Revista Brasileira de Enfermagem
REBEn

SUPPLEMENTARY EDITION 2
PROTECTION MEASURES FOR VULNERABLE POPULATIONS

ORIGINAL ARTICLE

Violence against children and adolescents: nurse's actions in primary health care

Violência contra criança e adolescente: atuação do enfermeiro na atenção primária à saúde

Violencia contra el niño y el adolescente: actuación del enfermero en la atención primaria de salud

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How to cite this article:
Marcolino EC, Santos RC, Clementino FS, Souto RQ, Silva GWS, Miranda FAN. Violence against children and adolescents: nurse's actions in primary health care. Rev Bras Enferm. 2022;75(Suppl 2):e20210579. https://doi.org/10.1590/0034-7167-2021-0579

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Submission: 10-13-2021 **Approval:** 10-28-2021

ABSTRACT

Objectives: to analyze the role of nurses in suspected or confirmed cases of violence against children and adolescents in Primary Health Care. **Methods:** an analytical research, with a qualitative approach. Thirty nurses participated in the study, and data were collected by means of an individual form and a semi-structured interview. The data received lexicographic analysis by the software IRaMuTeQ (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*) organized by Bardin's content analysis. **Results:** five categories emerged, in which it was possible to consider that the nurses' approach in cases of violence was based on the identification of violence through physical examination during nursing consultations, health promotion actions in the school environment, request for support from the multi-professional team, and transfer of responsibilities. **Final Considerations:** it is inferred that the fragility in the professional training of nurses to address situations of violence against children and adolescents produces deficits in comprehensive care for victims. **Descriptors:** Violence; Child; Adolescent; Primary Health Care; Nursing.

RESUMO

Objetivos: analisar a atuação dos enfermeiros em casos suspeitos ou confirmados de violência contra crianças e adolescentes na Atenção Primária à Saúde. **Métodos:** pesquisa analítica, com abordagem qualitativa. Participaram do estudo 30 enfermeiros, sendo coletados os dados por meio de formulário individual e entrevista semiestruturada. Os dados receberam análise lexicográfica do *software* IRaMuTeQ (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*) organizada pela análise de conteúdo de Bardin. **Resultados:** emergiram cinco categorias, nas quais foi possível considerar que a abordagem dos enfermeiros em casos de violência se pautou na identificação da violência pelo exame físico nas consultas de enfermagem, ações de promoção da saúde no ambiente escolar, requisição de suporte da equipe multiprofissional e transferência de responsabilidades. **Considerações Finais:** infere-se que a fragilidade na formação profissional do enfermeiro para abordagem de situações de violência contra crianças e adolescentes produz déficits de atenção integral às vítimas.
Descritores: Violência; Criança; Adolescente; Atenção Primária à Saúde; Enfermagem.

RESUMEN

Objetivos: analizar actuación de enfermeros en casos sospechosos o confirmados de violencia contra niños y adolescentes en la Atención Primaria de Salud. **Métodos:** investigación analítica, con abordaje cualitativo. Participaron del estudio 30 enfermeros, siendo recolectados los datos por medio de formulario individual y entrevista semiestructurada. Los datos recibieron análisis lexicográfico del *software* IraMuTeQ (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*) organizado por el análisis de contenido de Bardin. **Resultados:** emergieron cinco categorías, en las cuales fue posible considerar que el abordaje de los enfermeros en casos de violencia se pautó en la identificación de la violencia por el examen físico en las consultas de enfermería, acciones de promoción de la salud en el ambiente escolar, requisición de soporte de la equipe multiprofesional y transferencia de responsabilidades. **Consideraciones Finales:** se infiere que la fragilidad en la formación profesional del enfermero para abordaje de situaciones de violencia contra niños y adolescentes produce déficits de atención integral a las víctimas.
Descriptores: Violencia; Niño; Adolescente; Atención Primaria de Salud; Enfermería.

ONLINE VERSION ISSN: 1984-0446

INTRODUCTION

Violence against children and adolescents is a problem of global magnitude that affects nations of different cultures, socioeconomic levels, and social organization[1]. Moreover, it violates the basic human rights of millions of individuals in the childhood and adolescence phase with direct short and long-term impact on the dimensions of physical, psychosocial, mental and physical health[2], including negative effects on cognitive and behavioral development, well-being, quality of life and dignity of these subjects[3].

Due to the predominantly family and household nature of child abuse, this phenomenon is present in community settings, becoming an important health demand for Primary Health Care (PHC) services, since one of the basic roles of these services is to maintain and produce the health of individuals in community spaces. Such action requires from nurses skills for early identification and confrontation of these situations of child abuse and neglect[4-7].

The World Health Organization (WHO) conceptualizes "violence" as "the intentional use of physical force or power, actual or threatened, against oneself, another person, or against a group or community, that results in or has a high likelihood of resulting in injury, death, psychological harm, developmental disability or deprivation"[8]. Regarding children and adolescents, there are also acts of omission produced by parents, relatives, guardians, institutions, and society itself. Thus, violence against children and adolescents includes all situations that violate the guaranteed rights of these individuals to health and life[9].

In a WHO study, children around the world reported that they had suffered some form of violence in the year prior to the investigation, such as: physical abuse (23%), emotional abuse (36%), physical neglect (16%), sexual abuse (18% for girls and 8% for boys). It is noteworthy that countries with higher poverty levels have higher prevalence of physical violence against children and adolescents (Haiti: 61%; 57%; Nigeria: 50%; 52%; Kenya: 66%; 73%)[10].

The most common perpetrators of violence against children and adolescents are family members (more than 50% of cases), followed by fellow students. When it comes to sexual violence against adolescents, girls are the most affected[11].

The "Line of Care for the Comprehensive Health Care of Children, Adolescents and their Families in Situations of Violence" is a milestone in the fight against violence against children and adolescents. In this sense, it requires the accountability and the involvement of professional nurses in a chain of care production and social protection through the integration of all available resources capable of ensuring safe access to technologies needed for care, contemplating the following dimensions: health promotion, welcoming, care, notification, and follow-up[12].

This line aims to guide health professionals in the face of this problem in Brazil, however, the performance focused on children and adolescent victims of violence in health services still presents many challenges for the health team, including nurses, such as proper identification, notification and referral of suspected and/or confirmed cases of violence against children and adolescents[13-14].

The difficulty of identification may be related to the environment where the violence occurs. For example, a literature review characterized the violence against children in the Brazilian scenario and identified that the aggressor is always a family member, especially the parents, especially the mother[15]; this context is also found in a large study of schoolchildren in Germany, which found that physical violence was positively related to parent-to-child physical aggression and that family cohesion attenuated the harmful effect of violence[16]. Thus, it is evident the difficulty of intervening in the families as a barrier to care in this context[17]. Therefore, the professional nurse[12,18] has a relevant role in the chain of care for children and adolescents when identifying the suspicion or confirmation of a situation of violence, especially in the context of Primary Health Care, which surrounds families.

PHC is the locus of greatest potentiality for confronting violence against children, since it enables the construction of coordinated and systematized networks for preventive measures, harm reduction and priority care flows[19]. Seeking to understand the role of nurses in addressing violence against children in PHC subsidizes the identification of the network confrontation and individual and collective responsibilities. This is because such understanding can ratify the qualification to identify situations of abuse early, promoting a link with the network of assistance to victims in order to give continuity and follow-up to the case and offer an adequate care program[20].

Considering the potential that PHC has to develop the dimensions of the line of care for children and adolescents and their families in situations of violence, the following question is posed: How does the nurse act in suspected or confirmed cases of violence against children and adolescents in Primary Health Care?

OBJECTIVES

To analyze the performance of nurses in suspected or confirmed cases of violence against children and adolescents in Primary Health Care.

METHODS

Ethical Aspects

The study met all the ethical assumptions of resolution 466/2012, which governs the execution of research with human beings. It was initiated after approval by the Ethics Committee of the Federal University of Rio Grande do Norte.

Theoretical framework

The study was based on the document proposed by the Ministry of Health, "Line of Care for the Comprehensive Health Care of Children, Adolescents and their Families in Situations of Violence", which recommends the articulation of health care among five dimensions[12]:

The promotion of health and the culture of peace must encompass collective actions from health services, educational institutions, associations, groups, community and youth leaders[12].

The reception consists of the element of competent and effective listening that becomes a channel to access the experiences of violence[21].

The assistance should not be a solitary act by the nurse: on the contrary, it needs to be a multi-professional and shared action, in order to maintain a plan of care for the victim to avoid re-victimization[12].

Notification should be carried out among confirmed or suspected cases of violence, being perceived as an instrument of protection, rather than of denunciation and punishment[22-23].

The last dimension of care is the follow-up, which is characterized by the monitoring of the case in the Health Care Network; for this, it is necessary to have a structured service network with an internal flow of care, referrals, guaranteed returns, evaluation and re-evaluation of results[12].

Type of study

It is characterized by an analytical research, with a qualitative approach based on the Standards for Reporting Qualitative Research (SRQR) guideline, composed of 21 items that direct clear and essential standards to compose qualitative research.

Methodological Procedures

The research took place between January and March 2018, in Basic Health Units (BHU). Initially, the general management of PHC in the municipality was contacted to enable contact with the nurses of the Family Health Teams (FHT). After accepting to participate in the research, the data collection took place in the BHU, in a face-to-face conversation, by signing the Free and Informed Consent Term and the Voice Recording Form.

Study scenario

The research was developed in a municipality in the interior of the Northeast Region of Brazil, focusing on PHC health services. The health care territory at this level of care in the period of data collection was organized into six Sanitary Districts (SD) delimited to produce the planning and local organization of health services. In these districts, there were 84 UBSs, which is the privileged space for health care in PHC, and 107 multi-professional FHTs installed in the BHUs.

Data source

The study population consisted of all nurses who worked in the FHTs of the six SDs. The inclusion criterion was adopted: being a nurse working in PHC for at least one year, since the bond between nurses and the community, built over time of interaction with the subjects of the territory, directly influence the mechanisms for addressing situations of violence. Those who were on leave or on medical certificate and those who showed impediments to availability for data collection were excluded, and the exclusion occurred after three unsuccessful contact attempts.

The sample was intentional and stratified by convenience, consisting of 30 nurses from the FHTs, distributed in the six SDs in order to ensure territorial representation of the municipality. All the nurses who met the inclusion criteria agreed to participate in the study. Moreover, the sample size was defined during the development of the research itself according to the criteria of theoretical saturation[24].

Collecting and organizing data

The nurses were previously contacted by telephone to schedule the interviews so as not to interfere in the work process of each FHT. Two instruments were used for the collection: a form to characterize the research subjects; and a semi-structured interview among the five dimensions of the Line of Care for Comprehensive Health Care of Children, Adolescents and their Families in Situations of Violence[12]. All interviews were fully recorded with the aid of an MP3 audio recorder and transcribed to build the text corpus.

Data Analysis

The analytical treatment was done by the software IRaMuTeQ (Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires). Among the possibilities of textual analysis, we chose the Descending Hierarchical Classification (DHC) [25], proposed by Reinert[26]. It classifies text segments according to their own vocabularies; the set of them is subdivided based on the frequency of forms. Operationally, classes are obtained from the occurrence and co-occurrence of a vocabulary similar to each other, generating the chi-square of the terms and classes by mathematical and statistical processes[25].

The elements included in their respective classes were those with a frequency greater than twice the average of occurrences in the corpus and an association with the class determined by a χ^2 value equal to or greater than 3.84, considering that the calculation is defined according to degree of freedom 1 and confidence interval of 95%[27]. Subsequently, content analysis was performed[28] in the categorical formulation; and the steps of pre-analysis, material exploration and treatment of results, inference and interpretation were respected. Thus, five thematic categories emerged.

RESULTS

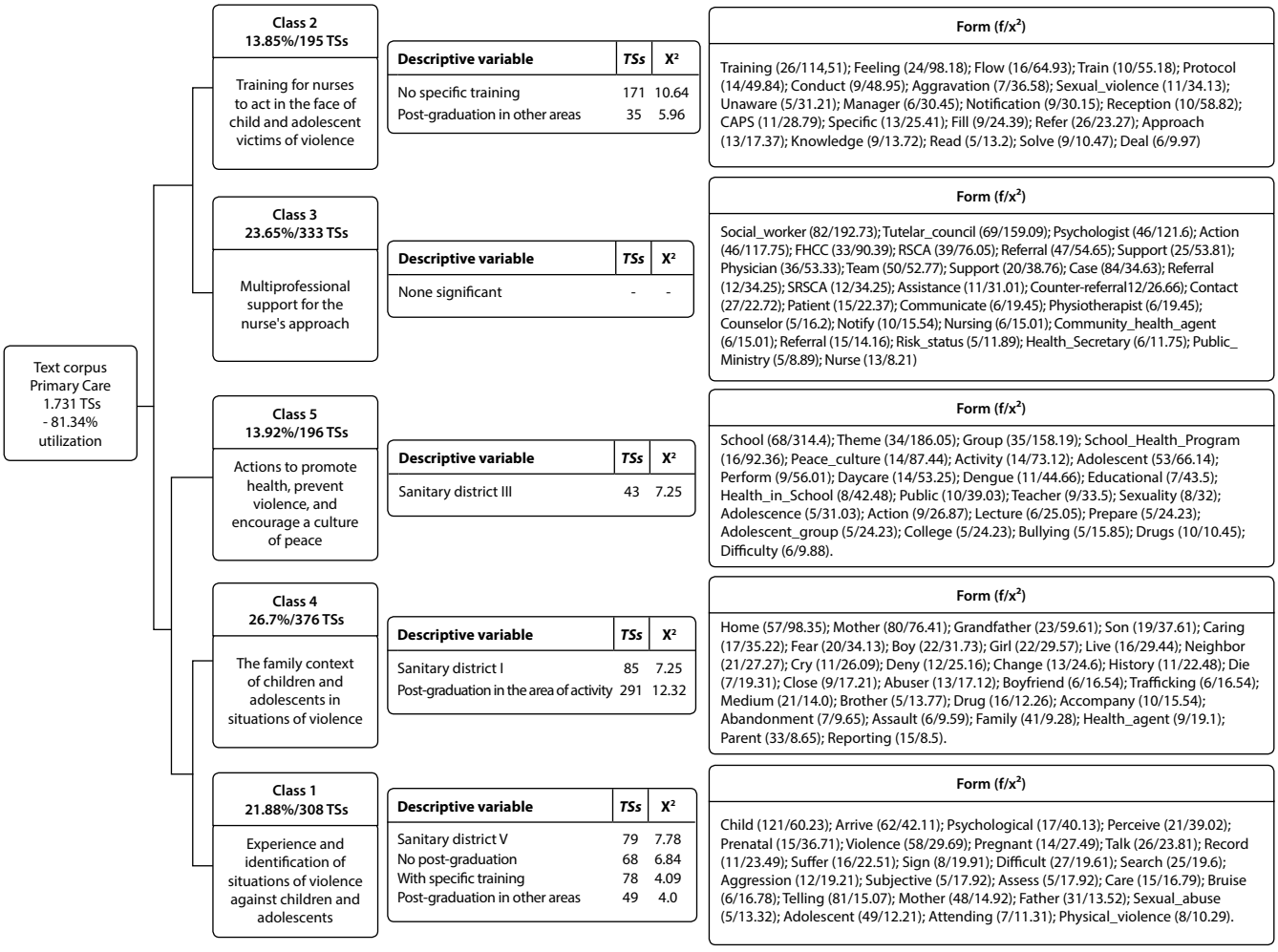
Of the 30 PHC nurses who participated in the study, most are female (27; 90%), over 40 years of age (12; 40%), more than ten years after graduation (19; 63.4%), and have worked in PHC for five to ten years (10; 33.3%). Regarding the specific training of nurses to approach children and adolescents in situations of violence, most said they had not done it (24; 80%). However, half of the nurses (15; 50%) mentioned hearing about the theme in other training processes, such as: training/improvement (8; 26.7%); graduate (3; 10%); undergraduate (2; 6.7%); congress (1; 3.3%); moments with non-governmental organizations (1; 3.3%).

The corpus processing denoted 59,545 occurrences of words, presented in 2,666 distinct forms, with an average frequency of 2.23 words for each form, this being the criterion used as a cut-off point for the inclusion of the elements in the dendrogram (double the average frequency, therefore, 4.6). To perform the

lexical analysis of the texts, the software analyzes them based on cuts made every 40 characters, corresponding, therefore, to 1,408 (81.34%) of 1,731 text segments analyzed. Therefore, it was considered satisfactory the performance in retention.

The lexographic analysis of the text corpus by the DHC is detailed in Figure 1, a diagram that demonstrates the dendrogram produced by the IRaMuTeQ analysis. As observed, Axis 1 includes Classes 1, 4 and 5 and is related to the dimensions "Reception", "Care" and "Health promotion" of the Line of Care, focusing on the nurse's approach to the biopsychosocial aspects of violence against children and adolescents. Axis 2 includes Classes 3 and 2, referring to the dimensions "Follow-up" and "Notification" (see also Chart 1).

Based on the text classes and segments evidenced by the DHC, thematic categories were built, supported by Bardin's content analysis[28], presented as follows:



TS - number of text segments; f - number of text segments containing the word in the class; χ^2 - chi-square of association of the word with the class.

Figure 1 – Diagram of the classes in the dendrogram of the text corpus referring to the interviews with nurses working in Primary Health Care, Campina Grande, Paraíba, Brazil

Chart 1 – Demonstration of the classes of the Primary Care text corpus (percentage, text segment, chi-square interval, composition terms) and the respective dimensions of the Comprehensive Care Line for Children and Adolescents in Situations of Violence

C	P	Interval of χ^2	Dimensions of the Line of Care
1	21.88% (*f* = 308 TSs)	χ^2 = 60.23 (Child) and χ^2 = 10.29 (Physical violence)	Reception; Attendance
4	26.7% (f = 376 TSs)	χ^2 = 98.35 (Home) and χ^2 = 4.92 (Mistreatment)	Attending
5	13.92% (f =196 TSs)	χ^2 = 314.4 (School) and χ^2 = 6.55 (Education)	Health Promotion
3	23.65% (f = 333 TSs)	χ^2 = 192.73 (Social worker) and x^2 = 8.21 (Nurse)	Attending; Follow-up
2	13.85% (f = 195 TSs)	χ^2 = 114.51 (Training) and χ^2 = 8.96 (Insecure)	Attending; Notification; Follow-up

C - class; P - percentage of representativeness of the class in the total corpus; TS - text segment; χ^2 - chi-square.

Category I - Experience and identification by nurses of situations of violence against children and adolescents

The content related to this category emerged from Class 1, which refers to the experiences of nurses in Primary Care when facing situations of violence against children and adolescents in the community where they work. These professionals perceived, identified, welcomed and assisted these situations, revealing their abilities and difficulties in their field of action, aspects that refer to the dimensions of welcoming and care. It was verified, in the interviewees' statements, that the welcoming of the victims is driven by the self-perception about the violence, since the users do not make explicit the violence suffered. Therefore, qualified listening is pointed out as a fundamental strategy for the identification, understanding, and direction of the situation, and subjective tools are needed for such action, as can be seen in the following excerpts:

> *So, it is different because, when it comes, when we know of a child that suffers a psychological trauma, right? So we approach it differently. Even because, when it comes with the mother, generally they don't accept it. They think* [...] *for them it is not, right?* (Nurs. 11)

> *I listen because* [...] *well* [...] *not always, or most of the time, no one will sit there and say what is going on, that the child suffers violence, this is easy to identify when you know the family; most of the time, we have to understand, I have to do the physical exam.* (Nurs. 3)

About the act of recognizing situations of violence in the family environment, the nurses surveyed reported that it is possible to perceive the violence implicit in family relationships and that the nursing consultation through physical examination can be decisive in identifying:

> *When there is a question of an injury to the child, investigate, ask the mother: "Mom, what was that? What happened? Did that child fall or not?" Sometimes I get to the child first rather than the mother to see what she will say.* (Nurs. 01)

> *He looks at his mother and it was his mother answering "No, I'm fine" and looking at his mother. Do you understand? So, then, we realize that the child is really different. Even in the childcare center itself, in order for us to notice some* [...] *I ask them to take off all their clothes. I turn the child upside down, as the popular saying goes.* (Nurs. 08)

Category II - The family context and violence against children and adolescents

Category II emerged from Class 4, which refers to the dimension of care. Some statements included the importance of producing a comprehensive care that involves the family, because the social and family context of these children and adolescents goes through weaknesses that enhance the occurrence of situations of violence, such as: unwelcoming family environment, use of licit and illicit drugs, and psychiatric problems. This scenario can be visualized in the following excerpts:

> *She stays here, then suddenly she is in Lagoa Seca, suddenly she is in José Pinheiro. And this mother, she has eight children. And she, we know that she uses drugs, right? She prostitutes herself and she leaves these children abandoned in the house.* (Nurs. 11)

> *We have a situation here in the area where a father is the provider of a huge family, because he has several children, and these children have several grandchildren, everybody lives in this house. So the father, who is a grandfather, has become the father of everyone. And he is an alcoholic, he also has mental illness and he is very aggressive* [...] *a big part of them uses drugs, and another part uses psychotropic drugs. So it is a very problematic house. And we have already tried to intervene, but the mother herself doesn't want to denounce her husband.* (Nurs. 16)

As for the family in which the aggressors and victims are found, the nurses themselves mentioned the need for a broad view of the whole family, instead of restricting the approach to the victim and the aggressor, highlighting the responsibility of the FHT nurse for a comprehensive approach to the victim:

> *He suffered a violence, yeah. A rape when he was a child. And so, he suffered the rape and he continued to suffer psychological violence from his own stepfather. Because until then I didn't know, and his mother told him that she didn't want him wearing women's clothes, that she didn't want him at home, that it was difficult for him to live at home like that. And this boy* [...] *suffered no, I think he still suffers psychological violence.* (Nurs. 11)

> *The mother came here saying that she had left this baby with the father's family, that they were separated. And this father had taken her to a brother's house. And she said that the people there were very messy, drunk that day, and the baby's brother noticed that her diaper was a little messed up*. (Nurs. 15)

Category III - Actions by nurses to promote health, prevent violence and encourage a culture of peace

The third category emerged from Class 5, related to the dimension Health promotion, which is one of the premises of PHC as the first level of complexity of health care and responsible for minimizing health problems in the communities through health education focused on health promotion and disease prevention.

The nurses' reports revealed that educational activities are predominantly carried out in schools. Some of these activities are specifically focused on the culture of peace and violence prevention:

> *Last year, we did an educational activity in the school, in the schools, in relation to the culture of peace, where the child was approached there together with the parents of the students. The approached theme was this, violence, culture of peace, and one of the themes was in relation to children.* (Nurs. 20)

> *We did the last one on the culture of peace, which involves in general. But for the little children.* (Nurs. 13)

On the other hand, other nurses mentioned that they had never carried out educational activities focused on the culture of peace or violence prevention. They claimed as a justification the adolescents' greater interest in approaching sexually transmitted infections (STIs) and other topics, to the detriment of violence.

Therefore, educational activities based on these themes were carried out as a priority:

> *More part of the adolescents, they seek to know more, even about sexually transmitted diseases. We take vaccines, dengue fever. But about violence and bullying it was not traced, no.* (Nurs. 26)

> *We, the culture of peace, have not yet done it. Our team hasn't done it yet. We did about Aedes aegypti and about updating the vaccine card.* (Nurs. 29)

Category IV – Multi-professional team and services of the network of attention to children and adolescents victims of violence as support for the approach of nurses

This category came from Class 3, which refers to care and follow-up. The interviewees call attention to the importance of the multi-professional team, emphasizing the need for support in other organs of the Health Care Network, such as the Guardianship Council, Reference Center for Social Assistance (RCSA), Specialized Reference Center for Social Assistance (SRCSA):

> *It has to involve the whole team. FHCC's too, since there is a psychologist from FHCC. And the social worker, she can also be in contact with RCSA, with the Guardianship Council. She would be giving this support.* (Nurs. 26)

> *A multi-professional team that is with me, that gives me this support, that we work in partnership, together. As I told you, with the team doctor, with the social worker, with the psychologist, that is, with the network of professionals that give us support. This in the first place, that is, the support of the team.* (Nurs. 20)

Besides the multi-professional support, the nurses demonstrated that they resorted, above all, to social workers and psychologists to approach and conduct the situations of violence, according to the specific area of knowledge of these professionals, considering them as competent for the resolution of the case and promptly calling on them:

> *As we also have a social worker here, I always call on her to approach this type of case.* (Nurs. 17; DS 05)

> *So, if I arrive, if I receive this case, I have to pass it on to the social worker, and she takes the other steps, which, in this case, is to communicate it to the guardianship council and then follow up with her.* (Nurs. 01; DS 03)

Category V - Training and performance of nurses facing children and adolescent victims of violence

This category emerged from Class 2, regarding the deficit in the process of training and capacity building to address children and adolescents in situations of violence, as well as the absence of support mechanisms for action, namely: flowcharts, protocols and institutional guidelines. Therefore, the approach to these situations is based on referrals, often due to the insecurity of these professionals.

The focus of this category refers to the training and the ways of approaching reality, relating to the dimensions of care, notification, and follow-up. Thus, professional training directly influences these dimensions of service.

> *I have nothing in relation to this, no training of any kind in relation to this. I don't feel* [...] *like* [...] *prepared to attend, no. If it happens, we will attend, of course, right? Trying to give the best support possible. But to say that we are one hundred percent prepared* [...]. (Nurs. 06)

> *I wouldn't feel able to. Not at all. Nor how to conduct the case* [...] *like this* [...] *at the moment. Nor how to make the proper referrals. Where should I send it? To the IML? Where do we send them? We don't have that, understand? So I wouldn't feel capable in any aspect. Neither for my own psychological, nor how would I deal with this mother, with this family, nor where would I refer this child.* (Nurs. 10)

DISCUSSION

The content analysis of the speeches of PHC nurses allowed the connection of the classes that emerged from the text corpus with the dimensions of the Line of Care for the Comprehensive Health Care of Children, Adolescents and their Families in Situations of Violence[12]. This proposes the integration of resources and services for the care of children and adolescents in situations of violence, through a network of intersectoral care guided by Primary Care[29].

In the first category, the embracement emerged as a stage in which the nurse is a key element at the time of welcoming and listening to demands of violence, since the presence of this professional in the process of caring for victims in the various health services favors the bond and interaction between professional and victim. This allows us to enter the subjectivity revealed by the victim and implicitly perceive the violence suffered, with the nurse being, in most cases, the first contact in the support network[30].

The identification or suspicion of violence in its different types depends on the health professional's ability to recognize risk situations in families, as well as signs and symptoms suggestive of violence[31]. Thus, health services that serve children and adolescents, which includes BHUs, should incorporate into their routine the surveillance of violence directed at these groups, through a posture of constant alert to these situations. They must consider the vulnerability of this group and the possibility of these situations occurring at any time, this being one of the strategies indicated by the World Health Organization for combating violence against these groups[32-33].

The specialty of forensic nursing emerges as an area of nursing capable of supporting the nurse's performance in identifying victims of violence. It also allows qualified assistance to cases of violence, approaching the victim in a systematic way, which implies collecting a comprehensive history followed by physical examination, clinical diagnosis together with multidisciplinary team, definition of care plan and, finally, referral to the appropriate institutions[34].

The subjectivity observed at the time of identification of violence in the family environment makes the phenomenon complex and invisible, which requires from the professionals of the family health teams permanent evaluations and changes in

daily practices, that is, it is necessary to act dynamically, without recipes or patterns, but that adapts to the needs and specificities of each family[35].

Given these barriers in the relationship between health professionals and families, situations of violence against children and adolescents are still not effectively identified. Study developed in the state of Ceará[36] found that 56.9% of the nurses surveyed reported not having identified cases of mistreatment against children and adolescents; and, of those who did, most came from spontaneous reports from the victim, relatives or other individuals, i.e., they were not situations effectively identified by the nurses.

It is known that the main means of investigation of violence against children and adolescents by nurses is the physical examination during childcare consultations, which inevitably produces a greater focus on the physical aspects of violence. However, other authors[37] emphasize that one should pay attention, primarily, to the reports and complaints of children and adolescents and look for signs not only of physical, but also psychological violence during consultations, that is, an integral approach should be taken.

It is essential to understand that violence against children and adolescents is not an isolated phenomenon: it is intertwined with other issues such as poor living conditions, unemployment, other forms of violence, use and abuse of alcohol and other drugs, and gender-related conflicts of power. Therefore, overcoming this problem present in the communities where nurses work requires both transversal and intersectoral measures that can modify social and cultural contexts[38] how to support children and adolescents and their families in a multidisciplinary protection perspective, as pointed out by a Norwegian study[39].

It is worth mentioning that the fear of possible reprisals, the desire to maintain the family bond and the financial dependence on the partner emerge as factors that contribute to the absence of denunciation by the family, especially in situations of intra-familial sexual abuse[40]. Maternal omission is associated with the social representation of the family, avoiding unraveling. Reporting the incest of the father or partner represents the recognition of one's own failure as a mother; several reasons lead the mother and other family members to omit or deny the violation, contributing to the low volume of reports[40].

Regarding health promotion actions, violence prevention and stimulus to the culture of peace by the nurse, the School Health Program (SHP)[41] was created to integrate the health and education sectors and, in this way, expand health care by the PHC multi-professional team to children and adolescents in their living space[42]. This program is characterized as the main means of promoting the culture of peace to these groups, and the school is the privileged environment for these actions.

Attitudes that stimulate the culture of peace in communities and schools encourage positive interactions between subjects and make them authors of the promotion of peace in these spaces, because the transformation and search for a less violent community must begin in/by the community itself.

The theme of culture of peace is still little discussed by nurses in school spaces, in which themes with some direct biological focus are addressed. However, the school space presents itself as a privileged place to discuss the culture of peace, in the sense of a culture of tolerance and solidarity, which respects all the individual rights of the subjects, ensures freedom of opinion and prevents relational conflicts, solving them at their sources[43].

The study elucidated the nurse's need for support from the multiprofessional team and from the equipment of the child and adolescent protection network. In this process, the Family Health Care Center (FHCC) stands out[44], in the figure of the psychologist. There, it is essential to establish a flow of welcoming, notification, care, and comprehensive monitoring of victimized children and adolescents and their families, defining the responsibilities of each professional and each sector, so that PHC nurses can understand their areas of action in a manner shared with other professionals[33].

This discussion point brings up the primary need to reflect on a likely transfer of child and adolescent victims of violence to other professionals and services, especially social workers. This is because nurses reveal difficulties in dealing with the phenomenon of violence, which involves identification, welcoming, co-responsibility of care, non-fragmentation between the victim's mind and body, as well as the effectiveness of a line of care in the face of these problems[45].

This transfer of responsibility may be directly related to the lack of training described by the nurses in the study, because international research[46-47] and national[35] highlight the unpreparedness of these professionals to act in cases of violence against children and adolescents. This is evidenced by the lack of knowledge in identifying signs and symptoms indicative of situations of violence, lack of institutional support from a structured support network known to all professionals, and the use of intuitive knowledge conceived by each nurse.

The fact that nurses often feel helpless and unaware of the procedures that should be performed in a situation of violence against children and adolescents generates physical and emotional wear, as well as dissatisfaction with their own performance[48]. Hence the need for workshops and continuing education, which corroborates the Sri Lankan study[49] on health professionals' practices and attitudes towards child abuse.

As a consequence, underreporting of violence against children and adolescents emerges, aggravated by the deficit in health professionals' knowledge about the nature of violence and its forms of expression, as well as the absence of immediate evidence (e.g., in the case of psychological violence), which directly influences the identification of cases[35]. A similar scenario was evidenced in a study in the United Kingdom, which highlighted the deficit of reporting and identification of child abuse[50].

This whole scenario of PHC urgently points to the technical and scientific qualification of nurses to work in addressing cases of violence against children and adolescents, so that they develop skills and competencies to fill the aforementioned gaps. However, nurses, when approaching or dealing with children and adolescents directly or indirectly, can appropriate the various standards of nursing knowledge, such as personal and aesthetic standards, and adopt language, behavior, and care plans appropriate to the target audience.

Study limitations

As limitations of the study, one can attribute the loco-regional cut, defined by a city in the interior of the Brazilian Northeast with

epidemiological, social and economic peculiarities, which influences the particularities of the occurrence of situations of violence against children and adolescents and the peculiarities of the nurses' approach. It is also noteworthy that the study was restricted to the first level of complexity of health care, which presents specificities of the work of nurses at this level. For an expanded analysis of this performance, it is necessary to explore other levels of health care.

Contributions to the field of Nursing

The PHC scenario shows the urgent need for qualified technical and scientific education and training of nurses in order to develop skills and competencies to fill the gaps in the performance of these professionals when facing cases of violence against children and adolescents.

This study provides subsidies for advancing the specialty of forensic nursing as essential and applicable in PHC. It points to the development of nurses in the specific qualification for forensic actions associated with health care, enhancing the capacity of these professionals to address situations of violence against children and adolescents.

FINAL CONSIDERATIONS

The empirical material from the study allows us to understand that nurses working in PHC approach suspected or confirmed cases of violence against children and adolescents through self-perception supported by physical examination in nursing consultations, which works as an important tool for identifying situations of suspected or confirmed violence against children and adolescents, welcoming and assisting the victim. This strategy emphasizes a focus on the child rather than the adolescent and the space for interaction with families.

Therefore, it can be inferred that although PHC is the ideal space for the implementation of the dimensions of the Line of Care for the Comprehensive Care of Children, Adolescents and their Families in Situations of Violence, this proposal has not been fully contemplated by the nurses' performance.

It is suggested the expansion of the debate on how to approach situations of violence during nurses' training to work in PHC, since such cases are part of everyday life in the communities and nurses must provide comprehensive health care to users in their assigned territory.

SUPPLEMENTARY MATERIAL

Thesis entitled "Analysis of the work of nurses at the three levels of health care from the perspective of the Line of Care for Comprehensive Care of Children and Adolescents in Situations of Violence," published in the repository of the Federal University of Rio Grande do Norte: https://repositorio.ufrn.br/handle/123456789/28626.

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