

## Coping with child violence in primary care: how do professionals perceive it?

*Enfrentar a violência infantil na Atenção Básica: como os profissionais percebem?*  
*Enfrentar la violencia infantil en atención primaria: ¿cómo la perciben los profesionales?*

Emiko Yoshikawa Egry<sup>1</sup>, Maíra Rosa Apostólico<sup>1</sup>, Teresa Christine Pereira Morais<sup>II</sup>, Caroline Carapiá Ribas Lisboa<sup>III</sup>

<sup>1</sup> Universidade de São Paulo, School of Nursing, Department of Public Health Nursing. São Paulo, Brazil.

<sup>II</sup> Universidade de São Paulo, School of Nursing, Postgraduate Program in Nursing. São Paulo, Brazil.

<sup>III</sup> Centro Universitário Adventista de São Paulo, Family Health Program. São Paulo, Brazil.

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### ABSTRACT

**Objective:** to know the perception of health professionals working in primary care about child violence, since this has increased progressively in the world, requiring every effort to intervene. **Method:** this is a qualitative, descriptive and exploratory study performed through interviews with professionals in primary care in a health district of São Paulo. The Alceste tool was used for analysis of data from the speeches. **Results:** perceptions of professionals point to the limits and difficulties of the care network with coping; need for intersectoral action; violence situations identified within the care setting; and causes and effects of violence on child development. **Conclusion:** there is need for qualified training of workers, health network organization for the provision of quantity and quality of care services, and financial resources for coping with child violence.

**Descriptors:** Domestic Violence; Child Development; Primary Health Care; Coping; Health Care.

### RESUMO

**Objetivo:** conhecer a percepção dos profissionais da saúde que atuam na Atenção Básica acerca da violência infantil, visto que a violência contra a criança tem aumentado progressivamente no mundo, requerendo todos os esforços para a intervenção. **Método:** trata-se de estudo qualitativo, descritivo e exploratório, realizado por meio de entrevistas com os profissionais da Atenção Básica em um distrito de saúde do município de São Paulo, sendo utilizada a ferramenta Alceste para a análise dos dados oriundos dos discursos. **Resultados:** as percepções dos profissionais apontam para os limites e dificuldades da rede assistencial para o enfrentamento; necessidade de ações intersectoriais; situações de violências identificadas no âmbito dos atendimentos; e causas e repercussões da violência no desenvolvimento infantil. **Conclusão:** constatou-se que há necessidade de formação qualificada dos trabalhadores, organização da rede de saúde para oferta de serviços assistenciais em quantidade e qualidade e aporte de recursos financeiros para o enfrentamento da violência infantil.

**Descritores:** Violência Doméstica; Desenvolvimento Infantil; Atenção Primária à Saúde; Enfrentamento; Assistência à Saúde.

### RESUMEN

**Objetivo:** conocer la percepción de los profesionales sanitarios que trabajan en atención primaria sobre el abuso infantil, pues la violencia contra los niños ha aumentado de manera progresiva en el mundo, lo que requiere todos los esfuerzos posibles para la intervención. **Método:** estudio cualitativo, descriptivo y exploratorio realizado a través de entrevistas con los profesionales de la atención primaria en un área sanitaria de São Paulo. La herramienta Alceste fue utilizada para el análisis de los datos de los discursos. **Resultados:** las percepciones de los profesionales apuntan a los límites y las dificultades de la red de cuidado en el enfrentamiento; la necesidad de una acción intersectorial; situaciones de violencia identificadas dentro de la atención; y las causas y efectos de la violencia en el desarrollo infantil. **Conclusión:** hay necesidad de una formación cualificada de los trabajadores, la organización de la red de salud para la prestación de servicios de atención en la cantidad y la calidad, y los recursos financieros para enfrentar la violencia contra los niños.

**Descritores:** Violencia Doméstica; Desarrollo Infantil; Atención Primaria de Salud; Enfrentamiento; Cuidado de la Salud.

**CORRESPONDING AUTHOR**

Emiko Yoshikawa Egry

E-mail: [emiyeegry@usp.br](mailto:emiyeegry@usp.br)

## INTRODUCTION

The World Health Organization (WHO) defines violence against children and adolescents as every form of emotional and/or physical maltreatment, sexual abuse, negligence, negligent or commercial treatment or other forms of exploitation, including the possibility of potential or real harm to their health, survival, development or dignity in the context of a relationship of responsibility, trust or power<sup>(1)</sup>.

In Brazil, the concern for maltreatment in childhood from the perspective of epidemiology, prevention of risk factors and specialized care are still very recent, originating in the 1980s, at the same time that the theme of violence became relevant in public health<sup>(2)</sup>.

Violence against children, whether it is in the form of abuse or negligence, it is incomprehensible to say the least, as they are beings who require protection and safety from the adult universe for their adequate development. As they find themselves in a growth and development process, children and adolescents are more vulnerable to violence, which could have repercussions for their health<sup>(2)</sup>.

Situations of violence can be significantly harmful to the health of individuals throughout time, thus increasing the importance of guiding actions and establishing strategies for comprehensive care for the health of children, adolescents and their families, integrated to social and human right policies. Although being a privileged space for the identification, welcoming, service provision, notification, care and protection of children and adolescents in situations of violence, apart from guidance for families, the *Sistema Único de Saúde* (SUS – Unified Health System) network routinely encounters the challenge of dealing with complex questions about violence, which involve moral, ethical, ideological and cultural aspects<sup>(3)</sup>.

In the context of health, this question must be approached with a focus on the perspective of those who are victims of violence, aiming to provide both adequate care and relief from suffering and to think about ways to prevent occurrences, in the sense of developing an increased way to produce health and promote a healthy society<sup>(4)</sup>.

Studies on domestic violence reveal both the lack of qualification of health professionals and the importance of their performance in the interruption of the cycle of violence, in the promotion of healthy inter-personal relationships, in the recognition and notification of cases and in the health care and intervention required by both victims and perpetrators<sup>(5-6)</sup>. This qualification process and adequate instrumentalization – in the human sense of knowledge and in the sense of equipment and installed capacity – must be a part of policies on coping with violence against children<sup>(7-8)</sup>.

The new knowledge acquired by the professionals involved in the services aimed at children who have suffered from violence and their families can improve health practices, so that they are capable of reorganizing them to provide better health care. On the other hand, the reality of violence against children and its different forms of manifestation also highlight the need to increase health professionals' knowledge, so that they

can understand and perform when facing the complex situations that occur.

To understand and work while dealing with domestic violence during childhood and adolescence represents a reality that has increasingly required health professionals to have an attitude, emphasizing the need to construct a theoretical-analytical framework that can enable it to be understood, considering its complexity and different forms of manifestation<sup>(9)</sup>.

## OBJECTIVE

To identify health professionals' perception of violence against children in Primary Care, aiming to support a program of specific qualification to cope with this phenomenon.

## METHODS

### Ethical aspects

The present study was approved by the research ethics committees of the University of São Paulo School of Nursing and City of São Paulo Department of Health, meeting the legal provisions from Resolution 196/96 issued by the National Health Council, which were in effect when this project was approved<sup>(10)</sup>.

### Theoretical-methodological framework

The *Teoria da Intervenção Prática da Enfermagem em Saúde Coletiva* (TIPESC – Theory of Nursing Praxis Intervention in Community Health)<sup>(11)</sup>, which is a productive theoretical-methodological instrument from the perspective of theoretical construction for nursing interventions in the health-disease process of populations. As a method, it allows for a dynamic systematization to identify and interpret a phenomenon integrated to social production and reproduction processes related to health and disease in a certain population. The TIPESC includes the following stages: identification of the objective reality, interpretation of the objective reality, intervention in the reality, and reinterpretation of the reality. The instruments used for data collection were adapted according to the systematization proposed by the TIPESC, more specifically associated with the stages of identification and interpretation of the objective reality.

### Type of study

A descriptive qualitative study was performed<sup>(12)</sup>, founded on the *Teoria da Intervenção Prática da Enfermagem em Saúde Coletiva* (TIPESC)<sup>(11)</sup>.

### Methodological procedures

#### Study setting

The study setting was the District of Capão Redondo, connected to the City of Campo Limpo Department of Technical Health Surveillance of the South Health Coordination Office, in accordance with the organization of the *Sistema Único de Saúde* (SUS – Unified Health System) in the city of São Paulo, Southeastern Brazil. The District of Capão Redondo has an estimated population of 270,716 inhabitants, a population

density of 19,549 inhabitants/km<sup>2</sup> and growth rate of 0.77% per year<sup>(13)</sup>. The Family Health Strategy has been implemented in 14 Primary Care Units (PCU), totaling 81 family health teams, whose percentage of coverage is currently 94.7%<sup>(13)</sup>.

#### Data source

Interviews were conducted with District Primary Care professionals, between July 2013 and March 2014. The inclusion criteria were as follows: to have worked in Primary Care for more than six months on a local, regional or central level; and to be available to answer the interview questions. There were no exclusion criteria. On the local level, participants were 22 professionals who comprised Family Health teams (community health agents, nursing assistants, physicians and nurses), Health Unit managers who were responsible for questions of violence or members of the *Núcleo de Apoio à Saúde da Família* (NASF – Family Health Support Center) in three different PCUs. On the regional (District of Capão Redondo) and central levels (City of São Paulo Department of Health), three members of the coordination office who were responsible for questions related to violence were interviewed.

#### Data collection and organization

Data collection was conducted with semi-structured interview guidelines where professionals had the opportunity to discuss the theme of violence against children, beginning with the description of a situation of violence experienced in their professional practice. Next, based on the situation described, they were asked to talk about the meaning of violence against children; the repercussions of violence for child development; notification of violence; the difficulties and facilitators to cope with violence against children; the contribution of institutions, professionals and public policies on health care for children who have been victims of violence. Interviews were conducted by two researchers, recorded, transcribed and reviewed by another researcher from this group. Interviewers were familiar with primary care units and other levels and researchers were introduced to participants by one of the researchers belonging to the District staff.

#### Data analysis

Participants' speech was processed by the Alceste software (Lexical Analysis by Context of a Set of Text Segments)<sup>(14)</sup>. This program performs an automatic lexical analysis of texts and quantifies the most relevant structures, within their context of occurrence, indicating which phenomena will have a scientific interest.

The analysis of textual data classifies the statements, comparing them to lexical profiles; in addition to considering the quality of the phenomenon studied, it provides criteria originated from the material itself for its consideration as an indicator of a phenomenon of scientific interest<sup>(14)</sup>. The following two conditions are required for this analysis to be performed by Alceste: the *corpus* must show thematic coherence as a whole and the document must have a large volume so as to enable the statistical element to be considered<sup>(15)</sup>.

## RESULTS

The set of data produced from the texts processed by Alceste<sup>(14)</sup> identified 25 Initial Context Units (ICU), which were compatible with the number of interviews conducted and processed by the software program. The corpus was divided into 1,011 Elementary Context Units (ECUs), which included 41,693 distinct forms or words, corresponding to 100% of the material made available. Moreover, a total of 762 ECUs were classified for analysis, which represents 98.51% of usage of the material submitted to such analysis.

The ECUs classified for analysis were grouped into four lexical classes, according to the distribution described in Table 1:

**Table 1 –** Distribution of elementary context units, according to the classes generated by Alceste

Class	ECU (n)	ECU (%)
1	136	18
2	291	38
3	235	31
4	100	13
Total	762	100

Note: ECU = Elementary Context Units

Class 1 primarily includes the discursive content of ECUs referring to individuals on the central level (members of the city coordination office who were responsible for questions related to violence) in the 15 ECUs out of the 20 that comprise it. Classes 2, 3 and 4 mainly include discourses on the local level (community health agents, nursing assistants, physicians, nurses, managers and professionals responsible for questions related to violence or the Family Health Support Center), corresponding to 70 ECUs out of the 72 that comprise them. The discourse of individuals on the regional level includes six ECUs in Classes 2, 3 and 4 and two ECUs in Class 1.

The standard analysis model was adopted, as it enables us to obtain results that are more in agreement with the *corpus* interpretation.

The first and second descending hierarchical classification (DHC) performed by Alceste point to the structuring of the ICUs into two main thematic groups: the first group is comprised by Classes 1 and 2 and refers to the limitations and difficulties found in health care services for situations of violence against children and the need for intersectoral actions to fight these situations. The second group is comprised by Classes 3 and 4, pointing to situations of violence identified in the context of services and the causes and repercussions of violence for child development.

Considering the fact that the division of contents into two thematic groups results from a common textual group, it is possible to understand that the classes comprising them are complementary in terms of the meaning of the contexts analyzed.

The contents from the discourse in Class 1, more in agreement with the limitations and difficulties of health care services for situations of violence against children, indicate that the ways to cope with this are restricted by an insufficient health care network that lacks organization, financial resources and qualified professionals to deal with situations of violence. The performance of this network is hindered by a sector- and vertically-oriented logic of performing actions in the context of the city, a slow and unbalanced communication and exchange of information, and the reduced number of professionals who work with prevention.

The speech of the professionals interviewed show important aspects that corroborate the difficulties and limitations for work when dealing with situations of violence against children: the perception that there has been an increase in the number of reports on violence, the need for actions aimed at working with perpetrators, recommendation and referral to professionals who specialize in situations of violence, lack of knowledge that professionals working with direct health care have about the flow of referrals for the situations of violence identified, the need to strengthen primary care as reference and support for the identification of situations of violence, and the need for clearer directives on the flow of referrals and health teams' greater knowledge about violence.

*Caring for perpetrators themselves is a concern, we even manage to refer some, we have a good partnership with the Department of Public Prosecution in the South [regional], which is always close to our institutions in terms of demands; and whenever there is need for a leave, we only need to take the case to them and the leave is ready (sic).* (par\_02)

*Especially to offer alternatives like conflict mediation, techniques like this. We have a partnership with the area of integrative practices, so the deal is that whenever there's a course on this area of relaxation, circle dance, empowerment, community therapy, there would be openings for the people from the centers.* (par\_02)

*While the numbers were low, there was a case in a PCU, then two, then another. Today we have 120 Primary Care Units in our area, so it was easy to work out these referrals. But the number of requests and needs has been increasing.* (par\_02)

*This morning we were discussing this with the technical area of mental health, that we need to construct and identify professionals in this area who can make the referral, so that Primary Care Units can deal with these cases better.* (par\_02)

Regarding Class 2, which deals with the need for intersectoral actions to fight situations of violence against children, the speech of professionals reveals the difficulties, while at the same time pointing to alternatives. In this sense, the difficulties refer to the following aspects: the lack of instruments to cope with questions related to violence during the qualification of nurses and other health team professionals, fear of

exposure of professionals in areas with great violence and a bureaucratic support network, as these situations take a long time to be resolved. With regard to the alternatives, they point to the need to have a multi-professional team as reference in the PCU for questions of violence, greater support and integration of local policies on social work, health, education, safety, employment, income transfer and justice to cope with violence and support for mothers who are also victims. Additionally, they emphasize the importance of health professionals in the notification of situations of violence, indicating a form of legitimization of the question of violence as a health priority.

*There is an advantage, but because this is an area that involves a lot of violence, there may be fear of being exposed to retaliation. The advantage is the question of morals, a health unit where people have a high moral sense and don't tolerate this kind of thing.* (par\_18)

*Because when we're qualified, we don't have tools to deal with this question of violence. To deal with this greater question, I think it goes beyond the biological question that we focus on during our qualification.* (par\_21)

Class 3 included situations of violence identified in the sphere of health services, showing a higher number of situations of negligence in the cases reported, followed by physical and subsequently sexual violence.

*This was the worst act of violence that I've witnessed against a child. We're not aware of time, this child cried a lot and one of the reasons was hunger, because I warmed some milk in a bottle at my neighbor's and the boy gulped it down.* (par\_04)

*They came for a consultation with the nurse, when I began to examine the child and saw that it even had burning marks.* (par\_10)

Class 4, which dealt with the causes and repercussions of violence for child development, points to the following as the main causes: the high number of children, drug use by one or both parents, large families sharing the same space, early pregnancy and mental disorder in the family. Regarding the repercussions, participants' speech revealed the association between violence and the development of mental disorders and violent acts in adulthood.

*So children suffer the consequences because a drug addict [...] he's sick, so he can't control his behavior well.* (par\_09)

*If she's not followed from an early age, she'll turn into an adult who'll treat others in the same way she was treated. If she doesn't learn that this is wrong, she'll think that this is common, that everyone is violent and scream and act like this, that it's normal behavior.* (par\_16)

*She's a child who'll become violent at school, she's a child that people will complain about, who'll fight other kids on the streets, who'll not learn how to express how they feel, who'll live with traumas, maybe for the rest of her life.* (par\_23)

## DISCUSSION

The need to have an efficient health care network that meets the demand and qualifies professionals for this service, producing intersectoral actions, has been shown in many studies and official documents<sup>(16)</sup>. Decree 936, issued on May 19<sup>th</sup> 2004 by the Ministry of Health, is the most symbolic official document, foreseeing the structuring of the National Network of Violence Prevention, Health Promotion and Establishment and Implementation of Violence Prevention Centers in States and Cities<sup>(17)</sup>.

In the area of health, the Ministry of Health emphasizes the importance of regionalized health care networks, defined as integrated structures that provide health actions and services, institutionalized by public policy in a certain regional space, according to collectively planned work and the deepening of inter-dependent relationships among the participants involved<sup>(18)</sup>.

Considering the fact that regionalized networks tend to offer better conditions for the implementation of health care comprehensiveness, the possibility of interaction among public policies shows that the network organization must not be restricted to the health sector, as other sectors include determinants of the health-disease process<sup>(19)</sup>.

In the area of health, based on the Community Health proposals, comprehensive health can be expanded to intersectoral network actions, which must be regulated by three key organizational principles: that of integration of professional actions, in which there are specific professional actions that must be maintained, although in an interconnected way; that of interaction of professionals, organizing work in services so that there is effective communication among them; and that of integration among services such as institutions from different sectors<sup>(20)</sup>. In this sense, according to professionals' speech, intersectoral actions need to be understood as the most relevant ones to cope with questions of violence against children. This is because the actions performed are restricted to specific sectors, without integration on local and regional levels.

Among the innumerable difficulties encountered when dealing with violence is the recognition that violence exists, or at other times that it is made visible, although the victim is blamed for having "provoked" such violence. Studies show that there is a naturalization of violence in general and that against children in particular, given the ways to interpret childhood that have predominated in the history of civilizations for a long time. Moreover, there is little debate on the influence of gender and generation on the denaturalization of the phenomenon of violence against children, as some studies have already indicated the relevance of such categories<sup>(21)</sup>.

The identification of this situation as negligence does not occur in an objective way, as it is mistaken for the lack of provision of basic needs for children with the deprivations and needs resulting from situations of poverty. It is in this sense that the lack of preparation of professionals to deal with this question comes in, revealing the need to acquire a theoretical-analytical framework which is capable of enabling the understanding of the phenomenon of violence against children,

apart from the factors of vulnerability and protection common to different cultures and society<sup>(22)</sup>.

Negligence is a type of violence that can be hardly defined, as it involves cultural, social and economic aspects found in each family or social group. Its identification can be facilitated by greater contact with families, so that their dynamics can be better understood. Primary Care teams represent an important resource to detect such situations, provided that they are well qualified. Home visits are a very efficient type of care, although depending on professionals who develop this activity specifically<sup>(23)</sup>.

Regarding the causes of intra-family violence, the following factors can be associated: family roles such as paternity and maternity during adolescence; overload of the mother or child role; pathologies such as alcohol and drug use; depression; educational practices such as parents' disagreements over the upbringing and lack of restrictions of their children; and aggressive behavior such as conjugal violence, violence between parents and children, and conflicts with laws. Furthermore, these factors show the vulnerabilities of family interactions<sup>(24)</sup>.

When analyzing the speech of the professionals interviewed, we can perceive the way the causes and effects of violence are associated with individual and social deviations, somehow reducing the understanding of the phenomenon to families' precarious material conditions, establishing a causal relation between poverty and violence, which emphasizes the culpability of these families for the failure of their members.

A study performed in a city of the metropolitan region of São Paulo showed other vulnerabilities in the recognition and coping with violence against children and adolescents in Primary Care: to be afraid of the drug traffic in the area as a justification for not coping with it, generating feelings of fear and lack of safety; to feel threatened and not to report cases of violence; to consider the family context as private and thus not subject to intervention<sup>(25)</sup>. However, there are studies showing that aggressive relationships between adults and children, mainly parents and their sons/daughters, occur in environments where family relationships are very violent.

In terms of the consequences of violence against children throughout the life of an adult, studies have shown the persistence of what is known as the "legacy" of violence. Martsolf and Draucker<sup>(26)</sup> performed a study on the influence of adversities occurring during childhood on the life of survivors of child sexual abuse and observed that all of them involved some legacy. Such legacy is passed on to the new family both in terms of rejection of patterns of violence and perpetration. The authors emphasized the importance of the work of nurses, as they found that adults continued to mistrust others. A study<sup>(27)</sup> performed in Brazil, Mexico and Chile showed that "men who had witnessed violence against their mothers perpetrated by male partners during childhood were more physically aggressive towards their intimate partners in their lifetime than those who had not been exposed to such violence".

The present study and others performed with health professionals, both in Brazil and abroad, revealed that there are important gaps in their knowledge about the following: the

existing legislation; national and international policies; history of child development; changes in childhood as a generational category; questions involving the episteme of gender; and the consequences of institutional negligence towards coping with violence and institutional and multi-disciplinary possibilities of coping with this phenomenon.

### Study limitations

The methodological limitation of the present study was the fact that the data collected were not immediately returned to participants. However, as the Tipesec was the continuous methodology used<sup>(11)</sup>, both participants and health professionals of the city will be receiving such data.

### Contributions to the area of nursing, health or public policy

The present study intends to contribute to a greater visibility of the phenomenon of violence against children in the context of health and nursing, showing the required qualification for several professionals who work in Primary Care, so that they learn how to cope with situations of violence against children and thus provide adequate care in the routine of their services.

### FINAL CONSIDERATIONS

The results shown reflect the main characteristics of the ways to cope with violence against children in the context of health care services provided by professionals of Family Health and Primary Care teams on local, regional and central levels. To achieve this, the aspects that hinder network actions are emphasized, according to an intersectoral perspective. Participants' speech indicate the need for training and qualification of professionals in several areas involved with situations of violence (health, justice, safety, social work) in the sense of improving the integration of their actions in a network, aiming to strengthen the rights of citizenship and guarantee full access to and quality of the services provided to children in situations of violence.

The adequate qualification of professionals in several areas, who are faced with situations of violence against children, has potentialities in terms of work processes, care, and specific measures performed by them to develop and promote

interventions suitable for the moment of the cycle of violence, including the possibility of breaking this cycle. In the area of health, whether it is on the federal, state or municipal level, the health care network lacks sufficient services and the organization, financial resources and qualified professionals to deal with situations of violence.

In the state and municipal spheres, there is great difficulty to guarantee implementation through the mobilization of power resources, so that political, institutional and bureaucratic obstacles can be overcome. Thus, one may question whether rights are being protected, when insufficient investment of public power has been made in human, financial and logistic resources that guarantee the rights of children and adolescents. Furthermore, an inexistent network to cope with different types of violence, care services and the guarantee of rights reveals the lack of a defined and effective flow for situations of violence. With regard to the evident changes in the legal and political fields, these are not reflected on changes in cultural patterns, whose patriarchal values naturalize inequalities of power in the family environment, labeling violence against children as a less important problem, restricted to the domestic and private reality.

Finally, what we are seeking is the confluence of several aspects, aiming to maximize efforts that can introduce the expected, required and effective changes in health care models and health work processes, which are focused on the needs of children exposed to violence. The aim is to seek the construction and implementation of comprehensive care and to develop the required conditions for protection, especially of those experiencing situations of extreme vulnerability to violence.

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