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Violence in the Family Health Strategy: risks to workers' health and care

Violência na Estratégia de Saúde da Família: riscos para a saúde dos trabalhadores e ao atendimento

Violencia en la estrategia de salud de la familia: riesgos para la salud de los trabajadores y la atención

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ABSTRACT
Objective: to identify the occurrence of violence in Brazil's Family Health Strategy and to analyze the repercussions on workers' health and on care. **Method:** this qualitative, descriptive study was conducted in 2018 with 27 workers from a Family Health Strategy unit in the city of Rio de Janeiro, using the semi-structured, scripted interview technique, and thematic content analysis to categorize interviewee discourse. The project was approved by the research ethics committee. **Results:** the violence identified was psychological, as perpetrated by users in threats, name calling and intimidation, and urban, in health personnel's exposure to gunfire, robbery, and fights during home visits, which had repercussions on the workers' mental health and impaired the quality of care. **Conclusion:** occupational violence is a risk to health workers' physical and mental integrity and to the quality of care.
Descriptors: Family Health Strategy; Workplace Violence; Patient Care Team; Mental Health.

RESUMO
Objetivo: identificar a ocorrência da violência na Estratégia de Saúde da Família e analisar as repercussões para a saúde dos trabalhadores e ao atendimento. **Método:** estudo qualitativo, descritivo, realizado com 27 trabalhadores de uma unidade de Estratégia de Saúde da Família localizada no município do Rio de Janeiro em 2018. Trabalhou-se com a técnica de entrevista semiestruturada mediante roteiro e para a categorização dos depoimentos a análise de conteúdo temática. Projeto de pesquisa aprovado pelo Comitê de Ética em Pesquisa. **Resultados:** identificou-se a violência psicológica perpetrada por usuários através de ameaças, xingamentos e intimidações e a urbana com a exposição dos profissionais a tiros, assaltos e brigas durante as visitas domiciliares ocasionando repercussões na saúde mental dos trabalhadores e prejuízos para a qualidade do atendimento. **Conclusão:** a violência ocupacional é um risco a integridade física e psíquica dos trabalhadores e a qualidade do atendimento.
Descritores: Estratégia Saúde da Família; Violência no Trabalho; Equipe de Assistência ao Paciente; Saúde Mental.

RESUMEN
Objetivo: identificar la ocurrencia de violencia en la Estrategia de Salud de la Familia de Brasil y analizar las repercusiones en la salud y la atención de los trabajadores. **Método:** este estudio cualitativo descriptivo se realizó en 2018 con 27 trabajadores de una unidad de Estrategia de Salud de la Familia en la ciudad de Río de Janeiro, utilizando la técnica de entrevista semiestructurada, guionizada y análisis de contenido temático para categorizar el discurso del entrevistado. El proyecto fue aprobado por el comité de ética en investigación. **Resultados:** la violencia identificada fue psicológica, perpetrada por los usuarios en amenazas, insultos e intimidación, y urbana, en la exposición del personal de salud a disparos, robos y peleas durante las visitas domiciliarias, lo que repercutió en la salud mental de los trabajadores y perjudicó la calidad de atención. **Conclusión:** la violencia laboral es un riesgo para la integridad física y mental de los trabajadores de la salud y para la calidad de la atención.
Descriptores: Estrategia de Salud Familiar; Violencia Laboral; Grupo de Atención ao Paciente; Salud Mental.

INTRODUCTION

The *Estratégia Saúde da Família (ESF)* [Family Health Strategy] is part of the *Rede de Atenção à Saúde (RAS)* [Health Care Network] and is considered the main entrance door of the Brazilian Unified Health System (SUS). Within SUS, care is provided both in health care centers or/and in the patients' homes, which begins by receiving patients and providing a resolutive response to their health problems. Receiving patients with attentive listening is intended to establish bonds with patients and provide integral care, which requires joint work with multi-professional and interdisciplinary teams, with everyone being willing to listen and value exchanges and experiences[1].

Humanized care favors access of the population to health care centers, qualifies workers' practice, and makes the service more effective, improving the health and quality of life of all those involved[2,3]. In general, however, there is a gap between motivation to seek a health service, and the needs health workers need to meet. That is, the workers' desires and those of the patients do not always intersect, often causing conflicts that are

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difficult to resolve—not listening with the purpose to negotiate, allied with a culture of violence already established in society, maybe a fertile ground for the outbreak of violence at work, with consequences for workers and care delivery[4-6].

Urban violence is added to the daily routine of RAS. The workers work in areas marked by high homicide rates; however, the strategies used to deal with violence are not effective. For this reason, health workers need to implement interventions guided by a broad conception of health in order to consider the social determinants of the health-disease-care continuum and care itself[7]. In this sense, it is essential to identify and discuss workers' exposure to work-related violence and how to face it at an individual, collective, and organizational level within RAS, considering that the services that compose the network are preferably located in areas of greater social vulnerability[8]. Work-related violence interferes in the dynamic of care delivery and leads to high rates of absenteeism for varied reasons, high turnover, and increased levels of physical and mental problems[9].

An integrative literature review of studies addressing work-related violence in the context of ESF was performed to support this study. Studies were searched in the Virtual Health Library (VHL) together with the Brazilian Nursing Database (BDENF), Latin American and Caribbean Health Sciences Literature (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE), and Cumulative Index to Nursing and Allied Health Literature (CINAHL). Studies published in Brazil between 2014 and 2018 were selected. A total of 96 papers were identified, and 12 studies, mainly debating work-related violence and its relationship with the health field, remained after duplicated versions, reviews, and reflection studies were excluded. A lack of studies addressing the topic is even more apparent when we focus on the ESF, which justifies the need to deepen analysis on this object.

This study's objectives were to identify the occurrence of violence in the context of the Family Health Strategy and analyze how it affects the health workers and care delivery.

LITERATURE REVIEW

Currently, violence is a public health problem that affects individuals and the community regardless of creed, race, age, sex, or purchasing power, with severe repercussions for the individual and society in general due to emotional, social, and economic burdens. Therefore it is essential to prevent violence in all social spheres such as family, school, and work[10]. The *Política Nacional de Redução da Morbimortalidade por Acidentes e Violência* [National Policy for the Reduction of Morbidity and Mortality by Accidents or Violence] acknowledges violence as a public health problem, guiding health services in this context, assuming violence to be "an event represented by actions performed by individuals, groups, classes, or nations causing physical, emotional, moral and/or spiritual harm to oneself or others"[11:7]

Work-related violence is any action, incident, or behavior based on the aggressor's instinctive attitude, and as a consequence, a worker is assaulted, threatened, harmed, or injured during work[12]. Concerns with work-related violence increased at the end of the 1990s when the field of Work-related Health also turned its attention to it. At this time, the International Labour Organization (ILO) and the World Health Organization (WHO) started discussing this event and proposed joint actions to deal with it. From this point on, the literature has given more attention to the problem, and some institutions started measuring this phenomenon and its repercussions on the organization and health of workers[13].

The idea that work-related violence involves uniquely personal factors is currently rejected. Work-related violence is now considered the result of a combination of causes related to people, environment, physical and social environments, job organizational and contractual conditions, as well as how the workers interact among themselves, with clients, and entrepreneurs[5].

METHOD

This is a descriptive and exploratory study with a qualitative approach. The study setting was an ESF unit opened in 2011, located in Rio de Janeiro, Brazil, with approximately 10,133 registered users. Five teams perform technical and care activities. The unit operates from Monday to Friday from 7 am to 6 pm, and on Saturday from 8 am to 12 pm, when the teams take turns. The ESF is part of the network service of Programmatic Area 3.2 (AP 3.2), which is managed by a Health Social Organization comprising 23 neighborhoods in the Northern area. The *Núcleo de Apoio à Saúde da Família (NASF)* [Family Health Support Center], composed of a complementary team that includes health workers from different professions, is part of the ESF and provide clinical, health, and teaching support to the ESF workers, to ensure continuity of care to the population.

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The Institutional Review Board approved the study project (Opinion report No. 2,668,601/SMS-RJ). After receiving clarification regarding the study's objectives and ethical aspects, the participants signed free and informed consent terms according to Resolution 466/12. A total of 27 health workers participated: 13 community health agents, 2 oral health assistants, 3 nurses, 4 physicians, 4 nursing technicians, and 1 oral health technician. Inclusion criteria were: professionals working for at least one year in the ESF and actively performing work-related activities at the time data were collected. Workers on sick leave or other kinds of leave or vacation were excluded.

The participants were informed that participation was voluntary and that they were free to withdraw at any time. Confidentiality was ensured and the participants were informed that the results would be presented in events or published in scientific journals. The reports are identified as CHA (Community Health Agent), OHA (Oral health assistant), NUR (Nurse), PHY (Physician), NT (Nursing technician), OHT (Oral health technician) followed by a number that corresponded to the order in which the interviews were held.

Data were collected in the first semester of 2018. Individual interviews were held for approximately 30 minutes in a private room free from interferences, scheduled according to the participants' availability. A semi-structured script with open-ended questions was used together with a structured form to characterize the participants.

After transcription, the reports were analyzed using the thematic content technique[14], based on decoding the reports in various elements, which were classified and composed analogical groupings. Finally, the following thematic axes emerged using the criteria of representativeness, homogeneity, reclassification, and grouping: psychological violence perpetrated by users and work-related violence in the territory.

RESULTS AND DISCUSSION

Psychological violence perpetrated by users

The health workers in the ESF play a relevant role by providing health education to the population, performing epidemiological surveillance, immunization, and other disease prevention actions. In this sense, we need to reflect upon the flow of care provided to families enrolled in the unit and those who seek the service with needs that are not always compatible with its capabilities. Hence, those seeking the service become stressed due to not having their needs met, which contributes to psychological violence against workers, such as:

> *The service does not work! Who gets in the middle of it are the workers. There are patients who come here many times, and their problems are not solved. At some point people lose their minds. And they blame us! They call us names, hit the table, and threaten us. Every day is like that (I10NT).*
>
> *It became a routine! You witness your colleagues being called names at the workplace or being threatened. Nowadays, these things happen so often; it became normal (I3NT).*
>
> *Some patients lose their minds… there are some workers here who have been verbally attacked, or there was an attempt to attack them physically (I17CHA).*

In addition to exposing the service's inadequate problem-solving capacity to deal with both problems of a technical and care nature, these reports reveal the workers' representations of patients, that is, aggressive patients. Because these patients lose control, they become the object of care, requiring workers to have skills to deal with violence and reflect upon power relations in the social space of work[4]. In turn, aspects such as longitudinal and integral care, community-oriented care, and the professionals' cultural competence should be considered because when implemented in the daily routine, these aspects transform the perspective of violence and its causes, showing it is a social determinant of health that demands planned interventions of an intersectoral nature with the participation of the community[7].

Providing training to workers and sensitizing them to prevent work-related violence is vital. Qualification of workers enables establishing closer bonds with patients and developing attentive listening to refer or schedule patients effectively[3]. Being aware of the existing relationship between access and satisfaction enables alternatives to improve the quality of health services, so aspects related to the flow of care, time spent in waiting rooms, and being satisfied with appointments, consultations, and exams should be considered. Hence, managers should assess the need to invest in infrastructure and human resources to adapt to demand[2].

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The users' behavior and eagerness to obtain and resolve health needs fast, allied with the fear of workers with the violence existing in the areas covered by the ESF, often leads to dissatisfaction and distress. The work performed by the ESF team requires the establishment of aligned relationships conducive to the delivery of resolutive health care actions[9]. Hence, work-related violence stands out as a collective health problem in modern times, and even though it is underreported, it has gained attention given its repercussions for the health of workers and care delivery[7].

This study shows that psychological violence at work has become trivial and natural. Workers seldom report violence unless there are continuous threats or an event considered to be serious. It seems that underappreciated health workers and a society in which violent acts are not punished discourage reporting on the part of workers who lose faith that any measures will be ever implemented.

Therefore, we ratify the importance of workers and the community to take part in projects intended to prevent, monitor and fight violence by reporting its occurrence, providing education and training, and adopting measures that ensure the safety of the staff within the unit and during home visits along with other technical activities[15].

However, violence reporting is still a weak institutional culture in family health teams, making it even more challenging to propose strategies to confront it effectively. Health workers are little interested in reporting violence cases because they do not know its repercussions, while results are not very helpful in their daily routines[16,17]. Nonetheless, not reporting violence experienced by workers regardless of its nature and the relationship between those involved leads to the cyclical perpetuation of the problem, hindering effective strategies intended to contain the problem[9,11,15].

Work-related violence in the territory

The purpose when the ESF was implemented in the 1990s was to provide health care to those areas under the greatest social vulnerability. Additionally, these teams' work is intended to be closer to the population, whose care is usually provided in open spaces or at the patients' homes[16]. The violence faced in these areas, together with violence resulting from drug trafficking, not only hinder the continuity of health care actions, but cause workers to feel unsafe and subject to unpredictable events because a violent event may occur at any time, threatening the physical and mental integrity of workers, as the following excerpt shows:

> *You are there (in the community) and there can be shooting any time! You have nowhere to hide! I don't know! Worse things can happen! I think it is pretty violent! Really dangerous! (I19NT).*
>
> *We pass in front of the drug den! So, you see young boys holding guns! It's really heavy, but you get used (I26PHY).*
>
> *I was mugged right here! They took my car! I was held hostage with a gun pointed to my head. They took everything I had! It was a very difficult situation! Traumatic! (I1PHY).*

Constant violence in the routine of communities is a barrier impeding access to health services. Organized crime groups linked to drug trafficking and guns impose rules for health workers to enter the community, compromising home visits on the part of the ESF. These rules also impede some residents from going to the area where the PHC center is located. Consequently, there is a higher turnover of workers due to violence, resulting in discontinued work processes and weakening the bonds established with the community[7].

There are symmetrical relationships between violence and the social, economic, and political structure of a country. Violence worsens with exclusions and lack of social protection, characteristics of the current neoliberal model, which generates all kinds of insecurity. In this context, health care and health promotion implemented in areas that are vulnerable to violence are usually characterized by poor infrastructure, and restricted material living conditions, and profound social inequalities. In addition to social issues, the people living in areas at risk face exclusion situations such as unemployment, lack of basic sanitation, lack of leisure, and insecurity[10].

The implications of violence on the workers' health are apparent in their reports, showing distress, fear, and insecurity in the face of risks imposed on their physical and psychological integrity. As reported, the care provided to users is harmed due to a feeling of not being protected and afraid:

> *It really affects me psychologically. We get here afraid! Afraid of commuting to the unit, afraid of making home visits, afraid of going back home… It's like this all the time, all the time you have this feeling (I5NUR).*

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Ah, we get afraid, very insecure, and it directly interferes in our practice. The care you provide is not the same. I guess we get too exposed! No protection. It makes me reconsider this job (I20OHT).

I guess workers feel very, very insecure, very afraid, all the time! There have been situations of workers not knowing how to find the balance to finish a consultation (I11NUR).

Urban violence has affected how the services are adapted to the local context, which means the teams have to face numerous obstacles to provide health care effectively. There are limitations to access the health unit and to perform home visits, which impede activities such as educational groups, consultations, preventive measures, or health promotion actions. There are also problems related to poor security and infrastructure and drug trafficking, among other factors that make the delivery of health care to be a daily challenge[8,18].

Violence and the trade of illegal drugs not only harm the quality of life of people, but it is also a threat to the physical and psychological integrity of all those involved. The trade of illegal drugs is predominant in violence and conditions numerous conflicts between traffickers and patients, leading to increased crime and the number of preventable deaths, and interruptions of essential services[6].

Lack of safety generates fear among health workers, restricts their access to the workplace, and interferes in the implementation of activities, negatively affecting the workers' satisfaction and motivation. The workers' reports reveal fear, insecurity, and anxiety, showing there is psychological distress[9].

The workers face a series of challenges that limit their professional practice, such as fear of confrontations between rival communities, coexistence with drug users, and trafficking. Limitations imposed include difficulty accessing the patients' homes, transporting the teams, being hopeless in the face of physical threats, struggling to obtain the population's trust, and the fact that the population is prevented from going to the health units[5].

Study limitations

Despite this study's limitations concerning the method, the number of participants, and also the fact the study addressed a single ESF unit, which impedes the generalization of results to other contexts of work, discussing urban violence and violence faced within the area covered by health units is relevant for violence reporting and training of teams to qualify care and minimize the occurrence of violence.

CONCLUSION

The conclusion is that ESF workers are exposed to psychological violence perpetrated by the services' users in the form of verbal threats, insults, and intimidation due to dissatisfaction with the service and its poor problem-solving capacity. These acts also interfere in the quality of care and represent risks to the workers' physical and psychological integrity.

Urban or commuting violence was found as workers are exposed to drug trafficking, gunshots, policing, and robberies, as the ESF unit is located in an area of greater social vulnerability.

Violence negatively interferes with the work of professionals, preventing health promotion and health education, as well as the prevention of diseases.

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