

Reporting child violence, health care flows and work process of primary health care professionals

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Abstract *This study aimed to analyze the flows of the network of children's protection against violence regarding reporting and decisions made. This is a qualitative research based on the Theory of Praxis Interpretation of Community Health Nursing – TIPESC, proposed by Egrý, which seeks nursing intervention through a dynamic and participative methodology. Data were collected through official documents and interviews with Primary Health Care professionals in three health facilities of a Brazilian city and analyzed through Dialectical Hermeneutics and the Flowchart Analyzing the Care Model of a Health Service. Results point to the difficulties and weaknesses of the care network in addressing issues, the need for intersectoral actions and the training of professionals to deal with situations of violence. In conclusion, strategies must be adopted to increase the capacity of monitoring and follow-up of reported cases, to provide qualified training of workers and organize the health network, with a view to offering a sufficient number of quality care services and to receive contributions from professionals to address violence against children.*

Key words *Child abuse, Workflow, Primary Health Care, Qualitative research*

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Introduction

The Unified Health System (SUS) seeks to interfere in the health conditions and care provided to the Brazilian population, whose concept is based on the formulation of a health model geared to the needs of the population, seeking to rescue the commitment of the State to social well-being, especially with regard to collective health, consolidating it as one of citizenship's rights¹. In Brazil, the inclusion of accidents and violence in health culminated in the publication of Ordinance No. 737 MS/GM, dated May 16, 2001, which approves the National Policy for the Reduction of Morbidity and Mortality due to Accidents and Violence (PNRMAV)². Thus, in line with recommendations of the World Health Organization (WHO) made at the General Assembly of the United Nations (UN) in 1996³, violence is assumed to be a major public health problem, and an instrument for the notification of suspected or confirmed violence against children and adolescents has been defined by means of Ordinance MS/GM No 19668, dated October 25, 2001⁴.

With regard to children and adolescents, the World Health Organization (WHO) defines violence involving this segment as all forms of emotional and/or physical abuse, sexual abuse, neglect or negligent treatment, commercial or other forms of exploitation, with the possibility of resulting in potential or actual harm to children's health, survival, development or dignity in the context of a relationship of responsibility, trust or power⁵. In Brazil, concern about childhood abuse from the perspective of epidemiology, prevention of risk factors and specialized care originated in the 1980s, coinciding with the inclusion of the issue of violence in the public health agenda⁶.

Since the promulgation of the Statute of the Child and Adolescent (ECA)⁷, according to the principles of comprehensive protection, Brazilian children and adolescents are treated as subjects of rights and as a priority group. With regard to violence, whether in the form of abuse or neglect, they are more vulnerable, since they are beings that require from the adult universe protection and safety necessary to develop better, and repercussions on their health should also be considered⁶.

Regarding violence, which is now one of the serious public health problems, networking is a requirement, which must occur in an articulated way among the organizations involved, in order to negotiate and share resources according to

collective interests and needs, whose decisions must be adopted horizontally on the principles of equality, democracy, cooperation and solidarity⁸. The networking method allows both the exchange of information and institutional articulation, as well as the formulation of public policies for the implementation of common projects, which contribute to comprehensive care, advocacy, protection and ensuring the rights of children, adolescents and their families in situations of violence⁸.

The flow of care established with the proposed network is fundamental to address violence, as long as it coordinates the different levels of health care, the sectors of society and professionals involved in the care of violence victims. Such coordination may be seen as a hindrance to the establishment of networks and a reason for discontinued shared actions, since it requires a change in the traditional working processes and relationships and institutional power sharing⁹. A study carried out in two Brazilian capitals identified the same hurdles to the consolidation of networks of care to women victims of domestic violence, indicating that the difficulties related to networking extrapolate the attention to cases of child violence, but it is a challenge for the reorganization of the violence care model as a whole, given its complexity¹⁰.

Under the current health policy, because they are geographically closer to families and because of the involvement of professionals with individual and collective health actions, primary care teams are more likely to identify situations of violence in children and adolescents, through reception, service (diagnosis, treatment and care), notification of cases and referral to a network of care and social protection. We highlight that the coordination between several types of professionals, services and sectors is a necessary condition for the development of actions for the comprehensive protection of children and adolescents, but health services have had a leading role in both the participation of networks and their articulation thereof¹¹. However, it is incumbent upon States and Municipalities to outline own strategies and mobilize efforts, teams and institutions, following the directives established in national regulations for the prevention and fight against violence⁹.

Considering the above and the issues discussed in a previous work addressing child violence in a network perspective and the understanding of PHC professionals¹², we ask: how do health professionals perceive the orga-

nization of the flow of the safety network in a given territory? Therefore, this study aimed to analyze the flows of the network of protection against child violence from official documents and statements of PHC professionals with regard to reporting and decisions made.

Methodology

Study characterization

This study was based on a qualitative methodology, given its descriptive and exploratory nature, whose theoretical basis builds on the Theory of Praxis Interpretation of Community Health Nursing (TIPESC), created by Egry¹³, which proposes the intervention of nursing through a dynamic and participative methodology. The theory's philosophical bases are historicity and dynamism, in accordance with the understanding of historical and dialectic materialism, and it considers the constant mobility of history and the continuous becoming of social transformations. Dialectic hermeneutics was used as a method to interpret the statements and responses stemming from interviews¹⁴ and as a technique to analyze the safety network the Flowchart Analyzing the Care Model of a Health Service^{15,16}. The use of the dialectic-hermeneutic presupposes that the understanding of the health services' work process must take into account both the historical process in its dynamism, provisional condition and social transformation, as well as the empirical social practice of individuals in society in their contradictory movement¹⁴. In a methodological perspective, hermeneutics and dialectics should not be reduced to a simple data processing theory, since, by allowing praxis-based reflections, they evidence an inventive and creative potential to conduct the analysis process and at the same time comprehensive and critical potential to study social reality. While hermeneutics realizes the understanding of texts, historical facts, daily life and reality, the dialectical orientation believes it is essential to criticize the ideas exposed in texts and institutions. Thus, from its historical specificity, it seeks the complicity with its time; and, in internal differentiations, its contribution to life, knowledge and transformation¹⁴.

The flowchart is a chart used by different fields of knowledge, with the perspective of outlining the way in which a set of interconnected work processes are organized around a production chain¹⁵. In the field of health, the flowchart

allows capturing and interrogating the functional senses of the service, highlight prevailing knowledge and practices and identify alternatives and pathways to address the different types of games of interest in the daily work routine of health¹⁶. Regarding this study, the use of the flowchart is due to the possibility of identifying working ways in a network in servicing child violence situations, both those in the official documents and those derived from the professionals' statements.

Symbols used to construct the flowchart are universally standardized shapes, such as ellipse, rectangle and diamond. The ellipse shows the beginning and the end of the production chain, representing the input and output of the production process under analysis. The rectangle shows the moments in which important stages of the productive chain are performed, where both the consumption of resources and the manufacture of products occur; By means of the diamond, it is possible to show the moments in which the production chain faces the decision processes that, besides indicating pathways to be followed, point to possible routes to reach subsequent and different stages¹⁵. Figure 1 shows the Flowchart's representative chart.

The study setting was the Capão Redondo District, one of the districts of São Paulo city, the largest Brazilian city in terms of population, which concentrates 6% of the national population and 27% of the state of São Paulo¹⁷ and in which, in 2010, the Municipal Human Development Index was calculated at 0.805. The municipality has population density of 7,398.26 inhabitants/km² and an estimated population of 11,967,825 people in 2015. Its territory is divided into 31 submunicipalities, with 96 linked districts. The District of Capão Redondo has an estimated population of 270,716 inhabitants, a population density of 19,549 inhabitants/km² and annual growth rate of 0.77%¹⁷. In this district, Primary Health Care is implemented through the Family Health Strategy in 14 basic health units (UBS), totaling 81 family health teams, covering 94.7% of the population¹⁷.

Data were obtained through interviews with PHC professionals of the District, from July 2013 to March 2014, due to their work in the local and regional servicing of situations of child violence, which makes them central participants to the study. The guiding documents that support the implementation of the care and protection network, with their decrees, ordinances, protocols and flows at both the municipal and federal levels represented documentary research.

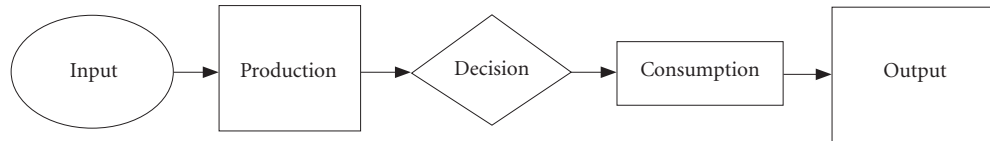


Figure 1. Representation of the analyzer flowchart model, its forms and meanings.

The criteria for the inclusion of respondents were to have worked in PHC for more than six months at the local, regional or central level and to be willing to answer to interview questions. There were no exclusion criteria. At the local level, respondents were 22 professionals who were part of Family Health teams. At the regional level, three members of the coordination who acted as reference for violence-related issues were interviewed. The selection of study subjects followed the criterion of convenience, since they could provide the necessary information for the research, and closing interviews occurred when recurrent information was detected.

Of the 25 research subjects, nine are Nurses, three are Physicians, three are Psychologists, two are Community Health Workers, three are Nursing Technicians, with one Odontologist, one Nutritionist, one Pharmacist and two Social Workers. With regard to gender, 24 are female and one is male. Ages groups ranged from 20 to 30 years (six people); 30 to 40 years (12 people), 40 to 50 years (four people) and 50 years and over (three people). Family Health strategy experience ranged from one to 12 years.

Interviews were carried out through a semi-structured script, where professionals had the opportunity to discuss child violence, notification and the processes deriving thereof. Regarding the analysis, we sought to identify how teams work in a network in the daily routine of their practice in dealing with child violence situations, using the analyzing flowchart to decode statements, which allowed a comparison between data obtained in the interviews and the institutional regulations related to the protection network. The analysis of the documentary sources was carried out in order to establish comparisons between the recommended flows and the realities of care in the scope of PHC work processes. This option is due to the assumption that different forms and characteristics of the protection network trigger different ways of signifying and confronting violence in health services and practices.

Since this research involves human beings and in compliance with the legal provisions contained in Resolution N° 466/12 of the National Health Council¹⁸, which was in force when the research project was approved, approval was given by the ethics committees of the Nursing School of the University of São Paulo and the Municipal Health Secretariat of São Paulo. In order to achieve the necessary methodological rigor, the criteria established for the Reporting Qualitative Research (COREQ) were observed, both in the elaboration and in the development and implementation of the research.

Results

In the analysis of the document that guides the operation of the care and protection network in the city of São Paulo¹⁹, we note that a Flow of Care for situations of child violence is defined, namely: any professional of the facility can receive and service the user at risk or situation of violence by completing the violence notification form (SIVVA); users should be directed to the Violence Prevention Center (NPV) of the facility to receive care; after identification or referral of a user in a situation of violence, one or more core professionals must carry out the case reception interview (filling out the violence notification sheet, if it has not yet been performed) and implement the first guidelines and referrals required by the user; one or more team professionals will be the user's reference in monitoring the entire process until its completion. The Flow of Care is shown in the synthesis flowchart below:

In relation to the professionals interviewed, different situations related to the flow of care to situations of violence were identified, revealing how they operate in their daily routine. Thus, of the 22 professionals who work at the local level, 13 recognized the need and importance of notification, but before situations of violence, they handed the matter to the social worker of the

facility or NPV representative, because they understand that it is their responsibility, as can be seen below:

Usually, my first move is to trigger some kind of social worker, we do not know the best way to solve this issue. (suj_22)

For example, what I did in the case of this child was to seek support, talk to the psychologist and try to address in a home visit. It was very difficult to find a social worker due to the lack of professionals in the network, so I sought support and handed the case to the manager who, in turn, hand it over to the manager above her in charge of support and family health support center. (suj_13)

My first access point is the NASF [Family Health Support Center], which has the staff that works with social assistance and they look for other facilities. However, other than that, if we do not want to do that, we can call in the guardianship council. (suj_19)

Here at the Family Health Program (PSF) we have the NASF team. Therefore, we have to seek support for every case. We have to train, and the NASF team consists of a social worker, a psychologist, a psychiatrist and a therapist, so it takes the whole team to tackle the situation, request the intervention of the Public Prosecutor's Office and the guardianship council. (suj_10)

Another eight professionals reported that they notify when they face the situation and refer patients to the protection network bodies, such as Guardianship Councils and Social Assistance Reference Centers.

Indeed, there is a notification form called SIVA, through which we notify any type of violence, it may be due to accident or assault, but this is more a compulsory attitude that generates data, it is not necessarily coming back. (suj_22)

Yes, when we take notice, yes. So much so that there is a case in one area, of children [...] that the mother left alone at home. The grandmother

worked, the mother went out to use drugs and left children alone. So much that the Guardianship Council was called in; The CRAS [Social Assistance Reference Center] of Capão called these days to find out where the case is at. (suj_06)

Yes, the Guardianship Council is called in as needed. (suj_08)

Only one of the professionals interviewed reported not knowing if there was any situation of care to child violence at the health facility, but if there was, he would find out how to notify.

When comparing the Flow of Care defined in the guiding document and shown in Figure 2 with the professionals' discourses, it can be seen that these fail to fulfill an important step in the care process, such as when they refer the situations of violence to the NPV and do not perform the notification directly. The same happens with those who, while notifying, refer to social assistance spheres, without mentioning the other levels underpinning the recommended flow of care.

The ways of referring notifications described in the guiding documents of the municipality are also found in the statements of the professionals interviewed, which enabled the construction of the care flowchart. The flowchart described shows how the work processes are structured in the PHC facilities investigated for the care and referral of situations of violence in relation to the notification.

The productive chain of this work process begins with the ellipse, which represents the entry of the situation of violence in the UBS; the rectangle informs the production of services; and diamond represents the peak, where a decision to notify is made. It is observed that there is no output from the productive chain in any of the analyzed contexts (flow of care and professionals' discourse), which would be represented by the ellipse at the end of the flowchart, since once the notification has been made, both children and

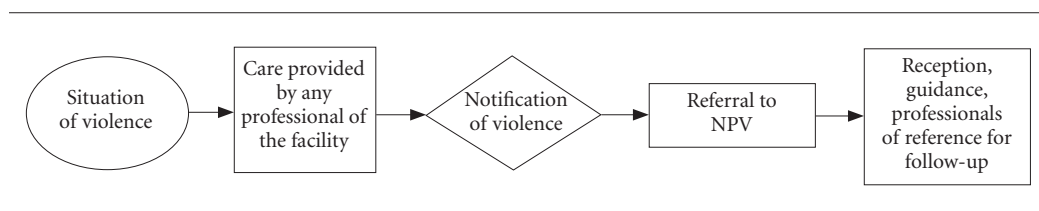


Figure 2. Synthesis flowchart of the Flow of Care to situations of violence, from guiding documents.

their families require a follow-up to tackle and prevent relapse. The flowchart of Figure 3 shows the flow of care identified from the respondents' statements:

The flowchart shown in Figure 3 depicts how professionals deal with situations of violence from the situations they serve. Therefore, they inform how the work process in which they are inserted is organized, with reference to existing normative and protocol guidelines. Of course, it can be inferred that there is a gap between the network recommended by institutional documents and the way in which services work in dealing with situations of child violence.

Discussion

The compulsory notification of situations of violence is established by normative and legal acts, such as the Statute of the Child and Adolescent²⁰, Law N° 10.778/2003²¹, which establishes the compulsory notification of violence against women; and Law N° 10.741/2003²², which establishes the Statute of the Elderly. As part of the surveillance actions of the Ministry of Health, with publication of Ordinance N° 104 of 25/01/2011²³, situations of violence were included only in 2011 in the list of illnesses and consequently were included in mandatory reporting. While Ordinance N° 104 was revoked by Ordinance N° 1.271 of 06/06/2014²⁴, compulsory notification was maintained.

Compulsory notification illnesses are those that must be reported to the local health authority. Notifications must be made by health professionals or those responsible for public or private healthcare establishments, in the event of

suspected or confirmed cases, which communication may be immediate or weekly. Situations of child violence are included in domestic violence and/or other violence and are considered as illnesses, as they represent damage to the physical or mental integrity of individuals, since they are caused by harmful circumstances, such as injuries resulting from interpersonal violence, assaults and abuse.

Situations related to the notification of child violence, as exposed by the professionals interviewed, are in line with the regulations set forth by Ordinance N° 1.271, dated 06/06/2014²⁴. Article 3 of this Ordinance establishes that *compulsory notification is mandatory for physicians, other health professionals or those responsible for public and private health services who provide care to the patient*. Thus, the professionals proceed to the notification, both individually and sharing the situation with another professional or group and through the health facility.

According to a report by the European Union Agency for Fundamental Rights²⁵, in most member states of the European Union, the notification of situations of violence is mandatory for professionals involved in activities involving children. In some countries, the lack of institutional notification protocols or documents setting out the responsibilities of professionals (such as Germany, Malta and the Netherlands) leads to underreporting of cases of violence against children, and reporting work lacks cooperation between the services. The report points out that most professionals fail to recognize, understand and comply with notifications due to difficulties in recognizing signs of child abuse and violence, pointing to a great need for training. In addition, in many Member States, anonymity of notifying

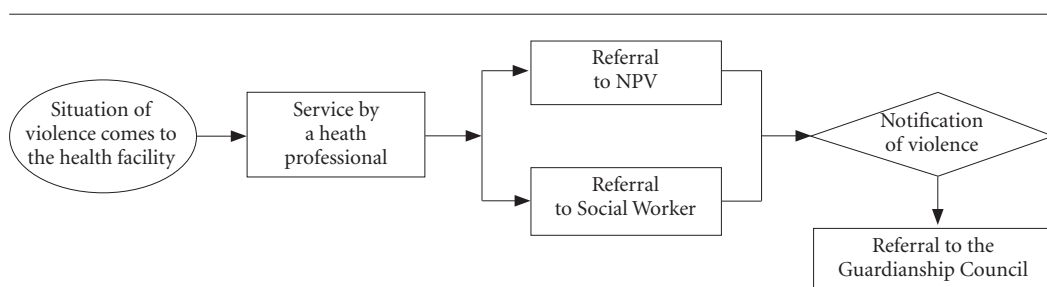


Figure 3. Flowchart-synthesis of care to situations of violence, from the interviewees.

practitioners is not always ensured, such as in Denmark, Greece and Lithuania, which can also discourage notification.

A Brazilian study evaluated a system of indicators of addressing violence and identified important shortcomings in the systematization of care records and cases monitored by guardianship councils and municipal health, education and social assistance secretariats. While they are registered in medical records, raw data prevent timely access to information²⁶. This indicates the poor quality of institutional records, due to an institutional culture of not recognizing records²⁶ and the need for professional training in care networks¹⁰. According to a systematic review study that aimed to evaluate the response of the health sector to child violence among Latin American and Caribbean countries²⁷, there is a clear gap between the established protocols and the way they are disseminated among health professionals and services, especially as regards the lack of training strategies for the implementation of its guidelines. In addition, there was a need to develop interdisciplinary work to strengthen child violence prevention and improve coping.

Care networks consist of three main elements: the population, the operational structure and the health care model. However, the main reason for its existence is the population. Thus, establishing population-based care processes evidences the ability of a system to identify the health needs of a given population to provide care in the context of its culture and preferences²⁸.

The concept of network refers to a set of services interconnected by common objectives and offering comprehensive and continuous care²⁸ through cooperation. Discourses analyzed both reveal the fragile performance of professionals in services and express the need to implement actions that foster the discussion about networking in an intersectoral perspective, pointing to the need to strengthen this network and train professionals to work in this perspective¹⁰. A qualitative study developed in the Netherlands that aimed to investigate how health professionals and nursery school teachers identify violence against children²⁹ pointed out that institutional regulations alone do not ensure sufficient support for the development of notification and prevention actions, and networking is necessary at both institutional level and where services are located.

Regarding the health model, it can be emphasized that concepts that support care, such as individual, family and violence determine how professionals recognize their need and face

vulnerabilities. Violence is still conceived by professionals as a private and family problem, and notification is perceived as a potential reason for family disruption, marital separation and child shelter³⁰. The blame lays upon the male aggressor, who is conceived as a subject devoid of feelings and values³⁰, and upon women, when violence is related to neglect of healthcare or education³¹.

According to the regulations analyzed, safety networks demand actions and intersectoral flows that can accommodate the demands, but also professionals qualified to deal with situations of child violence. In the field of health, whether at the federal, state or municipal level, according to respondents, the operationalization of guidelines to fight against violence bumps into what these establish, since the health network lacks care in quantity and organization, financial resources and people trained to deal with situations of violence. Training to work in cases of violence encompasses both aspects of flow and procedures and an expanded understanding of the phenomenon, including knowledge about gender, generation and diversified strategies of recognition and coping^{31,32}.

Within states and municipalities, there is great difficulty in securing implementation through the mobilization of power resources so that they can fight against political, institutional and bureaucratic resistance. The study points out that the way of overcoming unequal relationships that result in violence is in the promotion of policies that can coordinate different social sectors and that operate in the culture of subordination, promoting a transforming praxis³³. This study's limitation was its implementation in a single setting, since child violence notification actions have a national scope. Replicating the study into other realities may increase the visibility of hurdles to the necessary implementation of child violence reporting in health services.

Final considerations

Notification is one of the main steps in addressing child violence, since it triggers actions within the networks of care and protection, aimed at the promotion, relapse prevention and establishment of a care line for people in situation of violence. In addition, it enables the production of data for decision-making within local and national policies. While pointing out difficulties in reporting, professionals recognize their importance and the need for other professionals to understand

it. Notification is a necessary action and corresponds to an act of care, as it contributes to the definition of more adequate protection measures of health professionals and people in situations of violence and their families.

With regard to child violence, the greatest difficulty and at the same time greatest challenge is to build coordinated and systematized networks that prioritize preventive measures, since addressing situations of violence requires joint and effective articulation with different sectors and stakeholders in order to achieve the main objective, which is to prevent violence and

reduce harm. With regard to the flow of care to situations of violence in PHC, we understand that there is a need for greater appropriation of what has become the work of addressing issues in a network, with emphasis on individual and collective responsibilities. It is also worth mentioning that, while the National Network for the Prevention of Violence and Health Promotion³⁴ is part of the state's agenda, it still requires greater institutionalization, political support and implementation of sufficient financial resources to make violence prevention actions more effective, especially regarding violence against children.

Collaborations

EY Egry worked on the design of research, methodology, conclusions and final writing; MR Apostolico and TCP Morais worked on the research, worked on the design, methodology, conclusions and final writing.

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