

Perception of Violence by Community Health Workers During Home Visits

Percepção de Violência pelos Agentes Comunitários de Saúde Durante as Visitas Domiciliares

Percepción de la Violencia por Parte de los Agentes Comunitarios de Salud Durante las Visitas Domiciliarias

RESUMO

Objetivo: O Agente Comunitário de Saúde é responsável pelo trabalho no território, realizando visitas domiciliares e estabelecendo vínculo com as famílias. Essa inserção permite cuidado mais personalizado, mas também expõe o profissional a situações que podem comprometer sua integridade física e mental. Este estudo busca identificar as percepções de violência vivenciadas pelos ACS durante as visitas. **Método:** Trata-se de pesquisa qualitativa e descritiva, realizada por questionário online divulgado nas redes sociais, respondido por 14 participantes. **Resultados:** Os dados indicam que a violência é uma preocupação significativa: metade relatou episódios como assédio moral e sexual, maus-tratos, violência verbal e assaltos. Visitas individuais e contato com dependentes químicos foram os principais fatores de insegurança. Verificou-se falta de orientação e preparo para lidar com essas situações, o que afeta a saúde mental dos profissionais. **Conclusão:** Os achados reforçam a necessidade de estratégias integradas que incluam segurança, prevenção, educação e apoio emocional para fortalecer o trabalho dos ACS.

DESCRIPTORES: Agentes Comunitários de Saúde; Violência; Visita Domiciliar.

ABSTRACT

Objective: Community Health Agents are responsible for working in the field, conducting home visits and establishing ties with families. This involvement allows for more personalized care, but also exposes professionals to situations that can compromise their physical and mental integrity. This study seeks to identify the perceptions of violence experienced by CHAs during visits. **Method:** This is a qualitative and descriptive study, conducted through an online questionnaire posted on social media, answered by 14 participants. **Results:** The responses show that violence is a significant concern: half reported episodes such as moral and sexual harassment, abuse, verbal violence, and assaults. Individual visits and contact with drug addicts were the main factors contributing to insecurity. There was a lack of guidance and preparation to deal with these situations, which affects the mental health of professionals. **Conclusion:** The findings reinforce the need for integrated strategies that include safety, prevention, education, and emotional support to strengthen the work of CHWs.

DESCRIPTORS: Community Health Workers; Violence; Home Visit.

RESUMEN

Objetivo: El agente comunitario de salud es responsable del trabajo en el territorio, realizando visitas domiciliarias y estableciendo un vínculo con las familias. Esta inserción permite una atención más personalizada, pero también expone al profesional a situaciones que pueden comprometer su integridad física y mental. Este estudio busca identificar las percepciones de violencia experimentadas por los ACS durante las visitas. **Método:** Se trata de una investigación cualitativa y descriptiva, realizada mediante un cuestionario en línea difundido en las redes sociales, al que respondieron 14 participantes. **Resultados:** Las respuestas muestran que la violencia es una preocupación significativa: la mitad informó de episodios como acoso moral y sexual, maltrato, violencia verbal y agresiones. Las visitas individuales y el contacto con personas dependientes de sustancias químicas fueron los principales factores de inseguridad. Se observó una falta de orientación y preparación para hacer frente a estas situaciones, lo que afecta a la salud mental de los profesionales. **Conclusión:** Los resultados refuerzan la necesidad de estrategias integradas que incluyan seguridad, prevención, educación y apoyo emocional para fortalecer el trabajo de los ACS.

DESCRIPTORES: Agentes Comunitarios de Salud; Violencia; Visita Domiciliaria.

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INTRODUCTION

Community Health Agents (CHAs) play a key role in Family Health Strategy teams, mediating relationships between different healthcare providers and strengthening the link between the community and the points of care of the Unified Health System (SUS). Their duties include home visits and individual and collective educational activities aimed at prevention and health promotion. However, during home visits, these professionals may encounter situations that go beyond their sphere of action and pose risks to their physical and psychological well-being, including episodes of violence¹.

Violence is defined by the WHO as the intentional use of force or power, with the potential to cause harm, and can impact health services as a barrier to access and displacement, requiring local security measures and coordination with the public sector; however, the protection of health professionals still tends to be concentrated within the services, rather than in the assigned territories².

In addition, CHWs often witness or experience situations of violence against vulnerable populations, often without adequate preparation to intervene. In a multicenter study conducted in cities in the Northeast with

1,944 CHWs, 56.60% reported that violence interferes with their work³. In Fortaleza, more than 80% said they had been exposed to violence, with an increased sense of insecurity among female CHWs. During the pandemic, there was also an increase in exposure to violence in the territory, with gender and time jointly influencing this perception.

This reality generates fear, vulnerability, and ethical dilemmas, especially because these professionals live and work in the same community. Strategies such as discretion, avoiding dangerous areas, suspending activities in times of conflict, and not carrying valuables are recommended, but insecurity can limit territorial work and favor remaining in the UBS, to the detriment of direct work in the communities. Violence also contributes to professional turnover, weakening bonds and continuity of care².

Given this scenario, there is a scarcity of studies detailing the violence perceived during home visits and the coping strategies adopted. Thus, the objective of this study is to describe the violence perceived by CHWs during home visits and its associated factors.

METHOD

This is a qualitative, descriptive

study conducted in a virtual environment. A remote questionnaire was used to ensure greater privacy for participants, reducing the possibility of embarrassment or exposure when reporting situations they had experienced. Fourteen CHWs, either currently practicing or previously active in the profession, all with experience in home visits, participated. Participants were not identified.

The sample was obtained through dissemination in social media groups focused on the professional category. Interested parties received an online form containing the Free and Informed Consent Form (FICF) and the questionnaire, available for one month, between October and November 2023. There was no intention of numerical or territorial representativeness, and responses from CHWs from any region of the country were accepted until the end of the collection period.

The questions were based on Olsen⁸, who highlights the importance of formulating questions aligned with the study objectives in a clear and non-repetitive manner. The instrument included questions about working as a CHW, conducting home visits, experiences of violence, risk factors, situations of insecurity, knowledge of official recommendations, and the impact of safety on

work quality. The responses were sent via Microsoft Forms® at the researchers' affiliated university.

Data analysis consisted of describing the responses, which were short and objective, allowing for the full presentation of the material. Each question constituted an axis of discussion, used to identify patterns and nuances in the experiences reported, articulating them with the theoretical

framework. The organization of the data in tables favored clarity and understanding of the results.

The study was approved by the Research Ethics Committee of the Faculty of Health Sciences and Technologies/UnB, CAAE No. 74010023.7.0000.8093, and was conducted in accordance with CONEP Resolution No. 510/2016.

RESULTS AND DISCUSSION

Most of the participants who responded to the survey were from the Federal District, the state where the university responsible for the study is located, followed by CHWs from the state of Goiás. Of the total number of survey participants, seven reported experiencing situations of violence during home visits.

Table 1. Affirmative answers to the question "Have you ever experienced situations of violence during home visits? If so, which ones?"

1	"I have witnessed situations of violence that were not directly against me, but I have witnessed situations involving my ACS colleagues in the field and at the UBS. The most common are in relationships between ACS and other categories (moral harassment)."
2	"Mistreatment during visits, such as slamming the door in my face, threats, and verbal abuse."
3	"Yes, sexual harassment."
4	"A woman got upset because her test results weren't ready, even though that's not my responsibility. It was clear that this person had a lot of personal problems and was taking it out on me."
5	"Verbal abuse, assault."
6	"Yes, violent communication. I've been told: 'I don't want to register for this shit. You guys come with this vaccine ideology, and I don't even want to know about it, because communism will not enter my home.' It sounds like a joke, but that's what I heard, and I was told to leave."
7	"Yes... male harassment."

Based on the responses in Table 1, we can observe the presence of moral harassment in the relationship between CHWs and other professional categories during home visits. Moral harassment involves repetitive abusive behavior that harms the dignity and physical or psychological integrity of the worker, degrading the work environment⁹. The lack of understanding and recognition of the duties of CHWs by other categories, coupled with precarious working conditions, such as a shortage of resources and insufficient training, can intensify

tensions and encourage hostile practices¹⁰.

In addition, reports of mistreatment during visits—such as threats, verbal abuse, and sexual harassment—reveal the vulnerability of these professionals, especially women. Direct contact with the community in the domestic environment exposes CHWs to aggressive behavior, as it is feasible that SUS users express frustration or resistance to care in their own homes. These episodes highlight the complexity of interactions between agents and the community,

permeated by violence and, at times, political conflicts.

Urban violence, a phenomenon widely present in contemporary society¹¹, intensifies these risks, especially in areas with little policing and high crime rates. In these contexts, CHWs, who travel long distances and pass through different territories, become particularly susceptible to situations such as assaults. In this scenario, we sought to identify, from the participants' perspective, which circumstances increase the risk of exposure to violence during home visits.

Table 2. Responses to the question "What situations do you consider to contribute to an increased risk of violence during visits?"

1	"Insufficient number of CHWs per team to conduct home visits in pairs (at least) or trios."
2	"Vacant lots, isolated places."

3	"Patients who use drugs."
4	"Lack of family ties, social conditions, among others."
5	"Individual visits."
6	"Alcohol. Vulnerable situation. Unemployed families end up suffering psychological problems and resort to aggression towards their partners or children."
7	"Lack of access to healthcare."
8	"Dogs."
9	"Visiting alone; visiting too early before 9 a.m., because I notice that people are more stressed and some are still sleeping, or too late after 6 p.m., because it gets dark and people become suspicious. Carrying a bag, because it draws attention. Visiting without a uniform or badge increases suspicion and undermines credibility."
10	"Fake news and misinformation."
11	"Visiting alone."
12	"Social vulnerability."
13	"Harassment in all forms."

One of the responses was disregarded because it was incomplete due to technical problems with the submission. The others indicate that the lack of personnel to conduct visits in pairs or trios is seen as a risk factor, while group work is perceived as a safety measure because it reduces the likelihood of violence. Isolated or difficult-to-access locations also increase the vulnerability of CHWs, as they limit the presence of third parties and the activation of emergency services, making it difficult to access immediate help.

The presence of drug users, intoxicated individuals, and/or people with mental disorders was identified as an important risk factor, given the pos-

sibility of unpredictable or aggressive behavior, increasing the feeling of insecurity among professionals. The absence of family ties and precarious social conditions also contribute to increased exposure to violence, reinforcing the importance of understanding the social context of families served in mental health settings. In this sense, there is a need for ongoing mental health training for CHWs, regular meetings to discuss cases, continuing education initiatives—such as harm reduction—and the inclusion of matrix support and other support mechanisms in team planning¹².

Aspects such as visiting hours and the use of appropriate identification also influence receptivity and safety,

and it is recommended that professionals wear uniforms and conduct visits preferably between 9 a.m. and 6 p.m. Finally, fake news can spread incorrect information about health practices and vaccines¹³, creating mistrust, conflicts, and negative perceptions about the work of CHWs, which can increase their exposure to risky situations during activities in the field.

Among the actions that cause the most insecurity among agents, some points were reaffirmed and others were added to the reports from the previous question, as described in Table 3.

Table 3. Responses to the question "Is there any activity that makes you feel more insecure during home visits?"

1	"Yes, when I visit patients who use drugs."
2	"Active mental health screening (cases that are resolved by CAPS)."
3	"Only when we go in pairs."
4	"Visits from patients who are drug users. Chemically dependent individuals."

5	"Yes. When I have to visit areas that are controlled by drug traffickers, prostitutes, and men who live alone."
6	"Visiting single male patients."
7	"Walking alone on streets near the woods, where illicit drug dealing is visible."
8	"Active search in cases of death investigations, domestic violence, and child abuse."
9	"Bad-tempered people."
10	"Entering buildings."
11	"Yes, when I have to visit people with extremist views, they are dangerous and extremely arrogant."
12	"The visit itself in the area, depending on the location, such as drug dens, persecution, animals loose on the street such as dogs that can cause attacks, assaults, rapes, kidnappings."
13	"Visits nearby only drug trafficking."
14	"No."

The insecurity of visiting single men highlights a specific concern with certain demographic profiles that may present additional challenges or perceived risks, including the sexual harassment and male stalking already mentioned. Sexual harassment in the workplace is a reality that spans many professions, and community health workers are not immune to this challenge. Harassment can manifest itself in many ways, from inappropriate comments to invasive gestures, creating a hostile environment that undermines confidence and dignity, especially when it is a female professional¹⁴.

Actively investigating deaths, domestic violence, and child abuse is an activity that increases feelings of insecurity due to the complex emotional and social contexts involved. Performing such actions can expose CHWs to conflictive environments, where people may have experienced traumatic situations or be involved in legal and emotional disputes. Entering buildings, especially in unfamiliar communities, represents an additional source of insecurity for CHWs. Lack of familiarity with the layout of

spaces, building security, and the nature of interactions can generate uncertainty. Structural problems, lack of adequate lighting, obstacles, or even the possibility of acts of violence inside buildings are concerns that contribute to this feeling of insecurity.

The reference to insecurity when visiting people with extremist views highlights a specific concern related to individuals who tend to communicate violently and express intolerance towards different views, including the recommendations of health professionals, creating a potentially dangerous environment¹⁵.

Given this reality, it would be ideal for the Ministry of Health to provide guidance on how to react to this reality of violence or how to prevent it. When asked about their knowledge of recommendations and/or training to avoid the risk of exposure to violence, eleven CHWs responded that they were unaware of any. These responses demonstrate a significant gap in terms of the guidance and preparation offered to these professionals. During the research, no recommendations from the Ministry of Health were found that could help CHWs

stay safe when it comes to violence during home visits.

Due to the lack of guidance and training, it is possible to say that the CHWs interviewed do not have the knowledge to deal with the risk situations mentioned. This not only affects the well-being of health professionals, but can also compromise the effectiveness of community interventions and health promotion⁶.

Ideally, existing recommendations should also be in line with the reality of CHWs' work and respond to the risks they have identified. In the present study, the three people who received this knowledge responded that it was effective.

Given the above, CHWs were asked if and how situations of violence and insecurity affect the work they do (Table 4). Some CHWs express concern that the lack of security may impact the quality of their professional performance, leading to errors, forgetting important information, and even the inability to perform certain tasks. Insecurity can compromise the efficiency of health care delivery.

Table 4. Responses to the question “Do you consider that safety affects the quality of the work carried out during home visits? If so, in what way

1	“Yes. Because when they don’t feel safe, community health workers may not perform their role well and may even forget important information during visits.”
2	“Yes, I believe that violence prevention measures have a positive effect on the quality of work processes, whether in the field or at the UBS itself (relationships with other health professionals). The mental health of community health workers affects the work process and their relationships with the field and the team.”
3	Yes. Because we often leave patients unattended.
4	“Yes, productivity drops significantly.”
5	“Yes. Because fear makes us refuse to do our work.”
6	“Yes, we feel safer.”
7	“Yes.”
8	“Yes, in terms of customs, beliefs, and guidelines, which should be more cautious to avoid any kind of misunderstanding or misinterpretation on the part of the user.”
9	“Not very much.”
10	“Of course, working in unsafe conditions is terrible. I have to work carrying a cell phone, bag, and accessories that make me more visible, and I know I am at risk, as I have already been mugged while on duty.”
11	“Yes, because we don’t know what the person is capable of, so at that moment, it’s better to stay quiet.”
12	“Yes... policing on the streets because of robberies and other risks.”
13	“Yes.”
14	“So far, I haven’t had any cases of violence. But security does affect the professional’s actions, making them more assertive.”

There is a recognition that insecurity is linked to the mental health of CHWs and can influence the way professionals relate to the territory, the team, and even patients. A sense of security can contribute to a healthier work environment².

Some responses indicate that insecurity is associated with a decline in work productivity and effectiveness. Fear can demotivate CHWs, impairing productivity and the ability to provide adequate care to patients⁶.

Concerns about safety also extend to interactions with users, considering customs, opinions, and guidelines. CHWs recognize the need to be more cautious to avoid misunderstandings or misinterpretations, which highlights the complexity of the dynamics of home visits.

The reference to fear of violence, assaults, and other risks demonstrates direct concern for the personal safety of CHWs, reinforcing the need for preventive measures to ensure the safety

of agents during their field activities. Thus, insecurity is associated with the possibility of leaving the user unattended, which directly impacts the ability to provide continuous and adequate care to users during home visits¹⁶.

The limitations of this study include its qualitative nature, which prevents comprehensive generalizations for specific territories. In addition, online data collection did not allow for in-depth responses. However, it is worth noting that this is an initial study on the peculiarities of violence during home visits, a topic that has been rarely published in the country, and further research is recommended to deepen understanding of the topic, taking into account territorial diversity.

CONCLUSION

The responses showed that CHWs face a variety of challenges, ranging from workplace bullying to situations of abuse, threats, and sexual harassment

during home visits. These findings reflect the complexity of the violence experienced in the territory and reinforce the need for integrated approaches to reduce risks, including security measures, conducting visits in pairs or groups, a broader understanding of the social context, community education, and continuous training of professionals to prevent and manage situations of violence.

In this scenario, public health professionals play a key role in conducting more detailed risk assessments, identifying areas and patterns of greater vulnerability, and proposing specific protection measures, such as safe routes, use of emergency communication devices, and coordination with local security authorities. Future studies with larger samples and more territories analyzed are suggested in order to support the formulation of public policies more aligned with the security needs of CHWs.



REFERENCES

1. Vieira-Meyer APGF, Morais APP, Campelo ILB, Guimarães JMX. Violência e vulnerabilidade no território do agente comunitário de saúde: implicações no enfrentamento da COVID-19. *Cien Saude Colet* 2021; 26(2):657-668.
2. Benicio LF, Barros JP. Estratégia Saúde da Família e violência urbana: abordagens e práticas sociais em questão. *Sanare*. 2017 Jan;5(01):102-12.
3. Vieira-Meyer APGF, Albuquerque GA, Guimarães JMX, Ferreira RGLA, Aguiar ASW de, Pequeno AMC, et al. Processo de trabalho do agente comunitário de saúde: análise da influência da violência urbana e da COVID-19. *Ciênc saúde coletiva*. 2025;30(8):e19432023.
4. Vieira-Meyer APGF, Ferreira RGLA, Albuquerque GA, Guimarães JMX, Morais APP, Meyer CHC, de Lima Saintrain MV, Castro MC, Yousafzai AK. Gender and Violence in the Daily Routine of Community Health Workers in Fortaleza, Brazil. *J Community Health*. 2023 Oct;48(5):810-818.
5. Albuquerque GA, Ferreira RGLA, Aguiar ASW de, Campelo ILB, Dias MS de A, Vieira-Meyer APGF. Trabalho, saúde mental, qualidade de vida e suporte social de agentes comunitários de saúde durante e pós-pandemia de COVID-19 sob o recorte de gênero. *Cad Saúde Pública*. 2025;41(6):e00168824.
6. Ferreira CM, Pessoa VM, Silva MRF, Nuto SA. Estratégias de sobrevivência à violência utilizadas pelos agentes comunitários de saúde. *Rev Bras Promoc Saúde*. 2021;34:11-1.
7. Kebian LVA, Acioli S. A visita domiciliar de enfermeiros e agentes comunitários de saúde da Estratégia Saúde da Família. *Rev Eletr Enferm [Internet]*. 2014; 16(1):161-9.
8. Olsen W. Coleta de dados: debates e métodos fundamentais em pesquisa social. Porto Alegre: Penso, 2015.
9. Trindade L de L, Schoeninger MD, Borges EM das N, Bordignon M, Bauermann KB, Busnello GF, et al.. Assédio moral entre trabalhadores brasileiros da atenção primária e hospitalar em saúde. *Acta paul enferm [Internet]*. 2022;35:eAPE039015134.
10. Lima GK, Gomes LM, Barbosa TLA. Qualidade de Vida no Trabalho e nível de estresse dos profissionais da atenção primária. *Saúde em Debate*. 2020 Sep;44(126):774-789.
11. ATLAS DA VIOLÊNCIA 2023. São Paulo: Fórum Brasileiro de Segurança Pública; Rio de Janeiro: IPEA, 2023.
12. Cavalcanti ACS, Severo AK. Concepções e práticas dos agentes comunitários de saúde direcionadas a demanda de álcool e outras drogas no território da Borborema potiguar. *Saude soc [Internet]*. 2023;32(4):e220299pt.
13. Lopes AS, Santos STM, Ayres AS, Oliveira AEC, Santos JS, Silveira MRPV, Giuliani CD, Izidoro JS. Educação em saúde nas campanhas vacinais: estratégias educativas contra a desinformação. *Nursing (Ed bras Impr)*. 2025 Aug;30(325):11036-11047.
14. Fukuda RF. Assédio Sexual: Uma releitura a partir das relações de gênero. *Simbiótica. Rev Eletrônica*. 2021;1(1). DOI: 10.47456/simbitica.v1i1.4512.
15. Vasconcellos-Silva PR, Castiel LD. Câmaras que ecoam ódio, bolhas que destilam medo: constituição do Eu e intolerância como raízes da desinformação. *Ciênc saúde coletiva [Internet]*. 2025Apr;30(4):e10492023.
16. Goulart EP, Moura ATM, Rafael RMR, Edmundo KMB, Penna LHG. Visita domiciliar pela Estratégia Saúde da Família: limites e possibilidades no contexto da violência urbana no Rio de Janeiro. *Rev Bras Med Fam Comunidade [Internet]*. 2021 Jan 26;16(43):2651.