Revista Brasileira em Promoção da Saúde
e-ISSN:1806-1230
Original Article
DOI: 10.5020/18061230.2021.11152

Violence survival strategies used by Community Health Workers

Estratégias de sobrevivência à violência utilizadas pelos agentes comunitários de saúde

Estrategias de supervivencia a la violencia utilizadas por los agentes comunitarios de salud

Cibelly Melo Ferreira
Fortaleza Municipal Health Secretariat (*Secretaria Municipal da Saúde de Fortaleza*) - Fortaleza - (CE) - Brazil
Oswaldo Cruz Foundation (*Fundação Oswaldo Cruz*) - Eusébio - (CE) - Brazil

Vanira Matos Pessoa
Oswaldo Cruz Foundation (*Fundação Oswaldo Cruz*) - Eusébio - (CE) - Brazil

Maria Rocineide Ferreira da Silva
Ceará State University (*Universidade Estadual do Ceará*) - Fortaleza - (CE) - Brazil

Sharmênia de Araújo Soares Nuto
Oswaldo Cruz Foundation (*Fundação Oswaldo Cruz*) - Eusébio - (CE) - Brazil
University of Fortaleza (*Universidade de Fortaleza*) - Fortaleza - (CE) - Brazil

ABSTRACT

Objective: To identify violence survival strategies used by community health workers (CHW) living and working in highly vulnerable territories experiencing urban violence. **Methods:** This is a qualitative descriptive study that used the theoretical framework of community violence in the Family Health Strategy (*Estratégia de Saúde da Família – ESF*). Data were collected from 12 CHW through semi-structured interviews from March to April 2019. The interviews were recorded, transcribed and submitted to meaning interpretation analysis. The empirical themes were grouped into two categories: "violence in the territory" and "violence coping strategies used by CHW". **Results:** Six of the interviewees work in territories disputed between criminal organizations and six work in areas where there is no dispute between commands. However, even those who work in areas where there is no dispute feel the interference of violence in their health. The violence survival strategies were classified into three types: behavioral, use of preventive practices, and mental protection measures. **Conclusion:** "Being blind, deaf and hard of hearing" and "keeping a distance from the police" were the main strategies adopted to survive violence in the territories.

Descriptors: Violence; Community Health Workers; Family Health Strategy.

RESUMO

Objetivo: *Identificar as estratégias de sobrevivência à violência utilizadas pelos agentes comunitários de saúde (ACS) residentes e trabalhadores em território de alta vulnerabilidade e violência urbana.* ***Métodos:*** *Trata-se de um estudo descritivo, de abordagem qualitativa, em que se utilizou o referencial teórico de violência comunitária na Estratégia Saúde da Família (ESF). Realizou-se a coleta de dados com 12 ACS, por meio de entrevistas semiestruturadas, no período de março a abril de 2019. As entrevistas foram gravadas e transcritas e se procedeu à análise do tipo interpretação dos sentidos. Os temas empíricos agruparam-se em duas categorias: "Violência no território" e "Estratégias de enfrentamento à violência usadas pelos ACS".* ***Resultados:*** *Dentre os entrevistados, seis trabalham em territórios com disputas entre facções e seis em áreas sem disputas entre comandos. Entretanto, mesmo os que trabalham em áreas sem disputas, sentem a interferência da violência em sua saúde. As estratégias encontradas de sobrevivência diante da violência classificaram-se em três tipos: comportamentais, de utilização de práticas preventivas e medidas de proteção mental.* ***Conclusão:*** *"Ser cego, surdo e mudo" e "manter distância da polícia" constituíram as principais estratégias adotadas para sobreviver à situação de violência nos territórios.*

Descritores: *Violência; Agentes Comunitários de Saúde; Estratégia Saúde da Família.*

Received on: *06/20/2020*
Accepted on: *02/22/2021*

RESUMEN

Objetivo: *Identificar las estrategias de supervivencia a la violencia utilizadas por los agentes comunitarios de salud (ACS) que viven y trabajan en territorio de alta vulnerabilidad y violencia urbana.* ***Métodos:*** *Se trata de un estudio descriptivo y de abordaje cualitativo en el cual se ha utilizado el referencial teórico de violencia comunitaria de la Estrategia Salud de la Familia (ESF). Se realizó la recogida de datos con 12 ACS a través de entrevistas semiestructuradas en el período entre marzo y abril de 2019. Las entrevistas han sido grabadas y transcritas y se ha realizado el análisis del tipo interpretación de los sentidos. Se ha agrupado los temas empíricos en dos categorías: "Violencia del territorio" y "Estrategias de afrontamiento a la violencia usadas por los ACS".* ***Resultados:*** *De entre los entrevistados, seis trabajan en territorios de conflictos entre facciones y seis en áreas sin conflictos entre comandos. Sin embargo, incluso aquellos que trabajan en áreas sin conflictos sienten la interferencia de la violencia en su salud. Se ha clasificado las estrategias encontradas de supervivencia delante la violencia en tres tipos: de conducta, de utilización de prácticas de prevención y de medidas de protección mental.* ***Conclusión:*** *"Ser ciego, sordo y mudo" y "mantener la distancia de la policía" han sido las principales estrategias adoptadas para sobrevivir a la situación de violencia de los territorios.*

Descriptores: *Violencia; Agentes Comunitarios de Salud; Estrategia de Salud Familiar.*

INTRODUCTION

The strengthening of Primary Health Care (PHC) through the Family Health Strategy (*Estratégia Saúde da Família – ESF*) has been one of the most important actions taken by the Unified Health System (*Sistema Único de Saúde – SUS*) for the reorganization of the model of care. It is aimed at ensuring individual, family and collective health care actions, which include activities of promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance delivered by a multi-professional team responsible for the health of a defined territory[1].

In the ESF, the work that community health workers (CHW) carry out with the communities stands out as it contributes to bringing the population and the health care center closer through monitoring and visits to the social equipment and to the users' homes. The territory in which these professionals work generally stands out for their high social and environmental vulnerability, with a predominance of violence, drug trafficking, poverty, inefficient basic sanitation, and presence of garbage in the surroundings[2].

Urban violence causes fear, lack of confidence and individualism, impacting the work of ESF teams[3,4]. Professionals who work in ESF in violent regions experience limitations in their work process because, in addition to making home visits difficult, violence often makes disease prevention and health promotion activities unfeasible in the center and in other areas of the community. The creation of gaps in the care process generate feelings of frustration among professionals[4].

The term urban violence has different meanings and consequences. It is a social construction with temporal and spatial remarks. All violence continually has a context which corresponds not only to the perpetrators or victims, but jointly to those who perceive it[5].

The increase in violence rates and the concern with this phenomenon are not restricted to Brazil. Impacts are observed on public health as it is both one of the main causes of impairment to health and a threat to life and provision of services in more vulnerable territories[4].

The impact of urban violence on the structure, functioning and quality of health services offered, and the repercussions of continued exposure to indirect violence, such as hearing or witnessing domestic violence, related deaths, drug use and trafficking, should be more researched[6]. The complex reality of urban violence in Brazil, where criminal groups manage the territory through normative devices, affects, in particular, the CHW because they live in the territory and need to deal with situations involving the use and trafficking of drugs, the involvement of users and their families with illegal practices, and the possibility or the use of force in relationships[6].

The choice of this theme was motivated by the importance of the work of CHW in the ESF, as they are essential in facing the problems encountered in the daily lives of the communities. The fact that workers often live in the territory where they work makes the problem of violence evident. The daily, intense, and prolonged interaction of CHWs with the community has an impact on these workers, as they witness situations of assault and intense misery[7].

There are still scientific gaps in information on the exposure to occupational violence among ESF professionals, especially CHWs, with a very small number of qualitative studies on the theme and its implications. Greater emphasis

is given to research that seeks to describe the prevalence, magnitude and risk factors involved in the work of the teams. It is necessary to deepen the discussions based on the relationships that are established between the health centers and the violence present in the communities[6] as well as to develop coping strategies through practices of care and health promotion, as these actions[8] can also be useful for the health of ESF workers[9].

How do CHWs experience and overcome situations of urban violence in a large city in Northeastern Brazil? In an attempt to answer this research question, this study aimed to identify the violence survival strategies used by community health workers (CHW) living and working in a highly vulnerable territory facing a high rate of urban violence.

METHODS

This is a qualitative descriptive study using the theoretical framework of community violence in the ESF[6] carried out in a Primary Health Care (PHC) center in the city of Fortaleza, Ceará, Brazil. The PHC center is responsible for approximately 20,000 inhabitants and has four ESF teams. The center was not identified to protect the research participants, as this is a topic on which many are afraid to express their opinions. The criteria used to select the area for the study was based on the perception of the relevance and impact of some social, health and community violence indicators, such as the Human Development Index (HDI) and deaths from external causes, with the latter being a sensitive issue in the territory.

Initially, all the CHW assigned to the selected PHC centers were contacted individually to participate in a meeting in which the objectives of the research and its importance were clarified. After the invitation was accepted by all, data were collected from 12 CHW who were chosen intentionally. Municipal public servants working as CHW at the chosen PHC center were included, and those who had been working as CHWs for less than six months were excluded.

After clarifications, semi-structured interviews[10] were scheduled on a voluntary basis and held outside the territory of the selected PHC center and conducted by the study supervisor who did not know the interviewees.

Each interview lasted, on average, one hour and was held in an atmosphere of secrecy and trust. Interviews were conducted from March to April 2019 using a guide with semi-structured questions. The interviews were recorded and transcribed. The names of the interviewees are fictitious and were chosen by the interviewees themselves. To guide the report of the interviewees' experiences, the question guide was divided into four axes[6]:

Axis 1: Perceptions of the reality experienced by the CHW living in a highly vulnerable territory with a high rate of urban violence. Guiding question: What is the community where you live like? And how do you relate to the neighborhood? Axis 2: The work of the CHW in the ESF. Guiding question: How is your CHW work in this community?

Axis 3: Community violence and its relationship with the CHW working context. Guiding question: What is violence like in your community? Axis 4: Community violence and its relationship with the CHW's health. Guiding questions: Has urban violence affected your physical and/or mental health? How did you cope with the reported health problems?

Data were analyzed using the method of interpretation of meanings[11] through the following steps: i) comprehensive reading (exploration of the material, design of the analysis structure and identification of the themes); ii) exploration of the material, in which the analysis is structured by themes (excerpts from statements and identification of explicit and implicit ideas); iii) elaboration of the interpretative synthesis, in which the theoretical framework, contexts, field records and speeches are articulated.

In the first stage, during the exploration of the empirical material, the analysis structure was organized in two *corpora*: i) CHW living in areas with stability under the command of a criminal group; and ii) CHW living in areas with disputes between criminal groups, with the empirical themes grouped into two categories: violence in the territory and strategies to cope with violence used by CHW.

The Research Ethics Committee of the University of Fortaleza approved the study through Approval No. 3.192.862, and all CHW signed an Informed Consent Form prior to interviews.

RESULTS AND DISCUSSION

The respondents' mean age was 44.5 years, with age ranging from 33 to 59 years. Ten of the interviewees were women. The feminization of CHW is not only observed in the researched context, with the same characteristics being found in other studies[4,6]. This situation seems to highlight a common feature of this professional category, which dates back to the origins of the profession, when women were given the opportunity to work as health workers during droughts in the countryside of Ceará[12].

A total of ten of the interviewees had completed secondary school and two had completed higher education; five were single and seven were either married or lived in a common-law marriage. With regard to skin color, eleven considered themselves *pardos* (mixed-race Brazilians) and one was self-declared Black. In addition, eight participants were Catholic, one was a Protestant, one was a Jehovah's Witness and two reported following no religion. The length of experience in the center ranged between 5 and 20 years, with only five having less than 10 years of experience.

Of the interviewees, six work in territories with disputes between criminal groups and six in areas without disputes between these groups. Generally, these areas with disputes cause greater illness to the CHW, but even those who work in areas without disputes report compromised health. Only four said they did not feel affected by violence.

Violence in the territory

Most of the interviewees' statements were used to construct this category: violence in the territory.

The territory in which the study was conducted covers two neighborhoods in the city of Fortaleza, Ceará, where several communities are distributed with the HDI considered to be very low, between 0.29 and 0.16[13]. There is a high social contrast:

> *"Where you see, then, the needy community face to face, side by side with the big houses that make up the neighborhood, and you see the luxurious condominiums." (Helena)*

The community can be understood as an ideological construction based on needs, such as individual security, comfort, familiarity, and a sense of belonging. Within the community there is the familiar (us) and the stranger (others). In belonging to a community, the individual denies his/her individuality in order to desire the collective needs of intimacy and the construction of an "identity"[14].

All areas covered by the health center are controlled by some criminal organization. This command is not homogeneous throughout the territory, resulting in many conflicts, with differences in the speeches and in the relationship with violence being identified due to disputes or lack of them in the commands of the criminal organization in the territory of each CHW.

The term "urban violence" refers to a social phenomenon designated as a set of expressions that affect the feeling of continuity in daily routines and the individual security of people with or without ties of kinship outside the domestic environment. It is a phenomenon that requires a multifaceted, intersectoral and interdisciplinary approach and which can affect individuals, groups, classes, and institutions. Its relationships employ several methods and means of coercion and personal annihilation[4,6,15].

The CHW report that they experience some types of violence at work, such as sexual harassment and verbal violence, and witness situations such as homicides, armed people circulating in the community, fights between family members and neighbors, among others:

> *"When I experience sexual harassment, I feel, I don't know, humiliated, ashamed, I don't even want to work anymore. It feels bad, doesn't it?! But I pretend I don't listen and keep walking and pray. And I keep walking." (Leticia)*
>
> *"For example, sometimes people insult each other. Which is very strong too! People being insulted. A father who doesn't treat his son so well... sometimes a mother." (Marta)*

Understanding the context of CHW practices in territories of urban violence and understanding that they perform their activities and also live in this scenario help in understanding how these professionals act in the face of favorable or unfavorable conditions. CHW are exposed to some situations of daily social violence, such as being aware of criminal situations within communities, witnessing physical violence, living in intense misery and, even, in some cases, experiencing some type of violence[3].

The negative experiences faced by these professionals as a result of violence provoke feelings of loneliness and vulnerability in the exercise of work. Despite the negative reports, the CHW said that they like the community in which they work because good people live there and they like to do good. Most CHW live in the area where they work for a long time, so the fact that they know the neighborhood well generates a sense of protection and also helps them to understand the daily life and the way of being of each person, as well as the dynamics of the territory.

A very strong characteristic of CHW is that they have a longitudinal follow-up relationship with people, sharing their development and their passage through life cycles. Thus, some see residents as members of their family. The

proximity between the CHW and the community allows the creation of bonds, which favors the strengthening of trust relationships between them, as seen in the following statements:

> *"I know the alley, I know the neighbor, I know that that teenager has now grown up and formed that family." (Maria)*
>
> *"Because, due to the years of service, the time on the job, the time with them, today it makes the work that I do a lot easier and there's also the credibility that I have earned from them." (Gadelha)*
>
> *"My community is like my family!" (Florzinha)*

The legitimacy of the presence of CHW in the territory is related to the fact that they are residents of the neighborhood, have individual skills to earn people's trust and the existing (non-normative and prescriptive) relational bonds. An intrinsic characteristic of the teams' performance, especially with regard to the CHW, is the logic of mediation, which means building bridges between the different daily spheres of regulation[6].

One of the guiding principles of ESF is the establishment of a bond between the team and the residents. Knowing and living the reality of the community as double agents (workers and residents) makes it easier for CHW to access the community, and their presence offers greater credibility and trust compared to other health professionals[6].

CHW feel a little "responsible" for those "children" who grew up and joined the world of crime. This feeling is common among CHW who work in territories with stability and with command disputes:

> *"Look at the situation of the CHW: I weighed this child, and today I see him in the world of criminality! It's like he's a son to me!" (GADELHA)*

The close contact of CHW with drug dealers is evident in the statements when they refer to the offenders as "boys", "mischievous boys", "little friends", groups (criminal organizations), hardly using the term "drug dealer", which highlights the existing link between them and an exchange of protection with care. For CHW who reside in areas with stability under the command of criminal groups, security comes from the fact that they take care of the mothers, aunts, cousins, brothers and sisters of people who are leaders of these criminal organizations within the territory where they work.

The bonds established between workers and the "world of crime" are built through different relational strategies used by them, with points of contact, but also with limits and constraints[6]. When this relationship of protection between CHW and drug dealers does not exist, some CHW can even be expelled from the territory in areas with disputes between the commands, even without being directly involved with crime.

Currently, the high turnover within the community, with the presence of many "newbies" and "many rental houses", has caused a feeling of insecurity among CHW, especially in areas with disputes between criminal groups' commands: "there are different people", "not even the old resident is safe anymore". Tranquility existed in the past, but it is no longer observed. In areas with greater stability, the recurring phrases are "I know", "I have credibility", "he is our health worker", with these areas being referred to as "quiet areas":

> *"Because, you know, even though I live on the spot, I know everyone, I know everything, yet I'm afraid. Because you go into the house a lot, you know a lot about people, and you can be frowned upon, right? In the community today there are many different people, they are no longer those people, just the same people. There are people from different neighborhoods. You meet different people all the time." (Patricia)*

In a territory marked by criminal violence, few CHW report that they do not feel affected. The willingness of the majority to move to a less violent location was evident. This shows that violence is affecting the life of CHW and causing them concerns, mainly related to the safety of their families.

CHW know, to a greater or lesser extent, everything that happens in the community. Access to this information can often expose them, as well as their families, to constraints and risk situations[6]. In the present study, some CHW do not live in their micro area, not even in the neighborhood where they work. Some by their own choice, others because they were expelled from the community in which they resided.

Violence coping strategies used by CHW

In the performance of CHW activities, some strategies for coping with violence are developed to deal with the problems encountered in professional practice. The elaboration of strategies is important to avoid damages to the worker's health, generating motivation and satisfaction with the work[7]. As they reported violence in the territory, CHW described their coping strategies, which resulted in the construction of this category.

Violence survival strategies found in the interviews were classified into three types: behavioral, use of preventive practices and mental protection measures. Behavioral strategies were grouped into two: being blind, deaf, and hard of hearing, and seeking to make friends. The strategy of showing themselves as discreet professionals, who do not observe, do not listen, or talk about events, whether the criminal group disputed the territory or not, was a common report to all interviewees. CHW are people with extensive knowledge about the reality of families. And because they are very close to them, they are aware of everything in their micro area. Being a discreet person, who does not expose himself/herself and does not comment on what he/she sees, is one of the essential characteristics of being a CHW, being one of the main strategies to promote his/her own security within the territory:

> *"I say that the strategy is to pretend to be blind, deaf, and hard of hearing. We listen without showing that we are listening because we have to listen! You have to know what's going on around you, because otherwise, you're not going to come up with a strategy to protect yourself." (Helena)*

The professional and personal credibility of CHW in relation to the population depends on this "coexistence contract", but this "ethics" is questionable from the moment when necessary and indispensable complaints are omitted[6].

Every day, ESF workers experience situations of assault and intense misery. They experience conflicts that cause ethical dilemmas regarding the appropriate interventions for each situation. Some CHW avoid knowing about compromising situations[6].

Although there is a legal obligation to report suspected or confirmed cases of abuse and neglect, health teams only report the facts to the competent bodies when they are sure about the seriousness of the problem. An oblivious stance has been adopted as a form of security[16].

It is important to be aware of territorial dynamics so as to avoid attending certain places and unnecessary exposures and conversations that result in personal and family risk. This protection strategy is unanimous among the study participants:

> *"Because, you know, as I live there in that community, I know, practically, everything, but it's as if I didn't know, isn't it? Because I don't go out telling everyone... So, when you arrive to tell me one situation that I already know, I say 'no, I didn't know!' 'That's a lie?' 'No, I didn't know, I don't know!' You can tell me everything again, it will stay there, just the same. Even if you tell me in one way, and I know it in another." (Patricia)*

The strategy of seeking to make friends was also made very explicit by the CHW. As they live in the area and are inserted in the same social context, it is easier for CHW to contact the families and guarantee a bond[17]. Being an acquaintance, friendly and empathetic are protective factors:

> *"Treating people the way you would like to be treated. I see no difference in anyone. It could be the biggest outlaw; it could be anyone. It is your way of life, so I will treat you as normal." (Little Flower)*

Based on the interviewees' statements, strategies for using preventive practices were consolidated in the following attitudes: avoiding unnecessary exposures, wearing uniforms, not entering suspicious homes alone, suspending activities in times of conflict and keeping distance from the police.

One of the strategies cited by CHW highlighted the need to avoid unnecessary exposures, such as carrying valuable belongings when walking around the community, in order to avoid robberies. Some objects can be of great use to criminals, not only regarding the sale price, but also the use to carry out criminal activities:

> *"We used to use digital scales and I arrived and entered. I pushed the door, got in, and when I got in, I came across everyone... there, using, packing, weighing. Then one said: 'lend me that scale there! You are going to leave this scale here!' Then I said: 'but I can't!' Then I got completely nervous, and they saw tears in my eyes. Then he said: 'no, go, go, go, and don't come back here today, no!" (Maria)*

There have also been reports that there are places in the community that are meeting points for territorial disputes. It is important to know about the existence of these places, which can be street corners, *forró* clubs, bars, among others, and to avoid going there, since there is a greater likelihood of confrontations between criminals. The fear of violence makes CHW avoid having celebrations in their homes. In areas with disputes between criminal organizations' commands, relatives of CHW avoid visiting them because they live in communities ruled by other commands, for fear of reprisals, even though they are not involved with trafficking. The importance of wearing uniforms is controversial. For CHW who work in areas with stability under the command of criminal groups, the uniform is considered an

important instrument of identification in the community. For those who work in disputed territories, the use of uniforms was very important, but, nowadays, it is considered a risk as they can be stolen.

Not going into suspicious homes alone was also something that was strongly reinforced by CHW, because the fear of entering the homes and suffering some type of violence, such as harassment or violence due to drug use/trafficking, often means that CHW do not enter the home and make the visit outside the house:

> *"There are some houses in which I know there are people who... who are people involved with the drug trade, these things, then I do not enter. I arrive, call, ask the owner to talk with them, but I don't go in! I am afraid to go in. I stay out because I know it's dangerous there." (Little Flower)*

In the community, there are moments of tension that affect the routine of residents and workers, so one of the measures used is to suspend activities in times of conflict. Areas dominated by only one group are affected with less intensity and frequency when compared to areas with conflicts between rival groups.

Some events in the territory make CHW realize if they can go to work normally or if they need to protect themselves until the situation calms down. A lot of movement of criminals on the street, little movement of citizens, the death of someone and messages given by the offenders are warning signs for CHW. In all areas there are people who report whether there is the possibility of moving in the territory:

> *"In my area, it is quieter. It was rougher... Rough is when they are there in the area, you cannot walk. And quiet is when we can walk in the area, without fear." (Leticia)*

Urban violence directly affects the work of the health team, making it difficult or even preventing the performance of activities in the territory:

> *"We have already stopped making scheduled vaccination, medical appointments, visiting the home with the team, making my own home visits, when there were these conflicts." (Helena)*
>
> *"Because of the violence, we are stuck with a very important group, which is the children! A work that we had been doing within the community, together with the NASF, residents and other students... We took a break, stopped working with this group." (Gadelha)*

CHW use the strategy of not carrying out their activities in the territory in times of conflict between criminal groups for fear of being the target of stray bullets. They prefer to protect themselves in the health center until the conflict ceases. They report the need to feel supported by the coordinators of the health center in times of territorial disputes, carrying out internal work.

Limitations to providing care within the PHC center show a mischaracterization of care practices in the ESF as a result of violence[4]. It is very important that the health team finds alternatives so that the activities in the territory are not carried out. Therefore, the approximation with community leaders and with people who exert influence in the territory is essential, as they direct care alternatives, other possibilities of alternative locations and times:

> *"In this period of existence of the group, which is about seven years old, after this violence started, we had to move to five different places." (Gadelha)*

Keeping a distance from the police is a strategy reported by the interviewed CHW. Groups and criminal organizations filled a gap in the territories due to the total absence of the State, but, at times, the State seeks to recover the lost territory. Thus, armed conflicts were established and generated many repercussions for the residents of the communities[6]. Therefore, the "police" emerges as the possibility of social ordering or reorganization in view of the findings that the violence present in the territories is motivated by the lack of commitment to the social. However, what can be seen is that its *modus operandi* further strengthens violence in communities[4].

There is a stigmatization that the residents of the communities are mostly criminals or that they support the illicit attitudes of those who live there. This is reflected in the attitudes of some police officers when violently approaching residents who do not have any involvement with crime:

> *"In the place I live, not everyone, but the vast majority think that everyone who lives there is colluding with the criminals. And because they think that, they approach people equally! Nobody ever said anything to me, not even the police. But they already approached one of my children and asked what his previous charges were, and I didn't like it." (Patricia)*

The presence of the police in the communities is seen by most CHW as a risk factor. Their presence generates fear of armed conflicts between police and drug dealers. CHW feel more protected by drug dealers than by the police. According to them, drug dealers generally warn when there will be some risk, while the police enter the territory armed and willing to engage in crossfire with the drug dealers, and do not warn residents to keep their distance.

In a study conducted in Niterói, Rio de Janeiro[4], the statement made by a CHW, who stated that "violence is discouraging, because we have to go to the patient's house, there is a shot, there are police and you cannot go. We were unable to do the work as we would like to have done", is similar to that found in the present study.

This negative assessment of the police allows, from the point of view of CHW, that groups linked to drug trafficking offer a sense of security to residents through a mixture of coercion and protection. In some moments, communication is completely closed, as in curfews. Thus, the production of health services in the territory is always subject to new configurations and rearrangements, depending on the circumstances:

> *"I felt good, even though I knew that the boys were there keeping an eye on what we were doing. We felt more secure than with the police, because if the police arrived, they would break everything, but not with the boys. If they saw a different movement, they would warn us: 'look, you won't enter the community, something is going to happen', and so it was very quiet like that." (Mara)*

The presence of state public security agents provides uncontrolled risk situations. The arbitrary action taken by the police and the undifferentiation of suspicious targets influences the degree of trust that is offered to this institution. Health professionals analyze police incursions very critically, which generate a lot of insecurity due to their presence and way of acting in the territories[6]. Because of that, at least for most of the interviewed CHW, this institution does not seem to have sufficient legitimacy.

The presence of the police also causes discomfort, as drug dealers may suspect that there have been complaints from residents or CHW. In that case, they may be threatened by criminals to find out who would be the complainant. Given the above, CHW report that access to privileged information makes them even more afraid of the police and that they seek to distance themselves from it, thereby distancing themselves from the institution that should offer protection to citizens:

> *"'If we find out who called it... the person will die!'. And that is why you see that the community does not help the police." (Maria)*
>
> *"I avoid the police as much as possible, talking to the police, approaching them within the territory, because it is something that draws a lot of attention. They think you always know a lot and that you may be snitching. I don't approach a policeman at all! Whenever they are in the community, I avoid them as much as possible! When I see a police car, I stay away from it!" (Helena)*
>
> *"If I see the police in the community, it is time for despair, because if they see us in uniform, the first thing they say to us is: 'Do you know where the guy's house is?' And, if you say, 'no, I don't know', 'how come you are a CHW here and you don't know?' (Ester)*

The bond and credibility between CHW and drug dealers seem fragile as they express concern on the part of CHW in the face of the appearance of minimal signs of distrust by drug dealers. This is reflected in the attitude of many CHW when trying to make clear the existing dissociation between their work in the health field and the field of public security[6].

Important transformations, such as the retreat of the State in the exercise of its classic functions, in the guarantee of ensuring the legitimate monopoly of the control of violence, as well as the acceleration of the processes of globalization of the economy, which contributed to the development of informal market networks where illegal and illicit goods circulate, have strengthened organized crime, which has been structured, above all, around drug trafficking. Groups and criminal organizations then began to compete with the State for territorial control[6,18].

Proximity policy proposals need to be put in place to improve relations between the police and communities. Overt policing should listen to residents and use practices adopted to solve problems in other cities where gang violence is also faced. Public security organizations need to restore transparency and legitimacy so that they can work more effectively in territories[19].

The CHW in the present study emphasized the importance of adopting measures to protect mental health to work in an area with violence with the aim of preserving their mental and spiritual health. The social reality is generally precarious and people's survival conditions demand much more than what CHW can offer[20].

The work process developed at the ESF provides interesting perspectives for professionals through the combination of the technical act and innovative activities, thus generating satisfaction and professional engagement[6]. Of the CHW interviewed in the present study, seven identified mental protection strategies to face violence, such as religion, art, humor, daily prayers and faith, thereby overcoming the challenges of everyday life through creativity:

> *"At least when I am there, people can forget what they are experiencing on a daily basis. And, [in] being a bit of a comedian in that home I'm visiting, I can see that it's actually working." (Gadelha)*
>
> *"It's not just the material I live by, I also live by the spiritual. And the spiritual supports me in facing these difficulties from day to day." (Marta)*

As a characteristic of studies with a qualitative approach, this study had a small sample population of CHW from only one territory of the city being studied, thus preventing the generalization of the discourse found for the entire city. There is a need for further research to compare the existence of differences between this reality and that of other territories in Brazil because in order to measure the real impact on society and health workers it is necessary to carry out evaluative and procedural studies as it is an extremely complex and multifactorial theme.

Despite the limitations of the present study, the authors understand that its findings and the provisions of the National Health Promotion Policy (*Política Nacional de Promoção da Saúde – PNPS*)[8], which deal with "preventing violence and promoting a culture of peace", allowed problematizing, reflecting on, and systematizing the processes experienced in the daily lives of health workers, especially CHW, thereby supporting the decision making of municipal and local health managers to incorporate new initiatives and actions to prevent all forms of violence.

In addition to strengthening the PNPS, this study also created a space for these workers to speak, since talking about the concerns and discomforts is a form of health care that culminated in the thematic yarning circle "CHW performance in territories of social vulnerability: violence and health"[21] at the National Week of Science and Technology, in 2019, at Fiocruz - Ceará, with the participation of 361 CHW and community endemic disease control workers.

FINAL CONSIDERATIONS

Knowing and living the reality of the community on a dual role – as workers and residents – makes it easier for CHW access the community, and their presence offers greater credibility and trust compared to other health professionals. On the other hand, when working in a violent territory, CHW live under constant emotional tension caused by territorial instability.

Being a community health worker in territories with great social vulnerabilities requires some characteristics and skills to be able to do the job properly and satisfactorily. It is essential to be willing to help people, to know how to listen, to make friends, and to be ethical, cautious, and discreet.

Some of the strategies for coping with violence mentioned by CHW that should be highlighted are being "blind, deaf and hard of hearing", as it refers to a "coexistence contract" to be discreet to the detriment of being exempted from the legal obligation to report some issues for reasons of individual and family security, and "keeping a distance from the police", thus demonstrating that there is a disregard on the part of the State in relation to public security policies for and with the community.

Manuscript based on the master's dissertation titled: "Community Health Workers' knowledge and practices regarding urban violence in the territory and the repercussions for work and health". Professional Master's in Family Health - RENASF, Oswaldo Cruz Foundation, 2019, 101 pages.

CONTRIBUTIONS

Cibelly Melo Ferreira and **Sharmênia de Araújo Soares Nuto** contributed to the study conception and design; acquisition, analysis and interpretation of data; and writing and/or revision of the manuscript. **Maria Rocineide Ferreira da Silva** and **Vanira Matos Pessoa** contributed to writing and/or revision of the manuscript**.**

REFERENCES

1. Ministério da Saúde (BR). Portaria nº. 2436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica [Internet]. Brasília: Ministério da Saúde; 2017 [accessed on 2019 Aug 1]. Available from:

http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html

2. Simões AL, Freitas CM. Análise sobre condições de trabalho da Equipe de Saúde da Família, num contexto de vulnerabilidades, Manaus (AM). Saúde Debate. 2016;40(109):47-58.
3. Lessa MGG. O agente comunitário de saúde em Fortaleza: vivências profissionais [dissertation]. Fortaleza: Universidade Estadual do Ceará; 2013.
4. Machado CB, Daher DV, Teixeira ER, Acioli S. Violência urbana e repercussão nas práticas de cuidado no território da saúde da família. Rev Enferm UERJ. 2016; 24(5):1-6.
5 Gonçalves HCB, Queiroz MR, Delgado PGG. Violência urbana e saúde mental: desafios de uma nova agenda? Fractal Rev Psicol. 2017;29(1):17-23.
6 Almeida JF. Exposição à violência comunitária dos agentes da Estratégia Saúde da Família e repercussões sobre suas práticas de trabalho: um estudo qualitativo [dissertation]. São Paulo: Faculdade de Medicina da Universidade de São Paulo; 2015.
7 Tinoco MM. A relação saúde / doença no processo de trabalho dos Agentes Comunitários de Saúde: uma revisão de literatura [dissertação]. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca; 2015.
8 Ministério da Saúde (BR), Secretaria de Vigilância em Saúde, Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde: PNPS: revisão da Portaria MS/GM nº 687, de 30 de março de 2006. Brasília: Ministério da Saúde; 2015.
9 Ministério da Saúde (BR). Política Nacional de Saúde do Trabalhador e da Trabalhadora. Portaria MS/GM nº 1.823, de 23 de agosto de 2012. Brasília: Ministério da Saúde; 2015.
10 Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14ª ed. São Paulo: Hucitec; 2014.
11 Minayo MCS, organizador. Pesquisa social: teoria, método e criatividade. 33ª ed. Petrópolis: Vozes; 2013.
12 Santana JP, Castro JL. Os sanitaristas de Jucás e o agente de saúde: entrevista com Antônio Carlile Holanda Lavor e Miria Campos Lavor. Natal: UNA; 2017.
13 Robinson PCS. Desenvolvimento humano, por bairro, em Fortaleza. Fortaleza: Prefeitura Municipal de Fortaleza; 2010.
14 Bauman Z. Comunidade: a busca por segurança no mundo atual. Rio de Janeiro: Jorge Zahar Editor; 2003.
15 Krug EG, Mercy JA, Dahlberg LL, Zwi AB. Relatório Mundial sobre Violência e Saúde. Lancet. 2002;360(9339):1083-8.
16 Ribeiro RUP, Silva AL. Notificação compulsória de violência na atenção básica à saúde: o que dizem os profissionais? Rev Lab Estud Violência Segur. 2018;21(21):115-30.
17 Alonso CMC, Beguin PD, Duarte FJCM. Work of community health agents in the Family Health Strategy: meta-synthesis. Rev Saúde Pública. 2018;52(14):1-13.
18 Paiva LFS. “Aqui não tem gangue, tem facção”: as transformações sociais do crime em Fortaleza, Brasil. Cad CRH. 2019;32(85):165-84.
19 Alba MZ. Retomar o debate logo. Reciis Rev Eletron Comun Inf Inov Saúde. 2018;12(4):357-63.
20 Nogueira ML. Expressões da precarização no trabalho do agente comunitário de saúde: burocratização e estranhamento do trabalho. Saúde Soc. 2019;28(3):309-23.
21 Fundação Oswaldo Cruz. Semana nacional de ciência e tecnologia (SNCT). Relatório técnico científico. Fortaleza: Fiocruz-CE; 2019.

Mailing address:
Cibelly Melo Ferreira
Rua Pedro Rufino, 100/301 - bloco C
Bairro: Varjota
CEP: 60000 - Fortaleza - CE - Brasil
E-mail: cibellymf2018@gmail.com

How to cite: Ferreira CM, Pessoa VM, Silva MRF, Nuto SAS. Violence survival strategies used by Community Health Workers. Rev Bras Promoç Saúde. 2021;34:11152.