Original Article

Workplace violence in Family Health Units: a study of mixed methods

Violência no trabalho em saúde da família: estudo de métodos mistos

Violencia en el trabajo en salud de familia: estudio de métodos mixtos

Isabel Cristina Saboia Sturbelle[1]
Daiane Dal Pai[2]
Juliana Petri Tavares[2]
Letícia de Lima Trindade[3]
Deise Lisboa Riquinho[2]
Larissa Fonseca Ampos[2]

Keywords
Workplace violence; Occupational health; Working conditions; Primary health care; Family health

Descritores
Violência no trabalho; Saúde do trabalhador; Condições de trabalho; Atenção primária em saúde; Saúde da família;

Descriptores
Violencia laboral; Salud laboral; Condiciones de trabajo; Atención Primaria de salud; Salud de la família

Submitted
January 15, 2019

Accepted
June 11, 2019

Abstract
Objective: To verify the prevalence of workplace violence in Family Health Units, characterize the victims and know the implications of conditions and organization of work in workers exposure.
Methods: A mixed study of the concomitant type. The quantitative stage included a sample of 106 health professionals from 17 Family Health Units who answered questions about sociodemographic data and the Survey Questionnaire Workplace Violence in the Health Sector. At the qualitative stage, 18 violence victims workers were intentionally selected to respond to the semi-structured interview. Quantitative findings were subjected to descriptive and analytical statistics, and qualitative data to thematic analysis.
Results: About 69.8% of the workers were exposed to violence, with the main victims being younger workers and the nursing staff (p=0.047). Violence was also associated with a worse assessment of relationships with colleagues (p=0.003) and managers (p=0.008). The interviewees attributed to the reception of the unit the space of greatest risk of aggression. The lack of resources, absence of a doctor in the unit and its location in areas of trafficking were aspects related to the exposure of professionals to violence.
Conclusion: Violence has proved prevalent in work in family health units and improvements in structure, human and material resources as well as public safety are needed to control and prevent worker aggression.

Resumo
Objetivo: Verificar a prevalência de violência no trabalho em Unidades de Saúde da Família, caracterizar as vítimas e conhecer as implicações das condições e da organização do trabalho na exposição dos trabalhadores.
Métodos: Estudo misto, do tipo concomitante. A etapa quantitativa contou com amostra de 106 profissionais de saúde de 17 unidades de saúde de família que responderam questões acerca de dados sociodemográficos e ao *Survey Questionnaire Workplace Violence in the Health Sector*. Na etapa qualitativa 18 trabalhadores vítimas de violência foram intencionalmente selecionados para responder à entrevista semiestruturada. Achados quantitativos foram submetidos a estatísticas descritivas e analíticas, e os dados qualitativos à análise temática.
Resultados: Cerca de 69,8% dos trabalhadores foram expostos à violência, sendo as principais vítimas os trabalhadores mais jovens e da equipe de enfermagem (p=0,047). A violência também foi associada à pior avaliação sobre os relacionamentos com colegas (p=0,003) e chefias (p=0,008). Os entrevistados atribuíram à recepção da unidade o espaço de maior risco de agressões. A falta de recursos, ausência de médico na unidade e sua localização em zonas de tráfico foram aspectos relacionados à exposição dos profissionais à violência.
Conclusão: A violência se mostrou prevalente no trabalho em unidades de saúde da família e melhorias na estrutura, recursos humanos e materiais, bem como segurança pública são necessários para controlar e prevenir agressões aos trabalhadores.

Resumen
Objetivo: Verificar la prevalencia de violencia en el trabajo en Unidades de Salud de Familia, caracterizar a las víctimas y conocer las consecuencias de las condiciones y de la organización del trabajo en la exposición de los trabajadores.
Métodos: Estudio mixto, de tipo concomitante. La etapa cuantitativa contó con una muestra de 106 profesionales de la salud de 17 unidades de salud de familia que respondieron a preguntas sobre datos sociodemográficos y al *Survey Questionnaire Workplace Violence in the Health Sector*. En la etapa cualitativa, se seleccionaron intencionalmente 18 trabajadores víctimas de violencia para responder una entrevista semiestructurada. Los resultados cuantitativos fueron sometidos a estadísticas descriptivas y analíticas; y los datos cualitativos, a análisis temático.
Resultados: Cerca del 69,8% de los trabajadores estuvo expuesto a violencia, entre los cuales los más jóvenes y los del equipo de enfermería fueron las principales víctimas (p=0,047). La violencia también estuvo asociada a peores evaluaciones sobre la relación con los compañeros (p=0,003) y jefes (p=0,008). Los entrevistados señalaron la recepción de la unidad como el espacio de mayor riesgo de agresiones. La falta de recursos, la ausencia de médicos en la unidad y la ubicación en zonas de tráfico ilegal fueron aspectos relacionados con la exposición de los profesionales a la violencia.
Conclusión: La violencia demostró ser prevalente en el trabajo en unidades de salud de familia y es necesaria una mejora en la estructura y en los recursos humanos y materiales, así como en la seguridad pública para controlar y prevenir agresiones a los trabajadores.

Corresponding author
Isabel Cristina Saboia Sturbelle
https://orcid.org/0000-0003-1187-7273
E-mail: saboia.isabel@gmail.com

DOI
http://dx.doi.org/10.1590/1982-0194201900088

How to cite:
Sturbelle IC, Dal Pai D, Tavares JP, Trindade LL, Riquinho DL, Ampos L. Workplace violence in Family Health Units: a study of mixed methods. Acta Paul Enferm. 2019;32(6):632-41.

[1]Universidade Tiradentes, Aracajú, SE, Brazil.
[2]Escola de Enfermagem, Universidade Federal do Rio Grande do Sul, Porto Alegre, RS, Brazil.
[3]Departamento de Enfermagem, Universidade do Estado de Santa Catarina, Chapecó, SC, Brazil.
Conflicts of interest: nothing to declare.

Introduction

Workplace violence in health services has been the subject of national and international studies, especially in hospital services.[1-3] However, Primary Health Care Services, such as the Family Health Units (FHU), require that work activities be developed in the users' own territory, with a greater approximation of the households and social spaces of the community, which can lead to increased exposure to violence.

This situation worsens in the large urban areas of less developed countries, as rapid urbanization, associated with increased crime, significantly exposes professionals to violence.[4] International studies that have previously investigated the presence of violence in primary health care services have confirmed the phenomenon, pointing out that more than half of participants experience at least one type of workplace violence per year, with prevalence of 52.6% in Serbia and 90.2% in Spain.[5,6]

Workplace violence has been related to aspects that permeate working conditions, such as poor lighting, excessive noise, lack of materials and damaged physical structure and work organization, such as working alone, high circulation of unidentified persons, insufficient numbers lack of specific training to deal with violence.[7] According to the World Health Organization, healthy work environments depend on the organization and working conditions, the first one referring to everyday attitudes, values, beliefs and practices; and the second to the physical structure, materials, products, chemicals and production processes in the workplace.[8]

Work organization results from the social and intersubjective relationships of workers with organizations. In this perspective, working requires taking action for relationships with others, demanding joint, conscious and unconscious actions, in order to create an environment of coordination and cooperation. Thus, the present research starts from the understanding that the act of working is not only to produce, but also to transform oneself, being the central work on the worker's affective life.[9,10]

In relation to the mentioned aspects, it is worth considering that the fragmentation of work and the fragilities that result from the adoption of interactions marked by rigid hierarchy, as well as the inadequacy in the physical space of the BHU, the scrapping of equipment and materials, have already been described in the literature and can influence the behavior of users and the health team, fomenting violent attitudes in industrial relations.[11,12] These attitudes, in turn, confront fundamental assumptions of work in FHU, which requires teamwork, mediated by dialogue and bonding with users and community.[3,4,13] Previous studies highlight the importance of establishing the link in the implementation of health promotion and disease prevention actions. Speech, listening, bonding and weak negotiation have repercussions on the search for primary care services, as well as on the co-responsibility of users and on the trust relationship necessary for care longitudinality.[13,14]

Considering the above, there was the question: do professionals who work in FHU are exposed to workplace violence? Do the conditions and organization of work influence this phenomenon? The study aimed to verify the prevalence of workplace violence in FHUs, to characterize the victims and to know the implications of the conditions and organization of work in workers' exposure.

Methods

It was a research of mixed methods of the concomitant type. The quantitative step used a cross-sectional, descriptive and analytical design; the qualitative step was of the exploratory-descriptive type and occurred in the same encounter with the worker, immediately after the application of the questionnaire.

The study was conducted in FHUs of a district that makes up the basic care network managed by the city hall of a capital of Southern Brazil. FHUs base their assistance on the Family Health Strategy's principles. Therefore, they must guarantee access based on the recognition of the needs of the people and of the assigned territory, organizing activities between spontaneous demand and programmatic actions of health education and care at home and at the unit. The proposed activities should always

prioritize the multidisciplinary work and focused on actions of surveillance, prevention and health promotion.

The municipality studied had an estimated population of 1,481,019 inhabitants, with the service network at this level distributed in 17 health districts, with 45 Basic Health Units and 73 FHUs. The present research focused on 27 teams of 17 FHUs from a district management in which curricular activities are carried out at the *Universidade Federal do Rio Grande do Sul*, where students and professors have witnessed reports and/or situations of violence in the work of the teams. In addition, the choice of the study scenario is related to the vulnerability of professionals working at the FHUs, which needs to be considered considering the potential implications of violence on workers' health and continuity of the Family Health Strategy's actions in the municipality.

The study population consisted of nine physicians, 16 nurses, 25 nursing technicians/assistants and 56 Community Health Agents (CHA) (n=106). In the quantitative stage, all the professionals (n=190) who comprised the minimum family health team were invited to participate in the study. Those with less than 12 months of work at the FHUs (n=36), who were away (n=22) or on vacation (n=7) at the time of collection were excluded and those who were inaccessible due to suspension of activities due to conflicts (n=8) as well as refusals (n=11) were considered losses. The final sample of 106 workers from the quantitative stage was statistically significant, considering 95% confidence and 5% error, 50% prevalence, calculated with the aid of WINPEPI version 11.32.

At the qualitative stage, 18 professionals were intentionally invited, who stated in the previous stage that they had suffered violence in the last 12 months. This sub-sample was composed of six CHA, six nursing technicians, five nurses and one doctor. The intentional selection adopted sought to select, among the violence victims at work, professionals who proved to be better informers, that is, implicated in the problem and motivated to talk about it. 18 respondents were defined by the criterion of data saturation, which applies when no new element emerges and the increase of new information does not modify the understanding of the studied phenomena.[15]

The sample was collected between September and December 2017. The sample of professionals was invited to answer a questionnaire about socio-demographic and labor data (gender, age, skin color, years of study, marital status, children, tobacco use, medication use, chronic illness, professional category, years of health experience, years of FHU experience, if you work in another institution, as well as professionals' perception about work organization, satisfaction, recognition and interpersonal relationships) and the Survey Questionnaire Workplace Violence in the Health Sector, proposed by the World Health Organization, International Labour Organization and Public Services and International Council of Nursing.[16] The tool was translated and adapted into Portuguese and used in Brazilian research to assess violence in health work in the last 12 months, and the aggression may be physical or psychological (the latter modality includes verbal, moral, sexual or racial forms), which are assessed independently of their frequency and can form a global categorical measure (whether or not they have suffered some form of violence).[3,17,18] The tool also includes questions that make it possible to characterize situations of violence, victims, offenders and measures that require investments in the face of workplace violence.[16,17] The professionals who composed the qualitative stage also answered a semi-structured interview recorded in audio, following a pre-established script, which dealt with the conditions and the organization of the work in the FHUs and their relations with the occurrence of labor violence.

The analysis of the quantitative data was carried out by the software Statistical Package for the Social Sciences (SPSS), version 18.0. Values of $p \leq 0.05$ were considered statistically significant. The categorical variables were described by means of relative and absolute frequencies and the continuous and scalar variables were described by measures of central tendency and dispersion. The Chi-Square Test for association and Mann-Whitney Test were used

to verify differences between medians in the groups, after Shapiro-Wilk Normality Test.

The data from the transcripts of the interviews were submitted to the thematic type analysis technique, according to Minayo,[19] giving rise to the following categories (and their thematic subcategories): Characterization of workplace violence in FHUs (violence victims); Conditions and organization of work (Structure and resources, Interpersonal relationships) and; (Im)possibilities to prevent/control violence (Measures to prevent workplace violence and, Urban violence).

After the statistical analysis of the numerical data and categorization of the interviews, the findings were confronted and articulated, searching for identification of convergences, differences and combinations, in order to respond to the objectives through the complementarity of information, which allowed greater comprehensiveness to the look cast on workplace violence.

The study was approved by the Ethics and Research Committee of the proposing institution (no. 2,081,737) and co-participant (number 2,128,825) and all participants signed the Free and Informed Consent Term. The research respected the ethical precepts contained in Resolution 466/12 of the Brazilian Health Board (*Conselho Nacional de Saúde*).[20] As a guarantee of anonymity of the participants in the use of speech fragments, the acronym 'INT' was used for 'interviewee', followed by the interview order number.

Table 1. Distribution of workers victims and non-violence victims at work according to sociodemographic and labor characteristics

Variables	Workplace violence		*P value*
	Yes (n=74)	No (n=32)	
Gender*			
Female	61(71.8)	24(28.2)	0.430§
Male	13(61.9)	8(38.1)	
Age" (Years)	40.5(33 -50)	44.5(40 – 53.7)	0.047**
Skin color*			0.194§
Black	31(77.5)	9(22.5)	
White	42(64.6)	23(35.4)	
Studying years"	13(11 – 18)	13(11 – 17)	0.577+
Marital status*			
Single, widow(er) or without a partner	33(67.3)	16(32.7)	0.674§
Married or with a partner	41(71.9)	16(28.1)	
Children" (number)	1(0 - 2)	1(0 – 2)	0.776+
Tobacco use*			
Yes	9(60)	6(40)	0.377§
No	65(71.4)	26(28.6)	
Medication use*			
Yes	51(70.8)	21(29.2)	0.822§
No	23(67.6)	11(32.4)	
Chronic disease*			
Yes	43(74.1)	15(25.9)	0.298§
No	31(64.6)	17(35.4)	
Professional category*			
CHA	33(58.9)	23(41.1)	0.047§
Nursing tech/assist	21(84)	4(16)	
Nurse	14(87.5)	2(12.5)	
Doctor	6(66.7)	3(33.3)	
Experience years"	11(6.7 – 15.2)	13.5(5 – 16)	0.981**
Experience years at FHUs"	4(3 – 7.7)	5(3 – 16)	0.075**
Boss*			
Yes	12(85.7)	2(14.3)	0.220§
No	62(67.4)	30(32.6)	
Absence days"	7(2 – 20)	6(1.2 – 16.5)	0.803+
Works in other institution*			
Yes	10(76.9)	3(23.1)	0.750§
No	64(68.8)	29(31.2)	

* - n (%); - median (interquartile ranges); § - Chi-Square Test; + - Mann-Whitney Test; ** - Student t

Results

The sample composed of 106 FHU workers was predominantly female (80.2%), with a median age of 42.5 years (34.7-51), median of 11 years (6 - 16) of experience in the health area and four years (3 - 12.2) in the FHUs, 52.8% CHA, 23.6% nursing technicians, 15.1% nurses and 8.5% doctors. The prevalence of workplace violence in FHUs was 69.8% of workers exposed in the last 12 months. Table 1 shows the distribution of workers victims and not violence victims at work according to sociodemographic and labor characteristics.

In addition to the aspects highlighted in the table, the thematic sub-category "violence victims" dealt with reception as a place/activity of greater exposure to violence, since it is an environment that requires the professional to listen and receive the users who seek attendance, as well as determining flows to the demands. In addition to being the first contact between service and user, the schedules of professionals, organization of home visits and the order of care is under the supervision of the worker in activity at the reception. Thus, often those who are ahead of this first service is responsible for giving the unwanted information to users or even "deny" the intended assistance:

The staff at the front desk suffers much more (...). INT 18

(...) I know it's not my job, only I have to do as all the other colleagues have to do ... reception is something that makes you very stressed (...). INT 10

(...) so I think that these issues of a lot of crowds, of a lot of people, make people tense and this tension from my point of view can be one of the factors that predispose to violence, to attack ... not wanting to wait (...). INT 14

And this way they find to be served [at the reception] is screaming, offending (...). INT 7

Considering assessment aspects of the work, table 2 shows that workers violence victims have lower means in assessments on labor aspects.

Table 2. Averages and Standard Deviation of workers' assessments on labor aspects between victims and non-victims of workplace violence in FHUs

Variables	Workplace violence		
	Yes (n=74)	No (n=32)	
	Mean	Mean	*p-value*⁺
Working conditions	2.97 (±0.68)	3.19 (±0.86)	0.153
Work organization	3.58 (±0.84)	3.91 (±0.69)	0.068
Satisfaction with work	3.29 (±1.16)	3.47(±1.27)	0.314
Acknowledgment for the work	3.14(±1.23)	3.41(±1.16)	0.367
Relationship with colleagues	3.95(±0.68)	4.34(±0.65)	0.003
Relationship with the boss	4.18(±0.78)	4.59(±0.56)	0.008

⁺ - Mann-Whitney test
Note: The assessments were scored using a likert scale of five points, from the worst (1) to the best assessment (5). However, the test presented in the table compares the difference of medians to facilitate the interpretation of the findings, being chosen to present the means and Standard Deviation.

The interviews made it possible to understand the implications of the working conditions on exposure to violence in FHUs, it is pointed out that aspects related to the lack or scrap of materials, equipment and physical structure. The corresponding lines were attributed to the thematic category "structure and resources", and this can be seen in the following excerpts:

(...) It gets difficult when you do not have medication, sometimes we do not even have material to work with. There was a time without gauze, without tape because they did not send it to us and it was due to the lack of it (...). INT 5

(...) "not to have" is a reason to attack us (...). INT 1

(...) there are about six thousand five hundred users for a health post, we should have more teams, we should have three teams, we only work with two, with a reduced staff (...). INT 7

(...) people do not have any structure, the health center is poorly located (...) they are things related to the functioning of the unit, it bothers me a lot, because it is not me, it is not the relationship, it is not my job that is being, the person is talking, it is about the unit operation. INT 10

Also, in the same thematic category, the absence of physicians in the units was mentioned with emphasis on the occurrence of aggressions of the users, bringing to the surface implications of the organization of the work in which it corresponds to the assistance model, that advocates the integrality of the assistance and should be the entrance door of SUS users and represents the primary level of health care.

(...) if he had a doctor and he would not be too late to serve (...) It's the doctor's fault! Even because depending on the material they manage to pull it off somewhere else. It is more an issue of the lack of doctor (...). INT 3

(...) everyone wants appointments, they want to consult with the doctor, it's no use going through me, it's no use going through the nurse, they want the doctor. INT 8

Like, there is no medical service, the person comes and does not want to know, she has to find a guilty party and the culprit is the nurse or someone who is attending... I think people think that the post revolves around the doctor who has no other services (...) a day without a doctor is a little, it is very stressful ... having the full professional staff, would be the most important. INT 10

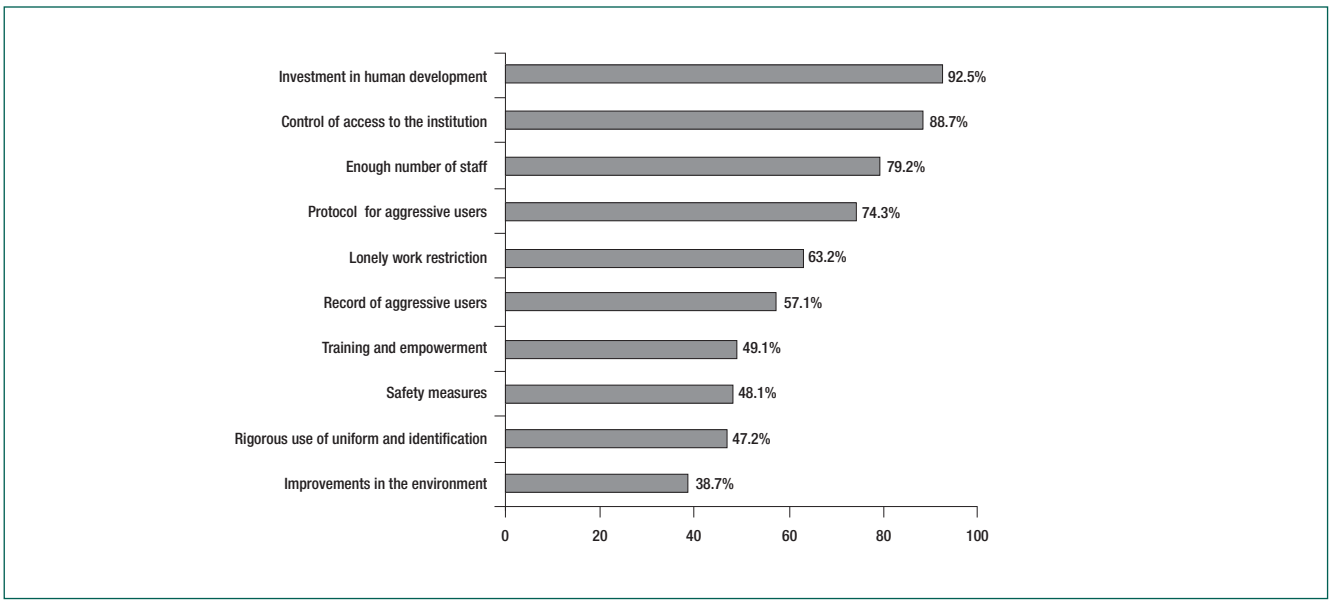

Figure 1. Measures that require investments to deal with workplace violence according to the perception of professionals

According to the reports, users are the main perpetrators of workplace violence in FHUs, which is also supported by the quantitative findings, since 71.6% of the aggressions suffered by workers in the last 12 months were practiced by users and 6.4 % by family/companions. Violence victims perpetrated by users reported in the interviews that this practice occurs mainly through swearing, insults and threats.

Colleagues accounted for 11% of the situations quantified and leaders 9.2%. In this direction, some discourses highlighted in the category "interpersonal relationships" show that the socio-professional relations also imply in the experiences of violence in FHUs:

> *You do not have this openness with your colleague sometimes to collaborate, sometimes it takes a little teamwork, (...) it ends up generating a stress and you take it, you take it, there comes a time when you blow up. INT 15*

> *(...) generates a tension in the team, because many people think of them and, rightly so, because they want to protect themselves. But someone will have to open the post, someone will have to make this post work and whoever gets here, whoever makes this post work, he will be attacked (...). INT 17*

In figure 1, it is possible to observe some factors that deserve greater investments in FHUs and that if improved, they may, in the opinion of professionals, influence the occurrence of violence.

Moreover, the fact that services are in territories with criminal factions and frequent situations in which drug traffickers do not respect community service spaces, arouses feelings of fear in professionals, as well as favors exposure to workplace violence in FHUs. These aspects were considered in the thematic category "urban violence" and can be evidenced in the following statements.

> *(...) a few days ago we did not go out to work [in the streets and in the homes] because there were some conflicts in the territory (...). INT 6*

> *We work in an area that has a traffic war, so you live, you stay on the hill and you end up experiencing all the conflict, the whole situation of violence (...). INT 10*

> *We had to close the unit and leave, as there were firefights nearby. INT 13*

For the professionals interviewed, their work process is hampered by the lack of public safe-

ty, revealing the vulnerability situation of FHUs' health team.

Discussion

The prevalence of workplace violence in FHUs reinforces findings from other studies.[4-6] As for sociodemographic characteristics, associated with violent episodes in primary care services, nursing was revealed in a study in Serbia as the most exposed category, with no differences for gender, age, marital status, education level and years of experience.[5] In a Spanish study, doctors and nurses were less exposed to workplace violence in Primary Health Care than other professionals who occupy the front line in services.[6] This finding differs from the present research regarding the most exposed professional category, but it resembles in relation to the greater risk attributed to the performance in the service's reception.

In a Brazilian study carried out with 269 professionals from the multidisciplinary team, it was observed that the victims were characterized by female gender, lower age and schooling, nursing technicians and more days absent at work, with a statistically significant difference.[3] In the present study, the time of experience in FHUs, working in another institution, tobacco use, skin color and number of children were not variables associated with workplace violence, a result similar to the study already cited.[3]

Chronic diseases and the use of medication were also not associated with exposure to violence, however, the high prevalence of workers living with chronic diseases and making use of medications. A study carried out with professionals of the health team who work in Primary Health Care pointed out that these workers experience physical pains and complaints, which relate to stress caused by lack of resources, conflicts at work, lack of professional recognition, work overload, among others.[9]

Regarding the workers' exposure at the reception of the unit, a Brazilian study developed in the state of Alagoas showed that there is a divergence between the problem identified by the professional and the need seen by the patient served. In addition, due to the link established between the professional and the users, the latter feels free to collect attention and care at the time that is convenient. Still, the request for fitting in care is frequent and not always possible, which also generates aggressive contestations.[21]

Absence or inefficiency of doctors in the FHUs was a factor attributed by participants to user dissatisfaction, which can mean the reproduction of the physician-centered model in the manifestation of users by the search for care, a finding also found in another study in the context of primary care.[22] A research carried out in the city of São Paulo, Brazil, showed that there is insecurity on the part of users about having their demands served by professionals and services, with a lack of information, which generates tensions, mainly with receptionists.[23] Thus, the lack of resolution in the FHUs can be a factor that triggers threats and offenses in their work environment.[24]

The shortage of human and material resources in primary care services abroad was also related to the intention to quit.[25] Thus, the search for health care is incompatible with the organization and working conditions offered in primary care, generating exhaustion for professionals and user dissatisfaction.[22,26] At this juncture, violence adds damages that influence productivity and quality of work, resulting in dissatisfied professionals, who do not feel recognized, and who have fragile or conflicted relationships with colleagues, bosses and users.[1]

In view of the findings, it can be inferred that the workers violence victims suffer doubly, since in addition to the daily aggressions from users and service colleagues, they still suffer from the lack of structure and human resources. This aspect was pointed out by the influence of structural violence on the moral integrity of workers, generating suffering since experiencing these structural problems can be reason for aggressions among their partners.[27] Moreover, it is possible to add urban violence as a form of workplace aggression in FHUs, which makes it possible to

say that professionals are threefold exposed to violence considering the threats and fear experienced in working with the often more dangerous communities.

Structural violence can also be seen through the invisibility with which workers' exposure to violence is treated at the SUS network. There are no flows established in cases of aggression between people, which shows that the institution/structure is indifferent to the victims, and that there is no solitary way of trying to deal with the situation from their own resources.

Among the measures to minimize cases of workplace violence, the research pointed out that authority figures, such as security guards, represent a protective aspect regarding the exposure of health professionals to violence, as well as access control to the service, education to the users of the services and adequate attitudes by the professionals in situations of violence.[28]

In addition, investing in strategies that strengthen teamwork, incorporating technologies that contribute to the resolvability of care, and reducing work overload can empower professionals to act on a daily basis. Thus, it is hoped that they will participate politically in the management of health services and in the instances of social control, seeking the implementation of measures that strengthen professionals and enhance universal access.[29]

When it comes to Primary Health Care, the aspects referring to regions with high crime rates and poorly lit environments may be the factors that deserve more attention, corroborating the indication of the literature.[7] Thus, it is understood that working in communities where crime is constant increases the fear and the chance of exposure of professionals to violence, which in the present study has been shown to affect the activities carried out in the community, affecting the quality of the service provided.

In addition, violence is a complex phenomenon that affects different spheres of society and encompasses cultural values, educational level, economic instability, social injustices and impunity. These aspects refer to a macropolitical conjuncture that is reproduced in the labor contexts, including the service sector. Among the strategies for confronting violence in Brazil and abroad, the United Nations Organization launches sustainable millennium goals, among which is the search for the promotion of peaceful and inclusive societies for sustainable development, providing access to justice and building institutions effective, accountable and inclusive at all levels. Furthermore, it is the responsibility of the health sector to collaborate jointly with intersectoral actions to foster a culture of peace and respect for all persons, workers and health system users.[30]

Conclusion

There was a prevalence of 69.8% of FHU workers exposed to workplace violence, being the victims characterized as younger workers, with occupation in the nursing and worse assessments on the relationships in the work. Carrying out work activities at the reception of the unit represented greater susceptibility to aggressions from users, either because they seek the service with revolt or because they become aggressive with the unwanted outcome. The absence of doctors in the health teams was mentioned as the main cause of verbal aggression, reinforcing the user's expectation for the biomedical care model and little compensation of Primary Health Care attributes. Failures in the unit structure, deficiency of material and human resources, instigate users' dissatisfaction, aimed at professionals, who are also exposed to urban violence related to areas of drug trafficking in the territory. Thus, the conditions and organization of work imply the occurrence of violence in FHUs. Violence in this daily work also has negative repercussions on the labor context, and can be considered a complex phenomenon composed of negative and interrelated cadences. The results of this research have as implications for health and nursing the need for investments in service infrastructure, worker safety and care strategies that foster the model of care sought

for the FHUs. As a limitation of the study, it is possible to consider that the methodological design does not allow a follow-up on the effects that these episodes bring to the professionals and to the resolution of the FHUs. In addition, the study was developed in a health district of the capital. It is recommended to carry out more comprehensive studies on Primary Health Care in order to broaden the picture of the assessed disease.

Collaborations

Sturbelle IC, Dal Pai D, Tavares JP, Trindade LL, Riquinho DL and Ampos L declare that they contributed to the study design, data analysis and interpretation, article writing, relevant critical analysis of intellectual content and approval of the final version to be published.

References

1. Fang H, Zhao X, Yang H, Sun P, Li Y, Jiang K, et al. Depressive symptoms and workplace-violence-related risk factors among otorhinolaryngology nurses and physicians in Northern China: a cross-sectional study. BMJ Open. 2018;8(1):e019514.
2. Wei CY, Chiou ST, Chien LY, Huang N. Workplace violence against nurses—prevalence and association with hospital organizational characteristics and health-promotion efforts: cross-sectional study. Int J Nurs Stud. 2016;56:63–70.
3. Pai DD, Lautert L, Souza SB, Marziale MH, Tavares JP. Violence, burnout and minor psychiatric disorders in hospital work. Rev Esc Enferm USP. 2015;49(3):460–8.
4. Silva ATC, Peres MFT, Lopes CS, Schraiber LB, Susser E, Menezes PR. Violence at work and depressives symptoms in primary health care teams: a cross-sectional study in Brazil. Soc Psychiatry Psychiatr Epidemiol. 2015;50(9):1347–55.
5. Fisekovic MB, Trajkovic GZ, Bjegovic-Mikanovic VM, Terzic-Supic ZJ. Does workplace violence exist in primary health care? Evidence from Serbia. Cent Eur J Public Health. 2015;25(4):693-98.
6. Ruiz-Hernández JA, López-García C, Llor-Esteban B, Galián-Muñoz I, Benavente-Reche AP. Evaluation of the users violence in primary health care: Adaptation of an instrument. J Health Psychol. 2016;16:295-305.
7. Occupational Safety e Health Administration (OSHA). Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers [internet]. United Stades of América: OSHA; 2015. [cited 2018 Jul. 18]. Available from: https://www.osha.gov/Publications/osha3148.pdf
8. Organização Mundial da Saúde (OMS). Ambientes de trabalho saudáveis: um modelo para ação para empregadores, trabalhadores, formuladores de política e profissionais [Internet]. Brasília; OMS; 2010 [citado 2018 Jul 18]. Disponível em: http://www.who.int/occupational_health/ambientes_de_trabalho.pdf
9. Dashtipour P, Vidaillet B. Work as affective experience: the contribution of Christophe Dejours' 'psychodynamics of work'. Organization. 2017;24(1):18–35.
10. Dejours C, Barros J, Lancman S. A centralidade do trabalho para a construção da saúde. Occup Ther. 2016;27(2):228–35.
11. Medeiros PA, Silva LC, Amarante IM, Cardoso VG, Mensch KM, Naman M, et al. Condições de saúde entre Profissionais da Atenção Básica em Saúde do Município de Santa Maria – RS. Rev Bras Ciênc Saúde. 2016;20(2):115-22.
12. Maciel RH, Santos JBF, Rodrigues RL. Condições de trabalho dos trabalhadores da saúde: um enfoque sobre os técnicos e auxiliares de nível médio. Rev Bras Saúde Ocup. 2015;40(131):75-87.
13. Kessler M, Lima SBS, Weiller TH, Lopes LFD, Ferraz L, Thumé E. A longitudinalidade na Atenção Primária à Saúde: comparação entre modelos assistenciais. Rev Bras Enferm. 2018 ; 71(3): 1063-1071.
14. Oliveira MAC, Pereira IC. Atributos essenciais da Atenção Primária e a Estratégia Saúde da Família. Rev Bras Enferm. 2013; 66(Spe):158-64.
15. Minayo, MC. O desafio do conhecimento: pesquisa qualitativa em saúde. 14a ed. São Paulo: Hucitec; 2014.
16. Di Martino V. Workplace violence in the health sector – country case studies – Brazil, Bulgarian, Lebanon, Portugal, South África, Thailand, and an additional Australian study [Internet]. 2003 [cited 2018 Jul. 18]. Available from: http://www.who.int/violence_injury_prevention/injury/en/WVsynthesisreport.pdf
17. Palacios M. Relatório preliminar de pesquisa. Violência no trabalho no setor saúde. [Internet]. Rio de Janeiro. Universidade Federal do Rio de Janeiro; 2002 [citado 2018 Jul 18]. Disponível em: http://www.assediomoral.org/IMG/pdf/pesquisa_sobre_Violencia_no_trabalho_Universidade_Federal_RJ.pdf
18. Silva IV, Aquino EM, Pinto IC. Violência no trabalho em saúde: a experiência de servidores estaduais da saúde no Estado da Bahia, Brasil. Cad Saúde P?blica. 2014;30(10):2112-22.
19. Minayo MC, Deslandes SF. Pesquisa social: teoria, método e criatividade. 25a ed. Petrópolis: Vozes; 2007.
20. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução n. 466, de 12 de dezembro de 2012. Aprova diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília, Diário Oficial da União; 2012.
21. Santos DS, Mishima SM, Merhy, EE. Processo de trabalho na Estratégia de Saúde da Família: potencialidades da subjetividade do cuidado para reconfiguração do modelo de atenção. Cienc Saúde Coletiva. 2018;23(3):861-870.
22. Arruda CA, Bosi ML. Satisfação de usuários da atenção primária à saúde: um estudo qualitativo no Nordeste do Brasil. Interface. 2017;21(61):321-332.
23. Melo SM, Cecílio LC, Andreazza R. Nem sempre sim, nem sempre não: os encontros entre trabalhadores e usuários em uma unidade de saúde. Saúde Debate. 2017;41(112):195–207.
24. Fontes KB, Santana RG, Pelloso SM, Carvalho MD. Factors associated with bullying at nurses' workplaces. Rev Lat Am Enfermagem. 2013;21(3):758–64.

25. Kadiri-Eneh NP, Azuike EC, Tobin-West C, Uzochukwu BS. An Assessment of the Potentials for Retention of Primary Health Care Workers in Rivers State, Nigeria. Afr J Med Med Sci. 2018;6(1):35–51.

26. Maissiat GS, Lautert L, Dal Pai D, Tavares JP. Work context, job satisfaction and suffering in primary health care. Rev Gaúcha Enferm. 2015; 36(2):42-49. DOI:

27. Dal Pai D, Sturbelle IC, Santos C, Tavares JP, Lautert L. Physical and psychological violence in the workplace of healthcare professionals. Texto Contexto Enferm. 2018;27(1):e2420016.

28. Vezyridis P, Samoutis A, Mavrikiou PM. Workplace violence against clinicians in Cypriot emergency departments: a national questionnaire survey. J Clin Nurs. 2015;24(9-10):1210–22.

29. de Pires DE, Machado RR, Soratto J, Scherer MA, Gonçalves AS, Trindade LL. Nursing workloads in family health: implications for universal access. Rev Lat Am Enfermagem. 2016;24(0):e2682.

30. Cerqueira D, Lima RS, Bueno S, Neme C, Ferreira H, Coelho D, et al. Atlas da violência 2018. Brasília: Ipea/ FBSP; 2018 [citado 2019 Abr 9]. Disponível em: http://www.ipea.gov.br/portal/index.php?option=com_content&view=article&id=33410&Itemid=432