Violence and Primary Health Care: perceptions and experiences of professionals and users

Violência e Atenção Primária à Saúde: percepções e vivências de profissionais e usuários

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ABSTRACT This study aimed to compare experiences and perceptions of users and health professionals on violence in the context of Primary Health Care. It is a cross-sectional study of qualitative and quantitative nature conducted in Ribeirão das Neves (Minas Gerais), in which semi-structured interviews were carried out using questionnaires applicable to users (n= 628) and self-administered to professionals (n=300). Descriptive analysis was performed – distribution of simple frequency, cross and bivariate – and correspondence analysis comparing the responses of users and professionals, stored in two different databases. The Thematic Categorical Content Analysis enabled the construction of three categories of analysis – from which were discussed and jointly, the quantitative and qualitative results: 1) Violence as a health problem; 2) Completeness of Care; 3) Social Participation. It is noted that violence permeates everyday life and activity of users and professionals, behaving as an event that deserves deepening by who is suffering, living and dealing with the problem. The social participation spaces were recognized as an important strategy of community inclusion in the discussion of their problems. However, users and professionals differ on the role of health care in addressing and violence. Primary care has great potential to produce quality of care but apparently does not accomplish it when deals with the violence approach.

KEYWORDS Violence. Primary Health Care. Family Health Strategy. Health services. Social participation.

RESUMO *O presente estudo teve por objetivo comparar vivências e percepções de usuários e profissionais de saúde relativas à violência no âmbito da Atenção Primária à Saúde. Trata-se de um estudo transversal qualiquantitativo realizado em Ribeirão das Neves (Minas Gerais), no qual foram realizadas entrevistas semiestruturadas utilizando questionários aplicáveis a usuários (n=628), e autoaplicáveis a profissionais (n=300). Foi realizada análise descritiva– distribuição de frequência simples, cruzada e bivariada – e análise de correspondência, comparando as respostas de usuários e profissionais, armazenadas em 2 diferentes bancos de dados. A Análise de Conteúdo Categorial Temática possibilitou a construção de três categorias de análise – a partir das quais foram discutidos, de forma entrelaçada, os resultados quantitativos e qualitativos: 1) A violência como um problema de saúde; 2) Integralidade da Atenção; 3) Participação social.*

Nota-se que a violência permeia o cotidiano de vida e atuação de usuários e profissionais, comportando-se como um evento que merece aprofundamento por parte de quem sofre, convive e lida com o problema. Os espaços de participação social foram reconhecidos como estratégia importante de inserção da comunidade na discussão dos seus problemas. No entanto, usuários e profissionais diferem quanto ao papel da assistência à saúde na abordagem e no enfrentamento da violência. A atenção primária tem grande potencial de produzir atenção de qualidade, mas, ao que parece, não o realiza quando se trata da abordagem da violência.

PALAVRAS-CHAVE *Violência. Atenção Primária à Saúde. Estratégia Saúde da Família. Serviços de saúde. Participação social.*

Introduction

Violence has become an object of study and a necessary and current field of action, being considered as a complex problem, capable of interfering in the quality of life of people and societies. The term translates into human actions of individuals, groups, classes or nations that cause death or that affect the physical, moral, mental or spiritual integrity of other human beings[1]. It is a growing demand for health services and has an important impact on the lives of the men and women involved.

The health sector, in turn, is a space with great potential to approach violence. The performance of the professionals is decisive and, depending on their suitability and quality, can contribute to the prevention, attention and development of studies about the problem. The notification of violence was inserted in the Notification of Injury Information System (Sinan) in 2009 and, in 2011, became part of the National List of Obligatory Notification. Currently, the National List of Obligatory Notification of diseases, injuries and public health events in public and private health services throughout the national territory is regulated in the Ministry of Health Ordinance nº 1.271 of June 6, 2014. In addition to revoking Ordinance nº 104, of January 25, 2011, this List reiterated the notification of the violence. Such measures provide information on violent incidents involving persons who have been assisted in the health system and universalize the notification for all health services[2].

Addressing situations of violence is not simple, nor are there ready solutions. Violence and accidents are responsible for much of the transformation in the health profile, imposing actions on social determinants, encompassing broad aspects ranging from lifestyle to environmental, economic, cultural and social relations[3]. Exactly in the performance of this task lies one of the greatest challenges of the Unified Health System (SUS) and, certainly, one of its limits[4]. Primary Health Care (PHC), by promoting closer relations with users, strengthening the bond, establishing relationships of trust and fostering the creation of spaces for dialogue and participation, is a robust alternative to such confrontations[5]. The purpose of this study is to analyze the correspondence between experiences and perceptions of users and health professionals related to violence, within the scope of PHC.

Methods

This is a cross-sectional study of quali-quantitative nature, whose methodology consists in carrying out semi-structured interviews with users and self-administered questionnaires with professionals from all Basic Health Units (BHU) of the municipality of Ribeirão

das Neves (MG) located in the metropolitan region of Belo Horizonte, with a population of 322.659 inhabitants, in 2015[6].

The Primary Health Care network of the municipality counts on 58 BHU, with 53 Family Health Units and 05 traditional primary care units (Basic Reference Units – UBR), distributed in the 05 Health Regions of the city[7], each unit counting on one family health team.

The sample of users was calculated with a margin of error of 3.71% for more or less, with their recruitment distributed among the units, 10 to 12 users in each of them. The interviews occurred within the services from a semi-structured questionnaire. Users were selected on a first-come, first-served basis according to a random number table. Inclusion criteria were: to be a resident of the place for more than one year, to be over 18 years of age and to have been treated at the BHU, at least once before the interview.

For professionals were used semi-structured and self-administered questionnaires with different profiles. For the higher education level, all the professionals of the family health teams were considered, including those inserted in the teams of the Family Health Support Center (Nasf). The questionnaires were also answered by the Community Health Workers (CHW), the nursing auxiliaries and the administrative staff. All of them fulfilled the following inclusion criteria: acting for at least one year in that health facility.

The questionnaires were elaborated by the team of researchers, based on the subsidies of updated literature on the subject and the models of available instruments already tested and used, especially, the questionnaires of the Project for the Expansion and Consolidation of the Family Health (Proesf) and the National Health Survey (PNS). They were tested with users and professionals in the municipality itself. The data were stored in two databases – one of users and one of professionals – using SPSS software – Statistical Package for Social Sciences, version 19.0.

For the quantitative analysis it was used descriptive analysis, namely, simple frequency distribution and three-way cross and also bivariate analysis using difference test between two proportions. Correspondence Analysis was also carried out, a specific method for working categorical data to reveal patterns of relationships between categories. The two databases were used, relating, in this way, variables referring to users with the same variables referring to professionals.

Four (4) dependent variables of users and professionals were used, as shown in *chart 1*. These are as follows: V1 – Have you ever witnessed any violent events in the neighborhood and/or neighborhood of the unit; V2 – Do you know anyone who was murdered in the neighborhood and/or neighborhood of the unit; V3 – Do you think it is possible to prevent violence and V4 – Do you consider that one of the functions of the unit is to prevent violence.

Chart 1. Dependent variables regarding users and professionals, (N = 928). Ribeirão das Neves, 2013

Variables regarding users and professionals
Quantitative Part of the Study
1 – Have you ever witnessed any violent events in the neighborhood and/or neighborhood of the unit?
2 – Do you know anyone who was murdered in the neighborhood and/or neighborhood of the unit?
3 – Do you think it is possible to prevent violence?
4 - Do you consider that one of the functions of the unit is to prevent violence?
Qualitative Part of the Study
5 – Perception on what are the functions of health in preventing violence.

For the qualitative analysis, all interviewees (users and professionals) who answered affirmatively to variable 4 of *table 1* and who did not leave variable 5 blank, totaling 350 users and 207 professionals, were included. Variable 5, *table 1*, deals with 'Perception about what are the functions of health in the prevention of violence'.

Content analysis was used. The technique of Thematic Categorical Content Analysis was applied which corresponds to the categorization of the discourses by means of processes of dismemberment of the text in units, according to analogical themes[8]. The categories of analysis were defined based on the articulation between the qualitative information, the ones coming from the quantitative instruments and the literature subsidies. Three categories of analysis, thus, were created: Violence as a health problem, Integrality of Care and Social Participation, under which, in an intertwined way, quantitative and qualitative results were discussed.

The project was approved by the Research Ethics Committee of the Federal University of Minas Gerais (Coep/UFMG) under opinion 01140812.1.0000.5149. All participants signed a free and informed consent form.

Results

The interviewed population was composed of 928 individuals, with 628 users and 300 health professionals. The sociodemographic profile of the interviewees is shown in *table 1*.

Table 1. Distribution and test of the difference between two ratios (R x non R): users and professionals, (N = 928). Ribeirão das Neves, 2013

Variables	Users			Professionals		
	Frequency	%	P value	Frequency	%	P value
Gender			**< 0,0001**			**< 0,0001**
Man	166	26,4		33	11	
Woman (R)	462	73,6		267	89	
Age group			**< 0,0001**			**0,0099**
Up to 24 years	104	16,7		19	6,3	
From 25 to 29 years	62	10		76	25,3	
From 30 to 39 years (R)	150	24,1		121	40,3	
From 40 to 49 years	107	17,2		59	19,7	
From 50 to 59 years	83	13,3		20	6,7	
60 or more years	116	18,6		5	1,7	
Race or color			**< 0,0001**			**< 0,0001**
White	119	19		75	25	
Black (R)	112	17,9		55	18,3	
Brownish	361	57,8		160	53,3	
Yellow	33	5,3		8	2,7	

Table 1. (cont.)

Marital Status			**< 0,0001**		**0,032**
Married / Stable union (R)	394	62,7		169	56,3
Single	160	25,5		103	34,3
Separated / Divorced	41	6,5		25	8,3
Widow	33	5,3		3	1
Level of Education			**<0,0001**		**< 0,0001**
Primary School (complete and incomplete)	377	61,3		0	0,0
Secondary School (complete and incomplete) (R)	221	35,9		197	65,8
Higher Education (complete and incomplete)	18	2,0		102	34,1

Source: Own elaboration based on research data.

It is verified on *table 2* the three-way cross-frequency distribution of the dependent variables. Having witnessed a violent event is much more frequent among users. As for the aspects related to knowing someone who has been murdered in the territory and believing that it is possible to prevent violence, the vision of the two groups is similar, besides being high the percentage of positive responses. In both groups, most interviewees acknowledge that the approach to violence is a function of PHC, but is more frequent among professionals. It is observed that the professionals tended more not to witness violent event and to not know victims of murder in the region in which they work. Although this index is lower than that among users it is high and, probably, is due to the fact that many professionals, but not all, reside in the territory in which they work.

Table 2. Distribution of three-way cross-frequency on the dependent variables of users and professionals (N = 928). Ribeirão das Neves, 2013

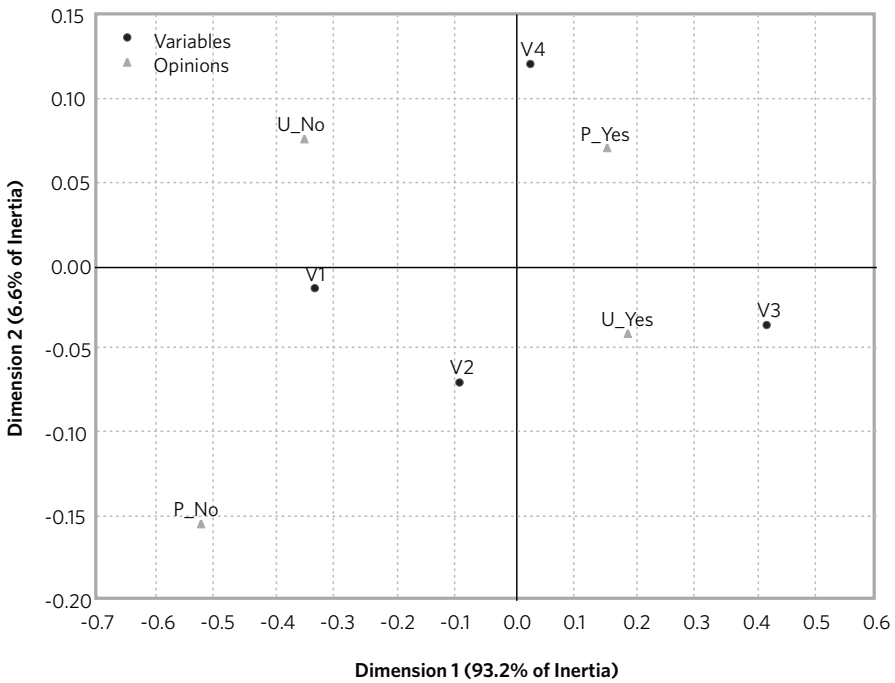
Variables	**Users %**		**Professionals %**	
	Yes	**No**	**Yes**	**No**
Witnessed violence event	71,7	28,3	35,8	64,2
Knew someone who was murdered in the region	66,2	33,8	63,6	36,4
It is possible to prevent violence	86,7	13,3	79,5	20,5
It is the function of PHC to address violence	64,6	35,4	81,0	19,0

Source: Own elaboration based on research data.

Figure 1 shows the map of the correspondence between user and professional opinions according to the variables studied. Dimensions 1 and 2 represent, together, 99.8% of the variability of the original data. In other words, only 0.2% is lost when representing these data in these two dimensions. For the interpretation of the association between variables V1, V2, V3 and V4 and the opinions U-Yes, P-Yes, U-No, P-No, *table 3* should be analyzed. On the contributions of dimensions 1 and 2 on variables V1, V2, V3 and V4, it is observed that

for the variables V1, V2 and V3, the interpretation must be done in dimension 1. This is because this dimension explains the largest percentages of inertia for each one (99.7% for V1, 62.0% for V2 and 99.2% for V3). The variable V4, in turn, must be interpreted in dimension 2, because this dimension explains 95.3% of the inertia related to it.

Figure 1. Correspondence map of user and professional opinions and variables studied



U_Yes – users who answered yes; U_No – users who answered no; P_Yes – professionals who answered yes; P_No – professionals who answered no; V1 – Has witnessed a violent event in the neighborhood or neighborhood of the unit; V2 – Has met someone who was murdered in the neighborhood or neighborhood of the unit; V3 – It is possible to prevent violence; V4 – It is one of the functions of the unit to prevent violence.

Table 3 also shows the contributions related to dimensions 1 and 2 on the opinions of users and professionals about the studied variables (U_Yes, U_No, P_Yes and P_No), being verified that all of them must be interpreted in dimension 1, since this dimension explains 95.4%, 95.5%, 82.5% and 91.9% of inertia concerning the opinions U_Yes, U_No, P_Yes and P_No, respectively.

Table 3. Relative contributions of dimensions 1 and 2 on row profiles (variables) and column profiles (opinions)

Variables	Dimension 1	Dimension 2
V1	0,997	0,002
V2	0,620	0,362
V3	0,992	0,007
V4	0,045	0,953
Opinions	**Dimension 1**	**Dimension 2**
U_Yes	0,954	0,045
U_No	0,955	0,044
P_Yes	0,825	0,166
P_No	0,919	0,080

Source: Own elaboration based on research data.

Guided by *table 3*, it is verified, in the Correspondence Map *(figure 1)*, for variable V2 (Knew someone who was murdered in the neighborhood or neighborhood of the unit) the association between affirmative answers of the users (U_Yes) and affirmative answers of the professionals (P_Yes), as well as an association between negative answers of the users and negative answers of the professionals. For variable V3 (It is possible to prevent violence), there is only association of affirmative responses of users (U_Yes) and professionals (P_Yes); for the variable V1 (Have witnessed a violent event in the neighborhood or neighborhood of the unit), there is an association between the negative answers of the users (U_No) and professionals (P_No). For the variable V4 (it is one of the functions of the unit the prevention of violence), however, the association between 'affirmative' responses of the professionals (P_Yes) and the 'negative' responses of the users (U_No) is verified. It is also possible to analyze the associations within the same profile, and in this case, the fact that the variable V4 is sufficiently separated from the other variables is highlighted, with special attention to the variable V3, indicating that the user's belief in the prevention of violence is not associated with the possibility of action of the health units.

Discussion

Violence as a health problem

The percentage of users and professionals who say they have witnessed violence (V1) or meet someone who has already been killed in the neighborhood of the health unit (V2), clearly shows that violence is a problem that affects the population of the territory studied. The fact that the sample was mostly composed of women expresses the real predominance of the female sex in the PHC services and does not imply, for the studied universe, any bias in the results. However, such a finding may stimulate the opening of new studies to deepen the discussion of violence among the male population that attends PHC.

The association found in the correspondence analysis for V2, both between the positive and negative responses of users and professionals, shows that, from the point of view of knowledge of the problem, users and professionals are close to each other, therefore, that professionals are aware of this situation experienced by users. Being PHC the level of attention that acts with greater capillarity and approach to the needs of the populations of the reference territories, the result highlights

the need to include and favor the approach of violence in its work[9]. The situation, however, is distinct when analyzing the opinions of users and professionals on the role of health in addressing violence (V4). In this case, there is an association between the opposing positions of these two actors, as well as a greater distance from this variable in relation to the others, suggesting that, although there is a recognition of the problem by professionals, it has not yet translated into effective actions or practice, which can be viewed and accepted by users. This fact could be related, on the one hand, to the limitations of the training of professionals still impregnated with the logic of productivity and the biomedical model, avoiding the construction of work processes based on the bond, reception, interdisciplinarity, focusing on the subject and the needs of the population[10,11]. Considering such conditions, the authors are right to emphasize the need to invest in the qualification of care and in the training of PHC professionals[4,9]. On the other hand, one must not forget the ineffectiveness of the continuing education programs of the professionals, that is, the inability of the training courses taught to promote the acquisition of skills and transform learning into practical action[12-15]. There are still other factors, for example, the lack of support and protection for professionals dealing with cases of violence in their daily lives[3] and the difficulty of articulating them in a network, since in order to deal with situations of violence, professionals need to know the network and effectively carry out the initial reception, orientation, notification and referrals[16].

The distancing between users and professionals increases when, in place of interpersonal and community violence, enter the scene, other types of violence, such as, lack of access to social rights, especially, in this case, quality health care, respectful and guided treatment in listening and reciprocal recognition between subjects. This is what the qualitative analysis shows: such concerns appear in the speeches of the users, but not in the speech of the professionals, turning to the initial discussion, the profile of the professional, more concerned with the logic of productivity, less affect to intersubjective relations[10,11,17]. Also, only users speak of institutional violence and express dissatisfaction with the inadequacy of physical space, lack of privacy, impersonality as explicit forms and that cause more violence. Moreover, as Schek et al.[18] mention, the high demand for care may contribute to the insufficient registration of suspected or confirmed cases that require more time to approach.

Integrality of care

The knowledge and recognition of violence as a relevant problem for the population linked to PHC, as can be seen, shows a certain mismatch between users and professionals, showing the need for new approaches, whose implementation must necessarily lead to the resumption of basic precepts of PHC, especially, for the case, integrality, indispensable in the face of complexity and multiple damages caused by violence[3,19,20]. However, the predominance of the biomedical model, centered in the biological body, almost always disregarding the subjectivity and the cultural aspects of human life, makes such solution not so simple or of immediate reach[9,21,22].

In the qualitative analysis, on the perception about what are the health functions in the prevention of violence (V5), users and professionals report, it is true, the performance of multiple and diverse actions to prevent violence; on the other hand, point to the need to advance in terms of quality of care, guarantee of safety in the units, construction of discussion spaces, and actions to promote and protect health addressed to the general population. Also worthy of note is the fact that users are concerned about taking care of the violence installed, making clear the existing gaps.

It is common, among professionals, the perception that the approach to violence should be carried out by specialized professionals, implying an attitude of transferring

responsibility for care[17]. Home visits and the performance of the CHW in the approach to violence have been identified as strategies of great potential[3,11] to identify situations of domestic violence and to prevent child abuse[13]. Interestingly, most interviewees do not cite such strategies inherent in the structure and functioning of PHC as alternatives for coping with and combating violence.

Social participation

The previous discussion refers directly to the matter of social participation and the praxis of autonomy as a central element of health promotion and violence prevention[23,24]. It is highlighted, here, the suggestions most expressively found in the speeches of the users, namely, the construction and involvement in continuous collective actions in the form of meetings, groups, space for discussion and dialogue, debates, conversation, clarification of views, interaction with the community, testimonies and participation to approach violence. This situation demonstrates that the population signals the construction of more democratic spaces of discussion, not only of health, but also of violence, in which everyone can actually debate the problem, in order to transcend the vertical model of transmission of information and knowledge[23].

For Habermas, linguistic communication and dialogue are a way out of the alienation of society that recovers there its autonomy and identity[25]. Civil society, in this model, is distinct from the system of economic action and public administration, becoming the social basis of autonomous public spaces that generate communicative power, from the construction of opinion and collective will, which then becomes the propitious power to be used at the administrative level. The author emphasizes that communicative action not only defines the strength of the capacity of integration of the society but also the construction of autonomous public spaces of will formation, fundamental for the demarcation of the borders of the other two media, money and administrative power[26].

Both the communicative dimension of public debate and that which is present in everyday life, in the informal interactions between people in their social environment, and which are the basis of the first, occur within the framework that Habermas calls the world of life. However, in later capitalist societies, the powers, administrative and economic, enter the world of life, preventing interactive relations from establishing themselves. The view of the interviewees, especially of the users, approximates to such theoretical presuppositions, which are translated by the creation of spaces of conversation and collective production of knowledge and practices. Durand and Heidemann[10] reiterate the need to intensify such practices with the aim of promoting dialogue and acceptance.

Conclusions

Violence is one of the most complex problems and difficult to approach in the health area. Dealing with people in situations of violence involves technical, social, psychological, and multiple skills. It was verified that violence pervades the daily life and performance of users and health professionals in the municipality studied. And that, somehow, there are possibilities of intervention, since professionals and users believe in this proposal – in a different way, it is true – in the sense that it is possible to prevent violence and that health should act in this prevention.

If, on the one hand, this study demonstrates the presence of violence in the context of life and performance of users and professionals, on the other hand, it shows that the problem needs to be better recognized by the PHC and treated in a systematic way, based on the improvement of professional practices. The principle of networking must be strengthened, in an intersectoral, integrated and consistent manner. The emphasis on participatory

proposals, considered as decisive in approaching the problem, reinforces the existence of a fertile context for the development of discussions, debates and conversations in the light of objectives that promote and rescue relationships of solidarity.

Collaborators

The authors of the manuscript contributed to the conception, planning, analysis and interpretation of the data, elaboration of the draft, critical review and final approval of the article. ■

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