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Isse Polaro, Sandra Helena; Takase Gonçalves, Lucia Hisako; Alvarez, Angela Maria
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NURSES CHALLENGING VIOLENCE IN THE SCOPE OF PRACTICE IN THE FAMILY HEALTH PROGRAM[1]

Sandra Helena Isse Polaro[2], Lucia Hisako Takase Gonçalves[3], Angela Maria Alvarez[4]

[1] Study extracted from the thesis - *Gerenciando o cuidado de enfermagem ao usuário idoso na Estratégia Saúde da Família*, submitted to the Nursing Graduate Program of the Federal University of Santa Catarina (UFSC), in 2011.

[2] RN, Ph.D. Adjunct Professor II at the Nursing School of the Institute of Health Sciences of the Federal University of Pará. Pará, Brazil. E-mail: shpolaro@ufpa.br

[3] RN, Ph.D. Retired Professor from the Nursing Graduate Program of UFSC. CNPq Researcher. Santa Catarina, Brazil. E-mail: lucia.takase@pq.cnpq.br

[4] RN, Ph.D. Adjunct Professor II at the Department of Nursing of UFSC. Santa Catarina, Brazil. E-mail: alvarez@ccs.ufsc.br

ABSTRACT: This study aimed to describe and analyze how violence affects the working process of nurses in the Family Health Program. It consists of an exploratory-descriptive study developed in a district in the suburb of Belém, Pará, Brazil. Data were collected between August 2009 and February 2010, by means of interviews with 14 nurses, and then submitted to the method of content analysis, generating one of the themes of this study: 'Challenging violence', with derivative sub-topics such as territorial violence, institutional violence and intrafamilial violence. The result showed the impact of the violence phenomenon on the working process of the nurses of the Family Health Program units. This violence induces them to feel fear and professional frustration due to embarrassment and limitation of their roles, although they still challenge the obstacles encountered in their daily work.

DESCRIPTORS: Violence. Nurse's role. Family health program. Aged. Home visit.

ENFERMEIRAS DESAFIANDO A VIOLÊNCIA NO ÂMBITO DE ATUAÇÃO DA ESTRATÉGIA DE SAÚDE DA FAMÍLIA

RESUMO: A pesquisa teve como objetivo descrever e analisar como a violência interfere no processo de trabalho das enfermeiras atuantes na Estratégia de Saúde da Família. Estudo descritivo-exploratório realizado em um distrito de periferia de Belém-PA. Os dados, coletados entre agosto de 2009 e fevereiro de 2010, por entrevista com 14 enfermeiras, foram tratados pelo método de análise de conteúdo, gerando um dos temas que é matéria deste artigo: Desafiando a violência, com derivação de subtemas como violência territorial, violência institucional e violência intrafamiliar. O resultado mostrou como o fenômeno da violência impacta o trabalho das enfermeiras em atividade nas unidades de ESF, induzindo-as aos sentimentos de medo e frustração profissional pelo constrangimento e limitação de suas funções, embora continuem desafiando os entraves encontrados no seu cotidiano laboral.

DESCRITORES: Violência. Papel do profissional de enfermagem. Idoso. Programa saúde da família. Visita domiciliar.

ENFERMERAS DESAFIANDO LA VIOLENCIA EN EL ÁMBITO DE ACTUACIÓN DEL PROGRAMA DE SALUD PARA LA FAMILIA

RESUMEN: La investigación tuvo el objetivo de describir y analizar de que manera la violencia interfiere en el proceso de trabajo de las enfermeras actuantes en el Programa de Salud para la Familia. Estudio descriptivo-exploratorio realizado en un distrito de la gran Belém, Pará, Brasil. Los datos obtenidos entre Agosto del 2009 y Febrero del 2010, entrevistando 14 enfermeras, fueron tratados por el método de análisis de contenido, generando uno de los temas que es materia en este artículo: Desafiando la violencia, con la derivación de subtemas como violencia territorial, violencia institucional y violencia intrafamiliar. El resultado mostró de que manera el fenómeno de la violencia impacta en el proceso de trabajo de las enfermeras en actividad, en las unidades de Programa de Salud para la Familia, induciéndolas a sentir miedo y frustración profesional por el constreñimiento y la limitación de sus funciones, aunque continúen desafiando los problemas encontrados en su rutina laboral.

DESCRIPTORES: Violencia. Rol de la enfermera. Programa de salud familiar. Anciano. Visita domiciliaria.

INTRODUCTION

Nurses have been providing basic health care more effectively towards patients in the scope of their families. However, a factor that limits their work in the Family Health Program (FHP) units is the urban violence that affects the suburbs of big cities, where families of low income, low education and low health level live in agglomeration. Lately, the working process of nurses in this context has been surrounded with great insecurity, reaching the extreme point in which their lives are at risk. In face of this situation, health professionals have safeguarded themselves, staying inside the health centers or units, and treating only the patients who are able to get there. This impossibility of full performance, however, makes them extremely frustrated.

As a complex phenomenon that has been destroying society, violence represents a threat to the individual, the family and the collectivity in general, being reported worldwide as a social and public health issue.[1] Violence has not been manifested homogeneously[2] over time. In the contemporary age, researchers see it as a complex and dynamic biopsychosocial phenomenon, whose manifestation is made, mainly, by means of life in society. In this sense, it is related with political, economic, moral, legal and psychic questions, interfering in the quality of human and institutional relationships, both in the collective and in the individual scope.[3] Violence becomes a public health problem once it compromises the health of the individual and the collectivity, demanding energetic intersectorial actions and the enablement of several specific public policies,[4] already formulated in the different levels.

Hanna Arendt, an important theorist of society and human phenomena, dedicated a book, among many, to the violence theme.[5] Among varied and broad interpretations of the phenomenon, she states that its questions remain hidden, given their nature, dimension and complexity. According to her, in order to understand violence it is necessary to examine its roots and nature. In this examination, correlated or antagonistic concepts require a detailed analysis. Hence, for instance, "power" and "vigor" correspond to the human ability of acting in unison, in agreement, and people invested with this power and vigor, for some reason, produce a threat to the opposing group, which is devoid of this characteristic. Accepted in the daily language as a synonym for violence, as a means of coercion, "force" is another concept that indicates the energy released by physical or social movements. "Authority", in an indefinite sense, may characterize an object of frequent abuse, such as in a relationship between parent and child, boss and subordinate.

Studies developed with nurses from basic health care units located in the suburbs of large Brazilian cities showed that, in their routine, they face several modalities of violence, from verbal assault to death threats. This violence results, mainly, from the consumption of illicit drugs and the deficiency of infrastructure in the units, imposing physical and mental weariness to the nurses and interfering in their work routine.[6-7]

In the context of the health sector, it is common to find classifications of violence such as: intrafamilial, structural and institutional. Intrafamilial violence concerns the violence occurring among intimate partners and family members, mainly in the domestic environment. It includes several forms of aggression: against children, against women or men, and against older adults. In general, it is considered a form of communication among people, in the family context.[8] Structural violence, on the other hand, corresponds to the structures organized and institutionalized as economical, cultural or political systems that lead to the oppression of groups, classes or individuals who are denied from the achievements of society. This situation makes them more vulnerable than others to suffering and prevents the practices of socialization, leading the individuals to accept or to inflict suffering "naturally", as per their corresponding role.[3] The designation of territorial violence, the study location and the life context of the families living in the area of the FHP units were adopted considering the theme that emerged from the data collected in the present study. Institutional violence denotes actions of embarrassment and depersonalization produced by the rules and guidelines of operation and bureaucratic and political relationships of the institutions, reproducing unfair social structures and imposing suffering to patients.[9] This includes not only patients, but also the professionals of these services and who assist these patients, given the emergence of data in the studied health services.

In order to learn the obstacles generated by violence and which make the nursing working process difficult, the authors aimed to answer the following study question: how do the nurses who work in the FHP units in the suburbs of Belém, Pará, perceive and cope with violence in their

working process? This question derives from a doctoral thesis developed with FHP nurses from a district in the suburb of the municipality of Belém-PA.[10]

The purpose of this study was to present answers to the guiding question, aimed to describe and analyze how violence interferes in the working process of nurses in the FHP.

METHOD

This study employed the qualitative-descriptive approach, and adopted the technique of open interview to obtain data. The content analysis of Bardin[11] was used as the method for data treatment, as well as the categorical or thematic analysis technique.[11]

The qualitative approach was adopted because it provides the knowledge of the representations of the subject through his/her statement, allowing the researcher to come closer to the reality of the social players, since it comprises the universe of perceptions, meanings, motivations, aspirations, beliefs, values and attitudes related with the process of human relationships that cannot be quantified.[12]

The present study was developed in six family health units in the administrative district of DAGUA, municipality of Belém, which concentrates a greater number of inhabitants with low income and a prevalence of urban violence.

The study sample consisted of 14 nurses who worked in the aforementioned units, at the occasion of data collection, the youngest being 27 years old, and the oldest being 64. Twelve nurses had taken a specialization course, eight in public or family health, and the others in the hospital area. Twelve nurses started working in the family health area in the first decade of 2000, and the other two in the 1990's. Ten nurses had graduated in the 1990's and four in the first decade of 2000.

Data were collected in the period between August of 2009 and February of 2010, once the nurses invited to participate in the study had signed the Free and Informed Consent Form. A copy of the term was filed by the main researcher and the other was given to the participant, in order to offer the necessary information as for the project and their participation, as well as to assure the confidentiality of the identity of the participants and the information provided. The research proposal complied with the recommendations of the resolution 196/96 of the National Health Council, which establishes ethical guidelines for studies involving human beings, being submitted to the Research Ethics Committee of the Federal University of Santa Catarina, and approved under the protocol n. 036/09.

RESULTS AND DISCUSSION

The emergence of the theme "Challenging violence" shows the impact of violence on the working process of nurses in the FHP, especially when they are out assisting older patients and families in their houses. In their routine, they use the possible resources found in the community, allied to their creative capability to handle the situations faced, and, in these circumstances, they challenge and face the obstacles found in their working process.

The theme presented in the previous paragraph, "Challenging violence", originated the following subthemes: territorial violence, institutional violence and intrafamilial violence, which emerged, together, from the significant speeches of nurses, as presented in the continuation.

Territorial violence

One of the characteristics of the work in the FHP is the location of the unit in a specific geographical area, in which the nurses develop their work both inside and outside the unit, delivering care to individuals, families and the community, in an interrelational process with the patient. However, in the context of this study, it was observed that the population living in the areas where these health units are located have low income and deal with several sorts of violence, which leads the nurses to challenge and cope with this situation in their work routine.

Territorial violence, as per the designation in this study, results from the context of the territory of the studied FHP units, which is similar to that of the structural violence,[3] resulting from behaviors marked with social exclusion and inequalities.

According to the speeches of the nurses, it was evidenced that the violence phenomenon permeates typical situations from populous urban suburbs, with precarious life conditions, practically no integrated public programs or policies to satisfy the real needs of the local population, such as health, sanitation, housing, education and security. In association with this situation, there is the presence of drug dealing, conflicts between dealers

for the control of the territory, and consumers who steal from the local residents and people passing through the area, including the members of the FHP team and students in internship, terrorizing them and making them feel threatened and unsafe.

The central proposal of the FHP is having the family to participate in the health-disease process, with individual and collective actions, in their physical and social environment. However, this focus is deviated when the main challenge of the team is overcoming territorial violence, a serious social problem that interferes in the development of the actions on the part of the team professionals.

In the case of nurses, their work targets individuals, families and the community, both in the unit and in their houses, where they establish bonds with the patients, despite all the ruling violence. The best example is the fact that the nurse is warned regarding the risks he/she is taking in certain areas and moments by patients who are under their care. The speeches of the nurses reveal the feelings of fear and insecurity permeating their working process, and the acknowledgement of the support of the families and community members to protect them:

[...] *when you are going to the house of a patient, if the day is busy, the community warns us: 'doctor, go back, do not continue;* [...] *there is a robbery going on* [...], *so this discourages our work* (E6); [...] *the CHA comes and says: 'look nurse, there's been a shooting in the area today'; or even someone from the community, before we get there: 'don't even go there, doctor'* [...] (E12).

The speeches evidence that the home activities have been harmed by the reduction in the frequency of home visits, concentrating the work journey almost entirely in the unit.

One of the greatest obstacles is the violence in the area [...], *we can only visit the houses until 10 o'clock.* [...], *in the company of more than one CHA, preferably male.* [...] *if the street is busy, we don't make the visit. Our greatest difficulty is the safety, so that we could visit the houses more often* (E2, E3, E4, E5, E11)*; Violence makes the visits difficult, you know* [...] *I work here in the morning, starting at 9 to make the visits; in the afternoon I only work in the unit, assisting those who come here* (E8).

This situation is also found in several studies,[6,13-15] demonstrating that violence constitutes an obstacle for the health professional who works in basic health care, mainly in the FHP, since care is provided directly in the community, in the patient's house, exposing the professional to violent environments. This vulnerability to violence generates feelings of fear, anxiety, powerlessness and frustration, compromising the physical and mental health of nurses. Violence also deprives the work in the FHP of its main characteristic, since the community care is harmed due to the limitation of assisting more patients at the health units.

The speeches reinforce the urgent need for investment in intersectorial projects, especially those articulating actions among the health units, public safety, community centers, religious institutions, and others.

It is important to highlight that, besides limiting the work of the nurses and the Community Health Agents (CHA), drug dealing and the frequent robberies practiced by drug users generate feelings of fear, anxiety and powerlessness. Violence was not only present in the streets, but also inside the houses:

[...] *once, a CHA from here went for a visit at 2 p.m. and was received by someone armed, asking what she wanted at that time, because they wanted to sleep.* [...] *the CHA said: 'we are afraid of entering your house'* [...]. *Sometimes, inside the house, they use drugs, threaten us and put our lives at risk, and there are older adults living in these houses, with violent and dangerous criminals threatening them; there is a place that sells drugs right in front of the PACS* [...]. *Drugs generate violence. I have been a victim of violence in the community, I was robbed by a young man who lives near here, whose parents are our patients* (E9, E11, E14)*;* [...] *we often have to pay a fee to make the home visit* [...]. *The unit is robbed by criminals and the team is threatened with violence; we reported it to SESMA* [local health administrating organ], *interrupted our work for a day to draw their attention, but nothing was done about it. We only received a visit from someone telling us to go back to work and nothing else. We invited and gathered the community center and the local police on our own and asked for help. Together, we decided on a contract of daily actions for our protection* (E10, E6, E7).

The vulnerability of the health team is clearly perceptible, which interferes in the dynamics of the working process. It is undeniable that violence interferes significantly in the planning of the FHP team, as well as in the service delivered to patients in their houses.

It is important to emphasize that the violence generated by the "drug" factor is a multi-causal and complex phenomenon, related with socioeconomic determinants: unemployment, poverty, low education and social exclusion, among others. In this context, violence appears as a social problem with implications, mainly, in the health of the

local population. As inferred from the speeches, the nurses perceive violence as a limiting factor for their work, since it not only complicates home visits, but also makes the activities at the unit in both shifts unfeasible, as in the case of group work and educational lectures, triggering feelings of frustration.

[...] *we cannot develop other types of activities with the older adults, such as activities in group or lectures, and it is very frustrating for us, who want to develop other sort of activity, but violence won't let us* (E2); [...] *we worked on a dramatization* [...], *a gang came in at the occasion, the older adults threw themselves to the ground, others had not action, they cried a lot, and now we cannot schedule a meeting with them, only three people showed up the last time* (E2); *As we work in the red area, our work is limited to one shift, because in the afternoon it is difficult to go to the community, or even to stay here. So there is always a team that is harmed* (E5); *We no longer do many of the things we used to; everything's changed because of the violence, which has increased a lot lately* (E6); *So, it is very complicated to develop any type of work here in the area: you have to know the best period of time. There were many deaths last week, it was very violent, and we get limited in these situations* (E7).

This evidences the changes that have been occurring in the work routine of the nurses, who stop performing certain activities due to the violence, even though they strive as much as they can to execute the attributions established by the Ministry of Health. As observed in studies developed in the municipalities of Belo Horizonte[15] and Rio de Janeiro,[7] the FHP teams experience similar situations, as both the population and the professionals working in the suburbs are punished with the experience of dealing with all sorts of violence.

The deficient police supervision is another difficulty emphasized by the nurses, since there are few police officers to cover a large territory. The robberies occur in the moment when they are in movement, making rounds:

[...] *there are three police officers who patrol here. The robberies happen when they are making rounds in other area. Violence is a great obstacle. Our work is concentrated here in the unit* (E6); *it is the question of violence in my opinion, in the neighborhood of Terra Firme. There is still the question of the visit, going and making the visit as it should be* (E12).

The speeches evidence that violence is one of the greatest challenges for nurses who work in the community, mainly in areas with high social and economical inequalities and without the necessary police support, which also makes their access to the houses difficult, to perform the home visits. As observed, this factor restricts the performance of health actions, obstructing the changes recommended in the basic health care policy.

This situation could be modified if intersectorial actions were established, in partnership with governmental and non-governmental institutions, with educational measures both in the public scope and in social institutions such as NGOs, schools and neighborhood associations, with programs to make people aware and informed regarding violence and its implication in health. The intersectorial work becomes imperative in the resolution of social problems, in the search for integrated resources and solutions with the articulation of knowledge and experiences, establishing social networks and partnerships.[16]

Institutional violence

Institutional violence may be observed within the health services in the rules, functional guidelines and political relationships imposed despotically to the professionals, as well as in the way the services are offered, or in the negligence of services they should offer.[9]

In this study, institutional violence is classified as: a) poor service or difficult access to specialized services for patients who visit the family health units; and b) situations of life risk for the service professionals, without the minimum infrastructure or logistics necessary for their work. The precarious work conditions that threaten the life of professionals and the non-comprehensiveness in the health care of patients, which is a constitutional right, are violent acts suffered both by the nurses and older patients, affecting not only the working process, but also the health of the patient, as perceived in the following speeches:

[...] *get an appointment? The waiting time depends on the specialty: ophthalmology, dermatology and endocrinology take 20 days*, *gastroenterology, 45 to 70 days; cardiology, 30 to 60 days; neurology, orthopedics and mastology are very difficult.* [...] *there isn't even the position for a mastologist anymore in the FHP, there is only the position for UMS* (E2, E6).

In a certain sense, institutional violence is an act of social exclusion that induces the interruption of the care of older patients due to the lack of access to the services of medium and high complexity, such as: difficulty to schedule an appointment with specialists, to perform specialized diagnos-

tic exams and to be hospitalized, as evidenced in the speeches. Another form of manifestation of violence against the patient and the health professional is the lack of basic medications, a factor that complicates the quality of the care and generates dissatisfaction in the nurses.

The problem with the medication is the quantity, it is not enough for everyone (E1, E3); *They come to the appointment, and there is no medication in the unit. They don't have the money to buy it, so what is the use in visiting the unit?* (E4, E14).

Regarding the performance of the health teams, a limiting element that is worth highlighting is the problem of composition of the teams, which are almost always incomplete, as well as the poor working conditions.

Actually, we cannot develop a good work here, because we don't have a complete team. The units have no infrastructure (E1, E5, E6, E12, E13).

Regarding the working process in the FHP units, the nurses manifest not only dissatisfaction with the lack of minimum infrastructure for their actions towards the patients, but, especially, the feeling of isolation at work, when they do not obtain answers from local administrators as for the critical questions forwarded, such as the request for advisement and support, if not to eliminate, at least to control the violence.

[...] *the unit is robbed by criminals and the team is threatened with violence; we reported it to SESMA* [local health administrating organ], *interrupted our work for a day to draw their attention, but nothing was done about it. We only received a visit from someone telling us to go back to work and nothing else.*

The previous speeches characterize the institutional violence imposed by the health service against patients and professionals. Another study developed in basic health care centers in suburban areas, near violent neighborhoods of Belo Horizonte[5] where six FHP teams worked, found similar results to those found in the present study. It is inferred that public health care services towards more deprived populations are practically inoperative, because administrators still lack, at all levels, accurate and effective decisions to pacify the chaotic situation of violence that is currently spreading throughout society.

Intrafamilial violence

The studied nurses perceived intrafamilial violence similarly to the way the Ministry of Health[16] characterizes it, as a social problem continuously affecting women, children, adolescents, older adults and disabled individuals, and which occurs in the domestic environment, within their homes. It is manifested in varied ways: physical, psychological, sexual or financial abuse; abandonment; negligence and self-negligence.

Despite being secular, violence against the elderly only started being reported and brought to public knowledge as of the last two decades of the 20th century, after the disclosure of child abuse and domestic violence.[1] Negligence is the most silent form of violence, expressed through the refusal or omission to listen to the complaints of the elderly, denying them the necessary care, on the part of family members who claim to be responsible for them, or the institutions, in case they are hospitalized. This is the most common form of violence striking older adults in this environment. It is associated with abuse and generates physical, psychological and social trauma and lesions, especially in older adults who are in situation of multiple dependence or incapability.[8]

The speeches evidenced several situations of abuse against older adults in their social settings, practiced mainly by family members:

[...] *there is certainly abuse against older adults. We get to the house of older patients and find them alone with the medication, taking it on their own, and they often can't even see well* (E3); *the negligence we mention is the fact that they don't care about him* [older adult], *don't go out with him, don't take him for a walk; this is negligence* (E10); *there is an old lady who stays alone at home. When her medication is over, her son doesn't come here for more. If the CHA doesn't go there to get the prescription she stays off her medication* (E8).

The literature indicates the son/daughter[17] as the family member who abuses most the older adult. The detected violence is not limited to the negligence, since there is also sexual violence, abandonment and financial abuse. In some cases, the nurses report the authorities, even if they are frightened, and in a risk area. In this case, both the Public Health Ministry and the City Health Department are notified, but, unfortunately, the notification is almost always unsuccessful, since the authorities rarely take action:

[...] *in this area, there are a few cases of abuse committed by sons and daughter. At this point, you visit the house, talk to the family and try to work it out* (E1); [...] *the son and the son-in-law of an old lady from here are criminals. At the first visit we identified the abuse and the precarious hygiene.* [...] *we called the Public Health Ministry, reported it, and we still*

haven't received an answer [...]. *I reported the situation to the coordination of SESMA,* [central level of the City Health Department] *because if something happens to her, the team may be held accountable for it* (E7); [...] *there is the case of an old man, which we reported* [...]. *He was being abused by his son and his partner, who spent his retirement pension and wouldn't buy him disposable diapers, letting him sleep naked and wet. The older adult had difficulties standing up, and spent the night wet with his urine. Sometimes he tried to turn and fell off* (E9); *there is an old lady, who lived with an alcoholic husband. He drank too much and took other alcoholics to their house, and they abused her* [...]. *We notified the Public Health Ministry; they came and took the old lady to a shelter* (E6); [...] *she is a little abandoned. If there is a medication to buy, he* [partner] *won't do it. So she stays there alone* (E5).

As observed, the older adults who have functional limitations or mental impairment are the most vulnerable to intradomestic violence, as the Ministry of Health has already stated: the greater the dependence, the greater the vulnerability.[8]

Although the territory of coverage of the FHP is a risk area with an increased level of intrafamilial violence, the nurses claim they do not report it because they fear retaliation by the families, as there are criminals and drug dealers in most of these families.

When I detect it, I call the family and give the necessary advisement. I haven't reported anything yet, also because we work in a risk area and deal with all sorts of people, we cannot expose ourselves even more (E3); *We have seen abuse cases. To be honest, it depends a lot, because we work in the red area. Most of the residents are criminals, and if you report something you are at risk. Working in this neighborhood, it is hard for people to report. I honestly don't do it* (E5); *It is very complicated to report here. We don't do it because we fear retaliation. There is a lot of violence and crime. God helps us if anyone calls the Public Health Ministry, they will know we did it, they will catch and kill us* (E8).

Even the older adults who preserve their independence and autonomy and who are capable of managing themselves, making decisions and having freedom of action deserve a minimum amount of care from their descendent family members. The lack of a healthy family relational dynamics may be characterized as negligence, even though this diffuse social negligence,[18] resulting from the difficulties (generally of social and economical character) faced by the families, does not always deserves attention:

[...] *there is an old lady who has two daughters: one works as a cleaning lady and the other is mentally impaired. The daughter who goes out to work leaves the mother with the mentally impaired sister. She* [older adult] *is often responsible for the family, and the family does not take care of her, does not help her, does not take her to the appointments or encourage her to perform physical activities, go to a church, or go out* (E7).

Studies have showed that it is almost impossible to maintain a healthy family dynamics without minimum and basic financial and housing conditions, transportation and effective access to health and social services.[19]

CONCLUSION

The present study allowed for understanding how nurses cope with the situations of violence experienced in their working process in the FHP, in the context of more deprived suburbs in the municipality of Belém-PA. It identified the presence of institutional violence, in the midst of the violence suffered by the population assisted by the health care service, as a consequence of urban violence, which may be characterized as territorial and intrafamilial violence. The characterization of the institutional violence evidenced: a) violence against constitutional rights of health care, when older adults have restricted access to services of high complexity and face the frequent unavailability of basic medications required; and b) violence against the health professionals, the FHP team, who find themselves unprotected by the authorities of the higher administration, in the development of their health work in the morning shifts and exposed to dangers in general, even at life risk.

It is worth highlighting that the nurses who participated in this study were at even higher risk of suffering threats of aggression for "invading" the territory, to perform the home visits.

Among the results found regarding the obstacles the nurses face in their daily work routine in the FHP, the professional frustration due to the embarrassment and limitation of their functions has been already evidenced in other studies, as well as in the empirical observation of the current practice. It is necessary, thus, to hope, with an active and responsible attitude, that the efforts made are intensified, by the entire civil society and the governments, in order to rapidly build a more equitable and righteous society, outlined in human values, in which violence has no place.

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Correspondence: Sandra Helena Isse Polaro
Universidade Federal do Pará - Faculdade de Enfermagem
Cidade Universitária Jose Silveira Neto
Campus Profissional II – Complexo Saúde
Avenida Augusto Corrêa, 01
66075-110 – Guamá, Belém, PA, Brazil
E-mail: shpolaro@ufpa.br

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