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CARE FOR CHILDREN AND ADOLESCENTS VICTIMS OF VIOLENCE IN PRIMARY HEALTH CARE

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ABSTRACT

Introduction: Medical residency programs should ensure the means of learning and applicability within the Unified Health System, in addition, to instigate the expectation of improvements in integral care and continued health of the population and in particular children and Adolescent victims of violence. **Objective:** To compare the quality of primary health care services in the category of violence against children and adolescents in health units without and with the Medical Residence Program in Family Health. **Methodology:** Descriptive, transversal and retrospective research conducted in 12 basic health units. The professionals of the Family health strategy teams responded to the instrument of evaluation and monitoring of QUALIAB primary care services and were extracted the questions 59 and 60. The data from units that have the residence program were compared with those that do not have by the chi-square test with $P < 0.05$ or 5%. **Results:** The sample was composed for 107 health servers, being 61 in units with residence program and 46 without. The medical questionnaire, nurses, nursing technicians, and Community Health Agents. In the items "team case discussion", "Home Visit", "denunciation to the Guardianship Council" and "attendance and monitoring of parents", "compulsory notification to epidemiological surveillance" and " multi-professional monitoring in the unit", the perception of Interviewed was that the units with residence program are better in the care. **Conclusion:** The research showed that the family and community Health Residency program as a policy of the unified health system, contributes to the improvement of the quality of service to violence against children and adolescents.

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INTRODUCTION

Basic care is the gateway to the Unified Health System (SUS). This is considered as the structuring pillar of the national health system and aims at priority care, expanding access and advancing in the process of universalization of health services, improving resolvability. It is an important access for children and adolescents victims of violence (World Health Organization, 2008). In Gurupi-TO, the basic care network consists of twelve urban primary health care units (PHC), covering more than 50.000 people, and these are directly installed in communities. Since 2013, the expansion of Medical Residency Programs in Family and Community Health (MRPFCH) in Brazil has been encouraged, through the Strategy for qualifying health care networks (HCN), and these were formulated with the objective of training physicians with knowledge and skills in prevention, early diagnosis, treatment and recovery of the most frequent diseases, seeking high rates of problem-solving capacity of the population's health problems. Its attitude must be integral, focusing on the family and social centers that make up the community. For the implementation of MRPFCH in the municipality of Gurupi-TO in 2017, readjustments of technical teams, physical structuring of the environments of Basic Health Units (BHU) receiving the program were performed, standardization of the work routine focused on application of current public policies of basic care, including the Comprehensive Child Health Care Program (PAISC), Integrated Care for Prevalent Diseases in

Childhood (AICPI) and the Adolescent Health Program (PROSAD). Domestic violence is one of the forms of human rights violations. Between 1980 and 2010, the number of homicides against young people grew by 346%, according to data from the Mortality Information System of the Brazilian Ministry of Health. During this period, 608.492 children died from violence and accidents, which are external causes considered preventable by the World Health Organization (WHO). In 2012, the homicide rate was 13 per 100 thousand children and adolescents, placing Brazil in 4ªplace among 92 countries worldwide. In the state of Tocantins, the State Department of Health conducted a survey between 2009 and 2018 demonstrating that more than 10 thousand children were victims of violence, and domestic violence was the most recurrent. As for the city of Gurupi-TO, where this study was conducted, 23 complaints were reported between 2015 and 2016, 23 complaints to the National Complaint Dial (Dial 100) were reported (Leite, 2016; Souto, 2017; Tocantins, 2017). Acts of violence, mainly committed against children and adolescents, have become obstacles to the development of these individuals, as well as a major global public health problem (Sá, 2010; Silva, 2012; Souto, 2017). Violence is a secular problem that affects all social classes, ethnicities, religions, races, and cultures, and affects thehuman being in its entirety.

Thus, violence cannot be seen only as a phenomenon of epidemiology or social sciences but should be analyzed under the paradigm of complexity and fought through interdisciplinary practices (Fonseca, 2013; Albuquerque, 2015 and Florentino, 2015). As domestic violence was considered a problem of social and legal areas for many years, health professionals did not act in their prevention and detection, nor did they intervene in its occurrence. The multidisciplinary evaluation, from the perspective of several health professionals, enables the global analysis of this problem, as well as enriches the range of information obtained and increases the depth of results analysis. Consequently, a greater number and variety of suggestions for the application of public policies emerge in order to cope with domestic violence (Minayo, 2001 and Florentino, 2015). Intra-family violence is the one exercised against children and adolescents in the private sphere. It is usually used to divide your most visible expressions into four types. Physical violence, sexual violence, psychological violence, and neglect (Veronese, 2012). The BHU work directly with groups of children and adolescents in their daily lives and face a serious problem that is the violence suffered by them.

Violence against children and adolescents is a universal phenomenon and represents an important public health problem and whose interest has become evident only in recent decades. No society, however or less developed, is immune to the occurrence of violence and ill-treatment of children and adolescents. Unfortunately, the numerous abuses committed are under-reported, not revealing the magnitude of this phenomenon. Thus, based on this conjuncture, characterized by children and adolescents who demand health care and health professionals who need to attend these in situations of violence, this work was proposed that aimed to evaluate the quality of the service executed in the BHU with MRPFCH in Gurupi primary care, comparing the quality of service provided in the basic units that have the said program with those who do not have, through the QualiAB tool (Castanheira, 2011) in 2017 and 2018.

MATERIALS AND METHODS'

The descriptive, cross-sectional and retrospective research conducted in 12 basic health units (BHU) in the municipality of Gurupi-TO, with all 20 family health teams, 10 (ten) had MRPFCH distributed in four BHU. The study was conducted strictly obeying Resolution number 466/2012 of the National Health Council approved by the Ethics Committee on Research in Human Beings (CEP) of Gurupi/ UnirG University under opinion no. 2.255.519/2017. From the list issued by Human Resources, 224 employees were found and addressed, where 132 answered the questionnaire, however, 25 were excluded because they incomplete filled out the questionnaire, thus the sample consisted of 107 volunteers (n= 107). Heterogeneity of 50%, margin of error of 10% and confidence level of 99% was used. All participants were approached directly in the unit itself to which it was crowded. The collection was carried out from December 2017 to February 2018 and took place in a room (office/auditorium) in the 12 BUH of the municipality, where they were given the instrument for evaluation and monitoring of quali AB primary care services containing 115 questions, validated by Castanheira *et al*.12, and reformulated in 2016. The data were entered in a computerized spreadsheet of Excel 2016. And for this study, questions 59 and 60 of multiple-choice were drawn, which were violence against children and adolescents. Subsequently, the chi-square test was applied to verify possible differences in the quality degree of services between BHU groups with and without MRPFCH. The significance level of $p<0,05$ or 5% through EPI INFO program 3.2.2. The result of the quality degree of the services found was analyzed contrasting with the indicators recommended in the PNS Policy related to the expected Standard of Quality of the SUS as well as other specialized literatures on the theme.

RESULTS AND DISCUSSION

We surveyed 107 health professionals, 61 in BHU with MRPFCH and 46 without. Were interviewed physicians, nurses, nursing technicians and community health agents (Table 1). The research was mostly answered by community health agents due to the large number of these servers to compose the multidisciplinary team in the BHU. This data corroborates the findings of Lima *et al* (Lima, 2011), in Feira de Santana, Bahia, where 57% of the total number of professionals in the BHU who participated in the identification of cases of violence were community health agents. Question 59 of the QualiAB questionnaire deals with 11 (eleven) items about the strategies used by the unit to detect violence against children and adolescents (Table 2). Statistically significant differences were observed for units with medical residency in items 5 (five) and 7 (seven). Items 8 (eight), 9 (nine),10 (ten) and 11 (eleven) were excluded since they were not perceived by the interviewees. Item 2 (two) deals with the identification of physical and psychological symptoms/complaints in children and adolescents who have suffered some type of violence. Costa *et al*. (Costa, 2015) they affirm that it is essential that the health professional acts in promoting peace and preventing violence by establishing a link with the population that is under their care. Lima *et al*. (Lima, 2011) affirm that the physician is the most sought-after professional, especially in simultaneous episodes of physical and sexual violence, and in view of the significant statistics, the units studied do not require improvements in the results satisfactory.

Table 1. Distribution of the type and number of professionals surveyed in the BHU studied

Professional Category	BHU CMR		BHU SMR		n. total bycategory	% total bycategory
	n.	%	n.	%		
Community healthagent	45	73.77%	25	54.35%	70	65,42%
Nurse	7	11.47%	8	17.39%	15	14.02%
NursingTechnician	3	4.91%	6	13.04%	9	8.41%
Doctor	6	9.85%	7	15.22%	13	12.15%
	61		46		107	100%

Table 2. Perception of health professionals about the strategies used by the Unit to detect violence against children and adolescents in BHU with and without MRPFCH in Gurupi, Tocantins, Brazil, 2019

Item		BHU CMR		BHU Without		χ^2	*P*
		n.	%	n.	%		
1. Protocolofcare	Yes	28	60.87%	27	44.26%	2.895	0.089
	No	18	39.13	34	55.74%		
2. Identification of symptoms/ physical complaints, psychological	Yes	33	71.74%	39	63.93%	0.726	0.394
	No	13	28.26%	22	36.07%		
3. Listening to other users' reports and checking the case	Yes	31	67.39%	31	50.82%	2.955	0.085
	No	15	32.61%	30	49.18%		
4. Free declaration of those responsible	Yes	29	63.04%	30	49.18%	2.037	0.153
	No	17	36.96%	31	50.82%		
5. Team case discussion	Yes	30	65.22%	23	37.70%	7.941	0.005
	No	16	34.78%	38	62.30%		
6. Awareness and training of the team to identify cases	Yes	27	58.70%	26	42.62%	2.710	0.099
	No	19	41.30%	35	57.38%		
7. Home visit	Yes	32	69.57%	26	42.62%	7.669	0.006
	No	14	30.43%	35	57.38%		

Table 3. Perception of health professionals about the procedures performed in case of detection of violence against children and adolescents in BHU with and without MRPFCH in Gurupi, Tocantins, Brazil, 2019

Item		BHU CMR		BHU Without		χ^2	*P*
		n.	%	n.	%		
1. Complaint to the Guardianship Council	Yes	40	86.96%	42	68.85%	4.800	0.028
	No	6	13.04%	19	31.15%		
2.Reportto DIAL 100	Yes	30	65.22%	30	49.18%	2.738	0.098
	No	16	34.78%	31	50.82%		
3. Parental care and follow-up	Yes	26	60.47%	20	33.90%	7.090	0.008
	No	17	39.53%	39	66.10%		
4. Referral to CRAS and CREAS	Yes	30	68.18%	32	53.33%	2.325	0.127
	No	14	31.82%	28	46.67%		
5. Compulsory notification to epidemiological surveillance	Yes	32	69.57%	29	47.54%	5.190	0.023
	No	14	30.43%	32	52.46%		
6.Multiprofessional monitoring in the Unit	Yes	27	58.70%	24	39.34%	3.937	0.047
	No	19	41.30%	37	60.66%		
7. Discussion with NASF/support team	Yes	32	69.57%	33	54.10%	2.631	0.105
	No	14	30.43%	28	45.90%		
8.Intersectoralmonitoring	Yes	-	-	61	100.00%	-	-
	No	-	-	46	100.00%		

Pinho, Garcia, and Martins (Pinho, 2017), and Gadelha and Barreto (Gadelha, 2018), corroborate that the MRPFCH contributes to strengthening the principles of the Family Health Strategy (FHS), through the mobilization of residents and preceptors outraged by the poverty of community care. For the identification of cases, item 3 (three) is related to listening to reports from other users and checking the case, demonstrating good results in all units studied and not requiring improvements, but Lima *et al*., (Lima, 2011), claim that most of the cases identified are through third-party reports and this is directly linked to the bond created with the community. There is a great need to discuss cases among the multidisciplinary team, as item 5 (five) treats. Saints and Yakuwa (Santos, 2015), they state that in many cases there is some difficulty among professionals in acting through cases of violence, often related to family silence due to threats from the aggressor, difficulties in the integrality of care and especially in the relationship between the multidisciplinary team that sometimes tend to feel unsafe to intervene in cases.

Teamwork is the key to detecting and making arrangements in cases of violence. Regarding item 7 (seven), related to home visits, Pinho, Garcia, and Martins (Pinho, 2017), affirm that visits are an opportunity to develop teamwork and bring families and FHS closer together, providing the humanization and integrality of care. Similarly, Moreira *et al*. (Moreira, 2014), confirm that it is through the approximation and knowledge of community agents, which is made known about the family dynamics of the territory in which BHU covers. Given the result obtained in this item, it is essential that periodic visits are made to families who are suspected of raping children and adolescents because it is through the active search of cases that it is possible to solve and prevent new episodes of Assaults. Question 60 deals with 11 (eleven) items about the procedures performed in case of detection of violence against children and adolescents, but items 9 (nine), 10 (ten) and 11 (eleven) were excluded since they are not perceived by professionals. Statistically significant differences were observed for units with medical residency items 1 (one), 3 (three), 5 (five) and 6 (six) (Table 3). The lack of training for

the detection of cases of violence was found in the study by Barbosa *et al*., (Florentino, 2015), where the authors found that most professionals never participated in specific training, but when this fact occurs 80,9% of the professionals refer the case to the Guardianship Council (item 1). Given the results found, it is necessary that training is implemented for professionals to have a better knowledge to identify and forward cases to the responsible bodies because only in this way it will be possible to promote improvements in the assistance to victims. In the detection of cases of violence, it is necessary to have a care and follow-up of parents, as treats item 3 (three) that obtained statistically significant differences for units with residence. Ferreira (Ferreira, 2005), states that it is necessary that the professional posture of the team is in a non-judgmental and non-punitive way, even if the aggressor is present.

This behavior avoids creating negative reactions for the child and his/her family members since they are experiencing some suffering. This type of relationship will provide confidence between professional and user, facilitating the evaluation of the situation, as well as long-term planning and monitoring, obtaining a higher probability of adherence to follow-ups. Garbin and Seraphim (Garbin, 2015) affirm that notifying and informing cases of violence to the Guardianship Council and Epidemiological Surveillance is the form of competent authorities such as the Public Prosecutor's Office and The Civil And Youth Court, to refer cases to support bodies such as CRAS and CREAS, such as addresses item 4 (four), but there was no need for improvement in this item since all units studied had satisfactory results. Regarding the notification of cases, item 5 (five), wherein the BHU with the MRPFCH had statistically significant results, it is observed that it does not corroborate as a study by Silva *et al*. (Silva, 2017) because the authors claim that the majority of professionals who carry out their activities in the BHU are unaware of normative provisions for the effectiveness of the notification. Ferraz and Wünsch (Ferraz, 2016) affirm that the Notification Diseases Information System (Sinan) virtually provides sheets to notify cases of violence, especially children. Therefore, it is necessary to include in the basic units forms of easy access to the professional, in addition to encouraging knowledge about these notifications.

In the matter of follow-up by the multidisciplinary team, item 6 (six), where BHU with MRPFCH also presented statistically significant results, the importance of team integration is observed. The MRPFCH follows a schedule of specific activities, often holds meetings between teams and is accompanied by a medical coordinator specialized in Family health and community. According to Pires *et al*., (Pires, 2016), in 2009, the Municipal Health Department of the state of Rio de Janeiro created the Center for the Promotion of Solidarity and Violence Prevention (NPSPV) with the objective of strengthening the monitoring of cases of violence, based on the guidelines of the Ministry of Health and the implementation of the Sinan plug in basic health units. With the development of the program, the authors confirm that it was possible to implement effective actions, ensuring quality in the care of cases of violence. Every day new cases of violence against children and adolescents are reported. The BHU and the professionals who develop their work there are the protagonists in the identification of cases of violence and responsible for follow-up, in order to avoid the occurrence of new cases.

CONCLUSION

It is concluded that the MRPFCH promotes improvement of the quality of care provided to children victims of violence in primary health care in the SUS, especially in the questions "Discussion of the team case", "Home visit", "Denounces the Guardianship Council", Care and parental follow-up", Compulsory notification of epidemiological surveillance", and "Multiprofessional monitoring in the unit". Some aspects still need to be improved for the effectiveness of care, as well as the importance of constant updating of the professionals involved in the health team, training regarding notification forms and also, how to act in the face of cases of violence. It highlights the importance of a study on the expansion of the Family and Community Health Medical Residency Program in the municipality of Gurupi-TO, as well as corrective measures, monitored in the process of improving local management and greater cooperation and strengthening education integration, health services, and the community.

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