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THE EXPERIENCES OF HEALTH PROFESSIONALS WITH THE MANAGEMENT OF VIOLENCE AGAINST CHILDREN

EXPERIÊNCIAS DE PROFISSIONAIS DE SAÚDE NO MANEJO DA VIOLÊNCIA INFANTIL

EXPERIENCIAS DE PROFESIONALES DE LA SALUD EN EL MANEJO DE LA VIOLENCIA INFANTIL

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Objective: to know the experience of primary healthcare professionals in the management of violence against children. Method: qualitative, descriptive, exploratory study. Health professionals who work in a Family Health Unit were interviewed. Data collection took place through interviews guided by questions regarding child assistance and families in risk of violence or situations of violence. Participant statements were submitted to Content Analysis. Results: many representations of violence from the perspective of interviewees were found, from which emerged the category "Dealing with violence against children: factors that compromise assistance". Conclusion: the experience of primary healthcare professionals in the management of child violence goes through many difficulties in practice, especially those related to lack of knowledge, interference and participation of the family, and to a disarticulated child protection network.

Descriptors: Child. Child Advocacy. Protection. Child Abuse. Violence. Domestic Violence. Health Personnel.

Objetivo: conhecer a experiência de profissionais de saúde da atenção básica no manejo da violência infantil. **Método:** *estudo qualitativo, descritivo, exploratório. Entrevistaram-se profissionais de saúde que atuam em uma Unidade de Saúde da Família. A coleta de dados ocorreu por meio de entrevistas norteadas por questões relacionadas à assistência à criança e à família em risco ou situação de violência. Submeteram-se os depoimentos à Análise de Conteúdo. Resultados: identificaram-se várias representações da violência na perspectiva dos entrevistados, as quais deram origem à categoria "Lidando com a violência contra a criança: fatores que comprometem a assistência". Conclusão: a experiência de profissionais de saúde da atenção básica no manejo da violência infantil experimenta diversas dificuldades na prática, especialmente relacionadas à falta de conhecimento, interferência e participação da família e desarticulação da rede de proteção infantil.*

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Descritores: Crianças. Defesa da Criança e do Adolescente. Maus-tratos Infantis. Violência. Violência Doméstica. Pessoal de Saúde.

Objetivo: conocer la experiencia de profesionales de salud de la atención primaria en el manejo de la violencia infantil. Método: estudio cualitativo, descriptivo, exploratorio. Se entrevistó a los profesionales de salud de una Unidad de Salud de la Familia. Se colectó los datos por medio de una entrevista guiada por cuestiones relacionadas a la asistencia a los niños y a las familias bajo riesgo o situaciones de violencia. Se sometió sus declaraciones al Análisis de Contenido. Resultados: se identificó numerosas representaciones de la violencia desde la perspectiva de los entrevistados, que originaron la categoría "Manejando la violencia contra niños: factores que comprometen la asistencia". Conclusión: la experiencia de profesionales de salud de la atención primaria en el manejo de violencia infantil tiene muchas dificultades en la práctica, especialmente relacionadas a la falta de conocimiento, interferencia y participación de la familia, y a la desarticulación de la red de protección infantil.

Descriptores: Niños. Defensa del Niño. Maltrato a los Niños. Violencia. Violencia Doméstica. Personal de Salud.

Introduction

Situations involving violence take place in different contexts and settings and are a major public health issue, especially due to the expressive number of deaths and morbidities they cause. Daily, women, children, adolescents and elders need to deal with physical, sexual, and psychological abuse, which increases the likelihood of biopsychosocial disorders for these people and society[1].

Violence against children, in turn, presents itself as an alarming reality that contributes for emotional and physical prejudice during childhood and, consequently, adult life[2-3]. Any action or omission that prejudices children, be it caused by parents, relatives, tutors, public or private institutions, or by society itself, is in the scope of the concept of violence against children[4].

In 2011 alone, 17,900 cases of violence against children of up to nine years of age were registered, among which 33% affected children of up to one year, 35.8% affected children from two to five years, and 31.2% affected children from six to nine years[5]. It stands out that parents are the main perpetrators of violence, especially with regards to five-year-old or younger children. Negligence is the most common form of abuse, which makes it a serious social problem which has no visibility in society[6].

According to its nature, child violence may be classified as physical (a violent act with physical force intentionally or unintentionally applied, which can harm, hurt, provoke pain and suffering, or destroy a person), psychological (any action that harms self-esteem, identity, or the development of the child, or put any of these factors at risk), sexual (any act or game aiming to sexually stimulate the child, committed by a person in a more advanced psychosexual development stage than the child)[4].

It stands out that no type of violence is justifiable, and any violence against children can be prevented[6]. However, to deconstruct this culturally accepted phenomenon, awareness and commitment from society as a whole are necessary, especially considering the iniquities of the contemporary world[5].

In Brazil, as a mechanism of child protection, health professionals, teachers, or anyone responsible for primary healthcare units, nurseries, or elementary or kindergarten schools, are mandated by law to notify any suspected or confirmed child aggression case. Not informing the Council of Guardianship or another adequate legal body from the place where the victim lives about the situation of violence is an administrative infraction that can lead to fines from three to twenty salaries[7]. Notification forms are an essential tool to identify and manage these cases[8].

From this perspective, the role of professionals who work in the Family Health Strategy (ESF) stand out, concerning adequate records of aggression cases to promote the protection of the

child[9-10]. In the ESF, it is possible to accompany and assess integrally and systematically the growth and development of the child, in addition to identifying problems to which children may be exposed in the context in which they live[11].

It is clear, however, that health professionals have limitations with regards to the recognition and management of violence, in addition to having difficulties to take an integrated and intersectoral approach. In addition, many institutions, such as health and education ones, have low report rates[12], although this type of shortcoming may jeopardize the prevention and confrontation of violence against children[5,12].

Although health professionals have an important role in the child protection network and in the management of cases of violence[12-13], and despite the fact that violence cases involving children and adolescents are expressed in national and international constitutions and declarations[4,7], the universalization of the guarantee of these rights is still a challenge[5].

Therefore, the results of this study may contribute to direct interventions that effectively answer to the demands of children and families in risk or situations of violence, qualifying and humanizing the assistance offered to them. They may also contribute to the prevention and identification of cases, as to break the cycle and avoid further offenses.

The objective of this article is to know the experience of health professionals from the primary care network in the management of violence against children.

Method

This is a qualitative, descriptive, and exploratory research, carried out according to guidelines of the Confidence in Evidence of Reviews of Qualitative Research (ENTREQ). Participants were professionals who were part of two teams of a Family Health Unit (USF) in the city of Palmas, Tocantins, Brazil.

The municipality had 32 USFs in its urban area, which together attend to an estimated 300 thousand people and execute activities to prevent and promote health.

The USF of this research had 3,629 families registered and was located in a region from which most population had low income. The group of professionals who worked in both family health teams was made up of two physicians (general practitioners), two nurses, four nursing technicians, one dentist, and nine community health agents, totaling eighteen health professionals.

This unit was chosen since it is the setting of the practical activities of the students at the Nursing Course of the *Universidade Federal do Tocantins*. The results found in this research will help developing interventions aimed at improving the assistance to children and families in situations of violence or risk of violence.

The interviews were carried out by a trained researcher, and took place in the facilities of the health unit from September, 2015, to January 2016, in a meeting room or in the office of the participants, as to guarantee the privacy pertaining to data collection. The interviews were previously scheduled, recorded in digital media, and guided by the following questions: "Tell me about your professional experiences in the cases of suspected of confirmed violence against children", and "If any, tell me the factors that make it more difficult or easier to take action in cases of suspected or confirmed violence against children".

The interviews were transcribed by the researcher who conducted them, and data was submitted to Content Analysis. To do so, an exhaustive and comprehensive reading of the material was carried out. Initial ideas were systematized and, later, aggregated into units that allowed to describe the content apprehended, through the elaboration of texts according to the analysis and categorization of the content[15]. In addition to the interviewer, three other researchers participated in this stage.

The inclusion criteria for this research contemplated: health professionals (physicians, nurses, Nursing auxiliaries, Nursing technicians, community health agents, and dentists) who had worked in the USF for at least six months. Professionals who were on leave or vacation were excluded.

To preserve the identity and avoid the exposure or embarrassment of participants, the results were presented using letters, to indicate the professionals, and numbers. In the alphanumerical system used, the letter "N" means nurse; "P", physician; "CHA", community health agent; and "NT" Nursing technicians. A number was added to these letters corresponding to the order in which interviews were conducted.

This research was approved by the Municipal Health Secretariat of Palmas, under protocol 008-02/2015, and approved by the Committee for Ethics in Researches involving human beings, under protocol 086/2015, according to the ethical precepts of Resolution n. 466/2012 of the National Council of Health.

Results

A total of 13 health professionals participated in this research, among whom 11 were females and two were males. They were 1 physician, 2 nurses, 4 Nursing technicians, and 6 community health agents. The duration of their work at the USF varied from 2 to 14 years, and their age group from 33 to 54 years. One physician, one dentist, and two community health agents were on vacation and thus did not participate. One community health agent refused to participate.

In the statements of the health professionals, many experiences with suspected or confirmed violence situations were found. These originated the category "Dealing with violence against children: factors that compromise assistance" and its subcategories, presented on Chart 1.

Chart 1 – Dealing with violence against children: factors that compromise assistance - Category and subcategories (continued)

Subcategories	Statements
Understanding of violence	*Violence is affecting the child's physical integrity* [...] *This child will grow up to be a traumatized child.* (CHA3). *Violence is anything that leaves a bruise.* (CHA4). [...] *if it's physical aggression* [...] *it's visible* [...] *If it's sexual aggression which happens a lot* [...] *than it's more, more difficult for us.* (NT1). [...] *physical violence is easy to see, generally, really easy to identify. You just have to differentiate the mechanisms of the lesion. Now, the psychological, depends a lot on the degree of psychological aggression.* (P1).
Family Interference	[...] *I think the difficulty comes from the family itself. Sometimes, the act of hiding, the act of not speaking. I think this is the difficulty.* (CHA2). [...] *the family hides it. Frequently, the family keeps it secret. Sometimes, we hear about it from third parties.* (N1). [...] *sometimes, it's the way the parents, I mean, or even the very aggressor* [...] *interferes, you know? We ask the child or try to talk to her, the father won't let us.* (NT3).
A Fragility in the Network	[...] *so, we have this role that, frequently, it's failed, due to the system, because people suffer institutional violence even in the system, because it doesn't work. And then we suffer too.* (CHA2). [...] *another difficulty too is that we try to locate this assistance and, sometimes, there's all this bureaucracy.* (NT3). *It lacks integration, because health is here, the guardianship is there. These axes need to be integrated.* (N2).
Omission in Care	[...] *I won't report, unless there's a lot of beatings.* (CHA5). *We, sometimes, even see it happening, but we're like "the child is not mine, it's not my relative, I don't know her". So, I prefer staying quiet.* (NT2). [...] *the only thing you can do is what you can do, in this case, it is sending the child to the doctor* [...] *because, in the end, we cannot do anything really.* (NT4).

Chart 1 – Dealing with violence against children: factors that compromise assistance - Category and subcategories

(conclusion)

Subcategories	Statements
Fear of Retaliation	[...] *so, well, I can see the aggression, but, sometimes, I feel afraid to report it, because I have to go there again*. (CHA1). [...] *we're afraid, for instance, to go there and see there was an aggression and then there's a report, and they* [the family] *think it was me, and I get assaulted afterwards*. (CHA5). [...] *it's a very complicated issue, because it involves a lot of people, and we feel fear, we're afraid. Not just me, the entire team*. (N2).

Source: Created by the authors.

Discussion

This research found that health professionals have a limited understanding of the concept of violence against children, and difficulties to recognize, in practice, its classification and the ways in which it expresses itself. Similarly, a study carried out in China with 877 health professionals found that there was insufficient knowledge to identify possible child abuse cases-especially with regards to sexual abuse. In that study, only 3.9% of interviewees had received training on how to deal with violence against children[16].

It should be highlighted that some types of violence, such as child labor and abandonment, were not mentioned by the participants of this research. In addition, many of them had a limited view of violence as occurrences in which there are physical lesions. This reiterates the fact that there are shortcomings in the attempts to effectively protect children[16-17].

Weaknesses in the formation of human resources in health with regards to abuse to vulnerable groups, such as children, contribute for the situation exposed. This theme is not in the syllabuses of most higher education health courses, not even in post-graduation, nor is it present in continued education training sessions of family health strategy teams[18].

Therefore, it is important to carry out strategies of continued formation, as well as to broaden mechanisms to offer support to health teams, so they have the instruments they need to effectively act towards children protection[17,19].

Another hindrance to the identification and action of the health team to confront violence against children, according to the reports of the professionals interviewed, is the fact that relatives are often the aggressors. National[5,19-20] and international[21-22] studies show that family is the main perpetrator of child abuse.

Therefore, it can be noted that the family nucleus does not always fulfill its role of protecting the child. On the contrary, families deny their responsibilities, and even become the perpetrators of the very aggression that disrupts the emotional development of children, whose psychosocial development and well-being are thus compromised[23].

Changing this reality is a current and complex challenge and requires rejecting the paradigm according to which child abuse is natural or just a private way in which parents deal with their children. To do so, families and society must understand that violence is a major disrespect of fundamental human rights[19-20].

There must be public measures that show society the many ways in which violence expresses itself, as well as its consequences, as an attempt to change culturally rooted standard behaviors according to which families use violent acts frequently and mistakenly as tools for children education[20].

In this setting, it can be noted that, though the proximity with the families contributes for professionals who work in primary healthcare to identify the real demands of the community, thus offering integral and personal assistance, it also exposes them to the risk of conflicts and retaliations. As a result, the lack of mechanisms

of protection contributes for the denial and omission of their role in the child protection network.

It is important to highlight that the professionals, in their daily practice, are afraid of being the victims of some type of aggression, and that, often, leads them to offer limited assistance, neglecting the role they were supposed to fulfill.

The fear of being identified and suffering a retaliation from the aggressors, especially due to the lack of protection to the professional who reports the situation and to the weaknesses of the healthcare network, is a barrier for the implementation of a conduct that is efficient in the cases of violence against children. This situation shows that legal aspects and the organization of the services itself need to be reviewed, as to protect the professionals who report[20], as well as the families and children who are the victims of violence.

The demands of care from health professionals who need to act in complex situations, such as cases of violence against children, also must be taken into account. Identifying the feelings experienced by these actors can contribute for the implementation of actions that can reestablish and promote their health[24]. Strategies to embrace, encourage, and emphasize the importance of the work carried out by these professionals may collaborate to improve their capacity of dealing with the challenges associated to child abuse, thus promoting their autonomy, safety, and offering them emotional support[25].

It is also worth pointing out that professionals who do not feel embraced, protected, and/or do not understand the importance of the role they must assume in the protection of children may offer fragmented, inhumane, or omissive assistance, basing their actions on a biomedical model of attention, one that is limited to identifying and treating diseases, something that can be seen here, as well as in other studies[8,16-17].

Therefore, many health professionals offer reductionist assistance, whose focus is only the treatment of the physical body, neglecting biopsychosocial demands of children and families. This type of behavior does not aid in the confrontation of violence against children, since, to do so, one needs to assume their responsibilities, have empathy, commitment, involvement, and social participation. This conduct also contributes for the lack of preventive and protective actions, in addition to transferring the responsibility to take action with regards to violence cases to other institutions[8].

Healthcare is impaired by reductionist actions, which leads to the neglect of the biopsychosocial demands of health service users, making it impossible for each one to be attended integrally and individually. Therefore, it is essential to implement continued education actions that can give health professionals the instruments to offer integral and humanized health care, in addition to arming them with the knowledge of how the child assistance network must work towards confronting violence, emphasizing individual and collective responsibility[9].

This research also found that child assistance services are still working with no articulation or systematization, making it difficult to consolidate a network that can effectively combat violence. Statements pointed out difficulties in communication, slowness, poor functioning of services, and bureaucracy, all of which are barriers to establishing and integrating child protection services and contribute for health professionals to be unable to adequately develop their role in the network.

The functioning of "Institutional Networks" that integrate assistance services is an efficient strategy to prevent and interrupt the cycle of violence[9,20], since they have mechanisms to protect the child and the health professionals. However, there are many challenges to establish and integrate the institutions of child protection[10,20]. To overcome these challenges, many things are necessary, such as the articulation of intentions, a permanent dialogue between the actors, the search for partners, and permanent training for collective and intersectoral training, in addition to financial investments[9].

Training health professionals to integrate attention, enabling early identification of victims, reporting cases, and an effective monitoring of

children victims of violence and their families, are all cornerstones for the improvement of rates of violence against children[8]. Therefore, it is essential to raise the awareness of all actors involved in the attention of children and adolescents and of the population as a whole about how important it is to notify this type of problem. The government must also invest in strategies that contribute for advances towards confronting violence against children[20].

From this perspective, health professionals stand out as extremely important actors in the implementation of strategies that can change violence rates[21,25], such as educational activities, and in the prevention and treatment, from an interdisciplinary, multiprofessional, intersectoral, and socially-engaged perspective, as to empower families and society to take on the role that is due to them in the task of child protection, aiding in the diminution of child abuse in its different forms and expressions.

A limitation of this study, despite the relevance of its findings, is the fact that the interviews included only Family Health Strategy professionals, meaning it was not possible to present the experiences that took place in other sectors of the child protection network.

Conclusion

The results of this study made visible many experiences of the daily practice of health teams who offer healthcare to children and families in risk or situations of violence. Among these are limitations with regards to understanding the concept and the types of violence against children, the naturalization of violence within family, the lack of support from families and the community, the disarticulation of institutions that should integrate the child protection network, health assistance based on a reductionist model, the eschewing of assuming responsibility, and the fear of taking action in cases of violence. These difficulties are not restricted to a single professional class, being expressed by physicians, nurses, Nursing technicians, and community health agents.

The actions of professionals who work in the UBSs were, oftentimes, found to be insufficient to prevent and manage violence against children. This could be related to the complexity of the problem and to the lack of knowledge and ability to act effectively. As a result, actions from the government to guarantee the qualification of health professionals in the ESF are urgent. Only then they will be able to effectively deal with the problem, as prescribed by the Statute of Children and Adolescents.

In general, it was found that health professionals lacked knowledge about violence against children, that there were conflicts with the families, and that the child protection network does not work properly.

It is clear that actions must be taken to empower the health teams with regards to the importance of the role they must assume in the child protection network, since, without the effective participation of the sectors that integrate this network, there will always be gaps that will lead to a fragmented assistance, uncapable of effectively to deal with these situations. Therefore, health professionals must act as engaged social agents for change and must be politically aware of their rights and duties.

Collaborations:

1 – conception, design, analysis and interpretation of data: Leidiene Ferreira Santos, Ana Carolina Rodrigues de Sousa Javaé, Maraína Moreira da Costa and Maitê da Veiga Feitoza Borges Silva;

2 – writing of the article and relevant critical review of the intellectual content: Leidiene Ferreira Santos, Cintia Flôres Mutti and Leonora Rezende Pacheco;

3 – final approval of the version to be published: Leidiene Ferreira Santos, Cintia Flôres Mutti and Leonora Rezende Pacheco.

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