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ORIGINAL ARTICLE

The care network of the families involved in violence against children and adolescents: the Primary Health Care perspective

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Aims and objectives. To contribute the understanding of the network care provided to families involved in family violence against children and adolescents (FVACA), from the Primary Health Care (PHC) perspective.

Background. Children and adolescents figure among the main victims of violence around the world, which occurs predominantly in the family context. PHC-guided network care has emerged as a new process that contrasts with traditional approaches, which rely on fragmented, punctual and compensatory actions and produce simplified and segmented interventions in response to complex phenomena like violence. The Paradigm of Complexity interacts with the network care approach and, by articulating the multiple dimensions of the research phenomenon, contributes to its understanding.

Design. Qualitative research, based on the Paradigm of Complexity.

Methods. Data were collected through minimal maps of the external institutional social network, focus groups and semi-structured interviews held with 41 PHC professionals in Brazil. The notions of comprehension and contextualisation as well as dialogical, recursive and holographic principles from complexity theory guided the data analysis.

Results. The two thematic categories that emerged revealed reduced institutional networks, with low-density and homogeneous bonds, which resulted in fragmented care in all stages of the care process.

Conclusions. Although the network organisation of care for the families involved in FVACA is fundamental, the construction of these networks still represents a great challenge, as it requires the joint work of a multiprofessional team.

Relevance to clinical practice. For nursing to respond to the contemporary care demands in a contemplative and pertinent manner, a perspective and a reference

What does this paper contribute to the wider global clinical community?

- Despite the scientific evidence concerning the need to organise the care network for families involved in family violence against children and adolescents, this construction still represents a challenge for Primary Health Care professionals. This study revealed a web of institutions characterised by reduced, low-density networks with highly homogeneous bonds and noninstitutionalised relations with power disequilibrium; this network entailed fragmented care in the process, ranging from the formulation of public policies to their execution.
- The care provided for complex phenomena like family violence against children and adolescents requires a broader and more contextualised approach, in which Primary Health Care is empowered as the care coordination centre for families and communities, with interdisciplinary, interinstitutional and intersectorial articulation. In addition, the construction and enactment of comprehensive public policies that guarantee community participation should address the guidelines mentioned, so as to produce care that guarantees the study population's physical and mental health.
- As nurses occupy a privileged space in the health system, they can improve their working skills by: (1) providing holistic care centred on the family and the community; (2) searching for the logic of health promotion and individual and collective empowerment; (3) focusing on care from the PHC perspective; (4) actively participating in an interdisciplinary care team; (5) acting at interinstitutional and intersectorial levels to overcome the health institution's barriers.

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framework need to be developed, leading to broader and more contextualised actions, with a multidimensional approach to the families and communities of which child and adolescent victims of violence are a part.

Key words: adolescent, child protection, community care, domestic violence, family care, health promotion, nursing, primary care, public health nursing, qualitative study

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Introduction

Violence has been considered a relevant and growing global public health problem, as it results from a complex interaction of factors that are deeply rooted in the social, economic, political and power structures present in society. The long discussion about violence during the World Health Assembly in Geneva held in the 1990s is evidence of its importance. Health professionals, researchers and health systems have been gathered to uncover the roots and social determinants of violence, aiming to prevent it and minimise its consequences based on evidence-based practice (World Health Organization, 2014).

Violence is responsible for more than one million deaths per year around the world and corresponds to 2·5% of global mortality. Thousands of people are victims of nonfatal violence each day; a minority receives care from health services and receives emergency, medical-legal or other types of care, but most of the victims will never have contact with protection services. According to the World Health Organization (WHO), children and adolescents between 0–19 years of age represent the main populations who are silent victims of violence (World Health Organization 2014).

The global epidemiological data on nonfatal victims are not precise, but it is estimated that 227 children and adolescents die each day as a result of interpersonal violence (World Health Organization 2014). In Brazil and other low- and middle-income developing countries, violence is the first cause of death in children over one years of age and up through adolescence, and this occurs in the family context, which is considered a space characterised by relationships of trust, responsibility and power (World Health Organization 2014).

Due to the complexity of circumstances and their own lack of management, the health professionals have faced difficulties identifying suspected cases of family violence against children and adolescents (FVACA), as well as intervening in and coping with them. The fragmented actions and perspectives to act on this phenomenon have been insufficient and hardly effective (Rivett & Kelly 2006, Anderson 2010, Cismaru 2013, Wright & Fagan 2013, Zannettino & McLaren 2014, Clarke & Wydall 2015, Deslandes & Campos 2015). In addition, nursing practice and academic research have shown that focusing only on children or adolescents strengthens their feeling of guilt about the violence (Clarke & Wydall 2015, Deslandes & Campos 2015).

In this sense, Primary Health Care (PHC) emerges as an important resource and strategy to surpass the traditional paradigm of care; it proposes the organisation of a health-care network where it coordinates the care to families and communities (World Health Organization 2008, Kringos *et al.* 2010). This study is focused on the network care for the families involved in FVACA, focused particularly on PHC. In this debate, nurses are essential agents, because their work aims to care for individuals and communities, at the management, clinical/practical, educational and scientific levels. The expressiveness of professional action allows the nurses to appropriate, encourage and disseminate care strategies for contemporary phenomena, such as FVACA, in view of the range of inherent interfaces and dimensions.

Background

Violence can be defined as the intentional use of strength or physical power, in reality or as a threat, against a person, group or community, which results or can very probably result in injury, death, psychological damage, deprivation or altered development (Violence Prevention Alliance 2014). The WHO identifies three types of violence, according to the relation between the victim and author of the violence – self-directed, collective and interpersonal – and four modes in which violence is inflicted – physical, sexual, psychological, and deprivation or neglect (Violence Prevention Alliance 2014). This study focuses on interpersonal

violence, that is the violence between individuals, which is subdivided into family and community violence.

The specified types and modes of violence happen at the same time or are associated in people's life (Anderson 2010, Roberts *et al.* 2013). Due to the particular growth and development period they are in, the children and adolescents are potential victims of violence. The violence against children and adolescents involves unequal power and trust relations and usually occurs in the family context (World Health Organization 2014). The fact that this type of violence is strongly associated with intimate partner violence against women points to the need to broaden the perspective to the family, rather than to look at each individual (Anderson 2010, Cismaru 2013, Clarke & Wydall 2015).

The consequences of FVACA appear in the short term and long term, such as alterations in physical, emotional and cognitive development, in social life, and in the skills to maintain healthy intimate relationships (Spinney 2013, Katz *et al.* 2016). Children and adolescents who experience violence against themselves or their parents are more vulnerable to suffering and/or practising new forms of violence (Osofsky 2003, Anderson 2010, Cismaru 2013, Clarke & Wydall 2015). In this sense, it is fundamentally important to include the families involved in FVACA in this discussion (Roberts *et al.* 2013, Zannettino & McLaren 2014, Taft *et al.* 2015, Katz *et al.* 2016, Pinna 2016), and not to be limited to contact with the children and adolescents, who were seen at one time as 'forgotten, silenced or hidden' or 'passive beings amidst cross-fire'; a pertinent reminder is that they are active people with needs that must be attended and protected (Clarke & Wydall 2015).

Only a small number of cases of FVACA are identified and investigated due to many factors: children are not able to report the violence of which they were victims; children and adolescents are afraid of retaliation from their perpetrators; children and adolescents are afraid of the local authorities' interventions regarding the violent act, which can worsen the problem due to their fragmented actions; as the victims feel shame and guilt, they do not report the violence to their friends, relatives or healthcare professionals (Stanley *et al.* 2012, Cismaru 2013). Considering the aforementioned factors and the complex and harsh nature of family violence, it becomes evident that the family members require the care and support of many assistance sectors and services throughout their lives; the particular needs of different families vary according to their own experiences with violence.

The fragmentary tradition of modern science has generated a specialised perspective that privileges part of the phenomenon to the detriment of its broader context, with a view to generate technical knowledge that predicts linear prescriptions based on a static and homogenising perspective of reality. A systematic, dialectic and complex view of the phenomenon sees FVACA as involving historical, social, cultural, economic, family and legal aspects, which are articulated in the production of recurring events that involve relationships of oppression between adults and children. In the family context, intergenerational levels, asymmetric gender relationships between men and women and economic aspects that determine power roles are also present. To enhance the safety and well-being of children and adolescents, the complexity of some phenomena needs to be observed in a holistic, contextual and historical manner (Wright & Fagan 2013, Martin & Harrod 2015, Pinna 2016).

The WHO proposes an ecological model to understand violence, based on the evidence that no singular fact can explain the greater risk of or greater protection of some people or groups in relation to interpersonal violence. This phenomenon results from the interaction among multiple factors in the individual, relational, community and social spheres (Violence Prevention Alliance 2014), requiring the articulation of actions and interventions at the different care levels. PHC stands out as the entry door to the health system, which welcomes all new problems and needs of the population and is globally considered to be the main strategy to inhibit inequalities (Lahariya *et al.* 2010). In addition, as PHC offers people-centred care, and not care centred on the course of the disease, it coordinates or integrates all other care levels (World Health Organization 2008, Kringos *et al.* 2010). Keeping in mind that the focus of PHC should be people's health, in the constellation of other determinants, such as the physical and social environment in which they live and work (Starfield *et al.* 2005, McPherson & McGibbon 2010, Bryant *et al.* 2012), PHC transforms into an essential agent in the debate on and in coping with FVACA, as well as in general care for this population and their families (Spinney 2013, Turner *et al. in press*).

Network care has emerged as a new process, opposed to the traditional approaches of public policies, which rest on fragmented, singular and compensatory actions, producing simplified and segmented interventions in view of what are, in reality, complex phenomena (Sylaska & Edwards 2014, Clarke & Wydall 2015, O'Hare *et al.* 2015, Vieira *et al.* 2015, Goodman *et al.* 2016, Turner *et al. in press*), as well as in child's and adolescent's health (Gregori *et al.* 2011, Guldbrandsson *et al.* 2012, Becker *et al.* 2014). This concept is systemic, dialectical and complex (Morin 2008). The characteristics of network care are as follows: the acknowledgement of the existence and importance of the other; knowledge of the other person's actions; and reciprocal

cooperation; cooperation through the sharing of knowledge, actions and powers; and the association with shared objectives and projects (Kothari *et al.* 2014). It is highlighted that these aspects – intersectorial approach, integrality, accessibility, referral and counter-referral, community participation and mobilisation, individual and community empowerment – interact with an expanded concept of health and constitute principles and guidelines that represent the solid base of the internationally renowned Brazilian Unified Health System (Monteiro *et al.* 2015).

The network care approach dialogues with the Paradigm of Complexity. The word complexity derives from the Latin word *complexus*, which means 'woven together' or 'interlaced'. The paradigm aims to understand complex phenomena, characterised by their unpredictability and by the impossibility of describing them in a finite number of steps and a finite time period. The distinct elements of this phenomenon constantly interact, from which unknown properties can emerge. These elements come with uncertainty and change, as the interconnected or intertwined parts maintain links that can produce additional information, in the same action process; therefore, there is always a possibility that the new, the unexpected, will emerge. The articulation among the multiple dimensions of the study phenomenon enhances the degree of understanding of knowledge, which can reveal its complexity (Morin 1999, 2008).

Regarding the relevant gaps in the literature, this study aims to expand the understanding of network care to the families involved in FVACA, from the perspective of PHC, and contribute to the construction of a contextualised and broader perspective on the FVACA phenomenon.

Methods

Design

This study adopts a qualitative strategic social research approach that rests on the Paradigm of Complexity. The method represents the research course that is inherent in and/or originates from the theory; therefore, theory and method appear as inseparable elements of complex thinking, where the theory permits knowledge and the method is the subject's means of thinking about the subject (Morin 1999, 2008). Based on the coherence between these two elements, the methodological trajectory was guided by the notions of comprehension and contextualisation, present in the Paradigm of Complexity. Contextualisation involves the effort to understand a certain phenomenon inside the context, and not isolated from it. That understanding aims to apprehend the meaning of an object or event and its relationships with other objects or events; thus, bundles of relationships are constituted and they are interwoven and articulated in socially and individually constructed webs and networks, remaining in a permanent state of recycling.

This study used three principles of complexity: dialogical, recursive and holographic. The first requires the combination and association of contradictory factors in the analysis of a given phenomenon. The second principle refers to organisational recursion, which refers to the image of a whirlwind and highlights that the recursive process is a process in which the products and effects are at the same time causes and producers of what produced them. The third principle looks for the image of the hologram, in which each point contains almost all the information about the object that is represented, so that not only the part is in a whole but, in a way, the whole is inscribed in the part (Morin 1999, 2008).

To guide the analysis of the study results, the retroactive, systemic, auto-eco-organisation principles and the reintroduction of the knowledge in all knowledge were also proposed. The principles are part of complex thinking as a whole and are complementary and interdependent. The holographic, dialogic and recursive principles were employed as a guideline for this research, without indicating the fragmentation, separation, making-absolute or consideration 'by itself' of each principle in isolation (Morin 1999, 2008).

Setting and participants

The place of study was a city in the State of São Paulo, Brazil, which currently occupies an area of 796 km^2, with a population of 1,144,862 inhabitants. The complexity of the health system in the city leads to division into health districts, which consists of the progressive decentralisation of health planning and management into areas of about 200,000 inhabitants, starting with PHC and extending to the secondary services. Hence, the city is geographically distributed into five Health Districts: North, South, East, Northwest and Southwest.

The city under study possesses 62 PHC service, organised into the Family Health Strategy, and approximately one primary healthcare service (UBS) for every 20,000 inhabitants. All UBS have multiprofessional teams that consist of physicians in the basic specialties (clinicians, paediatricians, gynaecologists–obstetricians), nurses, dentists, auxiliary nurses and dental aids. Some UBS have support professionals in mental health, such as psychiatrists, psychologists and occupational therapists.

The study participants were the professionals working at the UBS, selected based on the following inclusion criteria: (1) belonging to a service from each health district, according to the availability and authorisation of the district and local coordination; and (2) working for at least one year at the studied service and working with families involved in FVACA. A sufficient number of subjects were included for the purpose of reaching repeated information and theoretical saturation. The answers to the research objectives guided the sampling saturation criterion, emphasising the deepening of the guiding questions to understand and contextualise the theme.

The five participating UBS were defined based on availability and the local and district organisation of the services, while the professionals were selected based on the local team's decision. The fact that the number of participants and professional categories at each UBS varied did not impair data collection or analysis, because the data were collectively constructed with the teams' representatives – participation of every professional in the five PHCU was infeasible. In addition, it should be considered that this is a qualitative, not a quantitative study. In total, 41 professionals were selected: 17 community health agents, 4 auxiliary nurses, 4 nurses, 1 occupational therapist, 4 paediatricians, 2 psychologists, 1 psychiatrist, 2 clinicians, 1 dental office auxiliary and 5 multiprofessional residents in health. Six participating professionals were male and the remainder female. Most professionals were between 31–40 years old and, on average, had between 1–5 years of professional experience.

Data collection

To maintain the anonymity of the participating UBS, they were designated by the numbers 1, 2, 3, 4 and 5, in the order of the data collection, which took place between 04/24/13–12/17/13. The data were collected through focus groups, semi-structured interviews and Minimal Maps of the External Institutional Social Network (MNM), in a manner that permitted the triangulation of techniques and increased the reliability of the study. To assess the feasibility of applying the proposed techniques, a pilot study was conducted on 12/07/12 with a health team that did not otherwise participate in the study.

Before starting the actual information collection, the researchers presented the objectives of the techniques, explicitly reported that the participants' opinions would not be judged as correct or wrong, and requested permission to record the interviews and the focus group discussions, guaranteeing the participants' anonymity. The recordings were made in the program Easy Voicer, using an MP5 device. Then, the recordings were transferred to a computer and fully transcribed.

The MNM shows the establishment of bonds between the institution assessed and the groups organised in the community, the distinct governmental and nongovernmental institutions, and help to identify existing resources and gaps, with a view to integrating, strengthening and optimising the existing community network. Thus, the MNM provides a graphic image of the spatial dimension of a given phenomenon. The articulation of the MNM with the context of a given problem or knot for investigation permits identifying, representing, and signalling aspects that could compose a whole, with a global and articulated view of the component parts, with a view to understanding the context (Morin 1999, 2008).

First, in the MNM, the sectors were outlined with the participants considered necessary to deliver care to the families involved in FVACA: the name of the institution studied was placed at the centre of the MNM and, around it, the sectors/services were arranged in quadrants, as illustrated in Fig. 1. Then, the quality of the bonds between the institutions and the groups mapped in the quadrants was assessed: significant, weakened or broken/nonexistent. Finally, the geographical distance between the institution and the sector/institution assessed was verified and represented by lines arranged at a close, intermediate or large distances from the centre of the MNM. The three circles in the MNM represent the geographical distance between the institution (placed at the centre of the map) and the sector/institution assessed: close (first one), intermediate (second one) or large distances (third one).

The design of the MNM was assessed by means of the following criteria: size (number of institutional and group bonds established); density (quality of bonds); distribution/composition (number of people or institutions in each quadrant); dispersion (geographical distance between members and institutions); homo/heterogeneity (characteristics of the members and institutions, which reflect diversity and similarities in the network).

The analysis of the MNM guided the discussion of the focus groups, which were intended to understand and contextualise the theme. In each PHCU, two meetings were held in a well-lighted room with good acoustics, free from interruptions, with the participation of a recorder, an observer and a moderator; each meeting took approximately 90 minutes. The groups were identified as Gp1, Gp2, Gp3, Gp4 and Gp5, in the order in which they were held.

Some of the focus group members participated in the semi-structured interviews, preserving the heterogeneity of the professional groups; the focus groups and the interviews

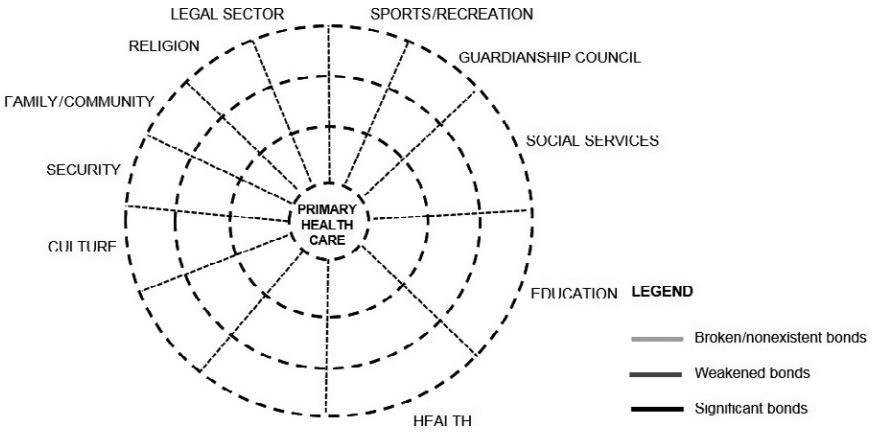

Figure 1 Minimal Map Model of External Institutional Social Network. This map was developed to explain the care networks structured based on Primary Health Care, focused on families involved in family violence against children and adolescents. The concentric circles represent the geographical distance between the institution (at the centre of the map) and the sector/institution assessed: close, intermediate or large distances.

were held on different dates. The script of the semi-structured interviews included three open guiding questions, which allowed the subject to have a singular perspective on the study object and minimised the interviewer's interference:

- In view of a suspected or confirmed case of FVACA, how does the health team act?
- What are the main difficulties faced in acting on these situations?
- And the easier aspects?

The interviews, which took approximately 20 minutes, were identified with the letter E, and numbered in the order in which they were held: E1, E2, E3 and so forth. The professional category of the interviewed individuals was not highlighted, except in case of specific information, in which the different categories would affect the analysis. After the tenth interview, the process-based analysis of the data revealed saturation had been reached and no new actors were included, in accordance with the recommendations in the literature (Morse *et al*. 2002).

Ethical considerations

The local Research Ethics Committee approved the study protocol, which was registered under n. CAAE 01726512.0.00005393. The participating subjects were asked for their voluntary consent through the signing of the Informed Consent Form. Authorisation for the study was obtained from the Municipal Health Department and from the district and local coordinators of the PHCU in the city.

Data analysis

The data analysis process was guided by the notions of comprehension and contextualisation proposed by the Paradigm of Complexity (Morin 1999, 2008); this is an inductive analysis (Elo & Kyngäs 2008), in which the analysis was performed based on the data collected, according to the following steps: (1) classification and organisation of the collected information through the attentive reading of the material and identification of the main points in the interviews and group debates, observing their pertinence and relevance for the research problem; (2) organisation of reference frameworks with the professionals' main answers, with a view to obtaining a comprehensive view of the information in order to categorise it; and (3) establishment of relationships among the data through their organisation into categories that were constituted by the grouping of elements, ideas and/or expressions of concepts capable of covering all of these aspects. Then, relations between the data and the Paradigm of Complexity were established – especially with the notions of comprehension and contextualisation and the dialogical, recursive and holographic principles – that included the legal devices and the literature on network care for families involved in FVACA.

The specific analysis of the MNM was based on the aforementioned criteria, and the results were combined with the collected data through the focus groups and semi-structured interviews.

Results

In this section, we will discuss: (1) the main characteristics of the network of institutions and sectors; (2) the factors the professionals revealed that enhance or hamper network care for the families involved in FVACA; and (3) some consequences of this organisation. These aspects will be unveiled through the categories 'Network care: the web of institutions and sectors'; and 'Network care: weaknesses and fragmentations'.

Network care: the web of institutions and sectors

PHCU-1 and PHCU-2 (Figs 2 and 3) presented a median network, while the other PHCU studied (Figs 4, 5 and 6) presented a reduced network, characterised by the limited number of bonds. PHCU-1 and PHCU-2 were the oldest units in the city under analysis and, although they were located in areas of great economic and social vulnerability, the webs contained more institutions, particularly those linked to social services.

The health professionals identified (1) significant bonds between all PHCU studied and the families and (2) weakened bonds between four PHCU and drug trafficking/organised crime, which emerged as both a protection factor and a factor of vulnerability to violence – these aspects will not be discussed in this study, due to their particularities and the depth needed for addressing them. The five PHCU presented low-density networks, marked by many weakened bonds and few significant bonds, to be discussed next.

The dispersion analysis of the bonds in the MNM revealed that significant bonds were not directly related with the geographic proximity between PHCU and institutions, and highlighted other distances and ruptures, related to relationships and access, among other factors:

Gp 3: It is not physical distance, it is personal distance

One category the PHCU professionals highlighted was the organisation of networks around people, specific professionals, instead of institutions or sectors. This fact contributed to the networks being ruptured and fragmented, as the departure of these professionals resulted in the interruption of ongoing actions.

Gp 4: I think it depends on the person... I think it is person-dependent!

Gp 5: When P. (paediatrician) was here, P. was very familiar with adolescent cases, he was very close (...) he stopped them, took the cases, but like, the rest of the PHCU did not have a clue...

The weakness and disharmony of effective public policies that could support and guide care for the families involved in FVACA was another noteworthy aspect in the reports:

Gp 5: Theoretically, everything is all right, only in theory, it is a showcase...

Gp 4: I think that, in a way, it is not a problem for this PHCU, for this city, it is a structural problem really (...) because it is the family who ends up being hurt in the end, the child and the adolescents. And not the institutions, which are quite protected, in fact

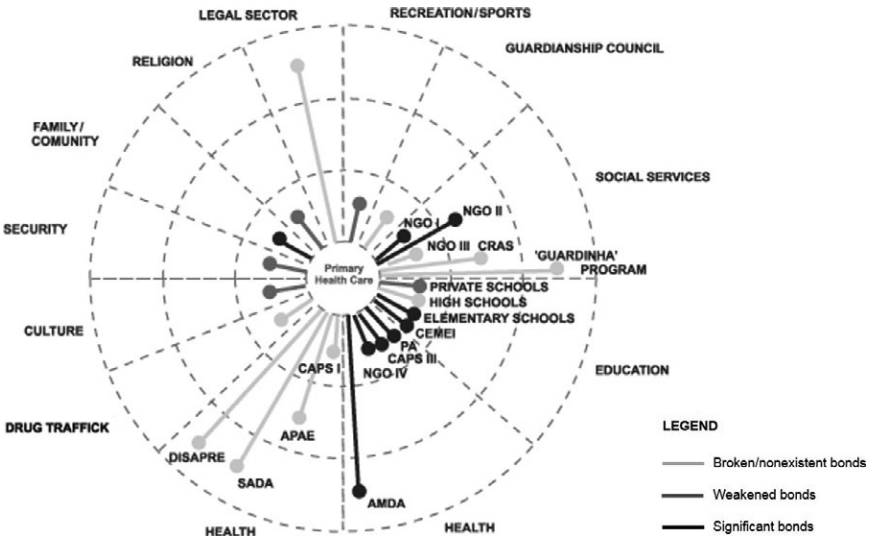

Figure 2 Minimal Map of External Institutional Social Network of the Primary Health Care Unit 1. The concentric circles represent the geographical distance between the institution (at the centre of the map) and the sector/institution assessed: close, intermediate or large distances. AMDA, Municipal outpatient care centre for sexually transmitted diseases and acquired immune deficiency syndrome (AIDS); APAE, Association of parents and friends of handicapped children; CAPS I, Psychosocial care centre type I; CAPS III, Psychosocial care centre type III; CEMEI, Municipal children's education centre; CRAS, Social assistance reference centre; DISAPRE, Research laboratory for learning difficulties and disabilities, and attention disorders; NGO I, Nongovernmental organisation n. I; NGO II, Nongovernmental organisation n. II; NGO III, Nongovernmental organisation n. III; NGO IV, Nongovernmental organisation n. IV; PA, Urgent and emergency care service; SADA, Support service for people with learning difficulties.

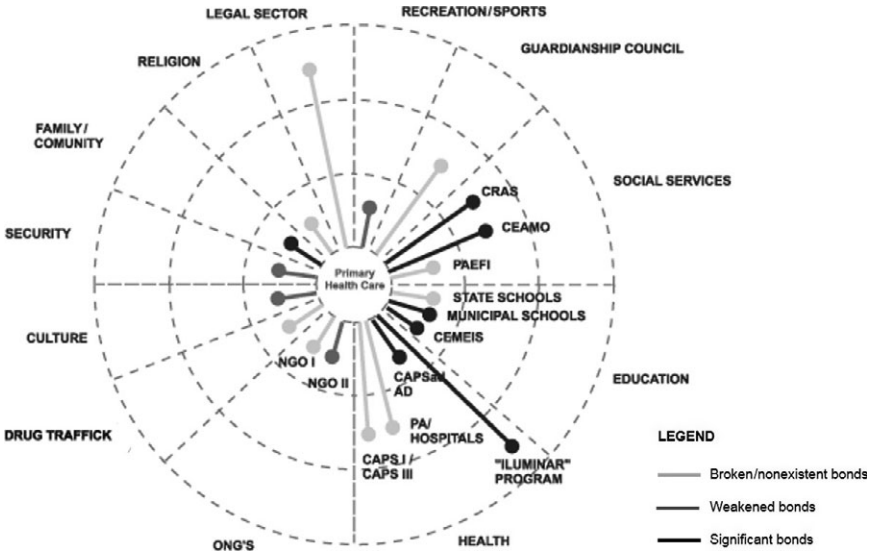

Figure 3 Minimal Map of External Institutional Social Network of the Primary Health Care Unit 2. The concentric circles represent the geographical distance between the institution (at the centre of the map) and the sector/institution assessed: close, intermediate or large distances. CAPS I, Psychosocial care centre type I; CAPS III, Psychosocial care centre type III; CAPSad, Psychosocial care centre for alcohol and drugs; CEAMO, Women's reference and support centre; CEMEIS, Municipal children's education centres; CRAS, Social assistance reference centre; NGO I, Nongovernmental organisation n. I; NGO II, Nongovernmental organisation n. II; PA, Urgent and emergency care service; PAEFI, Protection and specialised attention service to families and individuals.

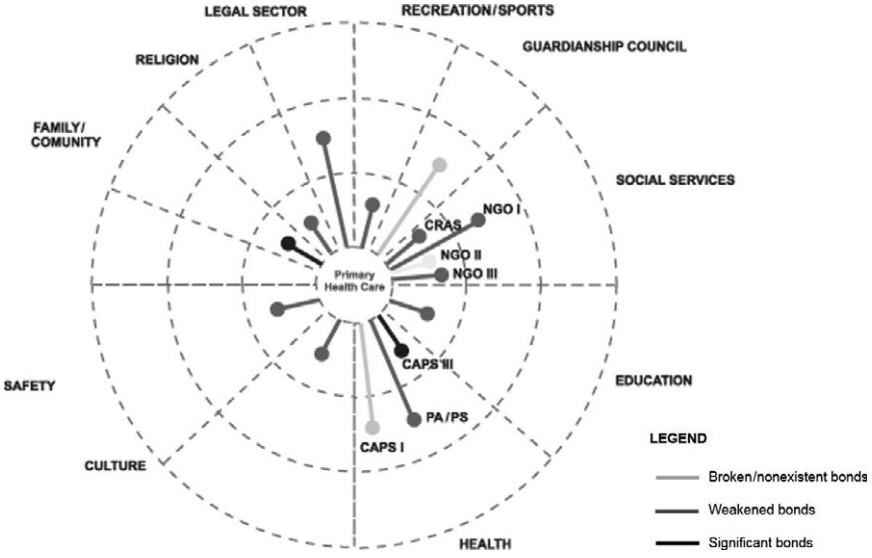

Figure 4 Minimal Map of External Institutional Social Network of the Primary Health Care Unit 3. The concentric circles represent the geographical distance between the institution (at the centre of the map) and the sector/institution assessed: close, intermediate or large distances. CAPS I, Psychosocial care centre type I; CAPS III, Psychosocial care centre type III; CRAS, Social assistance reference centre; NGO I, Nongovernmental organisation n. I; NGO II, Nongovernmental organisation n. II; NGO III, Nongovernmental organisation n. III; PA/PS, Urgent and emergency care service/Mental healthcare service.

The professionals highlighted that the lack of knowledge in the institutions and sectors in the care network has contributed to weakening the links in this structure:

Gp 5: But I also think that, because of not knowing, I particularly do not see any problem-solving ability in the work...

Gp 2: As long as we don't know what is out there, but they don't know what is here... It's this conversation between deaf people...

In all PHCU studied, social services and education were considered the main sectors needed to implement network care for families involved in FVACA. The particular and specific organisation of social services was responsible for part of the lack of knowledge concerning their activities, according to the interviewed professionals' reports. As social services have co-funded nongovernmental organisations, the institutions change from one territory to another. This sector is going through reorganisation and institutional reordering.

Regarding education, despite its importance in the dynamics of the FVACA problem, the bonds established between PHCU and the school are frail. Some reports revealed that, even if school played an essential and central role in the life of children and adolescents, frequently being the institution that stood closest to this population, the school institution was not co-accountable for care provided to these families:

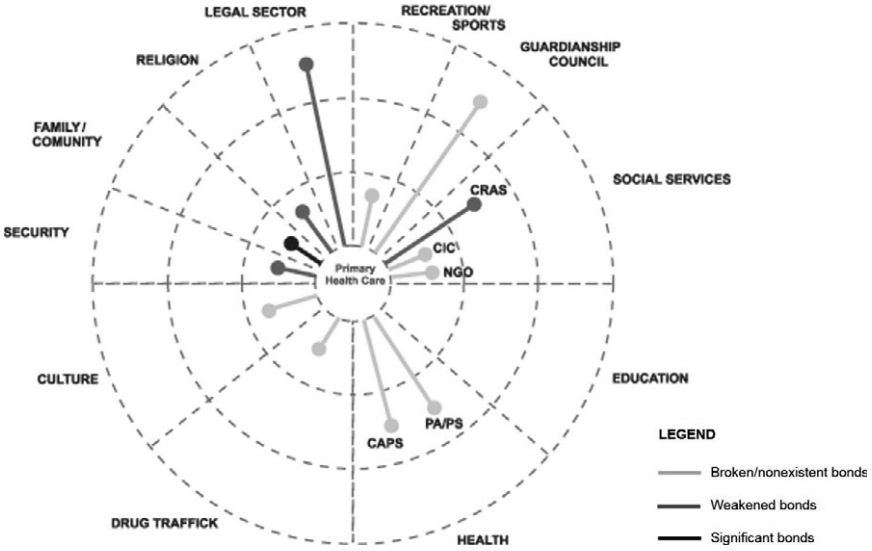

Figure 5 Minimal Map of External Institutional Social Network of the Primary Health Care Unit 4. The concentric circles represent the geographical distance between the institution (at the centre of the map) and the sector/institution assessed: close, intermediate or large distances. CIC, Integration and citizenship centre; CAPS, Psychosocial care centre; CRAS, Social assistance reference centre; NGO, Nongovernmental organisation; PA/PS, Urgent and emergency care service/Mental healthcare service.

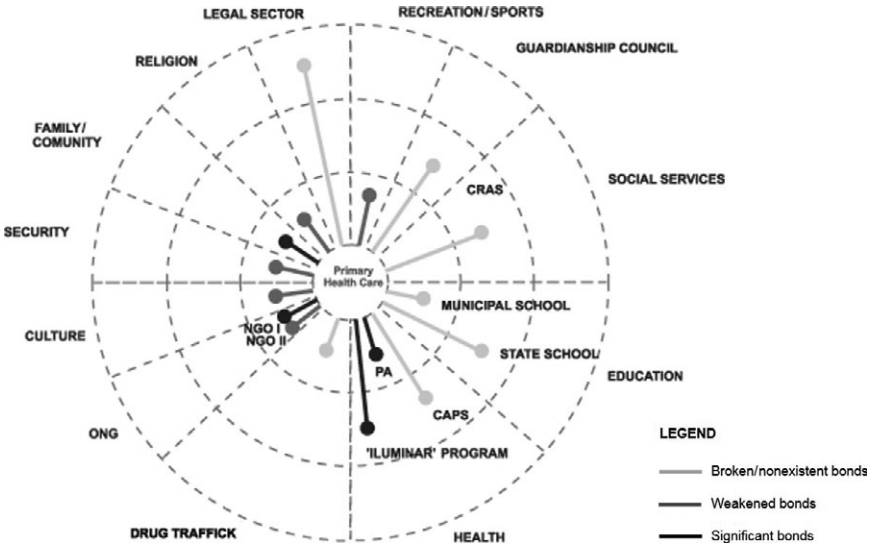

Figure 6 Minimal Map of External Institutional Social Network of the Primary Health Care Unit 5. The concentric circles represent the geographical distance between the institution (at the centre of the map) and the sector/institution assessed: close, intermediate or large distances. CAPS, Psychosocial care centre; CRAS, Social assistance reference centre; NGO I, Nongovernmental organisation n. I; NGO II, Nongovernmental organisation n. I; PA, Urgent and emergency care service.

Gp 3: It [school] forwarded it, but not with the suspicion of violence, right? But they suspected and did not make it clear on paper. They do not assume responsibility for the questions in the cases

Some PHCU developed activities for singular events in partnership with the school, such as oral health actions, which could be used as triggers for other actions; nevertheless, the initial actions were exhausted, demonstrating the one-dimensional and fragmented view that still continues in network care.

In the health sector, as observed in the MNM, the Urgent and Emergency Care Services were mentioned as the main units that have significant bonds with the PHCU, due to the identification of FVACA situations. Weakened bonds mediated the prevailing relationships in this sector, also with important services for care delivery to the families involved in FVACA, such as the Child-Juvenile Psychosocial Care Centre. The professionals considered a project linked to a university for care delivery to victims of sexual violence to be a very appropriate programme. According to the meaning of the statements, the positive assessment derived from the existence of concrete actions, such as the forwarding of cases for preventive tests and emergency contraception in cases of sexual violence.

In regard to the network distribution and composition, the following were observed: (i) a larger number of institutions linked to the health, social service and education sectors; and (ii) important gaps indicated by the absence of concrete institutional bonds in the other sectors. These aspects reveal a homogeneous network that does not permit any dialogue with the different institutions and sectors

needed to establish care for complex phenomena like FVACA. A reduced and homogeneous network like the one found in this study entails weaknesses coping with situations of violence, which are considered to be complex phenomena. The professionals discussed this problem:

Gp 4: (. . .) because really, right, we are unable to see joint actions. . . We think it's just the Guardianship Council, but that behind it there are other entities we don't have access to, you see. . .

The health professionals' main difficulty was related to their relationship with the Guardianship Council and the Juvenile Court. The reports revealed a relationship based on paper, which did not comply with the principles of care for a complex phenomenon, and in which the responsibility for the situations was neither shared nor diluted. In addition, the professionals' reports highlighted issues of force and opposition in the power relationships:

Gp 4: I have already received a letter from the Juvenile Court. . . I made the visit and returned the letter. . . With that clause below. . . With that oh-so-kind little note below (laughs). . . You're immediately forced to make the visit, right, you have to do it. . . I don't want to get arrested. . .

Gp 2: It's a matter of compliance. . . It's an obligation. . .

This power relationship between the Guardianship Council and the Juvenile Court seemed to be the factor that triggered the impersonal relationship:

E 4: (. . .) It seems that we are inferior in their eyes, you see?

Gp 2: If we had any idea of the mother's psychological treatment, who knows if the judge would discuss our idea. So, it means, obey and don't give your opinion, right? It's impossible to be any more distant. The relationship is strictly on paper. . .

Network care: weaknesses and fragmentations

The issues the professionals addressed, which emerged from the relationships with the sectors responsible for care of the families involved in FVACA, were reconsidered not only one-way, but in 'multiple ways'. Some health professionals demonstrated a certain lack of accountability and great expectation in regard to the actions of a single entity. This posture was evidenced in the reports:

Gp4: In fact, I think there is no network. . . I find this network extremely weak, I don't know if that is our fault, it can be bilateral. . .I think it's bilateral, right. . .

The logic of forwarding cases makes it impossible to strengthen interdisciplinary relationships and, consequently, the care to stakeholders in FVACA. Health professionals frequently understood the idea of working in networks as the forwarding of cases:

Gp 1: If there's, on the one hand, an adolescent drug addict, we'd have to pass on the problem to someone. . .

Other health professionals considered this care model to be 'ideal and expected':

Gp 1: Yes, I think there should be a structure here, which involves all types of care, but each in its own limits. . .

The frailty of network care entails significant consequences, which are directly related to the care offered to the families. The first consequence the professionals mentioned was the existence of a set of institutions and sectors that operate in isolation from one another, despite having a shared objective:

E 6: That we can all understand that we're in the same place, right? We only work in different places and have different roles, but our function in relation to that, right? In cases of violence, it means offering what's available, right, to help that person to get stronger, right?

The PHCU found it was isolated from the other institutions and presented itself as such, adopting the posture of 'we *versus* the others':

Gp 3: They [other health services] generally throw to first base and want the base to solve everything, or that the base offers continuity and that doesn't work, right?

Gp 2: The issue is that everything is fragmented, right, so I don't know, I don't know if the demand here is large, does not want to welcome, it's difficult to respond too and, then, I think that the response from education, is linked to the health service. . .

The latter statement concretely reveals the need for interdisciplinary and intersectorial work in health care. The professionals discussed the demands the population presented and, particularly for those related to violence, 'the answers' had to be 'linked'. In the course of the data collection, the professionals' great concern over the influence that the absence of network care had on the families was understood. The occurrence of fragmented care permeated the reports:

Gp 4: I think this weakened bond we have ends up not qualifying the assessment we may make, because we don't know what the council expects from us or from the case, because we know there's a report, sometimes very badly written. . .

The public policies focused on families in vulnerable situations were singular and fragmented; this issue was reflected in care for FVACA, where no work was observed that aimed to alter the family dynamics:

E 10: So I'm around there, so you're watching the family dynamics, totally destroyed, the whole family destroyed, so like, the child is out there, but everything is destroyed, the child, the father, the mother, the sister, everyone destroyed. So, like, you can't just focus on the child, right?

The families remained 'loose' in this service web, from the identification of the situation until the most directed interventions in view of confirmed cases of violence:

Gp 5: This family has no place, no work, no backup

E 9: It seems to be merely punitive in nature, no education whatsoever... I'm going to make the denunciation visit for the sake of the accusation... Without aiming to try and restructure the service...

Intelligent coordination is needed in response to the weakness and fragmentation implied in care for the families involved in FVACA:

E 9: The impression it gives is that there is no intelligent coordination that can grasp all this, you need to see the process as a whole

Discussion

The categories uncovered in this study – 'Network care: the web of institutions and sectors' and 'Network care: weaknesses and fragmentations' – are evidence that network care and the cross-disciplinary perspective face barriers to take form in the institutions' daily practice. However, these perspectives were legitimised and validated as the main possibilities to build qualified and effective interventions for complex phenomena like violence (Ramirez *et al.* 2012, Zannettino & McLaren 2014, Deslandes & Campos 2015, Hail-Jares *et al.* 2015). Characteristics like noninstitutionalised relationships ('person-dependent' relationships), nonrecognition of partners, weakened inter- and intrasectorial relationships, and homogeneous networks refer to the Cartesian and positivist paradigm, hampering or impeding care for complex health phenomena, especially in nursing. Recent studies strengthen the importance of articulating programmes and sectors to reduce the vulnerability of population groups, particularly children and adolescents, and acknowledge their skills, talents and creative capacity to (re)create different realities (Silva *et al.* 2014, Monteiro *et al.* 2015). The construction and implementation of public policies can further these characteristics.

In this study, the ongoing fragmentation and individualisation of public policies focused on families have provoked the rupture or duplication of actions; they do not reveal the full institutional potential for care and do not offer comprehensive care to the families. It is presupposed that the latter has been achieved through interinstitutional and intersectorial articulation and integration. Most of the social policies ignore the universes of family and community, or the territory or territories the families live in (Cismaru 2013, Wright & Fagan 2013, Monteiro *et al.* 2015).

The PHC represents an important strategy to warrant people's participation and social control (Serapioni & Matos 2014, Street *et al.* 2014); the main law that regulates the Brazilian national health system ensures these aspects. Actions intended to cope with violence should be associated with the right of the population and the community to participate in public healthcare decisions, with inclusive and deliberative approaches, as the law of citizens (Wiggins 2012, Serapioni & Matos 2014, Street *et al.* 2014). The inclusion in and deliberation of these forums, with a wide range of methods, entail a positive effect and guarantee civil empowerment, although for periods beyond what is recommended (Street *et al.* 2014).

The health systems from three countries in Southern Europe – Italy, Portugal and Spain – also obtained positive results in regard to the involvement of civil society in decision-making procedures in health care (Serapioni & Matos 2014). The debates between politicians and citizens reveal incomplete democracies, consisting of depoliticised citizens who are incapable of seeking solutions to complex problems, and by depoliticised politics, fragmented and reduced to economy, business administration and technocracy, which does not permit understanding nonquantifiable problems (Morin 1999). This discussion comprises a retroactive movement, as the disarticulation of public policies regarding care to the population leads to difficulties in the construction of network care, immobilising the professionals and the community in movement beyond the traditional paradigm. The actors' static positioning, in turn, makes broader, contextualised and integrative discussions impossible, constituting an obstacle to coping with complex contemporary problems, mediated by more effective public policies.

This study demonstrated that school is an important institution in the children's and adolescents' lives, as it appears as a mid-point in which they exercise their identities as subjects and start their social experiences beyond the family context. The results obtained support the reports of school as a space to connect with the rest of the world, which creates possibilities to trespass borders.

External institutional actions, especially when linked to other sectors, are essential strategies to tightening knowledge, cultures and values. The relationship between the health services and the schools has been empowered through specific programmes and the literature, also to facilitate perception of the health needs of children/adolescents and their families. The school context turns into a privileged space for health promotion actions that stimulate self-care and social and community co-participation, and to discuss heath, disease and care (Ramirez *et al.* 2012, Rasche & Santos 2013, Monteiro *et al.* 2015).

The Guardianship Council and Juvenile Court, which represent the main institutions for children and adolescent protection in Brazil, established weak links and asymmetric power relationships with the PHCU. The power relationships become more easily observable through discipline, as they reflect the command and the commanded. The formal and legitimate hierarchy of the work method makes the implementation of interdisciplinary actions involved challenging. The characteristics mentioned lead to the juxtaposition of services, to the sum of the Guardianship Council and Juvenile Court's actions, whose application does not establish care integration. Although both entities act in cases of violence, they do not recognise one another as institutions that strengthen their interventions and who can truly have something to share (Schraiber 2014).

This organisation can be called a service 'web' instead of a care network (Schraiber 2014). Similarly, the existence of tension between protection services for children and women, focused on a specific incident and the possibly systematic nature of violence, without considering the actors, factors and contexts involved, averts a true understanding and action in the case of violent situations (Rivett & Kelly 2006).

As a consequence of this organisation, this study revealed the existence of fragmented care for the families involved in FVACA, permeated by the logic of forwarding cases and institutional isolation. Care is focused only on the child and/or adolescent who experiences the violence, but not on the family and its broader life context. The withdrawal of children and adolescents from family life has been widely discussed and questioned because, despite existing in the space between the legitimate and the legal, this intervention should be exceptional and relativised and should offer protection against new episodes of violence; family violence is not a synonym of the need for institutional welcoming (Rivett & Kelly 2006).

The literature has emphasised the physical and mental health problems of children and adolescents who experience intimate partner violence against their caregivers, generally their mothers; this form of violence entails important implications for work with vulnerable families, such as maternal empowerment and the parents' support, at the same time as it expands the view to this broader and more immediate context in the children and adolescents' life (Melchiorre & Vis 2013, Roberts *et al.* 2013, Haselschwerdt 2014, Katz *et al.* 2016, Pinna 2016). In East Timor, violence against women was positively associated with childhood morbidity and mortality (Taft *et al.* 2015); in Australia, early interventions with children and families who experienced violence were relevant to breaking with the cycle of cross-generational violence and social exclusion, strengthening the need to redirect attention towards 'what is woven together' (Morin 2008, Spinney 2013).

The perspective on the family and on the community and social context are important factors for enhancing relationships or coping with FVACA (Cismaru 2013). In Chicago, the action of considering and contextualising the neighbourhood structure and the cultural conditions helped to interrupt the cycle of violence (Wright & Fagan 2013). The fact of living in vulnerable communities leads the individuals to confine themselves in their precarious homes, isolated from the problems of their neighbourhood, without access to the services, goods and spaces of the city (Monteiro *et al.* 2015).

Not only specific traumas, but also daily-life pressure, such as economic and social difficulties, have affected the mental and psychosocial health of Palestinian children. Despite the uniqueness of the situation in Palestine, the contextualisation of the phenomenon violence against children and adolescents related to the extension of a problem, the absence of a State structure and the lack of guarantees for human rights influence the health of not only these subjects, but that of their families, as well (Rabaia *et al.* 2014).

The factors referred to in the thematic categories of this study led to the organisational recursion illustrated in Fig. 7, where one factor gives feedback to the other,

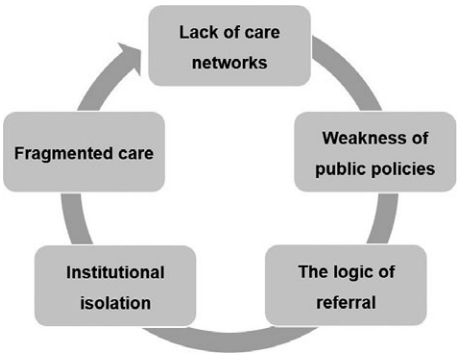

Figure 7 Organisational recursion of the care networks for families involved in family violence against children and adolescents.

preserving the inherent dynamics. The study participants were also involved in the emergence of this fragmented care, and they illuminated routes to overcome it. These routes, called 'linked responses', referred back to network care. It is believed that 'intelligent coordination' will be obtained through this interdisciplinary and intersectorial organisation, so that all stakeholders take responsibility for care and get organised.

Care for the families involved in situations of FVACA is a dynamic and complex phenomenon surrounded by uncertainties. Therefore, fragmented and reductionist action methods and perspectives, or a single institution or dimension, do not cover the inherent totality and frequently do not respect the context of culture and action. The health services in Brazil act on singular points in time in how they cope with violence against women, without guaranteeing the integrality needed in these situations (Vieira *et al.* 2015).

Care as a whole, as mentioned in the previous paragraph, can only be captured through the relationships among the parts. Besides the questions considered, complex and intersectorial actions in a network go beyond borders and respond to the demands through exchanges in health practices; in that context, different social groups are summoned to discuss and construct collective projects (Monteiro *et al.* 2015). A study developed in Malawi demonstrated that the service network can benefit child health care (O'Hare *et al.* 2015), while another study positively associated the poor social network of female sex workers with greater vulnerability to gender violence in China (Hail-Jares *et al.* 2015). The social support network for a child with aggressive behaviour, in another context, contributed to reduce its medicalisation (Becker *et al.* 2014).

In line with the results of the present study, the literature highlights the importance of PHC as a multidimensional strategy for the organisation of health care, which has implications for the performance of all other care contexts (Kringos *et al.* 2010, Lahariya *et al.* 2010); nevertheless, there are great challenges to qualifying this care, especially in service access and coverage (Bryant *et al.* 2012, Thomas *et al.* 2015). PHC also provides organised health care to the population (Kringos *et al.* 2010, Lahariya *et al.* 2010), improves and promotes their equitable access to the health system (Bryant *et al.* 2012), and ensures longitudinal care focused on people and communities, not on their individual diseases (Lahariya *et al.* 2010, Bryant *et al.* 2012).

The interdisciplinary, interinstitutional and intersectorial practices aim for the constitution of unity and integrality, but without causing a loss of multiplicity, which is present in the diversity of the component parts. As family violence is not a temporary traumatic event, the care for children, adolescents and their families involved in this phenomenon is highly complex and requires the cooperation of local and international researchers and professionals that construct pertinent knowledge deriving from each of the participants, including family experience, based on mutual respect and joint learning (Rabaia *et al.* 2014, Turner *et al. in press*).

Finally, it is necessary to broaden our view of violence to discuss and analyse the different facets of this phenomenon around the world properly. Health professionals, especially nurses, should actively participate in this debate due to the prominent place they occupy in healthcare teams, service management, science and the academy. A recent article incorporated some strategies for health professionals to engage in the construction of a culture of peace and prevention of violence, especially in terms of global conflicts, such as: the inclusion of humanitarian care and protection of civilians; the monitoring and disclosure of violations against humanitarian laws; and the description and measuring of the effects of conflicts/wars, including long-term intergenerational effects, through longitudinal studies, to understand prevention and intervention measures (McCoy 2015). These actions should be strategically constructed with other sectors and take form as international interventions.

Conclusion

The results of this study show the need to organise network care for families involved in FVACA, from the PHC perspective. Nevertheless, this construction still represents a challenge, as reduced networks characterised the web of institutions, with low density and high homogeneity of the bonds and noninstitutionalised relationships with a power disequilibrium. Consequently, care has been fragmented since its formulation in the context of public policies until its execution.

The main limitations of this study were the particularities of the study context, such as the organisation of public policies, especially regarding social services. To minimise them, the authors aimed to discuss the data in a broader sense and against the background of the international context. The qualitative nature of this study, conducted in accordance with the theoretical reference framework proposed, allowed the authors to indicate routes to cope with FVACA and to overcome the traditional care models for this phenomenon, which are currently in force. The need for further research is highlighted, which should consider the perspective of the families involved in FVACA regarding social support networks, with a view to understanding the multidimensional nature of the theme and to develop

strategies to prevent and intervene in the violent situations, from the perspective of PHC.

Relevance to clinical practice

Nursing should respond to contemporary care demands in a contemplative and pertinent manner. The nurse is always present in healthcare institutions, especially in PHCU, and provides direct and constant care to individuals, families and communities. Thus, this professional is an important agent to implement new care approaches and can directly influence other healthcare team members and other health sectors. Current care demands surpass the logic of the opposition between health and disease and are related to complex phenomena, such as care for families involved in FVACA. The considerations in this study aim to arouse health professionals to take a fresh look at this complex problem that consists of multiple determining and conditioning factors. In addition, the reference framework and the consequent actions also need to be changed to a broader and more contextualised form, including a multidimensional approach to the families and community in which the child and adolescent victims of violence exist.

The empowerment of PHC as the care coordination centre for families and communities, with interdisciplinary, interinstitutional and intersectorial articulation, has also been recommended by the scientific literature and official entities. In addition, the construction and enactment of comprehensive public policies that guarantee community participation should approach these guidelines and then produce care that guarantees the physical and mental health of children, adolescents and their families. As nurses occupy a privileged space in the health system, they can improve their working skills by: (1) providing holistic care centred on the family and the community; (2) seeking the logic of health promotion and individual and collective empowerment; (3) focusing on care from the PHC perspective; (4) actively participating in an interdisciplinary care team; and (5) acting at interinstitutional and intersectorial levels to overcome health institution barriers.

Contributions

Study design: DC, MF; data collection and analysis: DC, EP, LS, WM, MF; and manuscript preparation; DC, EP, LS, MS, ML.

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Conflict of interest

No conflict of interest has been declared by the authors.

Ethical considerations

The study was submitted for analysis to the Institutional Review Board of the University of São Paulo at Ribeirão Preto College of Nursing, in compliance with Resolution 196/96 of the National Health Council, Brazilian Ministry of Health, and considered approved on 14/11/12 (protocol CAAE 01726512.0.00005393, letter 217/2012).

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