



Primary Healthcare management strategies in socially vulnerable territories exposed to violence*

Estratégias de gerenciamento na Atenção Primária à Saúde em territórios de vulnerabilidade social expostos à violência

Estrategias de gestión en Atención Primaria de Salud en territorios de vulnerabilidad social expuestos a la violencia

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ABSTRACT

Objective: To identify management strategies used by the Family Health Strategy teams of a Basic Health Unit in organizing work in socially vulnerable territories exposed to violence. **Method:** A single case study with a qualitative approach in a family health unit located in the southern region of Brazil. Data collection was conducted through individual interviews with 27 health professionals from August to September 2017 and a focus group with 18 participants in April 2018. Data organization and processing was performed with the support of the IRAMUTEQ software program and subsequently the content analysis technique. **Results:** The five classes characterized strategies used by professionals to provide care to the population considering their experience in facing violent situations. A guideline was developed and validated in the focus group to guide the management and organization of work in these services. **Conclusion:** It was evidenced that professionals develop strategies which include strengthening the team as a form of collective protection, welcoming focused on comprehensive care and bonding, even without the support of specific public policies for these situations. The population is allied to facilitate access to care for vulnerable people and alerts professionals to critical situations in the territory.

DESCRIPTORS

Violence; Social Vulnerability; Health Personnel; Primary Care Nursing; Family Health.

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INTRODUCTION

Primary Healthcare (PHC) is the first care point and the main gateway to the Healthcare Network (*RAS – Rede de Atenção à Saúde*) of the Unified Health System (*SUS – Sistema Único de Saúde*) in Brazil, being responsible for ordering care, flows and counterflows of people in the RAS. PHC in Brazil can also count on the Family Health Strategy (FHS) as a strategy for expanding and consolidating the national territory⁽¹⁾.

The FHS has the following as guiding principles for its practice: care centered on the person and the family, the bond with the user and the population, comprehensiveness, care coordination, articulation with the care network, social participation and intersectoral action. These potentialities seek answers to most of the health needs of the population it serves, offering actions for promotion, prevention, health recovery, disease rehabilitation and surveillance of more frequent injuries. These actions can be minimized when inserted in complex and diversified territories⁽²⁾.

The work organization of the FHS teams is based on a territorialized PHC from an assigned population in a geographically defined location. The territory is understood as a dynamic and constantly changing space, and is subject to variability of risks and social vulnerabilities. When considered to be alive and dynamic, this space is capable of producing and reproducing the health-disease process for the FHS teams, which enables identifying factors and conditions related to social determination processes when analyzed from an epidemiological perspective⁽³⁾. In this logic, territory is the result of the historical, political and social processes which influence the way people live, and with regard to the work organization of the FHS teams, from recognizing the health needs to planning the actions to be developed.

Confrontation of violence by health service professionals and managers is a recent event which causes tension and fear. Professionals are still not sure how to act when faced with a complex social phenomenon which requires a broad, comprehensive and multidisciplinary approach, possibly due to training based on the biomedical and interventionist model⁽⁴⁾. The phenomenon affects an average of one in two professionals worldwide; in addition, 25% of violent acts at work occur in the health sector⁽⁵⁾. However, violence does not only impact professionals, but directly on the quality of services offered to the population, whether in their access to services or in the practice of health professionals⁽⁵⁻⁶⁾.

In view of the exposed context, this study aimed to identify the management strategies used by the FHS teams of a Basic Health Unit in organizing work in a socially vulnerable territory exposed to violence.

METHOD

STUDY DESIGN

A single case study with a qualitative approach. The case study is used in many situations and contributes to the knowledge of group and organizational phenomena⁽⁷⁾.

SCENARIO

A Basic Health Unit (BHU) with three FHS teams from a city in the south of Brazil, located in an area of high social vulnerability. Approximately 97% of its population uses the services exclusively offered by the unit, and its territory is in fourth place among the highest social vulnerability indexes in the city; the index is calculated by the Vulnerability Index of the Areas Covered by Municipal Health Units (*IVAB – Índice de Vulnerabilidade das Áreas de Abrangência*), which defines the equitable distribution of resources in the municipality. This was established from the Vulnerability Index of Families in Paraná (*IVF-PR – Índice de Vulnerabilidade das Famílias do Paraná*) and the population of the IBGE 2010 census by coverage area. A list of families residing in the municipality was used as criteria for calculating the IVAB, with the final IVF-PR greater than 0,2798, which denotes high vulnerability and for which the research region was classified as 0.256⁽⁸⁾.

This territory facilitated an emergence of the sale and trafficking of drugs due to its geographical position with quick exits from the place and the city. In this scenario, conflicts arose throughout its history over obtaining the power to sell drugs. A busy street which cuts the territory in half and divided the neighborhood with the name “gang from above” is located above the street, and the “gang from below”, located below the street. For this and other reasons, the scenario of this study faces several violent situations.

All effective and outsourced professionals at the BHU who work in the research scenario were invited by one of the researchers to participate during a team meeting, and this was the inclusion criterion for both stages. However, the exclusion criteria were only used in the first stage, namely: residents, interns and retired professionals. The exclusion criterion in the second stage was only professionals on leave.

DATA COLLECTION

Data collection took place in two stages, with the first occurring between August and September 2017 with semi-structured interviews with professionals from the three BHU teams, for a total of 38. There were 27 professionals who participated in the research in this stage and were present during the collection, as the others were on licensed leave and/or away working in other posts; there was no refusal by any participant. Questions which were linked to: (1) whether they had witnessed and/or suffered violence and whether there was an intention to transfer from the unit; (2) and if any strategy was used to prevent violence in their workplace were used. Each interview lasted an average of eight minutes, were recorded and conducted in a separate room in the service itself.

The second stage took place in April 2018, when a focus group was formed with 18 professionals who were present at the team meeting at the BHU, which was already scheduled as a specific program of the research unit. Those who had already participated in the first stage were among these participants. All those present at the team meeting agreed

to participate in the second stage, and the reasons for the absences of the other professionals were linked to the same justifications mentioned above. The focus group lasted an hour and a half and was recorded with the presence of two observers who took notes, including one of the authors.

DATA ANALYSIS AND PROCESSING

IRAMUTEQ software (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*) was used for data processing in the first stage after transcription of the recorded interviews and constructing the corpus. The corpus is a directly described text in a single text.txt file from the OpenOffice.org software, separated by command lines, according to the research variables. This phase enabled rapid identification of the entire text segment used in qualitative writing with scientific rigor, with the researcher being fully responsible for the analysis⁽⁹⁾. This software is free anchored in the statistical environment of the R software program, which enables various textual data analyzes.

This study used the Descending Hierarchical Classification (DHC) method, which initially divides the corpus into text segments (TS) according to its words and according to the frequency of the reduced forms, thus obtaining the classes of elementary context units (ECU). A word dictionary is then created using the Chi-squared test (χ^2), which reveals the strength association between them, analyzed when the test is greater than 3.84 (which represents $p < 0.0001$), and the use of TS must be greater than 75%. IRAMUTEQ then organizes the data in an illustrative way in a dendrogram, which shows the relationships and the words of the classes⁽¹⁰⁾. The researchers then began their analysis from this organization of data.

Bardin's content analysis technique was carried out in the thematic analysis modality in the second stage with a focus group after the transcription of the recording, in which

it is possible to deepen the reading, clarifying a portion of meanings which could induce a description which was previously not understood⁽¹¹⁾. The recording transcripts of the interviews, as well as the focus group, were not returned to the participants for comment and/or corrections.

The results led to creating a categorical framework, which favored theme repetition during the meeting in a structural deciphering process centered on the speeches in a non-systematic way, and with flexibility due to the verbal material itself. The analysis consisted of thematic transversality, separating the speeches by themes represented by letters in alphabetical order⁽¹¹⁾.

ETHICAL ASPECTS

This study was carried out with the precepts of Resolution No. 466/2012 of the National Health Council and submitted to two Research Ethics Committees; one of the Universidade Federal do Paraná, approved under Opinion no. 2.159.123/17; and the other of the Municipal Secretariat of Health of Curitiba, under Opinion no. 2.234.609/17. The professionals who agreed to participate in the research signed the Free and Informed Consent Form (ICF) with guarantee of confidentiality, using an identification code in the first stage (P), and the second (PGS), both with a numeric sequence.

RESULTS

Data processing by the IRAMUTEQ software lasted 16 seconds with 265 TS being obtained, and subsequently 207 TS being used, which is equivalent to 78.11%. A chi-squared greater than 9 was used in the relationship between the ECUs as a parameter of analysis, and some words were not analyzed even when highlighted by the system due to the expression form used by the participants, generating the dendrogram (Figure 1).

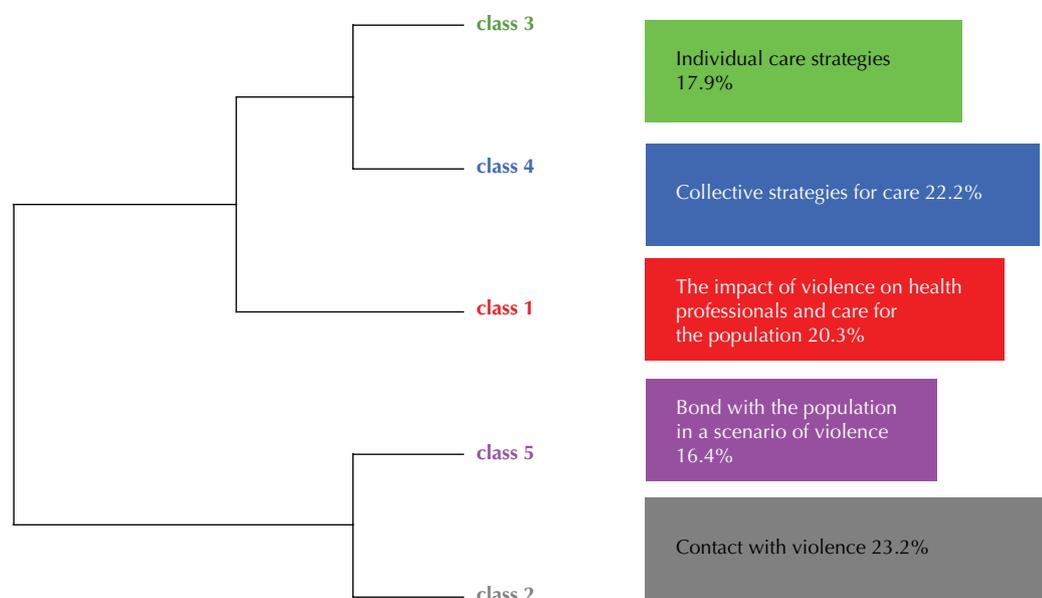


Figure 1 – Dendrogram of the classes provided by the IRAMUTEQ Software.

The reading for relating the classes of the dendrogram must be performed from left to right, from bottom to top. In Figure 1, it can be seen that the corpus was divided into two parts: on the one hand, two sub-corpus, class 2 with 48 ECUs (23.2%) and class 5 with 34 ECUs (16.4%); and on the other, class 1 with 42 ECUs (20.3%). Class 1 had a new division and generated class 3 with 37 ECUs (17.9%), and class 4 with 46 ECUs (22.2%), totaling 207 ECUs (100%), which promoted DHC stagnation due to a stabilization of TS in similar words. The percentage referring to the content is related to the number of times that the words inserted in the TS are repeated in relation to the total corpus⁽¹⁰⁾. The words were then analyzed in the context of the statements and the classes entitled by the researcher, as shown in Figure 1. The classes are described after the analysis in the first stage.

Class 1, referred to as: the impact of violence on health professionals and care for the population. The words: medication, home visit, stay and war are highlighted. The professionals reported their daily activities and the relationship between this context and the personal impact of violence, with emphasis on the following considerations:

You see the result of that [the violence] and it really ends up hurting us (...), I had [I attended] a child with a gunshot wound in the face and it's a very traumatic thing, we end up getting hit [by the violence] (P01).

In this class there were also situations in which fear and terror are made explicit and violence occurs within the health unit.

(...) they disarmed a boy inside [the health unit] and they kept his gun and then they came to get back the gun and then (...) when I saw a lot of guys wanting to jump in and invade the unit, I was very worried, I was scared of dying (P03).

With regard to the impact of violence on serving the population, one of the participants pointed out the following in another perspective:

When there was that situation of violence in the area, the gang war, we spent a few days not making a home visit and it affected patients because of the lack of visits (P17).

Class 2, referred to as: contact with violence. The words which achieved the greatest association were: work, think, leave, like, population and movement. This class showed direct contact with violence and how they organize themselves to protect themselves.

A boy was shot, he tried to enter the unit and failed and died there in front and the wife was pregnant and stood there holding a parasol so as not to let the sun [hit] his body until SLATE arrived. It scarred me a lot (P18).

Some speeches presented an approach on how they manage to warn each other in dangerous situations in the territory, with emphasis on Community Health Agents (CHA) and the community in these times:

We look through the CHA and the community, and they end up telling us oh, today it's very tense, take care (P01).

The CHAs always warn us (...) anything that's happening differently in the neighborhood, so we try to communicate as soon as possible via Whatsapp® to protect each other and ourselves (P03).

Class 3, referred to as: individual care strategies. The words that stood out were: talk, search, speak, try, right, avoid, say, way, contact and change. Strategies used individually linked to communication were reported to avoid or minimize conflicts within the BHU, with an emphasis on how to approach users.

Take care to soften the maximum [the response] no. Because sometimes, one no we say, they interpret it as a personal thing and then it can have consequences (P03).

The importance of maintaining a friendly and light relationship between peers within the BHU was alleged in order to maintain a calm and peaceful work environment:

I always say to maintain a peaceful work environment because its violent enough outside, we at least try not to let it affect so much (...) (P18).

Class 4 is referred to as: collective strategies for care. The highlights were: provide care, solving, problem, moment, attend, user, health unit and complicated. Participants described collective strategies which are added to individual strategies due to the involvement of the service team in the territory with this scenario. Its feelings of protection to the colleague stand out, the tranquility and assertiveness in the communication with the user in order to avoid conflicts, as well as the use of available and fast means of communication like Whatsapp® to warn about possibilities of risks in the territory. The use of the lab coat as a way of identifying the health professional is also highlighted in this class.

Look, we are very close to each other, if we see that a colleague had a difficult situation, if a colleague is going through a difficult situation, I try to go in and ease the situation there and resolve it. This is the way we act here (P08).

What protects us are the white coats (P19).

Class 5, referred to as: bond with the population in a scenario of violence, with emphasis on: violence, greater, considering, aggression, professional, family and experiencing. The professionals described that despite the impact of the violence, they are linked to the population and feel useful. The feeling of not wanting to leave BHU is distinguished in this class.

I don't have this feeling [leaving the service due to the violence], I think we are very useful here, especially in family health, we are more involved, you have a bond (P19).

Never! [leaving the unit due to the violence]. It's one of the best places I've ever worked. (...) Of the communities I worked in, I consider that [this] is the one that most needs my professional work, where I really see an immediate result of many of my interventions. And I find it easy to access for me and [it is] where I have been achieving a lot professionally, in my work (P24).

STAGE 2: FOCUS GROUP

The categories presented in this stage were separated by themes through thematic transversality, which were: (1) violence and the health professional; (2) the importance of the family health strategy; (3) bond with the population; (4) appreciation and support for professionals; and (5) strategies for assisting the vulnerable population exposed to violence.

1. Violence and the health professional: in this category, participants addressed their experiences and work in the violence scenario, inside and outside the BHU.

I already happened to be with my colleague in the field and the shooting is happening there in front of us, we can smell the powder. (...) You are faced with a situation like this and see that the risk is real (PGF02).

2. The importance of the family health strategy: a category in which the participants introduced the importance of care and comprehensive care to the population and work in the FHS.

Our work is based on the FHS (...). So we at the FHS have a different look, it is a different bond, a look at differentiated care (PGF01).

There are some assumptions of PHC which require an active care attitude towards the population in our coverage area. The role of PHC is care. So we are evaluated based on actions of promotion, prevention, including the work of a multidisciplinary team and with the participation of the community (PGF03).

3. Bond with the population: the research participants in this category addressed the importance of the bond with the population.

(...) And this created a huge possibility of creating a bond and creates great comfort, which is a very pleasant relationship, which is the continuity of care (PGF03).

4. Appreciation/support for professionals: professionals in this category discussed the importance of the work environment quality and the institutional support necessary for them.

The health unit became clearer, more beautiful with the reform, and we all improved, the community improved (...) (PGF04).

I think that the health teams together with the institution should be like this: they want to provide care in these areas, they need to provide care in these areas, for these people, they need to have a policy to serve these people. I think the institution needs to have a policy for serving vulnerable people (PGF03).

5. Strategies for assisting the vulnerable population exposed to violence, in this category they describe necessary strategies with local managers to qualify the service and avoid exposure to risk in areas exposed to violence.

That's why frequent meetings are important, because you speak, exchange ideas, give you guidance [target], you stop to think a little, it is very important (PGF01)..

The contact with the leaders, I think we could improve this, you know? Even to be able to know, in strategic points of the

area, how the situation is. There has to be better communication with the leaders. We must organize ourselves in a network (PGF05).

DISCUSSION

The strategies used in organizing health work in a socially vulnerable territory and evidenced in this research were characterized as being built by professionals during their work and by helping plan and develop the work. In this study and in the literature it was found that violence has an impact on professionals, causing feelings such as fear, frustration, impotence and anguish⁽¹²⁾.

Regarding what causes the most impact, situations were identified with violence penetrating the surroundings of the BHU, making this environment unsafe. However, it was observed that the resilience of research professionals emerged in offering comprehensive care to the population, transcending the limitations presented, which corroborates studies in similar territories⁽¹³⁻¹⁴⁾.

At another moment, they report the difficulties encountered in providing care and access to users in more critical periods of violence. This fact is consistent with studies which deal with urban violence and more critical confrontation situations and reveal different meanings and their consequences related to social construction, temporal and spatial demarcations. Circumstances in which the rules imposed by the factions compromise the actions of the health teams in their access to homes and the population to the BHU^(6,15).

When reporting on daily contact with violence and the importance of the FHS, these professionals described the communication strategies they use to warn each other when there is danger or risk in the territory, including a cell phone application. The strategies for providing care and bonding with the population were evidenced in the first stage which emerged from the individual level, and which are divided into two. The first with respect to communication with the user and in which they informed about the importance of communication in order to avoid or minimize conflicts; and in the second, the communication between the team in case of risk situations, which highlights the feeling of responsibility to care for the other, inferring the sense of protection of the group.

The results of this study showed the concern of health professionals to comply with the guiding principles of the FHS and highlighted care comprehensiveness, the bond and the need to work in a multi and interdisciplinary way. The team showed concern about these principles, which for the literature highlights the interest in meeting health needs in all situations⁽¹⁶⁾. And yet, that they do not feel they are the target of armed violence, but are surprised by it.

One of the strategies indicated in order to establish a bond with the community was assertive communication with the user, using it in a dialogical and empathic way; according to the studies, it has the intention of establishing therapeutic interaction, which is fundamental to overcome power relationship models and provide care according to

people's needs⁽¹⁷⁾. The strategy related to communication in the team reinforces the importance of everyone to promote it without the presence of noise in order to minimize possible situations of conflict with the population.

The professionals also brought a feeling of collective protection in the set of statements, which reveals that professional stress provides relationships, in which some support others and thus take care of themselves, corroborating a fact already evidenced in another study⁽¹⁸⁾. The literature also highlights that this is a cultural process whose scientific, organizational knowledge and experiences are articulated, and the practice of conflict prevention between the team and users is enhanced with the results of the work, making it a healthy organizational environment⁽¹⁹⁾.

Another mentioned strategy as a means of protection was the use of a lab coat inside and outside the BHU, classified in the literature as having two purposes: to identify the health professional and to serve as personal protective equipment. It is published in Federal Law No. 11.105, of March 25, 2005⁽²⁰⁾ being related to biosafety, and it is linked to recognition as a health professional⁽²¹⁾ as a form of personal identification regarding institutional use, corroborating the results of the research.

It became evident that in addition to the care focused on people's needs, the bond with the registered community also provides a means of protection in critical periods of violence, as professionals reported that they are warned by the community about possible risks. This fact is characterized in a study, mentioning that the bond with the population, operative groups and community leaders, provides approximation and favors joint construction of alternatives in facing experienced violence⁽²²⁾.

It is noteworthy that this bond extends to everyone and without distinction; therefore, this care is directed to the attacked and the aggressor, and in turn there is no need for professional judgment, but guidance when facing violent situations. When rethinking professional practice and after their experiences permeated by violence, professionals understand that their actions are not limited to the care of diseases, which is in line with one of the guiding principles of the FHS of comprehensive care, and is relevant for expanding cultural aspects of social life and family context⁽²³⁾.

The theme of logistics emerged with regard to the structural issue and inputs regarding the difficulties in providing care in vulnerable territories exposed to violence. The BHU scenario of this study underwent a renewal in 2015, which for the participants optimized welcoming and the community reacted positively to the changes. Corroborating the literature, a lack of adequate structure to perform activities and unfavorable conditions for work generate suffering, illness and lead to a situation of violence⁽¹⁴⁾.

Regarding how they feel in their workplace, a study revealed that violent situations can generate greater turnover of employees, which causes discontinuity in care and weakens the bond⁽¹⁵⁾. However, work satisfaction and feeling welcome by the community stood out among the professionals in this study, constituting a fact which is in line with literature which highlighted that acting in a highly

vulnerable universe promotes a sense of responsibility, usefulness and satisfaction, because it gives rise to a feeling of performing their activity in a coherent way as a citizen, even if alongside with the mental and physical fatigue caused by the experienced situations⁽²⁴⁾.

It becomes a challenge for the management of PHC services in vulnerable places and those exposed to violence to stimulate the bond between professionals and users. It is a consensus among professionals that integration of the team and a pleasant environment at work impact the care provided. The literature shows that activities developed in an environment with a favorable organizational climate promote comfort and ease, producing greater satisfaction and development of professional potential⁽²⁵⁾.

Even so, there is a gap in the literature with regard to protocols, team protection, as well as organization of work processes, as described in a study which addresses political fragility and little institutional involvement, conferring the need for public policies aimed at actions to prevent and confront violence, be it in any aspect⁽²³⁾.

With regard to the limitations of this study, the fact of having been carried out in a single BHU and the concentration of speeches in the focus group by higher education professionals, mainly doctors and dentists, are cited.

CONCLUSION

Violence has been experienced in several territories where PHC teams work, and a multidisciplinary and interdisciplinary action in elaborating violence prevention strategies is necessary in order to face it in this context. It is expected that the management strategies identified in this study, namely: communication, collective protection, wearing a lab coat and identification badge, establishing a bond, comprehensive care, team integration, favorable organizational climate, organization and work organization in order to meet the health needs of the population, can assist other teams in similar scenarios, considering that violence still has little visibility among health professionals and managers, despite being considered a public health problem.

Communication was cited as one of the main tools among the discussed strategies to avoid exposure to conflicts and risks related to violence in the territory. In this context and informally (as it is a strategy listed by the team), the use of applications such as Whatsapp[®] stands out, which promote rapid communication between professionals to warn about risk situations in the territory. Still regarding communication with a view to avoiding conflicts, assertive dialogue during appointments stands out, combined with the use of words which welcome health needs and using active listening without imposing judgments and preconceptions.

The attitude of always being ready to establish a bond shows a positive strategy. In this context with regard to communication with the team, the local manager has a responsibility to promote and maintain effective communication as a strategy for connecting and resolving conflicting situations. For meeting the needs of the community, it is evident that the curricular guidelines for training health professionals

present little information about coping with and serving citizens in situations permeated by violence. It is necessary to discuss this training in addition to the biomedical model, highlighting the multidisciplinary, intersectoral and social determinants of health.

The study identified gaps in relation to support in critical situations and introduces a proposal aimed at public policies on the subject through an elaboration of specific

protocols in the organization and management of PHC in highly vulnerable territories exposed to violence, and which establish mechanisms of technical and emotional support to these teams in order to base, guide and support their daily activities.

Lastly, the prominence of the bond, the concern of the team for the users and the satisfaction of the professionals for being present in the place can be emphasized.

RESUMO

Objetivo: Identificar estratégias de gerenciamento utilizadas pelas equipes de Estratégia Saúde da Família de uma Unidade Básica de Saúde na organização do trabalho em território de vulnerabilidade social exposto à violência. **Método:** Estudo de caso único de abordagem qualitativa, em uma unidade de saúde da família localizada na região Sul do Brasil. Coleta de dados por entrevistas individuais com 27 profissionais de saúde de agosto a setembro de 2017 e grupo focal com 18 participantes em abril de 2018. Organização e processamento dos dados com suporte do *software* IRAMUTEQ e, posteriormente, técnica de análise de conteúdo. **Resultados:** As cinco classes caracterizaram estratégias utilizadas pelos profissionais ao atendimento à população considerando sua vivência frente a situações de violência. No grupo focal, foi elaborada e validada uma diretriz para nortear o gerenciamento e organização do trabalho nesses serviços. **Conclusão:** Foi evidenciado que mesmo sem apoio de políticas públicas específicas a essas situações, os profissionais desenvolvem estratégias que incluem o fortalecimento da equipe como forma de proteção coletiva, acolhimento focado no atendimento integral e vínculo. A população é aliada ao facilitar o acesso ao atendimento de vulneráveis e alerta os profissionais das situações críticas no território.

DESCRITORES

Violência; Vulnerabilidade Social; Profissionais de Saúde; Enfermagem de Atenção Primária; Saúde da Família.

RESUMEN

Objetivo: Identificar estrategias de gerenciamento utilizadas por los equipos de Estrategia de Salud de la Familia de una Unidad Básica de Salud en la organización del trabajo en territorio de vulnerabilidad social expuesto a la violencia. **Método:** Estudio de caso único de abordaje cualitativa, en una unidad de salud de la familia localizada en la región Sur de Brasil. Colecta de datos a través de entrevistas individuales con 27 profesionales de salud de agosto a septiembre de 2017 y grupo focal con 18 participantes en abril de 2018. Organización y procesamiento de los datos con soporte del *software* IRAMUTEQ y, posteriormente, técnica de análisis de contenido. **Resultados:** Las cinco clases caracterizaran estrategias utilizadas por los profesionales al atendimento a la población considerando su vivencia frente a situaciones de violencia. En el grupo focal, fue elaborada y validada una directriz para nortear el gerenciamento y la organización del trabajo en esos servicios. **Conclusión:** Fue evidenciado que mismo sin apoyo de políticas públicas específicas a esas situaciones, los profesionales desenvuelven estrategias que incluyen el fortalecimiento de lo equipo como forma de protección colectiva, acogimiento condensado en el atendimento integral y vínculo. La población es aliada al facilitar el acceso al atendimento de vulnerables y alerta a los profesionales sobre situaciones críticas en el territorio.

DESCRIPTORES

Violencia; Vulnerabilidad Social; Personal de Salud; Enfermería de Atención Primaria; Salud de la Familia.

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