

APPROACH TO CHILD VIOLENCE IN THE FAMILY HEALTH STRATEGY: INTERFERING FACTORS AND COPING STRATEGIES

ABORDAGEM DA VIOLÊNCIA INFANTIL NA ESTRATÉGIA SAÚDE DA FAMÍLIA: FATORES INTERVENIENTES E ESTRATÉGIAS DE ENFRENTAMENTO

ENFOQUE DE LA VIOLENCIA INFANTIL EN LA ESTRATEGIA DE SALUD FAMILIAR: LOS FACTORES INTERMEDIOS Y LAS ESTRATEGIAS DE AFRONTAMIENTO

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Objective: identifying, in the perception of nurses, the intervening factors and strategies used to approach child violence in the Family Health Strategy. Method: a qualitative study with 22 nurses from Teresina, Piauí. Data were collected in October 2019, through individual interviews guided by a semi-structured script, submitted to Thematic Content Analysis. Results: nurses revealed inability to deal with situations of child violence. They sought to approach these cases through strategies based on dialogue, interprofessional work and intersectoriality. Final thoughts: there were intervening factors for the approach of child violence in the Family Health Strategy, the (non-recognition of signs of child abuse), the barriers to establishing bonds with families and difficulties in interlocution in the care network. The strategies for coping with child violence were interprofessional work, holistic care, articulation with the intersectoral network and dialogue with the family.

Descriptors: Nursing. Child Abuse. Family Health Strategy. Child Health. Public Health.

Objetivo: identificar, na percepção de enfermeiros, os fatores intervenientes e as estratégias empregadas para a abordagem da violência infantil na Estratégia Saúde da Família. Método: estudo qualitativo com 22 enfermeiros de

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Teresina, Piauí. Os dados foram coletados em outubro de 2019, mediante entrevistas individuais orientadas por um roteiro semiestruturado, submetidas à análise de conteúdo temática. Resultados: os enfermeiros revelaram inabilidade para lidar com situações de violência infantil. Eles buscavam abordar esses casos por meio de estratégias pautadas no diálogo, no trabalho interprofissional e na intersetorialidade. Considerações finais: foram fatores intervenientes para a abordagem da violência infantil na Estratégia Saúde da Família, o (não) reconhecimento de sinais de abuso infantil, as barreiras para o estabelecimento de vínculo com as famílias e dificuldades de interlocução na rede assistencial. As estratégias para o enfrentamento da violência infantil utilizadas foram trabalho interprofissional, cuidado holístico, articulação com a rede intersetorial e diálogo com a família.

Descritores: Enfermagem. Maus-Tratos Infantis. Estratégia Saúde da Família. Saúde da Criança. Saúde Pública.

Objetivo: identificar, en la percepción de las enfermeras, los factores y estrategias intermedios utilizados para abordar la violencia infantil en la Estrategia de Salud Familiar. Método: se trata de un estudio cualitativo con 22 enfermeras de Teresina, Piauí. Los datos fueron recopilados en octubre de 2019, a través de entrevistas individuales guiadas por un guion semiestructurado, sometidos al análisis temático de contenidos. Resultados: las enfermeras revelaron incapacidad para lidiar con situaciones de violencia infantil. Trataron de abordar estos casos a través de estrategias basadas en el diálogo, el trabajo interprofesional y la intersectorialidad. Consideraciones finales: fueron factores intermedios para el enfoque de la violencia infantil en la Estrategia de Salud Familiar, el (no reconocimiento de signos de abuso infantil), las barreras para establecer vínculos con las familias y las dificultades de interlocución en la red de atención. Las estrategias para hacer frente a la violencia infantil fueron el trabajo interprofesional, el cuidado holístico, la articulación con la red intersectorial y el diálogo con la familia.

Descriptor: Enfermería. Abuso de Menores. Estrategia de Salud Familiar. Salud Infantil. Salud Pública.

Introduction

Violence is considered, in the national and global scenario, a public health problem⁽¹⁻²⁾. Child violence is any type of action or omission that can harm the well-being, physical or psychological integrity, freedom or right to growth and development of the child⁽³⁾.

In Brazil, 159,063 cases of human rights violations were recorded in 2019. Among these, 86,837 were complaints involving children and adolescents, equivalent to 55% of the total and an increase of 13.9% compared to the previous year. Regarding gender distribution, 55% of the victims were girls. Of this total, 38% were cases of neglect, 23% psychological violence, 21% physical violence, 11% sexual violence; institutional violence and work exploitation accounted for 3%, respectively, and other types of violations of the rights of children and adolescents, 1%. It is emphasized that there was a greater worsening of cases of negligence when compared to the data of the previous year and there is a possibility of overlap of types of violence⁽²⁾.

To better understand the significant increase in cases of child violence and its interconnections, this study is based on the perspective that any

child is vulnerable to violence, and that it has an individual and a collective dimension. The individual dimension considers the knowledge of parents and/or guardians and the possibility of access to it, considering that it conditions the transformative capacity of behaviors. On the other hand, the collective dimension involves, through society, the guarantee of healthy development and the full exercise of citizenship, based on policies of access to health, education, culture and income – among other constitutional rights –, in addition to policies to combat violence, which includes professional training for childcare⁽⁴⁾.

Child violence, besides being a painful reality, has devastating consequences throughout life, both physical and psychosocial. In adolescence, the increase in morbidity and mortality observed in the last two decades is mostly related to the consequences of violence, such as injuries, disabilities, homicides, but also illnesses resulting from precarious living conditions, suicides and accidents⁽⁵⁾.

Social, emotional and psychological problems⁽⁶⁾, manifested through the adoption of health risk behaviors – such as alcohol and

other drug abuse, prostitution, early pregnancy and mental health problems, such as anxiety, depressive disorder, aggressive behavior and even suicide attempts⁽⁷⁾ –, may be related to child violence. This may also result in negative impacts on school performance⁽⁸⁾ and on the adoption of violent behaviors in adulthood⁽⁹⁾, including dating⁽¹⁰⁾.

Child violence is characterized as a public health problem of a multidimensional nature. It presents numerous variables and affects all socioeconomic and cultural levels of society. These reasons make it necessary to intervene in a multidisciplinary and interdisciplinary team, with joint, coordinated and interconnected action of all care services^(5,11).

Because it represents a negative experience in the individual's life, the possibility of a child overcoming this painful experience depends on the observance of the elements that integrate his network of protection and care, including health care^(3,9,11). Since the Unified Health System (SUS) plays an important role in preventing and coping with violence and in the integral care of people who have experienced this situation, the Brazilian Ministry of Health, in 2010, launched the Comprehensive Health Care Line for Children, Adolescents and their Families in Situations of Violence: guidance for managers and health professionals⁽¹²⁾.

In this system, Primary Health Care (PHC) is the first level of care, constituting a preferred gateway to health care networks. This situation occurs because the Family Health Strategy (FHS) teams – supported by the Family Health Support Center (FHSC) –, are geographically inserted close to family homes. This may favor the identification of signs and symptoms of child violence, as well as establish reception, adequate care from diagnosis to health care and, above all, notify cases and refer to the care and social protection network⁽¹²⁾.

In the context of PHC and health surveillance, nurses – as a member of the health team – have responsibilities for care and humanized support to children and their families, valuing biopsychosocial well-being, identifying and

intervening in needs and vulnerabilities⁽¹³⁾. However, a report by the European Union Agency for Fundamental Rights reveals that these professionals have difficulties in recognizing the signs of child violence⁽¹⁴⁾. Therefore, it is extremely important that nurses, as well as other members of the health team, be prepared to care for children at risk. A study highlighted that this professional has skills to provide health harm promotion and prevention care, perform protective actions, identify and report cases or suspected violence against the child⁽¹⁵⁾.

Despite the existence of studies on child violence, this proposal goes beyond looking, from the perspective of nurses working in the FHS, to nursing care in situations of child violence. We propose reflections on how professionals, at the forefront of the intersectoral network of child health care, have been facing, on a daily life, situations of child violence. Thus, the question was: What are the factors involved in the approach to situations of child violence and the strategies employed by nurses of the FHS to cope with it? In this perspective, elements of the nurse's work process are presented, which may act as facilitators and/or barriers of care.

Thus, the aim of this study was to identify, in the perception of nurses, the intervening factors and strategies employed to approach child violence in the Family Health Strategy.

Method

This is a qualitative study conducted in six Basic Health Units (BHU) in the city of Teresina, Piauí, in October 2019.

The participants of this study were 22 nurses who worked in the FHS of the state capital of Piauí. They met the inclusion criteria: being a nurse, a BHU employee who has been working on the FHS team for at least one year. Nurses absent during the data collection period were excluded due to leave of work activities for any reason.

The number of nurses invited to participate in this study sought to meet the collective representativeness and depth of the senses⁽¹⁶⁾. Empirical knowledge was used to interrupt

the capture of new participants, when speech representativeness and recurrence of the information obtained were achieved.

Data collection occurred through semi-structured individual interviews, with an average duration of 15 minutes, guided by a script composed of six questions, to trace the profile of nurses, and four open questions, with the objective of elucidating the phenomenon in their perception. These questions involved talking about what they thought about child violence, describing facilities and difficulties to deal with these situations, and perspectives of strategies for coping with them in the FHS. In the end, they could talk freely about the theme.

The participants were contacted at the BHU during the days of the week, in the morning or the morning shifts, in the intervals or at the end of the work activities, so that it did not interfere in the care activities.

After the consent of the participants, in a reserved room in the BHU premises, the interviews began to be conducted. They were recorded with the aid of an MP4 digital recorder. At the end of each interview, the participants validated the statements. At that moment, they were able to hear the audio from the recordings of their reports, enabling their withdrawal from the study, the addition of information or the modification of any reported statements.

After full transcription of the audios and modifications according to the validation by the participants, the extracted results were submitted to thematic content analysis. According to Minayo's operative proposal⁽¹⁶⁾, these are phases of this type of analysis: pre-analysis – transcription and organization of interviews for floating reading; exploration of the material – from a thorough reading, the extraction of the nuclei of comprehension of the text (themes) was operated, being observed their regularities, revealing three themes: the nurses' eyes on child violence, their facilities and difficulties in coping and the strategies used for this; finally, the treatment and interpretation of the results – in which inferences and interpretation of the

data were made and subsequent aggregation into thematic categories.

The research preserved the voluntary nature of participation, as well as the other ethical precepts contained in Resolution n.º 466/2012 of the National Health Council. The research project was submitted for consideration by the Research Ethics Committee, and was approved on September 12, 2019, under Opinion n.º 3,571,651. To guarantee anonymity to the participants, the names were replaced by the designation Nurse followed by Arabic numbers, according to the order of insertion in the research. The interview presented minimal risks of embarrassment and discomfort mitigated by the interruption, when requested by the participant.

Results

The profile of the participants was: 20 women and 2 men, between 29 and 58 years old, with an average age of 40.45; 12 were married, 3 separated/divorced, 6 single and 1 widowed; among the participants 2 were only students, 19 specialists and 1 master. Regarding the time of academic education, there was a minimum time space of 5 and a maximum of 34 years, with an average of 15.09 years; and, for the time of operation in the BHU, minimum time of 2 years and maximum of 22 years, with an average of 8.36 years.

The nurses' reports allowed the identification of three thematic categories, as described below:

The look and attitude of the nurse of the Family Health Strategy about child violence

Long and silent pauses were perceived when the nurse's view of child violence was questioned, but soon revealed the inability to deal with such situations, despite the recognition of the need for a critical and holistic look to identify the signs of child violence:

If we had a more critical look at this problem, we could detect and help a little more [...] these children. (Nurse 1).

I find it interesting that, in the health of the family, we can have a very general follow-up, and see this whole issue.

If you have a case of violence, identify and investigate the situation and see if you really need follow-up. (Nurse 2).

The look of the professional nurse should be, right, holistic, as we attend a lot of children in the consultation. (Nurse 3).

Always, in the care of children, it is with a physical examination, seeking both important data for the care itself, but also always attentive to indications that the child may be suffering abuse, mistreatment, violence within his home or even being the victim of other types of violence. (Nurse 10).

Today it [child violence] is rooted in areas of high vulnerability, as is our area, which is a periphery area, an area where the level of education is low, and the level of poverty is high. And we can see that [...] it is present more than often reach us, inside the office. (Nurse 11).

When dealing with possible cases of child violence, nurses can have a diversity of attitudes, which, according to reports, always includes multiprofessional work. This allowance is also used as a mechanism for maintaining the rights of the child. From this perspective, it is obtained, as answers, that the attitude of nurses to deal with this situation of vulnerability is aligned with their eyes linked to the eyes of other professionals, especially Community Health Agents (CHA), as a reflection of the bond with the community:

[...] the health agent who is also at home [...] so he has this look that we can't see. (Nurse 2).

The health agent is the community spokesperson to receive community information and pass it on to professionals. (Nurse 9).

[Child violence is a] relevant topic, which should always be addressed in meetings with CHA [Community Health Agents]. (Nurse 17).

Child violence is a present situation [and] captured, most of the time, by the CHA [Community Health Agents]. (Nurse 19)

Factors involved in the nurse's approach in the Family Health Strategy to situations of child violence

It was observed that there were no facilities of the FHS nurse to detect child violence, because the work process was seen as adversity, which brought confrontation and fear. Thus, the answers obtained guide the perception about a lack of clarity regarding the methods that should be adopted by nurses and other professionals:

There's no facility. As I said, I get the demand and I'm careful in guiding my health agents and how to observe

violence, how to gather the data before bringing me and how they should behave before the community. (Nurse 7).

There is no facility in dealing with child violence [...] more than 90% of cases occur within the family itself. So, in my opinion, there is no facility, on the contrary, there is a lot of difficulty. (Nurse 11).

We don't have facilities, we have difficulties. First, we've never been trained to... how to approach a case like this; so, we have much more difficulties than facilities. (Nurse 13).

It's not easy! Ease is difficult for you to say so "have this facility". (Nurse 14).

I don't see any facility. Maybe the only facility is that you really have an approach with this family. (Nurse 18).

Often, the team does not want to get involved [...] for their own safety and time to carry out the visits, and the danger of certain regions. (Nurse 22).

However, there were reports of possible benefits and facilities in the work process in the FHS, which helped to cope with these existing barriers in the detection of cases of child violence:

The facilities are precisely this issue of us having this access to these children [...] We follow many children since prenatal care and the relationship of trust also with the mother [...] makes it easier for us. (Nurse 1).

It can point out how easy, would be the form of detection right, of these cases of violence, because the children, they are known to the team, the family is known. (Nurse 10).

The facilities are in the fact that the Family Health Strategy teams are more present in the lives of these families. (Nurse 15).

Once again, when asked about the facilities of care for children in situations of violence, the nurses identified that the presence of CHA in the community was a differential for the team as a decisive factor in the identification of situations of child violence, in the same way that they revealed the integration of the intersectoral network as a facilitator of care:

The ease we have would be the proximity of the health agent to the patient. (Nurse 4).

The ease is the issue of having the health agent in the area. (Nurse 5).

My first and most, and most obvious tool in the matter, is the health agent. (Nurse 9).

But we have partnerships that facilitate assistance to families with cases of child violence, such as SRCSA [Specialized Reference Center for Social Assistance], RSCSA [Reference Center for Social Assistance], ECFH [Extended Center for Family Health], Program for the Eradication of Child Labor (PECL), and schools, for having an additional contact with parents. (Nurse 12).

The only facilitator is the Guardianship Council, together with the FHS [Family Health Strategy] where visits are made and, after that, they are forwarded to the Guardianship Council. (Nurse 20).

[...] the CHA [Community Health Agent] would be a gateway for us to be closer to these families and in the nursing consultation itself. (Nurse 22).

The reports, however, showed, as great difficulty in coping, the recognition, by the family, of the need to establish a bond with professionals, which, in some cases, is suggestive of the violence perpetrated by those who should protect the child:

The difficulties are, for example, if we notice a situation of suspicion and we do not get support from a family member. (Nurse 3).

It's the kind of thing if the health care agent doesn't have access to the home. Some people refuse the visit. (Nurse 4).

The difficulties, I think even the issue of changing the behavior of the family. (Nurse 5).

The greatest difficulty is because child violence is not exposed, it is camouflaged within the family itself. (Nurse 12).

The difficulties are many, because first, to separate, you start judging the mother-child relationship is very delicate. (Nurse 14).

The biggest difficulty is the resistance/omission of parents, silence of the raped child and difficulty in referral to specialized services, such as psychotherapy. (Nurse 19).

There were not only the difficulties of establishing a bond with the family, but also those that presented problems of articulation of the intersectoral network – which was revealed to be dialogical – at the same time being the greatest support felt by nurses:

So, like, I have a support network to articulate with her. So, like, it depends on the demand. I need to articulate myself [...] the network is good. (Nurse 7).

Besides the network, which is a whole state of play that we should have. (Nurse 8).

The difficulties, they are precisely in the inequalities and situation of misery that are the people who are usually associated with the low sociocultural and educational level, leading to ignorance, habits and customs not consistent with a healthy life, physically and psychologically. (Nurse 15).

The difficulty is in relation to the support network. (Nurse 16).

The nurses' gaze, described in the first category of this study, proved to be an important difficulty in coping with situations of child violence in the FHS:

Often, the nurse himself and the health agent do not understand the importance of this theme, do not bother to identify, know the area of local coverage and understand the issue of the area, the profile of the area, know the demands of the area. (Nurse 9).

It would sometimes be the unpreparedness of some professionals, of recognizing signs of violence, which is sometimes not a much-discussed subject. Then, it turns out that some professionals end up missing some signs unnoticed. (Nurse 10).

I've never notified any cases [...] we professionals are not involved in this situation because of the various activities of the nurse. We ended up not focusing so much on this [child violence] and not acting so much on prevention. (Nurse 22).

Strategies employed by nurses in the Family Health Strategy to approach child violence

In this analytical category, the perspectives of strategies that FHS nurses had been using to overcome the difficulties faced in daily life related to child violence were highlighted, with the main potentialization of the insertion of dialogue in the work process:

[My perspective] it's really a matter of awareness. I, for example, love to talk to mothers [...] we try to talk about it in the consultations themselves. (Nurse 1).

It's having a dialogue with the family. It's trying the culture of peace indoors. It is really encouraging respect for children, trying to discuss the issue of non-violence with the most impoverished families. (Nurse 10).

Through our visits, our childcare, our lectures both at the health center and the lectures in schools [...] and in active searches. (Nurse 15).

To carry out educational actions with the family to prevent new situations of violence, referral to the appropriate organs, identify child violence through home visits. (Nurse 21).

In the reports, perspectives and opportunities for coping with child violence favored by involvement with holistic care, social support, multiprofessional work and the articulation of the intersectoral network were observed:

The patient comes dirty or with irregular hygiene, so we talk to the mother and guide [...] in relation to hygiene and care, and we watched later, because, if we guided, then it is not for that child to come back the same way. (Nurse 2).

To address, well, we must follow all protocols. We follow and have the issue of notification. In the case of notifications [...] we try to be as subtle as possible and try as many answers as possible. (Nurse 3).

Well, the plan would be to be multiprofessional. (Nurse 4).

And we know that we have the issue of notification [...] some sectors, which we must call at that time, to be able to help. (Nurse 5).

I expected the partnership of these agencies with us, of us power, because it is no use only you, is to report the case, identify the case. (Nurse 6).

It is necessary that the team and/or the professional have adequate support to face violence, situations of stress in the care of victims and an intersectoriality with cohesion in actions aimed at prevention. (Nurse 12).

Have the competent bodies at your side and the facility for you to be able to trigger them when necessary. (Nurse 14).

[...] more than the organs involved. Educational activities in these communities are also important. (Nurse 22).

Discussion

The results of this study revealed elements of the work process of FHS nurses, especially those related to facilities and difficulties for the care and recognition of situations of child violence. The importance of establishing a bond with the family and the intersectoral network of childcare is emphasized. Nurses saw the FHS as a possibility of interaction between family and health service, fundamental to combating child violence. However, they described difficulties in the elaboration of this care, given the limitations inherent to their view of the recognition of signs of child abuse and difficulty in interlocution with other centers of the care network.

As a strategy to resolve their limitations inherent in the recognition of signs indicative of violence, they mentioned the importance of the CHA's work. They verbalized the figure of this professional – a member of the FHS team – as an event-investigating agent, which brings agreement with another study⁽¹⁷⁾, that evidenced the effective participation of the CHA in the community, as a tool to enable a sensitive perception about the health parameters of the population enrolled, because this professional is a resident of that community.

The nurses' reports identified the importance of holistic care and professional involvement with the person, family and collectivity, because they understand that the process of recognizing situations of child violence can occur from the visualization of physical and emotional signs,

through the nursing consultation, to complaints of cases by the community. Thus, it is realized in the perception that the nurses evidenced, stating that the CHA had relevance in the detection of violence. However, it is a concern that this professional can be seen by the population as a whistleblower, coming to suffer reprisals from the aggressors, as evidenced by research⁽¹⁸⁾ in southeastern Brazil, which demonstrated nursing care in situations of child violence permeated by fears and threats, contributing to underreporting.

Knowledge as a basis for change is one of the norths so that nursing action can generate differential against child violence, from the prevention process to the context of identifying this form of health problem. However, studies⁽¹⁹⁻²⁰⁾ have identified that nursing professionals do not feel prepared to act in these situations, which corroborates the data obtained here, emphasizing the need for training.

This study reveals that the eyes of professionals referring to children who suffer violence should be better exercised, since one report revealed that the professional never attended a child victim of violence. This is an impactful fact, considering the national social reality – approximately 55% of human rights violations records refer to children and adolescents⁽²⁾ – and the discrepancy in relation to the reports of the other participants.

Reflecting on the need for training of health professionals is essential for the exercise of quality, holistic and welcoming care, with attention to the demands of children and adolescents, establishing strategies oriented by the determinants of child violence. It is notorious that the programming of nursing care reveals a process that borders on no specificity; that is, they are strategies that do not focus on the determinants of child violence and, therefore, are characterized as another indicator of vulnerability. The strategies are punctual and reactive, organized as cases are identified in the community. The results showed that there is negligence of the services, especially about the organization of actions to prevent child violence.

Thus, the approach to child violence involves the development of prevention and control programs and strategies, as well as the provision

of means and input for its implementation. However, coping with child violence goes beyond reactive strategies, and should involve, above all, intersectoral public policies that meet needs and allow the full exercise of rights for children and adolescents⁽⁴⁾.

The nurses participating in this research reported difficulties inherent to the establishment of bonds, to the articulation with the intersectoral network, and inability to recognize cases of violence. However, there are reports that there may be benefits and facilities in the work process in the FHS capable of improving or reducing these barriers in the detection of cases of violence – such as the need for routine monitoring of children – to prove health conditions in social and care program registrations.

The challenges present in the approach to child violence are still related to the family context. Data show that 52% of reports of violations of the rights of children and adolescents occur in the victim's home, most of whom are practiced by people close to family life – parents, stepfathers and uncles –, of which, in 40% of cases, suspicion falls on the mother. This data may be related to the social construction of the mother's responsibility for the care of the children, since most violations refer to cases of negligence⁽²⁾.

A study⁽²¹⁾ with the objective of analyzing the network of social care and support from the perspective of family members of children and adolescents victims of abuse showed gaps in the victim's social support network. The relationships were weakened and low intensity, being the support mostly instrumental and material. They also reinforce the findings of this study, highlighting the importance of establishing affective relationships, in addition to support and bonding between services and families. It is perceived that individual and collective vulnerabilities are imbricated in each other since the social reproduction of learned behaviors establishes a cycle of precariousness of the rights system of children and adolescents⁽⁴⁾.

There are several difficulties that nurses can have with the family, in which situations will be determinant for social changes. A study highlights that the nurses' reports reveal great

difficulty in acting, because the identification of the aggressor can be masked, and the type of violence committed against the child, considered a "normal" situation by the offender, considering that they express models learned over generations⁽⁴⁾.

Research⁽²²⁾ evaluated the functioning of the family and its association with the risk of maltreatment in families expecting a baby, and pointed out that the age of partners, mothers' education, mental health problems of the father, mothers' concern with alcohol consumption and difficulties of mothers in talking about family problems are factors related to the increased risk of child abuse and abuse. Thus, it is reinforced that the conditions of individual vulnerability – which are not limited to the child, but involve cultural values, beliefs, age, education, marital situation and the employment situation of parents/guardians, as well as the experience of situations of violence within the family – can have repercussions in the form of abuse, ill-treatment and neglect, weakening the affective-relational bonds of the child⁽⁴⁾.

In this study, nurses recognized the need to give visibility to discussions about child violence, as it is still a neglected theme in health services, even though they are factors that affect the evaluation and achievement of children's growth and development goals. Nevertheless, the valorization of the theme can lead to improvements in the care provided by nurses and all health professionals, mitigating the conditions of individual and social vulnerabilities. For this, it is necessary to reinforce the knowledge of nurses, emphasizing their political and social commitment to the prevention and control of child violence.

The FHS has several mechanisms of reduction of injuries, which are expressed through educational processes, changes in habits, home visits, inclusive processes to the BHU, medication measures, compulsory notification, among others. However, when it comes to social problems – such as child violence –, only immersion in educational, dialogical and diplomatic processes, focusing on behavior change, can minimize harm. However, it is known that, in isolation, health services are

not sufficient; therefore, there is a need for the sharing of responsibilities and commitments of the different instances of society⁽⁴⁾.

Regarding the confrontation of violence, using instructional protocols, wheels of conversations, lectures and performance in care services, such as the school, were strategies mentioned by the interviewees as potential; therefore, it is evident that nurses understood the importance of articulating the intersectoral network for the protection of children. A study⁽²³⁾ corroborates the relevance of these professionals' work, showing a positive impact of a program of home visits by nurses in reducing child abuse among participants. Thus, the perspectives of FHS nurses, to reduce the vulnerability of children and adolescents to violence, involve health education, through interprofessional dialogue and with the community, and the articulation with the intersectoral network of childcare.

The nurses also reported the importance of anamnesis and clinical examination of the patient in PHC, through a rigorous and attentive nursing consultation, to notice some nonconformity that may be present in this body and in this mind and, in case of signs of violence, follow protocols that are facilitators of this process. Thus, understanding the child and adolescent as a vulnerable group *per se*⁽⁴⁾, is essential in the work process of nurses in the FHS.

In this sense, it is observed that nurses play a fundamental role in identifying signs and factors associated with child violence, given that they are the professionals closest to patients and, therefore, capable of performing a standardized and protocol-based approach. A study reports that it is added to the unviability of child violence in society, the fact that nurses, because they are more attentive to clinical aspects, present difficulties to establish nursing problems for situations of child violence. Nevertheless, the authors identified problems mainly related to the environment, interpersonal relationships and learning. They refer to the urgency of reformulating the training curricula to approach clinical reasoning and child violence⁽²⁴⁾.

Because it presents a threshold close to criminology, in this context, the perception of nurses about the approach in cases of child violence should be cautious and prudent, without pre-judgments, as evidenced in the reports. However, a Swedish study⁽²⁵⁾ reinforces the importance of reporting cases and reveals that more than half of nurses working in the school environment have identified at least one suspected case of children suffering from physical or psychological abuse, and cases of abuse are common.

In general, this research revealed that the strategies applied by the FHS nurses are focused on individual vulnerabilities, although policies and programs already reinforce the collective character of the vulnerability of children and adolescents to violence, as reproduced in another study⁽⁴⁾.

Among the limitations of the study, it is emphasized that it was conducted with a small sample of nurses and from a single region, in addition to the short duration of the interviews. Therefore, the findings reflect a limited part of the country. Another limiting factor was the average time of the interviews, which, being short, may have offered little material for the analysis.

Despite the limitations, the study shows that it is possible, within the FHS, to develop strategies for coping with child violence based on dialogue, multiprofessional work and intersectorality, with emphasis on the collective dimension of vulnerability. It also allows the reflection of the practice of nurses and their interconnection with the work process of the other team members and related areas involved in coping with this situation.

Final thoughts

This study revealed a broad understanding of the perceptions of FHS nurses about child violence. The professionals pointed out, as intervening factors in the approach to child violence in the FHS, the following difficulties: recognition of signs of violence, establishment of bonds with the family and articulation with the intersectoral network. These professionals showed that they move between health care and reporting to criminal spheres.

The strategies employed by the FHS nurse were fragmented and focused on the individual vulnerabilities of children and adolescents to situations of violence, contrary to the strengthening of social and programmatic determinants for coping. From the reports, it was evident that strengthening bonds with the community is essential for coping, as well as the work process of the CHA as a member of the on-site team. From the reports, it was evident that strengthening bonds with the community is essential for coping, as well as the work process of the CHA as a member of the on-site team. In relation to the daily work in the FHS, health education and articulation with the intersectoral network are important, to ensure healthy development and growth for the child.

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