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REPORT ON THE EXPERIENCE OF MONITORING CASES OF VIOLENCE AGAINST CHILDREN: THOUGHTS ABOUT THE PANDEMIC DUE TO COVID-19 CONTAMINATION

RELATO DE EXPERIÊNCIA NO ACOMPANHAMENTO DOS CASOS DE VIOLÊNCIA CONTRA CRIANÇA: REFLEXÕES SOBRE A PANDEMIA POR CAUSA DA CONTAMINAÇÃO PELA COVID-19

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Abstract
This research searches for reporting how the violence matter had been handled by the multidisciplinary Pediatrics heath staff, throughout 2009. The adopted methodology was based on the observation of the entire follow-up process and the analysis of the records conducted by the health team refered to eight cases identified as suspected or confirmed violence against children. It is a qualitative study descriptive in an experience report modality, based on the care provided to families in the outpatient clinic and in the wards through the intervention Project “Social Service in the health care of victims of mistreatment and violence” during the residency in Social and Health Services. The obtained results point to the necessity to enhancing the discussion and the development of team practices, considering the complexity in managing situations of violence in childhood and the accompaniment of these families aiming at the reduction of children health problems. Bedises that, build institutional flows for the organization of intervention on childhood violence. It’s concluded is pertinent to retake this discussion due to the increase of the violent cases against children during the pademic period because of the new Corona virus SARS-CoV-2.

Keywords: Violence; Health; Childhood; Coronavirus.

Resumo
Este trabalho tem por objetivo relatar como a questão da violência foi trabalhada pela equipe multiprofissional de saúde do serviço de Pediatria, durante o ano de 2009. A metodologia adotada foi a observação de todo o processo de acompanhamento e a análise dos registros realizados pela equipe de saúde referentes a oito casos identificados como suspeita ou confirmação de violência contra criança. É um estudo qualitativo de caráter descritivo na modalidade relato de experiência, a partir do atendimento às famílias no ambulatório e nas enfermarias, por meio do projeto de intervenção “Serviço Social na atenção à saúde da vítima de maus tratos e violência”, durante a residência em Serviço Social e Saúde. Os resultados obtidos apontam para a necessidade de aprofundar a discussão e a construção de práticas em equipe, considerando a complexidade em manejar as situações de violência na infância e o acompanhamento dessas famílias, com vistas a redução dos agravos à saúde das

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crianças. Além disso, construir fluxos institucionais para organização da intervenção sobre a violência na infância. Conclui-se que é pertinente retomarmos essa discussão devido ao aumento dos casos de violência contra criança durante o período de pandemia por causa do novo Coronavírus, o SARS-CoV-2.

Palavras-chave: Violência; Saúde; Infância; Coronavírus.

INTRODUCTION

This paper aims to present some considerations about the performance of the health team in the follow-up of situations of violence in childhood in 2009, relating them to the current pandemic context. This experience occurred during the residency period in the outpatient clinic and pediatric wards in a public hospital in the city of Rio de Janeiro.

We may question whether this experience would be appropriated to think about the interventions in health institutions during the pandemic, since twelve years have already passed. However, it is worth noting that just as the state of public calamity highlighted the structural violence in the country, it also brought to light the gaps in the health teams' interventions. About this structural violence, Minayo[1] makes important contributions, by bringing it as a reference for the analysis of violent behavior. The author defines it as a consequence of historical-economic and social decisions and states that violence is originally a social-historical phenomenon, since it has always existed in history.

Here it is intended to focus on the issue of violence in childhood, with the purpose of presenting one particular experience. However, the literature and the research already show its increase on different groups of the population. It is worth mentioning that there is no claim to exhaust the discussion in this report, but to start some reflections made during this training period.

Despite the theoretical accumulation on the theme of violence, we observed that it is still a new issue to be dealt with by health professionals. Moreover, there has not yet been an effective confrontation of this issue by all professionals of the institution. This impacts the work process of the multiprofessional team, considering that situations of violence are increasingly a significant part of the demands absorbed by the health field since the beginning of the pandemic because of the contamination by the new Coronavirus, the SARS-CoV-2. Moreover, because the health field remains with the challenge

of training capable professionals to deal with the issue of violence in the health field.

REPORT

The study has had as specific objectives to analyze whether the multiprofessional health team could identify and monitor situations of violence in childhood and propose interventions for them. The experiment was carried out during the participation in the care of cases and had as a source of exploration the observation of the intervention process and the analysis of institutional documents referring to eight cases attended by the Social Service for Child Health Care. In this period, 36 cases were followed up by the Social Service, which were classified as: Social Risk; Psychological Violence Negligence; Physical Violence and Sexual Abuse. It is worth mentioning that this number of patients may not represent the reality in its entirety, since, to reach this initial result, only the social service records were used. We opted for a qualitative analysis of documents, such as the social service forms, reports, and information from the Social Service registration books, general medical handbooks, and reports from other professionals that were attached. It is important to inform that the systematization of the data obtained from the appointments was part of the Social Service intervention process. Therefore, the methodological option chosen was based on the analysis of the follow-up of cases classified as confirmed or suspected of violence by the multiprofessional team.

It is pertinent to highlight the existence of an outpatient clinic specialized in assisting families experiencing situations of violence in this service. However, the purpose of this text is to report the experience with professionals who do not have their work focused specifically on the issue of child maltreatment.

REVIEW

It is true that in Brazil, mechanisms to guarantee children's rights have been promoted, and advances in the legislation that configure the concept of comprehensive protection of children and adolescents have followed, through the Constitution of 1988[2] and the Statute of the Child and Adolescent[3] (ECA). Despite this progress, according to Barbiani[4], violations of childhood rights have remained in society.

According to Barros[5], in the current Brazilian situation, the policy for the protection of children still presents many precariousnesses that significantly interfere in the interventions to confront the phenomenon of violence. This reality results in a social protection network with many deficiencies and gaps, which obscures the actions of health professionals. During the monitoring of cases, it was observed that, if the law is not accompanied by effective measures, it can easily become an instrument of guilt and not of protection for families living in situations of violence, because, according to Barbiani[4], while social inequalities endure, we will see society commit perversities in its sociais class, generational, gender, and race inscriptions. And especially in the most vulnerable groups, such as children and adolescentes.

Minayo[1] says that, although violence is part of the list of health problems in Brazil and worldwide, the insertion of this issue in the health sector occurred belatedly. According to her, violence against children has brought to the fore the importance of inserting the issue on the agenda of this sector. However, she concludes that the biggest barriers for this sector to assume the issue of violence as a demand is in the biomedical rationality, because this model would have to undergo changes that could also deal with complex issues related to social life. In addition, the rationality of the health sector would also need to undergo changes so that the rights that have been conquered could be enforced and health actions could be guided by the broad conception of health provided by the Constitution of 1988[2]. We agree with Barbiani[4], when she states that the hegemonic model of health care in Brazil focuses on the interventions on injuries and traumas resulting from situations of violence and that the precariousness of the actions related to prevention and notifications of the phenomenon are serious gaps.

Barros[3] pointed out isolation as one of the complexities existing in the prevention and assistance actions to combat domestic violence. What the author could not foresee at that time is that, from 2020 on, social isolation would be a worldwide strategy and the most effective one to curb the contamination from covid-19. And that this new way of living in society would result in the intensification of the phenomenon in Brazil during the pandemic. The increase in the number of cases is not a result of the clinical aspects of the pandemic, but of the social inequalities that already existed and produced great effects on the living conditions of children and their families.

According to Cabral, Ciuffo, Santos, Nunes, Lombas[6], the education policy in Brazil also has the attribution of protecting children in vulnerable situations, however, during the pandemic, this role could not be fulfilled because of the need for classroom interruption. There is no doubt that the social isolation strategy was fundamental in controlling the spread of covid-19. However, the authors explain that the growth of economic hardship, in conjunction with the social distancing measures, resulted in an increase in domestic violence and a decrease in reports and notifications. The authors conclude, therefore, that this conjuncture would have reverberated in the deepening of the invisibility of the issue. They also report that several remote tools and communication channels for denunciations were made available for the purpose of child protection. However, they point to the relevance of strengthening integrated actions, identification, and early intervention on rights violations to ensure the integrity of the protection of children and adolescents. This intervention process is exposed by the authors as a necessary path in the current pandemic situation. The considerations that we will present below will be supported by this perspective.

RESULTS ACHIEVED

The flow of care in the outpatient clinic and in the infirmaries starts through the entrance door, which is divided into two possibilities: previously scheduled appointments with professionals from different areas; or, SPA (Emergency Care Service) appointments, whose objective is to receive the demands of children with chronic diseases being monitored in pediatrics that arise between scheduled appointments. Before the medical appointments, the children are seen by the nursing team, which has the function of collecting developmental data. In this initial contact, these professionals sometimes witness situations of physical and psychological abuse and neglect. When the nursing team notices issues that suggest violence, it is common to request the intervention of the Social Services.

When violence is suspected or confirmed during health care, most of the time the professionals refer the situation to the Social Service, through a request for an opinion or referral, signaling the issue of mistreatment. In some situations, health professionals seek the Social Service to request advice and collaboration regarding the notification process, since many professionals claim to be unaware of this procedure.

During the analysis of the institutional documents, we verified some important data. In the firstly, the reduced number of reports that make the relation between the child's clinical state and the situation of violence. Most of the time, the reports only clarify the health condition, relating it only to the illness.

Second, the absence of reports in general medical records about situations of suspected or confirmed violence. This posture is common to the entire team, which, despite carefully recording the evaluations and conducts carried out regarding the illness, does not express its impressions and evaluations on the issue of violence in institutional documents. This gap in the records results in a lack of technical elements on which to base the evaluation and intervention of the multiprofessional team. During the articulations with the protection network, we observed the demand for documents that point out when there are indications that the illness is a consequence of the violation of rights.

The systematization of the care of high social complexity is of utmost importance, even though the confidentiality of some of the data collected is safeguarded, because this procedure has the ability to promote the socialization of each assessment and intervention performed by the multiprofessional team. Furthermore, it helps in the reflection of the professional exercise and, as Almeida[7] shows, for the team to remove itself from an alienating work process. That is, to rethink conservative and common sense postures that may be present during the follow-ups This method of evaluation is fundamental when dealing with situations of rights violations, because, according to Minayo[1], in many cases, these are experienced as a naturalized cultural element and part of social interactions. Thus, we believe that health professionals are not detached from this reality.

During the daily dialogues held with the health teams about the cases, it was possible to raise the hypothesis that the professionals would not be recording the issues related to these situations because they still have a reduced understanding of the concept of health. However, we can also question that such a posture may be a reflection of the insecurity generated by the difficulties encountered in the protection network.

In any case, it is important to understand the impacts that the lack of professional records can have on the management of the cases and, consequently, on the reality of these children. Some occurrences attended by the Health Service may not be notified and followed up because there is no record of the facts that suggest a situation of violence.

Analyzing the gaps in institutional documents regarding the issue of violence is indispensable, as these can be an expression of existing deficiencies in the intervention process. It is worth noting that this analysis is substantial for the qualification of the care and of the professionals who are being trained in the health unit.

Third, when a professional perceives the need for clinical investigation or intervention because of suspected violence, the child may be referred for hospitalization. This procedure is considered by the health team as sociais hospitalization. And, for this reason, the Social Service is called in to monitor the child and his or her family. Depending on the case, professionals from other areas are called in to contribute to the evaluation of the child's health conditions and the suspected violence.

In these cases, although other health professionals have assessed the need for social hospitalization, because from their technical knowledge a situation of suspected or confirmed violence was identified, the Social Service is understood to be directly responsible for the hospitalization, considering that the child was not admitted to the infirmary primarily for clinical causes but for social issues. In view of the above, we realize that the conception of violence as a public health issue, as defined by the World Health Organization[8], still presents itself as a challenge for the actions of the social service.

In other cases, violence can be identified during the hospital stay, by means of some indicators: the absence of those responsible for the child during hospitalization; violent relationships in the child's and caregiver's daily life; or even the conclusion that the clinical diagnosis is the result of the absence of care or a violent act. In all these situations, the posture of the health team is similar. From the moment the issue of maltreatment is identified, the multiprofessional team does not perceive itself as responsible for the follow-up, notification and possible interventions to confront violence.

Fourth, we identified that one of the aspects that generates tension in the practice of notification and follow-up of cases is based on the different organizational logics present in the institution. The pediatric service is organized in the following way: the staff in the outpatient clinic is not the same as in the wards. In addition, each ward has its own staff, and the children who undergo care in these different services may be the same. This system can give opportunity to different evaluations and disjointed interventions on the reality of the same family, if there is no management that coordinates the interventions within a logic of continuity.

Thus, a child who is admitted by the outpatient team for suspected violence may be evaluated by the ward team under another aspect, which will result in discharge without any intervention regarding the initial suspicion. This can occur without the health care teams responsible for the care of the child and his family discussing the proposed management.

In this sense, we observed an important gap in the process of monitoring situations of violence: absence of multiprofessional spaces for discussion of cases. There are meetings in which the clinical issues of the inpatients are dealt with by the health team. This is open to all professionals. However, it is not an opportunity to reflect on issues that go beyond the clinical aspects of the cases. The lack of meetings that promote dialogue and evaluation of different professionals has resulted in punctual contacts to elaborate possible referrals; absence of spaces to think about violence in a broader perspective and the impossibility of discussions that promote the construction of a solid and articulated intervention by the health team.

The Social Service working in the pediatric service has the same team that attends both the outpatient clinic and the inpatient wards, with the objective of providing integral care to children and their families. When social workers organize themselves as a single team to work in the different sectors of this service, the goal is to bring a proposal that leaves behind this fragmented logic, based on the conception of curing the disease. In addition, the professional work is shifted to the logic of integrality of actions, in order to implement what was proposed in the Sanitary Reform, in which health is understood from different determinants, as stated in the Constitution of 1988[4]. In this way, the subjects are understood in their totality so that the social situation of the children and their families is visible, as well as the situations of violence that may be present in these relationships.

The assistance provided by this service has great possibilities to advance in the qualification of the assistance to situations of violence if there is articulation among the teams in the daily work. These teams are highly prepared for assistance and teaching in their specialties, but they act independently from each other, without a flow that promotes articulation among them.

Peduzzi[9] reminds us of the difference between "team as a grouping of agents and team as interaction of work". The first would be characterized by the "juxtaposition of actions and the grouping of agents" and the second by the "integration, in which occurs the articulation of actions and the interaction of agents". The author understands by articulation "the work situations in which the agent elaborates correlations and puts in evidence the connections among the several interventions performed"[9].

It was observed that the teams' interventions are expressions of their training, worldview, and conception of what health, childhood, family, care, and violence are. Therefore, faced with this reality, the organization of a work flow that promotes what Peduzzi[9] calls articulation is a permanent challenge for managers in the health field.

Finally, when analyzing the intervention of the Social Service team, we found that the monitoring of cases of violence is developed from a set of actions that consist of: welcoming and monitoring the family; identifying, analyzing, and classifying the violence; planning about intervention strategies; elaborating a specific documentation; communicating and articulating with other services, competent bodies, and different policies.

However, It has been evaluated that this attention offered to the population can become more complex and qualified if the health teams are part of this whole process. After all, according to Deslandes[10], the phenomenon of violence is a complex process. Therefore, we can infer that interventions should have the same level.

It is worth saying that it was possible to identify professionals from different areas of health that allowed themselves to act and propose intervention paths, during the monitoring of high complexity social situations. Unfortunately, others evaluated the same issues as problems that hindered their professional practice. This difference of perception about the cases of violence occurred among different teams, and even among professionals of the same professional area.

It is certain that there is a hierarchy established in relation to knowledge within the health institution. Medical knowledge is conceived as preponderant to the others. Social knowledge has historically represented a subordinated knowledge and this translates into the devaluation of the social evaluation of the child and his family for understanding the process of illness and, consequently, in the direction given to the intervention.

The meaning given to illness is still linked to the cure of the disease in many professional practices. Thus, when the disease is identified as a result of a situation of violence, the team may feel limited in its intervention, since the issue requires interventions that go beyond "solving a diagnosis". When violence is one of the determinants of the pathology, the prescription of tests and medications

itself loses its meaning, because soon there will be new episodes of illnesses and hospitalizations. Moreover, it challenges the team, regardless of the professional area, to look at the social situation of the child and his family.

CONCLUSION

The pandemic due to contamination by the new Coronavirus, the SARS-CoV-2 challenges us to reflect on issues that were already present historically in the economic, political and social scenario. Just as they also already existed in the way health institutions had been preparing themselves to intervene in the issue of violence. We identified some gaps in the intervention of the multiprofessional team during the reported experience, but these are far from offering definitive explanations for the theme addressed.

This research shows that trainings can be a way to qualify the team's intervention, so that it can act on issues of violence. At the same time, it is of great importance to have an institutional organization that enables the articulation between different knowledge to think about intervention proposals. Moreover, it is essential to reflect on the conceptions of health, childhood, family, and violence present in order to make advances in teaching, research, and assistance. In the epidemic context, the issue of violence and the assistance to these situations have become more complex due to the possibility of contamination. Research shows that numerous obstacles have made it difficult for these demands to reach the institutions and competent bodies. Therefore, it is essential that professionals are prepared to identify and monitor the cases of violence that reach the health services, whether through a complaint, a pain, physical or emotional, or even silence.

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