25].

In line with WHO recommendations, Brazil developed the *Programa Vida no Trânsito* (life in the traffic program) in five state capitals, with the support of a group of national and international governmental and nongovernmental organizations coordinated by the Ministry of Health. The program was aimed at reducing accidents and addressing risk factors such as speeding and the use of safety equipment. The results produced by the program included improvements in the quality of data on road traffic accidents[26].

- *Monitoring the occurrence of accidents and violence*

In 2005, the Ministry of Health incorporated the Violence and Accident Surveillance System (VIVA, acronym in Portuguese) into sentinel services throughout the country. Created in 2006, the Sentinel Services Violence and Accident Surveillance Network (*Rede de Serviços Sentinela de Violências e Acidentes*) aims to analyze trends in violence and accidents based on out-of-hospital emergency care and propose prevention and promotion actions in coordination between surveillance and the care and protection network. VIVA has two components: periodic surveys (*VIVA Inquérito*) and the notification of violence (*VIVA Contínuo*). In 2011, the notification of violence became mandatory across all of the country's health services and the system became known simply as Violence and Accident Surveillance (*Vigilância de Violências e Acidentes* – VIVA)[27].

Five VIVA Surveys were conducted (in 2006, 2007, 2009, 2011, and 2014). In 2009, *VIVA Contínuo* was incorporated into the Notifiable Diseases Information System (SINAN, acronym in Portuguese), becoming know as VIVA/SINAN NET. The scope of mandatory reporting of violence was widened to account for situations that were not foreseen by the legislation that require individual intervention and follow-up of cases, as in the case of human trafficking, slave labor, child labor, torture, the effects of legal intervention, and indigenous peoples, among others[27].

The investment in VIVA Sinan Net obtained results in the data shown in Table 1. Between 2009 and 2014, the number of notifying municipalities increased by 370% and the total number of notifications of domestic, sexual and/or other forms of violence increased by 343%. Similar findings were reported by Ribeiro et al.[28]. These findings show that a growing number of municipalities are adhering to VIVA, contributing towards greater visibility of forms of violence that previously went unreported and unmonitored. Another benefit of accurately detecting and reporting the signs and symptoms of violence is that it helps ensure that the victim receives adequate health care in primary care services.

The top five states in the ranking of the number of cases of domestic, sexual, and/or other forms of violence notified during the period were São Paulo, Minas Gerais, Rio Grande do Sul, Paraná, and Rio de Janeiro, while the bottom five were Acre, Roraima, Amapá, Rondônia, and Sergipe.

The most frequently registered forms of violence between 2009 and 2014 were physical, psychological/moral, and sexual violence. Besides these forms, the frequency of self-inflicted injury, neglect/abandonment, and other forms was also consistently high (Table 2).

Women accounted for the largest number of cases across all forms of violence except child labor. The disparity between the victimization of men and women was most striking in the categories sexual violence psychological/moral violence, where victimization was 6.5 and five times greater, respectively, among women. Major disparities can also be observed with respect to torture and financial/economic abuse, where victimization was around 4 times greater in both categories.

With respect to hospital morbidity and mortality, important strides have been taken in improving the quality of data. Regarding hospital admissions, improvements have been made in primary and secondary diagnosis registration, which helps identify not only the procedure employed, but also the external cause of the injury. With regard to mortality, measures were taken together with the *Instituto Médico Legal* (the coroner's Office) to improve the registration of the external cause of death and reduce the pro-

Table 1. Number of notifying municipalities and notifications of domestic, sexual, and/or other forms of violence. Brazil, 2009 to 2014.

	2009	2010	2011	2012	2013	2014
Number of notifying municipalities	680	1,362	2,047	2,769	3,262	3,194
Total number of notifications	36,604	66,091	101,403	163,919	189,783	162,276

Source: Ministry of Health - Notifiable Diseases Information System - SINAN NET.

Table 2. Registered cases of domestic, sexual, and/or other forms of violence treated in Brazil's health services by form of violence and sex. 2009 to 2014.

Form of violence	Sex			Total
	Male	Female	Ignored	
Physical	169,120	320,776	72	489,968
Psychological/moral	31,448	154,219	25	185,692
Sexual	13,229	86,763	8	100,000
Self-inflicted injury	32,533	60,870	10	93,413
Neglect/abandonment	42,096	43,374	365	85,835
Other	18,311	35,344	13	53,668
Torture	3,735	15,090	3	18,828
Financial/economic	2,119	9,260	2	11,381
Child labor	1,118	971	-	2,089
Legal intervention	818	1,094	1	1,913
Human trafficking	106	378	-	484

Source: Ministry of Health - Notifiable Diseases Information System - SINAN NET.

portion of deaths where the cause is classified as event of undetermined intent.

Table 3 below shows hospital morbidity and mortality due to external causes in Brazil by sex between 2001 and 2015. A total of 13,161,006 hospital admissions and 2,065,189 deaths due to accidents and violence were registered over this 15-year period, showing that hospital morbidity was 6.4 times greater than mortality. Accidents accounted for 80.2% of hospital admissions due to external causes and 46.2% of deaths due to this group of causes. Self-inflicted injuries accounted for 6.1% of hospitalizations and 44.4% of deaths due to external causes. Men accounted for 70.2% of admissions and 83.1% of deaths across all external causes and the number of deaths due to assault was 11.3 times greater among men.

Although beyond the scope of this article, it is worth mentioning the groups complications of medical and surgical care (Y40-Y84) and sequelae of external causes (Y85-Y89), both of which were shown to be significant causes of mortality and morbidity. Further research on this issue could reveal important issues that need to be addressed to improve the quality of health care.

It is also important to mention events of undetermined intent (Y35-Y36), which is an indicator of the quality of accident and violence data. This group accounts for 5% of admissions and 7.9% of deaths due to external causes in Brazil, indicating adequate clarification as to the accident or violent event that led to admission or death. It is important to mention, however, that these rates vary substantially across regions, revealing that data quality challenges remain.

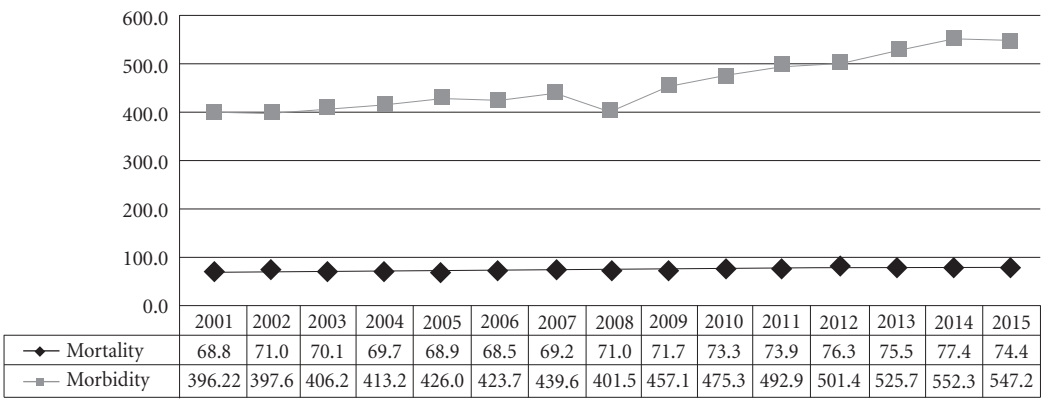
Graph 1 below shows that rates of mortality and morbidity due to external causes in Brazil increased during the period 2001 to 2015. Mortality rates per 100,000 population deaths rose from 68.6 in 2001 to 74.4 in 2015 (with the total number of deaths increasing from 120,954 to 152,136), while morbidity rates, expressed in hospital admissions, showed a significant increase, from 396.2 to 547.2 (with the total number of admissions increasing from 696,866 to 1,118,717). A time-trend analysis performed using R package version 3.4.3 obtained a positive and significant Spearman correlation coefficient throughout the period for morbidity and mortality rates (rho = 0.917 and 0.746, respectively).

Table 3. Hospital morbidity and mortality due to external causes in Brazil by sex between 2001 and 2015.

Group of causes	Hospital morbidity				Mortality			
	Male	Female	M/F	Total	Male	Female	M/F	Total
Accidents	**7,436,124**	**3,156,415**	**2.3**	**10,597,862**	**747,713**	**205,330**	**3.6**	**953,549**
Transport accidents (V01-V99)	1,699,677	500,976	3.4	2,200,654	478,924	106,724	4.5	585,902
Other external causes of accidental injury (W00-X59)	5,736,447	2,655,439	2.2	8,396,908	268,789	98,606	2.7	367,647
Violences	**862,967**	**280,106**	**3.1**	**1,142,995**	**841,207**	**99,297**	**8.5**	**941,525**
Self-inflicted injuries (X60-X84)	85,520	55,345	1.5	140,786	108,926	29,142	3.7	138,086
Assault (X85-Y09)	554,629	113,600	4.9	668,230	714,169	63,352	11.3	778,450
Event of undetermined intent (Y10-Y34)	465,766	174,782	2.7	661,948	124,861	37,771	3.3	163,040
Legal interventions (Y35-Y36)	2,313	930	2.5	3,243	8,338	82	101.7	8,420
Complications of medical and surgical care (Y40-Y84)	281,207	204,719	1.4	485,931	8,455	9,625	0.9	18,175
Sequelae of external causes (Y85-Y89)	214,960	102,515	2.1	317,477	3,815	1,652	2.3	5,469
Total(*)	**9,234,429**	**3,202,170**	**2.9**	**13,161,006**	**1,716,367**	**346,954**	**4.9**	**2,065,189**

Source: DATASUS - Hospital Admissions System (SIH, acronym in Portuguese) and Mortality Information System (SIM, acronym in Portuguese).

(*) In 2014, 4,573 admissions (3,010 men and 1,563 women) were not counted due to supplementary factors related to other causes (Y90-Y98) and 17,832 admissions due to unclassified external causes (S-T), 11,151 of which were men and 6,681 female. In 2015, the numbers not counted for these same reasons were, respectively: 6,132 (4,075 male and 2,057 female) and 4,550 (2,794 male and 1,756 female).



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Mortality	68.8	71.0	70.1	69.7	68.9	68.5	69.2	71.0	71.7	73.3	73.9	76.3	75.5	77.4	74.4
Morbidity	396.22	397.6	406.2	413.2	426.0	423.7	439.6	401.5	457.1	475.3	492.9	501.4	525.7	552.3	547.2

Graph 1. Rates of mortality and morbidity (hospital admission) due to external causes per 100,000 population. Brazil, 2001 to 2015.

Source: DATASUS - Hospital Admissions System (SIH, acronym in Portuguese) and Mortality Information System (SIM, acronym in Portuguese).

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• *Systematization, expansion and consolidation of out-of-hospital emergency care*

Growth in violence since the 1990s has resulted in a corresponding increase in the demand for emergency care, requiring specialized training for the treatment of transport accident victims and firearm projectile injuries, particularly multiple fractures and wounds and injuries to various organs. The PNRMAV confirms that out-of-hospital emergency care is essential for reducing length of hospital stay, sequelae, and deaths. It also states that it is important for improving the registration of violent events and highlights that regulation centers should set uniform operating procedures for emergency assistance.

A literature review addressing health care provision for victims of violence shows that mobile out-of-hospital emergency care in Brazil suffers from deep structural flaws, lack of service coordination, and ineffective counter-referral and that these problems are severely aggravated by the current funding/political crisis faced by the SUS[9].

• *Interdisciplinary and intersectoral care*

Increased violence and accidents in recent years has forced the health sector to develop a new approach to healthcare, involving interdisciplinary teams and the development of health actions and services through networks in coordination with other public sector and civil society organizations that also provide assistance to victims of violence.

This new reality demands a different type of healthcare to that which has been traditionally provided to treat infectious and parasitic diseases, resulting in an urgent need to enhance the capacity of professionals and shelter care facilities for delivering care tailored to the specific needs of children and adolescents, women and older persons suffering violence, particularly domestic abuse. In this respect, the government has invested in capacity building and training of healthcare professionals, as outlined below.

A literature review conducted by Minayo and Assis[9] covering the period 2001to 2013 discovered a large number of studies addressing care for violence victims provided through the Family Health Strategy, outpatient services, and specialist care centers. The authors highlight that the growth of literature on this topic reflects the progress made by the SUS in this area.

Promoting greater intersectoral involvement in the implementation of the PNRMAV remains a major challenge, reflecting the fragmentation of knowledge and practices within the sector.

• *Structuring recovery and rehabilitation services*

Apart from actions developed within the health sector, the Ministry of Health has established various partnerships with other government sectors, through programs addressing road safety issues such as the *Lei Seca* (dry law), and with nongovernmental organizations, through actions directed at reducing and preventing accidents and sequelae caused by these events. Minayo and Assis[9] have highlighted the precarious nature of actions and publications dealing with this theme. Unfortunately, this level of care has shrunk significantly in recent years, following the dismantling and closure of violence recovery and rehabilitation services. The few remaining services have lengthy waiting lists and do not have sufficient capacity to provide adequate care, making it necessary to discharge patients prematurely.

• *Human resource development and capacity-building*

Various studies have highlighted challenges faced by professionals and health services in providing adequate care to victims of violence[28-31].

Nonetheless, a number of partnerships have been established to develop the capacities of health managers and professionals alike. Examples include: the distance learning program developed by the Jorge Careli Department of Violence and Health Studies (CLAVES, acronym in Portuguese), beginning with courses designed to enhance and update knowledge or skills in 2006 and specialist training courses from 2009; the master's program "Health Promotion and Violence Prevention" offered by the Federal University of Minais Gerais; the distance learning program *Vida no Trânsito* (life in the traffic) and a Guide to *Vida no Trânsito* offered by the Federal University of Goiás as from 2015; center assessment conducted by the University of Brasília, CLAVES, and others. Minayo and Assis[9] have presented a number of studies of these kinds of initiatives showing that they have attained significant progress.

• *Research support*

The Ministry of Health has conducted several studies on violence in partnership with other institutions, including the National Cancer Institute, Ministry of Education, Brazilian Institute of Geography and Statistics, Osvaldo Cruz Foundation, University of São Paulo, and State University of Campinas. Examples include: *Inquérito Domiciliar sobre Comportamentos de Risco e Morbidade Referida de Doenças e Agravos Não Transmissíveis*

(Household Survey of Risk Behaviors and Morbidity Related to Noncommunicable Diseases), conducted in 15 state capitals and the Federal District between 2002 and 2003; *Pesquisa Nacional de Saúde dos Escolares* (National Schoolchildren's Health Survey) conducted in 2009, 2012, and 2015; *Pesquisa Nacional de Saúde* (National Health Survey), which incorporated the theme accidents and violence in 2013; *Vigilância de Fatores de Risco de Doenças e Agravos não Transmissíveis por Inquérito Telefônico* (Telephone Survey of the Surveillance of Risk Factors for Noncommunicable Diseases), conducted annually since 2006, including alcohol abuse, driving and violence. Efforts were also made to evaluate the implementation of a program directed at reducing morbidity and mortality due to road traffic accidents[32,33] and accident and violence prevention centers[34]. The findings of these studies have been widely disseminated in reports produced by the Ministry of Health, scientific articles, mainstream media, and social media channels.

The following organizations have also contributed to the fulfillment of this guideline: the National Council for Scientific and Technological Development, which launched several calls for proposals for research on the theme of violence; Coordination for the Improvement of Higher Education Personnel, which developed courses on the theme; and various state research support foundations. However, incentives for capacity building have waned in recent years in the wake of SUS funding reductions, particularly for actions tackling violence.

Final Considerations

Our findings show that numerous positive results have been achieved at the national and international level through actions directed at organizing the sector to provide healthcare for victims of violence, human resource development and capacity-building, and research development, demonstrating that it is possible to prevent and reduce violence that kills and injures[35-38]. Although many of these actions have not stemmed strictly from the health sector, they have an important impact on the area. Such is the case with regulatory frameworks that have contributed to the reduction of violent road traffic deaths, including the so-called *Lei Seca* and Desarmament Statute. However, numerous action developed by the Ministry of Health lack evaluation and monitoring. Data from the VIVA SINAN NET reveal a general increase in the detection and reporting of cases of violence that is probably due to an increase in adhesion to violence reporting services, increased capacity of professionals for detecting and reporting cases, thanks to continuing training programs, and improved access to services for violence victims. However, it is important to mention that adhesion to the system still falls short of the desired mark.

Violence against children and adolescents, women, and older persons was given priority on the health agenda. Other themes, such as child labor, human trafficking[32], homophobic[33] and racial violence[34], and violence against street dwellers[35] and people with diabilities[36], who are deprived of their liberty[37], are gradually finding their way onto the agenda. Their presence on the agenda depends largely on pressure brought by civil society and international organizations that advocate for these causes.

Drawing on specific research[12], it is possible to highlight a number of areas where greater investment is needed to ensure the effective implementation of the PNRMAV: the development of incentives to improve the information system, particularly in relation to out-of-hospital emergency and hospital care; out-of-hospital emergency and rehabilitation services, focusing on decentralization and bringing services closer to users; strengthening mental services; incorporation of the theme into the training and development of all of healthcare professionals and intensification of continuing training.

In the 16 years since the PNRMAV came into force, Brazil may commemorate the fact that it is one of the few countries that has a specific health policy directed at this social problem. This article shows that, although major strides have been taken, many challenges remain, demonstrating that violence, in all its distinct forms of expression, should assume a prominent position on the health agenda given the magnitude of the problem and the impact it has on quality of life.

Collaborations

MCS Minayo, ER Souza, MMA Silva and SG Assis also participated in the conception, design, editing, editing and revision of the article, under the coordination of MCS Minayo and all approved the final version.

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