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FIGHTING VIOLENCE UNDER THE FAMILY HEALTH STRATEGY: CHALLENGES FOR HEALTH CARE

O enfrentamento à violência no âmbito da estratégia saúde da família: desafios para a atenção em saúde

El afrontamiento de la violencia en la estrategia de salud de la familia: desafíos para la atención en salud

Milena da Silva Santos
School of Public Health (*Escola de Saúde Pública do Ceará - ESP*) - Fortaleza (CE) - Brazil

Juliana Guimarães e Silva
University of Fortaleza (*Universidade de Fortaleza - UNIFOR*) - Fortaleza (CE) - Brazil

July Grassiely de Oliveira Branco
University of Fortaleza (*Universidade de Fortaleza - UNIFOR*) - Fortaleza (CE) - Brazil

ABSTRACT

Objective: To understand the challenges faced by Family Health Strategy (*Estratégia Saúde da Família – ESF*) professionals in delivering health care areas vulnerable to violence. **Methods:** Qualitative descriptive study carried out with ten ESF professionals in the municipality of Aracati, Ceará, Brazil. Information were collected in March 2016 through semi-structured interviews. Data were organized and coded and then underwent thematic content analysis, which yielded the following fragments: Perceptions of the phenomenon of violence; Health care in a risky territory; Fear and resilience in the delivery of care; and Care limitations and coping strategies for violence. **Results:** Delivering health care in situations of violence involves social, physical and psychological issues. Drugs, trafficking, crime, power struggles, gunfire and death permeated the daily lives of users and ESF professionals. Some of the main limitations of health care are the insecurity and the fear involved in the delivery of care and the difficult access to the houses located in risk zones. **Conclusion**: Delivering care in areas vulnerable to violence represents professionals' exposure to adverse situations which require resilience and, above all, support from managers and public authorities so that they can develop strategies to facilitate the delivery of care to Primary Care users inserted in areas permeated by violence.

Descriptors: Delivery of Health Care; Primary Health Care; Violence.

RESUMO

Objetivo: *Compreender os desafios enfrentados pelos profissionais da Estratégia Saúde da Familia (ESF) no desenvolvimento da assistência à saúde em áreas vulneráveis à violência.* ***Métodos:*** *Estudo descritivo com abordagem qualitativa, do qual participaram dez profissionais da ESF no município de Aracati, Ceará, Brasil. As informações foram coletadas em março de 2016, por meio de entrevistas semiestruturadas. Após organização e codificação dos dados, seguiu-se a etapa da análise de conteúdo, evidenciando os seguintes fragmentos: Percepções sobre o fenômeno violência; Cuidado em saúde em território de risco; O medo e a resiliência no desenvolvimento da atenção; e Limitações assistenciais e estratégias de enfrentamento à violência.* ***Resultados:*** *O desempenho da assistência à saúde em situações de violência envolve questões de ordem social, físicas e psicológicas. As drogas, o tráfico, a criminalidade, as disputas pelo poder, o tiroteio e a morte permearam o cotidiano dos usuários e dos profissionais da ESF. Entre as principais limitações do cuidado em saúde destacam-se a insegurança e o medo no desempenho do cuidado e as dificuldades de acesso aos domicílios por estarem em área de risco.* ***Conclusão****: O desempenho da assistência em áreas vulneráveis à violência representa a exposição dos profissionais a situações adversas, havendo necessidade de resiliência diante das adversidades e, sobretudo, do apoio de gestores e autoridades públicas para que estes possam desenvolver estratégias que facilitem a assistência aos usuários da Atenção Primária inseridos em áreas permeadas pela violência.*

Descritores: *Assistência à Saúde; Atenção Primária à Saúde; Violência.*

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RESUMEN

Objetivo: *Comprender los desafíos afrontados por los profesionales de la Estrategia de Salud de la Familia (ESF) para el desarrollo de la asistencia en salud de áreas vulnerables de violencia.* ***Métodos:*** *Estudio descriptivo de abordaje cualitativo en el cual participaron diez profesionales de la ESF del municipio de Aracati, Ceará - Brasil. Las informaciones fueron recogidas en marzo de 2016 a través de entrevistas semi estructuradas. Después de la organización y codificación de los datos, se dio la etapa del análisis de contenido, en la modalidad temática con la evidencia de los siguientes temas: Percepciones sobre el fenómeno violencia; Cuidado en salud en territorio de riesgo; El miedo y la resiliencia para el desarrollo de la atención; y Limitaciones de la asistencia y estrategias de afrontamiento de la violencia.* ***Resultados:*** *El desempeño de la asistencia en salud en situaciones de violencia incluye cuestiones de orden social, físicas y psicológicas. Las drogas, el tráfico, la criminalidad, las disputas de poder, el tiroteo y la muerte permearon el cotidiano de los usuarios y de los profesionales de la ESF. Entre las principales limitaciones del cuidado en salud se destacan la inseguridad y el miedo para el desempeño del cuidado y las dificultades de acceso a los domicilios de área de riesgo.* ***Conclusión****: El desempeño de la asistencia en áreas vulnerables de violencia representa la exposición de los profesionales para situaciones adversas con la necesidad de resiliencia delante las adversidades y, sobre todo, del apoyo de los gestores y las autoridades públicas para que estes puedan desarrollar estrategias para facilitar la asistencia de los usuarios de la Atención Primaria de áreas permeadas por la violencia.*

Descriptores: *Prestación de Atención de Salud; Atención Primaria de Salud; Violencia.*

INTRODUCTION

Violence is a social problem with a strong impact on health. In 2001, the fight against violence was included the health agenda through the National Policy for Reducing Morbidity and Mortality from Accidents and Violence. With a difficult definition and polysemic nature, violence is defined in this policy as the event in which actions carried out by individuals, groups, classes or nations cause physical, emotional, moral and/or spiritual harm to themselves or to others. It also has a different typology, with criminal and interpersonal violence being the focus of such study[1].

It should be noted that violence is strongly related to social, economic and political structures. Such relationship gets stronger with social exclusions and lack of social protection, which are characteristics of the current neoliberal model that generates insecurity[2]. Added to this context are Health Care and the promotion of care in areas vulnerable to violence, which are usually characterized by precarious infrastructure, lack of material living conditions and deep social inequalities. In addition to social issues, people living in the territory experience situations of exclusion, such as unemployment, lack of basic sanitation, illegal dumping and lack of leisure and safety[1,2].

Health care in these areas demands the adaptation of the service to the local reality, which can represent numerous challenges for its effective promotion. Challenges include limitations on access to the health center, lack of safety, inadequate infrastructure, drug trafficking, among other factors, which make the implementation of health care a daily challenge. In the context of Primary Health Care (PHC), in the Family Health Strategy (*Estratégia Saúde da Família – ESF*), situations of violence are a reality present in several Primary Health Care centers (*Unidades Básicas de Saúde da Família – UBASF*)[3].

It is worth remembering that the work processes of the ESF in territories characterized by situations of violence have been limited due to urban violence in places where low-income families with low levels of education live in precarious and socially unequal situations. The work done by ESF professionals in these areas is unsafe, with situations where they can only perform their activities within the health centers, restricting health care only to users who attend the centers[3].

Studies on the issue[4,5] have reported that violence, which also includes illegal drug trade, has had a major impact on people's quality of life and may pose a threat to physical integrity. Illegal drug trade influences violence and leads to numerous situations of conflict between drug dealers and users, with countless consequences for the whole society. Violence related to drug trafficking and conflict relations establishes the complexity of the phenomenon, and the consequences that the trafficking of illicit substances has, such as increased crime rates, are one of the manifestations of violence[2,5,6].

Urban violence does not only ecnompass lethality, but also interpersonal conflict, armed robbery, assaults, beatings and, finally, murders[7]. However, violence is not restricted to physical aggression and homicide[8]. It has increasingly affected the quality of life of individuals, their families and community, generating various physical, psychological, moral and social problems, thus demanding the attention from health services.

In the United States, more than 30,000 people are killed by firearm each year, while 67,000 individuals have some non-fatal firearm-related injuries. The number of non-fatal firearm incidents increased by 52% between 1999 and 2012, while firearm suicides increased by 17% between 2006 and 2012[9].

In Brazil, according to the data from the Mortality Information System of the Ministry of Health (*Subsistema de Informação sobre Mortalidade – SIM*), 967,851 people were killed by gunshot wounds between 1980 and 2014. During the same period, the number of victims increased from 8,710 in 1980 to 44,861 in 2014, which represents an increase of 415.1%[10]. The Northeast region of Brazil presented the highest rates of firearm homicides (FH). In 2014, circa 32.8 people per 100 thousand inhabitants

were victims of FH. The states with the highest rates are Alagoas, with 56.1 cases, followed by Ceará, Sergipe and Rio Grande do Norte, with circa 40 FH per 100 thousand inhabitants[10].

Epidemiological data from the municipality of Aracati, Ceará, Brazil, showed that there were 202 cases of violence in the period between January 2013 and September 2015: 65 (32.1%) cases of physical aggression, 55 (27.2%) cases of sharp weapons, 56 (27.7%) cases of firearms, 12 (6.0%) of domestic violence, and 14 (7.0%) cases of violence with blunt weapons. The data show that the majority of the victims, 157 (77.8%), are men. Alcohol abuse was suspected in 61 (30.1%) cases, and 25 (12.3%) of the total cases resulted in death[11].

Given this scenario, the relevance of the present study for the Promotion of Health and Collective Health lies in the fact that the provision of care needs to be consistent with the social reality of the population to meet their health demands. The figures presented herein portrayed the reality of several communities of the municipality and demand the understanding of the challenges and limitations faced by the multidisciplinary team during health care in the health centers. This study seeks to answer the following question: What kind of challenges have ESF professionals faced in relation to violence when they provide care in the health facility?

Thus, the present study aimed to understand the challenges faced by Family Health Strategy (*Estratégia Saúde da Família – ESF*) professionals in delivering health care in areas vulnerable to violence.

METHODS

This type of study design, qualitative and descriptive, was chosen for providing a subjective approach to reality, allowing study participants to describe the phenomena as they were experienced[12].

The research was carried out in March 2016 at a UBASF located in the municipality of Aracati, Ceará, Brazil. The facility serves 1,464 families, with approximately 5,000 people. Currently, the ESF team of professionals is composed of six professionals with a higher education degree and seventeen professionals with a high school diploma. The team is also supported by the Family Health Support Center (*Núcleo de Apoio à Saúde da Família – NASF*) team, consisting of physiotherapists, social workers and physical educators[13].

The facility catchment area has serious health problems, such as rubbish-strewn streets and vacant lots, in addition to lack of basic sanitation. It has a low-income population with a predominance of unemployment. Safety conditions are precarious, as there is no police station and only one neighborhood policing team (*Ronda do Quarteirão*) serves the entire municipality.

Study participants were ten professionals out of the eighteen who work in the facility. The participants were selected according to the following inclusion criteria: being part of the multidisciplinary care team, working at the UBASF for a minimum period of one year and consenting to participate freely in the study. Professionals who were on vacation or work leave were excluded.

Initially, a visit was made to the PHC coordination office of the municipality to explain the research objectives and request authorization for data collection. After the research was approved, a visit was made to the health center, where the study objective was explained to the professionals who were then invited to participate.

The data were collected through individual semi-structured interviews, with a mean duration of 30 minutes. The interviews addressed identification data, such as age, gender, job position, time since graduation, time working at the center, and questions about the dynamics of health care in areas at risk of violence.

After data collection, the interviews were transcribed verbatim and then analyzed using the thematic content analysis technique[12], which consists of three stages: pre-analysis, in which the results are read exhaustively; the exploration of the material, in which an interpretative synthesis of the results is developed, dialoguing with the research objectives and questions; and interpretation, in which the important aspects pointed out by the study are listed and compared with the literature on the subject. Thus, four thematic categories emerged: Perceptions of the phenomenon of violence; Health care in a risky territory; Fear and resilience in the delivery of care; and Care limitations and coping strategies for violence.

In order to ensure the anonymity of the participants, the letter P (for professional) was used followed by the interview order number (P.1, P.2 ..., P.10).

The present research complies with the ethical guidelines established in Resolution No. 466/2012[14] of the National Health Council and was approved by the Research Ethics Committee of the Ceará School of Public Health (*Escola de Saúde Pública do Ceará*), with Approval No. 1407437.

RESULTS AND DISCUSSION

The interviewees' identification data will be presented first. Then, the thematic categories that emerged from the study will be presented. The the interviewees' statements allowed to understand several aspects that involve the implementation of health care, especially in the daily life of PHC.

Interviewees' identification data

Of the ten ESF professionals interviewed who worked at the UBASF, nine were women and one was a man. Regarding education, seven participants had secondary education and three had higher education. The mean age was 40.3 years and seven participants have been working in the facility for more than nine years. Of the three professionals with complete higher education, one specialized in Public Health and two in Family Health. This knowledge of the specificities of the catchment area and population is fundamental for the effective practice of health care in Primary Health Care (PHC)[15].

Perceptions of the phenomenon of violence

In this category, the participants highlighted their conceptions regarding violence and its impact on the UBASF catchment area. Their statements revealed a broad concept of violence, which can occur both in the form of physical, moral and emotional aggression, as described below:

> *"Violence takes place in both psychological or physical manners; either through physical contact or moral contact" (P.1).*

Violence is a social problem that affects individuals in a personal and collective way, with several problems for the promotion of health care. In its social and historical context, violence is a public health problem that relates to physical, emotional and social problems that influence the quality of life of the citizens, with consequences for the health conditions of the people. "It consists in the use of force, power and privileges to dominate, subdue and cause damage to others: individuals, groups and collectivities"[16-23].

The professionals interviewed remarkably presented an idea of violence as the intrafamily one, especially when it occurs through physical and verbal aggression against children, women and older people, as highlighted in the following statements:

> *"Violence begins within one's own family. Parents treat their children aggressively, without speaking with them politely and using Strong language; so, I think all this is violence. The physical violence, the aggressions, beatings, fights, situations of conflict" (P.3).*
>
> *"There are also situations in which a husband beats a woman, child and elder abuse... Sometimes we report, press charges, we talk to some people, but they come, they look and they leave" (P. 8).*

There is a predisposition to situations of conflict in the family, which can generate violent actions. It is common to experience intrafamily violence, especially when interpersonal aggression occurs against children, women, older people, and physically and mentally disabled people[1].

In the present research, situations of child and elder abuse, in addition to intimate partner violence, were reported and notified. Exposure to violence in early childhood can affect brain architecture, immune status, metabolic systems, and inflammatory cellular response, and may contribute to the development of health-damaging behavior in adulthood, such as the use of illicit substances and risky sexual behavior[17,18].

Given these consequences, violence in childhood worsens the health of adults through mental health problems and the development of chronic diseases, such as heart disease and cancer[17,18].

The participants of the present research emphasized that urban violence is present in several contexts of society, such as public spaces, streets, avenues and institutions. In addition, they highlighted violence in the community, which, according to them, was aggravated by the increase in the number of drug users and in drug trafficking in the region, which resulted in robberies, shootings and drug trafficking, as reported below:

> *"Violence is present in many places: in the family environment, in the streets, in institutions, in squares, in avenues, in public spaces. We can perceive violence in the place where the facility is located through the difficulty that we find in entering the areas to provide care, through the drug issue, drug abuse. Crimes occur very often in the area where we work. Robberies, shoot-outs and drug trade are common" (P.2).*

Crime is present and common in the Brazilian society, especially in vulnerable regions and in the outskirts of large cities. Armed robberies, assaults and murders, which result in serious social consequences, are common within this context and lead to an increase in violence and morbidity and mortality rates[4]. This reality directly affects the quality of life of people, generating several socioeconomic problems that impacts on the daily life of society[5].

Citizens live their lives with the limitations and uncertainties imposed by violence. As mentioned before, the community faces the illegal trade of illicit drugs. Disputes over this illegal trade, as well as conflict situations involving the domain of trafficking, cause citizens to lose their freedom within the community and feel coerced in their homes, generating a diversity of feelings and sensations that considerably affect their health conditions[3].

Thus, living with violence, in addition to interfering with socioeconomic and cultural issues, causes citizens to be trapped in this reality and face the daily risks arising from this situation, such as robberies, assaults, and especially the risk of being hit by shots during disputes between rivals and even police officers. Violence is seen as part of human experience and can be

experienced in an interpersonal or collective way, being present in the daily life of a community and influencing the economic, cultural and social context of human life[19].

Health care in a risky territory

This category aims to report that PHC, through the ESF, is the first means of access to health services; it carries out activities to promote health and prevent diseases. Multidisciplinary health care is targeted at the population of a certain territory with the aim of promoting integral care that contributes to improving the autonomy and the health situation of this population[15].

Thus, the ESF prioritizes the development of actions to involve the community, families and individuals in health care; its participation in the welfare and social activities developed in the UBASF is fundamental. However, when the community is vulnerable to situations of violence, the process of conviviality in the health centers is compromised, thus hampering health care[3].

The research participants realize that users are insecure and fearful because of rivalry between communities. Drugs, trafficking, criminality, disputes over power, gunfire and death are part of the daily life of users, as highlighted in their statements:

> *"I can tell from patients that they are frightened, they feel insecure. What happens next is: they do not seek the health center because they are fearful, and so are we, the professionals, we feel insecure. Violence is visible here, there are two communities that are rivals" (P. 5).*
>
> *"It was even hard working here in this area. I had to run, lock the doors of the health center because everyone was shooting everywhere. It was a real war, it was complicated, it was scary. People were all scared, they came screaming, we locked the doors" (P. 6).*

Given this reality, ESF professionals are likely to face situations of conflict and vulnerability to violence[3]. They emphasized that they experienced numerous situations of conflict near the health center, such as shoot-outs between members of rival communities, users attending the health center under escort, and news about murders, as described in the following statements:

> *"In the area where I work, they killed a young man inside a grocery store, and it was shortly after I passed it. It was even difficult to work in this area during that week due to 'gang' rivalry. They passed at all times" (P. 10)*

Another study also reports that professionals face situations of violence in their workplaces, noting that most of the interviewees had experienced situations of violence, such as shootings, assaults and threats[20].

A study on the repercussions of urban violence for health care also found similar results. The professionals participating in the aforementioned study had already faced violent situations, such as clashes between drug dealers and the police that resulted in shoot-outs[6]. In addition, drug trafficking and its consequences, such as threats, assaults and physical aggression, are part of the health professionals' catchment area[3].

Another form of violence experienced in the present research is the aggressive behavior of some users towards professionals:

> *"I have been offended a few times, which is a type of violence. The person comes in, hurts us with words, and even threatens us sometimes if we do not give what the person wants" (P. 6).*

The absence of services and the poor problem-solving capacity of the center can also trigger situations of conflict, which can generate violence, with the professional being subject to verbal aggression, such as the use of strong language and threats. It should be noted that users who are dissatisfied with the service raise their voice and yell at the professional so as to get what they need[21].

Fear and resilience in the delivery of care

This category shows that the participants pointed out a variety of feelings about the impotence in the face of the violence witnessed in the delivery of health care.

The feelings of distress, anxiety and despair were present in their daily life. In addition, they reported that they experienced fear while on the streets, at the health center and during the provision of home care, as reported below:

> *"People get afraid, frightened, because they are threatened; they stop going out and stay home" (P. 4).*
>
> *"We are afraid of everything: we are afraid of what we say, of leaving home, of whether there is a shoot-out going on. Can you imagine being afraid of your own kind? It interferes too much in people's lives. There were people who got sick and "freaked out". There are people who have moved. It is an absurd that you have to move out of your home because nobody solves the problem" (P.5).*

Therefore, violence stands out as a phenomenon that has a negative impact on the health conditions of users and professionals; it also interferes in the professional performance of workers who provide care in these adverse environments, as reported by one of the participants:

"Living with this is making us sick and getting us away from work activities" (P. 7).

This adverse reality can generate problems in the professional performance, absenteeism and psychological changes in the workers[22,23].

Transcending the limitations presented, the health professional's resilience stands out in the face of the challenges of promoting health care in areas vulnerable to violence. The participants emphasized that, despite the challenges faced in the delivery of care, they were able to gather strength and provide health care. These professionals faced an ongoing process of adapting to a new work reality permeated by a diversity of feelings; they relied on their capacity for resilience and facing their fears and desires to continue performing their work, as described below:

"Even with fear, with the difficulties in delivering care and the insecurity that we face here in the health center, the whole team unites and tries to serve the users in the best way possible. We make it possible for this service to be quick, to be faster. Their complaints are resolved so they can leave and have no problems with either themselves or the people who are serving them. [...] This is when we must have the courage to face this reality and continue to serve" (P. 4).

Human beings have the ability to overcome the adversities of life. When exposed to conflicts involving violence, they can transform actions, overcoming the adversities imposed. Thus, delivering health care involves the ability to face difficulties and put things together in the face of the adversities found in the care universe[20].

Care limitations and coping strategies for violence

The present study was able to identify how violence interferes in the work process of the health center insofar as the team is unable to deliver care according to the care schedule and also to deliver home care in some risk areas.

The participants faced daily several challenges, which sometimes limited their professional practice. Among them, the fear of confrontation between rival communities and of living with users of illicit drugs and drug trafficking. Thus, professionals were discouraged to promote actions within the community and were restricted to the physical space of the UBASF only.

They pointed out some care limitations imposed by the vulnerability to violence: the difficulty of access to homes in a risk area; the difficulty the team has getting around; fragility in the face of physical threats; the difficulty in getting the population of a risk area to trust them; the decrease in the frequency of the population in the health center because of the violence.

"The difficulty in entering areas to provide care, drug issues, drug abuse, crime is very common in the area where we work. It really interferes with the care we provide, the work that can be done in the community" (P.1).

"I think it is difficult to get to the area. It is difficult to get people to trust you in the area that you will work and where the problem is" (P.3).

Other studies also found that violence limits the delivery of care, with similar results. The authors' study shows that a nurse emphasizes that health care, both at the health center and at home, was compromised when there were shoot-outs in the area, which leads us to recognize the limitations that violence imposes on health care[3].

Violence interferes with health care delivery by limiting the access to the service, causing the population to not come to the center and, likewise, the professionals cannot deliver home care[24]. Access to home care, due to interference from violence, cannot be delivered to the users with quality[25]. The work of Community Health Workers (CHWs) was limited by the violence experienced in the area, as highlighted in the following statement:

"It is about working and having to leave, not doing my job because of disputes over drug trade between one community and another. I already had to come back from the area because of shoot-outs and I could not stay to work and had to leave. […] We could not do the work that we wanted to… I began to realize that I could not enter the area whenever I needed to. Sometimes you cannot make the visits. Those who suffer the most are the older people, the children, the postpartum women who need special care, and we cannot go because of this violence" (P. 9).

The work of CHWs is fundamental for the delivery of primary health care. They strengthen the link between the health center and users, identify the main problems and promote preventive actions in the households. When they are unable to visit the area assiduously, their activities are limited, and those who suffer the consequences are the users who do not receive the care they need.

It should be noted that violence in the community makes work difficult as it causes fear and anxiety, restricts access to some areas, and increases the risk of violence[3]. During home visits, health professionals are vulnerable to situations of violence such as drug trafficking, shoot-outs, robberies and personal intimidation[26].

Some CHWs also mentioned that, despite facing risk situations, they can carry out their work in the households, as shown in the following statements:

"Even with the ongoing violence, I went there and did my job. I had to show them that I was really there because I liked the job and liked to serve them. I was well received by them, so the risk I ran was if there was a conflict between them who were fighting and I got hit" (P. 7).

> *"We try to work naturally, try not to be afraid, this kind of thing, because even their neighbors are already scared, then we will not be afraid too, we have to overcome and be stronger to face this" (P. 8).*

This occurs because the community trusts the professionals and because they live in the catchment area as well, thus being familiar with the reality of the community and feeling more comfortable in the delivery of health care[27]. However, it is important to emphasize that these professionals coexist with violence, both for being a health professional and for being a resident of the risk area, which leads to a process of coping with violence as something that is part of their routine, both in personal and professional aspects.

Other factors highlighted by the participants were issues related to inadequate infrastructure in the area, such as: lack of leisure, unemployment, lack of basic sanitation, rubbish-strewn lots, lack of public safety and inappropriate environment for care in the area, as highlighted in the following statement:

> *"The difficulties are many. They are very poor people who needed better support. […] There are many unemployed people, there is no adequate leisure. They have no sanitation, rubbish is on the streets, it is unsafe, there is no pavement, the backyards are all open, there are still houses without a bathroom. [...] There is a lack of adequate care, a place to provide care here in the area" (P.8).*

Primary care does not yet get enough funding from the health sector. Working and socioeconomic conditions are still precarious in many places, making it difficult to carry out a humanized care, which corroborates the factors listed by the participants[15]. Faced with this reality, public health teams must identify the scenarios of violence and develop means of action in this reality[4].

The interviewees reported that appointments at the health center are rescheduled when there are situations that involve risk to users and professionals. It was emphasized that on the days when the shoot-outs or threats occurred the community did not attend the center for fear of violence, as highlighted in the following statement:

> *"We try to schedule different days so that these people come to the center without running the risk of meeting each other, people from both areas. It was difficult when there was a conflict, it was very difficult to get to the community. In fact, some people from the community came to the center to tell us not to go because there was no way we could go in, for fear of a stray bullet" (P. 2).*

It was observed, therefore, that, despite the difficulties presented, the care was provided by taking some precautions, such as the scheduling by microareas, prioritizing the division of the areas in conflict so that the appointments do not take place on the same day, in addition to contact with the community to schedule appointments so that the service can be delivered at the center and at home.

A relevant factor pointed out by the professionals was the importance of getting the community to trust them so that they can carry out health care:

> *"We have to try to bring together people from both areas so that we can try to talk, so that the community does not suffer and receive care" (P. 2).*

Talking with the people from both areas about violence and how it is affecting the quality of care is fundamental for the elaboration of actions to face this reality and to deliver care.

Therefore, during health care, the health team must be committed to the patient by having an empathic attitude towards their needs, so that it is possible to understand the real needs of the population of the catchment area[15]. This trustful relationship can only be achieved through strategies that promote a qualitative and empathic embracement of users so that they feel safe while receiving health care[28].

In the face of intrafamily violence, PHC professionals can report these cases to the Violence and Accident Surveillance System (*Vigilância de Violências e Acidentes – VIVA*), which allows others to know the reality and develop intervention strategies[29], as highlighted in the following statement:

> *"When we witness situations of violence and mistreatment in the family, they must be reported so that we can intervene" (P.1).*

Regarding urban violence and drug trafficking disputes, the participants emphasized that it is necessary to maintain a dialogue with the community to face this reality, addressing issues such as: community suggestions that facilitate access to health services, questions about the factors that lead the youth of the community to enter the universe of trafficking, the elaboration of strategies that facilitate the dialogue between the two areas of conflict, and the promotion of clarifications on the importance of health care for the population.

> *"The first step to working with these people in these areas is having the team leave the health center and work more in the area, delivering more care there through educational approaches and preventive actions instead of curative actions. The team should try to include these people in society, because in an area where we work here – for instance – you get there, you see people totally excluded from everything" (P. 3).*

The ESF, because of its close relationship with the community, plays an important role in coping with violence, especially through the development of health education activities. It is a tool for coping with situations of violence. Education enables to know the characteristics of the reality imposed, guide the residents and establish relationships with the communities, which are important for coping with violence in health care[20].

Violence is not just about drug trafficking and its consequences. It is present in the daily life of human life, and can arise due to structural issues resulting from the overlapping of deprivations and social segregation that ends up having a negative impact on health care.

The participants emphasized the importance of promoting health education actions for the youth and adolescents in the community, such as: promoting educational approaches, debates, round tables and workshops in schools and the community – in partnership with teachers – on illicit drugs, encouraging engagement in sport and leisure and first employment programs, as it is observed in the following statement:

> *"There should be more schemes to support employment, professionalization, and to offer space for these young people in sports, music, and leisure to occupy their minds" (P. 7).*

> *"More discussions on drug use should be carried out at schools. Using health education strategies to address drug-related issues and asking for help in schools, in partnership with teachers, to address these issues more often is key […] To develop educational projects, such as sports" (P. 10).*

To do so, intersectoral actions should be well developed, because violence prevention actions, when carried out in an integrated way through actions carried developed in different social sectors, are more successful when compared with actions carried out individually[6].

Joint action involving the Social Action, Education, Sports and Leisure and Health Secretariats should be promoted so that they can diagnose the problems of the community and, based on this reality, list the priorities, elaborating interventions that improve access to health and quality of life of users.

The limitations of the present study were related to the inclusion of only one health center. Carrying out the research in other health centers would allow an expanded understanding about the limitations imposed by violence on health care delivery.

Therefore, there is a need to implement intervention strategies in a multisectoral context to provide the necessary care to the population, especially to those residing in areas where drug trafficking disputes are experienced.

FINAL CONSIDERATIONS

Violence was presented as a reflection of the whole socioeconomic context experienced by the community, which coexists with unemployment, lack of public policies, lack of infrastructure, lack of cultural and leisure activities, and various sanitary problems.

Crime was widely reported by the participants. Drug use, drug trade, disputes over power, shoot-outs and murders were part of the daily life of ESF users and professionals. The main limitations of health care highlighted by the participants were the lack of safety and fear of delivering care and the difficulties of access to homes in risk areas.

Delivering care in areas vulnerable to violence means living with adverse situations that demand resilience in the face of adversity and, above all, the support from managers and public authorities so that professionals can develop strategies to facilitate the provision of care to PHC users inserted in areas permeated by violence.

Thus, the development of care strategies that promote a wide range of health care is necessary and urgent for this population, given the socioeconomic, cultural and sanitary problems faced.

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Mailing address:
Milena da Silva Santos
Rua Beira Rio, 1868.
Bairro: Pedra Redonda
CEP: 62.800-000 - Aracati- Ceará- Brasil
E-mail: mylenasantos19@hotmail.com