The armed conflict and the impacts on the health of workers acting in the Family Health Strategy in the city of Rio de Janeiro, RJ, Brazil

O conflito armado e os impactos na saúde dos trabalhadores que atuam na Estratégia de Saúde da Família na cidade do Rio de Janeiro

Raphael Sampaio dos Santos[a]
https://orcid.org/0000-0001-6250-4712
E-mail: enfe.raphael@gmail.com

Lucia Cardoso Mourão[a]
https://orcid.org/0000-0002-7058-4908
E-mail: luciamourao@hotmail.com

Ana Clementina Vieira de Almeida[a]
https://orcid.org/0000-0002-9342-6179
E-mail: ana.vieiradealmeida@gmail.com

Katerine Moraes dos Santos[b]
https://orcid.org/0000-0002-2064-5207
E-mail: katerinegm@gmail.com

Lutianni Dias Brazolino[a]
https://orcid.org/0000-0001-9535-3754
E-mail: lutianni.grs@gmail.com

Isabel Cristina de Moura Leite[a]
https://orcid.org/0000-0003-4459-7606
E-mail: isabelcristinademouraleite@gmail.com

[a]Universidade Federal Fluminense. Escola de Enfermagem Aurora de Afonso Costa. Rio de Janeiro, RJ, Brasil.

[b]Universidade Federal do Rio de Janeiro. Instituto de Atenção à Saúde São Francisco de Assis. Escola de Enfermagem Anna Nery. Rio de Janeiro, RJ, Brasil.

Abstract

With the expansion of the Family Health Strategy in Rio de Janeiro, RJ, Brazil, some health teams are inserted in territories permeated by armed conflicts becoming vulnerable to urban violence. The objective of the study was to analyze the effect these conflicts cause in the health of these workers. This is an intervention research, with qualitative approach, carried out with 13 health professionals in a family health unit located in the city of Rio de Janeiro, using institutional analysis as a theoretical-methodological referential. Stress, anguish, irritability, requests for leave of absence, among other findings, emerge from the speeches of the research participants. Armed conflicts are great tensors among health professionals, service users and management, making negative aspects to emerge, not only in the health of these workers, but also in their relations at work. The risks to physical and mental integrity that these workers undergo are constant and have a profound negative impact on their health.

Keywords: Armed conflicts; Violence; Worker's Health; Professional Practice; Primary Health Care.

Correspondence
Raphael Sampaio dos Santos
Universidade Federal Fluminense, Escola de Enfermagem Aurora de Afonso Costa. Rua Dr. Celestino, 74, Centro. Niterói, RJ, Brasil. CEP 24020-091.

Resumo

Com ampliação da Estratégia Saúde da Família no Rio de Janeiro, equipes de saúde inseridas em territórios permeados por conflitos armados tornaram-se vulneráveis à violência urbana. O objetivo do trabalho foi analisar o afetamento que tais conflitos causam na saúde desses trabalhadores. Trata-se de uma pesquisa-intervenção, com abordagem qualitativa, realizada com 13 profissionais de saúde de nível superior em uma unidade de saúde da família localizada na cidade do Rio de Janeiro, utilizando como referencial teórico-metodológico a análise institucional. Estresse, sentimentos de angústia, irritabilidade, pedidos de afastamento do trabalho, entre outros achados, emergem das falas dos participantes da pesquisa. Os conflitos armados são grandes tensionadores entre profissionais de saúde, usuários do serviço e gestão, fazendo emergir aspectos negativos, não só na saúde desses trabalhadores, como também em suas relações no serviço. Os riscos à integridade física e psíquica a que esses trabalhadores se submetem são constantes e têm impacto negativo profundo em sua saúde.

Palavras-chave: Conflitos Armados; Violência; Saúde do Trabalhador; Prática Profissional; Atenção Básica à Saúde.

Introduction

The Family Health Strategy (FHS) is a traditional-health-care reorganizing model that transforms the care process, focusing on the family and considering the context in which it is inserted to provide a better understanding and intervention in the health and disease process by health teams (Oliveira; Pereira, 2013). FHS, the gateway for many users in the Brazilian National Health System (SUS), has been expanded in Rio de Janeiro, where coverage went from 32.3% in 2010 to 52% in 2016 (Neves et al., 2018).

The Municipal Health Department prioritized the West Zone of Rio de Janeiro, scenario of this study, to begin the reorganization of health services, especially the FHS expansion (Jesus, 2013). This area stands out for having one of the worst economic and social development, marked by violence and a long period of disassistance (Nogueira; Marino; Ferreira, 2016). In this perspective, data also indicate the West Zone of Rio de Janeiro has the lowest Human Development Index (HDI) of the municipality, marked by significant social inequality and contrasting realities (Instituto Rio, 2013).

FHS expansion causes the allocation of some health teams in highly socially vulnerable territories, being exposed to urban violence.

These territories, which suffer with the State's absence, concentrate disassistance, unemployment and poverty, and their population, socially vulnerable, has to deal with urban violence on a daily basis, resulting in armed conflicts. Violence, evident in territories marked by poverty, changes family routines and reflects on service relationships in these communities (Costa; Ferreira, 2017).

Corroborating this statement, a study conducted in a community in Rio de Janeiro, which accompanied the treatment of individuals in primary care under the context of urban violence, was affected by the troubled social context and the field research was delayed for months because of armed violence (Ferreira; Engstron, 2017).

This panorama reflects the need to discuss the theme of violence from a complex and intersectoral point of view, which comprehends its diverse perspectives and the multiple sectors involved, such as health, safety and public policies, considering

that the various aspects involving this phenomenon strongly impact public health, either by the number of direct victims, or by the mental and emotional injuries of those involved, negatively impacting on the quality of life of individuals and collectivities (Cardoso et al., 2016).

From the above, it is evident that urban violence has a great magnitude and its discussion has been increasing in the field of public health. This study stands out its armed manifestation as a complex phenomenon that has impacted the work of FHS teams.

As the teams are mostly inserted in socially vulnerable territories, and consequently in permanent contact with their manifestations, to discuss violence as armed conflict is important, in the context of the health of FHS workers under these circumstances to better understand this phenomenon and intervene appropriately in its determinants in the health work process. Thus, this study aims to analyze the impacts of violence as armed conflict, on the health of higher-educated FHS professionals.

Notably, one of the investigation objectives was to identify the content on urban violence addressed in the higher education training of health professionals. Thus, professionals of technical training and community health agents were left out of the study, though recognizing their proximity to urban violence in the territory.

Method

This is an exploratory study with a qualitative approach, with institutional socioclinical design.

Institutional analysis (IA) began in the 1960s in France, spreading in Brazil in the following decade and having as French institutionalism references the authors René Lourau, Georges Lapassade and Félix Guattari, responsible for constituting the foundations of institutional analysis and socio-analysis. "IA arose from the articulation between intervention and research, between theory and practice" (L'Abbate, 2012, p. 197-198).

Institutional analysis in the institutional socioclinical aspect, proposed by Gilles Monceau, was used in this study for being considered an effective method to construct dialogues and to provoke collective reflections and debates on urban violence and its nuances in violent territories. Socioclinical intervention was carried out in two meetings coordinated by the main researcher with the aid of the research advising researchers, who had experience in conducting a socioclinical-institutional group. Noticeably, this is an intervention with institutionalist orientation, intervention research that proposes non-separation between subject/object, considering the researcher's implications and emphasizing his/her non-neutrality in the knowledge production (Romagnoli, 2014).

During the institutional socioclinical intervention, the researchers and the study participants experienced different moments, which can be translated from the methodology perspective into the institutional socioclinical characteristics proposed by Monceau, which can be achieved at the time of socioclinical intervention. These characteristics are: **analysis** of the order and demands; the subjects' **participation** in the devices; the analyzers' **work**; **analysis** of transformations as work progresses; **application** of restitution modalities; **work** of primary and secondary implications; **intention** of knowledge production; **attention** to institutional contexts and interferences (Monceau, 2013).

This methodology is not limited to protocols, but aims to start connections with social and, consequently, professional issues, allowing a relationship between the research subjects and the object to approximate them of the situations experienced by the participants, thus enabling the understanding of their implications and the institution dynamics (Monceau, 2013).

This study was conducted in 2017 in a Family Clinic located in the West Zone of Rio de Janeiro, which, at the time, consisted of seven teams, all working in violent territory. Each health team monitored an average of 3,000 to 4,000 users, with a total of 19,987 users registered in the Family Clinic at the time.

This article shows the results of institutional socioclinical meetings, which occurred in the meeting room of the family clinic in the afternoon, after the team meeting. The study included 13 higher-educated health professionals who performed their

activities on site at the time of data collection and made themselves available to participate, being: seven nurses, four physicians and two dentists from the clinic's family health teams.

In these meetings, a script was used to collectively conduct the discussion on the theme and the data were digitally recorded. The script brought questions related to the process of the work developed by the professionals in the midst of a territory permeated by armed conflicts and issues related to the training process. Given this text dimensions, we will consider the results obtained in the following question of the script: "In the group's opinion, what is it like to work in a place with episodes of armed violence?" Other issues related to urban violence expressed as armed conflicts do not meet the scope of this production but are just as important.

This study followed the ethical precepts of research with human beings, obtaining a favorable opinion from the Ethics and Research Committee of the proposing and co-participant institution in the first half of 2017.

Results and discussion

Armed conflict is a reality frequently manifested in the state of Rio de Janeiro and remarkable in vulnerable territories (occupied by the poorest population), where the State's inefficient performance is evident. Health establishments inserted in these territories have suffered the consequences of these conflicts.

Conceptually, work-related violence is pointed out as "all voluntary action of an individual or group against another individual or group that will cause physical or psychological harm, occurred in the work environment, or involving relationships established at work or activities related to work" (Oliveira; Nunes, 2008, p. 30). A study conducted with FHS workers identified that the violence felt by them is expressed by fear of the risk of exposure, of threatening their integrity and of reprisals (Lancman et al., 2009).

This investigation shows aspects related to the work of FHS health professionals from the perspective of the impacts on these subjects' health when experiencing urban violence expressed as armed conflict in their daily work. Analyzing the

participants' statements emerged during the institutional socioclinical meetings, it was possible to notice how armed conflicts influence their health.

In this sense, based on their statements, we will analyze the risks to the physical and psychological integrity of these health workers, whose condition triggers great concerns as a result of the tensions generated between users, health workers and local management, resulting from crossings in their practices. Such tensions are big stress generators for these health workers, risking psychic integrity in many of them.

FHS, because it is inserted in a highly vulnerable territory, is more exposed to violence (Lancman et al., 2009); health workers developing their activities in these places are more conducive to confronting urban violence in their different facets, since they constantly experience the territories dynamics (Benicio; Barros, 2017).

Velloso et al. (2005) point out that, in general, the professionals feel more protected inside health units, but that this feeling is shaken when shootings occur, exposing these people's vulnerability in the face of confrontations external to the unit. The following statements allow us to understand how these health workers, even developing their activities within the Family Clinics, have their physical and psychic integrity at risk:

> *All the offices were actually pierced! When they opened a doctor's office and saw the gunshot wounds, they said: "Wow, a shot really reaches here!"* (Paulão)

> *There was a shooting here from a confrontation between the police and bandits who started to pierce the entire clinic with bullet, and everyone threw themselves to the ground [...]. You see how it happened, that episode left bullet marks, broken glass, curtain rolled up, everything destroyed in the rooms.* (Inácio)

Armed violence killed 44,861 people in 2014, with an increase of 415.1% since 1980. Although considering population growth of 65% in this period, mortality by firearms is very significant and stands out for its magnitude. Homicides account for 95%

of this number, with mostly young, black and male victims (Waiselfsz, 2016). Its distribution is related to the populations' social living conditions and the lack of access to social policies (Benicio; Barros, 2017).

Violence is considered an obstacle to the population's access to health services and, at the same time, to health professionals' access to the community, blocking home visits and influencing in the routine of services and in planning work processes (Benicio; Barros, 2017). The participants' statements reveal that the risks to the FHS workers' physical integrity are potentiated when they need to perform their activities outside the clinic, becoming more vulnerable inside the territory. The following statement portrays a moment when a participant is surprised during a home visit and finds herself in the midst of an armed conflict:

> *I went out one day and, when I was about to enter the territory, the police came in with their battle taxi. I had time only to enter the bar, lie on the floor and wait it to calm down; and then I went back to the unit; sometimes it is of a sudden.* (Flor do Campo)

In addition to the risks to physical integrity, Machado and Daher (2013) highlight that health professionals working in dangerous territories coping with adverse realities is a complex phenomenon, which brings psychological problems due to constant stress, generating emotional exhaustion and impairment in different areas of personal and professional life, with a marked decrease in professional satisfaction in the work environment. The following statements portray this situation:

> [I] *was suffering with these shootings.* (Wood).

> *The stress and anxiety rate of professionals who provide care* [...] *this is highly worsened by urban violence. We are trying to give what we do not have! We sometimes transfer anxiety, the emotional burden we receive from one patient to another. Because we also vibrate in that* [...] *so, you see that sometimes the result of this comes later, when the shooting is not happening at that moment.* [...] *to*

> *assist people with shooting sounds on our back, thinking that at any time the clinic wall, that is made of very thin material, very fragile, would stick; my back, for example, always contracted when I heard a shot, thinking it could come in at any moment.* (Inácio)

The World Health Organization (WHO, 2008) warns of the high prevalence of psychosocial risks to which health workers in Europe are exposed, responsible for increasing problems such as work-related stress, violence, harassment and bullying in the workplace. Regarding violence, a survey conducted in two vulnerable territories in the municipality of Rio de Janeiro identified, in the participants' statements, urban violence as a permanent challenge that interferes in the management, in the professionals' work, and in the care of health system users (Prata et al., 2017).

The same survey refers to processes of sickening of professionals and patients, triggered by daily violence, highlighting greater vulnerability of professionals and reports of episodes of tension, stress and even cases of psychiatric symptoms and psychotic breaks. The authors affirm that "in the teams' report, we found the centrality of violence as a factor of illnesses and vulnerabilities production" (Prata et al., 2017, p. 47).

Because of armed conflicts, it is common for the units to terminate their activities in the territories covered by FHS. This, in practice, becomes a great problem for users, who lose their scheduled appointments. This situation generates conflict between users and health workers, often a source of discussion and stress. Frequently, users' insistence on keeping the clinic open even in the face of armed conflicts produces in workers a sense of anguish because they understand this as trivializing episodes of gun violence. The following statements demonstrate the above:

> *The patient is scheduled for more than a month, and when the day comes, there is shooting. It is also bad for them* [...] *there is no more room on the agenda, then we have to reschedule the patient, to squeeze him in* [...] *it complicates our work process a lot.* (Paulão)

The patient thinks if we work in an area of risk, we have to be used to it! (Flor do Campo)

Actually, I got upset with the patient. (Referring to a unit worker) *and I closed the main door; when I locked the door, the patient wanted to leave! He was an old gentleman, he said "I am going out!", "you are not going out this way! You can turn around and leave by the back door!", "no, I am going this way!"* (Paulão)

Some patients get mad when we have to close the unit. (Amora)

The varied manifestations of violence in the work process of nurses and other health professionals reverberate in different areas, but mainly on mental health. As they feel threatened in a work environment affected by armed conflict, levels of psychological distress rise. These repercussions exceed workplace aspects, since health-damaging events also reverberate on the worker's social and family life, bringing feelings of irritability, crying crises, anguish, sadness, with deep implications on health (Bordignon; Monteiro, 2016).

In the following statements, the consequences of violence in its armed manifestation in the family segment of the participants are evident, showing itself as a great cause of tension.

It affects our family's health; you see how it affects health [...] it spreads in our relationships. (Inácio)

It is a real burden, the family keeps holding us to it! It closed because of violence. [...] why don't you ask to get out of there? (Pétala)

A study conducted in the municipality of Belém, PA, Brazil, aiming to analyze how territorial violence impacts the work process of nurses working in FHS, showed that precarious working conditions that endanger workers' lives and the lack of minimum logistics supply are considered violence to workers and negatively impact not only on the work production, but also on the professionals' health (Polaro; Gonçalves; Alvarez, 2013). The following statement points to the professional's

mental suffering, caused by intense shooting in the territory, and then it comments how this affects his productivity at work.

I was suffering with these shootings! For 40 minutes everyone was lying on the floor, I was locked up with a five-day-old baby in my bathroom, the mother crying [...]. And then it is over, and they want us to forget, to continue with the care, and it is not like that! It psychologically affects us! The worst for me is that sometimes the shooting starts and then it stops, and you get nervous, you have to go back to the office to continue treating people and pretend it is okay! Except it is not, you are nervous. It takes a while, because of the things we have been through here, we are afraid to go through them again. (Wood)

Gonçalves, Queiroz and Delgado (2017) report that urban violence and its dimensions are little debated in the psychosocial field, making it necessary to pay attention on the important consequences of the impact of violence on mental health not only of users, but also of professionals working in these services.

The lack of discussion on the theme in the spaces of services and reception, and the lack of management for the above seems to be a cause of suffering for these workers, who care for health but do not feel cared for. To disregard the territorial peculiarities and not to take care of the workers' mental health reflect negatively on the process of caring for these teams in relation to the community, since they can request dismissal, transfer, or even have a leave of absence for health treatment, due to the impacts on their mental health, discontinuing care. The following statements corroborate this idea:

We must take care of each other, but no one gives any kind of psychological support to mental health, to the people who are here, so sometimes we take care without being able to. [...] The matter is not even that! The matter is this: we are taking care of people, but many of us, so much so that some of us have already left here, [referring to a health worker] *who worked here on the Alpha team* [fictitious name]*, she suffered from panic disorder, she cannot even pass through this street because of it! [...] The doctor who was from the Beta team* [fictitious name] *also asked*

to leave, [referring to a health professional]*, who was from the Gama team* [fictitious name] *asked to leave.* (Wood)

The doctor from here and I went together, she could not take it, so she quit! (Flor do Campo)

Notably, situations of violence promote high turnover of staff, influencing the discontinuity of work processes and breaking the bond between user and professional (Benicio; Barros, 2017).

Despite the above, it is important to emphasize that work is not essentially a source of suffering, for workers can build their identity and express their subjectivity by it. This results from the interaction of the subject with the dimensions of the work context–social relationships of work, working conditions, and work organization–, constituting a dynamic relationship, in which health at work materializes in the search for physical, psychic and social integrity (Ferreira; Mendes, 2003).

In this group of workers, socio-professional relationships act as mediators of the suffering they face on a daily basis, with reports of professionals who, after being transferred, returned to the unit, despite the permanence of the episodes of violence, because of established relationships.

We have a colleague who went through this, left the unit and went to [another unit] and said: "Paulão", I have fellow doctors who do not talk to each other. He asked his colleague for help, and he does not help. He said, "although there is violence, I prefer to stay there" [...] he would much rather the environment here with the shots than the environment in which his colleagues did not even talk. (Paulão)

I suffered, but not like here with the violence, but some professionals did not talk to each other, and this is tough! We already work in a conflicting place, we sometimes need support, a colleague partnership, and having this issue is difficult. I think it really is tough, so much so that I ended up coming back here. (Flor do Campo)

In this context, these relationships constitute defensive strategies, as defined by Dejours (1994 apud Mendes, 2007, p. 38), "rules of conduct constructed and undertaken by men and women vary according to working situations and are marked by subtlety, ingenuity, diversity and inventiveness, helping workers to support suffering without falling ill." Dejours points out the risk of these defensive strategies become a defensive ideology, no longer strategies to be the worker's own goal, leading to the risk of alienation, that is, at the same time that they enable coexistence with suffering, they lead to the alienation of their true causes (Dejours, 1994 apud Mendes, 2007).

A study conducted in Southern Brazil at a similar circumstance points out that good relationships at work contribute to the worker's well-being (Ferigollo; Fedosse; Santos Filha, 2016). Based on it, we can infer that working in a territory permeated by armed conflicts enabled these professionals to establish a group identity, strengthening their personal relationships, which, in this context, was significantly favorable to cope with the tensions caused by armed violence in the territory.

Final considerations

The risks to physical and mental integrity to which these workers are subjected when working in territories permeated by armed conflicts are notorious. The constant stress caused by urban violence in its armed manifestation triggers feelings of anguish, fear, irritability and sadness, producing mental exhaustion and directly affecting their satisfaction at work.

The studied territory is affected by constant conflicts between dealers and police, which makes urban violence not only a great creator of obstacles to the practices of family health teams, but also a generator of large risks to the physical and psychological integrity of the workers who carry out their activities there.

To investigate the dimensions and effects of urban violence expressed as armed conflicts is relevant because it reveals how it impacts on the health of health workers acting in violent territories. Thus, to bring this discussion to the workspaces and to consider intervening in the effects of armed conflicts to mental health and in the possible

damage to these professionals' physical integrity are necessary.

One of the strategies for dealing with this reality could be to offer psychological support and monitoring services to workers from violent areas. It is also relevant to discuss and improve existing tools, such as safer access in coping with urban violence, and to search new ways to produce protective measures for these workers, collectively involving professionals, users, managers, and other sectors of society.

References

BENICIO, L. F. S.; BARROS, J. P. P. Estratégia Saúde da Família e violência urbana: abordagens e práticas sociais em questão. *Sanare*, Sobral, v. 16, n. 1, p. 102-112, 2017. Disponível em: <https://bit.ly/2IjWSvL>. Acesso em: 4 ago. 2018.

BORDIGNON, M.; MONTEIRO, M. I. Violence in the workplace in nursing: consequences overview. *Revista Brasileira de Enfermagem*, Brasília, v. 69, n. 5, p. 939-942, 2016. Disponível em: <https://bit.ly/2LKLMSN. Acesso em: 23 abr. 2017.

CARDOSO, F. L. M. G. et al. Homicídios no Rio de Janeiro, Brasil: uma análise da violência letal. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 21, n. 4, p. 1277-1288, 2016. Disponível em: <https://bit.ly/2OM749y>. Acesso em: 16 jul. 2018.

COSTA, S. L.; FERREIRA, R. S. Violência urbana e assistência social no âmbito da proteção social básica. *Revista de Políticas Públicas e Segurança Social*, Teófilo Otoni, v. 1, n. 1, p. 54-76, 2017. Disponível em: <https://bit.ly/2LI8FWT>. Acesso em: 3 mar. 2018.

FERIGOLLO, J. P.; FEDOSSE, E.; SANTOS FILHA, V. A. V. Qualidade de vida de profissionais da saúde pública. *Cadernos Brasileiros de Terapia Ocupacional*, São Carlos, v. 24, n. 3, p. 497-507, 2016. Disponível em: <https://bit.ly/32YJFR1>. Acesso em: 10 nov. 2018.

FERREIRA, J. T.; ENGSTRON, E. M. Estigma, medo e perigo: representações sociais de usuários e/ou traficantes de drogas acometidos por tuberculose e profissionais de saúde na atenção básica. *Saúde e Sociedade*, São Paulo, v. 26, n. 4, p. 1015-1025, 2017. Disponível em: <https://bit.ly/2IeTxOL>. Acesso em: 16 jul. 2018.

FERREIRA, M. C.; MENDES, A. M. *Trabalho e riscos de adoecimento*: o caso dos auditores-fiscais da Previdência Social Brasileira. Brasília, DF: Ler, Pensar, Agir, 2003.

GONÇALVES, H. C. B.; QUEIROZ, M. R.; DELGADO, P. G. G. Violência urbana e saúde mental: desafios de uma nova agenda? *Fractal*: Revista de Psicologia, Niterói, v. 29, n. 1, p. 17-23, 2017. Disponível em: <https://bit.ly/32Xbp8E>. Acesso em: 3 maio 2018.

INSTITUTO RIO. *Sobre a Zona Oeste*. Rio de Janeiro, 2013. Disponível em: <https://bit.ly/30ESmi1>. Acesso em: 2 abr. 2017.

JESUS, R. V. L. *A expansão da Estratégia Saúde da Família na cidade do Rio de Janeiro 2009-2012*: estudo de caso na Área Programática 5.3. 2013. Dissertação (Mestrado em Saúde Pública) – Escola Nacional de Saúde Pública, Fundação Oswaldo Cruz, Rio de Janeiro, 2013. Disponível em: <https://bit.ly/2OgdmJb>. Acesso em: 6 jul. 2018.

L'ABBATE, S. Análise institucional e intervenção: breve referência à gênese social e histórica de uma articulação e sua aplicação na saúde coletiva. *Mnemosine*, Rio de Janeiro, v. 8, n. 1, p. 194-219, 2012. Disponível em: <https://bit.ly/2MbK1Nj>. Acesso em: 5 nov. 2015.

LANCMAN, S. et al. Repercussões da violência na saúde mental de trabalhadores do Programa Saúde da Família. *Revista de Saúde Pública*, São Paulo, v. 43, n. 4, p. 682-688, 2009. Disponível em: <https://bit.ly/2pIoogd>. Acesso em: 3 ago. 2018.

MACHADO, C. B.; DAHER, D. V. Violence in the area and its repercussions upon health care actions: descriptive-exploratory study. *Online Brazilian Journal Nursing*, Niterói, v. 12, p. 674-676, 2013. Disponível em: <https://bit.ly/2M9AdUj>. Acesso em: 27 mar. 2016.

MENDES, A. M. (Org.). *Psicodinâmica do trabalho*: teoria, método e pesquisas. São Paulo: Casa do Psicólogo, 2007.

MONCEAU, G. A socioclínica institucional para pesquisas em educação em saúde. In.: L'ABBATE,

S.; MOURÃO, L. C.; PEZZATO, L. M. (Org.). *Análise institucional & saúde coletiva.* São Paulo: Hucitec, 2013. p. 91-103.

NEVES, R. G. et al. Time trend of Family Health Strategy coverage in Brazil, its Regions and Federative Units, 2006-2016. *Epidemiologia e Serviços de Saúde*, Brasília, DF, v. 27, n. 3, p. 1-8, 2018. Disponível em: <https://bit.ly/396jFHh>. Acesso em: 22 dez. 2019.

NOGUEIRA, M. A.; MARINO, L. M. M. R.; FERREIRA, C. D. Investimento em atenção primária: uma revolução da saúde na Área Programática 5.3. *Revista Saúde em Foco*, Rio de Janeiro, v. 1, n. 2, 2016. Disponível em: <https://bit.ly/30GYJ4f>. Acesso em: 18 jun. 2018.

OLIVEIRA, M. A. C.; PEREIRA, I. C. P. Atributos essenciais da atenção primária e a Estratégia Saúde da Família. *Revista Brasileira de Enfermagem*, Brasília, DF, v. 66, p. 158-164, 2013. Número especial. Disponível em: <https://bit.ly/2nJ7mt4>. Acesso em: 25 mar. 2016.

OLIVEIRA, R. P.; NUNES, M. O. Violência relacionada ao trabalho: uma proposta conceitual. *Saúde e Sociedade*, São Paulo, v. 17, n. 4, p. 22-34, 2008. Disponível em: <https://bit.ly/2VckFDq>. Acesso em: 3 ago. 2018.

POLARO, S. H. I.; GONÇALVES, L. H. T.; ALVAREZ, A. M. Enfermeiras desafiando a violência no âmbito de atuação da Estratégia Saúde da Família. *Texto & Contexto Enfermagem*, Florianópolis, v. 22, n. 4, p. 935-942, 2013. Disponível em: <https://bit.ly/331cpbT>. Acesso em: 5 jul. 2018.

PRATA, N. I. S. S. et al. Saúde mental e atenção básica: território, violência e o desafio das abordagens psicossociais. *Trabalho, Educação e Saúde*, Rio de Janeiro, v. 15, n. 1, p. 33-53, 2017. Disponível em: <https://bit.ly/30Krm0y>. Acesso em: 3 ago. 2018.

ROMAGNOLI, R. C. O conceito de implicação e a pesquisa-intervenção institucionalista. *Psicologia & Sociedade*, Belo Horizonte, v. 26, n. 1, p. 44-52, 2014. Disponível em: <https://bit.ly/2IkcijA>. Acesso em: 23 abr. 2016.

VELLOSO, I. S. C. et al. A visão dos profissionais de saúde sobre a violência no cotidiano de trabalho em uma unidade básica. *Reme*: Revista Mineira de Enfermagem, Belo Horizonte, v. 9, n. 4, p. 302-08, 2005. Disponível em: <https://bit.ly/2IfmXwb>. Acesso em: 17 mar. 2016.

WAISELFSZ, J. J. *Mapa da violência 2016*: homicídios por armas de fogo no Brasil. São Paulo: Flacso Brasil, 2016. Disponível em: <https://bit.ly/2NojWzK>. Acesso em: 4 ago. 2018.

WHO – WORLD HEALTH ORGANIZATION. *PRIMA-EF*: guidance on the European Framework for Psychosocial Risk Management: a resource for employers and worker representatives. Genebra: World Health Organization, 2008. (Protecting Workers' Health Series n. 9).