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The protection network for children and adolescents victims of violence: old dilemmas, new perspectives

A rede de proteção a crianças e adolescentes vítimas de violências: antigos dilemas, novas perspectivas

La red de protección de niños y adolescentes víctimas de la violencia: viejos dilemas, nuevas perspectivas

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This is a cross-sectional study with a quantitative and descriptive approach, carried out in the year 2016, with the goal of identifying the profile of professionals in the System for Guaranteeing the Rights of Children and Adolescents (*Sistema de Garantia de Direitos da Criança e do Adolescente*), characterizing institutions that make up this system and raising the debate on contributions of nursing professionals to the safety net. 44 professionals from the System participated, 88.6% of them were women, 11.4% were health professionals, and 2.3% were nurses. The Third Sector represented 27.38%. There was an expressive number of professionals who integrated the Social Protection Services when considering public services and those in the Third Sector. Primary care and basic social protection can play a fundamental role in the protection network for children and adolescents, due to their wide insertion over the land. The strengthening of primary prevention against violence is urgent, in alliance with the training of professionals.
Descriptors: Violence; Public Health; Adolescent health; Child health services.

Este é um estudo transversal com abordagem quantitativa e caráter descritivo, realizado em 2016, com objetivo de identificar o perfil dos profissionais do Sistema de Garantia de Direitos da Criança e do Adolescente, caracterizar as instituições que compõem esse sistema e suscitar o debate sobre as contribuições dos profissionais de enfermagem para a rede de proteção. Participaram 44 profissionais do Sistema, sendo 88,6% mulheres, 11,4% profissionais da área da saúde, e 2,3% de enfermeiros. O Terceiro Setor representou 27,38%. Houve expressivo número de profissionais que integravam os Serviços de Proteção Social quando considerados os serviços públicos e aqueles do Terceiro Setor. A Atenção Primária e a Proteção Social Básica podem desempenhar papel fundamental na rede de proteção à criança e ao adolescente, devido à ampla inserção nos territórios. Urge o fortalecimento da prevenção primária às violências aliada à capacitação dos profissionais.
Descritores: Violência; Saúde Pública; Saúde do adolescente; Serviços de saúde da criança.

Este es un estudio transversal con enfoque cuantitativo y carácter descriptivo, realizado en 2016, con el objetivo de identificar el perfil de los profesionales del Sistema de Garantía de Derechos de los Niños y Adolescentes (*Sistema de Garantia de Direitos da Criança e do Adolescente*), caracterizar las instituciones que lo conforman y plantear el debate sobre las contribuciones de los profesionales de enfermería a la red de protección. Participaron 44 profesionales del Sistema, 88,6% mujeres, 11,4% profesionales de la salud y 2,3% enfermeros. El Tercer Sector representó el 27,38%. Hubo un número significativo de profesionales que integraban los Servicios de Protección Social al considerar los servicios públicos y los del Tercer Sector. La Atención Primaria y la Protección Social Básica pueden desempeñar un papel fundamental en la red de protección de los niños y adolescentes debido a la amplia inserción en los territorios. Existe una necesidad urgente de reforzar la prevención primaria de la violencia combinada con la formación de profesionales.
Descriptores: Violencia; Salud Pública; Salud del adolescente; Servicios de salud del niño.

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INTRODUCTION

Currently, the plurality of violence against children and adolescents can be referred to the violation of their fundamental rights, in the form of ineffective or non-existent public policies, or even given the privatization of social policy[1]. Rights based on the Universal Declaration of Human Rights of 19482, the Brazilian Federal Constitution of 1988[3] and the Statute of Children and Adolescents (*Estatuto da Criança e do Adolescente - ECA*)[4], 1990. The realization of this rich legal basis and the overcoming of this state of affairs demands more and more preparation and knowledge of the professionals involved in this area.

The understanding of violence, as a result of the combination of economic, legal, social, political, cultural, individual, family, community factors, therefore, in its structural dimension[5], must overcome superficial analyzes under penalty of reinforcing common sense, against which, it would be enough to harden legal punishment on aggressors and to equip the forces of repression with a strong military apparatus.

Structural violence has enhanced many forms of violence, including domestic violence. Their understanding for a long time had been sent to the education of their children and, therefore, in a functional-positivist apprehension, it was socially legitimized.

Seeking to overcome the positivist meaning attributed to violence, as a moral adjustment[6], we sought to expand the concept based on the notion exposed by the World Health Organization (WHO)[6], in 1946, defining violence as a term that can be used since physical violence attributed to the use of force, even as a threat. This act configures violence not only against another individual, but also against oneself and against the community and which can result in some psychological damage, disorder of body balance and deficiency/loss of any functions.

WHO, in 2015[7], brought to light 17 Sustainable Development Goals, which are seen as a global goal to be achieved by the year 2030. Among the topics in the extensive document are the goals for an equitable world and universal access to education, as well as guaranteeing health care and social protection in order to achieve biopsychosociospiritual well-being[8].

However, in the particular case of Brazil, the indicators of the Brazilian Institute of Statistical Geography (*Instituto Brasileiro de Georgafia e Estatística - IBGE*)[9] attest to the concentration of violence in territories of extreme poverty, whose impact is also shown in the integral development of children and adolescents, as advocated by the ECA (1990)[4]. Violence against children and adolescents is understood as "*[...] any act or omission committed by parents, relatives, other people and institutions, capable of causing physical, sexual and/or psychological damage to the victim*[10]".

Violence, understood as a result of social determinants, directly affects the health-disease process and challenges governments and society in the construction of health promotion strategies in an intersectoral and multisectoral way as a manner to prevent violence against children and adolescents , for example[6,11].

In general, health is related to everything that directly or indirectly affects the individual's life and daily life, encompassing concepts and complexities related to nutrition, housing, work, environment, religion, among others. State actions towards health must respect principles, such as equity and integrality of assistance, being guided in order to organize and reaffirm a Unified Health System (SUS), regionalized and, at the same time, interdependent[12].

In view of the theoretical scenario that allows a comprehensive analysis of violence and its impact on the health of Brazilians, gaps in the knowledge produced are identified.

Nursing has a fundamental role in facing the various types of violence, especially in the context of Primary Health Care (PHC). The Federal Nursing Council (*Conselho Federal de Enfermagem - COFEN*), in its directive attributions, drew up in 2019 a manual of guidelines for the Regional Nursing Councils to develop protocols for PHC. For the Council, the elaboration of protocols is based on the definition of the target audience, giving preference to the epidemiological approaches of the groups, such as age; risk groups, such as people diagnosed with diabetes and high blood pressure; the specifics of each group; the proposals of the actions,

the planning, the implementation, the accomplishment and the evaluation of the proposed activities, following the foundations of the nursing planning[13].

The Regional Nursing Council of Minas Gerais (COREN-MG) published in 2017 a Guide for Nursing Teams in Primary Care, and this includes protection and prevention actions for children and adolescents. The approach to the activities of nurses in the face of types of violence is focused on the risk of domestic violence[14].

Violence is treated in a framework of nursing diagnoses with guidelines related to the nurse's activities in this scenario, such as calling the Guardian Council, referring them to the reference service, investigating the possibility of child neglect, which is controversial since exposes as an activity to relate the adult's report with the violence/injury presented by the child[14].

Regarding the prevention of violence against adolescents, the guide of the state if Minas Gerais provides information on the procedures in case of sexual abuse, which, in turn, includes actions aimed at women, adolescents, adults and young adults. For the guide, the concern of the nursing team as a whole turns to the health of the student, vaccine effects and age-related diseases[15].

The National Council for the Rights of Children and Adolescents (*Conselho Nacional dos Direitos da Criança e do Adolescente - CONANDA*) is a collegiate body provided for in Article 88 of Law No. 8,069/90, ECA[4], which provides guidance on the reception of children and adolescents who have their rights violated. Among these guidelines is the number of professionals who must respect the number of children and adolescents in the place of reception, listening to this audience must be active and communication between professionals must occur equally, preferably in a multi and even interprofessional. Professionals must constantly undergo permanent education strategies to update their knowledge about violations and the rights guarantee system[16].

From the conceptual and normative scenario of the nursing field in the face of violence, some questions emerged: *Who are and what are the characteristics of the professionals who work in the Child and Adolescent Protection Network in a city in Minas Gerais? What is the role of the nursing team in the current scenario? How many nursing professionals permeate the network and actively participate in monthly conversation wheel strategies?*

Based on this scenario, the present study aims to identify the profile of professionals in the Child and Adolescent Rights Guarantee System, to characterize the institutions that make up this system and to raise the debate on the contributions of nursing professionals to the health network. protection.

METHOD

This is a cross-sectional study, with a quantitative and descriptive approach. The cross-sectional or sectional study is research carried out in a short period of time, at a specific moment in history, such as, for example, the exact moment when the study is taking place[14]. The descriptive character, according to Gil[17], portrays the characteristics of certain situations or phenomena. One of its peculiarities is the use of standardized data collection techniques, such as the questionnaire and systematic observation.

The SGDCA is composed of several sectors that work with children and adolescents with the aim of protecting, guaranteeing rights, promoting and recovering the effective rights, from these to Life and health, for example[7]. This System is made up of Education, from elementary to high school or vocational education; Public Security; social protection services, such as the Social Assistance Reference Center (CRAS) and the Specialized Social Assistance Reference Center (CREAS); Guardian Councils, Public Prosecutor's Office for Children and Youth and Society, in the form of Non-Governmental Organizations (NGOs).

In the city of Uberaba, the SGDCA is made up of 51 teams from the Family Health Strategy, 49 teams from Oral Health, 6 Support Centers for Family Health and a team of

Consultório da Rua[18]. The municipality also has a public security system composed of military, municipal police, headquarters of the civil and federal police. It also has 4 highly complex hospitals, two of which are served by the Unified Health System (SUS), one with partial care and the other for full coverage. In the education sector, there are 98 elementary schools, 37 high schools and 4 higher education institutions, 1 of which is federal[19,20].

In relation to civil society, the NGOs Brasil[21] website shows that the city has 40 NGOs that cover the most diverse services such as health, education, sport, leisure and culture.

In this context, the research was carried out with the professionals who work in the institutions that make up the SGDCA, including municipal, state, federal and third sector bodies.

The professionals who contributed to the research participated in the Conversation Wheel promoted by the Council for the Rights of Children and Adolescents (CMDCA), between the years 2014 and 2015. This element was attested by the access to the attendance lists at the monthly meetings held in the researched city, which contained their locations and telephone numbers. During the three months preceding the construction of the data, the researchers participated in the meetings of the Wheel to inform about the research and that they would be contacted to participate in it.

In the first stage, all participants in the Conversation Wheel were contacted, to verify if the participants worked in the network's reference sectors/services, registered in the presence lists, updating it. The losses were justified by dismissals, relocation, maternity leave, sick leave, approval of competitions, among others. This data led to infer about network turnover, for example.

After previous contact by phone, scheduling and visiting the chosen location, remaining participants were invited to fill out the socio-demographic data instrument, which covered issues such as profession, working time in the reference service, time since graduation and graduation completed, as well as such as age, gender and ethnicity.

To be included in the research, the worker should have participated in the Conversation Wheel at least once, and that they should consent and sign the Informed Consent Form (ICF). Professionals who were on vacation due to vacation, time off, sick leave or work during the data collection period were excluded.

Data collection was carried out between April and June of 2016, through a self-administered socio-demographic questionnaire, answered anonymously without identifying the subjects.

The database was built using Excel Software version 2017. The Statistical Package for the Social Sciences (SPSS), version 25.0, was used for the statistical treatment of the data. The data were analyzed using simple descriptive statistics.

The research was approved by the Research Ethics Committee (*Comitê de Ética de Pesquisa - CEP*) of the Universidade Federal do Triângulo Mineiro with a favorable opinion, CAAE: n.1.318.577. All ethical precepts recommended by Resolution 466/2012 of the National Health Council (CNS) were respected. Participants were informed about the objectives and methods and expressed their consent to a specific term.

RESULTS

Initially the list had 127 individuals and, after verification, a sample loss of 65.3% was found, which, however, did not make the research unfeasible. The losses resulted from exonerations, relocation, maternity leave, sick leave, approval in competitions, among others. This data led to infer about the network turnover, for example.

After contacting potential study participants, the sample consisted of 44 participants (N = 44) and the results are shown in Table 1.

Table1. Sociodemographic profile of SGDCA professionals. Uberaba / MG, 2016.

Variables	N	%
Gender		
Female	39	88.6
Male	5	11.4
Age		
Up to 29 years old	5	11.4
From 30 to 59 years old	38	86.4
60 years old or more	1	2.3
Self-reported color		
White/Yellow	22	54.5
Black/*Pardo*	17	43.2
Not informed	5	11.4
Educational level		
High school	3	6.8
Higher education/Post-graduate	40	90.9
Not informed	1	2.3
Profession		
Guardian counselor	19	43.2
Social worker	13	29.5
Nurse	3	6.8
Military police	3	6.8
Psychologist	2	4.5
Educator	1	2.3
Technician in social development	1	2.3
Other	2	4.5
Sector in which operates in SGD		
Social work	31	70.5
Health	5	11.4
Guardian counsel	3	6.8
Justice	2	4.5
Education	1	2.3
Other	2	4.5

The average age of the participants was 42 years. Regarding the length of service, there was a variation between 1 to 30 years, with an average length of experience in the reference service 8.3 years of work.

As for the undergraduate courses, the participants came from the following areas: Social Work (38.6%); Social Communication (11.4%); Pedagogy (11.4%), Degree in Chemistry (2.3%); Administration (2.3%); Journalism (2.3%) and Nursing (2.3%). However, 20.6% of the professionals did not report graduation and there were professionals with more than one graduation. The training time of professionals ranged from 1 to 31 years. The category "others", on the sector of activity, included participants who held positions as a journalist, analyst in psychology, analysts of the Public Ministry, department heads and Unit managers.

Regarding the sectors operating in the Network, they are subdivided into public bodies and services; and NGOs. Among those that made up the public sector, the greatest representation was Justice and Health, corresponding to 16.67% each, followed by Education and Social Protection: 11.11% each. Sectors such as Social Control, Government Secretariat and Analogs to the Executive Branch 5.6% each. NGOs accounted for 27.78% of the locations where the participants worked.

DISCUSSION

There was a significant presence of women working in contexts of violence. A finding made in the studies by Scopinho and Rossi[22] that, when analyzing the representations of care attributed by women who worked with children in a social assistance institution, reaffirmed "their" places as being those who, historically, take care of the "defenseless" and "abandoned",

in an "affectionate" and "loving" way. The sample data indicate that, in addition to these attributes, there is the requirement for greater education of these women, given that many of the occupations establish a higher level for performance, either in the public service or in the Third Sector[23].

There was an expressive number of professionals who integrate the Social Protection Services when considering public services and those of the Third Sector. This greater presence of Social Protection in the city and its consequent activation by other services (Schools, Guardianship Council), expresses a partial understanding that if violence is caused by social inequality, it is for Social Protection that its victims should be referred, that is, victims of poverty[24]. Thus, referring to Basic Social Protection services (CRAS - Service for the Living and Strengthening of Bonds) has two motivations: to strengthen family and community bonds, reducing the risk of violating a right; and when violating a right to care at CREAS[25]. However, this is a fragmented reading of the phenomenon.

As many studies mention[26-30], the majority of violence, especially physical (self-inflicted, beatings) and sexual (rapes and assaults), incur for health sector services, especially urgent/emergency services. The impact of this drainage movement in the most complex sectors of health reflects a scenario of gaps that begins at graduation and culminates in unpreparedness for the notification and reception of victims of violence who are often exposed to the revitimization organized by the system[31].

And, from these services, other referrals would be made to the SGDCA, which in an objective understanding, would have as a reference for decision making: a) which right had been violated, according to the ECA; b) the type of violence, according to WHO; c) which sector/service would be more consistent, according to the services available in the territory or in the municipality[31].

At best, even if the entities in the system are activated, guiding their actions through notification and systematization of information, intersectoriality challenges professionals. Contradictorily, the research demonstrates a greater participation of PHC, in the composition of the network of protection and prevention of forms of violence in their territoriality and integrality, which reinforces what is the primary care competence[32,33].

In the sample studied, 11.4% were health professionals, 2.3% being nurses. In absolute numbers, a picture that is far from ideal is found, as according to the Code of Ethics for Nursing Professionals, the fundamental principles of the profession reside in the art of caring. However, this is not limited to hospital care, but to care centered on the person, the family and the community, in order to guarantee the quality of life for everyone, always guided by ethical, legal and public health policies that support and guide nursing actions.

Professionals in the health sector held positions in the Municipal Health Department, from management to institutions in the Third Sector. The average age of these professionals was 44 years. All professionals had higher education and more than 10 years of training in their respective degrees. The management positions do not directly affect the actions or the decision of the bodies regarding the SGD's actions; on the contrary, they must guide such decisions.

It is important to note that, in the sectorial division of the collected sample, there is a predominance of institutions in the Third Sector. This demonstrates that there is a sharing of the State's responsibilities towards these institutions, which must be carefully observed since the work of the Third Sector is complementary to the State's actions and not a substitute.

In view of the complexity of violence and its impact on the SGDCA, the sample indicates insufficiency and lack of professionals in the system, especially nurses who participate in the Conversation Wheel. This data characterizes the loss or even the denial of the speech space of these professionals at times when dialogue and intersectoriality are fundamental premises for confronting violence, which guides the study to other paths, such as a qualitative approach on the theme.

CONCLUSION

Networking and the correct referral of those involved in the violation of rights to the reference sectors guides the practice of the participants. However, the reduction in public services and the rise of the Third Sector in recent years reveals that the public subsidy for private service is contradictory in terms of integral protection as a Constitutional Law. In view of the constant need to inspect Third Sector entities, either by the Guardianship Council or by the Public Ministry.

The presence of the nursing professional is of paramount importance in the context of services that address situations of violence against children and adolescents. At the same time, as a pluricausal phenomenon, confronting violence requires multi-professional debate, as a strategy that provides greater clarity to understand the phenomenon by allowing cohesive and concise decision-making in the face of the various types of violence that children and adolescents are subject to.

The reduced expressiveness of the nursing professional in strategies such as the Conversation Wheel raises important issues such as the effective performance of Nursing in the child and adolescent protection network. PHC is a strategic way to prevent the most complex sectors of the safety net from being activated, such as urgent and emergency services.

In this scenario, the impacts of the violation of rights, or even, of noncompliance with what is recommended in the ECA, put the service sectors, and in particular the Health and its professionals, in a constant state of alert, given that most cases incur Urgency and Emergency services.

Thus, it is urgent for the Health sector to launch itself as an engaged and articulated actor in guaranteeing the Rights of Children and Adolescents, especially in the territories of Primary Health Care. Since the non-compliance with the Right to Life and Health, for example, is an indicator and harbinger for the breach of other rights. Primary care and basic social protection can play a fundamental role in the protection network for children and adolescents due to their wide insertion in the territories. The strengthening of primary prevention against violence is urgent, together with the training of professionals.

The study's limitation lies in the need to expand the sample, especially with regard to PHC. At the same time, the articulation of the professional profile with the narratives about the professionals' experiences in dealing with cases of violence against children and adolescents could broaden the understanding of the functioning of the SGDCA and of the intersectoral action.

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CONTRIBUTIONS
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