Violence against children and adolescents: the perspective of Primary Health Care

Violência contra crianças e adolescentes: o olhar da Atenção Primária à Saúde

Violencia contra los niños y adolescentes: el punto de vista de la atención primaria de salud

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ABSTRACT

Objective: To analyze the care provided by Basic Health Units (BHU) to families involved in domestic intrafamily violence against children and adolescents. **Method:** Qualitative research, based on the Paradigm of Complexity. Data collection was performed with 41 professionals through focus groups and semi-structured interviews. **Results:** The following categories emerged from data analysis: 'Everything comes here', which reflects the legitimate place of BHUs for the population and the actions taken to build care for families; and 'We only do what is really necessary', which brings the look to violence still based on the positivist and biomedical paradigm. **Final considerations:** The model of understanding and construction of work processes in the BHU is structured in the aforementioned paradigm. Nurses have the possibility to become agents of change, both in professionals' training and in the care thought and provided to communities.
Descriptors: Domestic Violence; Child; Adolescent; Family; Primary Health Care.

RESUMO

Objetivo: Analisar o cuidado realizado por Unidades Básicas de Saúde (UBS) junto a famílias envolvidas na violência intrafamiliar contra crianças e adolescentes. **Método:** Pesquisa qualitativa, fundamentada no Paradigma da Complexidade. A coleta de dados foi realizada com 41 profissionais, por meio de grupos focais e entrevistas semiestruturadas. **Resultados:** Da análise dos dados, emergiram as seguintes categorias: "Tudo desemboca aqui", que reflete o lugar legitimado das UBSs para a população e as ações realizadas para construção do cuidado às famílias; e "A gente só faz o que é indispensável mesmo", que traz o olhar para a violência ainda pautado no paradigma positivista e biomédico. **Considerações finais:** O modelo de compreensão e construção dos processos de trabalho na UBS é estruturado no último paradigma citado. O enfermeiro tem a possibilidade de se colocar como um agente de mudanças, tanto na formação dos profissionais quanto no cuidado pensado e executado junto às comunidades.
Descritores: Violência Doméstica; Criança; Adolescente; Família; Atenção Primária à Saúde.

RESUMEN

Objetivo: Analizar la atención proporcionada por las Unidades Básicas de Salud (UBS) con las familias involucradas en la violencia doméstica intrafamiliar contra los niños y adolescentes. **Método:** Investigación cualitativa, basada en el paradigma de la complejidad. La recolección de datos se realizó con 41 profesionales a través de grupos focales y entrevistas semiestructuradas. **Resultados:** Las siguientes categorías surgieron del análisis de los datos: 'Todo termina aquí', lo que refleja el lugar legítimo de la UBS para la población y las medidas adoptadas para la construcción de la atención a las familias; y 'Sólo hacemos lo que sea realmente necesario', que trae el ojo a la violencia todavía gobernado en el paradigma positivista y biomédico. **Consideraciones finales:** El modelo de comprensión y construcción de los procesos de trabajo en la UBS se estructura en el paradigma previamente citado. Los enfermeros tienen la oportunidad de ser agentes de cambio en la formación de profesionales, y en la atención pensada y realizada en las comunidades.
Descriptores: Violencia Doméstica; Niños; Adolescente; Familia; Atención Primaria de Salud.

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INTRODUCTION

Primary Health Care (PHC) is called Basic Health Care (ABS - Atenção Básica à Saúde) in Brazil. It is the main proposal of the World Health Organization (WHO) health care model to improve health indicators. There have been great efforts in the Brazilian context for the care model reorientation from PHC, mainly with implementation of the Unified Health System (Brazilian SUS) and, more recently, the Family Health Strategy (FHS). PHC is the main gateway and communication center of the Health Care Network[1].

PHC develops through teamwork, democratic and participative management and care directed to populations in defined territories. It has complex and diversified care technologies to meet all the needs, health needs or suffering of the population. PHC is developed with the highest degree of capillarity and decentralization, close to people's lives[1].

Violence is among the demands met by PHC. It is understood here as the intentional use of physical force or power against another person, group or community that results or is highly likely to result in injury, death, psychological damage, developmental change or deprivation[2]. About 2.5% of the world mortality results from various types of violence, and thousands of people are daily victims of non-fatal violence. Violence is the fourth leading cause of death in the 15-44 age group[3]. In Brazil, children and adolescents are the main populations affected by this act[4]. According to WHO, violence against these actors includes physical, psychological, and sexual violence, neglect, and commercial or other form of exploitation in a context of responsibility, trust and/or power[4]. The main place of violence against this population is the space of home, and the main authors are family members[4]. The term 'intrafamily violence against children and adolescents' (VICCA – violência intrafamiliar contra crianças e adolescentes) will be used in this study following WHO recommendations.

The intervention with families involved in VICCA is still a challenge to the sectors of health, justice, human rights, among others. It is expected that PHC teams have privileged space to access and identify possible situations of VICCA. However, due to the phenomenon specificities, they live the dichotomy of breaking the present silence in these situations. Corroborating the assumption, the Ministry of Health proposes the integration of resources available in assistance in a network of care guided by PHC, according to the model of care line[4].

In the literature, one of the important characteristics of VICCA is the difficulty to identify and intervene in suspicious cases because of the complexity of circumstances and unpreparedness of professionals to deal with them[5-7]. The existing gaps in the scientific literature raise the following guiding question: What are the real actions taken by PHC regarding the care of families involved in VICCA?

The look at the care to families involved in VICCA from PHC health teams (that are closer to people's lives) with a theoretical framework allows the understanding and contextualization of actions developed by these teams and will make the experiences and challenges in this field more transparent.

The theoretical reference cited is the Paradigm of Complexity. It proposes the approach of what is 'woven together', implying the consideration of distinct and sometimes contradictory parts articulated in the phenomenon composition, and inserted in a context of dialogical perspective[8].

OBJECTIVE

The objective of the present study was to analyze the care performed by primary health care professionals with families involved in VICCA in a city in the interior of the state of São Paulo.

METHOD

Ethical aspects

The present study was approved on November 14, 2012, by the Research Ethics Committee of the School of Nursing of Ribeirão Preto, University of São Paulo, in compliance with the norms established by Resolution 466/2012 of the National Health Council of the Ministry of Health. Participants spontaneously agreed to participate in the study by signing the Informed Consent. The study was authorized by the Municipal Health Secretariat on 05/18/2012, and by the district and local coordinators of the basic health units (BHU) of the municipality.

Theoretical-methodological framework and type of study

A strategic social study of qualitative approach anchored by the Paradigm of Complexity in which the notions of understanding and contextualization guided the present theoretical-methodological path. The understanding seeks to apprehend the meaning of an object or event and its relations with other objects or events, constituting "clusters of relations, which in turn, intertwine, are articulated in webs and networks socially and individually constructed, in a permanent state of update". Contextualization consists of strategies to understand a certain phenomenon inserted in a context, and not isolated from it[9].

In addition to the aforementioned notions, were used the dialogic, recursive and hologramatic principles of the Paradigm of Complexity. The first requires the conjugation and association of contradictory factors in the analysis of a given phenomenon. The second concerns organizational recursion, referring to the image of the whirlpool, and emphasizing that in the "recursive process, products and effects are at the same time, causes and producers of what has produced them"[10]. The third seeks the hologram image in which each point contains almost the totality of information about the represented object, in a way that not only the part is in a whole, but in a certain way, the whole is inscribed in the part[8-10].

Methodological procedures

Scenario of the study

The study scenario was a municipality in the interior of the state of São Paulo with area of 796 km² and population of 1,144,862 inhabitants. It has 62 basic health units organized from family health teams, with approximately one BHU

per 20,000 inhabitants. Each unit has multiprofessional teams composed of doctors in basic specialties (clinicians, pediatricians, gynecologists and obstetricians), nurses, dentists, nursing assistants and dental practice assistants. Some BHUs have mental health support professionals (psychiatrists, psychologists, and occupational therapists).

Data source

The participants of this study were professionals from BHUs that were selected using the following inclusion criteria: (i) inclusion of a BHU from each health district according to the availability and authorization of the district and local coordination; (ii) consideration only of professionals working for at least an year in the BHU under study, and who performed actions with families involved in VICCA; (iii) consideration of such professionals in sufficient number to reach repetition and saturation of information. The 'saturation point' was related to the depth achieved in the objectives of this study, and comprehension and contextualization of the object of study. The five participating BHUs were defined according to the above criteria, and the district and local availability and organization of the BHU. Participating professionals were assigned by the local teams, with variation in number of participants and professional categories of each BHU, totaling 41 professionals.

Collection and organization of data

Data were collected through focus groups and semi-structured interviews by one of the study researchers. The selection process of the participating basic health units began on 14/01/2013 and involved meetings with leaders of the Health Districts of the studied municipality. After the definition based on availability and organization of the local team, data collection was performed in the period from 24/04/13 to 17/12/13. The participating BHUs were designated by numbers 1-5 according to the sequence of data collection to maintain confidentiality.

The focus groups were based on the following question: How is care provided to families involved in VICCA? In addition to this question, professionals were characterized regarding age; sex; professional nucleus; training; training time; working time at the BHU; presence or absence of content on violence in professional training; participation in courses on the issue of violence during working hours at the BHU. The focus group meetings lasted approximately 90 minutes and were held in a room with good acoustics and light, free of interruptions. As indicated in the literature, the groups had participation of a reporter, an observer and a moderator. Groups were identified as Gp1, Gp2, Gp3, Gp4 and Gp5 according to the sequence in which they were carried out.

After the focus group, the previously scheduled interviews were conducted with professionals, and the heterogeneity of the professional nuclei was considered for their selection. The script had two open and guiding questions that allowed a the participant's unique look on the object of study, namely: 1) In the face of a suspected or confirmed case of VICCA, how is the performance of the health team? 2) What actions are taken in response to these situations?

Interviews lasted approximately 20 minutes, were identified with the letter E, and numbered according to the sequence in which they were performed: E1, E2, E3, and so on. The professional category of the interviewed subjects was not highlighted, except in cases of specific information, in which the category differentiation would have implications for the analysis. Through procedural analysis of data, the researchers noticed data saturation after the tenth interview, and from that moment, they finalized the inclusion of actors in the study.

The recording of interviews and focus groups was authorized with guarantee of anonymity. The Easy Voicer program was used for recording in an MP5 device. Then, data was transferred to a computer and transcribed in full.

Data analysis

Data analysis comprised the following steps[9]: (a) classification and organization of collected information by carefully reading the material and identifying the main points of interviews and group debates, observing the pertinence and relevance for the object of study; (b) organization of reference boards with the main points of professionals' answers, so that researchers had a view of all information for its categorization; (c) establishment of relationships between data through organization in categories by grouping of elements, ideas and/or expressions in concepts that covered all these aspects.

RESULTS

Characterization of participants

The participants were 17 community health agents; four nursing assistants; four nurses; one occupational therapist; four pediatricians; two psychologists; one psychiatrist; two general clinicians; one oral health assistant; five residents in multiprofessional health. Six participants were male, and the rest were female. Most professionals were aged between 31 and 40 years, completed a technical or higher education course 1-5 years before, and have worked at the surveyed BHU for 1-5 years.

In the study group, 56% (n = 23) of professionals reported having received instructions and information about violence during academic training; 41.5% (n = 17) of professionals reported not having received this information; and a professional did not respond. This number was higher in BHUs of districts where professionals were younger and with less training time, which may indicate the recent incorporation of violence content into the curricula of undergraduate and vocational training courses. Approximately 51.2% (n = 21) of professionals reported having never participated in continuing education courses offered by the agency of the studied municipality with the objective to prepare them to deal with the problem of violence during working hours in the BHU. Among the 44% (n = 18) of professionals who reported having received training, the majority (25.7%, n = 5) were community health agents; the others (4.8%, n = 2) did not answer the question.

Next, the actions taken in situations of VICCA in the context of PHC are presented in two categories: 'Everything comes here'; and 'We only do what is really necessary'.

Category I: Everything comes here

The place of PHC as a center of care and reorganization of the health system was recognized by the population, and in a certain way, questioned by professionals:

The health center is right in the center, everyone ends up here ... (Gp 2)

(People) come here to ask for everything you can imagine, I guess it's the closest place because ... it's the only service available. (Gp 1)

Generally, the families involved in VICCA entered the BHU through the user embracement service or notifications from the Guardianship Council. Another form of access occurring less frequently was the perception of VICCA during pediatric visits and community health agents' visits to families. The community sees the BHU as a reference, and also goes there with demands related to VICCA.

Some professionals reported the identity of BHUs as ambivalent, since they act only with ready care service and do not perform actions to prevent injuries and promote health.

If I knew all my area, if I knew all the families ... If I could have more contact with them, maybe those cases of violence would appear more. But I don't! I work with the user embracement service there with people from my team, with people who are not from my team, I do adult consultations, but I do not know my population. (Gp 4)

The 'user embracement' mentioned in the speech above assumed the function of assisting acute complaints, and was usually performed by a nursing assistant and/or nurse. Thus, in practice, the place of 'user embracement' became a space for spontaneous entry of demands.

After the stages of identification and user embracement, professionals elaborated different care strategies with unique character including punctual home visits and individual consultations. Professionals' testimonies have revealed the positive meaning of team meetings and its identification as a legitimized and recognized space:

I think there's great potential in team communication, exchange of ideas, in this meeting we have, and today it's natural, the case appears, gets here and doesn't go to the psychologist first, it goes to the meeting first, and together we think of potentialities. (E 1)

The assistance to VICCA cases by mental health professionals was a dialogic issue in BHUs. The configuration of PHC teams of the municipality assumed these professionals would perform matrix-based strategies in family health teams. In some BHUs, the families involved in VICCA were under responsibility of mental health professionals because of the understanding that these were the only qualified professionals to assist them.

I think everything, even things that are not, everything from the Council comes directed to Mental Health, even matters

of vaccination, consultation, people do not bother to check what it means, you know? (Gp 1)

Because the first thing that messes up someone's life is their head, the psychological side ... So I guess this is directed at people who have a better understanding of what's inside people's minds, you know ... What can violence generate in the future, or instantly ... (Gp 4)

After analysis of the present study results, it was observed that some professionals did not understand the meaning of matrix-based strategies. This issue is closely related to the situation discussed below, about the professionals' difficulty in dealing with the phenomenon of violence. The identification, user embracement, co-responsibility, non-fragmentation between mind and body, and the whole line of care deriving from these actions before cases of violence, are still challenges.

Category II: We only do what is really necessary

The discussion on the place of domestic violence in health is pertinent, especially in the sphere of PHC given its direct implications in actions developed to deal with this problem. The following reports have shown the place of violence is still undefined and ambivalent for institutions, sectors and professionals.

They [other sector of child and adolescent protection] end up occupying the place of health instead of surveillance many times... (Gp 4)

In fact, we are not supposed to check this kind of situation directly [...]. In that case, we are the secondary service. It is not possible to be the mirror, the front teeth... (Gp 3)

But, let me say this, I try to get involved only in the health area itself, with the mother who is having difficulty breastfeeding, do you know what I mean? (E 10)

The reports of the present study showed professionals were not sensitized to perceive violence as a health problem, and did not understand the tackling of violence as an inherent, priority and/or indispensable activity in the organization of health care. These comments appear in the professionals' speeches:

We just assist! We have become a kind of production line that only does what is really indispensable, which is visit, something that there is no way... (Gp 5)

Professionals' testimonies revealed that their difficulties in dealing with families are in part, due to the lack of continuous training and practice. This point became evident in the speech of professionals who placed themselves closer to families involved in VICCA, the community health agents:

This matter of violence is difficult, also to characterize the existence of a situation of violence ... You know, apart from those with a black eye, which we have, but these are already on follow-up by the assistance, the council, the school. (Gp 5)

According to a nurse, the difficulty in handling situations involving violence exists since academic training. As observed in the characterization of subjects, 41.5% of the professionals did not receive specific information about violence during their academic training, and 51.2% of professionals did not participate in courses or other training activities on violence during their work time.

Another difficulty for the professionals' understanding of the care of VICCA was the thinking and consequent acting on/for this phenomenon. These professionals were based on the model learned since their infantile formation marked by the biomedical and positivist logic, and centered in the understanding of the cause and effect relation:

> Having a better flow to follow. Because at the moment ... it's like a work accident, we have a flow, do this, do that ... (E 3)

> You want to do an x-ray, you call someone, argue, send the patient here I'll provide assistance, a dermatologist... come around I'll see the patient ... There, you have an answer, with violence is that thing ... it drags on and on. (Gp 5)

This logic has also guided the care to such families that has sought to control and cure certain situations with the fragmentation of interventions, without considering the protagonism and autonomy of people.

> When someone decides to do something, it's done in a very crude way, we've seen it. Because you serve your anxiety and not the specifics of that child, that teenager. Then you send him/her for assistance at UNICAMP [Universidade Estadual de Campinas], send him/her for children's CAPS [Psychosocial Care Center], put the mother in some health center group, and then you take a breath and say "oh, I did my best". You did your best to yourself, without thinking of the user [...] because it serves you. (Gp 4)

DISCUSSION

PHC is organized as a communication center of Health Care Networks, and mediates actions directed at population care in a complex and multidimensional system[1,11]. The difficulties to understand the protagonist role of PHC involve multiple dimensions: political, cultural and technical. The hegemony of fragmented systems of health care ends up directing some health systems to assist acute conditions and acute events associated with chronic diseases. This fact enhances the cultural perception of devaluation of PHC functions, and of actions for health promotion and disease prevention[1].

In this context, user embracement emerges as one of the main technologies offered to the population in PHC, has a distorted understanding, and sometimes becomes a barrier to access[12]. In its essence, user embracement is not a space or place, but an ethical position that does not presuppose specific hours or professionals to be performed[1].

User embracement is the main strategy to get to know the families, establish bonds and be responsible for them, which are essential actions in PHC. User embracement in cases of families involved in VICCA situations is key to humanize and qualify care, and guarantee the continuity of these families' course along the care line. This first contact can be definitive to establish bonding with the family[11]. A recent study showed the monitoring of premature babies in PHC by physiotherapists has brought greater support and confidence to parents for the daily care of children[13]. Professional's sensitivity to perceive situations of intrafamily violence is relevant because in most cases, such situations are veiled and 'masked' by other complaints[14-15].

Team meetings appeared as important mechanisms to elaborate care for families involved in VICCA. The core and autonomy of professionals are not enough for the provision of care to these families. Therefore, the limits of competences must be flexible, provide actions in the field and interdependence among the autonomies[15-16]. Transdisciplinarity is still a challenge for health practices, and in other sectors, it seeks the reconnection of knowledge and the transit from the part to the whole, from the individual to the collective without extinguishing or disregarding the nuclear knowledge and, at the same time, without a reductionist view of reality[17].

Dialogically, some statements referred to the responsibility of psychologists, occupational therapists and psychiatrists, called mental health professionals, for the care of families involved in VICCA. As previously mentioned, the studied municipality has broader family health teams, usually with these professionals in a work logic guided by matrix-based strategies. The aim of this action is to ensure the specialized back-up for the teams and professionals responsible for the care of health problems. Matrix-based strategies are an organizational arrangement occurring through a specialized technical support offered to a team to broaden and qualify their field of action[18]. There is an intimate relationship between the lack of understanding violence as a health problem, and the consequent lack of prioritization and referral of care to this problem to 'mental health professionals'.

The contemporary historical moment is marked as a period of paradigmatic transition, with the challenge of an increasing complexity of human, social and natural phenomena and demands. Profound, new and constant transformations of traditional forms of investigation and analysis of the reality are necessary, as well as interventions in its various areas of knowledge. Since the twentieth century, new paradigms have brought the overcoming of fragmentation of thought and actions, with dissemination of an integrating and multidimensional view of men and their environment[19-20]. There is resistance to these changes, since traditions and habits are rooted in culture and the different forms of individual and social organization. In violence, especially VICCA, and in the elaboration of care to these families, professionals still exercise the thinking that includes the distinction, objective, analysis and selection, with focus on biological aspects[10,21].

The understanding and care elaborated for VICCA are grounded in the positivist paradigm. The concreteness, determination and order of actions (flows, radiographs), is not a response to the current individual and social demands[12]. In this sense, there are remnants of the know-how based on

the traditional paradigm. The notion and desire for order originated in the deterministic and mechanical conception of the world that perceived disorder as a result of the lack of knowledge of the mechanisms governing the world, and proposed the disjunction between philosophy/science in a reductive way. As a consequence, there was fragmentation of knowledge in compartmentalized and disciplinary fields that ignore the global view of knowledge. To study a phenomenon or solve a problem within Cartesian rationalism, it should be isolated in its temporal dimension and decomposed into simple elements that could be explained and verified by linear cause-effect relationships. This logic originated a simplifying reduction of the vision of the whole and the parts composing it, as if the whole could be merely the sum of the parts[10,22].

Complex thinking is not destroying other constructions of knowledge, or abandoning logic, but a dialogical combination in its use where applicable, and its transgression where it starts to not be applicable[8,10]. Moreover, complex thinking seeks to overcome the separation of knowledge from its object. In the present study, it was evident that some health professionals did not consider certain phenomena - for example, mental disorders and violence - as belonging to the health area or corresponding to the necessary visibility, corroborating the literature of the area[15,23].

Human beings are the reason and existence of care demands. Care is the 'wrapping of life', necessary and demanded to reach the goal of living well. Health emerges from the complex constituted by the individual, society and environment. Therefore, it is a totality that allows the knowledge of components of this relation when it is analyzed, but without reaching full intelligibility. Health and illness are similar dialogic dynamics although antagonistic, because they always refer to different relations of individuals in interactions with themselves or the environment[20,24]. Violence can be understood as a phenomenon to be envisioned by the health sector, with respect to its inherent multidimensionality.

The proposal of the Family Health Strategy (FHS) is closely related with the Paradigm of Complexity, the broader approach to health care, the autonomy of human beings, the territory, contexts of intervention, and the social determinants present in this contexts. However, the training of professionals working in the FHS leads to the perception of an idealized FHS and a real FHS[25]. A debate about how the training of doctors, nurses and dentists was adequate to the broader health vision of SUS/FHS showed the professionals' training was based on a fragmented and disciplinary view, they have not 'apprehended' how to articulate with other professions and did not understand the life 'lived' by the population[25]. The analysis of the PHC nurses' approach to cases of violence against children and adolescents revealed that the nursing habitus is still strongly anchored to the biomedical model, with the structuring of its know-how through these components. The approach of situations not understood from this perspective has been neglected[6]. In addition, a study conducted in the Australian countryside demonstrated the need to train general practitioners and non-specialists to make access to PHC equitable[26].

Limitations of the study

The main limitations of the study were related to the difficulty of contextualizing the factors in PHC that can make the elaboration of VICCA care difficult in the political and technical dimensions, since the literature on indicators and managerial aspects at this level of care is still scarce. In addition, during the data collection period there was a dengue epidemic in the studied municipality, making professionals' participation in focus groups difficult because of work overload.

Contributions to the area of nursing, health or public policy

Nurses assume an essential place in this debate, because the care of individuals, families and collectivities is the object and objective of their work. It brings the possibility of becoming an agent of change, both in the training of professionals - in the academic environment or the professional activity field, because they generally assume managerial functions - as in the care thought and provided to communities, assuming a more active position and in line with the new challenges of health practices and the population's needs.

FINAL CONSIDERATIONS

The present study met the proposed goal and reinforced the role of PHC, legitimized and validated by the population as the center and guidance of care. However, for several factors, professionals presented the care for violence as dispensable and not belonging to the health area. Placing this care in secondary place, they defended themselves from handling situations of violence and the consequent suffering resulting from them through reductionist and fragmentary mechanisms of care. Academic training of the diverse nuclei of knowledge is still based on biomedical models and centered on curativism.

Thus, is reinforced the assumption that although PHC has the necessary technologies for the elaboration of care for VICCA, this is still a challenge, especially for the understanding and consequent structuring of the work process in reductionist and fragmented models. In this context, there is no place for the construction of care for aggravations in the perspective of Complex Thought, considering the multidimensionality of the current phenomena in health work. The strengthening of interdisciplinary teamwork, and the understanding of the dialogic 'autonomy-dependence' as inherent to the teams' performance were placed as the strategy to overcome the reductionist logic.

The present study brings important contributions to the area of public health and nursing, indicating new looks and ways for the care of families involved in VICCA. There is need for further studies on the care for VICCA from the perspective of families, and communities and the service network for this population.

FUNDING

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