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Notification of juvenile violence in Emergency Services of the Brazilian Unified Health System in Feira de Santana, Bahia, Brazil

Notificação da violência infanto-juvenil em Serviços de Emergência do Sistema Único de Saúde em Feira de Santana, Bahia, Brasil

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ABSTRACT: ***Objective:*** To analyze the performance of professionals in the Emergency Units for the notification of cases of violence against children, considering sociodemographic characteristics, professional category and difficulties. ***Methods:*** Cross-sectional study with a simple random sample (n=200), selected from the universe of professionals (n=523) of these Emergency Units in Feira de Santana, Bahia, Brazil, from a regional general hospital and six polyclinics. Bivariate analyses and measures of association were performed to determine statistical significance. ***Results:*** Most professionals were female (82.5%), aged between 20 and 40 years old (75.5%), being nursing technicians (52.5%) and nurses (22.5%), 69.0% with a temporary employment contract. The notification was recorded by 69.5%, of them, and 60.0% asked for the opinion of another professional; 54.0% talked with the family and 42.9% reported to the Accident and Violence Surveillance System (VIVA). Statistical significance was observed in the nursing technicians category for the notification to sectors of reference, with a 95% confidence interval (95%CI) 1.28 – 2.09; and VIVA (95%CI 1.06 – 7.40). In the medical category, the significant result was not requesting the opinion of another professional (95%CI 1.02 – 3.51); not being afraid of judicial involvement (95%CI 1.19 – 4.06) and being trained in the violence matter (95%CI 1.21 – 5.00). The main difficulties cited were family omission (91.5%), fear of judicial involvement (63.5%) and lack of training (47.0%). ***Conclusion:*** Most cases of violence seen at the Emergency Units were notified, however, less than 50% of professionals did not notify VIVA, pointing the need for institutional investment in technical support and ongoing training. Actions addressed to notification strengthen institutions and make the sector responsible for victim care and protection.

Keywords: Violence. Health systems. Emergencies. Mandatory reporting. Child. Adolescent.

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RESUMO: ***Objetivo:*** Analisar a atuação dos profissionais das unidades de emergência em saúde para notificação dos casos de violência infanto-juvenil, considerando características sociodemográficas, categoria profissional e dificuldades. ***Métodos:*** Estudo transversal, com amostra casual simples (n = 200), do universo de 523 profissionais de Feira de Santana, Bahia, distribuídos entre um hospital geral regional e seis policlínicas. Foram realizadas análises bivariadas e medidas de associação para determinar significância estatística. ***Resultados:*** A maioria dos profissionais era do sexo feminino (82,5%), com idade entre 20 e 40 anos (75,5%), técnicos de enfermagem (52,5%) e enfermeiros (22,5%), sendo que 69,0% tinha contrato temporário de trabalho. A notificação foi registrada por 69,5% e 60,0% solicitaram parecer de outro profissional, 54,0% conversaram com familiares e 42,9% notificaram no Sistema de Vigilância a Acidentes e Violência (VIVA). Na categoria técnico de enfermagem foi verificada significância estatística para notificação aos setores de referência, com intervalo de confiança de 95% (IC95%) 1,28 – 2,09 e para o Sistema VIVA (IC95% 1,06 – 7,40). Na atuação dos médicos, o resultado significante foi não solicitar parecer a outro profissional (IC95% 1,02 – 3,51); não ter receio de envolvimento judicial (IC95% 1,19 – 4,06) e ter formação nessa área (IC95% 1,21 – 5,00). As principais dificuldades citadas foram omissão familiar (91,5%), receio de envolvimento com sistema judicial (63,5%) e falta de capacitação (47,0%). ***Conclusão:*** A maioria dos casos de violência atendidos nas unidades de emergência foi notificada, entretanto, menos de 50% dos profissionais não notificaram no Sistema VIVA, apontando necessidade de investimento institucional em apoio técnico e qualificação permanente. Ações direcionadas à notificação fortalecem instituições e responsabilizam o setor para atendimento e proteção às vítimas.

Palavras-chave: Violência. Sistemas de saúde. Emergências. Notificação de abuso. Criança. Adolescente.

INTRODUCTION

Violence has always been part of the human experience, but it currently stands out in the political agenda and in national and international organizations which are in charge of initiatives and proposals addressed to prevention, intervention and defense of the human rights[1]. Recognizing juvenile violence as a social problem has led to the need for discussion, as well as political and social mobilization worldwide. The magnitude of this phenomenon in different contexts and countries has shown how important it is to involve several segments and social sectors in the implementation of programs and actions, as well as cognitive aspects, development and social integration of the juvenile population.

International documents such as the Declaration of Human Rights (1948) and of the rights of the Child (1959) had repercussions in Brazil, however, only in the 1980s, with the Constitution, and in the 1990s, with the formulation of the Statute of the Child and

Adolescent (ECA), the violation of the rights in this population group stood out in the national scenario[2]. ECA is a social instrument, as well as an tool used by the public power to transform the reality of victims with regard to the different manifestations of violence, be it social violence, negligence, physical violence, sexual exploration, among other forms of human rights violation[1,3].

Integrating the Unified Health System (SUS), emergency units are one of the important sectors of care, being part of a privileged organization that analyzes the dimension of violence, once, in these services, the phenomenon gains visibility, and becomes part of the work process and of the interaction between professionals and clients[4]. By considering emergency units as protective services, the professionals of these units must be able to identify and conduct procedures and referrals related to cases of violence, especially with regard to notifying the Accident and Violence Surveillance System (VIVA), from the Ministry of Health. This system aims at knowing the dimension and the profile of the assisted external causes, thus allowing an approximation with the real situation, especially in cases of less severe injuries, which did not lead to death or hospitalization, considering the strong impact of these events on health, as well as the high demand of these cases in emergency units[5].

It is valid to mention that the VIVA system was implemented in the different regions of Brazil, in 2006, assuming the responsibility of monitoring non-fatal violent events and victims, in the different population segments and courses of life, assisted by SUS[6].

The identification and notification of violence to the competent authorities is decisive to fight it, as well as the insertion of health professionals in this process, which becomes essential due to their privileged position in terms of caring for the most evident consequences[7]. These professionals are presented as protective agents, responsible for activating the support of the multidisciplinary staff through groups of surveillance and care, as well as for enabling the process of notification and referral of suspected or confirmed cases[2].

This study aims at analyzing the work of professionals in emergency units in the process of notification of juvenile violence cases, considering sociodemographic characteristics, professional category and main difficulties.

METHODOLOGY

This is a cross-sectional study conducted with a sample of health professionals who integrate the emergency units of Feira de Santana, Bahia. The study included the units that provide this type of care in the city, accounting for a total of 7, distributed in 1 regional general hospital of the state (Clériston Andrade), with 523 professionals and 6 polyclinics, with 238 professionals, distributed in the following units: Tomba (57), George Américo (43), Parque Ipê (38), Rua Nova (44), Feira X (40) and Distrito de Humildes (18), which were

represented by categories of physicians, nurses, nursing technicians, physical therapists, dental surgeons and social workers.

The sample calculation was simple and casual, by considering a total of 523 technicians. Estimated prevalence was 20%, standard error, 5%, and 95% confidence interval, resulting in a sample size of 200. This study included those who had been employed for more than one year, the ones who were part of the staff and were performing their activities during the data collection period.

A standardized questionnaire was developed to study the action of the professionals towards the cases, and the study variables were selected based on literature[8,9]. The outcome variable was the notification of cases, suspected or confirmed, to the competent parties, considering medical appointments in the past six months (to prevent memory bias). The descriptive variables of the outcome were the ones with possible influence on the notification: (1) sociodemographic variables: gender, age group, marital status, presence of children; (2) professional characteristics: professional category, expertise, length of experience in the category and in the emergency service, type of professional contract; (3) assisted cases of violence: physical, sexual, negligence/abandonment; (4) professional decision in cases of violence: requesting the opinion of another professional, talking with the family, questioning the child, notifying competent parties, filling out the form from the VIVA system; referrals: child protective services, police, Public Prosecutor's Office; credibility towards reference institutions: confirmation/identification, accusation, referral/follow-up of cases; (5) education on the theme: offered by the unit and interest in learning about the theme; (6) difficulties with notification: fear of getting involved with justice; fear of separating the child from the family, retaliations from the aggressor, lack of professional education and family negligence.

The access to emergency units for data collection was documented and authorized by the Secretariat of Health (Sector of Permanent Education). The Informed Consent Form was signed by the professionals, after learning about the objectives of the study, and they were ensured of anonymity, confidentiality and the volunteer aspect of the participation. The questionnaire was answered individually and in secrecy. Afterwards, it received a numerical code and was stored in a sealed envelope. Collection was executed from October to December, 2010. The software SPSS, version 12.0, was used to process the data. Data were analyzed by descriptive statistics, bivariate analysis, and measurement of the association prevalence ratio (PR) and respective 95% confidence intervals (95%CI), with the Pearson's chi-squared test (χ^2) with $p \leq 0.05$.

This study was approved by the Research Ethics Committee of Universidade Estadual de Feira de Santana, protocol n. 057/2010, CAAE 0055.0.059.000-10. It is important to mention that this article constitutes the result of an original study of the authors, and there is no conflict of interests.

RESULTS

Two hundred professionals were analyzed, from the universe of professionals (n = 523), considering possible losses during the data collection process.

Among the analyzed sociodemographic characteristics (Table 1), the results showed most participants were women (82.5%), aged between 20 and 40 years old (75.5%), married or in a consensual relationship (61.0%), and with children (60.0%). As to professional characteristics: 52.5% were nursing technicians, 22.5% were nurses, 17% were physicians, 54% had specialization courses; 48% had up to 5 years of professional experience, and most of them (71.0%) worked in emergency units with a temporary work contract (69.0%).

In the past 6 months, 35.7% of the professionals informed having worked with at least one case of juvenile violence. In this group, types of violence were: physical (63.4%), sexual (43.7%) and negligence/abandonment (33.8%). Among the procedures adopted for the cases, asking the opinion of another professional stands out (60.0%), as well as talking with the family (54.0%), and notifying to competent parties (69.5%). However, only 42.9% (n = 56) of the professionals filled out the notification form of the VIVA system. Most of them reported referring the cases to child protective services (95.0%), and 41.5% called the police (41.5%). With regard to the credibility of reference institutions, most professionals claimed to trust them, especially in terms of referring and following-up the cases (65.0%).

Education to work on cases of violence and on the process of notification was reported by only 30.5% of the professionals, and 82.0% of them claimed to work differently after taking courses about this theme; 95.5% were interested in taking up courses about this subject. Among the difficulties to notify the competent parties, family negligence was mentioned (91.5%), as well as the fear of professional involvement with the judicial system (63.5%) and the lack of professional skills facing the procedures to be adopted in cases of violence (47.0%).

In the analysis of the associations between the notification of the case and the variables related to professional characteristics, education on the subject, referrals and credibility in reference institutions (Table 2), it was possible to observe a significant result ($p \leq 0.05$): with regard to professional category ($p \leq 0.001$); having taken a course in the work unit ($p = 0.041$); referring cases to the police ($p = 0.001$); having credibility towards the institutions regarding the confirmation/identification of cases ($p = 0.049$).

In relation to work, according to professional category (Table 3), it was possible to observe statistical significance, with positive associations for some aspects of work: in the category of physicians, regarding the fact of not asking the opinion of another professional (PR = 1.90; 95%CI 1.02 – 3.51); not being afraid of juridical involvement (PR = 2.20; 95%CI 1.19 – 4.06) and not lacking professional skills on the theme (PR = 2.46; 95%CI 1.21 – 5.00). Among nursing technicians, there was statistical significance for notifying competent parties (PR = 1.64; 95%CI 1.28 – 2.09) and filling out the notification form of the VIVA system (PR = 2.81; 95%CI 1.06 – 7.40). It was also possible to observe that the categories of physician and nurses showed statistical results with negative associations related to notification (PR = 0.39; 95%CI 0.16 – 0.96) and (PR = 0.39; 95%CI 0.16 – 0.96), respectively;

Table 1. Characteristics of health professional in Emergency units, of assisted cases, work, education and difficulties with notification, Feira de Santana, Bahia, 2010.

Health professionals (n = 200)		
Sociodemographic and professional characteristics	n	%
Sex		
Male	35	17.5
Female	165	82.5
Age (years)		
20 to 30	77	38.5
31 to 40	74	37.0
> 40	49	24.5
Marital status		
Single	62	31.0
Married/Consensual union	122	61.0
Others[a]	16	8.0
Children		
Yes	120	60.0
No	80	40.0
Profession		
Nursing technician	105	52.5
Nurse	45	22.5
Physician	34	17.0
Others[b]	16	8.0
Specialization in the professional category of origin		
Yes	108	54.0
No	92	46.0
Contract in the emergency unit		
Temporary contract	138	69.0
Effective	62	31.0
Cases of violence[c] (n = 71)	n	%
Assisted cases	71	35.7
Type of violence		
Physical	45	63.4
Sexual	31	43.7
Negligence/abandonment	24	33.8

Continue...

Table 1. Continuation.

Health professionals (n = 200)		
Work and professional education	n	%
Professional conduct[d]		
Requested the opinion of another professional	120	60.0
Talked with the family	108	54.0
Questioned the child	72	36.0
Notified competente parties	139	69.5
Filled out the VIVA form[e]	24	42.9
Referrals[d]		
Child protective services	190	95.0
Police	83	41.5
Public Prosecutor's Office	50	25.0
Credibility towards reference institutions		
Confirmation/identification	119	59.5
Accusation	128	64.0
Referral/follow-up	130	65.0
Courses on violence		
Yes	61	30.5
No	139	69.5
Unit offers courses addressed to violence		
Yes	24	12.0
No	176	88.0
Interest in courses to approach violence		
Yes	191	95.5
No	9	4.5
Difficulties with notification	n	%
Fear of judicial involvement	127	63.5
Fear of separating the child from the family	40	20.0
Fear of retaliation from the aggressor	27	13.5
Lack of professional skills	94	47.0
Family negligence	183	91.5

[a]Widower and separated; [b]Physical therapist, dental surgeon and social worker; [c]n = 61; [d]Multiple choice questions; [e]n = 56; VIVA: Accident and Violence Surveillance System.

Table 2. Notification of juvenile violence cases, according to professional characteristics, education on the subject, referrals and credibility towards reference institutions. Emergency Units, Feira de Santana, Bahia, 2010.

	Notification		p-value
	n	%	
Professional characteristics and education			
Sex			
Male	28	80.0	0.137
Female	111	67.3	
Age (years)			
20 to 30	52	67.0	0.507
31 to 40	55	74.3	
> 40	32	65.3	
Marital status			
Single	44	71.0	0.210
Married/Consensual union	87	71.3	
Others[a]	8	50.0	
Profession			
Physician	29	85.3	0.000
Nurse	40	88.9	
Nursing technician	61	58.1	
Others[b]	9	56.3	
Specialization			
Yes	81	75.0	0.067
No	58	63.0	
Courses on violence			
Yes	48	78.7	0.062
No	91	65.5	
Unit offers courses addressed to violence			
Yes	21	87.5	0.041
No	118	67.0	
Interest in courses to approach violence			
Yes	135	70.7	0.095
No	4	44.4	
Referrals			
Child Protective Services			
Yes	134	70.5	0.169
No	5	50.0	
Police			
Yes	68	81.9	0.001
No	71	60.7	
Public Prosecutor's Office			
Yes	40	80.0	0.063
No	99	66.0	
Credibility towards institutions			
Confirmation/identification			
Yes	89	74.8	0.049
No	50	61.7	
Accusation			
Yes	92	71.9	0.331
No	47	65.3	
Referral/follow-up			
Yes	94	72.3	0.240
Noo	45	64.3	

[a]Widower and separated; [b]Physical therapist, dental surgeon and social worker.

Table 3. Action and difficulties to notify juvenile violence according to the categories of health professional. Emergency Units, Feira de Santana, Bahia, 2010.

Action/difficulties[a]	Professional category									Others[e]		
	Physician[b]			Nurse[c]			Nursing technician[d]					
	n	%	PR (95%CI)	n	%	PR (95%CI)	n	%	PR (95%CI)	n	%	PR (95%CI)
Action												
Requesting the opinion of another professional												
Yes	15	44.1	1.90	28	62.2	0.91	69	65.7	0.78	8	50.0	1.50
No	19	55.9	(1.02 – 3.51)	17	37.8	(0.53 – 1.55)	36	34.3	(0.58 – 1.04)	8	50.0	(0.58 – 3.83)
Talking with the family												
Yes	17	50.0	1.17	29	64.4	0.64	51	48.6	1.24	11	68.8	0.53
No	17	50.0	(0.63 – 2.16)	16	35.6	(0.37 – 1.11)	54	51.4	(0.95 – 1.61)	5	31.3	(0.19 – 1.48)
Questioning the child												
Yes	12	35.3	1.03	21	46.7	0.64	35	33.3	1.12	4	25.0	1.68
No	22	64.7	(0.54 – 1.95)	24	53.3	(0.38 – 1.07)	70	66.7	(0.84 – 1.49)	12	75.0	(0.56 – 5.04)
Notifying competente parties												
Yes	29	85.3	0.39	40	88.9	0.28	61	58.1	1.64	9	56.3	1.77
No	5	14.7	(0.16 – 0.96)	5	11.1	(0.11 – 0.68)	44	41.9	(1.28 – 2.09)	7	43.8	(0.69 – 4.54)
Filling out the VIVA form[6]												
Yes	1	20.0	3.00	16	59.3	0.51	4	21.1	2.81	3	60.0	0.50
No	4	80.0	(0.35 – 25.15)	11	40.7	(0.29 – 0.89)	15	78.9	(1.06 – 7.40)	2	40.0	(0.09 – 2.76)
Difficulties												
Fear of judicial involvement												
Yes	15	44.1	2.20	28	62.2	1.05	74	70.5	0.72	10	62.5	1.04
No	19	55.9	(1.19 – 4.06)	17	37.8	(0.62 – 1.79)	31	29.5	(0.53 – 0.98)	6	37.5	(0.39 – 2.75)
Fear of separating the child from the family												
Yes	8	23.5	0.81	5	11.1	2.00	24	22.9	0.84	3	18.8	1.08
No	26	76.5	(0.39 – 1.65)	40	88.9	(0.84 – 4.73)	81	77.1	(0.62 – 1.13)	13	81.3	(0.32 – 3.62)
Fear of retaliation from the aggression												
Yes	2	5.9	2.49	5	11.1	1.24	18	17.1	0.75	2	12.5	1.09
No	32	94.1	(0.63 – 9.82)	40	88.9	(0.54 – 2.88)	87	82.9	(0.55 – 1.02)	14	87.5	(0.26 – 4.54)
Lack of professional skills												
Yes	9	26.5	2.46	19	42.2	1.21	58	55.2	0.71	8	50.0	0.88
No	25	73.5	(1.21 – 5.00)	26	57.8	(0.72 – 2.04)	47	44.8	(0.55 – 0.93)	8	50.0	(0.34 – 2.27)
Family negligence												
Yes	31	91.2	1.04	44	97.8	0.24	98	93.3	0.76	10	62.5	6.45
No	3	8.8	(0.35 – 3.05)	1	2.2	(0.03 – 1.66)	7	6.7	(0.42 – 1.37)	6	37.5	(2.67 – 15.59)

PR: prevalence ratio; [a]multiple choice questions; [b](n = 34); [c](n = 45); [d](n = 105); [e](n = 16).

for nurses, with regard to filing out the notification of the VIVA system (PR = 0.51; 95%CI 0.29 – 0.89). The same results were verified among nursing technicians, as to the fear of juridical involvement (PR = 0.72; 95%CI 0.53 – 0.98) and lack of professional education (PR = 0.71; 95%CI 0.55 – 0.93).

DISCUSSION

Facing the violence cases and from the perspective of the sentinel services, the emergency unit represents one of the "entrance doors" of the Health System, working as an opportunity to reveal the case. Therefore, this sector is strategic to analyze indicators of violence, its different manifestations and consequences[4]. It is worth to mention that Basic Care, represented by the Family Health Strategy (ESF), also provides access to the system, and has the same responsibility in terms of identifying and notifying cases of violence, especially due to the characteristics of the work process regarding the approach to families, household visits, care and connection[10,11].

The notification of juvenile violence in emergency units allows characterizing the limits and difficulties faced by professionals, especially the excessive number of visits, the lack of privacy, the absence of resources, as well as scarce professional training[12]. The invisibility of the phenomenon is accompanied by the disbelief in the responsibilization of competent parties and the maintenance of the cycle of violation by the approximation of the victim and the aggressor[9,13]. This evidence compromises the efficiency of the care network, tends to trivialize and postpone protective measurements, reinforcing the need to sensitize and educate professionals as to the importance of identifying and notifying cases in the work routine.

Among the difficulties pointed out in this study, the fear of judicial involvement, reported by many professionals, corroborates the findings of other researchers who observed this characteristic, attributed to the lack of or insufficient institutional support, as well as to the lack of influence of the professionals in terms of conflicting social relationships that are part of domestic violence[14]. The creation of institutional responsibility dynamics to notify cases and preserve the life and the dignity of the victim is essential for the success of actions against violence in emergency services. In this process, for the respective emergency units, the identification of attributions must be specific for each professional category, immediate management and board (social services, health professionals and board of the institutions), with regard to filling out the forms referring to the notification. By understanding that the notification is a responsibility (both ethical and legal) of the health professional, the institution must guarantee this practice, protecting the individual from all pressures and sharing the responsibility for the case[10].

In the mentioned study, even though most professionals denied having specific education in the field, about 70% of them confirmed having notified cases to reference institutions (child protective services), with significant results for the notification in the following

categories: physician, nurses and nursing technicians. These findings can suggest the possibility of articulation between the Health System and the System of Guarantee of Rights (SGDCA), which is essential to strengthen the Network of Care and Protection to children and adolescents who are victims of violence. Studies suggest that the establishment of an intrinsic and cohesive relationship between these systems is based on aspects such as the feedback/display of information concerning the notification for the professional, in order to strengthen the process of notification in the services[15].

The approach of domestic violence cases requires a social and committed professional practice. Literature recommends that technicians (professionals) and institutions should clarify the obligatoriness and the content of notifications for the families[2,3].

In this negotiation, the notification should be presented as a mean to access institutions and services, being necessary for prevention and intervention, thus reducing the effects and factors that favor violence[14].

Studies indicate the positive influence of education, access to courses and sensitization in the field addressed to the attitude of health professionals by notifying cases of juvenile violence[16,17]. The findings in this study showed that, even though most of the participants had not attended specific courses on the subject, the notification of violence cases was reported by 69.5% of the professionals, suggesting that the practice of approximation and the listening process contribute with the understanding of several aspects related to violence in health services.

Researchers recommend that courses should be seen as opportunities to work the main difficulties found by health professionals when assisting victims that go to the service, as well as the main procedures involving notification, considering the importance of education in the field[18]. Studies show that these gaps are present in the disciplines taught by graduation courses in the health field, which do not approach the multiple aspects related to violence[19].

The findings in this study, which verify that about 70% of the professionals did not attend courses in this field, corroborate other studies conducted in the same city, in which only 30.5% of the health professionals from basic care (ESF and Basic Health units) were skilled to work in the process of identification and notification of violence cases[8,18-20]. With regard to the credibility in SGDCA, evidence shows that this conduct can have a positive or negative influence on the notification process[21,22]. In this study, it was possible to observe a positive and significant association between the notification and the credibility in the institutions, with regard to the identification and confirmation of cases, thus suggesting the articulation between the practices of professionals from different sectors involved in care, defense and protection. With regard to referrals, child protective services, which is a permanent, autonomous and non-jurisdictional party, is reference in terms of guaranteeing the rights, by embracing and checking the accusations[3,23]. The results presented in this study show that most professionals referred the cases to child protective services, even though a considerable proportion of them have referred cases to the police sector, whose attributions are different. From the perspective of Whole Care provided to children and adolescents who are victims of violence, the police sector (Public Safety) is not part of the group of

institutions addressed to care and referral of the victims, even though it is part of a network of institutions that provide civil protection facing violent social events[24]. In this context, while most professionals referred the cases properly, part of them considers that juvenile violence is a problem involving Public Safety. The results in this study corroborate the findings of other analyses, which showed the inadequate conduct and referral for violence victims, thus contributing with the perpetuation of the cycle of victimization[8,25].

The fear of confrontation with the aggressor and the impact of these threats upon family members, are some of the difficulties mentioned by professionals to justify the non-notification of violence cases[26]. The closeness with the aggressor makes revelation more difficult, thus increasing the risk of recurrence. It also compromises the family core, which is often aware of the victimization. In this study, professionals reported this difficulty, among others, thus corroborating possible associations between the notification and factors related to aggressors and the family environment[27-29].

In the study from Feira de Santana, Bahia, it is important to mention the significant association between the notification in the VIVA system by the category of nursing technicians, which suggests the importance of professional education in all categories and levels of care in the health sector[5,6,30].

The complexity of the notification of violence cases in the health network has been an object of study in other countries (the United States and Australia), where barriers begin by the lack of record standardization, whose indicators show that the notified cases are not confirmed, and most of them do not receive any other type of care or referral, thus demonstrating the importance of strengthening and structuring the protective network for the victims[30].

The result of this study was significant in the category of physicians regarding the fact that they do not require the opinion of another professional. These results can possibly be a consequence of the dynamics from the emergency service, which requires immediate action, after fast evaluations. Therefore, it is more difficult to conduct more extensive discussions in possible cases of violence, together with the staff[10].

On the other hand, the results in the same study that pointed out significant results for the notification and filling out of the notification form in the VIVA SYSTEM, by nursing technicians, can be related to the longer length of care, which promotes more closeness and connection between victims and family members.

FINAL CONSIDERATIONS

Even though the health sector has been working for the institutional strengthening and the articulation with the Network of Prevention, Care and Guarantee of Rights/SGDCA, the violence scenario from the perspective of care and notification of health services is more complex than the lack of preparation in professional education addressed to care. This reality suggests the need to invest in actions and multidisciplinary education programs in the field.

The inadequacy of the biomedical model in the formation of professionals requires new alternatives to fill the gaps of education. From this perspective, the health sector is faced with the challenge to improve and extend its infrastructure by using skilled teams, with efficient routines and management for the institutionalization of the notification process, in order to care for victims and families[15].

It is recommended that the gaps of the results presented here should be further analyzed, and the matter of juvenile violence notification should be amplified, with more complex analyses of interaction models with longer activities in emergency units, in order to understand how the investigated context works.

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