



Workers at a basic health unit who interface with violence*

Trabalhadores de uma Unidade Básica de Saúde na interface com a violência

Trabajadores de una Unidad Básica de Salud en interface con la violencia

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ABSTRACT

Objective: This study sought to understand how social violence affects the work of family health teams in a basic health unit in Belo Horizonte - MG. **Methods:** This is a qualitative case study. Data were collected by semistructured interviews with 12 individuals working in a basic health unit in Belo Horizonte - two nurses, five auxiliary nurses, three ACS's, a doctor and a guard – interviews were then subjected to discourse analysis. **Results:** The workers recognized the violent situations in the community where they work; they feel fear, insecurity, and adopt several defense mechanisms to reduce suffering. They also reported feeling hurt by their poor working conditions. **Conclusion:** The effectiveness of health care is challenged by violence, and it requires strategies for coping with the same within the unit by establishing links with other social institutions.

Keywords: Violence; Patient care team; Family health; Working conditions

RESUMO

Objetivo: Este estudo buscou compreender como a violência social interfere no trabalho das equipes de Saúde da Família de uma Unidade Básica de Saúde de Belo Horizonte - MG. **Métodos:** Trata-se de um estudo de natureza qualitativa do tipo estudo de caso. Os dados foram coletados por entrevistas de roteiro semiestruturado com 12 trabalhadores de uma Unidade Básica de Saúde de Belo Horizonte – 2 enfermeiros, 5 auxiliares de enfermagem, 3 ACS's, 1 médico e 1 vigilante – e submetidos à análise de discurso. **Resultados:** Os trabalhadores reconheceram as situações de violência na comunidade onde trabalham, sentem medo, insegurança e adotam vários mecanismos de defesa para diminuir o sofrimento. Referiram também sentirem-se prejudicados com as precárias condições de trabalho. **Conclusão:** A efetividade da assistência à saúde é desafiada pela violência, e requer estratégias para lidar com a mesma dentro da unidade estabelecendo relações com outras instituições sociais.

Descritores: Violência; Equipe de assistência ao paciente; Saúde da família; Condições de trabalho

RESUMEN

Objetivo: En este estudio se tuvo como objetivo comprender cómo la violencia social interfiere en el trabajo de los equipos de Salud de la Familia de una Unidad Básica de Salud de Belo Horizonte - MG. **Métodos:** Se trata de un estudio de naturaleza cualitativa de tipo estudio de caso. Los datos fueron recolectados por entrevistas con preguntas semiestructuradas realizadas a 12 trabajadores de una Unidad Básica de Salud de Belo Horizonte – 2 enfermeros, 5 auxiliares de enfermería, 3 ACS's, 1 médico y 1 vigilante – y sometidos al análisis de discurso. **Resultados:** Los trabajadores reconocieron las situaciones de violencia en la comunidad donde trabajan, sienten miedo, inseguridad y adoptan varios mecanismos de defensa para disminuir el sufrimiento. Refirieron también sentirse perjudicados con las precarias condiciones de trabajo. **Conclusión:** La efectividad de la asistencia a la salud es desafiada por la violencia, y requiere estrategias para lidiar con la misma dentro de la unidad estableciendo relaciones con otras instituciones sociales.

Descriptores: Violencia; Grupo de atención al paciente; Salud de la familia; Condiciones de trabajo

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INTRODUCTION

In the health sector, the effects of violence can be observed in epidemiological profile changes which, in the last 30 years, have shown an increase in morbimortality due to external causes and violence, to the detriment of other causes. Violence includes all forms of interpersonal aggression, racial and social class discrimination, and abuse against and domination over children, women, and elderly and disabled individuals that have become culturally acceptable. It is manifested and becomes part of the concrete daily life reality, whether on an interpersonal or institutional level, and whether on a micro- or macro-political-social environment⁽¹⁾.

Due to the complexity of such phenomenon, to limit violence would mean to reduce it to the aspects present in routine life. However, the existence of four types of violence could be considered: “classic”, which is directly aimed at the body; “psychological violence”; “poverty”, which refers to the lack of basic material needs; and “repression”, which is the privation of human rights and alienation, referring to the privation of higher needs⁽²⁾.

In recent years, there have been reflections of violence in the health work process organization in Brazil, in the professionals’ behavior and in the service provided to clients. With the *Programa de Saúde da Família* – PSF (Family Health Program – FHP), the locus of health care, which was previously situated in the health unit exclusively, extended to the community in general, with a greater closeness between professionals and the problems and situations experienced by the population, including those related to violence⁽³⁾, which deteriorate the process of change and make it vulnerable⁽⁴⁾.

A study on the problems of occupational violence in a hospital emergency service, in the city of Londrina, PR, points to patients as the main aggressor and cause of suffering, in the perspective of health workers. It is believed that this situation is motivated by poor user service conditions, low working conditions and the country’s existing social inequality itself⁽⁵⁾.

As a result of its relevance in health care in the 1990s, violence was recognized as one of the main public health problems in Brazil⁽⁶⁾. In 1996, due to the serious consequences of violence and its effects, the members of the 49th World Health Assembly considered it urgent to seek alternatives to reduce violence-related problems⁽⁷⁾.

In societies marked by violence, such as Brazilian society, this becomes an “organizing language”, a system in which the rule of access is the pure and simple exercise of violence⁽⁸⁾. This represents an urban population sociability pattern, as it establishes new rules of conduct based on a set of values, representations of reality and routine practices⁽⁹⁾. The present study approached the experience of professionals with situations of violence in their broadest sense, as observed in society. This is known as social violence, which refers to all

forms of violence that have their levels altered by social factors, according to the World Health Organization⁽⁷⁾.

In this sense, public policies must be implemented, using all tools available to approach violence, including the use of more intelligence and less in-person or physical force from security instruments. However, the first stage is knowledge about its causes, forms and maintenance mechanisms, including social aspects. Thus, the present study aimed to understand in which aspects social violence interferes with the work of Family Health teams in a Primary Health Unit of the city of Belo Horizonte, MG.

METHODS

A qualitative study was conducted, as this type of analysis answers particular questions, dealing with a level of reality that cannot be quantified. It works with “meanings, reasons, aspirations, beliefs, values and attitudes, which correspond to a more in-depth space for relationships, processes and phenomena”⁽¹⁰⁾. Thus, a qualitative case study was conducted, seeking to portray reality in a deep and complete way, in view of the natural complexity of the situations; and emphasizing context interpretation⁽¹¹⁾.

The place of study was a Primary Health Center (PHC) of Belo Horizonte, MG, situated near one of the most violent areas of this city, where six Family Health teams work. Study participants included 12 unit workers, of which two were nurses, five were nursing assistants, three were Community Health Agents (CHA), one was a doctor and one was a security guard. Data were collected using recorded interviews and a semi-structured interview guide and subsequently submitted to Discourse Analysis, which aims to enable production conditions to be reflected upon and to understand the meaning of texts produced in several fields⁽¹²⁾. The following questions were asked of participants: ‘What is violence to you?’, ‘What aspects of violence interfere with your work in health?’ and ‘How have health teams structured themselves to deal with routine situations of violence?’. The present research project was approved by the Research Ethics Committee of the City of Belo Horizonte Department of Health, according to Resolution 196/96 of the *Conselho Nacional de Saúde* (National Health Council).

Data became operational according to the following steps: ordering, classification and final analysis. Data ordering included the full transcription of participants’ speech, reading of material, and organization of reports based on themes. Texts were read thoroughly and repeatedly to classify data, when relevant structures were obtained. Finally, data analysis occurred as the specificity of the object through the proof of what is experienced met the essential relationships⁽¹²⁾.

RESULTS

Data were organized according to the reading of

participants' speech, resulting in three categories of analysis: Experienced violence; the Context of violence and its repercussions for health professionals; and Influence on the work process.

Experienced violence

Professionals recognized that the environment is violent and their work is influenced by drug traffic activities:

...It's [violence] there during the day and night. So, even when we're working, we learn to live surrounded by it, right? We can't run away [...] It's aggression, death and traffic. (I10)

Another recognized form of violence is users' aggressive behavior towards professionals, which interviewees themselves seek to justify by establishing a relationship of causality between the population's living conditions and aggressiveness, due to the fact that they live in a violent place and experience several types of poor conditions:

...lack of politeness, users' aggressive behavior towards us, because of the violence they also experience in the place where they live. I mean, the type of violence related to housing and living conditions (I1)

Coercion, although subtle, is considered to be a form of violence. Professionals feel violated and disrespected, when approached by individuals who attempt to take advantage of their "good" contacts to obtain a privileged service:

...it's a subtle form of violence, when a patient comes to you and says, 'I'm so-and-so's brother, I'm so-and-so's uncle!'. It's a sort of hidden thing... (I4)

Professionals reported that certain users felt they had a privileged status, compared to unit workers and the remaining users. They demand their rights and privileges, as reported by the following participant:

They come to humiliate us, they want a privileged service, they don't want to wait in line, they sometimes use words that are worse than those used by high-risk patients... (I1)

In addition, they identified a form of violence associated with the professional-organization relationship, where the lack of work infrastructure is considered to be a type of institutional violence, thus resulting in conflict with users.

...To me, violence is all that we've been experiencing here, from the moment you arrive at the health center, where three or four professionals work... (I7)

Professionals feel used by the organization to reduce the latent indignation caused by the lack of response to

social problems. They feel violated and believe that users are violated too, as their health is treated with disrespect and they are deceived, rather than cared for, as observed in the following report:

...I feel used when I have to calm down someone who is on the other side. If they were not around, these people would break down something, you know? In fact, I think we do a lot to prevent violence, we deceive. (I4)

Context of violence and its repercussions for health professionals

Although physical aggression seems to be more relevant, non-physical aggression also causes loss of structure. Professionals associate work performance with their psychological status and identify verbal violence as a factor that "affects the psychological side".

Verbal violence is also serious, because it affects our psychological side. If we're not well-structured, psychologically speaking, how can we work well? (I8)

It is perceived that new values and behaviors are adopted in view of violent situations. Interviewees raise the possibility of witnessing a murder. In their perspective, the reaction that enables their work to continue would be their disregard for the scene they have witnessed. Workers consider it more prudent and correct to ignore something "on behalf of ethics".

...we're in a place where there's been a murder and we have to pretend this hasn't happened, so we can manage to work. [...]. We find out more about things [...] then, we have to be more ethical and pretend nothing's going on. (I6)

Influence on the work process

Work in the Family Health Program requires specific preparation and the ability to deal with the community and act in equally specific situations, involving more than clinical knowledge, as reported below:

...we sort of know who usually makes a scene... before arriving at the service, I already know who they are, so I can speed up things, act more calmly, prepare myself, and receive them in a more... in a way that calms them down... (I1)

Against the FHP premises, users' needs are individually analyzed and, if necessary, parallel agendas are created alongside regular ones. This is a strategy used to maintain the safety of the remaining users and workers.

There are users who are included in this whole process, who have to have a special time to be served, because they can't come down at the regular time. (I1)

The professional-user relationship is influenced by the population's reality of life, who feel afraid and reluctant and thus do not know who they should trust in certain situations:

...when the situation becomes risky and violence increases, people are afraid to receive us at home [...] they think we could be telling something to...to somebody, you know? They think we could be informing the police or something. (I6)

The fact of someone being a community member makes the border between them and the remaining inhabitants become more open, creating specific judgments and expectations and defining very particular positions and roles:

... they (community health agents) live there. So, they cannot put themselves at risk... we know that violence exists in a certain area, but it'll never be, how do you say, it'll never be talked about openly. So, we can actually see what's happening and why this is surrounded by fear... (I1)

There is an exhausting routine regulated by the fear of such brutal reality, which hinders the adoption of protective strategies that, when present, are individual and based on personal experiences:

...people here know how to reasonably deal with the population. They explain the situation, why a consultation was delayed, why drugs are lacking. This is because it's not always the workers' fault, it's usually the City Hall's or the State's fault. (I3)

In an attempt to avoid confrontations with users and their demands, participants reported that a specific time to receive patients was set "without the management's knowledge":

We set a time to receive them without the management's and the... the program's knowledge, you know? Because, in their view, we should receive patients the entire day, but receiving doesn't mean setting up consultations... (I4)

In addition, unit workers perceive that nurses who coordinate Family Health teams and unit activities are not adapted to the proposed work process. They attribute the difficulties in unit activity coordination to the time restriction:

...there's a shortage of team members, not only among us (nursing assistants), but among team nurses too. I think the team is a little out of tune [...] There are nurses who face the challenge with us. So, when a patient comes here and attacks us verbally, they come out and say this is disrespectful [...] (I2)

DISCUSSION

Violence is part of the human condition, and people,

as citizens, are simultaneously subject and object of this phenomenon. However, illegal drug traffic is the most consistent and despicable relationship between violence and drugs, causing violent actions between individuals who sell and those who buy them⁽¹³⁾. These actions are not restricted to their circle of business; instead, drug traffic harms society as a whole, including health workers.

It is possible to realize that there is not a well-defined limit about what is understood as violent behavior in the PHC routine. Users coming from violent environments show aggressive behavior which is considered to be natural. This "natural" violence is identified with social relations of inclusion/exclusion which, in truth, are not perceived as violence⁽¹⁴⁾. The working conditions evaluated according to the perspective of professionals reveal that the structure is inadequate and insufficient to meet users' rights. Reality is harsh for professionals and users, who see their citizenship violated and whose perspective of overcoming it seems distant.

In the work environment, there are two paths through which violence occurs, one is structural or institutional, the other is behavioral or relational. In addition to causing harm to workers themselves, these two paths can also harm those under their care⁽¹⁵⁾.

Work organization in the unit is perceived as a form of violence against the precarious integration between individual and organization. The small number of workers causes delays in the service, which leads to conflicts and aggression among the population. It is essential to build a service organization model based on socio-political, material and human conditions that allows for quality work for both workers and users to enable the FHP to be effective⁽⁴⁾.

FHP cost rationalization can be perceived according to the flexibility of forms of hiring teams and workers without professional qualification to perform health actions, thus resulting in worse work conditions⁽⁴⁾. There is high turnover of professionals in the unit, not only associated with temporary work contracts, but also workers who were hired after passing public examinations. These workers feel their work routine is tiring and end up trying other alternatives in the public health network.

Professionals understand that the work organization structure increases their lack of motivation, in the sense that the results of their work are not perceived as an improvement in the health conditions of the population, despite the high workload. There is disbelief in and indignation at the organization and the role workers play in it, i.e. to calm down people, rather than seeking real solutions to the problem. In this sense, professionals experience the conflict of working exhaustively without seeing the results of their performance, thus causing it to be meaningless, because the purpose of work lies in the achievement of a result that was an ideal in workers' minds⁽¹⁶⁾.

When facing fear, a change of values seems to occur.

The most important aspect in relationships becomes self-preservation. The ethical subject is a rational and conscious being; because they are free, they decide and choose what to do; because they are responsible, they account for what they do. The ethical action must result from an inner decision of participants, rather than from external pressure, which leads to the conflict between the autonomy of the subject's will and the heteronomy of society's moral values⁽¹⁷⁾. However, what can be observed is an individual's decision-making motivated by external pressure, due to the fear of the risk they face in their workplace. This behavior seems to be more of a reason for their actions, so they can continue to survive in a hostile environment and be a part of it, recognizing and ignoring facts simultaneously.

However, it would not be prudent to think that the change in behavior is not a painful process for professionals, whose health condition deteriorates. Workers reported that they were not simply "falling ill", but progressing towards a worse condition which caused them to feel as though they were "going crazy". Although not causing professionals to become ill, the strong pressure under which they perform their functions leads to lack of motivation. This results in weariness, whose effects cannot be easily measured or interpreted, both in terms of these professionals and the work they perform.

The fact that apparently healthy individuals, although victimized by violence and poor social conditions, seek health care in the unit causes the PHC to become a place where they can be heard and where solutions to all types of problems are sought. This, as a result, creates an overload on both workers and the system and low resolvability for users. Health professionals tend to believe that users need to be "educated" when seeking a PHC and having a serious disease. Devaluation of social motivation to seek health services is against the proposal to change the health care model, which considers individuals as social beings.

Lack of specific training for professionals, aimed at dealing with situations of violence, could interfere with their work performance, because they are not academically prepared, even after becoming responsible for their service. Learning from colleagues in an informal and non-systematic way and using communicative abilities are aspects that they develop to deal with their low level of experience in this context. However, time, dedication, bond and commitment are required to maintain a dialogue, because this involves the subjectivities of professionals and users and the maturity to organize work in a context which is not always favorable.

For community health agents (CHA), who are workers living in areas covered by PHC, the relationship with the community is established according to two perspectives: one is professional, the other is personal. Their function is

to bring these two parts, users and health system professionals, closer together. They are responsible for showing the face of the community to the health service that serves it. Social violence in the community is a factor that hinders and interferes with CHA activities, causing fear, restricting their access to the community and limiting the development of their work.

One of the organizational strategies to meet the demand in the unit is to use the help of CHA to identify users who may "cause problems". As these individuals are recognized, their service is planned before they arrive at the unit. It is believed that this enables the required psychological preparation when caring for them to change the aggressive environment that may be present among the user, the team and the remaining users.

Based on the interviews, it is difficult to know the reality of the community, because information is passed on through the CHAs. However, CHAs themselves feel intimidated, afraid to expose to the team what they actually know about the violent reality in which they work. Thus, an environment of mistrust is established in the Family Health Team, which slowly destroys one of the FHP pillars, which is team work.

Certain situations of violence lead to several interpretations that may be real or not, but which indicate risky situations, in which each individual seeks to protect their daily routine in any way they can. There are no effective mechanisms to deal with such situations. However, to know how to deal with them often means to be able to justify problems and not to seek ways to solve them. In addition, the major institutions are blamed for unit problems, reducing responsibility on the local level. Although flaws in the municipal and state departments of health can be pointed out, this attitude is a way to defend professionals, an alternative to improve the relationship with the community.

It is possible to observe how violence interferes with the work process, which is interrupted when professionals cannot deal with the problems created and require the intervention from one of their superiors. The following can be observed: fragmented work processes, manager's unnecessary duties, vulnerable interaction with users, and professional's restricted autonomy. In addition, managerial concern is emphasized by individual care, confirming the work of managers as that which brings order and control to the unit⁽¹⁸⁾.

The team considers attitude to be positive when workers are defended by nurses in situations of aggression caused by users. This is because they feel safe, despite the recognition that there has been no effective gain or change in the unit. What matters is the attitude at that moment, the fact that the user's behavior was explicitly shown not to be accepted passively by unit workers.

This supposedly individual act performed by a nurse

barely contributes to a concrete change in the situations experienced by health system workers and users. This is partly due to the fact that situations of violence occur at a highly complex level, as it is associated with extreme poverty and diverse social contrasts experienced by the Brazilian population, such as differences in access to income, education, health and good housing conditions⁽¹⁹⁾.

The accumulation of violent situations, including institutional ones, is a threat to workers' health, who are responsible for caring for the population. Urgent measures are required, as a way to guarantee that the achievement of the objectives proposed by the Family Health Strategy, which puts workers in direct contact with the community and its problems. The attended area is known to be violent, although revealing its essence means to perceive, apart from violence as a public health problem for the community, workers' excessive exposure to conditions surrounding the PHC.

The interference caused by violence in the work process of this unit is only the tip of a much larger problem, which must be the object of specific policies developed by the public power, aiming to improve the population's living conditions according to a more complete understanding of the interdisciplinarity of the process. The implementation of programs such as the FHP can only succeed when the well-being of professionals who perform in it is taken into consideration. Currently, an almost paralyzing fear affects

workers' actions and health.

CONCLUSIONS

Violence is understood as the result of a dynamic process in society which is maintained by individual interests. Changes in violent situations experienced in health units involve changes in professionals' and users' behavior and structural changes in the Health System itself. Primarily, the Community Health Agent Program and, additionally, the Family Health Program represent instruments that promote comprehensiveness and resolvability in health services, enabling an improvement in access. However, these programs need to broaden their perspectives, including health professionals as the objective of health care, because they are one of its foundations.

The effectiveness of health care is challenged by violence and needs to seek strategies to deal with it. These strategies must be implemented in the unit itself and relationships with other social institutions must be established, such as schools, nursing homes and neighborhood organizations, aiming to know more about the population served and their extramural resources, and to make themselves known by this population. In addition, it is necessary that users become more aware of the possibilities and limitations of the service provided by health units.

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